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MAKING MEDICAID WORK FOR THE MOST VULNERABLE

MONDAY, JULY 8, 2013

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 4:00 p.m., in Room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Gingrey, Cassidy, Griffith, Bilirakis, Ellmers, Dingell, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Sydne Harwick, Legislative Clerk; Monica

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Popp, Professional Staff Member, Health; Andrew Pawaleny, Deputy Press Secretary; Noelle Clemente, Press Secretary; Alli Corr, Minority Policy Analyst; Amy Hall, Minority Senior Professional Staff Member; Elizabeth Letter, Minority Assistant Press Secretary; and Karen Nelson, Minority Deputy Committee Staff Director for Health.

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Mr. Pitts. The time of 4:00 having arrived, we will call the subcommittee to order. The chair will recognize himself for an opening statement.

Today's hearing is the third in a series examining the current Medicaid system and ideas for reform. It builds on the subcommittee's March 18 hearing, "Saving Seniors and Our Most Vulnerable Citizens From an Entitlement Crisis," and our hearing of June 12, "The Need For Medicaid Reform: A State Perspective." It also complements the Energy and Commerce Committee's "Medicaid Check Up" report from March, Representative Upton and Senator Hatch's May report, "Making Medicaid Work," and the committee's recent Idea Lab on the program.

Medicaid was designed to protect the most vulnerable Americans, including pregnant women, dependent children, the blind, and the disabled. Nearly one in four Americans was enrolled in the Medicaid program at some point in 2012, making Medicaid the largest government healthcare program, surpassing Medicare. We have an obligation to ensure that the program provides quality health care to beneficiaries and has the flexibility to innovate to better serve this population.

As we have seen, we are failing on both counts. Only 70 percent of physicians are accepting Medicaid patients, leading to problems with accessing care and scheduling follow-up visits after initially seeing a provider. Medicaid beneficiaries often lack access to primary care and preventive services and are twice as likely to visit the emergency

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room. In some cases, outcomes for Medicaid patients are worse than the outcomes of those who have no insurance at all.

Regarding flexibility, instead of encouraging States to pursue new and innovative models of care, we have locked them into a one-size-fits-all program dictated by Washington. When States do try to modernize and tailor their programs to the individual populations they serve, they often spend years waiting for the Centers for Medicare & Medicaid Services, CMS, to approve their waivers. Before we implement a Medicaid expansion which, if fully adopted, would add another 26 million Americans to the program, we must first address these issues in the current program.

I look forward to hearing from our witnesses today about ideas to strengthen this vital safety net, and I welcome all of them to our subcommittee.

And I yield the balance of my time to the gentleman from Louisiana, Dr. Cassidy.

[The prepared statement of Mr. Pitts follows:]

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Dr. Cassidy. Thank you, Mr. Chairman.

The current debate over reforming the Medicaid program brings to mind -- and I am paraphrasing Samuel Johnson -- no one likes change, even from worse to better.

Even those who support Obamacare and Medicaid, the Medicaid component, said that they never would design Medicaid today as it was designed 50 years ago to meet today's needs. Now, there are many issues with the current Medicaid program. It serves a diverse group of people -- children, adults in long-term care, the disabled, pregnant women, and now able-bodied adults. If the intent of Medicaid is to take care of the most vulnerable, I raise issue with the child or individual with traumatic brain injury having to compete for limited Medicaid funds with a healthy childless adult.

There is also great variability in how much Federal money each State receives per Medicaid beneficiary. As evidence, the five wealthiest States receive almost twice as much in Federal Medicaid contributions toward the care of their low-income residents than those living in the five poorest States. If the intent of Medicaid is an implicit Federal guarantee to provide a baseline of coverage for the most vulnerable, why should a disabled Medicaid recipient living in New York receive twice as much Federal Government aid as a disabled person living in California?

Other problems include quality and access to doctors. The

chairman referenced a recent study that found that Medicaid patients have longer hospitalization, higher cost, and worse outcomes than even the uninsured. Yet despite being a high-cost program for States, Medicaid frequently pays below a physician's cost to see a patient, which effectively denies them access. Medicaid, as I like to say, is the illusion of coverage without the power of access.

I applaud the chairman and the committee for holding this hearing. We can't just simply add or subtract cash from the Medicaid system and call it reform. We have to be willing to reexamine the effectiveness of our Medicaid structure. I think that all the members of this committee can agree Medicaid should be structured in a way that provides benefits to individuals in the most efficient and effective way. I also would like to add that I recently introduced the Medicaid Accountability Care Act, which I hope can also be considered.

