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4 ``THE NEED FOR MEDICAID REFORM: A STATE PERSPECTIVE''

5 WEDNESDAY, JUNE 12, 2013

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The subcommittee met, pursuant to call, at 10 a.m., in  
11 Room 2322 of the Rayburn House Office Building, Hon. Joe  
12 Pitts [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pitts, Burgess,  
14 Whitfield, Shimkus, Murphy, Blackburn, Lance, Cassidy,  
15 Guthrie, Griffith, Bilirakis, Ellmers, Upton (ex officio),  
16 Pallone, Dingell, Capps, Schakowsky, Green, Barrow,

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17 Christensen, Castor, Sarbanes and Waxman (ex officio).

18 Staff present: Gary Andres, Staff Director; Sean

19 Bonyun, Communications Director; Matt Bravo, Professional

20 Staff Member; Julie Goon, Health Policy Advisor; Brad Grantz,

21 Policy Coordinator, Oversight and Investigations; Sydne

22 Harwick, Legislative Clerk; Monica Popp, Professional Staff

23 Member, Health; Andrew Powaleny, Deputy Press Secretary;

24 Chris Sarley, Policy Coordinator, Environment and Economy;

25 Heidi Stirrup, Health Policy Coordinator; Alli Corr,

26 Democratic Policy Analyst; Amy Hall, Democratic Senior

27 Professional Staff Member; Elizabeth Letter, Democratic

28 Assistant Press Secretary; and Karen Nelson, Democratic

29 Deputy Committee Staff Director for Health.

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|  
30           Mr. {Pitts.} This subcommittee will come to order. The  
31 chair will recognize himself for an opening statement.

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

41           Those enrolled in Medicaid today face significant  
42 difficulties in accessing care. According to a recent  
43 analysis, while 83 percent of physicians are accepting  
44 Medicare patients, only 70 percent of physicians are  
45 accepting those in the Medicaid program. Other studies have  
46 shown that compared to those with private insurance, Medicaid  
47 beneficiaries find it more difficult to schedule follow-up  
48 visits after initially seeing a doctor; are twice as likely  
49 to report difficulty in accessing primary care services

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50 including prevention services; and are twice as likely to  
51 visit the emergency room. Clearly, we are failing those most  
52 in need of our help. And we are spending enormous amounts of  
53 money for substandard care, and in some cases, worse outcomes  
54 than those with no insurance at all.

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

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

70 But we don't have to settle for subpar care or limited

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71 access and exploding costs. Many States have embarked on  
72 innovative Medicaid reforms to improve the quality of care  
73 and modernize their programs, ranging from payment  
74 incentives, to coordinated care, to consumer-driven options,  
75 to added services for their beneficiaries and more. This has  
76 been possible, in part, through the use of State  
77 demonstration waivers, but it can take years for the Centers  
78 for Medicare and Medicaid Services to approve these waivers.  
79 We need to provide States with the flexibility to pursue  
80 these options, not lock them in a one-size-fits-all model  
81 dictated by Washington.

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

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

90 [The prepared statement of Mr. Pitts follows:]

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91 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
92 Dr. {Burgess.} I thank the chairman for yielding.

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

107 One of the biggest is Medicaid reimbursement. Medicaid  
108 reimbursement rates are already embarrassingly low, forcing  
109 many providers to refuse new Medicaid patients. In Texas,  
110 only 31 percent of physicians in Texas currently accept new  
111 Medicaid patients. This trend only foreshadows the threat to

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112 access for millions of new Medicaid beneficiaries beginning  
113 next year. To sustain provider and plan buy-in, we must  
114 demand accountability from both the federal and State  
115 partners. That is the purpose of this hearing today. That  
116 is what we are investigating this morning. I certainly look  
117 forward to the testimony of our witnesses, and I will yield  
118 back to the chairman.

119 [The prepared statement of Dr. Burgess follows:]

120 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
121           Mr. {Pitts.} The chair thanks the gentleman and now  
122 yields 5 minutes for an opening statement to the ranking  
123 member, Mr. Pallone.

124           Mr. {Pallone.} Thank you, Mr. Chairman.

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

135           I fought hard to make sure that the expansion of  
136 Medicaid was included in the Affordable Care Act because it  
137 will not only improve access to health care for individuals  
138 across the country but it will improve States' economic  
139 health as well. While we expect all States to participate in  
140 the Medicaid expansion because it is an advantageous fiscal

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141 arrangement, I am troubled and discouraged that there are  
142 many who still have not decided to expand. I do believe,  
143 however, that eventually all States will recognize the  
144 importance of this provision to the health care system as a  
145 whole.

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

158         Now, while Republicans will tell you that States need  
159 greater Medicaid flexibility, I would argue that under the  
160 current law, a great deal of flexibility exists while  
161 simultaneously providing a baseline of protections for

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162 beneficiaries. States have the ability to manage the design  
163 of their Medicaid programs. Within federal guidelines, they  
164 can alter benefits or change cost sharing and premiums. The  
165 concept that States have significant flexibility in the  
166 management of their programs is reflected by the fact that  
167 States when they want to are taking on innovative approaches  
168 to improve their Medicaid programs. For example, States are  
169 experimenting with programs to reduce expensive and  
170 unnecessary hospital readmissions, programs to improve health  
171 and promote prevention and medical home models as well.

172       So let me talk for a moment about the Republicans'  
173 proposal, which I believe has been presented under the guise  
174 to provide greater flexibility. I am extremely concerned  
175 that their proposal will simply lead to higher premiums and  
176 greater financial burdens on low-income elderly or disabled  
177 Medicaid beneficiaries. Their call for block grants or a per  
178 capita cap on future Medicaid funding would reduce federal  
179 beneficiary protections currently in Medicaid since States  
180 would be permitted to eliminate benefits or restrict  
181 enrollment eligibility. While examining costs and exploring  
182 the relationship between the federal government and States is

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183 clearly important, we must be sure that we do not strip away  
184 protections from Medicaid recipients who depend on the  
185 program for access to quality, affordable health care.

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

191 Mr. {Pitts.} Without objection, so ordered.

192 [The information follows:]

193 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|

194           Mr. {Pallone.} Thank you, Mr. Chairman. I yield back  
195 the balance of my time.

196           [The prepared statement of Mr. Pallone follows:]

197           \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
198           Mr. {Pitts.} The chair thanks the gentleman and now  
199 recognizes the chair of the full committee, Mr. Upton, 5  
200 minutes for opening statement.

201           The {Chairman.} Thank you, Mr. Chairman.

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

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

216           Medicaid enrollees today already face extensive  
217 difficulties finding a quality physician because, on average,

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218 30 percent of the Nation's doctors won't see Medicaid  
219 patients, and studies have shown that Medicaid enrollees are  
220 twice as likely to spend their day or night in an emergency  
221 room than their uninsured and insured counterparts.

222         Instead of allowing State and local officials the  
223 flexibility to best administer Medicaid to fit the needs of  
224 their own populations, improve care and reduce costs, the  
225 federal government has created an extensive, one-size fits-  
226 all maze of federal mandates and administrative requirements.  
227 With the federal debt at an all-time high, closing in on \$17  
228 trillion, and States being hamstrung by their exploding  
229 budgets, the Medicaid program will be increasingly  
230 scrutinized over the next 10 years. Its future ability to  
231 provide coverage for the neediest kids, seniors and disabled  
232 Americans will depend on its ability to compete with State  
233 spending for other priorities including education,  
234 transportation, public safety and economic development.

235         Energy and Commerce Committee Republicans remain  
236 committed to modernizing the Medicaid program so that it is  
237 protected for our poorest and sickest citizens. We will  
238 continue to fight for those citizens because they are

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239 currently subjected to a broken system. The program does  
240 need true reform, and we can no longer tinker around the  
241 edges with policies that add on to the bureaucratic layers  
242 that decrease access, prohibit innovation and fail to provide  
243 better health care for the poor.

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

255 [The prepared statement of Mr. Upton follows:]

256 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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257           Dr. {Cassidy.} Thank you, Mr. Chairman.

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

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

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

274           Now, I will say I think that States are the best  
275 innovators for cost containment, far better equipped to offer  
276 thoughtful solutions addressing unique patient needs. One

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277 size does not work. The federal government should construct  
278 thoughtful incentives encouraging States to take an active  
279 role in restructuring Medicaid. I am pleased that the Energy  
280 and Commerce Committee has started to shed light beginning  
281 with this hearing. I look forward to hearing from the  
282 witnesses today, and I yield back.

283 [The prepared statement of Dr. Cassidy follows:]

284 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
285           Mr. {Pitts.} The chair thanks the gentleman and now  
286 recognizes the ranking member of the full committee, Mr.  
287 Waxman, 5 minutes for opening statement.

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

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

300           On the other hand, what my Republican colleagues have  
301 proposed in their two recently released reports is a cost  
302 shift to States, patients and providers, and abdication of  
303 federal responsibility. Block grants, per capita caps and  
304 increases in beneficiary premiums and copays do not reduce

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305 health care costs; they simply shift costs on to the  
306 beneficiaries, the providers and the States, and they make it  
307 less likely that people will be able to access care when they  
308 need it.

309         The Medicaid program operates with efficiency. Medicaid  
310 costs are nearly four times lower than average private plans.  
311 Over the next decade, annual Medicaid per capita costs are  
312 expected to grow by only 3.2 percent compared to 6.9 percent  
313 in the private market. Additionally, the Congressional  
314 Budget Office's most recent estimates of projected Medicaid  
315 spending have dropped by \$200 billion through 2020. This  
316 refutes the claim that burgeoning Medicaid spending is  
317 compromising the program's mission and therefore necessitates  
318 funding redesign and cost shifting to our Nation's most  
319 vulnerable.

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

324         Unfortunately, a number of States have not yet opted to  
325 provide insurance coverage for their residents. A RAND study

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326 estimates that these States will leave 3.6 million people  
327 uninsured, and these people will continue to seek high-cost  
328 services in the emergency department of a hospital and  
329 experience increased hospitalizations from lack of primary  
330 and preventive care. As a result, the study estimates that  
331 these States should expect to spend \$1 billion more annually  
332 on uncompensated care. So much for the States that choose  
333 not to cover their very poor people under Medicaid even with  
334 100 percent federal financing for the first several years.

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

345       The alternative path that we began in 2010 with passage  
346 of the Affordable Care Act is entitlement reform in a

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347 thoughtful way through delivery system reform that improves  
348 both efficiency and quality. The Affordable Care Act  
349 includes incentives to reward physicians and other providers  
350 for better coordinating care and improving health. It also  
351 includes policies to cut waste and inefficient care. But  
352 above all, it improves access to care, particularly  
353 preventive care, that saves dollars and lives.

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

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

361           [The prepared statement of Mr. Waxman follows:]

362 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
363           Mr. {Pitts.} The chair thanks the gentleman. That  
364 concludes our opening statements. We have one panel with us  
365 today, three witnesses. I will introduce them at this time.

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

372           Thank you each for coming. Your written testimony will  
373 be made a part of the record. You will be given 5 minutes to  
374 summarize your testimony. So at this time, the chair  
375 recognizes Ms. Verma for 5 minutes for opening statement.

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

|  
381 ^STATEMENT OF SEEMA VERMA

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

392 Designed in 1965 for our most vulnerable populations,  
393 the Medicaid program has not kept pace with the modern health

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394 care market. Its rigid, complex rules designed to protect  
395 enrollees have also created an intractable program that does  
396 not foster efficiency, quality or personal responsibility.  
397 The impact of these issues is more pronounced as States are  
398 entrenched in the fierce debate around Medicaid expansion.  
399 Reluctance to expand is not indifference to the plight of the  
400 uninsured, but trepidation for the fiscal sustainability of  
401 the program and knowledge that expanding without reform will  
402 have serious consequences on Medicaid's core mission to serve  
403 the neediest of Americans.

