

**STRENGTHENING MEDICAID AND PRIORITIZING
THE MOST VULNERABLE**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
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¹ Mr. Roy did not submit a response to questions for the record.

² Mr. McCarthy did not submit a response to questions for the record.

³ The information can be found at: <https://docs.house.gov/meetings/IF/IF14/20170201/105498/HHRG-115-IF14-20170201-SD006.pdf>.

²⁴ The information can be found at: <https://docs.house.gov/meetings/IF/IF14/20170201/105498/HHRG-115-IF14-20170201-SD003.pdf>.

STRENGTHENING MEDICAID AND PRIORITIZING THE MOST VULNERABLE

WEDNESDAY, FEBRUARY 1, 2017

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

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 Rayburn House Office Building, Hon. Michael Burgess (chairman of the subcommittee) presiding.

Present: Representatives Burgess, Guthrie, Barton, Upton, Shimkus, Murphy, Blackburn, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Eshoo, DeGette, and Pallone (ex officio).

Also present: Representatives Flores and Ruiz.

Staff present: Ray Baum, Staff Director; Mike Bloomquist, Deputy Staff Director; Elena Brennan, Legislative Clerk, Oversight and Investigation; Karen Christian, General Counsel; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Paul Edattel, Chief Counsel, Health; Blair Ellis, Digital Coordinator/Press Secretary; Caleb Graff, Policy Advisor; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Director of Communications; Peter Kielty, Deputy General Counsel; Katie McKeough, Press Assistant; James Paluskiewicz, Professional Staff, Health; Mark Ratner, Policy Coordinator; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Health Counsel, Health; Luke Wallwork, Staff Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Olivia Pham, Minority Health Fellow; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; C.J. Young, Minority Press Secretary.

Mr. BURGESS. My gosh, everything is new up here. I have got all kinds of buttons. I can actually silence you, Mr. Green, if I need to.

Mr. GREEN. Mr. Chairman, you know I don't need a mike.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Well, I want to welcome everyone of course back to the 2123. It is the best room in the Rayburn Building. Welcome

you to the first Subcommittee of Health hearing for this year. It is likely to be a very active term in the United States Congress on health care.

There are members of the full committee who have asked to waive onto this committee for the purposes of this hearing, so I will ask unanimous consent for Dr. Ruiz when he gets here, but right now I will ask for unanimous consent for Mr. Flores to be on this committee. Without objection, so ordered.

I will recognize myself 5 minutes for the purpose of an opening statement. Medicaid, a state and federal partnership designed as a safety net for the country's most vulnerable has grown at a very rapid rate. Today's Medicaid program is three times larger by enrollment and by spending than it was in 1997 under President Bill Clinton. This safety net program will cover up to 98 million people this year and will cost the taxpayers more than \$600 billion.

As a physician I have had the privilege of providing health care for hundreds of Medicaid patients. I have looked into their eyes, I have listened to their concerns, I have held their hands, I have delivered their babies, and I know of their stories. Now I have the privilege of trying to help many patients like this by holding this chair and by working with each of you on the subcommittee and the full committee to improve and modernize the Medicaid program.

As we embark on a new Congress together, while I know we will have real differences, I hope we can agree on some shared goals to improve the Medicaid program to provide access and high quality care to those who truly need it. Today we will start by examining targeted common sense steps that can be taken to cut states' cost and prioritize care for vulnerable patients who are awaiting access to Medicaid services.

One of the bills we will consider addresses an area of concern that states have repeatedly requested to Congress that they examine. Individuals seeking Medicare coverage for long-term care must have assets below established thresholds to be eligible. Medicaid's treatment of married couples' resources has resulted in a loophole that allows the community spouse to shield assets by purchasing an annuity that is not counted against asset thresholds.

Representative Mullin has written the Close Annuity Loopholes in Medicaid Act to put a stop to this gaming of the system. His bill would make half of the income generated from an annuity purchased by a community spouse within the 60-month look-back period that would count toward the institutionalized spouse's financial eligibility.

Another bill we will consider today originated with the state emailing the committee to express a concern. The Affordable Care Act required states to use the modified adjusted gross income for income calculations for determining Medicaid eligibility. Eligibility for Medicaid applicants is based on a monthly household income. Irregular income received as a lump sum such as a lottery or gambling winning, one-time gifts or inheritance is counted as income only in the month received. This means that lottery winners have been allowed to retain taxpayer-financed Medicaid coverage.

Representative Upton's bill would close this loophole. This bill would require states to consider monetary winnings from lotteries

as if they were obtained over multiple months for the purposes of determining eligibility. This provides a scalable approach so individuals with high-dollar winnings are kept off the program for an appropriate time.

Finally, each of these bills we are considering allocate some portion of the dollars saved into the Medicaid Improvement Fund to be used for the purposes of improving access to care for the vulnerable and needy individuals currently on Medicaid waiting lists.

While we will have additional hearings on Medicaid in the weeks and months to come, this hearing is focused on narrow issues and will cover bills that have been introduced in prior congresses. We all agree that it is important to secure care and keep our commitment to vulnerable Americans; I hope that we can begin by taking these small steps forward to put Medicaid spending on a sustainable path.

I would now like to yield the remaining time to Representative Flores to speak about his bill that we will be considering today.

[The statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

The Subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

Medicaid—a state-federal partnership designed as a safety net for the most vulnerable—has grown at a rapid rate. Today’s Medicaid program is three times larger-by enrollment and spending—than it was in 1997 under President Bill Clinton. This safety-net program will cover up to 98 million people this year, and will cost taxpayers more than \$600 billion.¹

As a physician, I have had the privilege of actually providing health care for hundreds of Medicaid patients. I have looked in their eyes, I have listened to their concerns, I have held their hands, and I know many of their stories. Now I have the privilege of trying to help many patients like this, by holding this Chair and by working with each of you to improve and modernize the Medicaid program. As we embark on this new Congress together, while I know we will have real differences, I hope we can agree on our shared goal: to improve the Medicaid program to provide access to high-quality care for those who truly need it.

Today we will start by examining targeted, commonsense steps that can be taken to cut states’ costs, and prioritize care for vulnerable patients who are waiting to access Medicaid services.

One of the bills we will consider addresses an area of concern states have repeatedly requested Congress examine. Individuals seeking Medicaid coverage for long-term care must have assets below established thresholds to be eligible. Medicaid’s treatment of married couples’ resources has resulted in a loophole that allows the community spouse to shield assets by purchasing an annuity that is not counted against current asset thresholds. Representative Mullin has authored the Close Annuity Loopholes in Medicaid Act, to put a stop to this gaming of the system. His bill would make half of the income generated from an annuity purchased by a community spouse within the 60-month lookback period countable towards the institutionalized spouse’s financial eligibility.

Another bill we will consider today originated with a State emailing the Committee to express a concern. The ACA required states to use Modified Adjusted Gross Income (MAGI) for income calculations for determining Medicaid eligibility. Under MAGI, eligibility for Medicaid applicants is based on monthly household income. Irregular income received as a lump sum, such as lottery or gambling winnings, one-time gifts, or inheritances, is counted as income only in the month received. This means that lottery winners are been allowed to retain taxpayer-financed Medicaid coverage.

Representative Upton’s bill would close this loophole. This bill would require states to consider monetary winnings from lotteries as if they were obtained over multiple months for purposes of determining eligibility. This provides a scalable ap-

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

proach so individuals with high-dollar winnings are kept off the program for an appropriate time.

Finally, each of these bills we are considering allocate some portion of the dollars saved in to the Medicaid Improvement Fund, to be used for the purpose of improving access to care for the vulnerable and needy individuals currently on Medicaid waiting lists.

While we will have additional hearings on Medicaid in the weeks and months to come, this hearing is focused on narrow issues and will cover bills that have been introduced in prior Congresses. We all agree that it is important to secure care and keep our commitment to vulnerable Americans. I hope that we can begin by taking these small steps forward to put Medicaid spending on a sustainable path.

With that, I'll yield to Representative Flores to speak about his bill, which we will be considering today.

Mr. FLORES. Thank you for yielding, Chairman Burgess. Chairman Burgess and Ranking Member Green, thank you for having me here this morning for this important hearing. I appreciate the opportunity to work with you to strengthen Medicaid and prioritize health care for our most vulnerable citizens. I also want to thank each of our witnesses for being here today. It is crucial that we work to identify and prioritize the populations that stand to benefit most from reform to our current health care system.

Today a growing number of hardworking Americans are on Medicaid enrollment waiting lists in all 50 states. At the same time, other populations who do not qualify are enrolling in Medicaid and hurting access for our nation's truly vulnerable populations. The Verify Eligibility for Coverage Act before us this morning addresses this issue. This bill prioritizes our neediest Medicaid populations by not forcing states to provide coverage for new applicants in Medicaid until those applicants have provided satisfactory documentation of lawful presence in the United States.

Again I thank the chairman and ranking member. These Medicaid improvement bills before us today are reason for great optimism for our most vulnerable populations. Mr. Chairman, I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. It is not lost on me that we are meeting today, well, of course this is the Dingell Committee Room, but also known unofficially as the Green Room. So it is now the chair's privilege to recognize the subcommittee ranking member, Mr. Green, 5 minutes for an opening statement, please.

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

Mr. GREEN. Thank you, Mr. Chairman, and I appreciate that. It was my decision but I want to thank the previous chairman and the current chairman for leaving the beautiful green walls. Thank you, Mr. Chairman, and congratulations on your chairmanship. I look forward to continuing to work with you on issues. We have done that over the years.

Medicaid is a lifeline, the safety net for more than 74 million Americans who depend on it for coverage. One in every five Americans receive health coverage from the Medicaid including 12 million people who now have health insurance thanks to the Affordable Care Act's expansion of Medicaid for low-income adults. It is the primary health insurer for ten million Americans with disabilities, finances more than half the births, and is a main source of

long-term care coverage. In fact, one in seven seniors on Medicaid and 70 percent of all nursing home residents rely on the program.

Today's hearing is entitled Strengthening Medicaid and Prioritizing the Most Vulnerable. Medicaid is both strong and protects the vulnerable, and this idea of covering one population deemed less vulnerable as done at the expense of another more vulnerable population is just wrong both morally and factually. Health insurance is a right and coverage and benefits are not a zero-sum game.

The idea of pitting one population or one benefit in a program against another is a red herring. It is in a poorly disguised plot to limit access/benefits and punish low-income Americans by undermining the effectiveness of the program. Medicaid is a health care safety net for coverage and this notion of one group being more vulnerable and thereby we should take money away from the other types of beneficiary goes against the intent of the program.

Medicaid is strong. It provides comprehensive care at a lower cost than private insurance. It is true that total Medicaid spending has grown significantly, but increased coverage has been overwhelmingly the driver. Enrollment growth is a cause for celebration not a reason to undermine the program. It is baffling that we have a debate on whether a person having health insurance is a good thing.

A part of the enrollment growth is driven by the ACA's Medicaid expansion which has helped drive the uninsured rate to 8.6 percent, the lowest in our history. States that expanded Medicaid have not only increased, seen increase in health coverage, but has also seen savings in their health budgets. Medicaid beneficiaries, those under a hundred percent of the federal poverty level and the expansion population which fall between 100 and 135 percent of federal poverty level, are not fat cats draining the system. For the overwhelming majority of them private insurance is not an option financially and Medicaid allows them to work more hours and care for their families and seek higher paying jobs.

More than 550,000 of my constituents fall into the Medicaid expansion gap because Texas refused to almost a \$100 billion in federal money over a decade left them without an option. The idea that being uninsured is somehow better than having Medicaid flies in the face of simple logic. Being uninsured is a terrible situation. One illness can mean bankruptcy and the only point of access to care is through the emergency room.

But even if that doesn't persuade you, having a large number of uninsured population is bad for everyone, for folks with coverage through their employers by driving up premiums, physicians and hospitals and state budgets. I hear from constituents every day about how coverage has literally saved their life and would hear from more in Texas if it would stop engaging in legislative malpractice and act in the state's best interest.

Last Congress and the congresses before we worked together on meaningful strengthening of Medicaid, expanding benefits, shoring up program integrity, and streamlining the program. The proposal before us today score a savings because they will delay or deny coverage to some or redirect funds to states that choose to operate waiting lists for Medicaid home and community based services.

The idea that states have waiting lists because resources had to be diverted to expand Medicaid doesn't hold water. It is absolutely no correlation between states' coverage levels and waiting lists for home and community based services. Texas has the biggest waiting list in the country but didn't expand Medicaid, while 12 of the states that did expand operate no waiting lists for these services of any kind.

The right way to truly strengthen Medicaid for the future is to build on the ACA with expanded coverage, promoting program integrity and transparency and advanced delivery system reform in the program. I think every member of our committee is a problem solver. If we have a problem we want to deal with it. I am glad to work with anyone to solve problems, but we will fight with all our means to save the safety net of our low-income and oldest and youngest Americans.

I thank you, Mr. Chairman, and I yield back my time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair would ask unanimous consent that Dr. Ruiz be waived onto the subcommittee for the purpose of this hearing. Without objection, so ordered.

The chair now recognizes the chairman of the full committee, Mr. Walden, 5 minutes for an opening statement, please.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Well, Mr. Chairman, thank you. And before the clock starts I just want to commend former Chairman Upton, I guess, on the color choice. And Mr. Green, I know that makes you happy. I hope what comes up next makes everyone happy because we have this new—we have new electronics. Oh, look at that, the University of Oregon. That will now be a permanent feature since I thought it actually went with the green. Are you OK with that?

I would like to yield to the gentleman from Clackamas County. Is that all right, Kurt? I can't get an orange one.

Mr. SCHRADER. Yes. No, I think this is a good example of how this committee is very bipartisan, sir.

Mr. WALDEN. That is right. All right, thank you very much, Mr. Chairman. Thanks for your leadership. This does mark the first hearing of the Health Subcommittee in this new Congress with a physician heading the subcommittee and with other professional physical and mental health care providers in key roles. Let there be no mistaking our intention. We will modernize America's health care laws by putting what is best for the patient as our top priority.

The days of putting overbearing, unaccountable Washington bureaucrats and their tens of thousands of pages of regulations first are over. Today we embark afresh on our efforts to strengthen, improve, and modernize America's Medicaid program. We share a common goal of making sure that those most in need of medical services in our communities get better quality affordable care. That is our shared goal.

We are committed to protecting patients and to supporting innovative patient-centered solutions at the state and local levels. We recognize the Medicaid program is critically important. It is a safe-

ty net for millions of Americans, Americans who are elderly, Americans who are low-income, or Americans who are blind or have disabilities. Individuals and families served by Medicaid are not just program enrollees, they are our neighbors. They are our friends.

Today we begin our work to modernize Medicaid and we turn to experts who have researched creative strategies to give us guidance on what is working and what is not. We should view our states as partners in a common cause to bring about a fresh approach to a big government program that began a half a century ago or more when Washington bureaucrats thought they knew what was best.

I want to commend our Health Subcommittee who worked hard last Congress to identify and adopt measures which would improve access to care for patients, empower states with more flexibility and tools, and yield better care for patients, but no, that was just scratching the surface. Our talented and experienced witnesses today offer us a set of new ideas and they offer us their counsel and how we can improve our own members' bills. Thank you for your input.

You can sense an eagerness among governors whom I have met with, and state Medicaid directors and think tanks who for the first time in a long time realize they actually have a partner who is serious about hearing from them and working with them to transform the most expensive health care system in the world into the most modern patient-centered, outcome-based model known around the globe. That is our opportunity here. They are overflowing with better ways to deliver health care to our most needy citizens.

I have read all of your testimony, it is terrific, and I hope you have only just begun to give those ideas to us. We have an obligation to improve Medicaid. We can make it more than just our country's safety net that catches people when they are down and out. We can do better than that. We can empower states to innovate, to harness savings and enhance the actual health of the patients who have been waiting years for a Washington bureaucrat to decide to throw the kill switch on every new idea.

The legislation we will consider today originates from our members listening to their constituents and state leaders back home who believe we have not done enough to root out waste, fraud, and abuse. Our committee was reminded of that yesterday in the Oversight subcommittee chaired by Mr. Murphy where we heard from the GAO and the HHS Office of Inspector General that for 14 years Medicaid has remained on the list of high-risk programs and that those tasked with identifying and preventing waste, fraud and abuse are still frustrated in their jobs because they cannot get the data, and the program's lack of transparency.

Prioritizing the most vulnerable and those in need necessarily requires setting priorities, so today we consider three proposals which make common sense changes to close loopholes, root out abuses and target savings to help patients most in need. A portion of those savings from each of these reforms would go to help individuals on Medicaid waiting lists for home and community based services.

These bills improve Medicaid. They help patients by scrapping outdated rules or correcting unintended consequences from existing

federal policy. Consider this just the start of our work as we identify other red tape and outdated requirements that add costs and deny care to those truly in need. So in the months and weeks ahead we look forward to hearing from you and others in our work because we want to give states more choices, more tools, more flexibility, all toward the goal of improving health care choices and affordability for patients.

With that I would yield to Markwayne Mullin the remainder of my time.

[The statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

This marks the first hearing of the Health Subcommittee in the new Congress. With a physician heading this subcommittee and with other professional physical and mental health care providers in key roles, let there be no mistaking our intention: We will modernize America's health care laws by putting what's best for the patient as our top priority.

The days of putting overbearing, unaccountable Washington bureaucrats and their tens of thousands of pages of regulations first are over.

Today, we embark afresh in our efforts to strengthen, improve, and modernize America's Medicaid program. We share a common goal of making sure that those most in need in need of medical services in our communities get better quality, affordable care. We are committed to protecting patients and to supporting innovative, patient-centered solutions at the state and local levels.

We recognize the Medicaid program is a critically important safety net for millions of Americans—Americans who are elderly, low-income, or Americans who are blind or have disabilities. Individuals and families served by Medicaid are not just program enrollees, they are our neighbors, and our friends.

Today we begin our work to modernize Medicaid. And we turn to experts who have researched creative strategies to give us guidance on what's working and what's not. We should view our states as partners in a common cause to bring a fresh approach to a big-government program begun a half-century ago when Washington bureaucrats thought they knew what was best.

I want to commend our Health Subcommittee who worked hard last Congress to identify and adopt measures which would improve access to care for patients, empower states with more flexibility and tools, and yield better care for patients, but know that was just scratching the surface.

Our talented and experienced witnesses today offer us a new set of ideas, and counsel on how we can improve our own members' bills. Thank you for your input.

You can sense an eagerness among governors and state Medicaid directors and think tanks who for the first time in a long time realize they have a partner who is serious about hearing from them and working with them to transform the most expensive health care system in the world into the most modern, patient-centered, outcome-based model known around the globe. They are overflowing with better ways to deliver health care to our most needy citizens. And I hope we've only just begun to hear from them.

We have an obligation to improve Medicaid. We can make it more than just our country's safety net that catches people when they are down and out. We can empower states to innovate, to harness savings and enhance the actual health of the patients without having to wait years for a Washington bureaucrat to decide to throw the kill switch on a new idea.

The legislation we will consider today originates from our members listening to their constituents and state leaders back home who believe we have not done enough to root out waste, fraud and abuse. Our committee was reminded yesterday in the Oversight Subcommittee hearing by the GAO and the HHS Office of Inspector General that for 14 years Medicaid has remained on the list of "high risk" programs and that those tasked with identifying and preventing waste, fraud and abuse are frustrated in their jobs by a lack of data and transparency.

Prioritizing the most vulnerable and those in need necessarily requires setting priorities. So, today we consider three proposals which make common-sense changes to close loopholes, root out abuses and target savings to help patients most in need. A portion of the savings from each of the reforms would to help individuals on Medicaid waiting lists for Home and Community Based Services.

These bills improve Medicaid and help patients by scrapping outdated rules or correcting unintended consequences from existing federal policies. Consider this just the start of our work to identify red-tape and outdated requirements which add costs and deny care to those truly in need.

In the weeks and months to come, we will actively work modernize Medicaid by giving our states more choices, more tools, more flexibility-all toward the goal of improving the health care choices and affordability for patients.

Mr. MULLIN. Thank you, Mr. Chairman. It is an honor to sit on the Health Subcommittee and I am looking forward to reforming health care with my colleagues in Congress. Our Medicaid system is in drastic need to reform. In my bill, Close the Annuity Loopholes in Medicaid, or the CALM Act, closes an obvious loophole. The CALM Act makes sure that individuals with significant means do not take advantage of Medicaid by hiding some of their assets.

Currently, some married couples are allowed to mask their assets by purchasing an annuity that pays out to their spouse. This also allows a couple to hide their true net worth when applying for Medicaid coverage. My bill closes the loophole and directs the savings to help those who are waiting for home and community based services. It is an easy loophole to close and I look forward to passing this with other Medicaid reform legislation to make Medicaid stronger. Thank you, Mr. Chairman, and I yield back.

Mr. BURGESS. The chair thanks the gentleman and the gentleman yields back. The chair now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement, please.

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

Mr. PALLONE. Thank you, Mr. Chairman. Since 1965, the Medicaid program has been an invaluable resource to poor families, pregnant women, children, seniors, and now thanks to the Affordable Care Act low-income working adults. It is also the program that individuals with disabilities depend on to maintain independence in the community. In 2016, over 97 million Americans depended on Medicaid at some point during the year. Together, Medicaid and CHIP cover one in three children in this country and nearly half of all births. It is undeniable that Medicaid coverage pays us back as a society tenfold and that is why improving and strengthening Medicaid for generations to come continues to be one of our primary goals.

Last Congress this committee worked together on targeted policies that generally strengthen and improve the Medicaid program for beneficiaries. Unfortunately the bills before us today do not share these priorities. In fact, one piece of legislation continues the Trump administration's assault against our legal permanent resident population and naturalized citizens.

The Republican strategy to strengthen Medicaid is to remove or exclude certain people from the program and then apply those resources to another person and this is a meaningless approach to resource management. There is no evidence to suggest that some beneficiaries take away resources from others or that excluding some beneficiaries will benefit others.

In today's hearing we will discuss three bills that are based on this very falsehood, bills that target specific beneficiaries for exclusion, bills that ultimately incentivize and reward those states that choose to operate waiting lists for home and community based services. In order to truly strengthen the Medicaid program we should expand coverage, protect against fraud and implement advanced delivery system reform, and the Affordable Care Act did just that. Thanks to the Affordable Care Act, 31 states and the District of Columbia have adopted expansion and dramatically lowered the uninsured rate.

All 50 states are testing innovative models of care and Medicaid eligibility and data collection systems have been modernized. Medicaid has always been under attack by Republicans, but the threat to this program and to its beneficiaries is more dangerous than ever before. Republican policies to cap or turn the program into a block grant would result in the rug being pulled out from under millions of children, elderly, individuals with disabilities, and low-income working adults.

These policies are nothing but bad for our providers and our state economics. In fact, one analysis by the Kaiser Family Foundation found that block-granting Medicaid would lead states to drop between 14.3 million and 20.5 million people from Medicaid, an enrollment decline of 25 to 35 percent, and would lead states to cut provider reimbursements by more than 30 percent.

Now I know my Republican colleagues keep saying they have a plan and that Americans will not lose their health coverage. But I think it is clear today that the Republicans' only game plan right now is to sabotage health coverage for tens of millions of Americans. I yield the remaining time to Mr. Luján from New Mexico.

Mr. LUJÁN. Thank you, Mr. Pallone. Hypocrisy isn't a term that I use lightly. Unfortunately today hypocrisy is the word that readily comes to mind. Let's start with the Republican title of this hearing: Strengthening Medicaid and Prioritizing the Most Vulnerable. Actions speak louder than words. Let's talk about what this hearing is really all about. My Republican colleagues are holding this hearing to lay the groundwork for ripping health insurance from millions of Americans.

Now I believe that access to affordable and quality health care is a right for all, not a privilege for some. We would be never be having a conversation like this if the topic wasn't Medicaid. If we were having a hearing on Medicare we would be talking about real ways to better serve beneficiaries, yet when it comes to health care for working families struggling to make ends meet, mainly those on Medicaid, all my Republican friends do is talk about how to cut-cut-cut and strip away access to care from millions of Americans.

Gutting Medicaid would be a disaster for 74 million Americans including nearly a million New Mexicans. Why would anyone want a less healthy country? And just listen to the argument my Republican colleagues are making, fewer people having health insurance and access to care is good for America. It is bad for America, a country with fewer health care jobs and a country with more working class families that could lose everything because of a health emergency like a car accident or a cancer diagnosis.

I have to believe this comes down to the fact that the leaders of the Grand Old Party don't think that some people are grand enough to deserve health care. That is wrong. And that is why the cloud of hypocrisy hangs over these discussions today and every day that we continue to discuss Medicaid solely through the lens of what Republicans can cut and how we can improve things for those millions of seniors and working families served by this program. With that I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. This concludes member opening statements. The chair would remind members that pursuant to committee rules, all members' opening statements will be made part of the record.

And we do want to thank our witnesses for being here this morning taking of your time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement and this will be followed by a round of questions from members. Our witnesses this morning are Dr. Avik Roy, the president of the Foundation for Research on Equal Opportunity; Mr. John McCarthy, the former director of the Ohio Department of Medicaid and the former deputy director of the DC Department of Health Care Finance; and Ms. Judith Solomon, vice president for health policy at the Center on Budget and Policy Priorities.

We do appreciate each of you being here today. We will begin the panel with Dr. Roy, and you are recognized for 5 minutes for the purpose of summarizing your opening statement, please.

STATEMENTS OF AVIK S. A. ROY, PRESIDENT, FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY; JOHN MCCARTHY, CEO OF UPSHUR STREET CONSULTING; AND JUDITH SOLOMON, VICE PRESIDENT, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF AVIK S. A. ROY

Mr. ROY. Thank you, Mr. Chairman, Chairman Burgess and Chairman Walden, Ranking Member Green, members of the Health Subcommittee of the Energy and Commerce Committee. Thanks for inviting me here today for your premier hearing as chairman.

My name is Avik Roy. I am the president of the Foundation for Research on Equal Opportunity, a nonpartisan, nonprofit think tank focused on expanding economic opportunity to those who least have it. In my remarks I will discuss Medicaid's poor health outcomes. I will describe why the program's outdated design is directly responsible for those outcomes and I will explore some avenues for reform.

Studies consistently show that patients on Medicaid have the worst health outcomes of any insurance program in America, far worse than those with private insurance and, strikingly, no better than those with no insurance at all. It seems inconceivable that we could spend \$450 billion a year on Medicaid without any improvement in health outcomes on average, but the evidence is overwhelming and it is detailed in my written testimony.

Why do patients fare so poorly on Medicaid? The key reason is that Medicaid pays physicians far below market rates to care for

Medicaid beneficiaries. In 2008, according to CMS, Medicaid paid physicians approximately 58 percent of what private insurers pay them for comparable services. These disparities have only increased over the ensuing decade. Surprisingly, a 2007 study by MIT economists Jonathan Gruber and David Rodriguez found that doctors fare even better treating the uninsured, economically, than they do caring for those on Medicaid because getting paid in cash by the uninsured is better than getting paid through Medicaid.

As a result of these disparities in reimbursement, fewer physicians accept Medicaid enrolled patients. Internists are 8.5 times as likely to refuse to accept any Medicaid patients relative to those with private insurance. Physicians are six times more likely to deny an appointment to children on Medicaid suffering from serious medical conditions like a broken arm or an acute asthma attack relative to those with private insurance. Without consistent access to physicians, Medicaid enrollees don't get their cancer diagnosed until it is too late, they don't receive adequate care for problems like diabetes and heart disease until it is too late.

So why is it that Medicaid's reimbursement rates are so low? It is because of the flawed way in which the program was designed in 1965. Medicaid as you know is jointly funded by state governments and the federal government, but because neither states nor Washington have full responsibility for the program both parties have engaged in irresponsible behavior.

As Medicaid has grown over time, state budgets have come under increasing strain. States' Medicaid obligations now crowd out spending on teachers, police and roads. But it is mostly illegal for states to increase co-pays, deductibles or premiums for Medicaid enrollees. Moving people off of the Medicaid rolls is highly controversial, and most attempts by state governments to enact minor programmatic changes must survive as you know this lengthy waiver process with HHS.

Federal law in some cases forces states to spend Medicaid dollars on people who don't need the help. For example, lottery winners who receive a lump sum payment in 1 month but have zero income for the rest of the year are eligible for Medicaid 11 months out of 12. Individuals whose spouses receive large annuities remain eligible in some cases for the Medicaid long-term care program.

Federal law also requires states to provide Medicaid funds to new enrollees for a period of time even if they have not documented that they legally reside in the U.S. and are therefore eligible for such funds. These provisions put additional pressure on states to reduce Medicaid spending and reimbursement rates for the vulnerable populations that the program was designed to help. The vast majority of states have responded to these constraints in exactly that way by reducing Medicaid's reimbursement rates to health care providers, paying hospitals and doctors less for the same level of service.

The Health Subcommittee is considering legislation that would address some of these problems and I look forward to exploring those ideas with you at this hearing. I know that many of you believe as I do that we can do much more to improve the quality of care and coverage for Americans below the poverty line.

At the Foundation for Research on Equal Opportunity, we have published a detailed and wide-ranging health reform proposal called Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency. We estimate that the plan would cover 12 million more people than current law, dramatically improve health outcomes for the poor by taking the dollars we spend on acute care Medicaid and giving them to patients in the form of refundable tax credits that can be used to purchase private coverage and build Health Savings Accounts.

Per capita caps, a reform contemplated by this subcommittee, can also be structured in a similar way. Aside from the fact that private coverage is superior to Medicaid coverage, integrating Medicaid enrollees into an individual health insurance coverage will ensure that as their incomes go up and down they can remain in one insurance plan in one physician network and thereby gain a continuity of care that they do not have in today's system.

This Congress has a once-in-a-generation opportunity to transform the quality of coverage and care that we offer to the neediest amongst us. I look forward to your questions and to being of further assistance to this committee. Thank you.

[The statement of Avik S. A. Roy follows:]



TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Committee on Energy & Commerce
Subcommittee on Health

STRENGTHENING MEDICAID

Improving Access to Care
and Health Outcomes for the Poor

AVIK S. A. ROY

President
The Foundation for Research on Equal Opportunity

February 1, 2017

The Foundation for Research on Equal Opportunity (FREOPP) is a non-partisan, non-profit, 501(c)(3) organization dedicated to expanding economic opportunity to those who least have it. FREOPP does not take institutional positions on any issues. The views expressed in this testimony are solely those of the author.

INTRODUCTION

Medicaid, enacted in 1965 under Lyndon Johnson's "Great Society" initiative, was designed to provide health coverage to low-income Americans, especially those with incomes below the Federal Poverty Level. The Affordable Care Act expands eligibility for Medicaid to individuals with incomes below 138 percent of the Federal Poverty Level.

However, under the June 2012 U.S. Supreme Court opinion in *NFIB v. Sebelius*, states can choose whether or not to expand their Medicaid programs along the ACA's lines. As of January 2017, 31 states and the District of Columbia have chosen to participate.

Studies consistently show that patients on Medicaid have the worst health outcomes of any insurance program in America—far worse than those with private insurance and, strikingly, no better than those with no insurance at all. Access to a robust market for private coverage could significantly improve health outcomes for the poor, without increasing federal spending.^{1,2}

MEDICAID'S POOR HEALTH OUTCOMES

A landmark study published in the *New England Journal of Medicine* compared health outcomes for Oregon residents who had won a lottery to enroll in that state's Medicaid program with demographically similar residents who had lost the lottery and remained uninsured.

After following these individuals for two years, the authors found that Medicaid "generated no significant improvement in measured physical outcomes" such as mortality, high blood pressure, high cholesterol, and diabetes.³

Other studies have found similar results. A University of Virginia study published in the *Annals of Surgery* examined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007.⁴

The authors divided their patient population by the type of insurance they held—private, Medicare, Medicaid, and uninsured—and adjusted the database to control for age, gender, income, geographic region, operation, and comorbid conditions. That way, they could correct for the obvious differences in the patient populations (for example, older and poorer patients are more likely to have ill health).

They then examined three measurements of surgical outcome quality: the rate of in-hospital mortality; average length of stay in the hospital (longer stays in the hospital are a marker of poorer outcomes); and total costs.

¹ Roy A, Oregon Study: Medicaid 'Had No Significant Effect' On Health Outcomes vs. Being Uninsured. *Forbes*. 2013 May 2; <http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicaid-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/#4829d92173aa>.