I yield the balance of the time to Dr. Gingrey.

[The prepared statement of Dr. Cassidy follows:]

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Dr. Gingrey. Mr. Chairman -- and I thank the gentleman for yielding -- our Medicaid program has continually underperformed for our most needy population. Instead of focusing Medicaid dollars on new, healthier people, as in the President's health care law, we should be directing more attention to improving the health outcomes of the existing populations. We must allow the States the ability to experiment with their programs to approve our results. An outdated and overly bureaucratic waiver process does not allow the proper freedom to develop new methods to deliver care to our poorest and most vulnerable.

Mr. Chairman, it is past time to repeal the maintenance of effort provisions in Obamacare and release the States to investigate novel ways to improve on a system that currently fails its participants. And thank you for the extra time, and I yield back.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Gingrey follows:]

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Mr. Pitts. Recognize the gentleman from Maryland, Mr. Sarbanes, who is filling in for the ranking member today.

Mr. Sarbanes. Thank you, Mr. Chairman. I appreciate your convening this hearing on the very important subject of the Medicaid program.

As you, yourself, said, Medicaid is an important program. We view it as a critical safety net that provides healthcare coverage for those individuals who have been shut out of private insurance, either because that is unaffordable to them or it is unavailable or it doesn't cover the benefits that they need.

It is important to recognize that when we talk about the Medicaid program, we are not just talking about a program that covers low-income families. We are talking about a program that covers children and adults with disabilities, and pays for nearly half of all long-term care services.

I had the privilege for 18 years of representing a number of health care providers as an attorney, in particular those who provide services to our elderly, and I understand how critical the support from the Medicaid program is for a lot of the services that are provided to those most in need among our elderly. And so it is important for us to understand the full dimensions of the Medicaid program. We are talking about home- and community-based services, we are talking about rehabilitative therapy, and we are talking about adult daycare and

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caregiver respite.

In 2011 -- and you mentioned this yourself -- the Medicaid program provided healthcare assistance for almost one out of every four or five people in the country, including 30 million children. That is why it is so critical to make sure that this program remains strong and that we build upon the most important elements of it.

I am particularly focused on how we can bring this kind of coverage to bear where people are. It is what I call place-based health care. I have championed efforts, particularly with respect to young people, to make sure that those who are eligible for Medicaid can get that care wherever they may be and where it is easiest for their families to receive it, including in their schools and in school-based health clinics.

The coverage for children under Medicaid is really one of the most important aspects of the program. And I would like to enter into the record, without objection, testimony from the American Academy of Pediatrics on this issue of why it is so important both to pediatricians and obviously to children as well. This is from Robert Hall with the American Academy.

Mr. Pitts. Without objection, so ordered.

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[The information follows:]

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Mr. Sarbanes. The Affordable Care Act, as we know, includes an expansion of the Medicaid program to include more low-income adults, taking it up to 138 percent of the poverty rate. Half of today's uninsured have incomes below the new Medicaid limit. So they stand to benefit from this adjustment going forward. Unfortunately, we do have States across the country who so far have declined to become partners in this effort, take advantage of the Medicaid expansion. The result of that is that you will have many low-income adults who will likely remain uninsured, with predictable results both for them and for our society.

We also have to look at this through an economic lens. And as the economy continues to improve, more and more people are still finding themselves in need of this very important healthcare safety net. If you cut Medicaid, that is essentially cutting jobs. Medicaid stimulates the economy. Every dollar spent is good economics. According to one study by the Kaiser Family Foundation, every dollar cut from Medicaid means up to $2.76 cut from the State economy in which that occurs. The loss of Federal Medicaid dollars means a loss of healthcare jobs and healthcare economic activity across the country, which means you are moving States in exactly the wrong direction that we want to be pushing them in terms of our economic recovery.

States and the Federal Government need to focus on creating jobs, on incentivizing economic growth, not on cutting the most vulnerable

programs, such as Medicaid. So I believe the expansion of the Medicaid program under the Affordable Care Act is not only something that makes tremendous sense for the health of vulnerable populations across the country, but for State economies as well. And I look forward to hearing from our witnesses today as they discuss this critical program and how we can all continue to push for quality affordable health care for all our citizens.

With that, I yield back.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Sarbanes follows:]

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Mr. Pitts. And now yields to the vice chair of the subcommittee, Dr. Burgess, for 5 minutes for an opening statement.

Dr. Burgess. I thank the chairman for yielding.