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

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415           Despite growing outlays of public funds, a Medicaid card  
416 does not guarantee access or quality of care. In a survey of  
417 primary care providers, only 31 percent indicated willingness  
418 to accept new Medicaid patients. In 2012, 45 states froze or  
419 reduced provider reimbursement rates. Medicaid access issues  
420 are tied to undercompensation of providers. On average,  
421 Medicaid payments are 66 percent of Medicare rates and many  
422 providers lose money seeing Medicaid patients. Medicaid  
423 beneficiaries struggle to schedule appointments, face longer  
424 wait times and have difficulty obtaining specialty care.  
425 These access challenges will be more pronounced as Medicaid  
426 recipients compete with the tens of millions of newly insured  
427 under the ACA. Studies also show Medicaid coverage does not  
428 generate significant improvements in health outcomes,  
429 decrease emergency room visits or hospital admissions, and  
430 participants have higher ER utilization rates than other  
431 insured populations.

432           At Medicaid's core is a flawed structure. While jointly  
433 funded, by the federal and state governments, it is not  
434 jointly managed. States are burdened by federal policy and  
435 endure lengthy permission processes to make routine changes.

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436 Notwithstanding the cumbersome procedure, 1115 waivers  
437 provide a pathway for State innovation. However, the  
438 approval route is so daunting that States often abandon  
439 promising ideas if a waiver is necessary. Absent are  
440 evaluation guidelines, required timelines, and there is a  
441 capricious nature to the approvals, as waivers do not  
442 transfer from one State to another. Even with positive  
443 outcomes, a new Administration has the authority to terminate  
444 a waiver. Despite intense federal oversight, results vary  
445 substantially and there are no incentives for States to  
446 achieve quality outcomes. For example, the average cost to  
447 cover an aged Medicaid enrollee is roughly \$5,200 in New  
448 Mexico versus almost \$25,000 in Connecticut, and annual  
449 growth rates also vary. Replacing oversight of day-to-day  
450 administrative processes, the federal and State governments  
451 should collaborate to identify program standards and  
452 incentives. States should be provided with flexibility to  
453 achieve these goals, and successful States should be rewarded  
454 with reduced oversight.

455 Medicaid's uncompromising cost-sharing policies are  
456 illustrative of a key failure. These regulations disempower

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457 individuals from taking responsibility for their health,  
458 allow utilization of services without regard for the public  
459 cost, and foster dependency. While some policies may be  
460 appropriate for certain populations, in an era of expansion  
461 to non-disabled adults, they must be revisited. Revised  
462 cost-sharing policies should consider value based benefit  
463 design and incent enrollees to evaluate cost, quality and  
464 adopt positive health behaviors. Indiana's Healthy Indiana  
465 Plan waiver applied principles of consumerism with remarkable  
466 results, lowering inappropriate ER use and increasing  
467 prevention.

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

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478 [The prepared statement of Ms. Verma follows:]

479 \*\*\*\*\* INSERT 1 \*\*\*\*\*

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|  
480           Mr. {Pitts.} The chair thanks the gentlelady and now  
481 recognizes Dr. Thompson 5 minutes for an opening statement.

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|  
482 ^STATEMENT OF JOSEPH THOMPSON

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

492 Our entire health care system has changed dramatically  
493 over the last five decades since the inception of Medicaid  
494 with increased therapeutic and diagnostic opportunities,  
495 increased treatments. The costs have grown, and with that  
496 have grown the cost on both the public and the private  
497 sector. Our private-sector costs in Arkansas have doubled  
498 over the last decade from \$6,000 to 12,000 for a family of  
499 four's premium. The costs have also increased for Medicare  
500 and Medicaid. As you have discussed, I want to commend this

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501 committee. The Medicaid partnership in funding for States  
502 and federal government is under intense duress and  
503 significant tension.

504 But I would like to back up. It is not just a Medicaid  
505 problem. Our entire health care system is under a cost  
506 threat that threatens our families, our communities, and  
507 indeed, the economic vitality of our Nation. It is not a new  
508 issue, it has been growing, but suddenly we are forced to  
509 face it, and if I can, we started off with private insurance,  
510 largely through employers, and Medicaid for the vulnerable,  
511 the poor and the disabled. I will leave Medicare off because  
512 that is not the topic of your discussion. Over time as we  
513 grew the therapeutic and diagnostic opportunities, we grew  
514 the ability to do things to and for people, and the costs  
515 grew and the valley of the uninsured, people who could not  
516 afford care, grew also, so we started having more and more  
517 uninsured individuals. Private costs went up but the private  
518 employers or affluent families could continue to afford those  
519 costs. The Medicaid program did not keep pace with those  
520 costs, and neither federal government nor State government  
521 budgets could afford it, and so we ended up with a huge,

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522 large valley of the uninsured. We ended up with expensive  
523 private insurance that some can afford, and we have Medicare  
524 programs that cannot afford either on the federal or State  
525 budget, so we end up with what is a problem of the iron  
526 triangle: cost, access and quality. If we are not willing  
527 to pay, we are going to have access problems. If we have  
528 access problems, we suddenly have quality problems. This is  
529 not a single issue about Medicaid. This is a systemic issue  
530 about our failure to gain control of rapidly rising health  
531 care costs that have outpaced federal and State budgets, that  
532 only a few employers and families are able to continue to  
533 afford and that have grown the valley of the uninsured.

534         So with that backdrop, let me share with you our  
535 experience in the State over the last 10 years. As of last  
536 year, we were operating nine different waiver programs  
537 designed by the State and approved by the federal government  
538 to provide Arkansans with better access, higher quality and  
539 more cost-effective care. Under the past Administration,  
540 President Bush's Secretary successfully supported our  
541 proposal to develop a waiver for support of small businesses  
542 for businesses with fewer than 10 employees who virtually had

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543 no option for private employer-based health insurance  
544 coverage. This small business was titled the AR Health  
545 Networks Program. It was a low-cost, limited-benefit  
546 program, largely successful at maximum uptake. It will be  
547 absorbed into the Affordable Care Act now for small business  
548 support going forward, but we started that in 2005, eight  
549 years before the implementation of the Affordable Care Act  
550 will go into place.

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

563 More recently, our Republican legislature and the

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564 general assembly with the Governor's support authorized use  
565 of the Affordable Care Act Medicaid programmatic funds to  
566 offer a totally new premium assistance program to buy health  
567 insurance premiums through the health insurance exchange, not  
568 to expand the Medicaid program in the traditional way,  
569 essentially to fill that valley in with private insurance,  
570 not to expand a State-run Medicaid program fraught with some  
571 of the issues that Ms. Verma alluded to. We will need to get  
572 a streamlined waiver from the Administration this summer. We  
573 have already started on that, and we have not identified a  
574 barrier to being able to do that at this point. So moving  
575 forward, we anticipate that of our 25 percent of the  
576 uninsured, we may have as many as a quarter million or almost  
577 8 percent of our population not be in the Medicaid program  
578 but be in the private health insurance program.

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

583 [The prepared statement of Dr. Thompson follows:]

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584 \*\*\*\*\* INSERT 2 \*\*\*\*\*

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|  
585           Mr. {Pitts.} The chair thanks the gentleman and now  
586 recognizes Mr. Keck 5 minutes for an opening statement.

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|  
587 ^STATEMENT OF ANTHONY E. KECK

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

593 While we don't run a \$6 billion agency on anecdote, I  
594 would like share a simple story with you that sums up our  
595 common challenge. I once ran a community clinic in a poor  
596 but vibrant and politically active New Orleans neighborhood  
597 known as the St. Thomas/Irish Channel. During that time, I  
598 took part in a focus group of pregnant teenage girls enrolled  
599 in Medicaid who were participants in a separate citywide  
600 program that matched each girl with a doula--a birthing  
601 coach--to help her better connect to the health care system  
602 and prepare for motherhood. One conversation still stands  
603 out. Paraphrasing her almost 20 years later, one of the  
604 participants said with exasperation near the end of our time  
605 together ``Look, I love my doula and my doctor and I

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606 appreciate all the help they give me, but I've slept on a  
607 different couch almost every night for the past 3 weeks, and  
608 that's why I'm having a really hard time.''

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

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

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

641           Yet Medicaid today operates under the default position  
642 that different populations and geographies face similar  
643 challenges and equity in health insurance benefits is the  
644 goal of the program rather than improvement in population  
645 health. Medicaid currently treats States more like  
646 subcontractors operating at a discount than partners  
647 contributing over 40 percent of the bill. Deviations from

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648 the norm require State plan amendments and special waivers.  
649 This may give the illusion of accountability, but promotes  
650 neither quick or effective local solutions nor cross-sectoral  
651 solutions, which consider public health, education, housing,  
652 employment, food security, personal responsibility and  
653 community action as important contributors to achieving  
654 better health and well-being for individuals and communities.

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

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

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669 you.

670 [The prepared statement of Mr. Keck follows:]

671 \*\*\*\*\* INSERT 3 \*\*\*\*\*

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|  
672 Mr. {Pitts.} The chair thanks the gentleman. I will  
673 begin the questioning and recognize myself 5 minutes for that  
674 purpose.

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

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

691 Ms. {Verma.} Thank you for the question. I think first

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

712 Mr. {Pitts.} Mr. Keck, do you want to add to that list?

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713 Specific bureaucrat hurdles.

714           Mr. {Keck.} Yes. First, I want to echo exactly what  
715 Seema said, that reciprocity is important. We spent a lot of  
716 our time trying to figure out what other States have  
717 negotiated with their regional office or with the federal  
718 office, and many times we know that our State has been  
719 denied. I think deadlines are important. We run on a State  
720 fiscal year, and when I need to respond to my legislature's  
721 budgeting process and their requirements to implement  
722 policies I cannot do that very effectively when we operate on  
723 such long timelines with the federal government. I have a  
724 waiver issue that is being resolved right now that has taken  
725 5 years to work through the system, and it involves \$3  
726 million worth of federal money but it has taken years to  
727 negotiate and hundreds, if not thousands, of hours of staff  
728 time.

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

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734 responding to questions and so on, and again, being on a  
735 State fiscal year where we have to get changes implemented on  
736 a timely basis, it adds significant problems in our  
737 operations.

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

745       Mr. {Keck.} We are strong believers in the VBID  
746 concept, and actually we are the first State to work with the  
747 University of Michigan Value Based Insurance Design Institute  
748 on implementing a VBID program in Medicaid. When we first  
749 met the folks that run this program, it was a Mill Bank  
750 conference and they were talking about the possibilities for  
751 VBID to work in State employee benefit programs. And along  
752 with one of my State senators, I raised my hand and said  
753 well, what about Medicaid because Medicaid is one of the most  
754 important payers in the country, if not the most important,

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755 and they said well, we don't do anything with Medicaid  
756 because the restrictions are so strong and Medicaid folks  
757 don't contribute to their premiums and they generally don't'  
758 have copays that are enforceable so we just ignored it, and  
759 we pushed them during that 2 days and said you can't just  
760 ignore it, we have to be able to build these concepts into  
761 Medicaid. The problem is, they are generally one-sided.  
762 When you talk to VBID folks, it is a set of carrots and  
763 sticks, and they have different effectiveness in different  
764 situations but unfortunately, generally in Medicaid, it is  
765 all carrots, and sometimes you need sticks, but right now we  
766 are generally stymied. There has been some recent  
767 flexibility that has been granted by the federal government  
768 related to copays but we are still convinced we need to go  
769 much further, and so in the next several months we will be  
770 approaching CMS with some of our ideas out of the VBID  
771 concepts.

772 Mr. {Pitts.} The chair thanks the gentleman and now  
773 recognizes the ranking member 5 minutes for questions.

774 Mr. {Pallone.} Thank you, Mr. Chairman. I wanted to  
775 ask some questions of Dr. Thompson.

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

790           Dr. {Thompson.} Thank you, Mr. Co-Chair. Our health  
791 care system is incredibly complex, and I think what we see in  
792 short-term fixes are essentially what has been around for a  
793 long time. It is an easy fix, which rarely works in a  
794 complex situation. We have found that when we bring to the  
795 Administration, and it has not mattered which Administration,  
796 an approach that is inclusive of the needs of the low-income

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797 and vulnerable population that is part of the long-term State  
798 strategy and that moves the system forward, we have been able  
799 to work through the regulatory challenges that are there. It  
800 is not always with the speed, and I think there are some  
801 comments by Ms. Verma and Mr. Keck that could be  
802 incorporated, are being incorporated by this Administration  
803 on streamlined waivers. But I think if we don't take the  
804 root problem that our payment system is causing us to have a  
805 growth in health care that does not equal value or outcomes,  
806 then we are not going to have a quick fix that increased  
807 flexibility. We will squeeze the balloon in one place and it  
808 will open up in another place, probably on State budgets or  
809 at the expense of the vulnerable and poorest of our citizens.