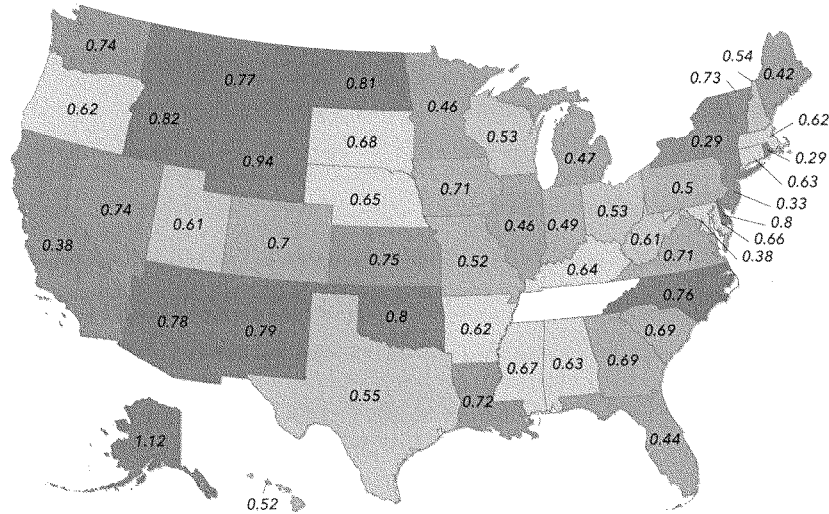
² Roy A, *How Medicaid Fails the Poor*. Encounter Books. 2013.

³ Baicker K et al., The Oregon experiment—effects of Medicaid on clinical outcomes. *New England Journal of Medicine*. 2013 May 2; 368(18): 1713–22.

⁴ LaPar DJ et al., Primary payer status affects mortality for major surgical operations. *Annals of Surgery*. 2010 Sep; 252(3): 544–51.

The in-hospital death rate for surgical patients with private insurance was 1.3 percent. Medicare, uninsured, and Medicaid patients were 54 percent, 74 percent, and 97 percent, respectively, more likely to die than those with private insurance.

Figure 1. Medicaid Reimbursement Rates for Primary Care, vs. Private Insurers, 2008



States have reduced Medicaid reimbursements to physicians in response to fiscal pressures.

States that have been most aggressive in expanding eligibility and services within their Medicaid programs—like California, New York, and New Jersey—have faced the most pressure to reduce reimbursement rates to physicians and hospitals. (Source: Urban Institute, FREOPP analysis)

The average length of stay in the hospital was 7.38 days for those with private insurance; on an adjusted basis, those with Medicare stayed 19 percent longer; the uninsured stayed 5 percent shorter; and those with Medicaid stayed 42 percent longer.

Total costs per patient were \$63,057 for private insurance; Medicare patients cost 10 percent more; uninsured patients 4 percent more; and Medicaid patients 26 percent more.

A University of Pennsylvania study published in *Cancer* found that, in patients undergoing surgery for colon cancer, the mortality rate was 2.8 percent for Medicaid patients, 2.2 percent for uninsured patients, and 0.9 percent for those with private insurance.⁵ The rate of surgical complications was highest for Medicaid, at 26.7 percent, as compared with 24.5 percent for the uninsured and 21.2 percent for the privately insured.

A Columbia-Cornell study in the *Journal of Vascular Surgery* examined outcomes for vascular disease. Patients with clogged blood vessels in their legs or clogged carotid arteries (the arteries of the neck that feed the brain) fared worse on Medicaid than did the uninsured; Medicaid patients outperformed the uninsured if they had abdominal aortic aneurysms.⁶

A study of Florida patients published in the *Journal of the National Cancer Institute* found that Medicaid patients were 6 percent more likely to have late-stage prostate cancer at diagnosis (instead of earlier-stage, more treatable disease) than the uninsured; 31 percent more likely to have late-stage breast cancer; and 81 percent more likely to have late-stage melanoma.⁷ Medicaid patients did outperform the uninsured on late-stage colon cancer (11 percent less likely to have late-stage cancer).

A University of Pittsburgh study of patients with throat cancer, published in *Cancer*, found that patients on Medicaid or without insurance were three times as likely to have advanced-stage throat cancer at the time of diagnosis, compared with those with private insurance. Those with Medicaid or without insurance lived on for a significantly shorter period than those with private insurance.⁸

A Johns Hopkins study of patients undergoing lung transplantation, published in the *Journal of Heart and Lung Transplantation*, found that Medicaid patients were 8.1 percent less likely to be alive ten years after their transplant operation, compared with those with private insurance and those without insurance. Medicaid was a statistically significant predictor of death three years after transplantation, even after controlling for other clinical factors. Overall, Medicaid patients faced a 29 percent greater risk of death.⁹

LOW REIMBURSEMENT RATES RESULT IN POOR PHYSICIAN ACCESS

Why do patients fare so poorly on Medicaid? The key reason is that Medicaid pays physicians far below market rates to care for Medicaid beneficiaries.

In 2008, according to the Centers for Medicare and Medicaid Services, as shown in *Figure 1*, Medicaid paid physicians approximately 58 percent of what private insurers paid them for comparable services. These disparities have only increased over the ensuing decade.

⁵ Kelz RR et al., Morbidity and mortality of colorectal carcinoma surgery differs by insurance status. *Cancer*. 2004 Nov; 101(10): 2187–94.

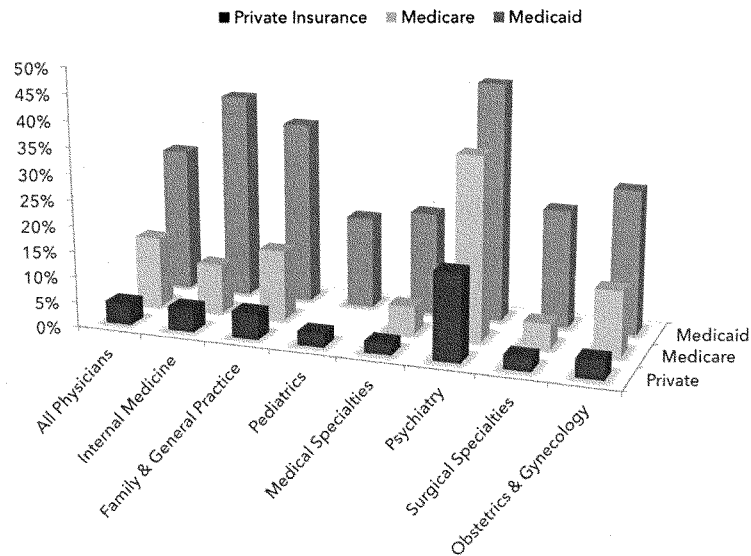
⁶ Giacobelli JK et al., Insurance status predicts access to care and outcomes of vascular disease. *Journal of Vascular Surgery*. 2008 Oct; 48(4): 905–11.

⁷ Roetzheim RG et al., Effects of health insurance and race on early detection of cancer. *Journal of the National Cancer Institute*. 1999 Aug; 91(16): 1409–15.

⁸ Kwok J et al., The impact of health insurance status on the survival of patients with head and neck cancer. *Cancer*. 2010 Jan; 116(2): 476–85.

⁹ Allen JG et al., Insurance status is an independent predictor of long-term survival after lung transplantation in the United States. *Journal of Heart and Lung Transplantation*. 2011 Jan; 30(1): 45–53.

Figure 2. Proportion of Physicians Who Accept No New Patients, by Insurance Status, 2008

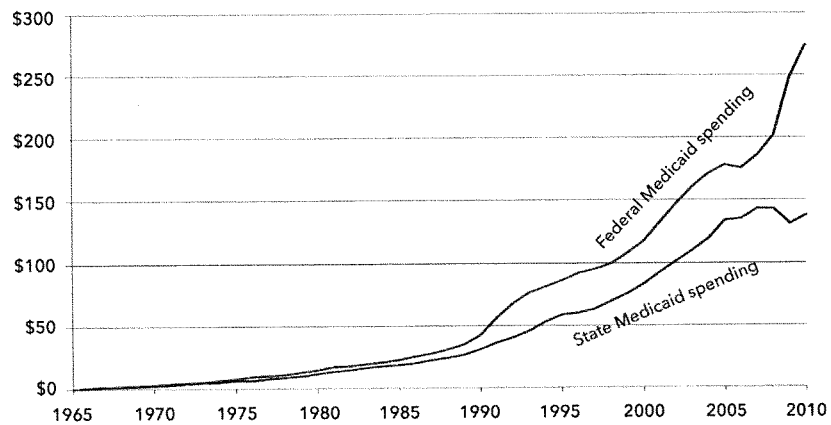


Fewer physicians are willing to see Medicaid and Medicare enrollees. The 2008 Health Tracking Physician Survey found that individuals with commercial health insurance enjoyed broad access to physicians, while those in Medicaid—and increasingly Medicare—do not. Reimbursement rates for Medicaid and Medicare, relative to private insurance, have fallen since 2008, suggesting that these access gaps have widened further. (Source: *Center for Studying Health System Change*)

Surprisingly, doctors fare even better treating the uninsured than they do caring for those on Medicaid.

A 2007 study by MIT economists Jonathan Gruber and David Rodriguez found that, for nearly 60 percent of physicians, the average Medicaid fees were less than two-thirds of those paid by the uninsured, and that three-quarters of physicians receive lower fees for treating Medicaid patients than they do for treating the uninsured.¹⁰

Figure 3. Growth in Federal vs. State Spending on Medicaid, 1966-2009 (Billions)



States have gamed the system to attract more federal funds, while still reducing provider payments. During the first two decades of the Medicaid program (1965-85), state (red) and federal (blue) spending on Medicaid grew in concert. However, a federally mandated expansion of Medicaid eligibility in the 1980s drove states to deploy creative accounting techniques, such as provider and premium taxes, that could increase the proportion of Medicaid spending borne by the federal government. According to the official government formula—the Federal Medical Assistance Percentage, or FMAP—the federal government is paying for 60 percent of the pre-ACA Medicaid program, while the states are paying 40 percent. In reality, however, the federal government is paying 67 percent, and the states 33 percent: a difference of more than \$30 billion per year. (Source: Bipartisan Policy Center, CMS)

The difference in reimbursement rates does not capture the additional hassles involved in treating Medicaid patients—such as late payments from the government and excessive paperwork—relative to the uninsured, who pay in cash.

¹⁰ Gruber J and Rodriguez D, How much uncompensated care do doctors provide? National Bureau of Economic Research. 2007 Nov; <http://www.nber.org/papers/w13585>.

Surveys consistently show that patients with private insurance have far superior access to care than those on Medicaid. As shown in *Figure 2*, The 2008 Health Tracking Physician Survey found that internists were 8.5 times as likely to refuse to accept any Medicaid patients, relative to those with private insurance.¹¹

A 2011 study published in the *New England Journal of Medicine* found that individuals posing as mothers of children with serious medical conditions were denied an appointment 66 percent of the time if they said that their child was on Medicaid (or the related Children's Health Insurance Program), compared with 11 percent for private insurance—a ratio of 6 to 1.¹²

Among clinics that did accept both Medicaid/CHIP and privately insured children, the average wait time for an appointment was 42 days for Medicaid and 20 days for the privately insured. A related study, published by the same group in *Pediatrics*, found that 63.5 percent of Medicaid/CHIP beneficiaries were unable to get an appointment, compared with 4.6 percent of those with private insurance—a ratio of 14 to 1.¹³

These differences in access to physician care go very far in explaining why Medicaid patients suffer from poorer health outcomes than their counterparts with private insurance. It is likely that the poor outcomes of cancer patients on Medicaid are caused by the fact that those patients' cancers are not diagnosed early enough to receive effective treatment.

In addition, even when Medicaid patients gain access to care, the quality of that care is below average. A UCLA study published in the *Journal of the American Medical Association* found that those on Medicaid were far more likely to be treated in low-volume surgical centers than high-volume ones; high-volume surgical centers have consistently demonstrated superior outcomes.¹⁴

CREATIVE FINANCING GIMMICKS HAVE DISTENDED MEDICAID'S BUDGET

In turn, the principal driver of Medicaid's poor provider reimbursement rates is its dysfunctional fiscal structure. Medicaid is jointly funded by state governments and the federal government. Because neither party has full responsibility for the program, both parties have engaged in irresponsible behavior.

As Medicaid has grown over time, state budgets have come under increasing strain. States' Medicaid obligations now crowd out spending on other important responsibilities, such as education and public safety.

But it is mostly illegal for states to increase co-pays, deductibles, or premiums for Medicaid enrollees. Moving people off of the Medicaid rolls is highly controversial. And most attempts by state governments to enact minor programmatic changes must survive a lengthy waiver process with the U.S. Department of Health and Human Services.

¹¹ Boukus E et al., A snapshot of U.S. physicians: key findings from the 2008 Health Tracking Physician Survey. Center for Studying Health System Change. 2009 Sep; <http://www.hschange.com/CONTENT/1078/1078.pdf>.

¹² Bisgaier J and Rhodes KV, Auditing access to specialty care for children with public insurance. *New England Journal of Medicine*. 2011 Jun; 364: 2324–33.

¹³ Bisgaier J et al., Disparities in child access to emergency care for acute oral injury. *Pediatrics*. 2011 Jun; 127(6): e1428–35.

¹⁴ Liu JH et al., Disparities in the utilization of high-volume hospitals for complex surgery. *Journal of the American Medical Association*. 2006 Oct; 296: 1973–80.

As a result, the path of least political resistance has been for states to reduce Medicaid's reimbursements to health care providers: paying hospitals and doctors less for the same level of service.

But states are not innocent victims of the federal government; they, too, have at times imprudently expanded their Medicaid programs by establishing creative financial schemes that transferred the costs of Medicaid expansions onto federal taxpayers.

As a result, when it comes to Medicaid, the interests of states and the federal government have diverged.

States have attempted to offload more costs onto the federal government, and the federal government has attempted to offload more costs onto the states.

As the Bipartisan Policy Center describes in its 2010 fiscal-reform proposal drafted by a panel co-chaired by Pete Domenici and Alice Rivlin, a federally mandated Medicaid expansion of Medicaid eligibility in the 1980s drove state governments to seek "every possible opportunity to amend the financing structure of state- and locally funded health care programs to cover additional services under Medicaid, and hence receive federal matching payments for these services."¹⁵ In addition:

States became highly creative in obtaining Medicaid for health services—such as visits to the school nurse by low-income children—that were previously fully funded with state and local resources. This search for federal dollars, referred to as "Medicaidization," brought dozens of new provider types and service categories under Medicaid.

States then created additional strategies to drive up federal funding.

In order to siphon additional Medicaid funding from federal taxpayers, they invented special Medicaid hospital taxes that increased state tax revenue, while also driving up the cost of care and thereby triggering additional federal Medicaid subsidies.

For example, a state hospital tax of \$100 might be entirely passed on to the Medicaid program in the form of higher costs. If the federal government is required to fund 60 percent of a state's Medicaid program, that \$100 tax results in a net gain to the state of \$60 in extra federal Medicaid funding.

Similarly, states have also instituted sales and excise taxes on private health insurance premiums, and then contracted out their Medicaid programs to private insurers in order to collect premium taxes on the privately managed Medicaid plans.

These schemes did nothing to improve the quality of care offered to Medicaid beneficiaries, or increase reimbursement rates, but merely drove federal funds to state budgets, giving states the freedom to pursue other priorities with their own tax revenue.

The Bipartisan Policy Center observes that "by the early 1990s, the effective [federal contribution] for [Medicaid] hospital services exceeded 70 percent, far more than the national average matching rate of 56 percent that had prevailed throughout the first 25 years of the program" (*Figure 3*).

¹⁵ Domenici PV et al., *Restoring America's future: reviving the economy, cutting spending and debt, and creating a simple, pro-growth tax system*. Bipartisan Policy Center. 2010 Nov; <http://bipartisanpolicy.org/projects/domenici-rivlin-debt-reduction-task-force>.

To this day, what BPC describes as a “shoving match” continues between state governments and the federal government, as each party strives to engage in ever more complex fiscal engineering, decreasing the stability of Medicaid’s financial structure.

FOCUSING MEDICAID’S RESOURCES ON VULNERABLE POPULATIONS

Congress is considering three measures that could help states avoid the need to further cut provider reimbursement rates in the Medicaid program.

Focusing Medicaid subsidies on U.S. citizens and legal immigrants. In certain cases, federal law requires states to subsidize Medicaid-based coverage for those who have not yet documented that they legally reside in the U.S. To the degree that such individuals are not legally present in the U.S., the law forces states to spend scarce resources on those who are not eligible for Medicaid at the expense of those who are. Federal law should require proper documentation to enroll in Medicaid.

Shielding a spouse’s assets from Medicaid eligibility tests. Medicaid is designed to provide financial assistance to those who cannot afford to provide health coverage for themselves. However, a loophole in federal law allows spouses of Medicaid long-term care enrollees to receive large annuities. Annuities, and all other assets, should count toward Medicaid eligibility thresholds.

Shielding lottery income from Medicaid eligibility tests. An individual who receives a \$10 million lottery in one month is not eligible for Medicaid in that month, because his income is too high. But if his income goes to zero for the remainder of the year, he becomes eligible again for Medicaid due to his low monthly income. Congress should reconsider the treatment of lottery winnings and other lump-sum payments, so that Medicaid eligibility is reserved for those who are truly poor.

OFFERING PRIVATE INDIVIDUAL COVERAGE TO MEDICAID ENROLLEES

A system of means-tested, advanceable, and refundable tax credits to purchase private health insurance for the population currently eligible for Medicaid could address Medicaid’s structural problems, and also substantially increase the quality of health coverage currently available to those on Medicaid.

Such tax credits are contemplated by many of the proposals to replace the Affordable Care Act, including the Patient CARE Act proposed by Senators Orrin Hatch and Richard Burr, former Sen. Tom Coburn, and Rep. Fred Upton, former Chairman of the House Energy & Commerce Committee. The Affordable Care Act itself deploys means-tested tax credits to subsidize coverage to those whose incomes are higher than Medicaid’s eligibility thresholds.

FREOPP’s health-reform proposal, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, proposes gradually migrating the entire Medicaid acute-care population onto a reformed individual market in which the subsidies now expended for Medicaid acute-care coverage are converted into premium assistance tax credits and health savings account deposits.¹⁶ (For the purposes of simplicity, when this

¹⁶ Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep; <https://drive.google.com/file/d/0B4VpAFwBu2fUyK5aV3Rud3NsUTg/view>.

document refers to “Medicaid” it is referring to both the adult Medicaid program and the related CHIP.)

Under the FREOPP proposal, called the Universal Tax Credit Plan, the premium and cost-sharing subsidies for private acute-care coverage that are now available to those with incomes between 100 and 138 percent of the Federal Poverty Level, under the ACA, would under the Universal Tax Credit Plan be also available to all those with incomes below the poverty line.

By default, Medicaid acute-care enrollees would be gradually migrated onto the benchmark individual market plan in their states. Those who wished to remain in Medicaid, and not migrate onto the individual market, could opt out and remain in the legacy Medicaid program until January 1, 2027.

Another important problem facing the Medicaid population is the problem of churn between different types of insurance coverage. Poor individuals tend to have highly volatile incomes, leading to eligibility for different health insurance programs from month to month. This can end up disrupting relationships between patients and doctors, as different health plans offer different physician networks. By migrating Medicaid-eligible individuals into the reformed individual market, the Universal Tax Credit Plan would considerably mitigate the problem of churn.

States fund, on average, approximately 40 percent of the traditional Medicaid program; the federal government funds the remainder. However, the Affordable Care Act’s insurance exchanges are entirely funded by the federal government. Hence, migrating the Medicaid acute-care population into the individual market, over a ten-year period, would increase federal funding responsibilities by approximately \$1.2 trillion, and reduce state spending by a corresponding amount, excluding the impact of higher per-member costs with individual coverage (accounted for elsewhere in the Plan), and the fiscal offsets described below:

1. Returning responsibility for long-term care to the states

Under the plan, states that agree to transfer their Medicaid acute-care populations into the reformed individual market would be required, over time, to take over full funding and administrative responsibility for the Medicaid long-term care program.

This would operate, in effect, like a block grant from the federal government to the states, with two important differences: most states would eventually be 100 percent responsible for funding their long-term care programs; and they would be required to fund the program at levels that were no less than what the Centers for Medicare and Medicaid Services would have projected as the annual costs of the long-term care program through 2036 (i.e., a “maintenance of effort” requirement).

By requiring states to fund their long-term care programs at existing levels, but increasing their administrative flexibility, states could do much more than Medicaid currently allows. For example, they could assist beneficiaries with capital expenditures, such as increasing the accessibility of their homes to wheelchairs. Giving beneficiaries the tools they need to remain in their homes, instead of in long-term care facilities, will improve the quality of their lives while also optimizing program expenditures.

One significant advantage of cleaning up Medicaid’s lines of responsibility is that it would substantially improve states’ authority over their Medicaid-eligible populations. While the Universal Tax Credit Plan assigns to the federal government the financial responsibility of funding acute-care insurance for this cohort, state governments would have the authority to regulate the private health insurance plans that individuals would purchase on the reformed individual market.

This feature, combined with states' full authority over the long-term care program, would end the "1115 Waiver" system, in which state governments must ask federal permission, and wait years, to implement even trivial Medicaid reforms.

As John Holahan of the Urban Institute has pointed out, moving financial responsibility for Medicaid long-term care to the states will affect different states differently, depending on the size and scale of their long-term care populations.¹⁷ Under a swap, a minority of states would end up as fiscal "losers," with a total net loss amongst them of \$4.5 billion a year in 2011 dollars. These disparities can be managed through a gradual transition in which states with large long-term care populations receive supplemental grants from the federal government.¹⁸

In sum, the Medicaid swap and related offsets below would be designed in such a way so as to be modestly fiscally advantageous to every state government, relative to the federal government, in order to encourage states' participation.

2. Prohibition of state Medicaid provider taxes

The report published in 2010 by President Obama's National Commission on Fiscal Responsibility and Reform—popularly known as Simpson-Bowles—recommends "asking states to take responsibility for more of Medicaid's administrative costs by eliminating Medicaid payments for administrative costs that are duplicative of funds originally included in the Temporary Assistance for Needy Families (TANF) block grants."¹⁹ We estimate that doing this would reduce federal spending by \$3 billion between 2017 and 2026.

Importantly, the Simpson-Bowles report took on the issue of creative financing, noting that "many states finance a portion of their Medicaid spending by imposing taxes on the very same health care providers who are paid by the Medicaid program, increasing payments to those providers by the same amount and then using that additional 'spending' to increase their federal match. We recommend restricting and eventually eliminating this practice."

3. Sales and excise tax exemption for subsidized health insurance

An important driver of inflated health insurance premiums in the United States is state-based sales taxes and premium taxes. These taxes are passed onto consumers in the form of higher premiums, and passed onto taxpayers in the form of larger federal and state subsidies for health insurance premiums.

Take the example of an employer-based family health insurance plan costing \$15,000 per year. Ohio, for instance, imposes a 5.5 percent sales tax and a 1 percent premium tax, amounting to an additional \$975 per family. If that family is in the 25 percent federal tax bracket, and is liable for 15.3 percent in payroll taxes, these state taxes also result in \$393 in lost revenue to the federal government. In other words, federal taxpayers are subsidizing Maryland's sales and premium taxes.

¹⁷ Holahan J, Restructuring Medicaid through a swap: an alternative to a block grant. Urban Institute. 2011 Apr; <http://www.urban.org/UploadedPDF/412327-restructuring-medicaid-through-swap.pdf>.

¹⁸ Holahan argues for a different, somewhat more complex, swap, under which: (1) acute-care and dual-eligible Medicaid spending would be transferred fully to the federal government; (2) long-term care spending would shift to state funding supplemented by a federal closed-end matching grant; (3) Medicaid disproportionate share hospital payments would be eliminated or greatly reduced; (4) state "claw-back" funding for non-dual-eligible acute-care Medicaid where needed as a fiscal offset. Holahan does not propose migrating the acute-care Medicaid population onto the ACA exchanges.

¹⁹ Simpson AK et al., The Moment of Truth. The National Commission on Fiscal Responsibility and Reform. 2010 Dec; http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

The problem is even worse in states that contract with private managed-care companies to administer their Medicaid programs. A \$15,000 Medicaid plan, thereby subject to \$975 in sales and premium taxes, might be 60 percent subsidized by the federal government, leading to \$585 in additional federal spending.

The state government, by contrast, makes money on this deal: \$975 in additional tax revenue, for \$390 in additional state Medicaid spending, for a net gain of \$585. In effect, the tax gimmick allows states to tax the citizens of other states. For every dollar of taxes that a state levies on its Medicaid program, 60 cents are levied upon the taxpayers of other states. It is not difficult to see why many state-based politicians have found this maneuver appealing.

Furthermore, these premium taxes give states a perverse incentive to mismanage their Medicaid programs, by making commitments they cannot sustain over time. In order to rectify this problem, the Universal Tax Credit Plan renders all federally subsidized health insurance plans—from Medicare, Medicaid, CHIP, individual tax credits, and employers—as exempt from state and local sales and premium taxes.

We estimate that the gross federal deficit-reducing effect of this change could exceed \$100 billion in 2019, though it would be more than offset under the Plan by decreased state spending on the Medicaid acute-care population.

HARMONIZING FEDERAL ASSISTANCE FOR THE DISABLED

The federal government provides assistance to the disabled through the Medicaid and Medicare programs. Under the Universal Tax Credit Plan, Medicaid's long-term care for the disabled would be transitioned fully to the states, while Medicaid's acute-care coverage for the disabled would become entirely a federal responsibility.

The Universal Tax Credit Plan would take into account the special needs of the disabled population by consolidating acute-care coverage for the disabled in Medicare with the federal government's newly expanded responsibilities for acute care for the disabled Medicaid population.

The Plan would create a bipartisan commission to consider and enact reforms of this consolidated acute-care program for the disabled, in order to achieve the following goals:

Ensure that federal resources are focused on the truly disabled. This involves reexamining Reagan-era reforms that rolled back the use of objective health criteria in evaluating eligibility for disability coverage.²⁰

Address the currently uninsured disabled population. The commission would examine the broader suite of eligibility criteria to see if there are gaps in the disabled population for whom assistance is warranted.

Harmonize asset limitations. Under Medicaid, many states require a disabled individual to have very low amounts of assets—under \$2,000, for example—in order to gain certain types of disability coverage. However, Medicare does not have asset limits. As a result, low-income individuals have far stricter asset requirements than high-income individuals for

²⁰ Roy ASA, How Americans game the \$200 billion-a-year 'disability-industrial complex.' *Forbes*, 2013 Apr 8; <http://www.forbes.com/sites/theapothecary/2013/04/08/how-americans-game-the-200-billion-a-year-disability-industrial-complex>.

federal disability coverage. These asset limits should be harmonized across the federally assisted population.

Rationalize the relationship between cash aid and health coverage. It may be worthwhile to convert some of the cash assistance offered to disabled individuals into health coverage, or vice versa, in order to maximize the efficacy of federal assistance.

Fiscal neutrality. Reforms adopted by the commission should, in total, have the net effect of maintaining federal spending on the disabled at its currently projected levels.

'DUAL ELIGIBLES' CONSOLIDATED ONTO THE REFORMED INDIVIDUAL MARKET

Approximately 10 million U.S. residents, primarily low-income retirees, are eligible for both Medicare and Medicaid. Because these individuals today gain health coverage from two very different government programs, with overlapping benefits and differing physician networks, care for these vulnerable individuals is often of poor quality and excessive cost.

Under the Universal Tax Credit Plan, all of these “dual eligible” individuals would be migrated onto the reformed individual market, where they would receive a tax credit-based insurance benefit of the same actuarial value as that represented by their existing Medicare and Medicaid coverage.

This would amount to a benchmark individual plan with the cost-sharing subsidies—in the form of health savings account subsidies—needed to achieve actuarial equivalence. In this way, dual-eligible individuals could gain coverage from a single health plan managed by a single insurer, with a unified network of physicians and hospitals. Over time, such an approach should lead to substantially higher-quality care, and lower costs, than the existing patchwork system.

Mr. BURGESS. The chair thanks the gentleman and the chair recognizes Mr. McCarthy 5 minutes for your opening statement, please.

STATEMENT OF JOHN MCCARTHY

Mr. MCCARTHY. Good morning, Chairman Burgess, Ranking Member Green and distinguished members of the subcommittee. I am John McCarthy, currently the CEO of Upshur Street Consulting. I recently stepped down from the position of Medicaid director for the State of Ohio and previous to that was the Medicaid director for the District of Columbia. I appreciate this opportunity to share my recommendations for strengthening the Medicaid program.

The three bills that are up for discussion began to address some common sense reforms to eligibility requirements for the Medicaid program. Having recently served as the vice president on the board of directors for the National Association of Medicaid Directors, I know that it is important to Medicaid directors that the integrity of the program is maintained to make the program financially viable to serve those who qualify. These three bills promise to move the program in that direction.

First, the discussion draft of Prioritizing the Most Vulnerable Over Lottery Winners Act of 2017 would place reasonable exclusion periods for Medicaid eligibility when a person wins the lottery. Limiting Medicaid eligibility for lottery winners is an eligibility change that many support and a policy change I advocated for the last few years.

Second, the discussion draft of the Close Annuity Loopholes in Medicaid Act requires a state to apply half of an annuity's payout to the spouse that is not institutionalized to the income of the spouse that is institutionalized and applying for Medicaid. Ensuring that Medicaid eligibility is limited to people without resources to pay for long-term services and supports, or LTSS, instead of also covering those who can shelter their resources would be an important improvement.

For most states the greatest spending per person is for the aged, blind, and disabled population who are the greatest users of LTSS, so this is an important area to carefully explore. However, the bill does have some technical issues that need further examination. For example, the institutionalized spouse could purchase the annuity and then name the spouse the annuitant and avoid assigning half of the payment to the institutionalized spouse. Because this area of Medicaid policy is so complex, a very close analysis of this issue is needed to ensure the problem is fully addressed.

Lastly, the Verify Eligibility for Coverage Act eliminates federal dollars being used on services before a person proves their citizenship or immigration status. This change would provide the person requesting eligibility with an incentive to produce documentation as quickly as possible and help to ensure federal dollars are not spent on individuals who do not qualify for the program.

All the bills include the creation of the Medicaid Improvement Fund. The main stated goal of this fund is to reduce waiting lists for home and community-based service waivers. I agree that this is an important issue. It was one of the goals of the first Kasich

administration budget to eliminate the wait list for the PASSPORT waiver which serves people over the age of 60.

We eliminated that wait list and reduced the number of nursing home bed-days that were paid for which in turn led to over \$1 billion in savings over 4 fiscal years. A small initial investment was needed, but in the long term this offered a cost savings. However, this cost savings is only realized for cases in which there is a diversion from an institution.

If the person who is on the wait list is never institutionalized, the Medicaid program is likely to have lower expenditures than HCBS would entail. That does not necessarily mean that the person does not have the care he or she needs, the person may be enrolled in the Medicaid program and receiving some amount of state plan services at home and additional services may be provided by non-paid caregivers or from services paid by local dollars. This program therefore will need to be carefully managed so that costs do not grow uncontrollably. In particular, in caution I offer that since this bill creates a competitive program with priority given to states with the highest number of people on wait lists that provides an incentive to a state to have higher wait lists.

Other methods for determining the appropriate funding level per state should be explored in order to manage the cost of the change. One alternative may be to tie the proposal to the Money Follows the Person program and provide financial incentive to states to move people out of institutions and back into the community. Another option may be to have the dollars proposed—the Medicare program needs reform. There is simply too much unneeded and overly burdensome regulation that has been promulgated over the last few years and that does not provide a benefit to beneficiaries.

The new Access to Care Regulation and the Managed Care Mega Rule are just two examples. The Access to Care Regulation was a backdoor method to take away the ability for a state to set reimbursement rates for providers by putting that authority in the Centers for Medicare and Medicaid Services' hands. The amount of information that is requested by CMS, such as surveys of providers and private sector rate data, is not a true measure of adequacy of the proposal. Additionally, the staff time needed to complete this work pulls the staff away from more impactful tasks such as implementing value-based purchasing.

The areas in need of reform that I have laid out above are only a subset of issues that are currently not working optimally in the Medicaid program. I do not have enough time today to go through all the areas. A good resource to use on what reforms are needed is the document published by NAMD, the National Association of Medicaid Directors legislative priorities for 2017. However, for real reform the fundamental role of CMS must be rethought. Currently it acts as a regulator for states. It should shift into the role of a payer and oversee the program. Instead of telling a state how much a state should reimburse providers, CMS should monitor health outcomes.

With that, in conclusion, the Medicaid program is in need of reform. We need to think of new ways to oversee this program, and I am happy to answer any questions.

[The statement of John McCarthy follows:]

Testimony of

John McCarthy
CEO Upshur Street Consulting

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

On

“Strengthening Medicaid and Prioritizing the Most Vulnerable”

February 1, 2017

Testimony Summary

- Reform of the Medicaid program is needed and long overdue
- Ensuring that Medicaid eligibility is limited to people without resources to pay for long-term services and supports (LTSS) instead of including those who can shelter their resources would be an improvement, but this is a complex area and should be fully analyzed to ensure it is effective.
- The Medicaid Improvement Fund can provide an incentive for states to reduce their waiting lists for HCBS services, but how funding allocations are made can create unintended incentives and therefore should be carefully developed.
- Six areas for which reform is sorely needed are eligibility levels and requirements, reasonable and enforceable co-pays and premiums, services for people dually enrolled in both Medicare and Medicaid, managed care, prescription drugs, and value-based purchasing.
- In addition, other reforms are needed to reduce the undue administrative burdens on states.
- Finally, Congress should explore changing the role of the Centers for Medicare and Medicaid Services (CMS) in Medicaid. Specifically, instead of a command and control model, a pay-for-performance approach could help manage costs and incentivize innovation.