As we meet here today to discuss Medicaid, recognize that it was created to protect and care for some of the poorest and most needy in our Nation. However, in reality, the program, because of weak oversight, chronic underpayment of providers, lack of coordination of benefits, ends up being only another empty promise made by the Federal Government. The ability of Medicaid to provide healthcare coverage for the most vulnerable is further threatened by the Affordable Care Act and the drastic expansion of the program to nearly 72 million Americans in 2014.

Medicaid currently consumes almost a quarter of States' budgets, surpassing expenditures on education, transportation, and emergency services. Many States have been forced to cut Medicaid reimbursement rates to providers as a way to address budget shortfalls.

Look, as someone who has provided services to Medicaid beneficiaries, I understand firsthand that coverage does not guarantee access. Medicaid low reimbursement actually creates increased barriers to care, limiting beneficiaries' access to services because Medicaid pays less for comparable service than private insurers or, in some instances, even Medicare itself, making finding providers and appointments hard and sometimes impossible. Escalating costs and

shrinking access are symptoms of the greater systemic problems within the Medicaid system.

And look, we need to move beyond small reforms and instead address the underlying system's structural problems. We sat here this very room with a Health Subcommittee hearing in 2008 and talked about this very problem. Many of you will remember, it was the day that Lehman Brothers collapsed and the economy was headed for a crisis. We heard in that hearing that day that if you wanted to do health care reform on the cheap you just expand Medicaid. You are not really paying the providers to see the patients but, after all, that is not really what is critical, it is critical that we provide the coverage.

Well, anyone who has practiced in the Medicaid system will tell you that the ability to meet the cost of providing the care is critical for a hospital, for a clinic, for a doctor's office. And if you can't meet that, your doors will quickly be closed. But as we sat here in that room that day in September, we never even asked ourselves, is the best we can do Medicaid? And wouldn't we be better to reform the program before we expanded it? But unfortunately, those questions were never answered.

So I would submit today, it is time for us to get back to the basics. We need to ask ourselves, what was Medicaid created to do, and is it doing the best it can do under the circumstances? We know the structural and fiscal problems in the healthcare system. How long

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will America tolerate staring at these problems without fixing them for future generations?

It is time not just to reform Medicaid. We actually need to reboot the entire system. As we have seen from the events of the last week and a half, the problems in the Affordable Care Act are beginning to mount. They are reaching critical mass. This subcommittee has within its power to take up this issue and act.

I thank the chairman. And I will yield the balance of my time to the full committee chair, who is not here, so I will yield back my time.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Burgess follows:]

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Mr. Pitts. Now recognize the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

Mr. Waxman. Thank you very much Mr. Chairman.

The hearing today is called "Making Medicaid Work For the Most Vulnerable." I think that is a good topic. But I do want to talk about what the Republicans have proposed. They have proposed making Medicaid a block grant. So the States would be told, this is the amount of money you would get, no more, no less, you don't have to do anything, no requirements, do the best you can. And if you can't afford to do what you have been doing, well, you do less. That is up to you.

What the Republicans, in effect, are proposing is to shift the responsibilities to the States, the cost to the patients and providers, and avoid continuing a Federal responsibility. Block grants, or per capita grants, increases in beneficiary premiums and copays do not reduce healthcare costs, but simply shift the cost onto the beneficiaries, providers, and States. And they make it less likely that people will be able to access care when they need it.

Are there things we can do to improve the program? Certainly. One thing we could do is to make it a Federal program, not have State differences, have a Federal Medicaid program, guarantee that providers will get the same reimbursement rates as the Medicare providers get paid. That would improve the program. But I don't think that is something that we are likely to hear much support for from the majority

party that is in control.

I think this is a good hearing to have. I know we have a number of witnesses. I am particularly interested in hearing from Mr. Weil on what the States have been able to do to make the program innovative, effective, and efficient, cover low-income beneficiaries within the flexibility afforded the State Medicaid programs right now. Things the States can do today. I believe Mr. Weil will tell us that States continue to advance their Medicaid programs by implementing innovations, such as the multipayer collaboratives to improve access to primary, well-coordinated care; efforts to increase access to higher-quality, lower-cost developmental and oral health services; and others for the prevention of chronic disease.

Due to efforts like these, multiple studies have shown that Medicaid enrollees have comparable access to care as those with private coverage and much more reliable access than to those who are uninsured. When we hear complaints about Medicaid, the Republicans are forgetting that before Medicaid these people were uninsured and didn't have access to any care. And under the Medicaid program, if beneficiaries can get access with lower cost sharing, if we make very poor people -- which is the bulk of who the Medicaid patients are -- have to come up with more money out of pocket, they just won't have access to care because they can't afford it. Not only does the Medicaid program ensure equal access to care, it operates with efficiency. Medicaid costs are nearly

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four times lower than average private plans.