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

815 Dr. {Thompson.} This is what led our Republican  
816 leadership in part to take advantage of the Affordable Care  
817 Act. We have 25 percent of our Arkansas 19- to 64-year-olds

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818 that are uninsured. We have 40 percent, approaching 40  
819 percent in some counties. Those individuals are not well.  
820 Fifty percent of our population has a chronic condition.  
821 They are seeking care. They are using the emergency room in  
822 an inefficient way. And so by taking advantage of the  
823 Affordable Care Act but, importantly, tying it to our payment  
824 reforms and putting it in the private sector with the new  
825 cost sharing and copayments, which we intend to push on and  
826 expand, we hope that we can actually design a new and  
827 sustainable health care system inclusive of Medicaid and one  
828 that rewards providers for the care that they give and  
829 achieves equal high-quality care for all regardless of  
830 income.

831 Mr. {Pallone.} Thank you. Can I ask you, what was your  
832 experience as far as the flexibility, responsiveness,  
833 timeliness of CMS, you know, the Centers for Medicare and  
834 Medicaid Services, when you applied for the State plan  
835 amendment for this?

836 Dr. {Thompson.} Our State plan amendment went through  
837 in roughly less than 2 months, and this was from our  
838 inception to our successful achievement. It was like Mr.

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839 Keck mentioned, important to be timely because we were  
840 concurrently running rules and regulations in our general  
841 assembly, so we had to get both general assembly through rule  
842 and regulation and federal government support, and I think it  
843 is important for the feds and for the local general  
844 assemblies to recognize those are often in concert, not  
845 totally separate issues. But we successfully got approval to  
846 have upside and downside risk on our providers within 2 weeks  
847 of request from the Centers for Medicare and Medicaid  
848 Services.

849 Mr. {Pallone.} All right. Thank you very much. I  
850 yield back.

851 Mr. {Pitts.} The chair thanks the gentleman and now  
852 recognizes the vice chair of the committee, Dr. Burgess, 5  
853 minutes for questions.

854 Dr. {Burgess.} Thank you, Mr. Chairman. I will try to  
855 make good use of Mr. Pallone's time that he yielded to me.

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

859 Mr. {Keck.} A doula is essentially a birthing coach

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860 that is of the committee that generally she but sometimes he  
861 works in to help--

862 Dr. {Burgess.} Not a medical person?

863 Mr. {Keck.} Not a medical person.

864 Dr. {Burgess.} So not a midwife?

865 Mr. {Keck.} That is right.

866 Dr. {Burgess.} Basically someone who daubs a forehead  
867 and says it will be all right. Is that correct?

868 Mr. {Keck.} Well, and also helps a woman connect with  
869 the health care system that is sometimes very difficult.

870 Dr. {Burgess.} So is it correct to think of a doula as  
871 sort of a navigator or a precursor to a navigator?

872 Mr. {Keck.} I would consider them a community health  
873 worker but to help navigate the health system because it is  
874 so complex.

875 Dr. {Burgess.} And no disagreement there. And in fact,  
876 so good to have all of you all at this hearing. I cannot  
877 tell you the number of times we had hearings in 2007 and 2008  
878 where you wondered where Mitch Daniels was when we were  
879 having all the discussions how to provide more for less, and  
880 you correctly identified Governor Daniels as being a leader

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881 in this issue, and he found that something magic happens when  
882 people spend their own money for health care, even if it  
883 wasn't their own money in the first place. Would that be a  
884 correct observation of the Healthy Indiana program?

885 Ms. {Verma.} Yes, that is correct. I mean, within the  
886 Healthy Indiana Plan, participants are required to make  
887 contributions into an account. The State also funds that  
888 account, and then they use those dollars to cover their first  
889 \$1,100 of health care services, and if they complete their  
890 preventive health care, then at the end of the year whatever  
891 money is left in that account rolls over and it decreases the  
892 amount that the person would have to pay in the subsequent  
893 years. And so we have had great results, lower emergency  
894 room, higher generic use.

895 Dr. {Burgess.} And this is the Medicaid population, not  
896 the State employee population that also was written about in  
897 the Wall Street Journal. Is that correct?

898 Ms. {Verma.} That is correct.

899 Dr. {Burgess.} And what kind of savings did you achieve  
900 in the Medicaid program with Healthy Indiana?

901 Ms. {Verma.} I think what we have seen in the Healthy

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902 Indiana program in terms of savings is a real shift in  
903 patient behavior. We have seen patients--

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

911 Ms. {Verma.} That is correct. I mean, I think that so  
912 many of the policy changes or regulations are aimed at  
913 providers, they are aimed at insurance companies,  
914 pharmaceutical companies, but we sort of miss the point that  
915 the individual has a very significant role to play in  
916 controlling health care costs, and that is not just for  
917 commercial populations but even the low-income population.  
918 They are perhaps the best consumers of a dollar. They have  
919 had experience stretching a dollar, and I think when you  
920 empower them that they start to make decisions about where to  
921 seek their health care, how to seek care in more appropriate  
922 ways and seeking more preventive care.

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

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

938           Ms. {Verma.} That is correct.

939           Dr. {Burgess.} And the reason that that is so  
940 important, of course, is, we will all talk about it here in  
941 glowing terms that an ounce of prevention is worth a pound of  
942 cure, and so we are basically paying for that ounce of  
943 prevention but we want to see the pound of cure. It is

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944 important because I am told by my staff that the total  
945 federal spending over the next 10 years, combined federal and  
946 State spending over the next 10 years for Medicaid is \$7.5  
947 trillion, \$750 billion a month. I mean, that a phenomenal  
948 amount of money. If we could even bend the cost curve just a  
949 little bit with preventive care, that ounce of prevention,  
950 that is a hell of a pound of cure.

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

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

959 Dr. {Burgess.} Thank you. Mr. Chairman, I just have to  
960 observe that I was there on the second day of the Supreme  
961 Court oral arguments, and the discussion from the Solicitor  
962 General was repeatedly, it is the cost of these free riders  
963 that are driving up our health care. No. We reimburse so  
964 poorly in Medicaid that the patients can only do what they

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965 have always done, which is go to the emergency room, the  
966 highest point of contact. If we expand the program, we are  
967 going to expand the problem. I yield back.

968 Mr. {Pitts.} The chair thanks the gentleman and now  
969 recognizes the distinguished ranking member of the full  
970 committee, the Ranking Member Emeritus, Mr. Dingell, 5  
971 minutes for questions.

972 Mr. {Dingell.} Mr. Chairman, I thank you for your  
973 courtesy and I thank you for holding this hearing.

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

983 Doctor, I want to commend you for your helpful  
984 testimony. Doctor, did Arkansas recently implement the  
985 Arkansas Payment Improvement Initiative after receiving

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986 approval from the federal government? Yes or no.

987 Dr. {Thompson.} Yes, sir.

988 Mr. {Dingell.} Doctor, how long did it take for  
989 Arkansas to get that approval?

990 Dr. {Thompson.} We worked 3 years on the development  
991 within the State but the approval itself was relatively  
992 rapidly received in 2 months.

993 Mr. {Dingell.} What does that mean? How relatively  
994 rapid?

995 Dr. {Thompson.} Two months after our request.

996 Mr. {Dingell.} Okay. Doctor, did this new initiative  
997 begin to transition away from the fee-for-service models  
998 towards a more value-based payment model? Yes or no.

999 Dr. {Thompson.} Yes, sir.

1000 Mr. {Dingell.} And I happen to think, and will you  
1001 confirm or deny this, that that is the direction we are going  
1002 to have to go because one of the things about our system is  
1003 it is broken because we are paying for work done and not for  
1004 results achieved?

1005 Dr. {Thompson.} I believe we must align the financial  
1006 incentives for the outcomes that we want, not for the

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1007 services that are provided, and I think that is one of the  
1008 fundamental issues that has yet to be resolved in our health  
1009 care system.

1010 Mr. {Dingell.} Thank you. Doctor, have the reforms  
1011 implemented in Arkansas resulted in cost savings which can be  
1012 quantified? Yes or no.

1013 Dr. {Thompson.} Through the first three quarters of the  
1014 year since we implemented this, we have seen a dramatic  
1015 reduction in growth in the Medicaid program. It is lower  
1016 than it has been in the last 25 years.

1017 Mr. {Dingell.} Would you submit this for the record? I  
1018 gather the answer to that is yes.

1019 Dr. {Thompson.} Yes.

1020 Mr. {Dingell.} And would you please submit that for the  
1021 record? Because I have got a lot of questions and very  
1022 little time.

1023 Dr. {Thompson.} Yes, sir.

1024 Mr. {Dingell.} Doctor, could you now please submit for  
1025 the record a detailed explanation of the initial results  
1026 following the implementation of this new Arkansas plan,  
1027 please?

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1028 Dr. {Thompson.} I would be glad to.

1029 Mr. {Dingell.} Doctor, in your testimony you mentioned  
1030 that nearly every State has a Medicaid waiver and that there  
1031 are current 381 active waivers. Is that correct?

1032 Dr. {Thompson.} To the best of my knowledge, yes, sir.

1033 Mr. {Dingell.} It seems to me that the States currently  
1034 have a viable existing pathway to get some flexibility under  
1035 Medicaid. Do you agree with that statement?

1036 Dr. {Thompson.} I agree that they have that  
1037 flexibility.

1038 Mr. {Dingell.} Now, this leads me to questions of how  
1039 many of the reforms proposed in a recent report issued by my  
1040 good friend, Chairman Upton, and my other good friend,  
1041 Senator Hatch, titled ``Making Medicaid Work.'' This report  
1042 proposes to eliminate the medical loss ratio provision in the  
1043 Affordable Care Act, which gave the consumers over \$1 billion  
1044 in rebates in 2011. The report also suggests that we repeal  
1045 the maintenance-of-efforts provision in ACA, which would  
1046 allow the States to restrict eligibility for the program and  
1047 would reduce access to care. Finally, instead of turning  
1048 Medicaid into a block grant, as has been proposed in years

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1049 past, this year the proposals are a per capita cap on  
1050 Medicaid spending. Now, Doctor, would this new proposal  
1051 still result in the loss of coverage and benefits for  
1052 beneficiaries? Yes or no.

1053 Dr. {Thompson.} Well, sir, I think the report that you  
1054 allude to has several recommendations that I would concur  
1055 with. The three that you identified, I would agree have  
1056 potential problems for the States. A per capita block grant  
1057 to the States in the face of escalating health care costs  
1058 that are not contained is a cost transfer to the State for  
1059 future rate increases on health care.

1060 Mr. {Dingell.} It should scare the hell of the States,  
1061 shouldn't it?

1062 Dr. {Thompson.} My advice to any governor for a block  
1063 grant is watch out because you are getting a transfer of  
1064 responsibility without control of future rate increases. We  
1065 have to control the cost increases on health care before we  
1066 can actually transfer fiscal responsibility or block off  
1067 fiscal responsibility in the Medicaid partnership.

1068 Mr. {Dingell.} Now, Doctor, do you believe that the per  
1069 capita would actually cause innovation by the States or would

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1070 it cause a disruptive nature which would place consumer  
1071 protection of our most vulnerable citizens at risk? I gather  
1072 you agree with that statement, yes?

1073 Dr. {Thompson.} I have concerns, and I think I share  
1074 those with others, that caps of any kind without a long-term  
1075 strategy to assure quality while maintaining cost is a risk  
1076 to the beneficiary and it is a transfer of financial and  
1077 responsibility risk to whoever is being capped.