Good morning, Chairman Burgess, Ranking Member Green, and distinguished Members of the Subcommittee. I am John McCarthy, currently the CEO of Upshur Street Consulting, LLC. I recently stepped down from the position of Medicaid Director for the state of Ohio, and previous to that was the Medicaid Director for the District of Columbia. I appreciate this opportunity to share my recommendations for strengthening the Medicaid program.

The three bills that are up for discussion begin to address some common-sense reforms to eligibility requirements for the Medicaid program. Having recently served as the Vice President on the Board of Directors for the National Association of Medicaid Directors, I know that it is important to Medicaid Directors that the integrity of the program is maintained to make the program financially viable to serve those who qualify. These three bills promise to move the program in that direction.

First, the discussion draft of “The Prioritizing the Most Vulnerable Over Lottery Winners Act of 2017” would place reasonable exclusion periods from Medicaid eligibility when a person wins the lottery. Limiting Medicaid eligibility for lottery winners is an eligibility change that many support, and a policy change I advocated for over the last few years.

Second, the discussion draft of the “Close Annuity Loopholes in Medicaid Act” requires a state to apply half of an annuity’s payout to the spouse that is not institutionalized to the income of the spouse that is institutionalized and applying for Medicaid. Ensuring that Medicaid eligibility is limited to people without resources to pay for long-term services and supports (or LTSS), instead of also covering those who can shelter their resources, would be an important improvement. For most states, the greatest spending per person is for the aged, blind, and disabled (ABD) population who are the greatest users of LTSS so this is an important area to carefully explore. However, the bill does have some technical issues that need further

examination. For example, the institutionalized spouse could purchase the annuity and then name the spouse the annuitant and avoid assigning half of the payment to the institutionalized spouse. Because this area of Medicaid policy is so complex, a very close analysis of this issue is needed to ensure the problem is fully addressed.

Lastly, the “Verify Eligibility Coverage Act” eliminates federal dollars being used on services before a person proves their citizenship or immigration status. This change would provide the person requesting eligibility with an incentive to produce documentation as quickly as possible, and help to ensure federal dollars are not spent on individuals who do not qualify for the program.

All the bills include the creation of the Medicaid improvement fund. The main stated goal of the fund is to reduce waiting lists for home- and community-based services (HCBS) waivers. I agree this is an important issue. It was one of the goals of the first Kasich administration budget to eliminate the wait list for the PASSPORT waiver, which serves people over the age of 60. We eliminated the waitlist and reduced the number of nursing home bed days that were paid for, which in turn lead to over \$1 billion in savings over four fiscal years. A small initial investment was needed, but in the long term this offered a cost savings. However, this cost savings is only realized for cases in which there is diversion from an institution. If the person is on the waitlist is never institutionalized, the Medicaid program is likely to have lower expenditures than HCBS would entail. That does not necessarily mean that the person does not have the care he or she needs. The person may be enrolled in the Medicaid program and receiving some amount of state plan services at home, and additional services may be provided by non-paid caregivers or from services paid by local dollars. This program, therefore, will need to be carefully managed so that costs do not grow uncontrollably. In particular, a caution I offer

is that since the bill creates a competitive program with priority given to states with the highest number of people on waitlists, that provides an incentive to a state to have higher waitlists. Other methods for determining the appropriate funding level per state should be explored in order to manage the cost of this change. One alternative maybe to tie this proposal to the Money Follows the Person program that provides financial incentives to states to move people out of institutions and back into the community. One option may be to have the dollars proposed for this fund be able to cover the cost of the HCBS services for two years after a person leaves an institution.

The Medicaid program needs reform. There is simply too much unneeded and overly burdensome regulation that has been promulgated over the last few years that does not provide a benefit to the beneficiaries. The new Access to Care regulation and the Managed Care “Mega Rule” are just two examples. The Access to Care Regulation was a backdoor method to take away the ability for a state to set reimbursement rates for providers by putting that authority in the Centers for Medicare and Medicaid Services’ (CMS) hands. The amount of information that is requested by CMS such as surveys of providers and private sector rate data is not a true measure of the adequacy of the proposed rate. Additionally, the staff time needed to complete this work pulls the staff away from other more impactful tasks such as implementing value based purchasing.

Another rule CMS promulgated that was over complicated and was an overreaction to a couple of states that had difficult transitions from fee-for-service to managed care is the Managed Care “Mega Rule.” It is true that the managed care rules needed to be updated, but it is unclear if CMS has enough resources to implement what has been put in place. CMS should have worked more closely with the National Association of Medicaid Directors (NAMd) to update

the managed care rules, and to deal with states moving from fee-for-service to managed care CMS should have used rules that were already in place specifically the contract review and approval process along with the readiness review process.

There are several areas for which reforms are sorely needed. I will go into detail about some of them here. But this is not a complete list - there are many opportunities for improvement that I will not have time to discuss in my time today. The areas that I will briefly mention are: Eligibility levels and requirements, reasonable and enforceable co-pays and premiums, services for people dually enrolled in both Medicare and Medicaid, managed care, prescription drugs, and value-based purchasing.

Eligibility levels and requirements. States are required to cover individuals up to 133% of the federal poverty level (FPL), which is effectively 138% FPL with the 5% income disregard. However, exchanges provide subsidies to people down to 100% FPL. Requiring states to cover individuals who are also covered by the exchanges does not make sense. The Medicaid eligibility level should be set at 100% FPL to align the two programs. Additionally, states should have the option to implement other requirements such as work, education, or training in order to be consistent with the values of the people of that state.

Reasonable and enforceable co-pays and premiums. While the current law does allow for co-pays and premiums, CMS regulations make it nearly impossible to implement them. Furthermore, the amounts allowed for people above the federal poverty level are so low that it is often cost-prohibitive to implement.

Services for people dually enrolled in both Medicare and Medicaid. Ohio was the third state approved to implement a Duals demonstration. CMS has stated that Ohio's program is one of the better demonstrations in the country. A major barrier to success of the

demonstration is that a state is not able to require a dually eligible participant to enroll in a managed care plan on the Medicare side. A state can make it mandatory on the Medicaid side. Another barrier to success is that people on the program can change managed care plans any time. This policy leads to people changing plans multiple times within a short period of time, which then leads to confusion by the plans, providers and patients, and a loss of care coordination which is known to improve health outcomes and reduce cost. To address these issues, mandatory enrollment in a plan should be required, and a person should only be allowed to change a plan in the first 90 days or if there is a justified reason why the plan cannot meet the person's needs. Additional changes are needed to streamline the grievance and appeals process.

Managed Care - CMS should eliminate the need for waivers to put special populations in managed care. Many states are using managed care to efficiently and effectively deliver services to all populations, and it does not make sense to limit the ability to do so.

Prescription drugs - States are forced to cover all FDA-approved drugs and in turn receive rebates. However, for new high cost drugs, the rebate is not high enough to offset the large increase in expenditures. One consideration would be to let states opt out of the rebate program and requirement to cover all FDA approved drugs. A state could then create their own formulary and decide what drugs to cover in their Medicaid program. This approach could lead to negotiation on drug prices, which is currently prohibited.

Value-based Purchasing - States such as Ohio won State Innovation Method (SIM) grants to implement value based purchasing. Ohio and other SIM states ran into barriers in the fee-for-service portion of the program because of outdated laws and regulations. Such barriers need to be removed to promote innovation in approaches that the value-based purchasing models are meant to enable.

Provider Requirements - The “any willing provider” requirements for the fee-for-service program stifles provider competition, increases costs, and rewards low quality providers. States should be able to issue request for proposals for services. In Ohio, there is a surplus of nursing home beds. The average vacancy rate is about 15% statewide, but in some areas of the state that vacancy rate is much higher. A common-sense approach would be to let Ohio issue a request for proposal for a specific number of bed days and quality level. Providers would submit bids containing their price proposal and quality scores, and a state could choose the providers offering the best value. This approach would be expected to reduce costs and increase quality.

The areas in need of reform that I laid out above are only a subset of issues that are currently not working optimally in the Medicaid program. I do not have enough time today to go through all the areas. A good resource to use on what reforms are needed is the document published by the NAMD, “NAMD’s Legislative Priorities for 2017¹.”

However, for real reform, the fundamental role of CMS must be re-thought. Currently, it acts as a regulator of the states. It should shift into the role of a payer and oversee the program. Instead of telling a state how much a state should reimburse providers, CMS should monitor health outcomes. This could be done by using financial incentives tied to measures like the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures. For example, using the current federal medical assistance percentage (FMAP) formula, a state could receive a higher or lower percentage based on quality measures such as vaccination rates and rate of follow up appointments in seven days after an inpatient stay in a psych unit. This is similar to how states currently use pay-for-performance with their managed care plans. Other measures could also be used to obtain the outcomes desired, for example, measures like uninsured rates, patient satisfaction, or provider satisfaction,

¹ http://medicaiddirectors.org/wp-content/uploads/2016/12/NAMD-Legislative-Top-Issues-for-2017_FINAL.pdf

to name a few. This same concept could be used with other funding mechanisms such as per capita allotments or block grants.

In conclusion, the Medicaid program is in need of reform. We need to think of new ways to oversee the program. We should focus less on command and control. Instead, both states and CMS need to be held accountable for the health outcomes of the people on the program. As health outcomes improve, the rate of growth of the program should move towards sustainability. I hope this testimony has provided you with a valuable high level overview to inform your deliberations about these bills and the reform of the Medicaid program. I'm happy to take any questions.

Mr. BURGESS. The chair thanks the gentleman and the gentleman yields back. Ms. Solomon, you are recognized for 5 minutes for the purpose of an opening statement.

STATEMENT OF JUDITH SOLOMON

Ms. SOLOMON. Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee. I am really happy to be here to testify today. I am Judith Solomon, vice president for health policy at the Center on Budget and Policy Priorities. I am going to cover three things in my statement, provide some background on home and community-based service waivers which I will refer to as HCBS, talk about how they work, explain why there are waiting lists, and briefly discuss how waiting lists should and should not be addressed.

HCBS waivers became available in Medicaid in 1981 to give states a way to provide long-term care in people's homes. Up until then because skilled nursing care and home health have been mandatory services in Medicaid there was a bias toward institutional care. Families often had to face the dilemma that the only way they could get their loved ones the care they needed was to put them in a nursing home.

HCBS waivers gave states new ways to address the needs of children, adults with disabilities, and seniors. States can make people eligible for Medicaid who would only be eligible in a nursing home and create packages of services specifically designed to allow them to stay at home. These include home modifications, respite care, and enhanced home health services. Progress has been dramatic. In 2013, for the first time over half of long-term services and supports were for HCBS rather than for institutional care, and Figure 1 in my testimony shows that trajectory.

So why are there waiting lists? Well, HCBS waivers are the epitome of flexibility in Medicaid. States can target waivers to people with intellectual and developmental disabilities, seniors, people with HIV/AIDS and people with traumatic brain injury, and they can create packages of services that are specifically designed for the group they select. According to CMS there are now over 275 waiver programs nationally serving well over a million people.

Part of the flexibility states have is to limit their waivers to a defined number of slots and create waiting lists. The flexibility was important to states when these waivers were created because the waivers are expensive and states were concerned that the demand would just put them in the red. So the number of people on waiting lists shows that demand. They have grown every year going back to the data I have in my testimony to 2005, well before the Medicaid expansion. They have grown it an average rate of 14 percent a year and there is significant variation across states.

Eleven states and the District of Columbia have no waiting lists, and of these states without waiting lists only two haven't expanded Medicaid, Maine and Missouri. The two states, as was mentioned, with the longest waiting lists are Texas and Florida which have not expanded Medicaid. Another fact that is often overlooked is that people on waiting lists, the vast majority, are actually getting Medicaid so they are getting other services. The specialized services are

very important to them but they aren't being left without the core services that Medicaid provides.

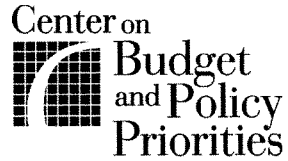
So how do we deal with waiting lists? Certainly at CBPP we join the goal of people here to decrease them, but we think there are better ways to address the waiting lists than by taking savings from the three bills before you today to provide enhanced federal funds for states with the longest waiting lists.

It would be much fairer to all states to provide incentives to enhance the provision of home- and community-based services which could include metrics to measure state progress. This could include continued funding for the Money Follows the Person program and the balancing incentive programs for which both the funding has expired. These were initiatives that have allowed states to make progress. The concern, and I think Mr. McCarthy said it as well, is by rewarding states with the highest waiting lists with higher match you really almost encourage states to grow their waiting lists.

So in closing though I would like to note what I think the real threat to Medicaid is and to home- and community-based services specifically. The most recent House budget plan would have given states the choice of a block grant or per capita cap to achieve cuts in federal Medicaid funding of \$1 trillion over 10 years, cutting the program by 30 percent in the 10th year and then even more in the decades after this. Cuts of this magnitude would likely lead to huge increases in waiting lists or elimination of the programs altogether because these are optional for states.

I thank you, I look forward to answering your questions about this and also about the bills. I can talk about those as well.

[The statement of Judith Solomon follows:]



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February 1, 2017

Existing Medicaid Flexibility Has Broadened Reach of Home- and Community-Based Services

**Testimony of Judith Solomon
Vice President, Center on Budget and Policy Priorities
Before the Health Subcommittee of the House Energy and
Commerce Committee**

Thank you for the opportunity to testify today. I am Judith Solomon, Vice President for Health Policy at the Center on Budget and Policy Priorities, an independent, non-profit, nonpartisan policy institute located here in Washington. The Center conducts research and analysis on a range of federal and state policy issues affecting low- and moderate-income families. The Center's health work focuses on Medicaid, the Children's Health Insurance Program (CHIP), the Affordable Care Act (ACA), and Medicare. I have spent over 35 years working on Medicaid, beginning as a legal services attorney representing clients and in several positions focusing on Medicaid policy issues affecting children, seniors, and people with disabilities.

The three bills before you would make changes to various aspects of the Medicaid program, including the process for verifying citizenship, eligibility for people receiving certain lump-sum income including lottery winnings, and the eligibility of seniors who purchase annuities for their benefit of their spouses. As I understand it, an amount equal to the projected federal savings

resulting from these bills would be transferred to the Medicaid Improvement Fund. Monies in the Fund would then be used to provide funding at a 90 percent federal match to a select group of states to reduce their waiting lists for home- and community-based services. The criteria for selecting the states would be based on the size of the state's waiting list, how long people remain on the list, and the incomes of people on the waiting list, with preference given to states with lists including the lowest-income people. As I will explain later in my testimony, while we support the goal of decreasing HCBS waiting lists, there are better ways to help states make progress in this regard.

Medicaid HCBS Services: Background

Later in my testimony, I discuss our concerns regarding two of the bills, but I would like to start by providing some background information on how Medicaid provides home- and community-based services (HCBS) for millions of vulnerable individuals, and more specifically why some states have waiting lists for people applying to receive these services. I especially want to address the claim that the Medicaid expansion has resulted in longer waiting lists and kept vulnerable people from getting the services they need. As I will explain, while waiting lists are something we all would like to eliminate and avoid in the future, they are a direct result of state choices on the design of their Medicaid programs and the amount of resources states make available to provide HCBS. There is no evidence that states are choosing to expand Medicaid or keep their expansions at the expense of vulnerable people waiting for HCBS, and examining state choices on both expansion and HCBS waivers actually leads to a contrary conclusion.

HCBS waivers became available in 1981 to provide states with a way to provide long-term services and supports (LTSS) outside of institutions. Skilled nursing care and home health services are mandatory services in Medicaid, but because many individuals need additional services beyond home

health to stay in their homes Medicaid was biased toward institutional care. Families often had to face the dilemma that the only way they could get their loved ones the care they needed was to put them in a nursing home. The choice was especially difficult for parents of children and adults with intellectual and developmental disabilities who needed significant supports to stay at home.

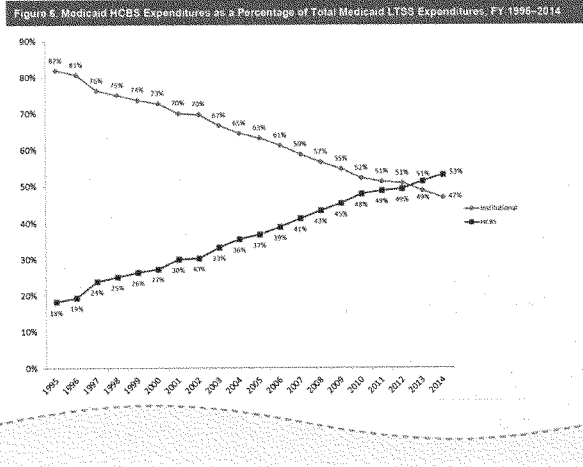
HCBS waivers gave states new ways to address the LTSS needs of their residents, including children, adults with disabilities, and seniors, leading to a dramatic shift in the program since 1981. Using HCBS waivers, states can make people eligible for Medicaid who were previously only financially eligible if they were in a nursing home or other institution. States can also create packages of services specifically designed to keep people in their homes, including home modifications, respite care for family caregivers, and enhanced home health services.

In 2013, for the first time, over half of LTSS expenditures were for HCBS rather than for institutional care. Progress has been dramatic, with the share of LTSS spending on HCBS climbing from 18 percent in 1995 to 53 percent in 2014.¹ (See Figure 1.)

¹ Truven Health Analytics, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014," April 15, 2016, <https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>.

FIGURE 1

Reproduction from Truven Health Analytics:
Medicaid Expenditures for Long-Term Services and
Supports (LTSS) in FY 2014



HCBS Waivers Demonstrate Medicaid's Existing Flexibility

HCBS waivers are responsible for much of the progress in moving care out of institutions into homes and the community, and they are the epitome of how Medicaid provides states with flexibility to design their own programs. States can target waivers to particular groups such as people with intellectual and developmental disabilities, seniors, people with HIV/AIDS, and people with traumatic brain injury, and create packages of services specifically designed to meet the needs of

certain groups. According to the Centers for Medicare & Medicaid Services (CMS), there are currently more than 275 waiver programs active nationwide serving well over 1 million individuals.²

Part of the flexibility states have is to limit their HCBS waivers to a defined number of slots, and to create waiting lists once those slots are filled. States can also increase or decrease the number of slots by submitting amendments to CMS, and they can keep slots open if state funding isn't sufficient to fill them. This flexibility is important for states, because waiver services can be costly, although on average waiver services are cheaper than care in a nursing home. In 2013, the total expenditures per person for all waiver types was \$27,768, with waivers for people with intellectual and developmental disabilities the most expensive at \$46,644 and waivers for people with HIV/AIDS the least expensive at \$4,072 per person.³

Unlike nursing home care, which must be provided to all financially eligible beneficiaries who meet functional and medical criteria for skilled nursing care, states determine eligibility criteria for HCBS waivers and the services that are provided through the waivers. States can control their expenditures based on their fiscal and organizational capacity to support their initiatives and the budget decisions made by their legislatures. The availability of providers to provide the necessary services and supports can also influence state decisions on the number of available waiver slots.

² Centers for Medicare and Medicaid Services, "Medicaid & CHIP: Strengthening Coverage, Improving Health, January 2017, <https://www.medicare.gov/medicaid/program-information/downloads/accomplishments-report.pdf>.

³ Kaiser Commission on Medicaid and the Uninsured, "Medicaid Home and Community-Based Services Programs: 2013 Data Update," October 2016, <http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/>.

Data on HCBS waivers show enormous state variation, which is evidence of the flexibility Medicaid provides. The Kaiser Commission on Medicaid and the Uninsured has tracked Medicaid HCBS programs over the last 15 years. The Commission's most recent report looks at expenditures and participants in state programs in 2013, although it includes data on waiting lists through 2015.⁴

The number of people on waiting lists shows the growing demand for HCBS. Waiting lists have grown every year, increasing over the period from 2005 — well before the start of the Medicaid expansion — to 2015 by an average rate of 14 percent a year. (See Figure 2.)

There is significant variation across states, with 11 states and the District of Columbia having no waiting lists at all. Of these states without waiting lists, only two — Maine and Missouri — haven't expanded Medicaid.⁵ The two states with the longest waiting lists are Texas and Florida, which have not expanded Medicaid. In fact, Texas' waiting list of over 204,000 individuals represents almost one-third of all people on waiting lists in 2015.⁶ Moreover, the number of people in Texas enrolled in HCBS waivers has declined by 38 percent over the last ten years, and this decrease may be contributing to the size of its waiting list.

As noted, expenditures for people with intellectual and developmental disabilities are the highest of all waiver types, and over two-thirds of people on waiting lists in 2015 were in this category. For example, only California had a waiting list for people with HIV/AIDS in 2015, amounting to just 65 people.

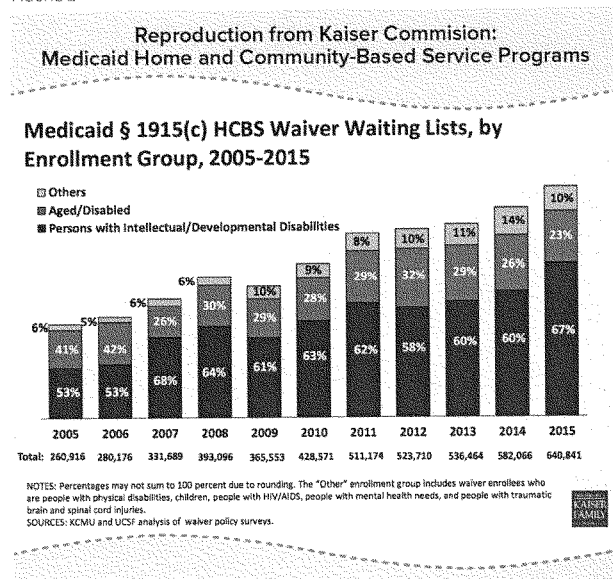
⁴ Kaiser Commission on Medicaid and the Uninsured, 2016.

⁵ The other states besides the District of Columbia without waiting lists are Delaware, Hawaii, Massachusetts, Michigan, North Dakota, New Hampshire, New York, Oregon, and Washington.

⁶ Table 14 of the 2013 data update.

Another fact that is overlooked in discussions of waiting lists is that the vast majority of people on the lists — 93 percent for waivers for people with intellectual and developmental disabilities and 100 percent for seniors — are enrolled in Medicaid and receiving all medically necessary services available from the state’s program other than waiver services. These individuals are Medicaid beneficiaries, and they are able to get home health services, personal care services if covered under the state’s plan, and of course prescription drugs and the full range of medical and specialty care Medicaid covers. This is not to say that they don’t have a need for the additional HCBS waiver services that should be addressed, but just to make it clear that the waiting list is to receive the additional package of waiver services, not for services covered by the Medicaid program.

FIGURE 2



ACA Added Options for States

It's also important to note new options and incentives states received in the ACA, which are contributing to the shift from institutional care to care in the community. Similar to HCBS waivers, states have made their own decisions whether to take up these new options, some which provide grant funding to help states rebalance their programs away from institutional care.

The ACA made significant improvements to an option first added to the Medicaid statute in 2005 by allowing states to target services to particular populations and making other changes that help states address the needs of people with behavioral health conditions who aren't eligible for HCBS waivers. Under this option, states can provide HCBS under their state plans rather than through a waiver, and 18 states have taken up this option. Unlike HCBS waivers, states must cover all those who meet the eligibility requirements defined in the state plan, which means that states can't have waiting lists when they take up the HCBS option. Of the 18 states that have approved state plan amendments for HCBS services, 14 have also expanded Medicaid, again showing that state decisions on HCBS and expansion are independent and instead depend on state decisions regarding how they want to serve their residents.⁷

The ACA also provided grants to states to help them rebalance their programs through the Balancing Incentive Program, a continuation of the Money Follows the Person program, which helps people transition from institutional care to the community, and the Community First Option to provide attendant services and other supports through the state plan rather than through waivers.

⁷ The four non-expansion states are Florida, Idaho, Mississippi, and Wisconsin, and the 14 expansion states are California, Colorado, Connecticut, Indiana, Iowa, Louisiana, Michigan, Montana, Nevada, Ohio, and Oregon.

Bills Before the Subcommittee Aren't Best Way to Extend HCBS to More Individuals

There is broad support for the goal of decreasing state waiting lists for HCBS — and CBPP is highly supportive of this goal — but there are better ways to address the waiting lists than by taking savings from the three bills before you to provide enhanced federal matching funds to states with the longest waiting lists. It would be much fairer to all states to provide incentives to enhance the provision of HCBS, which could include metrics to measure state progress. For example, while Texas has by far the longest waiting list for HCBS, it did participate in several of the ACA-provided options, including the Balancing Incentive Program and the Community First Choice Option. Providing increased resources through these types of program is aligned with the overall structure of the Medicaid program to provide states with an array of choices to meet their needs. Moreover, it avoids having states forgo their own efforts to reduce their waiting lists in order to get a chance to get 90 percent match available to states with the longest waiting lists.

I would like to address two of the bills before you, starting with the “Verify Eligibility Coverage Act.” We have significant concerns regarding this bill, because we think it will leave many eligible U.S. citizens without coverage. People must be U.S. citizens or have an eligible immigration status in order to be eligible for Medicaid, and their citizenship or immigration status must be verified. When completing applications, U.S. citizens must attest that they are citizens. The vast majority of applicants provide their Social Security number, which is used along with other personal information to complete an electronic data match with Social Security Administration (SSA) records to verify U.S. citizenship. Citizenship of a vast majority of applicants is successfully verified through the data match, but there are cases where the match isn't successful. When this happens, applicants have to send in documents to prove they are U.S. citizens. If applicants have satisfied all other eligibility requirements such as having income within the state's eligibility limits, the applicant receives

Medicaid during a defined time period that is referred to as a reasonable opportunity period. States get federal funding for Medicaid provided during the reasonable opportunity period.

The bill being considered today would end federal funding for Medicaid benefits provided during a reasonable opportunity period for applicants who have not had their U.S. citizenship verified. As noted, the vast majority of applicants attesting to U.S. citizenship have their citizenship verified through the electronic data match with SSA. Naturalized citizens and adult citizen applicants born abroad are the groups most likely unable to have their citizenship verified by SSA. This would include people who were born to members of the U.S. military serving abroad before 1972 when Social Security began including citizenship information in its records.

The savings from this bill would largely result from delays or denials of eligibility for eligible people, especially naturalized citizens. Under legislation enacted in 2006, states were required for several years to ask families to present proof of their citizenship and identity — generally by producing a birth certificate or passport — when they applied or renewed their Medicaid coverage. In the eight months after this requirement took effect, states reported large declines in Medicaid enrollment, particularly among low-income children. This requirement was subsequently modified to allow states to use Social Security Administration databases to confirm citizenship or eligible legal immigrant status in most cases and to provide a reasonable opportunity period to provide documents to those who couldn't successfully verify their citizenship through the electronic match understanding that it takes time to provide documentation for the small group of people whose citizenship can't be verified through Social Security.

I would also note that the language of the bill refers to “aliens,” who are individuals “declaring to be a citizen or national of the United States.” Legal immigrants applying for Medicaid must prove they have a status that qualifies them for the program. There are strict rules for verifying their status found in a separate part of the Social Security Act. So despite the reference to aliens, this bill would affect people who are citizens.

The second bill is “The Prioritizing the Most Vulnerable Over Lottery Winners Act of 2017.” The current version of this bill is a vast improvement from where it started in 2015. As we wrote in a paper then, the earlier version would have undermined the streamlined, coordinated eligibility approach that health reform established for Medicaid and marketplace subsidies and would have resulted in a number of low-income people who would otherwise be eligible, including people with disabilities, becoming uninsured.⁸ The bill still raises concerns, however, as to its impact on the streamlined enrollment process and coordination with the marketplace. It will require new questions on the application and new tracking by states for what may be a limited return. Michigan’s current Medicaid expansion waiver allows the state to garnish state tax refunds and lottery winnings to recoup unpaid premiums and cost-sharing from participants in the program. In all of 2015 and through the third quarter of 2016, the state collected a total of \$380.67 from just six lottery winners.⁹ It is certainly possible that the payments to Michigan’s contractor to collect these amounts exceeded the amount collected.

⁸ January Angeles, “House Medicaid Bill Would Result in More Uninsured Low-Income Individuals and Families, Center on Budget and Policy Priorities, September 9, 2015, <http://www.cbpp.org/research/health/house-medicaid-bill-would-result-in-more-uninsured-low-income-individuals-and-families>.

⁹ “Michigan Adult Coverage Demonstration Section 1115 Quarterly Report: Third Quarter 2016,” January 17, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topic/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrdy-rpt-jul-sep-2016.pdf>.

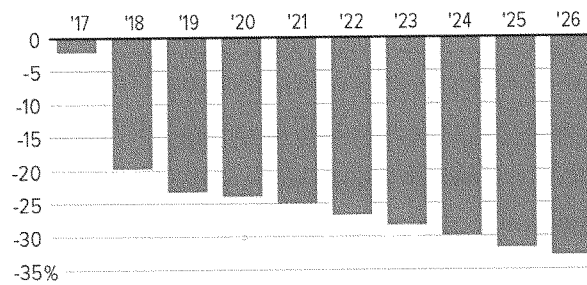
Threats Posed by Changing Medicaid's Structure

In closing, I would like to note the real threat other Medicaid proposals present to HCBS services in contrast to the Medicaid expansion, which is not responsible for waiting lists. While not before the Committee today, President-elect Trump, House Speaker Paul Ryan, and Health and Human Services Secretary nominee Tom Price support radically changing the Medicaid program's basic structure by converting the program to a block grant or what is known as a "per capita cap" and reducing federal funding for the program over time. The most recent House budget plan (for fiscal year 2017), would have given states the choice of a block grant or per capita cap in order to achieve cuts in federal Medicaid funding of about \$1 trillion over ten years and even more in the decades after that. These cuts would be in addition to repealing the Affordable Care Act's Medicaid expansion, which would withdraw roughly another \$1.1 trillion in federal Medicaid funding for states over ten years. (See Figure 3.)

FIGURE 3

Medicaid Cuts Would Grow Over Time Under House Budget Committee Block Grant

Percent cut in federal Medicaid funds, relative to current law



Source: CBPP analysis using Jan. 2016 Congressional Budget Office Medicaid baseline and House Budget Committee documents.

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Cuts of this magnitude would likely lead to huge increases in HCBS waiting lists or elimination of HCBS waivers altogether in many states. As states consider how to deal with these cuts, it is unlikely that they would risk terminating coverage for people in nursing homes, who could suffer serious harm or even death should they lose their coverage. Moreover, states would not be able to make the upfront investments often needed to expand their capacity to provide HCBS.¹⁰ With deep cuts in federal funds, it is far more likely that states would cut HCBS and other services for people in the community, reversing the admirable progress states have made since the inception of HCBS waivers in 1981 to allow families to keep their loved ones at home.

¹⁰ Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, <http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie>

Mr. BURGESS. The chair thanks the gentlelady. I really thank all of our witnesses for being with us today. This brings us to the question portion of the hearing and I am going to begin the questioning by recognizing myself for 5 minutes.

Dr. Roy, Mr. Flores has a bill before us today that would require individuals to provide documentation of their citizenship or lawful status before the states begin covering them. Is this in fact a problem? Is this an area where regulation needs to perhaps be tightened up a little bit?

Mr. ROY. If you talk to state Medicaid directors and other people at the state level they will say that this is a significant expenditure for them. And I am not aware of a CBO score for the previous—I know there has been a bill that has been scored previously along these lines, but I want to say at least several hundred million dollars potentially could be saved by ensuring you are dedicating Medicaid resource to people who are legally resident of the country and you don't have these windows where people who aren't documented are getting those benefits.

Mr. BURGESS. And just as a consequence of that there is no way to retrieve those dollars once they have been spent, once they go out the door they are gone?

Mr. ROY. They are gone. And as I mentioned both in my written testimony and my oral testimony, to me the biggest challenge is what we see is most states when they face a cost crunch what do they do, they lower reimbursement rates to providers, particularly physicians, which ends up in particular harming access to care for the people who are enrolled in the program who are eligible for the program in reality.

Mr. BURGESS. And I appreciate your comments on that.

Mr. McCarthy, under the Affordable Care Act of course expanded Medicaid and the expansion populations were eligible for a federal match of 95 percent this year, tapers down to 90 percent in 2020 under current law. And there has been a concern expressed because a state that expanded is paying a smaller portion of the cost for care of the expansion population, in times of a budget crunch the incentive would be for a state to reduce services or benefits for the traditional population. Can you talk about the degree, do you think that this is a fair concern?

Mr. MCCARTHY. Mr. Chairman, every state is different. They all make their different decisions. I would say that depending on where a state is and the number of advocates in that state for different services you would have to look at those things.

I would agree with Dr. Roy that the first place a state would probably look is at reimbursement rates rather than looking at eliminating services for individuals. It partially goes back to what I was talking about on home- and community-based services. If you, for instance in Ohio where we had a waiting list for our PASSPORT program, which was our waiver for individuals who are aged above the age of 60, the service that they could get is nursing home. But we had a 20 percent nursing home vacancy when I began that role, so where a person would end up is just in that higher cost service anyway so just further driving up the cost of the program.