And there are other proposals that I think will streamline State payment systems, improve provider reimbursement timelines, ultimately increase their participation in State programs. One thing that I am very proud of is that at least we are going to, for a couple of years, require that preventive and primary care providers be paid the same rate as Medicare. But we didn't make that a permanent change, which would make a lot of sense. We put it in for a couple of years only in hopes that after it is in, people will -- either at the Federal level or the State level -- will try to keep it in place because it makes a lot of sense. If we can't afford to pay everybody a Medicare rate who serves Medicaid patients, at least pay those for whom we would like people to have access the most, and those are people who will provide primary and preventive care.

The Affordable Care Act expands the Medicaid program. I think this is a good thing to do. And I am proud of the Affordable Care Act. I think it is going to mean for millions of people they are going to have access to care, access to health insurance, whether it is through Medicaid, if they are lower income, or through the purchase of a private health insurance plan in the marketplace exchanges.

Let's stop complaining, let's make this law work because the Republicans don't have anything to offer but driving costs and shifting them over to people who can't afford to pay them and thereby denying

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them the services they need.

Thank you, Mr. Chairman. Yield back my time.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Waxman follows:]

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Mr. Pitts. That completes the opening statements of the members. We have one panel today. I will ask them to take their seats at the table. And I will introduce them at this time.

First we have Ms. Nina Owcharenko, director, Center for Health Policy Studies of the Heritage Foundation. Secondly we have Mr. Alan Weil, executive director of the National Academy for State Health Policy. And finally, Mr. Tarren Bragdon, president and CEO, Foundation for Government Accountability.

Welcome. Thank you for coming today. You will each have 5 minutes to summarize your testimony. Your written testimony will be entered into the record. And so at this time, Ms. Owcharenko, we will recognize you for 5 minutes for your opening statement.

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STATEMENTS OF NINA OWCHARENKO, DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, HERITAGE FOUNDATION; TARREN BRAGDON, PRESIDENT & CHIEF EXECUTIVE OFFICER, FOUNDATION FOR GOVERNMENT ACCOUNTABILITY; AND ALAN WEIL, EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY

STATEMENT OF NINA OWCHARENKO

Ms. Owcharenko. Chairman Pitts, Ranking Member Waxman, and members of the committee, thank you for having me today.

As has already been well noted, the challenges facing the Medicaid program are not new. These challenges are unavoidable and raise serious concerns about whether Medicaid will be able to meet the needs of those who are enrolled in the program today, especially the most vulnerable.

The program serves a very diverse group of low-income people: children, pregnant women, disabled, and the elderly. The Affordable Care Act adds to this growing government health program by expanding eligibility to all individuals with incomes below 138 percent of the poverty level. And unlike traditional Medicaid, eligibility will be based on income alone.

I see three major challenges facing Medicaid in the future: demographic, structural, and fiscal.

The demographic challenges. With in the addition of the new Medicaid expansion, the Centers for Medicare & Medicaid Services' 2011 Actuarial Report on Medicaid projects that nearly 80 million people -- one in four -- will be on Medicaid by 2021. By enrollment alone, children will remain the largest and primary category of Medicaid enrollees, although it is worth noting that as a result of the Affordable Care Act, the able-bodied, non-elderly adults will be a very close second. But while only 16 percent of total enrollment, 64 percent of spending in 2011 was for the aged and disabled. As these competing trends continue, Medicaid will be more diverse and more complex to administer.

Structural challenges. Payment rates are one of the key indicators for access and physician participation in Medicaid, it has already been noted today. In its annual report to Congress, MACPAC notes that while varying by State, Medicaid fee-for-service payments to physicians are on average two-thirds those of Medicare and even worse for primary care services. A 2006 published survey found that 21 percent of physicians reported that they were not accepting new Medicaid patients while only 4 reported not taking new privately insured patients and 3 percent reported not taking new Medicare patients.

While the Affordable Care Act did provide Federal funding to boost Medicaid payments for primary care physicians, that funding, as has

been noted, is temporary. And also as noted by the MACPAC report, several States have already indicated that it is unlikely that they will be able to maintain those new rates. Therefore, access and quality issues will remain a challenge for Medicaid beneficiaries in the future.