1078 Mr. {Dingell.} I am going to make a quick statement and  
1079 ask this. I have the impression that our system is broken  
1080 because we are paying for work done and not for  
1081 accomplishments and for completion of assuring health for the  
1082 people and that we are trying to figure a way to transfer  
1083 from the current system to a system which recognizes the need  
1084 to get results as opposed to just paying for work.

1085 Now, Dr. Verma and Dr. Thompson and Mr. Keck, do you  
1086 agree with that statement? Yes or no.

1087 Mr. {Keck.} Yes.

1088 Mr. {Dingell.} Yes?

1089 Ms. {Verma.} Yes.

1090 Mr. {Dingell.} The reporter doesn't have a nod key so

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1091 you have to say yes or no.

1092 Ms. {Verma.} Yes, I do.

1093 Mr. {Dingell.} Have you all agreed with that?

1094 Dr. {Thompson.} I will be the third to agree, yes.

1095 Mr. {Dingell.} Thank you. Mr. Chairman, I thank you  
1096 for your courtesy to me.

1097 Mr. {Pitts.} The chair thanks the gentleman and now  
1098 recognizes the gentleman from Illinois, Mr. Shimkus, 5  
1099 minutes for questions.

1100 Mr. {Shimkus.} Thank you, Mr. Chairman.

1101 Dr. Thompson, I want to follow up on Mr. Dingell's, your  
1102 little discussion there. You said how many waivers you asked  
1103 for? Three hundred and eighty?

1104 Dr. {Thompson.} No, that is the total number that are  
1105 active across the United States from the most recent  
1106 information we had from the Centers for Medicare and Medicaid  
1107 Services.

1108 Mr. {Shimkus.} And so you all have submitted--

1109 Dr. {Thompson.} We have 12.

1110 Mr. {Shimkus.} You have 12. And were those 12 active  
1111 waivers all adjudicated or decided in that 2-month window of

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1112 approval?

1113 Dr. {Thompson.} No, some of those waivers took much  
1114 longer. Some of the waivers, as Mr. Keck alluded to, in the  
1115 past have taken years to get conclusion on.

1116 Mr. {Shimkus.} Go back through your timeline.  
1117 Developing your program by the State of Arkansas took how  
1118 long?

1119 Dr. {Thompson.} So specific to the payment improvement  
1120 program, which is the most current experience that we have--  
1121 our Medicaid expansion will be this summer's experience--we  
1122 started off with advice that Mr. Dingell alluded to. My  
1123 advice to the Governor was that our fee-for-service system  
1124 was broken 3 years ago. So we spent 2 or 3 years working  
1125 with both the public and private sector. We have Medicaid,  
1126 we have Blue Cross, we have Qual Choice of Arkansas. We have  
1127 had Walmart as a self-insured company join because of their  
1128 interest in changing the way the health care system works.  
1129 Last October, we had Medicare join in our patient-centered  
1130 medical home effort. So we have been developing this over  
1131 the last 3 years. This summer because we were changing the  
1132 way that we were going to incentivize providers to engage

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1133 with patients to increase the individual accountability of  
1134 patients and also the outcomes availability of the providers,  
1135 we needed to get a State plan amendment from the Centers for  
1136 Medicare and Medicaid Services. We applied in, I can't  
1137 remember if it was June or July but within two months had  
1138 approval from CMS to implement those changes, and we started  
1139 aligning different incentives on providers in October.

1140 Mr. {Shimkus.} So if nationwide there is 380, on  
1141 average seven-plus waivers applications per State in the  
1142 process, my interest is, obviously I am from the State of  
1143 Illinois. In my personal opinion, we have done a very poor  
1144 job, and what the State did last year, \$1.6 billion of cuts  
1145 to Medicaid program and established a moratorium on expansion  
1146 for 2015, even though then we increased enrollment by 15  
1147 percent, and by the beginning of 2013 the State had a funding  
1148 gap of \$3 billion. Just last week, the State received yet  
1149 another credit rating downgrade. It is our second. This is  
1150 all the cost of a burden of States of pension and Medicaid  
1151 benefits. These are real life stories so Illinois has now  
1152 another credit downgrade, which means the cost of borrowing  
1153 goes up.

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1154           So if you were in the position of the State of Illinois,  
1155 because we are going to expand its Medicaid under ObamaCare,  
1156 bringing on new applicants to a system that is already  
1157 spending \$5 billion more, is already expanding our roles,  
1158 what would you suggest the State of Illinois do? Let us go  
1159 left to right, rapidly, because my time is--

1160           Ms. {Verma.} Okay. I mean, I think you need to take a  
1161 look at managing care, putting in more managed care. I think  
1162 looking at expansion without addressing the core issues and  
1163 where they are spending their money. I think they need to  
1164 explore different innovations, value-based purchasing that we  
1165 have talked about, you know, some sort of a reform on how  
1166 providers--but I think it is also very critical to include  
1167 the individual in that.

1168           Mr. {Shimkus.} The individual has to be in the process  
1169 of--

1170           Ms. {Verma.} The individual has to be part of the  
1171 equation.

1172           Mr. {Shimkus.} Dr. Thompson?

1173           Dr. {Thompson.} My quick advice to any governor,  
1174 including my own, was, expansion without efforts to contain

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1175 costs is a budgetary as well as a State failure.

1176 Mr. {Shimkus.} I will take that. Mr. Keck?

1177 Mr. {Keck.} I hesitate to make a suggestion for

1178 Illinois but--

1179 Mr. {Shimkus.} Please. We need any help we can get.

1180 Mr. {Keck.} We want to meet our commitments, and I

1181 think we are not meeting our current commitments, and what we

1182 have told our legislature is, we have to pay for our current

1183 commitments before we expand.

1184 Mr. {Shimkus.} And just to finish with Dr. Thompson on

1185 this. So the way Arkansas has approached this, since

1186 ObamaCare has really--we are buying off expansion with a

1187 promise of federal dollars which we will then walk away from

1188 the new expansions after that. So your bet is, you are going

1189 to have a reformed system within your State that is able to

1190 carry the increased Medicaid individuals past a time frame

1191 when ObamaCare and the additional dollars are gone?

1192 Dr. {Thompson.} We undertook payment improvement 3

1193 years ago, so it predates our expansion that will go into

1194 effect this year. Your premise is correct. It is not just

1195 for the Medicaid program, however. It is that we think our

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1196 private sector, that our business sector, that our economic  
1197 attractiveness will outpace with all due respect our sister  
1198 States around us because we are going to both expand and get  
1199 coverage in place at the same time we are reforming the  
1200 payment system to make sure that it is sustainable.

1201 Mr. {Shimkus.} I appreciate that. Thank you, Mr.  
1202 Chairman.

1203 Mr. {Pitts.} The chair thanks the gentleman and now  
1204 recognizes the gentlelady from California, Ms. Capps, 5  
1205 minutes for questions.

1206 Mrs. {Capps.} Thank you, Mr. Chairman, and thank you  
1207 all for being here today and for your testimonies.

1208 As we know, Medicaid is a critical program. It serves  
1209 over 70 million families, seniors and individuals with  
1210 disabilities. I think it is important to keep in mind that  
1211 it is a safety net for these people who are otherwise shut  
1212 out of private insurance, either because it is unaffordable,  
1213 unavailable to them or doesn't cover the benefits that they  
1214 need. So we know that individuals with Medicaid are more  
1215 likely to receive preventive health care and less likely to  
1216 have medical debt than their uninsured counterparts.

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1217 Medicaid, like private insurance and Medicare, is trying to  
1218 confront the same challenges of improving quality and cost.  
1219 So a dialog today about improving the system to provide cost-  
1220 effective, high-quality health care to many of these  
1221 individuals who need it is really a valuable discussion to  
1222 have.

1223           But I think we must be mindful about exactly who will be  
1224 impacted by the decisions that we make or that Congress  
1225 makes, and if we are truly improving care or just passing the  
1226 buck to States, persons with disabilities, seniors and  
1227 struggling families, in other words, the vulnerable. We have  
1228 a responsibility, I believe, to make our best-faith effort to  
1229 improve the system on behalf of these individuals while  
1230 protecting their access to affordable care. With the  
1231 flexibility provided by Medicaid, a number of States have  
1232 initiated quality improvement activities to improve access to  
1233 preventive services, increased chronic-disease management and  
1234 prevention and address population health.

1235           So Dr. Thompson, you are here because the Arkansas  
1236 Medicaid program has had great success in collaborating with  
1237 health care providers and the Arkansas Foundation for Medical

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1238 Care to improve quality of care and health outcomes. What  
1239 are the quality issues? I know you have talked about this,  
1240 but if you don't mind restating them, the quality improvement  
1241 initiatives and how do you rank your success to date?

1242 Dr. {Thompson.} Well, our State is burdened with a  
1243 heavy risk burden in our population. Fifty percent of our  
1244 citizens have a chronic disease. Our QIO, the Arkansas  
1245 Foundation for Medical Care, has worked closely with our  
1246 providers, both physicians and hospitals, particularly on the  
1247 hospital side, reductions in readmissions, improvements in  
1248 outcomes after delivery, more recently, efforts to reduce  
1249 premature delivery that then result in negative neonatal  
1250 outcomes. So there are real interests and opportunities with  
1251 providers if the engagement is right, if the incentives are  
1252 aligned correctly to move the system forward in a positive  
1253 way.

1254 Mrs. {Capps.} So that is exactly what I was hoping we  
1255 could get at. Could you speak to the success of this program  
1256 and the ways that you have seen care coordination improve  
1257 across the Medicaid providers, and do you believe this  
1258 program, some of the models that you are using, could be

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1259 enhanced and expanded so that other States could take  
1260 advantage of it?

1261 Dr. {Thompson.} What we have done is, we have taken  
1262 what was a quality improvement effort, which is what I have  
1263 just described, and we have now tied the payment mechanism  
1264 for providers to reinforce quality outcomes. We have  
1265 actually taken, for example, our hip and knee surgeries and  
1266 we have said there is a responsibility of the surgeon from 30  
1267 days before to 90 days after for the outcome, and now their  
1268 payment is tied to what the outcome for that patient is. It  
1269 increases engagement with the patient, it increases the  
1270 decision process of the team, and we think it will reduce the  
1271 cost and inefficiencies in the system over time.

1272 Mrs. {Capps.} Wow. And you have seen some indications  
1273 that it is working?

1274 Dr. {Thompson.} We are starting to see provider  
1275 behavior change, both within the OB episodes, within the hip  
1276 and knee episodes, within the hospitalization episodes, and  
1277 as we talk to providers, almost every association says there  
1278 is 20 to 30 percent waste in the system but nobody has ever  
1279 aligned the financial payment mechanisms to have providers

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1280 lead in eliminating that waste.

1281 Mrs. {Capps.} That is a good thing to discuss, ways to  
1282 do that without making it seem punitive and punishing. Well,  
1283 anyway, I wanted to get one last question on the table. The  
1284 initiatives that you have undertaken, have they all been done  
1285 within the current statutory and regulatory framework of the  
1286 Medicaid statute? In other words, what kind of waivers have  
1287 you used, how much of this have you been able to do  
1288 straightforward?

1289 Dr. {Thompson.} Well, I hope they are all within the  
1290 regulatory and statutory framework of the current Medicaid  
1291 program, or somebody is in trouble. No, we have been able to  
1292 do it. I think it is not an easy path. I think the current  
1293 Administration is streamlining that path, and our recent  
1294 experience has been much better than our past experience.  
1295 Again, that is not with any prejudicial interest on prior  
1296 State or federal Administrations.

1297 I do think that when a State has a desire to come with a  
1298 plan that safeguards the beneficiaries and their needs, that  
1299 fits into a long-term State plan and that moves the Medicaid  
1300 system as a whole forward, is a prerequisite for successful

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1301 negotiations between the federal and State government.

1302 Mrs. {Capps.} Thank you, Mr. Chairman. This was good  
1303 to hear.

1304 Mr. {Pitts.} The chair thanks the gentlelady and now  
1305 recognizes the gentleman from Louisiana, Dr. Cassidy, 5  
1306 minutes for questions.