So that is the home- and community-based services we wanted to keep in place because that actually saved us a large amount of money. Actually, if you look at the Ohio program and you look at the number of people age 65 or older in January of 2011 when the Kasich administration came into office and you just looked at how that actually grew the number of the people in the program and then you plotted against that a line of the number of nursing home bed-days that we paid for, that line actually went down.

So that is what generated that savings in there so we used that savings to go back into the program to do that. So I understand your question of, well, it is only ten percent and we wouldn't get savings but at the same time the other costs are pretty large also. We hadn't talked about duals population. That for us in Ohio was a huge portion of the costs and growing costs. Also the Medicare growing costs that we had, so our Part D and Part B expenditures for this budget that just got put in ate up almost our entire growth of the Medicaid state share of the budget.

So there is a lot of moving pieces in there. I am not sure of going to where there would be cuts in services would be the first place probably would be in provider reimbursement.

Mr. BURGESS. Which in turn has a deleterious effect downstream which Dr. Roy has detailed. Let me yield back my time and I will recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for questions, please.

Mr. GREEN. Thank you, Mr. Chairman. Multiple studies show that Medicaid is a lean and high-performing program that provides access to quality health care for those who need it the most. Unfortunately the bills we are discussing here today are rushed and not well thought out and could undermine the program and its beneficiaries. Medicaid matters and it works. I think we have been in an audience to alternative facts and skewed in some of the testimony we have heard.

I would like to use my time to ask Ms. Solomon questions to help set the record straight. Ms. Solomon, what are the benefits of having Medicaid coverage? I read in a recent study that the folks are literally dying while waiting for Medicaid expansion, yet we hear from some that it would be better to be uninsured than have Medicaid. I would like to see if you can debunk that myth that it is better to be uninsured than to have Medicaid.

Ms. SOLOMON. Thank you. I think that it is very clear and the data on access show that Medicaid patients have a usual source of care at rates approaching that of privately insured and double that of uninsured people. I think the studies that Dr. Roy has cited are really looking at people with serious illness and comparing people on Medicaid to others, and it is really unclear where they were. Were they insured before they got sick? And the expansion, what the expansion has done has allowed that to happen. So if we look at this 10, 20 years from now assuming we stay steady, I think we would see a very different picture.

And I think what has happened in Louisiana where they are really documenting it is amazing. They have a dashboard that shows kind of how many cases of breast cancer have been diagnosed from their expansion that just started actually last year, how

many cases of colon cancer, how many cases of diabetes and hypertension. You can look at that up to the minute.

And what you are seeing is that in that expansion population that now has access to care, people are getting the exams and they are finding those things so that when people do have cancer and need surgery their outcomes will likely be better because they were covered up until the time that they got sick. Before the expansion you either had to be a very, very low income parent, a senior, a person with a disability, a severe disability. So what the expansion does is really open the door to allow access to care for everybody who can't afford to purchase coverage on their own.

Mr. GREEN. Can you describe access to care in the Medicaid program, for instance the timeliness in which Medicaid patients are able to make an appointment with a primary care doctor? Are Medicaid patients generally satisfied with their care? Have there been studies on that?

Ms. SOLOMON. Yes. I think there is high levels of satisfaction. And again, a study from researchers at the Urban Institute showed that timely care was at about 78 percent of people reported they could get care in a timely manner. And that again compared favorably with patients that were insured, and people that were uninsured had obviously a much harder time getting care they needed when they needed it.

Mr. GREEN. Do you believe that the Medicaid program will be able to serve the same number of people with the same quality and same benefits if the program were converted to a capped or a block grant program? How would states adjust to a capped or block grant system?

Ms. SOLOMON. It is impossible. With the level of those cuts the Urban Institute—and a prior proposal—estimated a loss of 14 to 21 million people covered by the program after a few years. It is just impossible to serve the same number of people when you are making a cut of that magnitude. And I think over time, you would see cuts in provider payments. But you would see other things as well. You would see cuts in eligibility, you would see cuts in benefits.

And I think when we are talking about home- and community-based services you have to think about it from the perspective of you have people in nursing homes that is not, you are not going to be able to turn those people out of nursing homes so where are the cuts going to be made? I think the home- and community-based services are particularly vulnerable as the topic of today that it is worth highlighting.

Mr. GREEN. Thank you. Mr. Chairman, given some of Ms. Solomon's answers I would like to submit two research studies for the record. The first study, the research that covers reducing mortality as evidence from states that expanded Medicaid prior to the ACA; and second, Mr. Chairman, illustrates the bipartisan support of the Medicaid program in the ACA expansion by both Republicans and Democratic governors.* I ask unanimous consent to put those in the record.

Mr. BURGESS. Without objection, so ordered.

*The information has been retained in committee files and can be found at: <https://docs.house.gov/meetings/IF/IF14/20170201/105498/HHRG-115-IF14-20170201-SD006.pdf>.

Mr. GREEN. And I yield back my time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the chairman of the full committee, Mr. Walden, 5 minutes for questions, please.

Mr. WALDEN. Thank you very much, Dr. Burgess, appreciate it.

Dr. Roy, I was intrigued by your, well, all of your testimonies, I read it all. It was all very helpful. I am curious, Dr. Roy, do you think it is appropriate for millionaires, maybe billionaires, to receive Medicaid while at the same time we do have people waiting for care? I mean I know we heard that there is nothing to that, but indeed we have heard from states.

I have heard from Medicaid directors, I have heard from governors. They would just like the flexibility to close what some would say is a loophole that allows somebody to get a windfall. It is not just the lottery winner but it could be and it is in some cases, and then the way the rules are written they still qualify for Medicaid when actually they are flush with money. Do you think we ought to close that loophole? Does that harm somebody?

Mr. ROY. I entirely agree with that Mr. Chairman, and let me take a minute to respectfully correct the record in terms of what Mr. Green did to characterize, how he characterized my remarks. I didn't say that Medicaid beneficiaries were worse off than people with private insurance, I said they were no better off based on the gold standard research which comes from work that was published in the New England Journal of Medicine, not known as a sort of alternative facts.

Mr. WALDEN. It is actually a peer-reviewed journal of high renown, right?

Mr. ROY. Absolutely. And my written testimony contains 14 footnotes from peer-reviewed journals that discuss Medicaid help, how it comes in and the challenges thereof.

Mr. WALDEN. See, and I approach this from the fact that why aren't we looking at the science, why aren't we looking at the peer-reviewed journal and saying, OK, what is wrong there and how do we fix it?

Mr. ROY. Absolutely. And this is one of the things that I hope that this committee can do in a bipartisan way is say look, this is not about a debate about whether we should provide and subsidize and help people who need—

Mr. WALDEN. Correct.

Mr. ROY [continuing]. Health insurance who are poor, it is what is the best way to do that.

Mr. WALDEN. Right.

Mr. ROY. And I firmly believe that the best way to do that is through giving those patients more control over the health care dollars that are spent on their behalf. You get less waste and fraud, more accountability and more innovation in the delivery of health care.

Mr. WALDEN. And in the meetings I have had with governors, just to continue this, they are begging for that flexibility at the state and local level. They are the ones that are managing and helping these patients. They have talked to me about really impressive things like, what was it, the high-risk assessments where

they get around a person and say this is a person with a lot of issues going on.

They may need this kind of health care, this kind of mental health care, they may actually need some modification of their house and yet they have to come beg Washington and some bureaucrat back here to get a waiver to do this that or the other thing or they can't plow the savings in to continue to expand and improve the patient's health.

I have always approached this having been on a local hospital board and then working on this stuff in Oregon that you start with the patient and if you get your hands around it that is where I see it is going trying to devolve some of the decision making back to the states. Are there other examples that you have run across in your work where states have had innovative ideas and yet can't get past somebody back here in Washington to be able to implement it that would improve, improve patient care?

Mr. ROY. We could spend all day talking about innovative ideas at the state level that have been stymied by CMS. One I can bring up is the Healthy Indiana program in Indiana. When it was first installed by then governor Mitch Daniels, they tried to do some very simple things to install a larger co-pay if you use the emergency department for non-urgent medical needs and instead they tried to create financial incentives for Medicaid enrollees to go to urgent care clinics or primary care physicians for those issues. They couldn't do it because it is contrary to the Medicaid statute passed by Congress in 1965. They can't even get a waiver for that because the statute itself forbids those practices.

I can tell you it is not just policymakers at the state level who are concerned about these problems. If you have ever spoken to a patient who has spent a week trying to get a doctor's appointment for their child or for themselves and can't do it because so many physicians don't take Medicaid, those are heartbreaking stories.

Mr. WALDEN. And don't your peer review data also show that?

Mr. ROY. Yes.

Mr. WALDEN. That the wait times are longer for Medicaid patients than for others, it is a fairly significant wait-time differential, right?

Mr. ROY. Absolutely. And again in my written testimony I have referenced to some of that literature.

Mr. WALDEN. I know in conversation I had with Governor, I think it is Governor Herbert from Utah talked about trying to be able to communicate with Medicaid patients in Utah by email, apparently some new and novel communication technique. He had to appeal to Washington to get a waiver, waited months, only to get an email from Washington saying no, sorry, you can't do that.

Now I don't know what else was all involved there, but I assume they would have a backstop. If they didn't have e-mail you would still do other ways to communicate because not everybody does, but that struck me as something pretty bizarre. Do you run into those sorts of things? Is he unique?

Mr. ROY. Every Medicaid director, Democrat or Republican, has stories like that. It is a huge problem. And again this is why it is not only important to give states more flexibility in how they man-

age these populations, but it is also important to give individuals more flexibility—

Mr. WALDEN. There you go.

Mr. ROY [continuing]. In how they use their health care dollars.

Mr. WALDEN. Back to a patient-doctor, patient-provider system. I have used up my time. Thank you very much, all of you, for your comments, counsel and testimony. I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from New Jersey, Mr. Pallone, 5 minutes for questions, please.

Mr. PALLONE. Thank you, Mr. Chairman. My questions are to Ms. Solomon. There is a lot of misinformation, or maybe alternate facts is a better word, about Medicaid that continues despite all evidence to the contrary, so I would like you to help us set the record straight, Ms. Solomon. What do you say to claims that the Medicaid expansion funding threatens the truly vulnerable? Can you clarify why that is not the case?

Ms. SOLOMON. Yes, thank you, Mr. Pallone. As I said in my written testimony, there really is just no correlation. And I think this was explored at the hearing yesterday and resolved that the states with the biggest waiting lists have not expanded. The states that don't have waiting lists in large part have expanded.

Another metric is the state option that the Affordable Care Act gave states to actually provide HCBS services without a waiver. Eighteen states have taken that up. The option actually doesn't allow waiting lists, so this is opening up programs to everyone who qualifies. Eighteen states, fourteen are states that have expanded. So I think what you see, Texas unfortunately has one-third of the people, all the people on the waiting list is really no correlation between wait lists and the decision whether or not to expand. They are totally independent.

Mr. PALLONE. All right. And in a similar vein, Mr. Roy claims that Medicaid is simply fiscally unsustainable due in part to the Medicaid expansion under the ACA. Can you clarify why this is not the case? Why have most states that have expanded Medicaid for instance actually experienced net budgetary savings associated with the expansion?

Ms. SOLOMON. I mean it is true and they have documented them. New Jersey, for example, has put out reports and they have saved money in a variety of ways, primarily by lowering their payments for uncompensated care through hospitals and other providers as Medicaid has picked that up. They have also been able to better utilize the services that they have already been providing to people with behavioral health conditions, mental health, and substance use disorders.

And that is where the expansion—and I know it is really true in Ohio—has been particularly helpful in dealing with the opioid epidemic in allowing states to use their own dollars more effectively to wrap around services for people, for example, who are chronically homeless, and address the social determinates of health recognizing that health care is only a small part of what is going to keep very low income and vulnerable people healthy.

Mr. PALLONE. And Ms. Solomon, over the past 2 days in this committee we have heard from some sources that Medicaid expan-

sion discourages work. It is my understanding that numerous studies have disproven the myth that Medicaid expansion diminishes work incentives and I want to know if that is correct. But also, furthermore, several states that expanded Medicaid have found that the expansion populations have not experienced greater job losses or work reduction, so would you comment on those?

Ms. SOLOMON. That is absolutely right. And I think what the Medicaid expansion has been shown to do is allow people to work and to have greater earnings knowing that they can then transition to the marketplace and get subsidies or, assuming their employer doesn't provide work. The other thing that is really important particularly for people who have mental health and substance use disorders is that states are creating supported work programs so that they are able through Medicaid to provide the supports that people need to help them get a job and stay employed.

And Medicaid has been able to do that not only for people with disabilities in the disability category but also for people in the expansion. Most of the people that are getting expansion coverage actually are people who are working but they are working in low wage jobs or part-time jobs or multiple part-time jobs that don't provide coverage. So Medicaid allows them to get the care they need to stay employed and to remain healthy, so it is a work support not a work discourager, I would say.

Mr. PALLONE. And then also the studies have found that Medicaid expansion likely improves the financial situation of those who gained Medicaid coverage under the ACA including reducing unpaid bills and medical debts. Just a few seconds left, if you could comment on that.

Ms. SOLOMON. Absolutely. A National Bureau of Economic Research study shows that a dramatic fall-off in people with debt sent to third-party collections in states that have expanded Medicaid compared to states that haven't.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman. The chair recognizes the gentleman from Kentucky, the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thanks. My first question is for Mr. McCarthy. There is a new CRS memo, CMS Collections of Information from states under the Medicaid Program that tallies the burden states face when complying with CMS requirements under current law. Mr. Chairman, I request unanimous consent this be placed in the record.*

Mr. BURGESS. Without objection, so ordered.

Mr. GUTHRIE. This new memo shows that the reporting burden is higher than many people probably appreciate. One thing I have heard a lot over the past year is that CMS collects information from states but it is often focused on the wrong issues and it is not clear what CMS even does sometimes with the information reported. I mean we don't even have good data matching expenditures by category of service to beneficiaries, and everyone knows how bad Medicaid data is.

*The information has been retained in committee files and can be found at: <https://docs.house.gov/meetings/IF/IF14/20170201/105498/HHRG-115-IF14-20170201-SD003.pdf>.

I strongly believe in accountability for states, but I wonder if CMS has been focused on the wrong things at times. What reporting requirements do you think add costs and not value and what could we cut back on without negatively impacting accountability?

Mr. MCCARTHY. I think what needs to be done is going through all of those reports that are identified in there to determine what information it is needed and how it will be used going forward. It is the same thing we did at the state when we came in. We looked at all the different reports we had and decided one way, should we keep the report or should we get rid of the report or is there something in there that we need?

Often at the state level the report that we requested was partially due because a legislator at some point had asked for information and so you gathered that information and you just kept on gathering it. There are two reports from CMS that we always had to turn in. It was the CHIP report and also the EPSDT report, and I was unclear always of how CMS used those two reports. Our federal matching percentage isn't changed because of those. It doesn't go up or down. There is no penalties or rewards for those things.

So I think that is a part of looking at those reports and saying OK, what information do we need? Information, giving that to CMS is very important. They get questions, you are talking about transparency especially on demonstration projects I know there is a number in there. We need to turn over that information, but the question is then how do they use that and if it is not good information or it is not used then let's let it go.

Mr. GUTHRIE. So in your testimony you talked about CMS should be more focused on outcomes for patients in Medicaid and less prescriptive on how states get there, and I agree with the sentiment and direction. Can you think of a few concrete steps to move incrementally that direction?

Mr. MCCARTHY. So we, many states I should say, use managed care plans, private sector managed care plans to help provide services to the population. You hold them accountable and it is often called pay for performance for the managed care plans. And what you do is you hold back a percentage of their capitation rates from one percent to five percent, and some of that is changing right now. So it provides that incentive and then you use some type of measure. We often use NCQA HEDIS measures to be able to then measure those plans. The better they did they could get that money back.

So one of my ideas has always been, well, why doesn't CMS do the same thing with states and back off some of the command and control and instead hold states accountable for healthy outcomes. Dr. Roy brought those up. So if you have bad outcomes maybe a state should be penalized for that, but if you have good outcomes why isn't there an increase in funding for that state to provide that incentive? States do what we are incentivized to do. Right now the incentive is how do you draw down the maximum amount of federal dollars that you can get, so it is how do you move from that to something else that can be measured?

Mr. GUTHRIE. OK, thank you. And just from some of the other things that we have talked about, I am from Kentucky and Kentucky is an expansion state, elected a new governor recently. And

at some political peril to himself he decided we are going to try to figure out how to keep the expansion and make it work.

And it is kind of news, it would be news to Kentucky that expansion has made the budget better. Maybe when the previous governor expanded it was a hundred percent federal, but the Medicaid program is going to take up 100 percent of the new additional revenues grown to Kentucky over the next biennium which means it is going to sacrifice what we can pay teachers, what we can do to colleges and universities.

So our governor is actually trying to—and he is hearing some of the same rhetoric that we have heard in some of the opening statements. And when he is really trying to keep the program and make it better a lot of people say, well, keep it and make it better and he is trying to, and one of the things he is trying to do is co-pays.

So there are people in the expanded population, so he has the traditional Medicaid, the disabled and the traditional Medicaid, looking at the expanded population—and he gets a lot of negative rhetoric for this. He says maybe they should pay \$1 minimum to \$15 maximum for health care per month, and the other one is a work requirement. And he says that people are in the expanded population working. There are working poor in the expanded population, but some people aren't.

And he says if you are able bodied and you are not, you should work at least 20 hours a week, volunteer work, and I think you can even classify maybe taking care of your grandchild. You can get it certified that as long as you are doing that 20 hours a week so somebody else can go work then you get credit for that. And so there are people trying to make this better and it is not sustainable the way that it is. And I know no one has offered a big tax increase to make Medicaid balance in states and at the federal level and so that is what we are trying to do. We are trying to be serious with it and have people covered and move forward.

And I have run out of time so I will yield. I was going to ask a question but I ran out of time so I will yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Florida, Ms. Castor, for 5 minutes for questions, please.

Ms. CASTOR. Thank you, Mr. Chairman. Mr. Chairman, many people in organizations are speaking out about the difference that Medicaid coverage makes in the lives of millions of Americans and they have contacted the committee this week to make their views on Medicaid known. And I would like to ask unanimous consent to submit some of their letters from the record including a letter from the National Coalition on Health Care opposing the defunding or repealing of the Medicaid expansion.

The coalition represents nearly 90 of America's leading associations of health care providers. A letter from the Asian & Pacific Islander American Health Forum which works to improve the health of 20 million Asian Americans and nearly one million native Hawaiians and Pacific Islanders; a letter from the AARP representing 38 million seniors in all 50 states; a letter from the Save Medicaid in Schools Coalition representing more than 25 organizations invested in the education of our kids; and a letter from the Associa-

tion of American Medical Colleges representing the nation's medical schools and major teaching hospitals.

This is just a sampling of the diverse array of groups that proactively have reached out to this committee just recently to express support for the flexible federal-state partnership that is Medicaid and to offer their ideas to truly strengthen and protect vital Medicaid services.

Mr. BURGESS. Will the gentlelady yield to accept her unanimous consent request?

Ms. CASTOR. Yes, I will.

Mr. BURGESS. Without objection, so ordered.

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

Ms. CASTOR. Thank you very much.

Ms. Solomon, the fear is palpable across the country among families that the Republicans aim to devastate care that is provided through the Medicaid partnership, families that relied on skilled nursing and home and community based services, families with an Alzheimer's patient, children's health care especially kids with complex medical conditions, people with disabilities, and now according to many news sources at the start of the Trump administration it appears that yes, indeed, they intend to target families who rely on Medicaid for elimination of care and services disguised by the terminology of per capita caps and block grants.

And this committee has put out a press release as recently as last night Republicans also plan to target Medicaid through reconciliation so we are gearing up for that. I want to get it clearly on the record what American families can expect if Republicans try to change Medicaid to block grants or per capita caps. It looks like a real draconian process.

I have served on the Budget Committee the past few terms as a representative of the Democrats on the Energy and Commerce Committee and we have seen those budgets. And we have always had this backstop of President Obama and the White House and senators that said no way are we going to devastate care for families, but I think it is really at risk. You have studied these budgets that have passed the past couple of terms; is that right?

Ms. SOLOMON. Yes, I have.

Ms. CASTOR. And could you describe the impact on health services for American families that rely on Medicaid if that approach is enacted into law?

Ms. SOLOMON. Yes. In my testimony Figure 3 shows the trajectory of cuts over 10 years from the latest proposal, the proposal for fiscal year 2017 and it is enormous. And it is very clear that what these proposals do is basically pull federal funds out of the program and shift not only the cost to states but the responsibility to deal with the cuts and it is the states that then have to decide where those cuts should fall. They have to figure out whether they can put more of their own money in at the expense of education and other vital areas of the budget. But these are cuts. These are cuts in federal funds changing the partnership dramatically.

Ms. CASTOR. And how many Americans would be left without health care services?

Ms. CASTOR. Well, as I said, the estimate from a previous proposal was somewhere between 14 and 20 million and the cuts get

bigger over time. And they also can get bigger if things happen that are not anticipated. So the trajectory in my testimony shows what would happen based on expenses growing as expected.

Ms. CASTOR. And we even have Republican governors speaking out against this approach. For example, Governor Charlie Baker of Massachusetts wrote recently we are very concerned that a shift to block grants or per capita caps for Medicaid would remove flexibility from states as a result of reduced federal funding. States would most likely have to make decisions based on fiscal reasons rather than the health care needs of vulnerable populations.

Isn't that true that when you devastate care and take a hammer to the federal-state partnership you are really saying to states you have less flexibility to care for your citizens?

Ms. SOLOMON. You certainly can innovate. States have been innovating and they have been getting flexibility to provide some upfront funding to build the technology they need to coordinate across providers and deliver care in a more coordinated way. That is gone under these proposals.

Ms. CASTOR. Thank you. Mr. Chairman, I will yield back my time.

Mr. BURGESS. The gentlelady's time has expired. The chair thanks the gentlelady. The chair recognizes the gentleman from Texas, the vice chair of the full committee, 5 minutes for questions, please.

Mr. BARTON. Thank you, Mr. Chairman and thank you for holding this hearing. I was a little surprised to hear the tone and the tenor of our friends on the minority side. I have been on this committee 30 years. I missed the memo apparently where it said we were trying to gut Medicaid, destroy the program.

The memo I got said that we have a budgetary crisis and we need to find ways to strengthen the program to reform and improve it and make sure that we get the money to the most vulnerable, and in doing that hey, we might give the states a little bit more flexibility. We might change the waiver process which is fairly bureaucratic. Again I am only the vice chairman and the past chairman and I have only been on the committee for 30 years, so maybe there is some things that have happened behind my back and if so I will take that up with Chairman Walden and make sure it doesn't happen.

I do know that the federal budget is about \$4 trillion, Mr. Chairman. I know that the federal government is right now spending about \$350 billion on Medicaid and that is supposed to double in the next few years. In total, state and federal spending is going to be about a trillion dollars. I also know that the expansion of Medicaid, which the Affordable Care Act engendered, added about ten million people to the rolls and we are spending in the neighborhood of \$60 billion to cover those people and that as the federal hundred percent match is phased out the states are scrambling to find ways to continue to cover this.

So I guess my first question to Dr. Roy, do you think it is possible to maintain the existing growth rate in Medicaid spending at the state and federal level and actually do it in a way that the hardworking taxpayers of America can afford?

Mr. ROY. No, Mr. Barton. And I will go back to something that Ms. Castor said. There is no state in America that does not make decisions about care and coverage for the Medicaid population based on fiscal consideration today. Every single state does that today. Every single state did that last year and the year before that and the year before that because for every state in America Medicaid expenditures are either the number one or number two line item in their budget.

So fiscal considerations are dominant in the way states have to manage their Medicaid programs and they don't, they simply don't have the flexibility to focus their resources, their limited resources on the needs of their populations.

Mr. BARTON. So you could say that the states right now are capitulating Medicaid spending.

Mr. ROY. They effectively are and in very ineffective ways by reducing reimbursement rates to physicians and to other providers. And if we gave them full flexibility, particularly if we gave individuals the flexibility to control the dollars that are being spent on their behalf for the health care needs that they have, we could dramatically improve their access to primary care, their access to specialist care and their access to high quality hospitals in a way that would substantially improve their health outcomes.

We have been talking a little bit today about health outcomes for people in Medicaid versus being uninsured. The most important point I could make today is that health outcomes for people on private insurance are dramatically better than those for people on Medicaid. And so more—

Mr. BARTON. Well, we have three, this is called a legislative hearing so we have three bills before us. One of them has the radical idea that you should count lottery winnings. Now there are not very many of these lottery winners, 6,000 I think nationwide. Would that gut Medicaid if we actually counted lottery winnings as part of the income test?

Mr. ROY. Not in the least. If someone can afford private coverage or otherwise is not the kind of person who the Medicaid program is designed for it just defies common sense why we would devote those scarce resources to subsidize those individuals as opposed to the individuals who need the help.

Mr. BARTON. Congressman Flores has a bill that would say we give the states the discretion on covering undocumented workers or illegal aliens. They could cover it with their dollars but the federal government wouldn't have to automatically cover them; now that is a little bit more controversial. These are people that have come into country illegally, don't have the proper documentation. Do you think that the majority of the citizens and the taxpayers of the country would support that idea?

Mr. ROY. As the child of immigrants to this country from this country from India I find it very puzzling that we are even having this debate. It seems entirely commonsensical that we would restrict Medicaid funding and resources to people who are legally resident in this country.

Mr. BARTON. In my congressional district if I did an opinion poll it would be about 95/5, 95 in support of restricting Medicaid to citizens or legal residents. With that Mr. Chairman, I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman Mr. Luján, 5 minutes for questions, please.

Mr. LUJÁN. Thank you, Mr. Chairman. And Ms. Solomon, at the Center on Budget and Policy Priorities have you had a chance to review the Republican proposal, some of which was listed in Speaker Ryan's Better Way document on—

Ms. SOLOMON. Yes.

Mr. LUJÁN [continuing]. What they would do to Medicaid? Can you talk about that?

Ms. SOLOMON. Yes. I mean I have mentioned it. It would really just shift huge amounts of costs to the states, as I said, along with the decisions of how to absorb the major cuts and also leave states shorthanded, essentially, if things that were not anticipated happened such as an epidemic. We have had the Zika threat, drugs, new blockbuster drugs, the ability to provide those to people, the aging of the population; all of the proposals are based on what the population looks like now.

And we have that bulge of the Baby Boomers which right now are at the sort of lower end of the seniors, 10 years from now that is an older population and 20 years even more so. So none of that is really taken into whatever the formula would be that we would have a lot more people who are very old and need a lot more care. So basically states would have to figure out how to deal with that.

Mr. LUJÁN. So Ms. Solomon, I know this is a complex issue as we are trying to better understand it to do our due diligence to make a difference to keep this program strong. The way that I understand, when the federal government shifts costs to the states that means that the federal government is going to cut the federal investment and put that burden on the state. Is that a fair assessment?

Ms. SOLOMON. That is it. I mean that is exactly what these, we call them block grants, we call them per capita caps, but they are cuts. They are cuts in federal funds when it is very easy for Congress to do it because it really leaves the states with the hard decisions of how to absorb that change in the partnership between the federal and state government.

Mr. LUJÁN. I appreciate that Ms. Solomon. So if there is any question associated with the Republican plan, I think Speaker Ryan has something called a Better Way that everyone can go take a look at that pamphlet. And when we are talking about what is happening here, if you are saying and using terminology to shift the cost from the federal government to the states that means you are cutting the program. I don't know why we are parsing over this. It is what it is. Let's just accept the programs that both sides are putting forward here.

Now there is a lot of conversation, Ms. Solomon, associated with one of these areas and a term that we are learning more about called the reasonable opportunity period which is being talked about in one of these bills. It is my understanding that there is a verification process that has been established when someone applies for these programs that you have to submit your Social Security Number or documentation.

In cases maybe where Social Security doesn't exist, but where it does exist you submit that that is verified Social Security Administration whether someone is eligible or not. If they don't have their Social Security Number or their Social Security Number process is not one that is recognized by the Social Security Administration then an applicant would submit paperwork to show that they are citizens and then they would be put in this what is called an ROP. So can you tell me if there is challenges for naturalized citizens?

Ms. SOLOMON. Yes.

Mr. LUJÁN. Do they have to submit additional paperwork and then would they land up in an ROP? Would citizens born outside of the United States fall into that situation and have to fall into an ROP and namely children born on military bases outside of the United States, would their number fit into that process and would they fall into this ROP?

Ms. SOLOMON. Yes, those are the groups that would be most affected by the bill that is before you because that bill if you look at the language it talks about aliens declaring that they are citizens. It actually affects the verification process for people who are attesting to being citizens or U.S. nationals. A vast majority of those individuals have their citizenship verified electronically pretty instantly by the Social Security Administration.

There are several groups, the groups that you mentioned, naturalized citizens, people who are born abroad, say, to military parents and some newborns who have to provide documentation because Social Security can't verify it quickly. The reasonable opportunity period was put into the law after we saw large numbers of children and others not being able to get through this without delays so that they could get benefits while they were submitting their documentation.

Mr. LUJÁN. Thank you, Ms. Solomon. And as my time expires, Mr. Chairman, I think that we all want to make this system work, but citizens of the United States should not be left out. Thank you very much.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions, please.

Mr. SHIMKUS. Thank you, Mr. Chairman. It is great to be here, great new hearing room and so I get to do the inaugural chart through this new technology. Obviously we are talking about the budget and we are talking about spending. I think you can see it.

[Chart shown.]

Mr. SHIMKUS. You should be able to see it right—can't they see it in front? All right, see, it is all new to us. So you got it right in front of you. Does anyone dispute this as a federal budget pie in 2015? No. Mr. McCarthy?

Mr. MCCARTHY. No.

Mr. SHIMKUS. Ms. Solomon? No, that is it. Now, so we are debating—look, this is an important budget chart to show that we fight our budget on the blue area which is the discretionary numbers. The red is the mandatory, the red is spending out of control and as that continues to grow it squeezes the blue portion.

And Ms. Solomon, you mentioned it on Medicaid, or someone, Mr. McCarthy, you mentioned it on Medicaid. As Medicaid in the

states expand it squeezes schools, public health, state budgets, so the debate on reforming the process to make it solvent, I think, is a very fiscally responsible debate, but people have to see the whole chart. So really, our challenge here is try to address the mandatory spending and make it fiscally sustainable and then we don't have these discretionary budget fights. So that is just a good way to start.

Now I want to go to specific questions. Mr. Guthrie just returned. He kind of talked a little bit.

You can take that chart down now unless we want to keep it up just for the allure of it.

But Mr. Guthrie at the end of his filibuster kind of started talking a little bit about the, what we call the work requirement. So I know, Mr. Roy, you have done some research on that. Can you talk about that "work requirement" as far maybe some possible reforms?

Mr. ROY. Yes. So let me highlight, Mr. Shimkus, one of the things that we in the health policy community support about a work requirement and that is that there is a lot of emerging research that shows that individuals who have health insurance and who have health care needs who have work, who have a job are much more engaged in their actual health care and just the wellness that comes with having a job, going to work every day, feeling needed.

A lot of these things are subtle, but the research is quite compelling in showing that people who have jobs do a much better job in terms of health outcomes versus people who don't. Not because of income because you can stratify these results for income, but because of their engagement in their own lives and their own health. And so a lot of what I think our ambition is is to see a work, a relationship between work and the Medicaid program and other programs that help low-income individuals so that there is an encouragement for those individuals to be engaged in their lives and engaged in their health.

Mr. SHIMKUS. And these are not, the elderly or the disabled are not involved in this work requirement discussion, correct?

Mr. ROY. Correct.

Mr. SHIMKUS. And Mr. McCarthy, having your experience in the state you know that the 1115 waiver supposedly has that ability to do that. Can you talk about how a requirement that an individual not just take from the Medicaid program but actually give back to the community can help that individual?

Mr. MCCARTHY. So from the standpoint of what we saw in Ohio as many of the people on the program were working so we believed—and we had a Healthy Ohio waiver which we turned into CMS that was disapproved—that having people participate not only in their health care but in just making their lives better would be something that would be beneficial to everyone.

I think one of the things that we get distracted on, and somebody brought this up earlier, was the issue just simply work. There was a discussion of could it be education or other things that are going on, just engagement of a person to say here is the things we need to do. Many people are already doing it. There is a subset that is

not, so let's engage them to figure out what that is that they can do to better themselves.

Now there was——

Mr. SHIMKUS. Let me in my last 45 seconds ask, don't we do this already for TANF, for the Temporary Assistance for Needy Families, isn't there some quantification right there already and that could be used in that same process?

Mr. MCCARTHY. Yes.

Mr. SHIMKUS. I yield back my time.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions, please.

Mr. KENNEDY. Thank you, Mr. Chairman. I appreciate the opportunity here. I want to thank the witnesses for being here, discuss an important topic to our health care system and the underpinnings for how we try to make good on a promise that everyone in this country gets access to the care that they need when they need it and that is a fundamental bedrock for not just our medical community but our society. No one wants to be checking a health insurance card after you get hit by a bus, or a passport or for a green card.