1307 Dr. {Cassidy.} Thank you, Mr. Chairman.

1308 Dr. Thompson, I notice you are wearing Arkansas colors  
1309 in your tie, so I will just say, I am an LSU guy, I couldn't  
1310 help but notice that.

1311 Listen, I was very intrigued by your testimony. You say  
1312 that the State of Arkansas is contracting on a per-  
1313 beneficiary payment to managed care companies. They are at  
1314 upside and downside risk, correct?

1315 Dr. {Thompson.} We do not use a managed care mechanism  
1316 so it is the State itself that is at risk for cost increases  
1317 or cost savings.

1318 Dr. {Cassidy.} But there is a per-beneficiary amount,  
1319 because you mentioned there is an upside and a downside.

1320 Dr. {Thompson.} The upside and downside risk that I  
1321 mentioned was actually what we have now shifted to our

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1322 episodes of payment to providers. Providers now have the  
1323 responsibility, upside and downside, for the outcomes of the  
1324 episodes as I mentioned.

1325 Dr. {Cassidy.} And I am sure they protested, but on the  
1326 other hand, as you point out, they have been able to achieve  
1327 cost savings and increased efficiency.

1328 Dr. {Thompson.} Actually, our providers are relatively,  
1329 I will say with some caveat, supportive of our effort. They  
1330 knew the system had to change. They did not want another  
1331 bureaucrat layer put on top, and they said we will take  
1332 responsibility for that clinical--

1333 Dr. {Cassidy.} I don't mean to interrupt. So, if you  
1334 will, you are capping the amount of money that goes per  
1335 episode, and I guess the point I am trying to make is that  
1336 whenever my colleagues on the other side tend to suggest that  
1337 any sort of cap whatsoever is going to be deleterious, in  
1338 reality, you all have caps and you have actually seen  
1339 success?

1340 Dr. {Thompson.} In actuality, sir, we have not capped  
1341 anything. The providers--

1342 Dr. {Cassidy.} So when there is a bundle-of-care

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1343 payment, that is not really a capped amount but rather it can  
1344 be--

1345 Dr. {Thompson.} It is not a cap.

1346 Dr. {Cassidy.} So there is not a true upside and  
1347 downside?

1348 Dr. {Thompson.} There is a target that the lead  
1349 quarterback for the team will have financial impact, but  
1350 every member of the team is still paid.

1351 Dr. {Cassidy.} I understand they are still paid, but if  
1352 they exceed that target, do they lose money?

1353 Dr. {Thompson.} Not the members of the team but the  
1354 quarterback does.

1355 Dr. {Cassidy.} The quarterback does. Yes, so for that  
1356 particular quarterback, there is a cap.

1357 Dr. {Thompson.} There is a target.

1358 Dr. {Cassidy.} I think we must be using terminology  
1359 because if there is a downside for them, then effectively  
1360 there is a cap.

1361 Dr. {Thompson.} Again, sir, I would be glad to share,  
1362 but we have not capped any provider's payment. We have set  
1363 goals that they share in the gains--

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1364 Dr. {Cassidy.} Then somebody I don't understand how  
1365 your downside works, but let me ask, Mr. Keck speaks about  
1366 how really on a county-by-county basis for somebody, there  
1367 should be variability. I have to imagine our States are  
1368 similar, that in the Delta there is a different patient  
1369 population and different structure of health care as opposed  
1370 to Fayetteville.

1371 Dr. {Thompson.} And without question, different health  
1372 care needs.

1373 Dr. {Cassidy.} With that said, who is better equipped  
1374 to make that determination? The county or the State official  
1375 or rather somebody in Washington, D.C.?

1376 Dr. {Thompson.} Well, I would say it would be a local  
1377 provider, local community.

1378 Dr. {Cassidy.} That seems right. So I think when Mr.  
1379 Keck speaks about the flexibility, I think that is something  
1380 we can all agree on.

1381 Next I would ask, on the other side there is a lot of  
1382 defense of the status quo in terms of Medicaid, but Dr.  
1383 Thompson, would you agree, I mean, are you aware that some  
1384 States really manipulate the Medicaid system in order to

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1385 maximize federal payments to their State? For example, New  
1386 York, which has half the population of California, gets 33  
1387 percent more federal payments than California.

1388 Dr. {Thompson.} I am aware of different strategies that  
1389 States have employed that don't necessarily tie directly to  
1390 patients.

1391 Dr. {Cassidy.} Yes, some people call it gaming, and  
1392 that seems to be the legal way to describe it. I am struck  
1393 that even the Democratic witness would agree that there is  
1394 some problems with the status quo, which it seems as if the  
1395 other side doesn't want to admit. In fact, I noticed that  
1396 you were nodding your head yes when Ms. Verma stated that  
1397 when Medicaid empowered patients to consider cost savings,  
1398 there was actually good results that result from that. Could  
1399 you accept what Ms. Verma was saying?

1400 Dr. {Thompson.} Well, I think our approach through our  
1401 Medicaid expansion will have cost sharing on individual  
1402 patients.

1403 Dr. {Cassidy.} So I was struck that Mr. Waxman  
1404 suggested if any of that occurs, it is going to be terrible  
1405 for the patient, but in reality, I think I am hearing from

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1406 the witnesses that there is actually some positive things  
1407 that happen both for the patient as well as for cost savings.

1408 Dr. {Thompson.} But it is with safeguards on the  
1409 patient.

1410 Dr. {Cassidy.} Of course. Everybody accepts  
1411 safeguards, but on the other hand, status quo is status quo,  
1412 and right now if we can do something different, we may  
1413 improve. I think even our Democratic witness is not agreeing  
1414 with Mr. Waxman on that one.

1415 Mr. Keck, you seem to suggest that the States could  
1416 accept some limitations on payments as long as they had  
1417 flexibility and net they would come out better. Would you  
1418 agree with that?

1419 Mr. {Keck.} And that is how we pay our managed care  
1420 plans. We capitate them and give them a lot more flexibility  
1421 and negotiate rates, to change benefit structures. They take  
1422 significant risk. We are able to put high accountability on  
1423 them in terms of performance measures.

1424 Dr. {Cassidy.} So when Mr. Waxman suggests that any cap  
1425 whatsoever is unworkable and any flexibility given to the  
1426 States to manage is going to be terrible for patients, you

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1427 are saying that wouldn't necessarily be the case?

1428 Mr. {Keck.} I don't believe that would be the case at  
1429 all.

1430 Dr. {Cassidy.} You have experience in two States with  
1431 high poverty levels, both Louisiana and South Carolina, so  
1432 you really are where the rubber meets the road, not an ivory  
1433 tower in Washington, D.C., but really where you have to see  
1434 those patients in New Orleans get care. Is that a fair  
1435 statement?

1436 Mr. {Keck.} The rubber meets the road in both South  
1437 Carolina and Louisiana.

1438 Dr. {Cassidy.} Okay. I am out of time, and I yield  
1439 back. Thank you.

1440 Mr. {Pitts.} The chair thanks the gentleman and now  
1441 recognizes the gentleman from Texas, Mr. Green, for 5 minutes  
1442 for questions.

1443 Mr. {Green.} Thank you, Mr. Chairman.

1444 I know our committee started out with concerns about the  
1445 reimbursement rates. I assume reimbursement rates in  
1446 Indiana, South Carolina and Arkansas are the same as in  
1447 Texas. Reimbursement rates for Medicaid are set by the

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1448 State, correct?

1449 Ms. {Verma.} That is correct.

1450 Mr. {Green.} And I know the pecking order. You know,  
1451 you have private insurance here, you have Medicare here, you  
1452 have Medicaid here, and I found out when we started  
1453 mobilizing our reserves in Houston 10 years ago how low  
1454 TriCare reimbursed our physicians and hospitals. But that is  
1455 set by the State.

1456 The other issue was, I don't think that in 3 years the  
1457 federal government is going to walk away from--now at 3 years  
1458 it is 100 percent and after that is 90 percent reimbursement.  
1459 Is that correct?

1460 Ms. {Verma.} Yes.

1461 Mr. {Green.} I wouldn't quite call that walking away  
1462 from the Medicaid responsibility. But anyway, just so we  
1463 know that.

1464 I have a district in Texas, a very urban district, and  
1465 one of the highest uninsured rates in the country. I am  
1466 disappointed our legislature did not do something with  
1467 expanding Medicaid similar to what Arkansas has worked on,  
1468 and every once in a while I am jealous of Arkansas's football

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1469 program too when they beat a Texas school. But I would hope  
1470 we would see that change.

1471 One of my concerns is the churning rate, and in Texas we  
1472 make folks come in for Medicaid every 6 months and even for  
1473 the SCHIP program. Do any of your States have a longer term  
1474 for enrollment than 6 months? Does Indiana have 6 months or  
1475 a year? Arkansas?

1476 Mr. {Keck.} We make people redetermine every 12 months,  
1477 but if they have a change in status--

1478 Mr. {Green.} Oh, sure, if they have a change in status,  
1479 but you don't make them show up and redo it every 6 months?

1480 Mr. {Keck.} No, and we do redeterminations through  
1481 express-lane eligibility, which we found to be very  
1482 effective.

1483 Mr. {Green.} What about Arkansas?

1484 Dr. {Thompson.} Ours is 12 months. I think important  
1485 to your churning question, our expansion effort, which will  
1486 use private plans, we believe will largely eliminate the  
1487 churn process entirely. People will stay in the plan. The  
1488 plan will re-enroll them. They will not have to touch the  
1489 Medicaid program.

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1490 Mr. {Green.} Ms. Verma, what about Indiana?

1491 Ms. {Verma.} Yes, in Indiana they have continuous  
1492 eligibility. If there a change, it has to be reported.

1493 Mr. {Green.} Sure. That seems reasonable. If there is  
1494 a change, you have the opportunity to go in and check it and  
1495 do that.

1496 Congressman Barton and I both identified that as one of  
1497 the concerns we have because as a former State legislator, I  
1498 also know we can quantify if we do it every 6 months and 1  
1499 year as compared to a year how much money we can save over  
1500 that period of time making Medicaid recipients come back and  
1501 sign up, and I have seen the lines out in front of the  
1502 offices. So hopefully we will look at that piece of  
1503 legislation to have that, unless it is changed circumstances.  
1504 That is the issue.

1505 Let me talk about Arkansas a little bit. Again,  
1506 congratulations, Dr. Thompson, on some of the considerations.  
1507 What do you think the consequence of not expanding Medicaid  
1508 would have been for Arkansas?

1509 Dr. {Thompson.} I believe our health care system was at  
1510 a tipping point. I mentioned earlier we had 25 percent

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1511 uninsured statewide. We had some counties that were  
1512 approaching 40 percent of the 19- to 64-year-olds. These  
1513 people were consuming care but not able to pay for it. Our  
1514 providers were not able to stay in business to provide it. I  
1515 think we were at a tipping point that the opportunity under  
1516 the Affordable Care Act, which I won't speak for or against,  
1517 but as an implementer of the Affordable Care Act, I think it  
1518 led a safe line, particularly for our rural health care  
1519 providers where the uninsurance rates were much higher.

1520       Mr. {Green.} Well, and again, I am concerned because  
1521 our percentages are the same as Arkansas but with a lot more  
1522 folks that are losing that kind of opportunity to have it.

1523       Mr. Keck, South Carolina has both a lower rate than  
1524 Texas for churn because you do it on a year. Mr. Keck, in  
1525 addition to the CHIP law, Congress enacted provisions that  
1526 provide bonus money for States to go out and exceed  
1527 expectations on enrolling low-income Medicaid children. I  
1528 understand South Carolina received CHIP bonuses in 2011 and  
1529 2012. Would you agree that the bonus program is good and  
1530 positive incentive for States to find and enroll lower-income  
1531 children?

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1532 Mr. {Keck.} Yes.

1533 Mr. {Green.} Do you know how much money the South  
1534 Carolina program received? Because all that money goes back  
1535 into Medicaid, I assume.