So the question then is, getting back to the pie chart Mr. Shimkus put up, is yes, there is issues on the discretionary spending and the mandatory spending side, and the focus of this hearing is looking at that smallest piece of the mandatory side and taking out that side interest on the debt and squeezing out efficiencies there, which I would point out is close to 50 percent of the Defense Department budget.

So I think it is also important to put these reforms in context and to put a human side on them too. As we consider these reform bills that we go through we should remember that there is by some estimates 32 million Americans that are on the cusp of losing health insurance depending on what this committee decides to do.

I toured a series of community health centers last week in my district and you heard the same message from their doctors, from their patients, from their advocates, from their staff which was don't sabotage the Affordable Care Act, don't gut Medicaid expansion and don't jeopardize the progress that we have made in our health care system. It is not as simple as redirecting that funding.

As more and more people lose coverage and access to preventive care which many of them can get from a community health center they turn to emergency room treatment, then uncompensated costs go up at hospitals and premiums increase with them. One of the health centers I visited, the North Shore Community Health Center, Medicaid makes up 60 percent of the total patient service revenue. Statewide community health centers serve over one-fifth of all Medicaid beneficiaries in the Commonwealth of Massachusetts and account for less than two percent of our Medicaid expenditures.

So yes, while we need to look for innovative ways to deliver new care we should dismiss catchy ways to kick people off of Medicaid. We should be debating reforms that would replicate those efficiencies that we have seen across the country. In Massachusetts by the way—that has a 2.8 percent unemployment rate and a 2.8 per-

cent uninsured rate, the idea that the Affordable Care Act is somehow a job killer is demonstrably false, as we have seen in Massachusetts.

So we also know that going forward the immediate repeal of the Affordable Care Act would result in a loss of three million jobs worldwide, would lead to \$165.8 billion in hospital losses over the next 8 years, Medicaid expansion would, in fact the progress we have made on lowering marketplace premiums would be gone, and repeal without a replacement would lead to nearly 44,000 deaths annually by conservative estimates. There is a reason why Republican governors, many of them represented in states that my colleagues here represent, are begging Congress to try to defend that Medicaid expansion.

And I would like unanimous consent, Chairman, to submit for the record a letter by my governor, Republican Charlie Baker, in response to a solicitation put out by leader Kevin McCarthy, detailing some of the reforms that he would like to see going forward as a health care executive, former health care executive.

And he mentions in here, Chairman, that maintaining state health care safety nets including retaining existing federal health subsidies and uncompensated care pools that support health care coverage and charity care providers, avoiding proposals that only offer more flexibility and control in exchange for shifting costs to states, providing flexibility with then pulling back money does not solve the problems that we have heard from today.

Mr. BURGESS. Will the gentleman yield for action on his unanimous consent request?

Mr. KENNEDY. I will for that. Thank you.

Mr. BURGESS. Without objection, so ordered.

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

Mr. KENNEDY. Thank you, Mr. Chairman. So I realize I filibustered there for a little while, apologies. But Ms. Solomon, two very simple questions and then just so I leave with: do you support repealing the Medicaid expansion and do you believe that health outcomes improved in states with expanded Medicaid versus those that did not?

Ms. SOLOMON. I obviously support the expansion and do believe that it has made a huge difference in the states that have expanded in addition to lowering the un-insurance rate, more people getting care, its evidence is indisputable.

Mr. KENNEDY. And then very briefly since we have about 30 seconds left, the largest payer of mental health services in this country is Medicaid. There has been in this committee a bipartisan commitment to look at some of the issues around mental health. How can we possibly address the systemic failures of our mental health system without addressing Medicaid?

Ms. SOLOMON. You can't because it really is providing the foundation for things such as the initiatives that were in the CURES bill and elsewhere. Those are going to wrap around the foundation that is provided through Medicaid for behavioral health services.

Mr. KENNEDY. Thank you and I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Pennsylvania, Mr. Murphy, 5 minutes for questions, please.

Mr. MURPHY. Thank you, Mr. Chairman. First, Dr. Roy, you were talking about how people who are on Medicaid don't really differ much from people who have no insurance at all and cited a few studies, looked at things like cancer, diabetes rates and things like that. And I just want to make sure I got it on the record you are not implying that being on Medicaid causes cancer.

Mr. ROY. Of course not.

Mr. MURPHY. That being on Medicaid worsens cancer or reduces life span, and you also say that people who are on Medicaid, the doctors are paid below market rates, and you are not saying that when doctors are paid less that reduces life span, but you are talking about an access to care.

And I believe one of those studies, I looked it up here, is also Kwong, et al., University of Pittsburgh, my alma mater. But what is happening is that people actually come in worse. They put off care. And this is where I agree with some of my colleagues on the other side of the aisle, when people don't have insurance they put off care.

And it has actually been some of the problems of the Affordable Care Act. It was supposed to have been that it would increase outpatient visits and actually reduce inpatient and emergency room visits and it has had the opposite effect because what people have found they have high co-pays and deductibles. Does that make sense?

Mr. ROY. That is correct. Emergency room volume has increased through the Medicaid expansion and it has not increased the rate of primary care physician access relative to what Medicaid's performance was previously.

Mr. MURPHY. Mr. McCarthy, I want to understand. You had made some references in your comments about co-pays and premiums that were reasonable and enforceable which should keep—is that meant to keep people from the emergency rooms and keep those costs down?

Mr. MCCARTHY. It is designed, the purpose of it is to have a person actually make a choice of where they are going to go and make a reasonable choice to say—

Mr. MURPHY. I understand. And the same thing with formularies and for drugs there, because initially we were trying to grapple with that when dealing with the cost of drugs that formularies and negotiated drug prices in selecting one can be part of a cost savings, correct?

Mr. MCCARTHY. Right. The problem with the Medicaid program right now is that a state is forced to cover every FDA-approved drug and it leaves you with no negotiating room for new drugs.

Mr. MURPHY. OK. And part of the issue we dealt with here on another hearing was that when a state chooses, for example, a formulary in mental health drugs that assumes that all anti-depressants are anti-depressants the same and all anti-psychotics are the same just because they have that same function, they are not the same because they have different side effects and because of different side effects people may not take them. When they don't take them their situation gets worse.

And I know that Ms. Solomon, you also made some comments about when people have to make a choice about care and they are

on waiting lists to get into long-term care. And I am assuming you would be supportive that if there was an option for an alternative payment model and if someone could be cared for in-home that would save money and probably be more preferable to that patient. Am I correct?

Ms. SOLOMON. Absolutely. And there are multiple options and flexibilities for states that want to do that including the new state option for home and community based services. This is where there is enormous flexibility in Medicaid for states to pick up different ways of doing that.

And as Figure 1 in my testimony shows, the result has been that—

Mr. MURPHY. I have to cut you off. I am trying to get to another point here, but if you can get me that I want it because here is the thing I want you to think, although I think we are not there yet. We are talking about moving around how things are paid for, whether doctors are paid more, what is happening there. A number that keeps coming up to us is that 5 percent of the people on Medicaid account for 55 percent of Medicaid spending and they are not a homogeneous group.

One thing I would like to submit, Mr. Chairman, is an article by Gregorio, et al., on inflammatory bowel disease in medical homes, talking about this in an op-ed that I wrote called A Better Model for Healthcare in America from the Washington Examiner that when you actually wrap service around something and you identify the over utilizers versus someone who just is a high utilizer you can make a massive difference.

So not all of those people on Medicaid are the same, and it isn't just paying doctors more. This is where I want to know, I am not sure the bill, I mean the bills we are dealing with today have some effects here on spending but they don't have an effect on changing medical models. So now Ms. Solomon, if you can complete your thought, how do we change an alternative spending model that saves money in Medicaid and provides better care? You have 30 seconds.

Ms. SOLOMON. It is going on today in multiple states that have done exactly what you are saying, identify those high utilizers. The health home program that was in the Affordable Care Act, things like the programs at the Camden Coalition which has become a national model—

Mr. MURPHY. Very important. Can we do more to incentivize those, because as some of those even worked it is kind of state by—the Camden model is a great model, but the question is, and this is where I would like all of you to get back to this committee, it is extremely important that we find ways of effectively helping those and it isn't just going to be raising their co-pays and deductibles to do that.

With that Mr. Chairman, also one other thing I want to ask unanimous consent to submit for the record. It is a letter from the National Association of Psychiatric Health Systems too, on these models too.

Mr. BURGESS. So just to clarify the gentleman had two unanimous consent requests?

Mr. MURPHY. Three.

Mr. BURGESS. Was there one embedded in that previous discussion?

Mr. MURPHY. There is three. One is an article by Gregorio, et al., where—

Mr. BURGESS. Without objection, so ordered.

The gentleman's time has expired. The gentleman yields back. The chair recognizes the gentlelady from California, Ms. Eshoo, for 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman. Glad to be back on the subcommittee. I am a returning member because I did serve on this subcommittee for several years. Thank you to the witnesses. There is an advantage to coming in a little later in terms of asking questions because we have been listening to both questions, answers, comments of members.

My takeaway on the three bills here is that they, all three of them, change Medicaid eligibility requirements, and when eligibility requirements narrow some Medicaid beneficiaries who previously qualified for coverage will no longer qualify and will lose their Medicaid coverage. So the results in coverage are essentially being taken away from these people, so this is subtraction. This is subtraction. That is my take on the three bills. I could say more about them. I am just fascinated with some of the things that have been said.

Now I want to go to you first, Dr. Roy. I am not familiar with your organization, the Foundation for Research on Equal Opportunity. Who funds you?

Mr. ROY. We are a nonpartisan, nonprofit think tank that has donors from—

Ms. ESHOO. Yes, but who funds you? Where does the money come from?

Mr. ROY. The money comes from donors just like every other think tank who are individuals.

Ms. ESHOO. And who are they? Who are your major donors?

Mr. ROY. We don't disclose our donors. We are 4 ½ months old.

Ms. ESHOO. Does the committee require in the witness background to submit to the committee who funds organizations, et cetera that witnesses come here to testify on behalf of? If we don't I think that we should consider that.

Mr. ROY. I am not testifying on behalf of donors. I am testifying on behalf of the Foundation for Research on Equal Opportunity and myself.

Ms. ESHOO. Well, that is why I am asking about the Foundation because we have foundations and we have foundations. But since you don't wish to disclose, I think that the committee should for all witnesses make that determination and make it a requirement so that members do know.

Now did you support the ACA when it was passed?

Mr. ROY. We don't take institutional positions on legislation.

Ms. ESHOO. Do you support it today?

Mr. ROY. What I do support—

Ms. ESHOO. No, no, no. Answer it. I only have 5 minutes.

Mr. ROY. What I do support is universal coverage, and we have put out a plan to achieve universal coverage.

Ms. ESHOO. Do you support the elimination of Medicaid?

Mr. ROY. I don't support the elimination of Medicaid. I support covering everyone who needs financial assistance to afford health insurance.

Ms. ESHOO. Right. In your research—the chairman of the full committee made mention of millionaires and billionaires who use Medicaid. In your research have you found anyone in those two categories that are in Medicaid, using Medicaid?

Mr. ROY. There are lottery winners who by law if they receive all their income in a lump sum in 1 month—

Ms. ESHOO. So it is lottery winners, and how many of those are there?

Mr. ROY. It is not merely lottery winners. It is anybody who receives a lump sum payment. So for example someone who received a financial bonus from work—

Ms. ESHOO. So if someone is in an automobile accident and there is a settlement then that makes them a millionaire or billionaire. I have to tell you that this is a bad rub when these things are thrown around that millionaires and billionaires are on Medicaid.

Mr. McCarthy, do you support eliminating the federal dollars of Medicaid and then have the states be the laboratories of invention and be able to expand or contract or write their own rules with their own money and believe that people will still be served?

Mr. MCCARTHY. I believe that people can be served if the states are given the proper flexibilities in whatever—

Ms. ESHOO. No, I am asking about the federal dollars though, picking up on Ms. Solomon's testimony.

Mr. MCCARTHY. If the federal dollars change the states will—

Ms. ESHOO. Do you support subtracting the federal dollars out and just have the states carry out with their own dollars whatever they want to design?

Mr. MCCARTHY. If you are asking if all federal dollars, no. That would be very difficult for a state to do.

Ms. ESHOO. Sure would. And at what point do you support the reduction of federal dollars? What level reduction are you—

Mr. MCCARTHY. It depends on what flexibilities are given to states. Those two things have to go hand in hand.

Ms. ESHOO. So you don't want to name the amount of dollars that you are willing to subtract as a former director of the program from a state, from a major state.

Mr. MCCARTHY. Again it would depend on what flexibilities come with it.

Ms. ESHOO. Ah-ha. So we want the money for sometimes, we don't know how much but someone is going to decide it. That is quite a proposition. Well, what the conclusion that I have come to, and it is not hard listening to the testimony, is that there is really not support for this program and so there is a nitpicking around the edges.

In anything we do there is always room for improvement, but this, I don't think today's hearing is about improvement. I think it is about elimination, subtraction and I don't—

Mr. BURGESS. The lady's time has expired.

Ms. ESHOO [continuing]. Think your surveys and whatever you presented in your testimony are reliable or acceptable because I think they hurt people. Thank you.

Mr. BURGESS. The chair would request that we respect other members' time, and I am now going to recognize Mr. Lance from New Jersey 5 minutes for questions. Mr. Lance lost interest. Mr. Griffith, 5 minutes for questions, please.

Mr. GRIFFITH. Thank you very much. I appreciate our committee working hard on this. As you have heard we can always make things better. And one of the things that the American people want and my people that I represent in Virginia and my district want is folks to make sure that if they need the help they get it. But if they suddenly find themselves millionaires because they won the lottery or they have gotten some other lump sum payment, they don't think those folks ought to necessarily be getting Medicaid.

And so while I have heard it said that throwing it around that millionaires are getting Medicaid is a bad rub, currently it is a bad rub the average hardworking American taxpayer is paying for it, wouldn't you agree, Dr. Roy?

Mr. ROY. My foundation, the Foundation for Research on Equal Opportunity is dedicated to expanding economic opportunity for those who least have it. Generally speaking, millionaires and billionaires are not people who at least have economic opportunity in this country.

Mr. GRIFFITH. And in fact when I read the bill I noticed with some interest that I thought it was fairly generous because it basically allocates it out as roughly \$40,000 a month for the first, say, hundred thousand and then it is more than that. So it is not like we are saying that if you win a million dollars you can never be on Medicaid again, it is fairly loose. Wouldn't you agree?

Mr. ROY. I mean to me it is very simple. If you can afford to buy health insurance yourself, please do so. If you can't afford health insurance on your own and you need the financial assistance and are eligible for the financial assistance that Medicaid provides then let's find a way to get you that assistance. It seems completely non-controversial and I really don't understand why members of the minority find this problematic.

Mr. GRIFFITH. And I am going to switch gears but stick with you, Dr. Roy, if I might. In your written testimony, and I don't believe you have had an opportunity and I apologize if I have missed it somewhere, but I don't believe you have had an opportunity to discuss it. On page 8 of your written testimony you start getting into issues about how "the interest of state and federal governments have diverged in Medicaid because of the way it is set up."

And I am not sure these bills directly get to that but I thought that was interesting testimony because it is one of the things that has been a bad rub for Virginia. And that you then go on to talk about how the federal government has done some things that maybe they ought not to have done and the state governments have responded and done some things where they came up with creative financing and you actually reference Medicaid hospital taxes. And in Virginia we rejected that concept because we saw it as a tax on the sick and that they wanted to create a bed tax where, if you were a Medicaid patient you would get the money back as increased costs and you would receive as you said in your testimony whatever your match was, in Virginia it is 50 percent but you used 60 percent in your example, you would get that

money back and so the states have actually gamed the system in some states to get more federal dollars from Medicaid and in some cases like New York they have actually had to have reforms because they gamed it so much they had so much money floating around they were wasting millions of dollars. Isn't that true?

Mr. ROY. Absolutely. And a number of the states in fact nearly I would say a majority of the states that have expanded Medicaid under the ACA in theory there—

Mr. GRIFFITH. Just a second. Mr. Chairman, I am having a hard time hearing.

Mr. BURGESS. The gentleman is correct and the time will suspend. The chair notices a significant difficulty hearing the testimony of the witness even with amplification, so could I ask conversations be taken off the dais in respect to our witnesses who have agreed to be with us this morning?

Mr. GRIFFITH. Thank you.

Mr. BURGESS. The gentleman continues to suspend. Conversations off the dais to allow the witnesses a chance to be heard. The chair thanks the committee. The gentleman may proceed.

Mr. ROY. A majority of the states that have expanded Medicaid under the ACA have used provider taxes and health insurance premium taxes to fund the theoretical ten percent match that they are supposed to contribute. We have heard some descriptions of the so-called savings that states have achieved by expanding Medicaid. There are no so-called savings.

What has happened is that state governments have raised taxes on Medicaid providers and on managed Medicaid managed care companies and use those revenues to fund the Medicaid expansion in their states, in other words increasing the federal liabilities for the Medicaid programs in ways that the ACA did not contemplate.

That is not just true of the ACA. In my written testimony I cite the fact that on average the FMAP, the match rate at the federal level is around 58 to 60 percent. At least that is what it is supposed to be on paper, in reality it is closer to 70 percent because of these taxes that states use to game the system and attract raised costs in the Medicaid program and drive revenue to the states from the federal government that they otherwise wouldn't gather and aren't supposed to obtain.

Mr. GRIFFITH. And I want to summarize and probably then have to conclude, but in summary, if the federal government gives the state \$2 million and the state was only going to spend a million dollars, the state has not saved a million dollars, the federal government has spent a million dollars it maybe didn't need to.

Well, I support all three of these bills, but I would invite all of our witnesses if you have ideas on ways that we can improve these bills, please let us know because we are trying to make sure—I agree with the philosophy, but if there is some way that we can make the bills better, please let us know and I would appreciate it very much if you will give that in writing. That would be great. And with that Mr. Chairman, I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman and the chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DEGETTE. Thank you so much, Mr. Chairman, and it is good to be back on the committee, on the subcommittee, although this morning I can't help but feel like I am in a Lewis Carroll book because here we are talking about lottery winners and undocumented people getting Medicaid, but then the testimony particularly from the majority witnesses is all about the full Medicaid expansion.

We saw this yesterday in the Oversight and Investigations hearing on the Medicaid expansion and I think we really need to clarify what we are talking about. I don't think the biggest problems facing Medicaid are lottery winners getting Medicaid advantages, and also under current law although it may not be good from a health care policy standpoint, people who are not citizens or have documentation they can't get Medicaid right now under current law. And with respect to people who are vulnerable, as has been demonstrated by all of the evidence, if you expand Medicaid then you actually are more able to insure the vulnerable.

So let's talk about what we are really discussing today under the guise of these three bills. What we are really discussing today is the majority's intention to gut the Medicaid expansion for a variety of reasons. And that is what I want to talk about.

Ms. Solomon, I want to ask you, now I understand that in the Medicaid expansion under the Affordable Care Act 80 percent of the people who are getting that Medicaid expansion are actually working; is that right?

Ms. SOLOMON. That is right.

Ms. DEGETTE. What is the situation with the other 20 percent of the population?

Ms. SOLOMON. So it is varied, but you do have a large share of people if you think about who was not covered by Medicaid before and is picked up by the expansion you have the people we sort of shorthand call the childless adults. And these are people that didn't fit a category and we did away with the categories. So you do have people who are chronically homeless, people with substance use disorders, people with mental illness and then just a group of people who are caring for family members and low income, unable to work.

So it is probably a diverse population, but there really isn't—the people that are mostly affected are the people who didn't have a pathway to coverage before and who were working because they were working in jobs without coverage.

Ms. DEGETTE. And how did those people get their health care before we had these Medicaid expansions?

Ms. SOLOMON. They didn't. I mean they didn't have insurance so they—

Ms. DEGETTE. Well, if they got sick what did they do?

Ms. SOLOMON. Yes. They went to the emergency room. They went to hospitals. They went to community health centers that would—

Ms. DEGETTE. Right, and eventually we the taxpayers paid for that, right?

Ms. SOLOMON. Correct.

Ms. DEGETTE. Now you heard Dr. Roy say that he did a study—and Doctor, I read your testimony and also the article that you wrote that you cited in your testimony. And he said that the data

shows that people on Medicaid have no better outcomes than people who are uninsured. Is that supported by the rest of the data?

Ms. SOLOMON. I don't think so. People are getting care. And I think again the studies are very, very narrow and they look at people with very serious illnesses, and I think Dr. Roy said that they came in late. They didn't have their conditions diagnosed, and that is exactly what the Medicaid expansion is allowing. I would just commend everybody to look at the dashboard in Louisiana where they are tracking the people that are being found through their pretty new expansion.

Ms. DEGETTE. OK. So some of you who were at yesterday's hearing in O&I, I talked about some of the people I had last week in Denver. I had a listening session for people to come and talk about their experiences in the ACA. And I had one woman, Lisa Scheim of Denver. She developed a neuroimmune illness and so she has only been able to work part-time. Because she works part-time she is not eligible for insurance through her employer, and before the ACA she was rejected for insurance because she had a preexisting condition.

We had a high risk pool in Colorado, but the premiums were so high she couldn't buy in. So then she got ulcerative colitis and an autoimmune disease, she couldn't even go in for a diagnosis because she couldn't pay for it. Finally she got a part-time job but she couldn't get insurance. In the meantime her medical bills went to collection and she even got a letter that said she was going to jail. So now she is on the Medicaid expansion. She works part-time, she gets her treatment, and if we eliminate this expansion she now won't have insurance again.

Mr. Chairman, those are the types of people who are getting health insurance now. I can't help but believe Lisa Scheim and all the other millions of people who are getting insurance are getting worse care now than no care before. I yield back.

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it and I thank the panel for their testimony.

Mr. McCarthy, in your testimony you noted that giving priority to states with the biggest wait lists would only incentivize states to have high wait lists. I am from Florida and we are the number two when it comes to the size of our home and community based care waiting lists, and I understand Texas is number one. Right, Mr. Chairman?

You also mentioned tying funds to the Money Follows the Person program. There are 44 states that have that program, Florida does not. How do you propose allocating funding to promote more home and community based care, something I strongly support, and yet not disadvantage states such as Florida and Texas that have a greater need?

Mr. MCCARTHY. It has to do with how we provide that incentive. So the idea is like in Ohio—our Money Follows the Person program, when we started we had about 600 people that we moved out of institutions. By the time I left that number was over 5,000 peo-

ple. So in 6 years we were able to do it. We focused on how to get people out of institutions, looking at that to pull people out.

We also used the money that came to the state by the one percent increase for rebalancing, so we used that also. So my point of it was if you were to say that it only goes to the states with the highest wait lists, then in Ohio my incentive would be to let the wait list grow that I have so as to be able to access that that funding was 90/10 in the bill, so that would be my incentive to get there.

So instead of doing that I was saying, how do you just tie it to programs that are out there and hopefully other states will be looking at what we have done in Ohio or other states and learning from that and that is where CMS can come in and do a better job of getting states to collaborate to figure those different pieces out to move forward in those areas.

Mr. BILIRAKIS. Thank you. Again for Mr. McCarthy, Medicare is moving towards value-based payments. Some forward-thinking Medicaid directors of programs have been adopting this model while others have been much slower. Can you talk about why value-based purchasing is important and what some of the existing barriers are both regulatory and statutory that need to be removed? How can we promote, really, generally how can we promote innovation?

Mr. MCCARTHY. So Ohio is a State Innovation Model grant winner and so that was a benefit to the state to move forward in that. And the reason value-based purchasing is important in Medicaid is because it rewards better health outcomes, it doesn't just put money into the program.

So in Ohio for instance even in this last budget that was introduced Monday, there weren't just simply for physicians putting money into increases in fee-for-service physician rates. It was going into the per member per month amount going to doctors which then get rewarded for bringing down costs but having better outcomes.

And so that is why value-based purchasing is important. The barriers that you run into are all at the CMS level. I have talked to CMS about this. The Center for Medicare and Medicaid Innovation don't talk to CHDS at the Medicaid side. And for instance in Ohio we ran into a barrier. The only way we could do patient-centered medical homes in the fee-for-service world was through a state plan and that meant then we had to bring up a PCCP program, which we didn't run in Ohio.

So there is this whole barrier of how do we get there? Those things need to be waived, because what we were trying to do is bringing more value to the program and increasing outcomes.

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

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for questions, please.

Mr. SCHRADER. Thank you, Mr. Chairman. I appreciate having the hearing, and some of these fixes to the Medicaid population issues and the Medicaid expansion issues I think are fine. I think unfortunately it doesn't get at the big gorilla in the room which is

what do we do with the Medicaid expansion population and how do we deal with Medicaid going forward.

And I apologize to Dr. Roy right off because I am going to ask you a few questions. When was study, the New England Journal of Medicine study done that cites some of the issues in the Oregon Medicaid program that you cite in your testimony?

Mr. ROY. The study was conducted in the late 2000s and early 2010s, and I believe it was published in 2014.

Mr. SCHRADER. Yes, so it predated the ACA.

Mr. ROY. It wasn't about the ACA expansion, but it was about—

Mr. SCHRADER. I understand, reclaiming my time. The problems you cite with outcomes, no better no worse, but no better than traditional Medicaid with the waiver program. Second question, do you think it is cheaper based on your information to give tax credits and subsidies for the federal government, for the federal taxpayer to do that rather than have eligible people be on Medicaid?

Mr. ROY. In Transcending Obamacare, our health reform proposal, we propose taking the same dollars. So it is not about a reduction in dollars relative to the Medicaid program, but it is about taking the dollars that are spent, providing acute care coverage to the Medicaid population and giving them the option of having a tax credit that allows them to purchase—

Mr. SCHRADER. Thank you, I appreciate that. And the answer is it is unfortunately to put people in the Medicaid population for the American taxpayer. I am trying to be a little fiscally responsible as we look at the costs of all these people. I prefer not to have to take care of people that are unable to afford health care, but on the back end I don't want to pay for them in the emergency room or for long-term, serious, life-threatening issues at the end of their life.

Mr. ROY. If you buy an East German car it might be cheaper than buying a Toyota or a Ford but that doesn't mean you get more transportation out of it in the end.

Mr. SCHRADER. I totally agree.

Mr. ROY. So cheaper isn't necessarily better.

Mr. SCHRADER. I am a businessman. Spending money sometimes saves you money up front, right? So if you spend your money you can hopefully make it up on the back end. How many people do you think that are under 138 percent of poverty level or earning \$16,000 a year are going to be able to afford to put money into an HSA account that you recommend in your proposal?

Mr. ROY. If it is subsidized through these tax credits they would be able to afford it.

Mr. SCHRADER. If it is subsidized. So in other words we need to have money in the Medicaid expansion population or whatever system we have to be able to make something go forward in a reasonable way that Joe Sixpack could actually afford things.

Mr. ROY. Absolutely.

Mr. SCHRADER. The issue I have here right now is that, you know, the bottom line is the Medicaid expansion population has been an unqualified success. We have red states, red state governors, some of my Senate colleagues, some of my Republican colleagues who cross the aisle, you know, really excited about the opportunity to serve people. That is really the goal, right? People, you

don't want them not to have health care. You don't want them not to show up to work. You don't want them to be a burden to the taxpayer, and health care is kind of a central way to make that thing happen.

I am very worried that the block grant math is unfortunately a death spiral. That has been talked about. It is a block grant. I don't care if it is a Medicaid expansion population, I don't care if it is Medicaid itself. I don't care if it is all these little bills that we are talking about that are supposed to fix, not repeal Medicaid or Medicaid expansion, you know, we need to make sure that these things are there at the end of the day. The block grant math doesn't do that.

Population in America is going increase. By definition 20 percent of Americans are on Medicaid, 25 percent in my district, 50 percent in the chairman's district are on Medicaid. You put that on a block grant with increasing population it is a death spiral not just for the individuals, not just for the families, but for the taxpayers of this country.

Rural districts in particular benefit by the Medicaid expansion. In my district, in my state alone in rural parts of my district and the chairman's district, the coordinated care organizations are giving better care for less money. It doesn't always have to be this Hobbesian choice where you cut provider reimbursement. That is a medieval technology. That is a medieval technology, colleagues.

What you want to do is incentivize with block grant global payments like we have talked about with the SGR, you know, to give these local districts, local control to the states to create their own way to provide Medicaid services to these people. In Oregon, contrary to that study that you cite in your testimony, it has been an unqualified success. You know, emergency room admissions are down 20, 30 percent; primary care visits up 60 percent. Diabetes, one of the studies they are doing and looked at, much better outcomes, almost 60 percent better outcome than we see before. And I could on with COPD, all these.

If you give people the right incentives to get good health care, not burden them with financial burdens we can get this thing done. So I would urge my colleagues to think thoughtfully as we look at this Medicaid expansion issue going forward. And I yield back. Thank you, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman; precisely why we are having the hearing. The chair recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions, please.

Mr. BUCSHON. Thank you very much, Mr. Chairman. Indiana expanded under the Affordable Care Act under current Vice President Pence, so obviously, you know, a state based program like HIP 2.0 is a flexible program but required a difficult to acquire waiver.

Mr. Roy, in House Republican health care proposal Better Way would allow states to use Medicaid to provide a defined contribution in the way of premium assistance or a limited benefit to work-capable adults who are working or preparing to work. States can do this now but require a waiver as in HIP 2.0. This would allow states to use this approach without a waiver so they can enroll more low-income adults in private coverage if they are working.

This is similar to the goals, as I mentioned, Healthy Indiana Plan 2.0 and in fact it is being implemented and I would like to explore this idea legislatively, so what are your thoughts on this type of policy reform?

Mr. ROY. Thank you for the question. I think it is better than nothing to have more flexibility for states to do the kinds of things you are talking about. As I alluded to earlier in response to a different question though, the Medicaid statute severely limits the flexibility even if CMS grants waivers to states to do certain types of things with their Medicaid program.

So what is very important is to reform the statute so that individuals have more control over their healthcare dollars, they can buy the kind of insurance that really serves their needs, deploy Health Savings Accounts sometimes for example to use retainer based direct primary care so they can get much bigger and much more frequent access to primary cares and specialists when they need them. If you do that it will dramatically improve health care outcomes relative to the Medicaid program today.

Mr. BUCSHON. Thank you. Mr. McCarthy, in your testimony you said the fundamental role of CMS should be rethought and we should focus less on command and control. There are nearly 400 staff at CMS and CHIP—well, Centers for Medicaid and CHIP services at CMS. Do you know how many of them have worked in a state program for a health provider or a managed care plan?

Mr. MCCARTHY. I do not know how many of them worked in—

Mr. BUCSHON. Well, I will give you the data. Using LinkedIn to look at publicly available information it was examined in 2016 that about 40 percent of the staff had a bachelor's degree and nearly 15 percent had a law degree or Ph.D., but only 4 percent held a credential as a health care provider. The majority of the staff, 57 percent of the staff had spent their career in Federal or state government, but only 5 percent had previously worked for a state Medicaid program or fewer than 20 percent had ever worked for a health plan or provider.

Of course none of this is to suggest that these aren't great employees and are doing the best that they can, but it does raise the question of whether or not there is an unintentional institutional bias for individuals who are writing the rules and regulations for state Medicaid programs if you only have 5 percent of the people that have ever actually worked for a state Medicaid program.

What could be done to devolve CMCS authorities or assure there are more people at CMS that have more real-world experience in this area?

Mr. MCCARTHY. One of the things that often comes up is the fact that CMCS treats the National Association of Medicaid Directors as just another stakeholder group. They are no different than a hospital association or anyone else.

And so one of the things I have advocated for a long time is the Medicaid directors should be brought in earlier to talk about rules and regulations and what will work and not work. They should not be treated as just another stakeholder because they are part of the system that is putting up a bunch of the money, so they need to be talked about. For instance, the latest rules, the mega rule where you brought up that came up around the IMDs, Institutions for

Mental Disease, in that final rule states cannot implement what was put in and that was because CMCS didn't talk to states specifically around how could this be implemented.

So I don't know how to change getting people who work at CMCS to come from states because obviously they would have to move across the country there or you would just be some of my old staff from the district or Maryland would be the only two places that people would move there for. But the rules and regulations and how states are looked at have to be—

Mr. BUCSHON. So I think what at the end of the day, which we see this across federal agencies, federal agencies should reach out to people who have subject matter expertise probably in a better way than they have. Not necessarily have those people with that expertise in the agency, but they should probably reach out more to people like yourself and others.

Ms. SOLOMON. do you believe that all citizens of the United States should be on Medicaid or on Medicare?

Ms. SOLOMON. All citizens, no. I mean the ones that—

Mr. BUCSHON. Yes. That would be a single payer. Do you believe in a single payer?

Ms. SOLOMON. I believe in universal coverage. I think what we did in—

Mr. BUCSHON. No, the answer is you do or you don't.

Ms. SOLOMON. No, I don't believe in single payer. I believe in whatever gets us there.

Mr. BUCSHON. Yes.

Ms. SOLOMON. And the ACA made a big start in that.