1536 Mr. {Keck.} We don't have our latest bonus calculated  
1537 but we are committed to--when our legislature sets an  
1538 eligibility limit, we are committed to getting everybody  
1539 enrolled under that eligibility limit.

1540 Mr. {Green.} And again, I know private-sector employees  
1541 offered health care benefits with continuous coverage for  
1542 their employees as long as they remain there, and again, Mr.  
1543 Chairman, I would hope we would look at considering that bill  
1544 that Congressman Barton and I have, and I yield back my time.  
1545 Thank you for being here.

1546 Mr. {Pitts.} The chair thanks the gentleman. The chair  
1547 recognizes the gentleman from Pennsylvania, Dr. Murphy, 5  
1548 minutes for questions.

1549 Mr. {Murphy.} Thank you, Mr. Chairman. I welcome the  
1550 panel, particularly Dr. Thompson. I come from a long list of  
1551 Murphys in Pennsylvania who are physicians: Garland Murphy,  
1552 Dodie Murphy of Springdale, and I don't know if you know any

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1553 of those but if you do, please extend my greetings to them.

1554 I wanted to ask you first, Dr. Thompson, some questions

1555 about where Arkansas stands. Your state has recently agreed

1556 to this Medicaid expansion proposal that carries with it the

1557 assumption that HHS will let you have approval. Now, my

1558 understanding is, HHS and CMS have consistently noted

1559 publicly that nothing is approved for your State. In fact,

1560 Administrator Tavenner recently said before the Senate

1561 Finance Committee: ``We haven't approved anything.'' So

1562 could you outline for this committee what Secretary Sebelius

1563 in coordination with OMB has explicitly agreed to allow

1564 Arkansas to do in 2014 as it relates to individuals not

1565 currently enrolled in your Medicaid program under 138 percent

1566 of federal poverty level?

1567 Dr. {Thompson.} First, let me deal with the approval

1568 issue. Approval for a State-federal waiver is actually a

1569 financial contract. So until it is signed by both parties at

1570 the end of the process, there is no approval. Where we are

1571 in our process, what we call the private option on Medicaid

1572 expansion, which is to take Medicaid dollars and use them

1573 essentially for premium assistance on the private health

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1574 insurance exchange is an accepted concept. Premium  
1575 assistance has been used before by Medicaid programs in  
1576 limited way to buy private employer-based coverage when it  
1577 was more efficient, effective and cost beneficial to the  
1578 Medicaid program. We are extending that in concept to be  
1579 premium assistance for all newly eligibles on the newly  
1580 established insurance exchange. We think that by harmonizing  
1581 both the cost sharing on individuals above and below the  
1582 Medicaid eligibility line, that we will educate our Medicaid  
1583 eligibles on how to use the health care system as they then  
1584 go up into the health insurance system. They will be better  
1585 informed and prepared to use the health care system in a more  
1586 appropriate way. We will eliminate churn, as we talked about  
1587 before, because people will be in a health plan and probably  
1588 stay in a health plan year after year. The health plan will  
1589 want them to.

1590 So where we are now is, we have a conceptual agreement  
1591 of where we are going. We are working through the specifics  
1592 of what will end up being a streamlined waiver to get to the  
1593 essentially contractual agreement between the State and the  
1594 federal government on guarantees of coverage and the

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1595 financial aspects of the agreement.

1596 Mr. {Murphy.} Let me add one other thing that you can  
1597 provide for us as a follow-up, that is, to provide us with  
1598 updated projected State and federal 10-year costs if Arkansas  
1599 did not expand and thus the individuals above 100 percent of  
1600 federal poverty level acquired private coverage, and two,  
1601 expanded and every individual would be under traditional  
1602 Medicaid below 130 percent of federal poverty level, and  
1603 three, to move forward under the legislature per your  
1604 proposal. That is information I would like you to get for us  
1605 in the future.

1606 Dr. {Thompson.} Sure.

1607 Mr. {Murphy.} Mr. Keck, I think in your testimony you  
1608 said that 30 percent of health care is waste?

1609 Mr. {Keck.} According to the Institute of Medicine and  
1610 many other sources. That is the latest estimate.

1611 Mr. {Murphy.} Let me ask you this. When Medicaid  
1612 dollars come through in the federal government, the State  
1613 level and other things, what percent of that is spent on a  
1614 wide range of administrative costs that never get to actual  
1615 patient care? Do you have some estimates of that? Under the

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1616 current way things are spent, do you have any idea?

1617 Mr. {Keck.} Well, if you just look at the Medicaid  
1618 expenses in terms of administering the program on the fee-  
1619 for-service side, it is about 3-1/2 percent. On the managed  
1620 care side it is about 9-1/2 percent with a percent of that at  
1621 risk, but that additional expenditure is because they are  
1622 managing the care better.

1623 Mr. {Murphy.} So when that is being, rather than that  
1624 being seen as three times the cost and they manage the care  
1625 better, there is an actual difference in improved health care  
1626 outcomes when they specifically coordinate that care of that  
1627 patient?

1628 Mr. {Keck.} Absolutely. I mean, on an annual basis,  
1629 our legislature requires that we compare the cost of our  
1630 managed care programs on a per-member per-month basis to that  
1631 of the fee-for-service program, and even with the additional  
1632 costs, managed care is cheaper than fee-for-service and it  
1633 produces better outcomes.

1634 Mr. {Murphy.} One of the things I look upon, when the  
1635 managed care movement hit in the 1990s, I didn't care much  
1636 for it because much of that was managed money and not managed

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1637 care. That is why I like it at more as coordinated care  
1638 where physicians and nurses are in charge of decisions.

1639 Let me ask another way this can be coordinated. The  
1640 Federally Qualified Community Health Centers, can you tell me  
1641 how your State may work with them with Medicaid to make sure,  
1642 because I am concerned, a lot of people on Medicaid don't  
1643 really have a primary person they keep going to as their  
1644 home. Too often their lives are disrupted. They go from  
1645 person to person to person. Can you give me as an example if  
1646 that is something you work with in your State to help  
1647 coordinate that?

1648 Mr. {Keck.} Absolutely. I mean, in a broad sense, we  
1649 are working with all primary care providers. We are now  
1650 making patient-centered medical home incentive payments. If  
1651 you become certified, you get a per-member, per-month bump to  
1652 encourage people to become certified and eventually we will  
1653 convert that into broader care management payments to these  
1654 folks. But specific to the Federally Qualified Health  
1655 Centers, I think when we talk about the rates of uninsurance,  
1656 we forget that in most States we have very robust networks of  
1657 Federally Qualified Health Centers that were chartered to

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1658 serve these folks, and we spend a lot of money on them and  
1659 are a great resource, and this year in South Carolina we are  
1660 actually putting quite a bit of additional investigation,  
1661 probably the largest single investment that has been made by  
1662 the State in the history of the Federally Qualified Health  
1663 Centers to expand the presence of those and their ability to  
1664 work with patients.

1665 Mr. {Murphy.} Thank you, Mr. Chairman.

1666 Mr. {Pitts.} The chair thanks the gentleman and now  
1667 recognizes the gentlelady from Virgin Islands, Dr.  
1668 Christensen, for 5 minutes for questions.

1669 Dr. {Christensen.} Thank you, Mr. Chairman.

1670 Just for informational purposes, I noted from a Kaiser  
1671 report that in 2001, there were 36.6 million people enrolled  
1672 in Medicaid, and by 2009, there was as many as 62.9 million.  
1673 That was the year that President Obama took office. Just for  
1674 informational offices.

1675 Dr. Thompson, as a person who worked with some of my  
1676 colleagues when we were drafting the Affordable Care Act who  
1677 advocated for everyone to participate in the exchange  
1678 including those who were previously on Medicaid, I was really

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1679 pleased to read and hear from you that you are transitioning  
1680 to premium assistance, and so you are really demonstrating  
1681 flexibility and the support over the last 3 years of CMS and  
1682 the Department. So I want to applaud Arkansas's creativity  
1683 and I want to say that I enjoyed being in Little Rock last  
1684 year when the University of Arkansas and the Clinton  
1685 Foundation joined several of us in having the conference on  
1686 health disparities in Little Rock last year. So thank you  
1687 for that.

1688 Are you using navigators of any kind as you plan that  
1689 transition? Because many of the Medicaid beneficiaries would  
1690 not have much experience in going to a private insurance  
1691 market.

1692 Dr. {Thompson.} Since the action of our general  
1693 assembly, we have actually increased the number of navigators  
1694 our health insurance department planned to hire on a short-  
1695 term basis to reach the lower-income community, communities  
1696 of color, those that are Medicaid eligible in a more  
1697 successful way. We are also looking at information we now  
1698 have inside the Department of Human Services, for example,  
1699 parents of children that are on the Our Kids program so that

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1700 we may have already determined who is likely to be eligible  
1701 for the private option, if you will, through the exchange  
1702 that we have already done an income eligibility assessment.

1703 Dr. {Christensen.} And when we were talking about this  
1704 back 4 years ago or so, there was concern about wraparound  
1705 services in Medicaid that might be lost. Are you seeing that  
1706 your Medicaid patients would lose anything by going to the  
1707 exchange?

1708 Dr. {Thompson.} This is one of the issues that we are  
1709 in negotiations with CMS about. All of the Medicaid  
1710 eligibles are eligible for wraparound services. However, a  
1711 majority don't use those. They are able-bodied, working  
1712 individuals that are just low income, and so it is those  
1713 individuals that we anticipate putting into the private  
1714 market, letting them have a private experience, not be, if  
1715 you will, managed by the State, but for those whom the  
1716 private market is not going to be best mechanism, we will  
1717 retain them in the State Medicaid program, assure them of the  
1718 wraparound services and make sure that they get the  
1719 guaranteed benefit as required under federal law.

1720 Dr. {Christensen.} Thank you. And in the wake of the

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1721 Newtown shooting, again to Dr. Thompson, last fall, and the  
1722 recent shootings in Santa Monica, our Nation remains  
1723 concerned with access to mental health services to people  
1724 with mental illness. Congress passed mental health parity  
1725 legislation in 2008 and additional provisions were included  
1726 ensuring parity for mental health services in the Affordable  
1727 Care Act. A significant barrier to access is, of course, not  
1728 having health insurance, so how do you anticipate the  
1729 Medicaid expansion will help Arkansas to address the issue of  
1730 access to mental health services and what challenges do you  
1731 see in the State for improving that access?

1732 Dr. {Thompson.} Yes, I believe the requirements under  
1733 the essential benefit plan of the Affordable Care Act and our  
1734 actions on the Medicaid program to buy into that essential  
1735 benefit plan will singularly help both the mental health and  
1736 the substance abuse community because it brings to true  
1737 parity finally the financing mechanism for those services.  
1738 It will have an effect on our workforce. We are going to  
1739 have to look at the organization of our mental health  
1740 workforce to make sure they are in the right place because  
1741 rural Arkansas does not have as deep a bench when it comes to

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1742 that workforce but I think financial barriers have been the  
1743 number one reason we haven't had the right providers and the  
1744 right place at the right time, and through we are trying to  
1745 solve that first barrier.

1746 Dr. {Christensen.} Thank you, and I am sure you have  
1747 seen this report by NAMI, the National Alliance for Mental  
1748 Health, titled ``Medical Expansion and Mental Health Care.''  
1749 They quote an analysis by SAMHSA that shows that if all  
1750 States proceed with expanding Medicaid, as many as 2.7  
1751 million people with mental illness who are currently  
1752 uninsured could get coverage that includes almost 1.3 million  
1753 with serious mental illness, and Mr. Chairman, I would like  
1754 to submit this report for the record.

1755 Mr. {Pitts.} Without objection, so ordered.

1756 [The information follows:]

1757 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
1758 Dr. {Christensen.} Thanks. I also want to agree with  
1759 your statement, Dr. Thompson, that caps of any kind are a  
1760 risk to the beneficiary, and I would like to add my own point  
1761 of view that not setting the FMAP according to the  
1762 jurisdiction's average income also presents a risk, and I  
1763 want to thank the committee for, one, increasing our cap in  
1764 the territories although we did not remove it entirely but I  
1765 am still asking the committee to help me in passing my bill  
1766 to change the match to give the territories State-like  
1767 treatment. It costs nothing to the federal government but it  
1768 saves lives and decreases the risk for our beneficiaries.