Mr. BUCSHON. Yes. OK, thank you. I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions, please.

Mr. ENGEL. Thank you, Mr. Chairman. We have heard Republicans describe their alternative picture of Medicaid before. In fact we have had a hearing on most of these bills before. I don't think anyone here would disagree with meaningful efforts to shrink waiting lists and afford Americans the services they need quickly, but that is not what these bills do. These bills represent yet another Republican attempt to gut Medicaid based on total falsehoods.

I think it would be helpful to talk about the real Americans for whom Medicaid is lifesaving. First, let's clear up any misconceptions about who Medicaid covers. Nearly a quarter of New Yorkers were covered by Medicaid or CHIP in 2015. The vast majority of New York's Medicaid beneficiaries come from working families. These Americans cannot afford private health insurance even with a full-time job. For them, Medicaid is a chance to stay healthy which means a chance to work longer hours and provide for their families.

Now I would like to debunk another misconception. My friends on the other side of the aisle allege that Medicaid spending is out of control. In fact, Medicaid spending is lower than the spending growth rate of Medicare and private insurance, and again I will point to New York. Despite charges that Medicaid is inflexible, our state has dramatically revamped our program to improve program integrity, better care for patients and save money. These efforts

have avoided costs to the Medicaid program in excess of \$1.8 billion. New York achieved this while expanding Medicaid and cutting our uninsured rate in half.

There is one more issue I would like to address and that is the one before us today. A Republican's ideas to strengthen Medicaid entail delaying or denying coverage to Americans that need it to redirect funds to other parts of the program, specifically to those states that choose to operate waiting lists for Medicaid home and community based services. They are suggesting that if states have high coverage levels they are also letting Americans suffer on waiting lists.

Let me ask you this, Ms. Solomon. I am wondering if you can help us delve into that claim. You said in your testimony that 11 states and D.C. do not operate waiting lists. I believe my state of New York is among them. Is that correct?

Ms. SOLOMON. That is right.

Mr. ENGEL. Thank you. As I said a minute ago, New York cut its uninsured rate in half, thanks in part to its decision to expand Medicaid. Now even with that major expansion of coverage zero New Yorkers, nobody, was forced onto a waiting list. So Ms. Solomon, let me ask you again. Would you say that New York's example is representative of most states without waiting lists?

Ms. SOLOMON. It is. As I said, only two of the states without waiting lists have not expanded, so there isn't a correlation there.

Mr. ENGEL. Thank you. And I have one final question for you, Ms. Solomon. Is there any evidence that refusing or holding up Americans' Medicaid coverage as these bills would do, would reduce waiting lists for home and community based services?

Ms. SOLOMON. I don't think they would because these are all state choices. States have made a choice whether or not to lower their waiting lists to provide more services to take up options. It is all state choices. It is not necessarily because another state has done something for other people.

Mr. ENGEL. Thank you very much. Let me say that if as this hearing title suggests my Republican friends are serious about strengthening Medicaid, and I quoted this is what this about, "Strengthening Medicaid and Prioritizing the Most Vulnerable," well, let me suggest there is a way to do that. The Affordable Care Act strengthened Medicaid tremendously by modernizing it and promoting program integrity. The ACA also helped America's most vulnerable. Thanks just to the law's Medicaid expansion, more than 12 million people gained insurance coverage.

So in short, let me say this. If you want to strengthen Medicaid, if you really want to strengthen Medicaid, strengthen the Affordable Care Act. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions, please.

Mrs. BROOKS. Thank you, Mr. Chairman. I would actually like to talk about something that we have done in Indiana that my colleague from Indiana has talked about which I do believe will strengthen Medicaid, and that is Healthy Indiana Plan 2.0, which I might say the logo is health coverage equal peace of mind.

So we in Indiana do believe that health coverage equals peace of mind. And the Healthy Indiana Plan which was approved by our General Assembly prior to the Affordable Care Act being implemented had incredible difficulties with CMS getting waivers during the time that it has been in existence, and our new governor, Governor Holcomb, just resubmitted Healthy Indiana Plan 2.0 with some modifications just yesterday. And I have to just share some of the year one results, and this comes, some of this information comes from analysis of 2015 member surveys.

There are over 370,000 members approved for coverage. Seventy percent of the members choose to make contributions into their POWER accounts, and we could go into more. Forty two percent emergency room visits lower, 42 percent emergency room visits are lower for individuals that have moved from traditional Medicaid into Healthy Indiana Plan. Eighty percent HIP plus members report satisfaction, so do providers. Three and four providers, and we started out the hearing talking about providers, believe HIP will improve health care in Indiana. And there is a gateway to work in trying to incentivize for the expansion population more and more people to seek work opportunities and to get them training.

So I would like to just focus a little bit on what your thoughts are about Healthy Indiana Plan 2.0, each of you, what do you think are the best things, and maybe a challenge very briefly in my 3 minutes, about what you know about Indiana's innovative, the first consumer-directed health care program in the country for the Medicaid population.

Dr. Roy.

Mr. ROY. So in my view the Healthy Indiana program and in particularly the initial version that was passed under Governor Mitch Daniels is the most innovative Medicaid program in the country. And I think it is very encouraging that Seema Verma who was one of the chief implementers of that plan has been nominated by the President to be the CMS administrator.

I think one thing we should mention about the Healthy Indiana Plan 2.0 is that under the Obama administration CMS there was lot of pushback on some of the important features of Healthy Indiana that made Healthy Indiana so attractive. So, for example, in the POWER accounts that Healthy Indiana, the program has, the Health Savings Account-like instruments in the Healthy Indiana program, there were certain requirements. To be eligible for the Medicaid expansion under HIP 1.0 you had to do very small things, provide a small premium payment of like a dollar in some cases.

Mrs. BROOKS. A dollar a month.

Mr. ROY. Exactly, a dollar a month. Do some basic annual check-up tests like checking your cholesterol, checking your diabetes, your HbA1c, other basic checkups to make sure that you were engaging in the primary care and wellness health activities that would help people manage their care in a really good way.

A lot of those requirements were watered down in Healthy Indiana Plan 2.0 because the ACA Medicaid expansion is mandatory and so there isn't the same carrot opportunity to say, look, if you do these things we will give you the reward of expanded access to coverage under HIP 2.0 the way it was for HIP 1.0. So that is one

of the very disappointing aspects of how the Obama administration——

Mrs. BROOKS. Thank you. And Dr. Roy, because I would like to get Mr. McCarthy because my time is running out, I would appreciate it if you would supplement your testimony with other responses if you might.

Mr. McCarthy.

Mr. MCCARTHY. I agree with what Dr. Roy said. It is really important to say that it was the pre-ACA versus post-ACA. And I would also point out that in Ohio under our Healthy Ohio program that we had with something similar we also hired Seema Verma to help us write that waiver. And that was called Health Savings Account, but we called it a BRIDGE account so that a person could take the money that was in that account with them when they moved off of Medicaid to help them pay for health care services when they weren't on Medicaid any longer.

Mrs. BROOKS. Can you please quickly explain your concept? You mentioned in your written testimony about money following the person approach. Could you briefly touch on what that means?

Mr. MCCARTHY. Yes. So that is where people who are in home and community, well, basically people who are in institutions so they are institutionalized. And what you are doing is trying to get the person out of the institution back into the community and the issue is often that person doesn't have the money to do some of the very basic things and that is where Money Follows the Person works, like buy people pots and pans and help on the first month's rent.

The idea there was to use those dollars that would be available to then also pay for home and community based services for a year or 2.

Mrs. BROOKS. Thank you. I am sorry, my time is up. I yield back.

Mr. BURGESS. The chair thanks the gentlelady. The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for questions, please.

Mr. CARTER. Thank you, Mr. Chairman, and thank all of you for being here. This has been a very informative session today and I appreciate all of your input.

Dr. Roy, I want to start with you. First of all, I want to thank you. Today you have articulated the fact that Medicaid spending is climbing and that unfortunately the health outcomes in Medicaid are not what they should be and they are far worse than many other programs. So it seems like we are at an impasse. And my question is, all of us want to improve care and we want to decrease costs and cut costs and decrease spending but, and we are looking for ways that we can do that and certainly the bills that have been presented here today that we are discussing will do that and we are thankful for that.

But what are some other solutions very quickly that you envision that perhaps could help us in this goal?

Mr. ROY. Absolutely. Thank you for the question. I think the most important thing is to maximize the flexibility that individuals have and also states and localities to take the health care dollars and the financial systems that we are offering so that individuals can buy the health coverage and health care that they need.

The biggest problem with the Medicaid program and the reason why it doesn't work is not because we don't spend enough money or we spend too much money, it is because there is very little flexibility in how those dollars can be spent. And so a lot of the dollars have to be spent in massively inefficient ways that prevent people from getting the care that they need.

Mr. CARTER. Where does personal responsibility come in and how do you legislate that? I mean it is difficult.

Mr. ROY. Well, I think when individuals are controlling more of those health care dollars they are naturally going to be much more responsible for their coverage and care, because they know that if they manage those dollars wisely they are going to have savings later on in a POWER account or something like that that cannot only accrue to their future health care needs but those of their children, their spouses, their descendants, the caregiver, the people they have to take care of.

So that is an important aspect of when you take the dollars out of the bureaucracy and give it to patients to control themselves; surely we can all agree that the more the patient controls the dollar the better that patient is.

Mr. CARTER. Absolutely. Thank you for that. And I am going to stay with you, Dr. Roy, and I am going to ask you one more. In your written testimony you discussed the 2010 Simpson-Bowles report, and that of course took on the issue of creative financing and noted that many states finance a portion of their Medicaid spending by actually taxing the providers. We did this in the state of Georgia. I was in the state legislature for 10 years and we actually, I was on the Appropriations Health Subcommittee, I was on Health and Human Services, so I was right in the thick of it.

And we actually drew down, we were drawing down more federal dollars from Medicaid at a 1:2 ratio. In other words for every dollar we would put in we were getting two. Well, obviously we balanced our budget that way, and in fact the state of Georgia this year is reauthorizing that in this legislative session. How can we do this better? That just doesn't make much sense to me.

Mr. ROY. Thank you again for this question. What we propose in Transcending Obamacare, and it is an idea that we actually borrowed from the Urban Institute and a scholar there named John Holahan, a left of center think tank, is that the best way perhaps to reform the Medicaid program broadly is to restructure it so that instead of having both states and Washington offload these costs onto each other and split the responsibility in ways that don't work, have the states and Washington divide the responsibilities up.

So for example what we propose is have the federal government say we are going to take over the part of Medicaid that is providing financial assistance to poor people who need acute care health insurance, just like we do for tax credits for the uninsured, et cetera, and then the long-term care, trade that and give that fully to the states to manage. If you do it that way, if you clean up the lines of responsibility—states control one aspect, federal government supports the other—you eliminate all these poor and bad incentives for mismanagement.

Mr. CARTER. OK. Mr. McCarthy, I have got about a minute and there is something that is very important to me. In your testimony you said that states are forced to cover all FDA-approved drugs and in turn receive rebates. However, for new high cost drugs the rebate is not high enough to offset the large increases in expenditures. Would we not be better off letting the states opt out of the rebate program and do it themselves?

I will be quite honest with you we used to do it ourselves in Georgia. We used to have our own rebate system before this started with the federal government. Dr. Bucshon can certainly attest to the fact that in the South we are in the Cardiac Belt. We utilize more of a certain type of drugs than they do in other parts of the country. Dr. Murphy mentioned the anti-psychotics, and of course as a pharmacist I understand all this. And how do you think that idea would go if we let the states do their own rebate program?

Mr. MCCARTHY. As always if you let states have that option and don't force them to do something I would be in support of that because right now you can only negotiate on additional rebates.

Mr. CARTER. Good. OK, well, I am out of time, but thank all of you again for this.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from California, Dr. Ruiz, for 5 minutes for questions, please.

Mr. RUIZ. Thank you, Mr. Chairman. Thank you, panelists, for being here. I am not on this subcommittee, but I am still here because this issue is so very important to me personally, my patients, and my constituents. I am an emergency physician and there is just so much to say about this conversation.

First, all doctors, Republican or Democratic doctors prefer health insured patients over uninsured patients. There is no doctor on this committee or anywhere in our nation that prefer their patients to be uninsured. Two, Medicaid patients have higher morbidity because they are a higher risk group. They are the sick, vulnerable, and poor. That means that actually Medicaid is working because we are targeting those patients that it is intended to target.

Three, block grant and per capita block grants will create more uninsured patients and physician reimbursement rates will worsen because states will choose to cut eligibility, reduce insured patients, and cut reimbursement rates to physicians. Tax credits will not cover the full cost of health care, in fact it will have our vulnerable populations pay higher premiums and deductibles and therefore patients will have to pay more out-of-pocket.

Since the expansion of Medicaid under the Affordable Care Act, emergency departments around the nation including mine have seen a dramatic decrease in uninsured patients by 50 percent or more. That is good for the patient. That is good for the emergency department and that is good for hospitals and taxpayers. And the reason why emergency departments have seen an increase in patients is because there is not enough physicians to see the newly insured. The over 20 million newly insured patients in our nation now have insurance.

So these patients who have been putting off taking care of their chronic illness because they couldn't see a doctor because they couldn't afford it are now insured and they can't see physicians in

their community because of the severe physician shortage crisis so they go to the emergency department.

OK. I have concerns that the Verify Eligibility Coverage Act will hurt American citizens. This bill will prohibit federal funds until citizenship is proven. So let me give you a real-life case of a citizen that this bill will hurt. At the Mass General Hospital where I was training in medical school I took care of a patient that arrived in the emergency department after a severe motorcycle accident and suffered severe multi-organ trauma including completely degloving of his face.

He was in the trauma ICU for 2 months without any identification of who that person was. He couldn't speak, he was intubated, and there was no information about him and nobody, no family was calling in to look for him. so we simply didn't know who he was. What do we do with them? What do we do with that citizen? Are we not allowed to pay for his care because he couldn't prove his citizenship?

So in regards to the lump sums and lottery winning legislation, Ms. Solomon, while I think it is safe to say that an overwhelming amount of millionaires aren't trying to qualify for Medicaid, I would like to clarify the impact of this legislation. It should be noted that this bill has changed since last Congress and reflects some additional nuances and protections that are very important.

This legislation is a prime example of why it is so critical that we slow down and take the time needed to truly consider a policy proposal and its impact on lives of millions of Americans. So is there any evidence that this bill actually solves a rampant problem?

Ms. SOLOMON. Thank you, Dr. Ruiz. This bill has changed considerably and I commend the drafters for filling in a lot of the problems that were identified initially, and now I think what it really will do is very modest and just create hassles for states.

It is really interesting to look at what has happened in Michigan which actually is recovering from lottery. In their Medicaid waiver they were given permission and over the 21 months that this provision has been live they have recovered \$380, but they have a contractor that needs to track so it is not clear it does much of anything.

Mr. RUIZ. Let me ask you another question regarding tax credits. Can you explain why tax credits don't work in place of Medicaid coverage?

Ms. SOLOMON. Especially these tax credits that are being proposed that are flat and not based on income would clearly not work. But the other thing that we need to remember is that Medicaid is a very different program than private insurance that is specifically designed and very flexible to cover the multiple populations that are served. A tax credit isn't going to have that same flexibility that Medicaid has to provide the kinds of substance use treatment, behavioral health treatment, programs for kids with special needs; it just isn't going to work.

Mr. RUIZ. Thank you.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions, please.

Mr. SARBANES. Thank you, Mr. Chairman, I appreciate it. I want to thank the panel for its testimony.

And Ms. Solomon, I wanted to ask you a question, but I also wanted before that just to say that it is unfortunate that our Republican colleagues seem to want to take parts of the Medicaid program that really do represent innovation and flexibility and then instead of identifying that as a real opportunity to build on a strong foundation in the overall program, they use it to distract from good parts of the program or actually go pull money away from that foundation.

So you talk about the home- and community-based waiver program which is a terrific innovation, I think. When I was still in the health care arena representing a lot of health care clients in Maryland, we were looking at a waiver program that would allow some Medicaid funding to flow to assisted living facilities where there is a lower need for care and less costly, but didn't usually qualify for Medicaid reimbursement.

So we wanted to explore that as an alternative to nursing home care which is very high cost, the home- and community-based care waiver is an extension of that thinking and so we ought to pursue it in a meaningful way, but we shouldn't just then use it as a shiny object to be able to then argue that we should go take money from other important parts of the program.

In the same way the idea of flexibility is an important one. I think you do want to give state Medicaid programs flexibility to innovate and try other things, but then using the flexibility argument that our colleagues on the other side say, OK, that is why we should block-grant things because that is the ultimate flexibility, so again they go take a concept that could be a constructive one and they use it to advance something which has the effect of undermining the core strength of the Medicaid program. And I think it is unfortunate. It is a missed opportunity for us to talk about how we can continue to strengthen and improve a program that works pretty well already.

So I would like you to maybe speak to that idea of how you keep the foundation of the program strong even as you are looking at potential for innovation and flexibility. And in fact that if you did maintain the strength of the program and gauge states' flexibility, they would actually go identify sources of savings and you would probably achieve more savings than as what is being proposed by these three bills to take away from the existing beneficiaries.

So if you could speak to that because I think it is important if we want to get a more efficient program that provides solid care and maintains a strong foundation that is the way flexibility and innovation ought to be pursued.

Ms. SOLOMON. I totally agree with that. And we have been actually cataloguing on our Web site examples of states doing exactly that and they have been given tremendous flexibility to innovate, including being able to use upfront dollars which often are necessary to build the communication system across providers, to increase provider capacity and then achieve the savings in the long run.

When I worked in Medicaid at the state level that was always the barrier, because as an advocate we would argue but you would

be able to save money if you make this investment. And the money wasn't there. And if you look at the innovation through the SIM grants that Mr. McCarthy spoke of and other initiatives that have taken place that is exactly what has been going on.

And I really take issue with Dr. Roy's statement that Medicaid doesn't work. Medicaid works really well. And I think that is really the thing that we are trying to lift up through highlighting these innovative programs, targeting the high utilizers that are responsible for a great portion of the costs by providing better coordination with some of the alternative models that have been put forth in the Affordable Care Act and elsewhere. So I think we could go on for all day on how Medicaid works.

Mr. SARBANES. Thank you for your testimony. I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from California, Mr. Cardenas, 5 minutes for questions, please.

Mr. CARDENAS. Thank you very much, Mr. Chairman. Don't let these people distract you from the big picture, ladies and gentlemen. They keep talking about less than six—

Mr. BUCSHON. Would the gentleman yield?

Mr. CARDENAS. Yes.

Mr. BUCSHON. We are not these people, we are elected members of Congress that represent over 700,000 citizens.

Mr. CARDENAS. Would you please give me back my time, Mr. Chairman? Thank you very much. Don't let these elected Congress members distract you from the big picture. They keep talking about less than 6,000 people. The big picture is the more than 74 million Americans today that have a life of dignity because they are using Medicaid and Medicare, 74 million, ladies and gentlemen, right now in the United States of America. Six thousand, let's deal with that.

Let me be very clear here, ladies and gentlemen, for the majority of Americans, middle class Americans, Medicaid is what gets you or your mother or your father into a nursing home. It is what allows you to have a nurse help you in your home with things you otherwise need to live a basic life of dignity. It is not Medicare, ladies and gentlemen. It is Medicaid that provides that. Medicare doesn't even get you through the door.

Seniors, families with seniors who need help cooking, walking or even changing their clothes, I want you to be very clear about this. We are talking about you, ladies and gentlemen, we are talking about your loved ones. This is important here. Your long-term care doesn't come through Medicare. It comes through Medicaid. Many people don't understand the program. They want to demonize it to basically rip it out of your hands.

But Republican and Democratic governors are begging Republicans here in Washington, please don't do this Congress members, because if Republicans in Congress do, these governors know that their state, the people in their state are going to suffer. Governors are going to have to decide what to cut from your life. Ladies and gentlemen, they are going to turn their backs on Grandma and Grandpa and we are going to have sick people in the streets more than there are today and we will be right back where we were, and that is not the good old days, folks.

Today people on Medicaid walk into the doctor's office. If Republicans make these changes, people will be flooding emergency rooms. That will increase health care costs for everyone. Doctors and nurses and hospitals won't be able to handle the workload.

Now according to the study in the New England Journal of Medicine, one of the oldest and most prestigious medical journals, if Republicans take away everyone's coverage over 43,000 people could die each year based on these actions. In California that means over 7,600 people could die in 1 year. In Texas that is over 2,400 people a year. I am sure my colleague chairman of the Health Subcommittee understands the value in saving lives and doing no harm. In Illinois that is over 1,400 people a year. I am sure my colleagues from Illinois think that is unacceptable. In Oregon that is over 1,200 people a year. I am sure the chairman of the committee doesn't want to see Medicaid dollars get slashed in his state.

We cannot accept this. We cannot allow Republicans to do this to seniors, to children and to the people with disabilities. These are hardworking Americans. Republicans in Congress want to take that care away, but they won't own up to it. Republicans say to you that they don't want to pay for Medicaid. What they don't want you to figure out is that they want to pocket your tax dollars. They are going to cut Medicaid while lowering taxes for the wealthiest people. They are going to lower taxes for Trump's billionaire friends, and in the committee down the hall, but raise taxes on everyone else. It is not fair. It is just another trade-off, and Republicans are sabotaging the American health care system.

Ms. Solomon, people in L.A. County where I am from have truly benefited from the Affordable Care Act. I have seen it with my own eyes. Can you talk a little bit about what repealing the law and what kicking people off of Medicaid would mean for people in Los Angeles?

Ms. SOLOMON. I think you probably have as many people as many states do in your county. I have had the opportunity to meet the people from the community health centers across L.A. County. I think large numbers would just lose coverage as they would in every state, hospital uncompensated care would grow, same for other providers, and as you noted there would be real harm.

Mr. CARDENAS. Thank you very much, my congressional colleagues. I yield back.

Mr. BURGESS. The gentleman's time has expired. The gentleman yields back. Seeing that there are no further members wishing to ask questions, I do want to thank our witnesses for being here today.

The chairman would remind the committee that we all agree it is important that we secure the care and keep our commitment to vulnerable Americans. The very fact that we are holding this hearing today as the first Subcommittee of Health hearing, I think, is evidence of that fact and I hope we can continue to take these steps and have the discussion in a rational manner.

Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their response within 10 business days on the receipt of these questions, and without objection, the subcommittee is adjourned.

Mr. GREEN. Can you yield just for a second?

Mr. BURGESS. One second.

Mr. GREEN. OK.

Mr. BURGESS. Time is up.

Mr. GREEN. Mr. Chairman, I think on our side we want to work with you and I will leave this, I think a start of a good hearing. So we will go from here and to see what we can do.

Mr. BURGESS. Well, again, Mr. Chairman, the very fact that this was the first hearing of the subcommittee, I mean I know there are members on my side who actually resent the tone that this committee ended up on today. I regret that fact. I hope that we can keep this on a civil and unemotional level going forward. This is important work that we do and it is literally the future of our country.

Again I want to thank our witnesses for being here today, and without objection, the subcommittee is adjourned.

[Whereupon, at 12:43 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The National Coalition on Health Care (NCHC) opposes the repeal or defunding of the state option to expand Medicaid eligibility to beneficiaries with incomes at or below 138% of poverty. The repeal or defunding of this option would undermine important reform initiatives at both the state and federal levels and make health care less affordable for millions of Americans.

In a letter dated January 5th, 2017, Governor Brian Sandoval (R-NV) urged leaders of the House of Representatives to “ensure that individuals, families, children, aged, blind, disabled and mentally ill are not suddenly left without access to the care they need to lead happy productive lives.” We agree.

[illegible]

To date, thirty-one states and the District of Columbia have opted to expand Medicaid eligibility to more than 11 million Americans, making health care accessible to many who previously lacked affordable coverage options. Putting at risk these states' achievements or restricting the remaining nineteen states' flexibility to expand Medicaid would undercut state-level efforts to reform health care and protect the most vulnerable. This alone is sufficient reason to preserve the state option to expand Medicaid eligibility and the enhanced federal financial support which makes that option viable.

However, NCHC is also gravely concerned that repeal or defunding of Medicaid expansion would roll back the bipartisan achievements of the 114th Congress.

1. To support physicians and other clinicians who embrace new high-value models of care, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) took crucial steps to support alignment of payment policies across all payers - including Medicaid. Grappling with a rollback of Medicaid eligibility would consume the attention of state officials and the health care providers who serve Medicaid beneficiaries. This would effectively sideline the nation's second-largest payer and many of the providers which rely on it- just as MACRA's historic value-based payment reforms are getting off the ground.
2. MACRA also reaffirmed the bipartisan consensus that has sustained two crucial parts of our safety net: community health centers and the Children's Health Insurance Program (CHIP). Unfortunately, disrupting Medicaid expansion coverage will have disastrous consequences for FQHCs, which rely on Medicaid for 44% of their revenue. Additionally, he added strain on state budgets occasioned by repeal or defunding of Medicaid expansion could limit states' investments in children's coverage, including CHIP.
3. Just last year, to improve and expand treatment for mental illness and substance abuse, Congress passed two landmark pieces of legislation, the Comprehensive Addiction and Recovery Act and the mental health provisions of the 21st Century Cures Act. Eliminating the Medicaid expansion coverage which makes treatment possible for adults earning at or below 138% of the federal poverty level would move federal policy in the opposite direction.

NCHC is committed to fixing what is broken in our health system. However, repealing or defunding the state option to expand Medicaid would put at risk recent state health reform initiatives, impair health care access for vulnerable populations and detract from recent, bipartisan federal legislative achievements. We call upon you to reject any repeal or defunding of the state option to expand Medicaid eligibility.

In the weeks and months ahead, we look forward to discussing this issue further and sharing our perspective on health policy issues not addressed in this letter. If you have questions about this or related issues, please contact me directly at jrother@nchc.org or 202-638-7151.

Yours truly,



John Rother
President and CEO





WRITTEN STATEMENT FOR THE RECORD

**FOR THE HEARING ENTITLED "STRENGTHENING MEDICAID AND PRIORITIZING
THE MOST VULNERABLE"**

UNITED STATES HOUSE COMMITTEE ON ENERGY AND COMMERCE

February 1, 2017

BY THE

ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the February 1, 2017 hearing before the House Committee on Energy and Commerce entitled "Strengthening Medicaid and Prioritizing the Most Vulnerable." APIAHF is a national health justice organization that influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of the over 20 million Asian Americans and nearly 1 million Native Hawaiians and Pacific Islanders (AAs and NHPs) in the United States. For over 30 years, APIAHF has worked at the federal, state, and local levels to advance sensible policies that reduce health disparities and promote health equity.

Congress is debating the importance of ensuring that Medicaid is available to our most vulnerable. Medicaid represents a vital piece of our country's health care system and is the sole source of health insurance for many AAs and NHPs. Since 1965, it has served as the safety net for those in need of help, including persons with disabilities, those in poverty and older Americans. The Affordable Care Act (ACA) expanded Medicaid to cover poor, childless adults for the first time. In this testimony, APIAHF describes the importance of Medicaid to AA & NHP communities, the value of the program and the current access immigrant populations have to Medicaid.

Medicaid Serves Our Most Vulnerable Members of Society

Access to health insurance is a critical part of ensuring a strong public health infrastructure. Medicaid and the Children's Health Insurance Program (CHIP) provide essential health coverage to 78 million people, about half of whom are children.¹ Medicaid also serves as a vital resource to seniors. As our country ages, many families struggle to find care for aging parents. Medicaid is the primary payer for

¹ Centers for Medicare and Medicaid Services (2016). Medicaid & CHIP: August 2016 Monthly Applications, Eligibility Determinations and Enrollment Report. <https://www.medicaid.gov/medicaid/program-information/downloads/august-2016-enrollment-report.pdf>.

more than half of long-term services and supports.² Medicaid is also critically important to providing reproductive and maternal healthcare to women. Together with CHIP, Medicaid covers nearly half of births across the country.³

Medicaid represents an important part of our country's ability to minimize harm at times of growing poverty rates and increasing need. Medicaid's recent growth as a share of insurance coverage represents this design. In addition to the eligibility expansion under the ACA, much of that growth is a reflection of greater need, corresponding with higher poverty rates for children, seniors and adults.⁴

Efforts to ensure Medicaid is accessible to the most vulnerable are important, but must be approached carefully. For example, fraud rates in Medicaid are comparable to the broader health care system.⁵ Efforts to combat fraud must be focused on the true sources of misallocated funds, namely a small minority of providers, rather than targeting beneficiaries.⁶ Providing for effective allocation of Medicaid involves targeted efforts that address the causes of fraud and must be carefully approached. Otherwise, eligible beneficiaries could face burdensome barriers to care.

Medicaid Plays an Important Role for AAs and NHPIs

AAs and NHPIs are among the fastest growing racial groups in the United States. Between 2014 and 2015, the AA population grew by 3.4 percent, more than any other group, while NHPIs grew 2.4 percent, following only mixed race individuals.⁷ Planning for a successful Medicaid population in the future must take the needs of AA & NHPI communities into account. Like many Americans, health care ranks as one of the top issues of importance to AA families. This is reflected in polling showing that among AAs, healthcare was mentioned as the second most important issue affecting voters personally. In addition, 60 percent of AAs voters have said they support the Affordable Care Act.⁸

Medicaid provides coverage to racial and ethnic minorities, including AAs and NHPIs, who would otherwise have to go without essential health care and therefore plays a pivotal role in addressing health disparities.

² ca L. Reeves & MaryBeth Musumeci (2015). Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

³ Markus, A., Andres, E., West, K., Garro, N., & Pellegrini, C. (2013). Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform. *Women's Health Issues*, 23(5), e273-e280

⁴ Bradley et al (2017). Strengthening Medicaid as a Critical Lever in Building a Culture of Health. National Academy of Social Insurance.

https://www.nasi.org/sites/default/files/research/Strengthening_Medicaid_as_a_Critical_Lever_Low_Res.pdf

⁵ Berwick, Donald and Andrew Hackbarth. (2012). Eliminating Waste in US Health Care. *Journal of the American Medical Association*. www.oregon.gov/oha/analytics/MetricsDocs/Eliminating_Waste_in_US_Health_Care.pdf

⁶ The Challenge of Health Care Fraud. National Health Care Anti-Fraud Association.

<https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud.aspx>

⁷ Lam, Charles. (2016). Asians Remain Fastest-Growing US Group as Pacific Islanders, Mixed-Race Numbers Grow: Census. NBC News. <http://www.nbcnews.com/news/asian-america/asians-remain-fastest-growing-us-group-pacific-islanders-mixed-race-n597711>

The importance of Medicaid to AA & NHPI communities is emphasized by the 17 percent of AAs and 34 percent of NHPIs who are enrolled in its coverage.⁹ NHPIs match American Indians as the racial community with the highest percent of its population on Medicaid. Twelve percent of AAs live in poverty, as do 17.3 percent of NHPIs.¹⁰

Through Medicaid, AA & NHPI populations can access treatment for conditions that disproportionately impact these communities, such as liver and stomach cancers, hepatitis and diabetes.¹¹ AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention. AAs are 25 percent more likely to be diagnosed with diabetes than Whites, while NHPIs are 3 times more likely.¹² AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.¹³ Certain AA and NHPI subpopulations suffer from even greater health disparities. Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.¹⁴ Vietnamese women have cervical cancer rates five times higher than White women.¹⁵

Medicaid Expansion Covers the Vulnerable

Under the ACA, states were required to expand Medicaid to all individuals making under 138% of poverty. While the Supreme Court made that expansion optional in *NFIB v. Sebelius*, 32 states including Washington, DC, have chosen to make Medicaid available for that population, many for the first time and many on a bipartisan basis. Before the ACA, a childless adult could be penniless, yet not be eligible for subsidized health insurance and often struggled to stay healthy, even while working. The expansion of Medicaid has served as a critical part of the ACA's coverage expansion.

Many of those who are fortunate enough to live in states that expanded Medicaid gained health insurance for the first time, along with the ability to manage chronic diseases and access preventive services. Medicaid expansion has already been associated with reductions in preventable deaths and delayed care due to cost, as well as an increase in self-reported good health statuses.¹⁶ For example, in

⁹ National Health Interview Survey. (2015). United States Centers for Disease Control.

ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf

¹⁰ 2015 American Community Survey One Year Estimates. Table S0201.

¹¹ Asian American & Pacific Islander Health Disparities Compared to Non-Hispanic Whites. (2014). Families USA. <http://familiesusa.org/product/asian-american-pacific-islander-health-disparities-compared-non-hispanic-whites>

¹² Asian and Pacific Islander American Health Forum. (2010). Native Hawaiian and Pacific Islander Health Disparities. www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf

¹³ Heron, Melonie. (2016). Deaths: Leading Causes for 2014. National Vital Statistics Reports Volume 65, Number 5. United States Centers for Disease Control.