1769 Thank you. I yield back the balance of my time.

1770 Mr. {Pitts.} The chair thanks the gentlelady and now  
1771 recognize the gentlelady from North Carolina, Mrs. Ellmers,  
1772 for 5 minutes for questions.

1773 Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you  
1774 to our panelists today for this important subcommittee  
1775 hearing.

1776 I am a representative of North Carolina. North Carolina  
1777 has chosen not to opt in to the Medicaid expansion, and I

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1778 applaud that decision that Governor McCrory and the State  
1779 legislature made. Just to quote Governor McCrory, ``The  
1780 federal government must allow North Carolina to come up with  
1781 its own solutions.'' It is a \$13 billion program and he  
1782 refers to it routinely as ``broken'', and because of that  
1783 does not want to expand a system that is in much need of  
1784 fixing.

1785           So with that, and again, I appreciate your testimony  
1786 today on this issue, I have a question for Ms. Verma and Dr.  
1787 Thompson in relation to what Director Keck has basically said  
1788 in his testimony, notes that he sees an opportunity for  
1789 bipartisan agreement that States need more flexibility to  
1790 manage programs locally in exchange for more accountability  
1791 to improve health and reduce costs. Ms. Verma and Dr.  
1792 Thompson, do you agree that Washington's approach, you know,  
1793 this far with Medicaid is outdated, and do you also believe  
1794 that States have the ability that they can with outcome  
1795 measures and greater flexibility improve care and reduce  
1796 costs?

1797           Ms. {Verma.} Yes, I do.

1798           Mrs. {Ellmers.} Thank you.

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1799 Dr. {Thompson.} I think the whole health care system is  
1800 going through a great transition and that States are bringing  
1801 innovative ideas. I think this Administration and the new  
1802 Center for Innovation has 41 different models for States to  
1803 choose from, and I think the partnership between the federal  
1804 and State government should be maintained because that is how  
1805 we are going to get the whole U.S. health care system to a  
1806 different place.

1807 Mrs. {Ellmers.} I also have a question, Mr. Keck, for  
1808 you. In South Carolina, I know that South Carolina is  
1809 working with CMS right now on integrating physical and long-  
1810 term care services for 65,000 enrollees. Can you speak to  
1811 the status of those negotiations and maybe give a little bit  
1812 of a timeline where we may go with that in implementation?

1813 Mr. {Keck.} Well, we are very supportive of the dual  
1814 integration to manage Medicaid and Medicare patients together  
1815 under a cap, I might add, per member. We have a good working  
1816 relationship with the Office of Dual Eligibles and are  
1817 working hard on that, but to be honest, it is a very, very  
1818 slow process. I think that is the experience that most  
1819 States have encountered, and it is primarily because of

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1820 working with the particular restrictions that Medicare has on  
1821 the program, but we hope to get to a memorandum of  
1822 understanding by the end of this month or the end of July and  
1823 go live by the middle of 2014, which is about 6 months behind  
1824 schedule, but we think it is a good effort, and it is a  
1825 needed effort. The dual eligibles are a very large portion  
1826 of our expenditures, and for both Medicare and Medicaid, we  
1827 have been doing great disservice to the taxpayers and to the  
1828 individuals to not manage these folks together.

1829 Mrs. {Ellmers.} I agree. Thank you so much.

1830 And my last question, I have about a minute left. Ms.  
1831 Verma, can you elaborate a little more on some of the  
1832 innovations that your State is making right now to improve  
1833 upon the Medicaid system?

1834 Ms. {Verma.} I work with a lot of different States, so  
1835 it is kind of hard specifically, but I will take the Indiana  
1836 example because I think that is the one that I have worked  
1837 extensively, and I think other States are looking at Indiana  
1838 because of some of the innovations it has done. I think what  
1839 they have really done, as we discussed earlier, is trying to  
1840 empower the individual and have the individual as part of the

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1841 equation. I think some of the cost sharing policies are  
1842 where Indiana and other States are seeking waivers, and it is  
1843 not--you know, the cost-sharing policy is not to burden the  
1844 individual or to, you know, try to ration care or limit them  
1845 from getting care. I think it is to incentivize them and to  
1846 empower them to be a part of the equation. And so I think  
1847 that that is where a lot of States are very interested in  
1848 those types of programs that really do put that individual in  
1849 the position of focusing on prevention, focusing on outcomes,  
1850 and I think a lot of the programs, you know, that are based  
1851 on the physicians--we have talked a lot today about outcomes  
1852 and physician outcomes. Well, the individual has to be a  
1853 part of that. The physician is not going to be able to  
1854 achieve those without it, and I think outcomes are also not  
1855 just for the physicians but even for States, and we need to  
1856 hold states accountable for outcomes as well, and so we need  
1857 to align the providers, the individuals and States together  
1858 in the same direction.

1859 Mrs. {Ellmers.} Thank you so much for your testimony,  
1860 and I see my time is expired. Thank you, Mr. Chairman.

1861 Mr. {Pitts.} The chair thanks the gentlelady and now

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1862 recognizes the gentlelady from Florida, Ms. Castor, 5 minutes  
1863 for questions.

1864 Ms. {Castor.} Well, thank you, Mr. Chairman, and thank  
1865 you very much to the panel today.

1866 Over the past decades, the federal-State partnership  
1867 that is Medicaid has evolved and it has changed into more of  
1868 a managed care system. More States have adopted managed  
1869 care. CMS has been granted great flexibility for States to  
1870 tailor managed care Medicaid services.

1871 I am concerned, though, that we lose some control to the  
1872 managed care companies, some accountability. Could you all  
1873 give me your opinion and identify the most effective waiver  
1874 conditions, oversight initiatives in the states to ensure  
1875 that our tax dollars actually go to medical care and health  
1876 services and not to excessive administrative costs or to  
1877 excessive profits for insurance companies and HMOs?

1878 Ms. {Verma.} I think there are a lot of strategies that  
1879 States can take in their managed care contracting, and it all  
1880 has to do with how that contract is set up. I think they can  
1881 put in medical loss ratio requirements that would limit the  
1882 amount of dollars that are spent on administration and on

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1883 profit. There are outcomes measures, and I think that is one  
1884 of the main differences between State government and  
1885 contracting out with a managed care company is that you can  
1886 require outcomes of managed care companies. You can have  
1887 standards for access, standards for maternal and child health  
1888 outcomes in terms of low-birth-weight babies. You know,  
1889 whatever a State wants to attach to the contract, they can in  
1890 terms of outcomes, and that is something that you don't have  
1891 with, say, government with its regular fee-for-service within  
1892 the Medicaid program there is no accountability for the  
1893 outcomes they achieve.

1894 Dr. {Thompson.} I would concur with Ms. Verma. I would  
1895 add, I think it is important to start with what the  
1896 beneficiaries' needs are and make sure that the outcome  
1897 indicators, the expectations of the managed care plan, a  
1898 managed care plan that covers both an urban and a very rural  
1899 area, network adequacy is an important issue so that access  
1900 issues become important, and I think in the 30, 35 States  
1901 that have large rural areas, an important aspect is, how are  
1902 we going to actually manage care in a decentralized,  
1903 relatively fragmented health care system.

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1904           Mr. {Keck.} I would agree with both those statements.  
1905 We have had much better luck actually assuring network  
1906 adequacy in our State working with our managed care companies  
1907 because they are able to negotiate individual rates and so if  
1908 they are having a hard time getting a doctor in a particular  
1909 area, they can pay more. We can't do that through our fee-  
1910 for-service program. So we are very specific and spent a lot  
1911 of time understanding our network through geo coding and so  
1912 on. And we also put our plans at financial risk now for  
1913 outcomes, and they have both incentives and they have  
1914 withholds.

1915           Ms. {Castor.} So if they drop the ball, they are not  
1916 providing the services. Are there penalties built into the  
1917 waiver conditions or the contracts, and are you aware of  
1918 States really holding their feet to the fire and providing  
1919 proper oversight?

1920           Mr. {Keck.} We don't operate our managed care under a  
1921 waiver but through the contracts, we do hold their feet to  
1922 the fire, and the amount of potential penalty that we have  
1923 this year on our managed care plans could potentially be  
1924 their entire profit margin, and so we are moving forward very

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1925 aggressively with that. Some States are even more  
1926 aggressive. But again, we clearly measure our outcomes and  
1927 our cost per member per month, and we know that managed care,  
1928 coordinated care is making a difference. We think there is a  
1929 long way to go in terms of better managing care on the ground  
1930 but this is the tool to do it.

1931 Ms. {Castor.} Dr. Thompson?

1932 Dr. {Thompson.} I think we are taking a little bit  
1933 different, maybe a next-generation approach with our payment  
1934 improvement initiative. We are asking the lead provider to  
1935 manage the clinical risk and to have financial incentives,  
1936 upside and downside, while we are retaining the actuarial  
1937 risk, kind of the chance that somebody who has a hip  
1938 replacement also has a heart attack back with the insurance  
1939 company or with the State. So I think both are actually  
1940 trying to put alignment of financial incentives with the  
1941 outcomes that the State, the Medicaid program, the federal  
1942 government desire, and I think we need to probably accentuate  
1943 the sharpness of our knife that we start looking.

1944 Ms. {Castor.} In Arkansas, do you all have managed care  
1945 or waiver for the elderly population, skilled nursing and

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1946 services that keep folks out of--because Florida is about to  
1947 embark on privatization of managed care for that population.  
1948 That is news to us. All of the providers are scared to  
1949 death. They don't want to go through a gatekeeper. What has  
1950 your experience been?

1951 Dr. {Thompson.} We have not used a third party, a  
1952 managed care entity, to exercise that option. We do have a  
1953 waiver, our home- and community-based service waiver, that  
1954 allows the family to use the allocated resources that would  
1955 have been spent inpatient in a nursing home for skilled or  
1956 family-assisted living to help them stay at home. So we have  
1957 a waiver in place. It is actually high sought after by our  
1958 families to keep their loved one at home. It does not use a  
1959 third-party manager in a manager care type of arrangement.

1960 Ms. {Castor.} Thank you very much.

1961 Mr. {Pitts.} The chair thanks the gentlelady. I  
1962 recognize the gentleman from Virginia, Mr. Griffith, 5  
1963 minutes for questions.

1964 Mr. {Griffith.} Thank you, Mr. Chairman. I appreciate  
1965 that.

1966 According to the CBO, Medicaid will cost the federal

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1967 government \$5 trillion over the next 10 years with as much as  
1968 \$638 billion of that directly linked to the expansion of  
1969 Medicaid from PPACA. Recently, the Governor of my State,  
1970 Governor Bob O'Donnell, laid out the need for vast reform to  
1971 make Virginia's Medicaid program more cost-effective before  
1972 the Commonwealth can consider an expansion. The State  
1973 legislature set up a system where they can consider expansion  
1974 if these reforms are met, and there were five tenets that he  
1975 laid out for Medicaid reform: one, service delivery through  
1976 efficient market-based system including more managed and  
1977 coordinated care; two, reducing financial burdens to the  
1978 State by getting assurance from the federal government that  
1979 expansion will not increase the national debt; three,  
1980 maximize the waivers that currently exist to achieve  
1981 administrative efficiency through streamlining of payment and  
1982 service delivery; four, obtain buy-in from health care  
1983 stakeholders in the State for statewide reform; and five,  
1984 achieve greater flexibility by changes to federal law  
1985 including value-based purchasing, cost sharing, mandatory  
1986 engagement in wellness and preventive care, the development  
1987 of high-quality provider networks and flexibility around

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1988 essential health benefits. That is a mouthful. The bottom  
1989 line is, these reforms that Virginia is now discussing are on  
1990 part with the plan laid out by Chairman Upton and Senator  
1991 Hatch to provide States with more flexibility to implement  
1992 their Medicaid programs in a way that makes sense for them  
1993 while better controlling costs.