¹⁴ Spanakis, Elias and Sherita Hill Golden. (2013). Race/Ethnic Difference in Diabetes and Diabetic Complications. *Curr Diab Rep.* 13(6) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/>

¹⁵ Miller BA et al. (1996). Racial/Ethnic Patterns of Cancer in the United States, 1988-1992. <https://seer.cancer.gov/archive/publications/ethnicity/>

¹⁶ Benjamin D. Sommers, Katherine Baicker, & Arnold M. Epstein (2012). Mortality and Access to Care among Adults after State Medicaid Expansions. *New England Journal of Medicine*, 367, 1025-1034. <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099>.

expansion states, more people were able to access a diabetes diagnosis, a critical first step towards controlling the chronic condition often underdiagnosed in AA and NHPi communities.¹⁷

The Medicaid expansion filled a gap for low income workers whose employers did not offer health insurance. Of adults who would have become eligible in states that did not expand Medicaid in 2015, more than half were working.¹⁸ Many of these workers are in industries that offer little to no paid sick leave, making health insurance an important part of promoting public health and safety.

Medicaid expansion has furthered state's roles as policy laboratories. Medicaid's structure as a joint federal-state partnership includes flexibility that allows states to tailor their expansions to best suit the needs of their residents, while ensuring coverage and quality are maintained under existing law and guidance. Medicaid expansion states are using the flexibility that exists within the program to experiment in how to deliver better care, such as linking payment to performance for federally qualified health centers.¹⁹

Prior to the ACA, AAs and NHPis faced major disparities in access to health care, in part because many lacked health insurance.²⁰ These communities, particularly certain subpopulations, faced higher uninsured rates in addition to cultural and language barriers. While the ACA has not eliminated health disparities, Medicaid expansion has played an important role in helping to reduce the number of AAs & NHPis without insurance. States that expanded Medicaid had nearly twice as big a drop in uninsured than states that did not.²¹ Since 2010, the uninsured rate for AAs has dropped from 15.1 to 7.5 percent. The percentage of NHPis without insurance fell from 14.5 to 7.8 percent. These are among the biggest gains in health coverage among all racial and ethnic groups.²²

If all states had expanded Medicaid, nearly 800,000 AAs and NHPis would have become newly eligible for the program.²³ Currently, people in the coverage gap, those who make too little to qualify for ACA subsidies but are not in an expansion state, are disproportionately from communities of color.²⁴ In states

¹⁷ Kaufman, Chen, Fonseca, and McPhaul. (2015). Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act. *Diabetes Care* 38, no. 5: 833.

¹⁸ Mahan, Dee. (2015). Medicaid Expansion Helps Low-Wage Workers: Non-Expansion States. *Families USA*. <http://familiesusa.org/product/medicaid-expansion-helps-low-wage-workers>

¹⁹ Peter Shin, Jessica Sharac, Zoe Barber, & Sara Rosenbaum (2016). Community Health Centers and Medicaid Payment Reform: Emerging Lessons from Medicaid Expansion States. Geiger Gibson RCHN Community Health Foundation, Issue Brief #45. <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Community-Health-Centers-and-Medicaid-Payment-Reform-45.pdf>

²⁰ Kim W, Keefe RH. (2010) Barriers to healthcare among Asian Americans. *Soc Work Public Health*. 25:286–95.

²¹ Greater Drop in Uninsured Rate Among Adults in Medicaid Expansion States. (2016). Center on Budget and Policy Priorities. <http://www.cbpp.org/greater-drop-in-uninsured-rate-among-adults-in-medicaid-expansion-states>

²² American Community Survey Table S2701. (2015 and 2010). United States Census.

²³ Wendt et al. (2014). Office of The Assistant Secretary for Planning and Evaluation. Eligible Uninsured Asian Americans, Native Hawaiians, And Pacific Islanders: 8 in 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid Or CHIP. https://aspe.hhs.gov/sites/default/files/pdf/180311/rb_UninsuredAANHPI.pdf

²⁴ Rachel Garfield & Anthony Damico (2016). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation, Issue Brief.

that expanded Medicaid, the gap between uninsured whites and people of color narrowed, while it expanded in non-expansion states.²⁵

Medicaid is Good Care

Medicaid plays an important role in our healthcare system, promoting public health and ensuring vulnerable populations can access health care. Medicaid's entitlement nature and ability to cover all who are eligible is at the center of that role. Uninsured adults are more likely than those with insurance, including Medicaid, to die from a heart attack, be diagnosed with advanced cancer, have uncontrolled hypertension and have higher hospital mortality rates.²⁶ Medicaid beneficiaries access and use of care is comparable to people with employer sponsored insurance. If they lost access to Medicaid, beneficiaries would be more than four times as likely to have unmet needs for medical care.²⁷

A study of the 2008 Oregon Medicaid lottery found that Medicaid beneficiaries were 25 percent more likely than the uninsured to report having good, very good or excellent health and 10 percent less likely to have depression. They had better access to preventive healthcare services and saw increased utilization of mammograms (60 percent), cholesterol tests (20 percent) and blood sugar or diabetes tests (15 percent).²⁸

Medicaid provides the necessary federal support to allow states to respond to new and deepening health crises. For example, in response to the Flint water catastrophe, Michigan Governor Rick Snyder used a Medicaid waiver to ensure the city's population had access to care.²⁹ Because Medicaid is available to any eligible individual, if a city or state experiences a similar disaster, its residents can be assured access to care.

Over 43 million Americans face some kind of mental health challenge, including 13 percent of AAs and 22 percent of NHPs.³⁰ Over a quarter of mental health dollars come through Medicaid, a number that is expected to grow over time. Before the federal government took greater responsibility for improving mental health in recent decades, this burden fell on state and local governments (whose share of

²⁵ Courtemanche, Marton, Ukert, Yelowitz, and Zapata. (2016). Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States. The National Bureau of Economic Research. Working Paper No. 22182.

²⁶ America's Uninsured Crisis. (2009). Institute of Medicine of the National Academies.

<http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf>

²⁷ Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope, & Dean Resnick (2013). What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation.

<https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf>.

²⁸ What is the link between having health insurance and enjoying better health and finance? (2012) Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72145.

²⁹ Sara Rosenbaum (2016). Caring for Flint: Medicaid's Enduring Role in Public Health Crises. The Commonwealth Fund. <http://www.commonwealthfund.org/publications/blog/2016/feb/caring-for-flint>

³⁰ Any Mental Illness (AMI) Among U.S. Adults. (2014). National Institute of Mental Health.

<https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml>

spending on mental health has dropped 10 percentage points in the last 30 years). These states and local governments, with strapped budgets, would be unlikely make up the difference now.³¹

Federal Law Already Restricts Access to Medicaid for Immigrant Populations and Creates Burdens to Accessing Care

Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, legal permanent residents are subject to a five-year bar for means-tested public benefit programs. Undocumented immigrants are barred from Medicaid, regardless of their tenure in the country. Some states, such as New York and California, have chosen to recognize the public health benefits of providing healthcare to immigrants and do so using state dollars. Thirty-two states have chosen a state option to waive the five-year bar for immigrant children and/or pregnant women, exercising the inherent flexibility in the program to tailor coverage to best meet the needs of state residents.

Many immigrants go without care because of existing restrictions on Medicaid eligibility, despite working hard, paying taxes and contributing financially to the same program. Restricting access to care limits the ability of immigrants to access routine care, including preventive services that can identify serious chronic conditions before they worsen. Given the existing barriers that immigrants, including those with lawful status, face in accessing care, additional restrictions targeting immigrant communities would move Medicaid in the wrong direction. The program's ability to help the most vulnerable, which includes many immigrants, would not be furthered by such proposals.

Notably, immigrants do not use a significant amount of public healthcare resources. The libertarian CATO institute found that immigrants use public benefit programs, including Medicaid, less than their native-born counterparts. Subsequently, according to the report, "the cost of public benefits to non-citizens is substantially less than the cost of equivalent benefits to the native-born."³² Immigrants constitute 5% of the United States' population, but only constitute 1% of healthcare spending, as they tend to be younger and healthier than native born people.³³

Medicaid Must Continue to Serve All Vulnerable Persons

APIAHF is committed to working to ensure Medicaid continues in its role as a source of health insurance for the most vulnerable Americans. As Congress debates the future of Medicaid and the health care system, we urge policy makers to take into consideration the needs of AA and NHPI communities, many of whom would have to forgo healthcare if Medicaid was cut or eligibility was further restricted.

³¹ Substance Abuse and Mental Health Services Administration (2014). Projections of National Expenditures for Treatment of Mental and Substance Use Disorders: 2010-2020. <http://store.samhsa.gov/shin/content/SMA14-4883/SMA14-4883.pdf>.

³² Ku, Leighton and Brian Bruen. (2013). Poor Immigrants Use Public Benefits at a Lower Rate Than Poor Native-Born Citizens. Cato Institute. <http://www.cato.org/publications/economic-development-bulletin/poor-immigrants-use-public-benefits-lower-rate-poor>.

³³ Ku, Leighton. (2009). Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States," American Journal of Public Health, 99(7):1322-1328. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696660/>.



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January 30, 2017

The Honorable Tim Murphy
 Chairman
 Subcommittee on Oversight
 and Investigations
 Committee on Energy and Commerce
 U.S. House of Representatives
 2125 Rayburn House Office Building
 Washington, DC 20515

The Honorable Diana DeGette
 Ranking Member
 Subcommittee on Oversight
 and Investigations
 Committee on Energy and Commerce
 U.S. House of Representatives
 2125 Rayburn House Office Building
 Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

Thank you for holding this hearing on Medicaid Oversight: Existing Problems and Ways to Strengthen the Program. AARP appreciates the opportunity to share this letter on Medicaid with the subcommittee. AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

As Congress considers changes to Medicaid -- a joint federal and state funded program -- it is important to look at the impact of Medicaid on the people it serves. Medicaid is a vital safety net and intergenerational lifeline for millions of individuals, including 17.4 million low-income seniors and children and adults with disabilities who rely on the program for critical health care and long-term services and supports (LTSS, i.e., assistance with daily activities such as eating, bathing, dressing, managing medications, and transportation).

Of these 17.4 million individuals: 6.9 million are ages 65 and older (which equals more than 1 in every 7 elderly Medicare beneficiaries)¹; 10.5 million are children and adults living with disabilities; and about 10.8 million are so poor or have a disability that they

¹ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50", May 2015, 13. Available at: <http://files.kff.org/attachment/report-medicaid-at-50>

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qualify for both Medicare and Medicaid (dual eligibles).² Dual eligibles account for almost 40 percent of Medicaid spending.³ While they comprise a relatively small percentage of enrollees, they account for a disproportionate share of total Medicare and Medicaid spending. While some use fewer services, many have intensive care needs associated with exceedingly high costs. As a group, they tend to be sicker, poorer, and more expensive to care for than other individuals covered by either the Medicare or Medicaid programs.

Medicaid beneficiaries with disabilities include younger individuals with physical conditions such as multiple sclerosis or epilepsy; HIV/AIDS; spinal cord and traumatic brain injuries; disabling mental health conditions such as depression and schizophrenia; intellectual and developmental disabilities such as Down syndrome and autism; and other functional limitations, as well as older adults in nursing homes or receiving home and community-based care.⁴ Disabling conditions that affect older adults include Alzheimer's disease, stroke, and chronic and disabling heart conditions. Individuals may have low incomes, high costs, or already spent through their resources paying out-of-pocket for LTSS, and need these critical services. For these individuals, Medicaid is a program of last resort.

Individuals with disabilities and older adults rely on critical Medicaid services, including home and community based services (HCBS) for assistance with daily activities such as eating, bathing, dressing, and home modifications; nursing home care; assistance with Medicare premiums and cost-sharing; and other benefits such as hearing aids and eyeglasses.⁵ People with disabilities of all ages rely on Medicaid for access to comprehensive acute health care services. Medicaid also helps some people with disabilities stay in the workforce and lead productive lives. Children with significant disabilities are able to stay with their families and receive the help they need at home or in their community because of Medicaid.⁶

As Congress considers possible changes to Medicaid, it is important to understand how any proposed changes will affect real people. AARP opposes Medicaid block grants and per capita caps because we are concerned that such proposals will endanger the

² Medicaid and CHIP Payment and Access Commission, "MACStats: Medicaid and CHIP Data Book", Exhibit 14. Available at: <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2013.pdf>

³ Rudowitz, Robin, Kaiser Family Foundation, "Medicaid Financing: The Basics", December 22, 2016. Available at: <http://kff.org/report-section/medicaid-financing-the-basics-issue-brief/>

⁴ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015", 1. Available at: <http://files.kff.org/attachment/report-medicare-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015>

⁵ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50", May 2015, 13. Available at: <http://files.kff.org/attachment/report-medicare-at-50>. Not all 17.4 million people receive LTSS.

⁶ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50", May 2015, 10, 11, 13. Available at: <http://files.kff.org/attachment/report-medicare-at-50>

health, safety, and care of millions of individuals who depend on the essential services provided through Medicaid.

A block grant would end the guaranteed access to care for millions of Americans who are eligible and instead provide a fixed amount of federal funding to each state for its Medicaid program, which may not take into account increases in actual cost or need. We oppose the end of the guarantee and are concerned that fixed federal funding to states will result in cuts to program eligibility, services, or both – ultimately harming some of our nation's most vulnerable citizens.

In addition, moving from the current Medicaid financing structure to fixed federal Medicaid block grant funding would shift costs to states and state taxpayers. With aging demographics, the rising needs of the chronically ill, and individuals with some form of dementia, states cannot meet these increased Medicaid costs. The National Governors Association has also recently stressed the importance of protecting states from unforeseen financial risks and not shifting costs to states.

Per capita cap proposals would provide a fixed amount of federal funding per person, while allowing for enrollment growth. This approach to financing would also likely result in overwhelming cost shifts to state governments and families unable to shoulder the costs of care without sufficient federal support. It is unclear how Congress would determine the baseline amount of the caps in ways that would accurately reflect the cost of care for individuals in each state, let alone determine growth rates that would accurately reflect the cost of care for individuals in each state.

We are especially concerned with how caps would be set for children and adults with disabilities, as well as for seniors. There is great variation among people of all ages living with disabilities in terms of the severity of their condition. Such variation makes it very challenging to establish realistic baseline cap amounts that would be sufficient to meet the very costly needs of those living with the most severe disabling conditions. Establishing unrealistic baseline spending for this population would make it impossible to meet the needs of those who have very high levels of need.

In terms of poor seniors, we have serious concerns about setting caps at a time when per-beneficiary spending for poor seniors is likely to increase in future years. By 2026, when boomers start to turn age 80 and older, they will likely need much higher levels of service—including HCBS and nursing home—moving them into the highest cost group of all seniors. As this group continues to age, their level of need will increase as well as their overall costs. We have not seen any per capita cap proposals that take this into account.

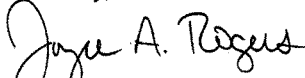
If Congress is interested in changes to improve Medicaid, there could be an opportunity to address Medicaid's longstanding institutional bias. When Medicaid was created in 1965, nursing homes were the only option for a person who needed LTSS. States receive the funding they need to provide nursing home care for those who are eligible, but they can only provide home and community-based services (HCBS) to a more

limited extent in practice. The funding is now treated differently for nursing homes and services in homes and communities. It is time to update the law to reflect where and how people want to receive services today. In addition, governors have called for additional flexibility in the administration of the Medicaid program. We suggest that states should be given the flexibility to use Medicaid dollars for HCBS – without having to request permission from the federal government. About 90 percent of older adults want to remain in their own homes and communities for as long as possible.⁷ They want to maintain their independence and have control over their own decisions.

On average, in Medicaid, the cost of HCBS per person is one-third the cost of institutional care.⁸ HCBS are more cost effective and help people live in their homes and communities where they want to be – this makes fiscal sense and commonsense. States should be able to access funding for HCBS in the same way they can access nursing home funding. Eliminating the institutional bias in Medicaid aligns public policy with consumer preference. In addition, such efforts can yield significant returns on investments both to governments looking for more cost-effective solutions and taxpayers.

AARP appreciates the opportunity to provide written input and looks forward to working with you to keep Medicaid's vital safety net in place and help people live in their homes and communities for as long as is reasonably possible. If you have further questions, please feel free to contact me or have your staff contact Rhonda Richards on our Government Affairs staff at richards@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

⁷ Nicholas Farber and Jana Lynott. Aging in Place: A State Survey of Liability Policies and Practices (Washington, DC, AARP Public Policy Institute and the National Conference of State Legislatures, December, 2011)

⁸ Terence Ng, Charlene Harrington, MaryBeth Musumeci, and Erica L. Reaves, "Medicaid Home and Community-Based Services Programs: 2011 Data Update" (HCBS) and 2013 Medicare and Medicaid Statistical Supplement (Nursing Homes). Available at: <http://dataexplorer.aarp.org/indicator/31/medicaid-its-spending-per-user/#/bar?primarygrp=dist18&secondgrp=loc&dist18=102,103,104,105,106,107,108&loc=1&tf=12&fmt=132?>

January 31, 2017

The Honorable Michael Burgess
Chairman, Subcommittee on Health
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Gene Green
Ranking Member, Subcommittee on Health
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Re: Hearing on Strengthening Medicaid and Prioritizing the Most Vulnerable

Dear Subcommittee Chairman Burgess and Ranking Member Green:

On behalf of the undersigned member organizations of the Save Medicaid in the Schools Coalition, we would like to outline several ways that significant changes to Medicaid, such as converting it to a block grant, or instituting per capita caps, would most likely result in harm to our nation's most vulnerable children: students with disabilities and students in poverty. We are deeply concerned that critical services and professionals in school will be reduced or eliminated if proposals to refinance Medicaid are advanced. A per capita cap or attempt to shift Medicaid costs to states will undermine the entitlement of America's neediest children to access vital healthcare that ensures they have adequate educational opportunities and contribute to society. Given that children comprise less than 50% of Medicaid beneficiaries, but only about 19 percent of the costs for Medicaid, current proposals to cap or limit state funding are misguided and threaten to disproportionately harm children's access to care.

Schools Provide Critical Health Care for Students

A school's primary responsibility is to provide students with a high quality education. However, children cannot learn to their fullest potential with unmet needs, including physical and/or mental and behavioral health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive. Schools provide an efficient and impactful delivery system because they are where children spend their days. Increasing access to health care services through Medicaid improves health care AND educational outcomes. Providing health and wellness services and services that benefit students with disabilities ultimately enables more children to become employable and attend higher-education.

Since 1988, Medicaid has permitted payment to schools for certain medically necessary services provided to children under the Individuals with Disabilities Education Act (IDEA) through an individualized education program (IEP) or individualized family service program (IFSP). Schools are thus eligible to be reimbursed for direct medical services to Medicaid eligible students with an IEP or IFSP. In addition, districts can be reimbursed by Medicaid for providing Early Periodic Screening Diagnosis and Treatment Benefits (EPSDT), which provides Medicaid eligible children under age 21 with a broad array of diagnosis and treatment services. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problems become complex and treatment more costly.

School districts use their Medicaid reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, it was reported that two-thirds of Medicaid dollars are used to support the salaries of health professionals and other specialized instructional support personnel (e.g. speech- language pathologists, occupational therapists, school psychologists and school nurses) who provide comprehensive health and mental

health services to students. Districts also use these funds to expand the availability of a wide range of health and mental health services available to students in poverty, who are more likely to lack consistent access to healthcare professionals. Further, some districts depend on Medicaid reimbursement to purchase and update specialized equipment (walkers, wheel chairs, exercise equipment, special playground equipment, equipment to assist with hearing and seeing) and assistive technology for students with disabilities so they can learn alongside their peers.

The Consequences of Medicaid Block Grants or Per Capita Caps Will Potentially Be Devastating for Children

Significant reductions to Medicaid spending could have devastating effects on our nation's children, especially those with disabilities. Due to the significant underfunding of IDEA, districts rely on Medicaid reimbursements to ensure students with disabilities have access to the supports and services they need to access a Free and Appropriate Education. If a per-capita cap or block grant were to be enacted, school districts would stand to lose much of their funding for Medicaid. A block grant could mean that districts would no longer have a dedicated funding stream based on reimbursement for the services they are providing to students. However, cuts to Medicaid will impact all students, not just those receiving special education services. The Center on Budget and Policy Priorities estimates that these structural funding changes could result in 30% reduction in Medicaid funding to states, and therefore, school districts. Potential consequences of this critical loss of funds include:

- **Fewer services:** Providing comprehensive physical and mental health services in schools improves accessibility for many children and youth, particularly in high needs and hard to serve areas such as rural and urban communities. In a 2017 survey of school district leaders, half indicated they have taken steps recently to increase Medicaid enrollment in their districts. Reduced funding for Medicaid would result in decreased access to critical healthcare for many children and youth.
- **Cuts to general education:** Cuts in Medicaid funding would require districts to utilize funds from other sources to provide the services as mandated under IDEA. The subsequent reduction from other sources would result in elimination of equivalent costing program cuts in "non-mandated" areas of regular education.
- **Higher taxes:** Many districts rely on Medicaid reimbursement to cover personnel costs for their special education programs. A loss in Medicaid reimbursement could lead to deficits in districts that require increases in property taxes or new levies to cover the costs of the special education programs.
- **Job loss:** Districts use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. A 2017 AASA survey found 68% of districts use Medicaid funding to pay for direct salaries for health professionals who services for students. Cuts to Medicaid funding would impact districts' ability to maintain employment for school nurses, physical and occupational therapists, speech-language pathologists, school social workers, school psychologists, and many other critical school personnel who ensure students with disabilities and those with a variety of educational needs are able to learn.
- **Fewer critical supplies:** Districts use Medicaid reimbursement for critical supplies such as wheelchairs, therapeutic bicycles, hydraulic changing tables, walkers, weighted vests, lifts as

well as items that are very student specific and are necessary for each child to access the curriculum as closely as possible to their non-disabled peers. Replacing this equipment would be difficult if not impossible without Medicaid reimbursement.

- **Fewer mental health supports:** Seven out of ten students receiving mental health services receive these services at school. Cuts to Medicaid would further marginalize these critical services and leave students without access to care.
- **Noncompliance with IDEA:** Given the failure to commit federal resources to fully-funding IDEA, Medicaid reimbursement serves as a critical funding stream to ensure districts can provide the specialized instructional supports that students with disabilities need to be educated with their peers. NAME estimates that 1% of all Medicaid reimbursement goes to local school districts (between \$3-4 billion), which is roughly a quarter of the investment we make in IDEA (\$17 billion).

We urge you to carefully consider the important benefits that Medicaid, as it is currently structured, provides to our nations' most vulnerable children. Schools are often the hub of the community, and converting Medicaid to a block grant, or instituting per capita caps threatens to significantly reduce access to comprehensive health and mental and behavioral health care for children with disabilities and those living in poverty. We look forward to working with you to prevent unnecessary changes to this highly effective and beneficial program.

If you have questions about the letter or wish to meet to discuss this issue further, please do not hesitate to reach out to the coalition co-chairs via email: John Hill (john.hill@medicaidforeducation.org), Sasha Pudelski (spudelski@aasa.org) and Kelly Vaillancourt Strobach (kvaillancourt@naspweb.org).

Sincerely,

AASA, The School Superintendents Association
 Accelify, LLC
 American Occupational Therapy Association
 American Dance Therapy Association
 American School Health Association
 Association of Education Service Agencies
 Association of School Business Officials International
 Colorado School Medicaid Consortium (The Consortium)
 Council of Administrators of Special Education
 Easterseals
 Health and Education Alliance of Louisiana
 Judge David L. Bazelon Center for Mental Health Law
 Learning Disabilities Association of America
 Michigan Association of School Administrators
 National Alliance for Medicaid in Education
 National Association of School Nurses
 National Association of School Psychologists
 National Association of Social Workers
 National Association of State Directors of Special Education (NASDSE)
 National Center for Learning Disabilities

National Education Association
National Rural Education Association
Paradigm Healthcare Services
School Social Work Association of America
Society for Public Health Education



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Darrell G. Kirch, M.D.
President and Chief Executive Officer

January 30, 2017

The Honorable Greg Walden
Chairman
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20510

The Honorable Michael Burgess, M.D.
Chairman
Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20510

The Honorable Tim Murphy
Chairman
Oversight and Investigations Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20510

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20510

The Honorable Gene Green
Ranking Member
Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20510

The Honorable Diana DeGette
Ranking Member
Oversight and Investigations Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20510

Dear Chairman Walden, Chairman Burgess, Chairman Murphy, Ranking Member Pallone, Ranking Member Green, and Ranking Member DeGette:

On behalf of the nation's medical schools and major teaching hospitals, I write to reiterate the Association of American Medical Colleges' (AAMC) commitment to informing policies that address opportunities and challenges in our health care system, and to ensuring that all individuals receive the comprehensive insurance coverage and high-quality care they need.

We appreciate the House Energy & Commerce Committee's commitment to a public dialogue regarding how best to improve the Medicaid program, including the Medicaid hearings scheduled this week in the Subcommittee on Health and the Subcommittee on Oversight. To that end, the AAMC is committed to working with Congress to strengthen the Medicaid program, the low-income health program that provides health coverage to more Americans than any other type of insurance. As Congress considers changes to the Medicaid program and additional health care reforms, maintaining, and in some cases improving, coverage and access to high quality care for Medicaid beneficiaries will be essential.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51

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Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, 115,000 resident physicians, and thousands of graduate students and postdoctoral trainees in the biomedical sciences.

Teaching hospitals and their medical school faculty physicians achieve world-renowned heights of clinical excellence, while also tending to the basic needs of our nation's most vulnerable patients. Though they represent only five percent of America's hospitals, AAMC-member teaching hospitals (also known as academic medical centers) provide nearly 25 percent of all hospital care - including 24 percent of all Medicaid inpatient visits and 20 percent of all Medicare inpatient visits - and deliver nearly 40 percent of the nation's charity care. These institutions also are committed to their communities and the nation as drivers of high-quality health care, pioneers of cures and treatments for diseases, leading employers, providers of safety net and critical emergency services, and partners in public health. We work for a just health care system for all, including rural and urban underserved populations, children, veterans, and seniors, among others.

This depth of experience and advanced capability mean teaching hospitals support efforts to ensure that Medicaid is a strong and reliable payer and source of robust coverage. However, teaching hospitals are all too aware when these programs fall short of this goal. State Medicaid programs vary considerably, and Congress must do more to ensure that this variation is used to innovate and improve health outcomes, while not inadvertently disadvantaging patients and providers.

The AAMC urges Congress to adhere to the following principles when considering any potential changes to the Medicaid program:

- **Congress should protect states, taxpayers, and Medicaid beneficiaries by maintaining the Affordable Care Act's (ACA) Medicaid expansion.** Many states have achieved expansion using Medicaid waiver authority, which has allowed them to tailor programs according to state priorities. Repealing the Medicaid expansion would leave states with fewer resources, threatening not only patients but also the safety net providers who care for them. If Congress wants to empower state decision-making, the use of waiver authority combined with the resources provided by the ACA can successfully achieve this objective. Existing Medicaid Section 1115 demonstration authority already allows for considerable state flexibility and innovation. Indiana, for example, includes Health Savings Accounts (HSAs) as part of its Medicaid program to empower beneficiaries in prioritizing wellness activities. Nearly every state has experimented with managed care and other cost containment strategies. Innovation for the betterment of beneficiaries cannot occur, however, when resources are scarce or unpredictable. Repealing the Medicaid expansion places these innovations and Medicaid beneficiaries at risk.
- **Congress should maintain the federal government's commitment to match state spending on medical care for Medicaid beneficiaries - without limits, caps, or block grants. Current eligibility levels and federal matching rates should be sustained.** Proposals to block grant or cap federal Medicaid spending would undermine the federal government's commitment to states and the health care needs of the most vulnerable. Setting fixed Medicaid budgets would mean states would be unable to accommodate the availability of new drugs or treatments, or weather downturns in the economy that necessitate increased enrollment. Congress should pursue policies that promote innovation and fiscal responsibility but not those that limit the federal government's commitment to Medicaid beneficiaries.

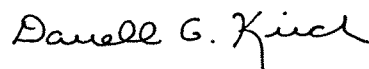
Chairman Walden, Chairman Burgess, Chairman Murphy, Ranking Member Pallone, Ranking Member Green, and Ranking Member DeGette
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- **The federal government should ensure that Medicaid beneficiaries have meaningful access to high-quality care by maintaining and enforcing network adequacy requirements and mandating sufficient payments to providers.** One of the Medicaid program's recurring challenges is ensuring adequate access to timely, high-quality care. States should continue to innovate with new models of care delivery, especially ones that promote care coordination and population health, but within the parameters of clearly defined and enforced federal standards regarding network adequacy, timely access, and sufficient provider payments.
- **Congress should delay scheduled cuts to Medicaid disproportionate share hospital (DSH) payments.** The ACA included more than \$9 billion in cuts to the federal contributions to DSH, to be phased in beginning in FY2014. Subsequently delayed, they are now scheduled to begin in September 2017. Cuts of this magnitude would devastate the health care safety net, including teaching hospitals around the country, which depend on these payments to help care for the 24 million Americans who remain uninsured despite the coverage expansions achieved by the ACA. Any increase in the number of uninsured coupled with Medicaid DSH cuts would cripple teaching hospitals' ability to ensure a strong health care safety net. Medicaid DSH cuts should be delayed until universal coverage is achieved.
- **Congress should permanently reauthorize the Children's Health Insurance Program (CHIP) and make CHIP funding permanent rather than subjecting it to the appropriations process.** The Children's Health Insurance Program - which covers over 8 million low-income children nationwide - enjoys strong, bipartisan support. Despite this support and its well documented success, CHIP continues to be at risk because of the recurring need to reauthorize it every two to three years. The value of covering kids, for its own sake and for the long term health of our nation, is unquestionable. Continued funding for a program that effectively achieves that aim should not be questioned either.

Medicaid is a lifeline for tens of millions of working families, individuals with disabilities, children with complex health needs, and low-income seniors with disabilities. The AAMC supports the laudable goals of efficiency, flexibility, and long-term healthcare cost containment but believes the best way to achieve this - for both the Medicaid program and health care generally - is by working to continue to reduce the growth in underlying health care costs. We look forward to engaging with Congress on this goal, as it will benefit not only the Federal government but states and individuals as well.

Please feel free to contact AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org) or me if we can provide any additional information or answer any questions you might have.

Sincerely,



Darrell G. Kirch, MD
President and Chief Executive Officer



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CHARLES D. BAKER
 GOVERNOR

KARYN E. POLITO
 LIEUTENANT GOVERNOR

January 11, 2017

The Honorable Kevin McCarthy
 Majority Leader
 United States House of Representatives
 H-107, U.S. Capitol Building
 Washington D.C., 20515

Leader McCarthy,

Thank you for the opportunity to provide initial input on how to improve upon the goals of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). For more than ten years, the Commonwealth of Massachusetts has been deeply engaged in designing and implementing health care reform solutions, first on a state level with our comprehensive, bipartisan state reform in 2006, and later with implementation of the Affordable Care Act. Although our state's initial implementation of the Affordable Care Act was deeply flawed, today more than 220,000 individuals have health care coverage through our state exchange, 180,000 low to modest income residents receive federal and state subsidies, and an additional 300,000 adults are enrolled in Medicaid as a result of the expansion allowed through the Affordable Care Act.

As an overarching statement, Massachusetts believes strongly in health care coverage for its residents. Working with the federal government, we have made considerable progress toward a goal of ensuring near universal health care coverage for our residents. Over 96.4% of Massachusetts residents were insured in 2015, the highest in the country.¹ Massachusetts retains a vital employer-sponsored insurance market, covering just under 60% of those insured.² And, the Massachusetts state-based exchange, known as the "Connector" maintains a robust individual insurance market with more than 10 health insurers. Affordability of health care remains a significant challenge, including double digit health care premiums.

Additionally, while health coverage is important first and foremost for its benefits to residents, health care is an economic engine for Massachusetts. The health care industry contributed \$19.77 billion to the state's economy, outpacing any other industry. One out of every ten workers is employed in health care related fields.³

¹ <http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf>.

² <http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf>.

³ <http://247wallst.com/special.report/2016/09/23/largest-industry-in-each-state-3/6/>

Massachusetts attributes much of its success in expanding health care coverage through a strong bipartisan effort across insurance, business, health care, political and advocacy communities that began in the 1990's and resulted in the passage of our state's health care reform law in 2006. Our belief is that health care coverage is a shared commitment, not the singular responsibility of government. Some of the changes to its health care law that Massachusetts had to make to comport with federal provisions have resulted in unintended consequences particularly impacting the employer sponsored insurance market and Medicaid program. Since 2011, the Commonwealth has seen a costly shift of approximately half a million lives from the commercial, employer-sponsored market into public coverage. The Medicaid program now accounts for just under 40% of the state's budget. Since 2012, the percent of residents on commercial insurance has decreased by 7 percentage points while Medicaid enrollment increased by 7 percentage points and now covers 28% of the population. The uninsurance rate has remained constant at 3%. The significant shift in lives from private to public coverage as a result of implementing the ACA – without a change in the uninsurance rate – has disrupted the stability of the Commonwealth's coverage landscape and contributed to challenges in the growth of the Medicaid program.

Massachusetts seeks flexibility to achieve the goals inherent in the Affordable Care Act and Medicaid programs while meeting the needs of its state.