1994 Ms. Verma, how do you feel about these Medicaid reforms  
1995 that Virginia is currently exploring? What can we do to help  
1996 the States better service the vulnerable populations that  
1997 need Medicaid while giving the States the flexibility that  
1998 improves the quality of their program, promotes access and  
1999 gets costs under control?

2000 Ms. {Verma.} I think that Virginia has all the right  
2001 elements there. I think they have covered the span of  
2002 identifying incentives for providers and individuals but I  
2003 think the key part there is that they are going to need  
2004 flexibility from the federal government to implement those  
2005 pieces, so that will be a critical component. But I think  
2006 they have the required elements of a reform package.

2007 Mr. {Griffith.} So you think that that is a good first  
2008 step?

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2009 Ms. {Verma.} I think it is a good approach. I am, you  
2010 know, glad to hear that they have also included the  
2011 individual in that piece. I think that is important. They  
2012 have got the providers. They are looking at the benefits.  
2013 And I think they also recognize the important role that the  
2014 federal government plays in this to making that happen.

2015 Mr. {Griffith.} Now, as a part of that flexibility for  
2016 the States, how do you feel about the situation where, you  
2017 know, yes, we want to reward folks for doing the right things  
2018 but what if they consistently do the wrong things? Do you  
2019 think there ought to be some kind of a stick that can also be  
2020 applied in that flexibility if somebody continually goes to  
2021 the most expensive health care provider because they just  
2022 don't seem to care that they are running up the cost?

2023 Ms. {Verma.} Absolutely, but you have to use those  
2024 sticks appropriately. You have to be mindful of the  
2025 population. I think that the carrots and sticks work  
2026 differently, the different populations. I think a disabled  
2027 population, those are a little bit harder to apply. However,  
2028 as we are talking about Medicaid expansion and able-bodied  
2029 individuals, I think those are probably more appropriate

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2030 populations that those could be effective.

2031 Mr. {Griffith.} And that does make sense.

2032 For everyone, there is always a lot of debate around  
2033 when States can and cannot implement cost sharing. From your  
2034 perspectives, when does cost sharing work and what can be  
2035 done to really allow the customization of cost sharing at a  
2036 local level?

2037 Ms. {Verma.} I think cost sharing needs the most work.  
2038 I know CMS did put some proposed rules out that increased the  
2039 cost-sharing levels. I think it is a very rigid structure.  
2040 It only requires copays. There is no opportunity to enforce  
2041 premiums for people below 100 percent of poverty. There is  
2042 no flexibility to do value-based where you would be able to  
2043 vary the copays depending on the types of services. And I  
2044 think the enforcement piece of critical. I mean, what  
2045 happens with copays and the way that they have it structured  
2046 is that it ends up being a decrease in the provider  
2047 reimbursement because providers can't collect it.

2048 Mr. {Griffith.} And let me go to the others. I only  
2049 have about 45 seconds left.

2050 Mr. {Keck.} I will add to that. My hospitals would be

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2051 remiss if to that particular question about cost sharing, I  
2052 didn't mention that we need to do some reforms to EMTALA  
2053 because EMTALA has turned into sort of a blanket reason to be  
2054 able to use the emergency room without regard for appropriate  
2055 use.

2056 Mr. {Griffith.} Sure. Dr. Thompson?

2057 Dr. {Thompson.} I think we are on a path to change the  
2058 Administration's proposed rule, which we have incorporated  
2059 into our private option. It is on the right path. I think  
2060 it is a complex system, and at some point, cost sharing, if  
2061 you are only making \$6,000 a year, does become a barrier to  
2062 access. The other piece that we have had to work with on our  
2063 providers and our workforce strategy, if you are working an  
2064 hourly job and the doc is only open 8 to 5, you are going to  
2065 end up going to the emergency room. So we need our docs have  
2066 an after-hours clinic and weekend clinics where people are  
2067 going to do exactly what you would expect them to do. They  
2068 are not going to lose an hour's wage to go to the doctor in  
2069 the middle of the day when they can go to the emergency room  
2070 at night. So this is part of a total system change. It  
2071 involves workforce, it involves access, and most importantly,

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2072 it does involve finance.

2073 Mr. {Griffith.} I thank you all for being here. Mr.  
2074 Chairman, I yield back.

2075 Mr. {Pitts.} The chair thanks the gentleman and now  
2076 recognizes the gentleman from New Jersey, Mr. Lance, 5  
2077 minutes for questions.

2078 Mr. {Lance.} Thank you, Mr. Chairman. I yield my 5  
2079 minutes to Dr. Burgess.

2080 Dr. {Burgess.} I thank the gentleman for yielding.

2081 Dr. Thompson and Mr. Keck, really to both of you, there  
2082 seems to be a good deal of antipathy toward the fee-for-  
2083 service system, and yet the fee-for-service system is what  
2084 many doctors have grown up with, what we rely upon. I would  
2085 submit--and I realize that the Medicaid system is not  
2086 directly analogous to the food stamp system but I suspect  
2087 that if you tried to do a food stamp system that was not fee-  
2088 for-service based, taking the basket to the marketplace and  
2089 not paying a fee for every service that you loaded into the  
2090 cart would be problematic. Is that an unfair observation?

2091 Mr. {Keck.} Well, I think fee-for-service is not  
2092 universally the cause of all our problems, and there is

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2093 actually within the system places where you want to use fee-  
2094 for-service to encourage volume and productivity, and there  
2095 are other areas where you want to use bundled payments and  
2096 capitation and so on to encourage parsimony in the use of  
2097 services.

2098 Dr. {Burgess.} Dr. Thompson, do you have an observation  
2099 on that?

2100 Dr. {Thompson.} Yes. I would just offer, our payment  
2101 improvement still pays claims in the same way that we did  
2102 under a fee-for-service system, so we are still paying  
2103 providers for the care at the point of delivery when they  
2104 have care. What we have done is, we have put a quarterback  
2105 on the team that now has the responsibility for the outcome.

2106 Dr. {Burgess.} Let me ask you a question about that.  
2107 Is the quarterback always a physician? You referenced  
2108 prenatal care. Is the quarterback always the OB doctor in  
2109 that instance?

2110 Dr. {Thompson.} The quarterback has been decided by our  
2111 multi-payer effort to date consistently. It is the provider  
2112 who has the most influence on the system, the most ability to  
2113 make change and the most financial interest. It is usually

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2114 the physician. With respect to congestive heart failure  
2115 readmission rates, it is the index hospital because they know  
2116 when they are discharging the patient and--

2117 Dr. {Burgess.} But they own all the doctors now so  
2118 there is no--it has to be the hospital. There is no other  
2119 entity to be identified.

2120 Well, you know, when I think about the food stamp system  
2121 and the Medicaid system, when I go to my market at home and I  
2122 am behind someone in line who has the Lone Star code, which  
2123 in Texas is the food stamp, the way that is utilized, there  
2124 oftentimes will be a brief discussion between the cashier and  
2125 the individual buying the products, and, you know, they have  
2126 identified out of a large bill, here is a certain number of  
2127 dollars of things you have picked up that are not covered and  
2128 you will have to pay cash for those, and there is no effort  
2129 to embarrass the person. It is just simply they pay the  
2130 dollars that are required. Why would it be hard to construct  
2131 a system like that within the Medicaid system? That is, the  
2132 patient comes and in fact some of the bill could be borne by  
2133 the patient. You referenced the harshness of copayments or  
2134 people who would have to pay some of their own money, but it

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2135 seems like there has got to be a happy medium there where  
2136 some additional money can be brought to the system by the  
2137 person who is ultimately utilizing the system.

2138 Dr. {Thompson.} Well, let me use your food stamp  
2139 example. Our payment improvement effort is like sending a  
2140 nutritionist through the aisle with the patient, with the  
2141 individual, so we are actually putting a nutritionist with  
2142 that food stamp recipient as they buy their food. To your  
2143 issue on sharing, that is exactly what the Affordable Care  
2144 Act does through the exchange. We set an essential benefit  
2145 plan. There is a tiered level of coinsurance, co-risk that  
2146 decreases the lower a family's income is. What we have done  
2147 in our State is, we have layered one more layer underneath  
2148 that that says for the poorest of the poor, we will put some  
2149 cost sharing in place but we are going to offer some  
2150 protections.

2151 Dr. {Burgess.} And let me ask you a question about the  
2152 concept of premium support because, I mean, to some degree  
2153 that has gotten a bad rap here in Congress. It is called a  
2154 voucher, and it is talked about in a derogatory term, but it  
2155 sounds like you are using that to your advantage. Premium

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2156 support is part of your so-called private option. Is that  
2157 not correct?

2158 Dr. {Thompson.} We believe, our Republican leadership  
2159 and our Democratic Governor believes using the private sector  
2160 with competition for provider rates and with competition for  
2161 patients essentially is the best way to consider expanding  
2162 Medicare because it is not a traditional State Medicaid  
2163 expansion. It does not have the cliff of people then wanting  
2164 to stay on Medicaid and not moving to private insurance.

2165 Dr. {Burgess.} Let me ask you this, because Dr. Murphy  
2166 asked a question about the Federally Qualified Health  
2167 Centers. The liability coverage is handled differently in a  
2168 Federally Qualified Health Center. Texas several years ago  
2169 experimented with providing the first \$100,000 of liability  
2170 coverage to a provider who was doing a certain percentage of  
2171 Medicaid in their practice. Have you looked at that in  
2172 Arkansas as a possibility? You need to bring providers into  
2173 the system. Most of us recognize that it is that first  
2174 \$100,000 of liability that is where the real vulnerability  
2175 exists. Medicaid patients do sometimes carry higher  
2176 liability risk. Have you looked at that in Arkansas?

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2177 Dr. {Thompson.} We have not looked at that as a way of  
2178 recruiting providers. We have a relatively high provider  
2179 participation rate because we use electronic payment within  
2180 72 hours of service delivery. So our discounted prices we  
2181 have combated with increased cash slow and responsiveness to  
2182 treatment, but that has been our tool. I think your  
2183 suggestion would be very open to our medical society and  
2184 probably our Medicaid program.

2185 Dr. {Burgess.} Is that something you are willing to  
2186 look at?

2187 Dr. {Thompson.} I would be glad to.

2188 Dr. {Burgess.} Thank you.

2189 Mr. Chairman, I have a series of questions on Medicaid  
2190 as the payer of last resort. I guess the appropriate think  
2191 would be to submit that for the record because I would like  
2192 each of you to respond to that. The Government  
2193 Accountability Office did a study back in 2006 and looked at  
2194 the States that were collecting from--that were covered under  
2195 Medicaid but also had simultaneous coverage under either an  
2196 individual plan or a group plan. For each of your States, it  
2197 is about a 10 percent rate of people who are covered, have

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2198 dual coverage, and I would just be interested in your  
2199 thoughts as you expand managed care, are we going to make  
2200 that problem worse, and how can we get at--I mean, when you  
2201 talk of \$750 billion a year, 10 percent of that is a lot so  
2202 we really ought to attempt to--we can't just leave that money  
2203 on the table. If it is owed by private insurers, it should  
2204 be paid by private insurers. But I will submit that in  
2205 writing. I would each of your responses to that.

2206 And finally, Mr. Chairman, I would like to ask unanimous  
2207 consent to put into the record an article from the New  
2208 England Journal of Medicine titled The Oregon Experiment:  
2209 Effects of Medicaid on Clinical Outcomes.

2210 Mr. {Pitts.} Without objection, so ordered.

2211 [The information follows:]

2212 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
2213           Mr. {Pitts.} That concludes the questions from the  
2214 members. The members will have additional questions that we  
2215 will ask them to submit in writing. We will ask the  
2216 witnesses to please respond promptly.

2217           Thank you very much for your testimony today, and let me  
2218 remind members, they have 10 business days to submit  
2219 questions for the record, and members should submit their  
2220 questions by the close of business on Wednesday, June 26.

2221           It has been a very informative hearing. Thank you very  
2222 much. Without objection, the subcommittee is adjourned.

2223           [Whereupon, at 11:50 a.m., the Subcommittee was  
2224 adjourned.]