In addition to expanding health care coverage, there are other important provisions contained within the Affordable Care Act. These include but are not limited to patient protections such as the ban on pre-existing condition exclusions, elimination of annual or lifetime limits and gender inequities. The ACA also closed the Medicare "donut" hole, extended the solvency of the Medicare trust fund and allowed for young people to remain on their parents' coverage through the age of 26. In addition, the ACA authorizes an important demonstration for integrating care for individuals dually eligible for Medicaid and Medicare.

However, as is true for any complex and complicated piece of national legislation with significant impact on the delivery of health care in 50 unique states, there is an opportunity to review and amend legislation to ensure it meets its intended goals and provides states with flexibility to implement health care reform in a way that meets states' needs. Any changes to the Affordable Care Act must also take into account the impact changes would have on the Medicaid program. MassHealth, the Massachusetts Medicaid and Children's Health Insurance Programs, provides health care coverage for nearly 1.9 million residents; it is an important safety net for a significant portion of our state's population. Medicaid is a shared federal/state partnership. Proposals that suggest states may be provided with more flexibility and control must not result in substantial and destabilizing cost shift to states.

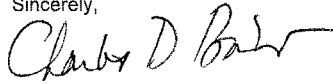
As Congress considers options related to health reform, we believe that a measured and objective analysis of the opportunities and challenges for states in the current federal landscape is essential. During this period of deliberation, it is important that coverage gains, patient protections and market stability are maintained. Our overall recommendations going forward include:

- Maintaining market stability as reform options are considered.
- Reviewing and revising key provisions of the Affordable Care Act and Medicaid program to provide states with flexibility to meet the unique needs of their state's population.
- Providing ample time for transitioning into new health care coverage and/or delivery models to ensure operational readiness.

- Maintaining state health care safety nets, including retaining existing federal subsidies and uncompensated care pools that support health care coverage and charity care providers.
- Avoiding proposals that only offer more flexibility and control in exchange for shifting costs to states.
- Expanding state flexibility in response to unique state needs that meet the overarching goals of health care coverage, access, quality and affordability in both the ACA and in the Medicaid program.

Massachusetts passed a version of universal health care coverage. The Affordable Care Act has provided both opportunities and challenges. The opportunities included further expanding coverage and receiving increased federal support for expansion. The challenges include implementing provisions that have added to state health care complexity and cost, rather than outcomes and affordability. We believe the path forward is to build upon a strong federal and state partnership in agreeing to the goals we all share while allowing states sufficient flexibility to tailor their health care system to meet the needs and demands of their unique state.

Sincerely,



Charles D. Baker
Governor

1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?

- Massachusetts has appreciated the flexibility that Congress and the Department of Health and Human Services have made available to states in the past, such as existing Section 1115 and Section 1332 waiver pathways. Massachusetts values the availability of federal infrastructure and funding for states to continue innovating to meet the specific needs of their populations and markets. Critically, and during the next few years, we request that Congress offer states the option to maintain state flexibility agreements already in place, when considering any future changes.
- Massachusetts believes there are opportunities to expand upon flexibility provided to states with both the 1115 and Section 1332 authorities. State innovation is key to achieving health care coverage, managing health care costs and affordability, as well as improving patient outcomes and satisfaction.
- Going forward, greater flexibility should be provided to states with regard to:
 - state specific benefit rules, beyond what is permitted under Essential Health Benefit standards
 - state specific actuarial value calculator for benefit standards
 - state specific rating factors to apply for small group premium development
 - a more flexible risk adjustments system or elect not to apply risk adjustments
 - insurance products offered through group purchasing cooperatives and professional employer organizations
 - administrative rules and regulations, simplification regarding compliance and other reporting requirements.
 - greater authority and flexibility to ensure that mental health parity rules are complied with.

2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?

- Congress and the incoming administration should introduce any legislative or regulatory changes on a gradual timeline, ideally with state flexibility to opt out or grandfather existing programs, to prevent market shocks and to improve market stability.
- Congress should consider:
 - allowing states to maintain the individual mandate to allow stability within risk pools
 - maintaining risk corridor and reinsurance payments in 2017 with coverage in place in 2016
 - maintaining risk adjustment for 2017 as carriers have built risk adjustment into already offered 2017 premiums.
 - allowing states to determine risk adjustment system for 2018 and onward.
 - permitting states to develop state specific open enrollment rules.
- **What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?**

- Medicaid represents a significant portion of state budgets (just under 40% in Massachusetts) and is a shared federal/state partnership. While we strongly support maintaining and increasing flexibility for states (such as through existing Section 1115 waiver authorities), proposals that suggest states be provided with more flexibility and control must not result in substantial and destabilizing cost shift to states. We are very concerned that a shift to block grants or per capita caps for Medicaid would remove flexibility from states as the result of reduced federal funding. States would most likely make decisions based mainly on fiscal reasons rather than the health care needs of vulnerable populations and the stability of the insurance market. The federal/state share varies by state, ranging from 80/20 to 50/50; Massachusetts is a 50/50 state. Any Medicaid reform should start with the assumption that every state's current federal share establishes the baseline.
 - Medicaid provides the option for states to pursue flexibility through the use of Section 1115 Demonstration Waivers. Massachusetts has had an 1115 in place since 1997, allowing the state to deviate from traditional Medicaid rules with expanded eligibility, streamlined eligibility processes, mandatory managed care and, most recently, a move to value-based purchasing and Accountable Care Organization programs. Our projections show that this move to ACOs will result in reducing spending while also improving health outcomes. We urge our federal partners to maintain flexibility for states through 1115 waivers.
 - While our Medicaid program has been a crucial prong in the state's approach towards achieving almost universal health coverage for our residents, we do believe that the Medicaid program could be improved through certain changes to Medicaid rules allowing greater flexibility around benefit design while maintaining patient protections. In particular, the ACA added new Essential Health Benefits (EHB) requirements to the coverage provided to the Medicaid expansion population. This construct is unnecessary and adds unneeded complication to the development of benefit packages. States already make decisions regarding the optional benefits provided to their non-expansion populations and the EHB requirement for expansion populations removes the flexibility states may need to make appropriate benefit decisions for their populations. We also would support the removal of the requirement to provide non-emergency medical transportation to the expansion population.
3. **What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?**
- The Affordable Care Act changed important elements of the Commonwealth's previous version of health care reform with unintended consequences. The ACA employer mandate (for employers with 50 or more FTEs) replaced the Commonwealth's fair share contribution for employers with 11 or more FTEs and added significant administrative burden for employers. In addition, the ACA changed a number of previous rules governing eligibility for subsidized coverage for individuals with access to employer sponsored coverage, changing the dynamic between employers, employees and taxpayer-funded programs in concerning ways.
 - As a result, over the past several years, the Commonwealth has seen a shift of ~500,000 lives from the commercial, employer-sponsored market into public coverage. Since 2012, the percent of residents on commercial insurance decreased by 7 percentage points from ~65% to 58%; over the same period, Medicaid enrollment increased by 7 percentage points and now covers 28% of the population. The

uninsurance rate has remained constant at 3%. The significant shift in lives from private to public coverage as a result of implementing the ACA – without a change in the uninsurance rate – has disrupted the stability of the Commonwealth's coverage landscape. It has also contributed to challenges in the growth of the Medicaid program, with 85% of growth over the past several years being driven by enrollment.

- Massachusetts maintains an unwavering commitment to universal coverage and, based on its experience, supports maintaining many components of the ACA, combined with increased flexibility for states to make adjustments based on state-specific needs. This must include more flexibility for states through 1332 waivers to sustain universal coverage, including allowing states to waive the ACA employer mandate for employers with more than 50 FTEs with certain conditions attached (e.g., if states have a better suited alternative) and giving states more flexibility to stabilize commercial coverage options for both individuals and small employer segments.
- As Congress considers changes to the employer-sponsored insurance market, we would request consideration of the need for ample lead-time in order to ensure that employers, insurers, and individuals are able to prepare and possibly alter their choices without undue disruption.
- We suggest revisiting mechanisms to support employers seeking to contribute to coverage through targeted, market-based incentives and administrative simplifications.
- To control the shifting of cost and responsibility for coverage from the commercial market to public programs, rules that allow individuals with access to employer sponsored coverage to enroll in Medicaid should be revised.
- States should be allowed to waive certain ACA provisions, such as the employer mandate for employers with more than 50 FTEs and the definition of full time as 35 hours/week, which can be done with certain conditions attached (e.g. under condition of implementing an approach better suited to the particular state).
- Tax subsidies should be offered to small employers providing affordable coverage to low income employees.
- Flexibility on utilization of existing (and hopefully new) 2 year SB tax subsidies – allow states to access available funds immediately and disburse it by setting own customized eligibility for businesses.
- Allow access to APTC to eligible employees, before applying defined contribution funds provided by employer.
- For example, Congress could:
 - revisit tax code provisions that prohibit employers from setting aside pre-tax money under a Section 125 plan or other tax-preferred mechanisms, so that non-benefit eligible employees can use pre-tax dollars to purchase the non-group coverage of their choice. Massachusetts has substantial experience administering a similar program.
 - refine the ACA's small business health care tax credit, by allowing states to repurpose federal funds toward small group coverage incentive programs that meet local business needs.
- Congress should give states more flexibility to:
 - establish state-specific benefit rules, beyond what is permitted under Essential Health Benefits standards.
 - establish preventive health standards and applicable cost-sharing requirements.
 - develop a state-specific Actuarial Value Calculator to establish benefit standards or elect not to use one.
 - establish state-specific rating factors to apply for small group premium development.

- develop a more flexible risk adjustment system or elect not to apply risk adjustment.
- permit insurance products offered through group purchasing cooperatives and professional employer organizations.
- eliminate ACA premium taxes, including the so-called Cadillac tax.

4. What key long-term reforms would improve affordability for patients?

- Over ten years of state-level reform, Massachusetts has learned that lower-income residents require a substantial level of subsidization in order to take-up and maintain coverage.
- In addition to federal subsidies, Massachusetts offers a program that “wraps” around individual coverage available through the Exchange with additional subsidies for eligible low-income individuals who do not qualify for Medicaid. This level of subsidization, exceeding the current federal level, is critical to enrollment and retention of a healthy risk pool. Massachusetts recommends flexibility to preserve this program in order to boost coverage efforts among hard-to-cover populations.
- Congress must address the growing cost of prescription drugs and foster greater transparency in the cost of high cost health care providers.

5. Does your state currently have or plan to enact authority to utilize a Section 1332 Waiver for State Innovation beginning January 1, 2017?

- a. If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?
 - b. If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?
 - c. If allowed, which requirements would your state seek to waive under a 1332 waiver?
 - d. If allowed—and if applicable—what changes would be necessary to current guidance to accelerate your states’ ability to pursue a 1332 waiver?
- Massachusetts supports granting states more flexibility under a variety of waiver authorities (Section 1332, Section 1321(e) for states with pre-ACA state health reforms, and Medicaid 1115 waivers) to maintain stable, universal coverage. Massachusetts would also welcome the opportunity to participate in the development of “fast-track” waiver authority to expedite processing and approvals.
 - Specific examples of flexibilities include allowing states to:
 - Waive the ACA employer mandate for employers with more than 50 FTEs and the definition of full time as 35 hours/week with certain conditions attached (e.g., if states have a better suited alternative), and/or significantly simplify the administrative burden on employers for reporting
 - Support employers who are seeking to contribute to coverage through market-based incentives, including:
 - More flexibility for Section 125 plans (for example, Defined Contribution models to purchase coverage on the exchanges)
 - Flexibility to ensure effective implementation of new provisions from the 21st Century Cures Act related to Health Reimbursement Accounts

(HRAs) and opportunities for employees to make tax-deductible contributions for employees purchasing coverage on the exchanges

- Maintain flexibility for low-income coverage options through Medicaid 1115 waivers (the Commonwealth's 1115 waiver allows for premium and cost-sharing wraps for individuals purchasing coverage on the exchange with income <300% of FPL)
- Access small business tax credits and other subsidies
- Waive conflicting eligibility standards between Medicaid and the Exchange (income standards, household size, etc.)
- Implement state-specific Actuarial Value Calculators and rating factors
- Maintain flexibility through Medicaid 1115 waivers on the structure of uncompensated care pools

6. As part of returning more choice, control, and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?

- Massachusetts has to date not considered such a plan. The establishment of a high risk pool would depend on the rules and structure of the program; however, we would be concerned given the history of high-risk pools, which has not been particularly successful.

7. What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements, should we consider while making change?

- We appreciate Congress' attentiveness to the local timing needs that would be critical to the successful implementation of any ongoing federal reforms.
- Carriers need clear guidance to develop appropriate products and to set premiums for the insurance market.
- Key deadlines in Massachusetts include:
 - For all individual plans and some small group plans effective January 1, 2018 insurance carriers must complete their development of plan designs and submit them to the Division of Insurance by April 1, 2017 for their review and approval in the previous mid-summer. Carriers must submit the development of rates and submit them to the Division of Insurance by July 1 for their review and approval by mid-summer. For example, plans starting January 1, 2018 will be proposed by insurers by early July 2017.
 - For small group plans effective other than January 1, insurance carriers must forward plan design and rates to the Division of Insurance at least 90 days prior to their effective dates.
 - Open enrollment for individual plans begins November 1, 2017 and ends January 31, 2018. Small group plans have open enrollment on a continuous basis throughout the calendar year.
 - IT and systems changes for the state-based Exchange are generally calendared at least one year in advance – for example, the Massachusetts Health Connector has planned and budgeted for its 'systems releases' through Fall 2017.
 - Legislative sessions in Massachusetts are for two years, with the new session starting January 2017. Formal sessions run through November in the first year and July 31 in the second year. Massachusetts government is funded on a fiscal

year basis, running from July 1 through June 30. The annual budget process begins each year when the Governor files recommendations as a bill by the 4th Wednesday of January. If federal changes that affect the annual state budget were to materialize, the Governor's primary opportunity to propose any required policy adjustments would arise the following January in his annual recommendation with final implementation the following July.

8. Has your state adopted any of the 2010 federal reforms into state law If so, which ones? What impact would repeal have on these state laws?

- Massachusetts has enacted many health reform-related provisions into law, some of which predate the ACA but are substantially similar (such as the state's individual requirement to maintain coverage).
- However, since Massachusetts has not adopted every provision of the ACA into state law, and in some cases state law refers to federal citations, any Congressional repeal effort on a rapid timeline could cause significant confusion in the market. We ask Congress to offer states an ample runway to prepare for any significant federal changes with corresponding state law changes, as needed.
- Massachusetts is actively working to manage health care costs for federal and state payers, individuals, and businesses -- such as through the launch of a comprehensive payment reform initiative in the Medicaid program.
- Massachusetts has enacted many legislative changes relative to the Affordable Care Act (ACA) include:
 - Changed definition of "eligible individual" in Small Group Laws.
 - Established transition period for phase-out of certain small group rating factors in Small Group Laws.
 - Revised timing of filing rates in Small Group Laws.
 - Established authority for Division of Insurance to enforce ACA provisions.
 - Conformed dependent coverage provisions to ACA (age 26).
 - Conformed Massachusetts preexisting conditions and waiting periods to ACA.
 - Revised timing of submission of rate filings to conform with ACA.
 - Conformed external review process to ACA.
 - Granted authority for EOHHS and Connector (Exchange) to obtain necessary data from any state or public entity for certain administrative functions.
 - Conformed Medicaid eligibility requirements to the ACA.
 - Revised Connector's enabling statute; removed references to Connector Care.
 - Enacted technical changes authorizing Connector to administer premium and cost-sharing wrap.
 - Conformed Connector premium requirements to ACA.



**Energy and Commerce Committee
Subcommittee on Health
Hearing on "Strengthening Medicaid and
Prioritizing the Most Vulnerable"
February 1, 2017**

3M Company ("3M") appreciates the opportunity to submit this statement for the record before the Energy and Commerce Subcommittee on Health Hearing on "Strengthening Medicaid and Prioritizing the Most Vulnerable."

3M thanks the Committee for its continued efforts to improve all of the critical programs within the health care system to keep pace for the betterment of patients. As the Committee considers ways to strengthen the program and provide states with greater flexibility, we would recommend encouraging states to reduce costs by tying payment incentives to improved patient outcomes.

Background on 3M Health Information Systems

3M is a large U.S.-based employer and manufacturer established over a century ago in Minnesota. Today, 3M is one of the largest and most diversified manufacturing companies in the world. We are a global company conducting the majority of our manufacturing and research activities in the United States.

3M Health Information Systems works with providers, payers and government agencies to anticipate and navigate a changing healthcare landscape. 3M provides healthcare data aggregation, analysis, and strategic services that help clients move from volume to value-based health care, resulting in improved provider performance and better patient outcomes. 3M HIS is one of the industry leaders in **hospital and health system payment classification systems tied to quality**, computer-assisted coding, clinical documentation improvement, performance monitoring, quality outcomes reporting, and terminology management.

Targeting the Problem to Improve Quality and Reduce Costs

The 2012 Institute of Medicine (IOM) study *Best Care at Lower Cost* estimated that unneeded services, mistakes, delivery system ineffectiveness and missed prevention opportunities were leading to \$395 billion in annual healthcare expenditures that could be avoided without worsening health outcomes.

If the health care system can focus on targeting these potentially preventable services, complications, inefficiencies and missed opportunities, we can improve patient care and save valuable health care resources.

We know that failures in quality typically result in a need for more interventions to correct the quality problem resulting in high rates of potentially preventable:

- Complications,
- Readmissions,
- Admissions,
- Emergency room visits, and
- Outpatient procedures and diagnostic tests.

These five potentially avoidable events represent the vast majority of avoidable adverse outcomes. The added benefit of this definition of avoidable outcomes is that each of these can be translated into dollars. As a consequence they also represent a large proportion of the unnecessary spending within our health care system and should be the target of state and federal efforts to make our system more efficient and effective for patients and tax payers. We can improve our health care system if we can reduce these kinds of events through better collaboration, information, payment incentives and care coordination.

State Efforts to Improve Outcomes and Reduce Costs in Their Medicaid Programs

For most states, expenditures for Medicaid are one of the largest or the largest items in the state budget. This has necessitated that states seek innovative ways to control Medicaid expenditures. **Many of the successful state based payment system reforms are practical, transparent, and identify opportunities for improvement that are being realized today.**

Leading Medicaid programs have focused on payment system reforms that link the outcomes of care to payment. These state programs are boldly leading the way on healthcare system payment reform as they respond to their urgent state budget issues. States like Texas, New York, Pennsylvania, Illinois, Maryland, Ohio, and Minnesota have adopted payment systems that create clear financial incentives for providers to increase efficiency and improve quality outcomes.

The payment reforms implemented by these and other state Medicaid programs have been more comprehensive than those implemented by Medicare. Examples include outcomes focused pay for performance programs that target a wider range of clinically-related readmissions and a more comprehensive set of healthcare acquired complications than is currently included in Medicare payment policies.

While some of the implementation details across these state Medicaid reforms may differ, they all have the following characteristics in common:

- Payment adjustments for quality are based on the outcomes of care
- Measureable and clinically meaningful objectives for improving the outcomes of care are established
- Comprehensive provider specific information on the outcomes of care are made publicly available

The core objective of an outcomes payment reform is to motivate provider behavioral change that leads to improved outcomes, better quality and lower costs. Outcomes related payment adjustments are directed at health delivery organizations with a consistently higher risk-adjusted rates of PPEs because they are more likely to have underlying quality problems that can be identified and corrected. By focusing on outcomes that are potentially preventable, healthcare delivery organizations can direct their quality improvement efforts on problems where quality can actually be improved.

As an inherent byproduct of responding to the financial incentives in an outcomes payment reform, healthcare delivery organizations must find new and innovative ways to coordinate care and improve quality. Because there is a clear and unambiguous relationship between each PPE and its financial consequences, reductions in the rate of PPEs directly translate into lower cost of care. The only way to significantly improve outcomes performance is to provide better care coordination and improved quality. As a result, the care for patients will improve as healthcare delivery organizations strive to improve their outcome performance.

State Examples

Several state Medicaid agencies are in the process of implementing comprehensive outcomes payment reforms.

- **Texas** passed comprehensive Medicaid reform legislation in 2011 to establish quality outcomes based payment adjustment targeting managed care plans, hospitals and regional healthcare partnerships. As of 2016, Texas was generating annual savings of \$90 million via plan and provider reductions of potentially avoidable events.
- **New York** has created a delivery system reform and value based payment program designed to reduce state-wide avoidable hospital use (readmissions, admissions and emergency department visits) by 25% over a five year period ending 2020.
- **Pennsylvania** has revamped its Medicaid managed care program, which will measure plans' quality outcomes, and will require plans to make 40% of their transactions with providers to be value based transactions within three years. Pennsylvania has also established a Hospital Quality Incentive Programs to reward hospitals showing year-to-year improvement in reducing avoidable readmissions.
- **Illinois** established a hospital inpatient rate adjustment program based on potentially preventable readmissions performance that generated \$40 million in savings.
- **Maryland's** potentially preventable complication outcomes payment program has generated a state-wide 50% reduction in inpatient complications over a five year period.
- **Ohio** has established outcomes based payment programs to reduce hospital potentially preventable readmissions and nursing potentially preventable admissions.
- **Minnesota's** state hospital association sponsored "Reducing Avoidable Readmissions Effectively" Program reduced avoidable readmissions by 2% over three years, generating over \$70 million in savings—and won the National Quality Forum Patient Safety Award in 2014.

Application for Medicaid Reform

As the Committee considers ways to strengthen the program and provide states with greater flexibility, we would recommend encouraging states to reduce costs by tying payment incentives to improved patient outcomes. The existing Federal Medical Assistance Percentage (FMAP) for Medicaid funding has resulted in a rising a Federal share along with increased complexity, cost and frustration experienced by states from CMS oversight. The existing Medicaid financing

relationship between CMS and the states should be transformed from a contractual arrangement to a simplified regulatory structure in which superior operational performance of a Medicaid agency and its bottom-line success are closely linked and do not require burdensome retrospective oversight measures.

Specifically, we would recommend replacing the current FMAP with a risk-adjusted, per capita matching payment system that ties payment incentives to efficiently delivered improved outcomes. This would permit states to have greater control over their program under a national rate not based on “covered costs” but instead based on spending adjusted for patient mix and achieved outcomes. This is an extension of the pricing approach used in the Medicare inpatient prospective payment system (IPPS) implemented in 1982. The IPPS had the effect of saving the Federal government billions of dollars while maintaining quality.

At the same time, we would recommend establishing quality outcomes targets for Medicaid programs to provide objective measurement of relative performance within the matched funding budget. Under such an approach, states could be allowed to earn a greater relative match by reducing their cost, thus driving reductions in overall costs but allowing states to share in their program efficiency improvements. Long term this would reduce federal share as average matching dollars will fall.

Conclusion: We Should Learn from and Respond to What is Working

Successful state Medicaid program efforts that are fully operational and producing improved outcomes should provide the basis for reforming and strengthening the Medicaid program going forward. A more widespread adoption of these innovative payment system reforms across entire Medicaid program should be encouraged. Payment system reforms that are practical, transparent, clinically credible, and identify opportunities for improvement can yield better outcomes at lower costs.

We would appreciate the opportunity to present additional findings and would welcome the opportunity to answer any questions. Please contact Megan Ivory Carr at mmivory@mmm.com or 202.414.3000 for any information.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH 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) 225-3641

February 17, 2016

Dr. Avik S. A. Roy
President
The Foundation for Research on Equal Opportunity
3267 Bee Caves Road
Suite 107-375
Austin, TX 78746-6773

Dear Dr. Roy:

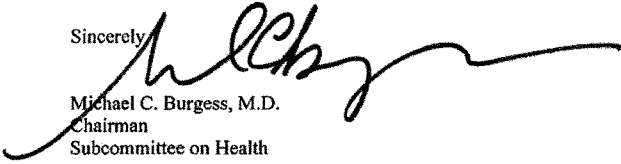
Thank you for appearing before the Subcommittee on Health on February 1, 2017, to testify at the hearing entitled "Strengthening Medicaid and Prioritizing the Most Vulnerable."

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 March 3, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

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

Sincerely


Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record**The Honorable Gus Bilirakis**

1. There was an idea in the House Republican health proposal, A Better Way, which would grandfather successful waivers for managed care if they have already been renewed twice. It's my understanding Arizona has operated their program through a managed care waiver since the 1980s, and I know other states are largely managed care. Florida has a statewide managed care plan. Does it make sense to require successful waivers to be repeatedly renewed?

The Honorable Cathy McMorris Rodgers

1. In your testimony, you talked about the need for Congress to adopt solutions that would better coordinate care and constrain costs for dual eligibles – individuals who are enrolled in Medicare and Medicaid. I know this is an area of bipartisan interest, and I think we all know we can do better by these vulnerable patients. What concrete steps do you have in mind that you think Congress should consider in this space?
2. While I believe in a strong Medicaid safety net, I certainly want to see a robust private sector. So, since waiting lists may demonstrate unmet need, what is the appropriate role for private sector resources and entities to play in preventing public funds crowding-out private fund or cost-shifting to the public sector?
3. Many individuals with intellectual and developmental disabilities require ongoing long-term services and supports for their entire life. In 2015, there were 640,841 individuals on HCBS waiver waiting lists across the country. Individuals with IDD made up 67 percent of those waiting. You suggest in your testimony that Medicaid's long-term care for the disabled could be transitioned fully to the states. What policies could be put in place to ensure states prioritize serving IDD individuals – who make up the largest portion of those waiting for care today?

The Honorable Richard Hudson

1. What would you think about such a proposal – not to change what the Secretary can approve, but to add transparency, show outcomes data, etc.?

The Honorable Michael C. Burgess

1. One of the concerns we have had with traditional Medicaid expansion is how it crowds out the private market. Even research from Jonathan Gruber has shown this. In your research, have you observed trends in which the presence of public insurance (like Medicaid) causes someone with private insurance to drop coverage for public insurance? If so, what solutions would you offer to counter this trend?

GREG WALDEN, OREGON
CHAIRMAN

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February 17, 2016

Mr. John McCarthy
Former Director
Ohio Department of Medicaid
8375 Nemain Loop
Dublin, OH 43016

Dear Mr. McCarthy:

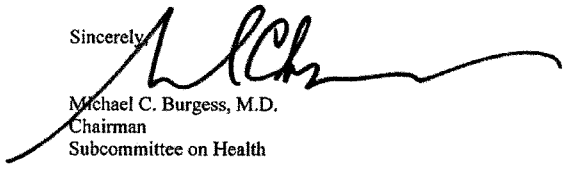
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2. While I believe in a strong Medicaid safety net, I certainly want to see a robust private sector. So, since waiting lists may demonstrate unmet need, what is the appropriate role for private sector resources and entities to play in preventing public funds crowding-out private fund or cost-shifting to the public sector?
3. Are there other types of patients who may be eligible for Medicaid but face barriers accessing timely care that you would recommend the Committee examine?

The Honorable Richard Hudson

1. Under the Medicaid statute, the Secretary of HHS can allow federal financial participation for Costs Not Otherwise Matchable for State programs. However, there is no requirement that requires federal matching funds be spent on programs that serve care needs of Medicaid patients or uninsured or low income patients. In fact, oversight by the Government Accountability Office has found the Obama Administration approved some really questionable spending. There was an idea in the House Republican health proposal, A Better Way, which would require transparency from the Secretary of HHS in exercising this authority. The idea would be to require the Secretary to merely report on how federal funding helps prioritize the most vulnerable -- Medicaid patients or uninsured individuals below a specific income threshold. What would you think about such a proposal?

The Honorable Michael C. Burgess

1. In your testimony, you recommended CMS shift into the role of a payer and oversee Medicaid, especially by monitoring health outcomes. You note "this could be done by using financial incentives tied to measures" like HEDIS or NCQA measures. This is a fascinating and compelling idea. Can you tell us more about how it could work?

2. I am also interested in getting your perspective on the growing body of literature that shows that Medicaid often doesn't improve health outcomes. Is that research just focused on specific States? Do you think some of the challenges are attributable to socio-economic factors? As we think about ways to strengthen Medicaid in your opinion, what health outcomes and measures should we assess to best gauge the value of health care or long-term care patients receive?
3. It's disappointing that we are still paying for volume in traditional Medicaid Fee-for-Service, though I appreciate 2/3 of beneficiaries are in managed care. You mentioned CMS should act less like a regulator and more like an oversight entity. It should allow states flexibility and then monitor, and hold States accountable for health outcomes. How would you do this? Would you look at total Medicaid population? I assume you would have different quality and outcomes measures for the disabled, elderly, pregnant mothers, children, and able-bodied groups?
4. GAO has found that one state reported seeing annuities for the community spouse worth more than \$1 million. Would Ohio's Medicaid program choose to cover these individuals if given flexibility in federal law?
5. As I sit here listening for ideas on how we can cut costs, I have to ask you about two different ideas: presumptive eligibility, and retroactive eligibility. Obamacare expanded presumptive eligibility – where an applicant is basically presumed to be eligible. Medicaid also allows for retroactive coverage – where coverage can go back not only to the date of application but also to three months prior to the application. Both of these policies are more generous than commercial insurance. These policies seem excessive to me and many others. Are there reasons why Congress should not curb both policies?
6. In your testimony, you explained that “the ‘any willing provider’ requirements for the fee-for service program stifles provider competition, increases costs, and rewards low quality providers.” You offered a few ideas about alternative approaches. Could you please elaborate on how those alternative approaches would work for the Committee?

GREG WALDEN, OREGON
CHAIRMAN

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February 17, 2016

Ms. Judy Solomon
Vice President for Health Policy
Center on Budget and Policy Priorities
820 First Street, N.E.
Suite 510
Washington, DC 20002

Dear Ms. Solomon:

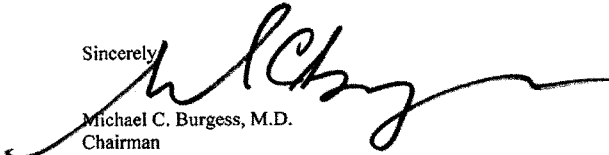
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Sincerely,



Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Questions to Judith Solomon From The Honorable Ben Ray Lujan –

In New Mexico, as part of the Affordable Care Act, Medicaid Expansion took Medicaid from a safety net for the poor to a ladder for the middle class.

Before passage of the ACA, the number one reason that middle class families declared bankruptcy – lost their houses, lost their cars, lost everything – was medical debt.

We should not go back to a time where the difference between being middle class and living in poverty is a cancer diagnosis. The difference between having a house and being homeless is one bad car accident. Without this ladder, our middle class families will fall and many working class New Mexicans will slip into poverty.

- 1. Ms. Solomon, are the bills we are considering today the best way to help the program succeed?**

The bills considered at the February 1 hearing would not improve or strengthen the Medicaid program. Instead, they would likely keep people who are now eligible from obtain health care services they need.

The elimination of the Medicaid expansion program in New Mexico will gut nearly 4,800 healthcare and social assistance jobs in our state.

In my state, healthcare is not only about physical health, it is also about jobs. Over 2,500 jobs were lost in the healthcare sector due to under-funding Medicaid last year. If Medicaid expansion is stripped away, we will lose thousands more.

While much of the rest of the state's economy has declined, the health care field has become an economic driver, accounting for seven of the top 10 fastest-growing job categories.

- 2. Ms. Solomon, are the bills we are considering today going to help us keep the health care jobs we have?**

In my opinion the bills considered at the February 1 hearing would have little or no impact on health care jobs. They would likely result in fewer people having coverage but it's unlikely that the decrease in coverage would be large enough to affect health care employment.

I would like to zoom in on what the Verify Eligibility Coverage Act would do.

- 3. Ms. Solomon, I understand from your testimony that most people can have their citizenship status verified quickly through a data match with the Social Security office, so can you describe the kinds of people likely to be impacted if this bill were to become law?**

The bill considered by the committee changed how citizenship is verified. As noted, the vast majority of people have their citizenship status verified quickly through a data match with the Social Security Administration. Naturalized citizens and adult citizen applicants born abroad are

the groups most likely unable to have their citizenship verified by SSA. This would include people who were born to members of the U.S. military serving abroad before 1972 when Social Security began including citizenship information in its records.

In my state, as in many other states the stereotype of Medicaid as a program for single mothers and their kids simply isn't accurate – the Medicaid program serves thousands upon thousands of elderly and disabled New Mexicans.

4. Ms. Solomon, how will the bills we are considering today help those who depend on Medicaid to pay for long-term care or other services for their parents and grandparents later in their life?

As I noted in my testimony, states have a great deal of flexibility regarding their Medicaid programs, including how they provide long-term services and supports. There are far better ways to help states expand home- and community based services than by providing enhanced funds to states with the longest waiting lists as was proposed in the bills considered by the Committee on February 1. It would be much fairer to all states to provide incentives to enhance the provision of HCBS, which could include metrics to measure state progress. Making increased resources available to all states through programs like the Balancing Incentive Program and the Community First Choice Option, which were part of the Affordable Care Act, is better aligned with the overall structure of the Medicaid program to provide states with an array of choices to meet their needs. Moreover, it avoids having states forgo their own efforts to reduce their waiting lists in order to get a chance to get 90 percent match available to states with the longest waiting lists.