Fiscal challenges. Entitlements, including Social Security, Medicare, and Medicaid, are fueling this country's spending crisis. These three programs represent 62 percent of the Federal budget in 2012 and will absorb all tax revenue by 2048. By 2021, total Federal and State spending on Medicaid alone is projected to reach $795 billion and 3.2 percent of GDP by 2021.

For States, which have to operate under a real budget, the fiscal situation is no better. When the Federal contributions are included, Medicaid is the largest budget item for State budgets, representing 24 percent. In its recent fiscal report, the GAO warned that absent any intervention or policy changes, State and local governments would face an increasing gap between receipts and expenditures in the coming years. This is due in large part to rising healthcare costs for Medicaid, as well as health benefits for government employees and retirees.

Although these fiscal challenges are well established, the lack of action only makes the future outlook worse for Medicaid and its beneficiaries. I suggest there are a few basic principles that should

guide efforts to addressing the key challenges facing Medicaid.

One, meet current obligations. Rather than expanding to new populations, attention should be given to ensuring that Medicaid is meeting the needs of existing Medicaid beneficiaries. Moreover, population should be prioritized based on need first.

Two, return Medicaid to a true safety net. Medicaid should not be the first option of coverage but a safety net for those who cannot not obtain coverage on their own. Careful attention should be given to transitioning those who can into the private insurance market.

Three, integrate patient-centered, market-based reforms. Efforts to shift from traditional fee for service to managed care have accelerated at the State level, but more should be done. Empowering patients with more choices and spurring competition among providers, including insurers, will help to deliver better quality of care at a lower cost.

Four, ensure financial sustainability. Similar to other entitlement reforms, the open-ended Federal financing model of Medicaid means reform. Sound budgeting at the Federal and State levels should provide a predictable and sustainable path for the program and taxpayers alike.

In conclusion, I think it is encouraging to see efforts both in the House and in the Senate that are aimed at addressing these serious challenges facing Medicaid's future. With Federal and State

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policymakers working together, meaningful change in Medicaid will ensure that the most vulnerable are not left behind.

Thank you.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Ms. Owcharenko follows:]

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Mr. Pitts. Now recognizes Mr. Weil for 5 minutes for an opening statement.

STATEMENT OF ALAN WEIL

Mr. Weil. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to appear before you today.

I am the executive director of the National Academy for State Health Policy, a nonprofit, nonpartisan organization that works with State leaders to promote excellence in State health policy and practice. My own experience includes a cabinet position in Colorado running the Medicaid agency.

Ten years ago I wrote that Medicaid is the workhorse of the American health care system, and that characterization remains true today. Unambiguous evidence demonstrates Medicaid's success in providing access to care and relieving the financial burdens associated with that care.

My testimony is a report from the field where I observe a Medicaid program that is dynamic, continually evolving to meet the changing needs of vulnerable populations, leading how care is structured and delivered, and participating in transformations of care delivery that are occurring around the country.

For example, Medicaid has led the way in promoting the use of

developmental screening methods to identify children who would benefit from early intervention services. The percentage of children receiving such screening has grown from under 20 to more than 30 percent. In North Carolina, it is 75 percent. Nationwide, children with public health insurance are actually more likely to receive critical developmental screenings than children with private health insurance.

In 2000, Surgeon General David Satcher called poor oral health America's silent epidemic. Medicaid programs around the country are actively pursuing efforts to ameliorate this crisis through early interventions in medical practices, not just in dental offices. Washington State and Maryland, among others, have innovative programs designed to increase access to dental care for vulnerable children.

Medicaid is the Nation's primary payment source for long-term services and supports, and now States are spending more than a third of their long-term service budgets on home- and community-based supports that meet people's needs more effectively and more humanely.

In the area of eligibility and enrollment, Louisiana has led the way in streamlining processes for Medicaid applicants and those seeking to renew their coverage. Oklahoma launched the Nation's first online realtime enrollment system for Medicaid.

But some of the most exciting work in Medicaid is how it works with other private and public programs. All but three States now rely

on managed care for delivering care to at least some of their Medicaid enrollees. Two-thirds of Medicaid enrollees receive most or all of their benefits in managed care. And States are increasingly relying on mandatory managed care programs in Medicare for more complex populations, such as children with special healthcare needs and people of all ages with a variety of disabilities.

Medicaid has been a leader in promoting the development of patient-centered medical homes; 29 States have launched one or more programs in Medicaid or the Children's Health Insurance Program to promote patient-centered medical homes. In 18 of those States, public and private payers and purchasers are working together to support these medical home projects. And in 15 of those initiatives, Medicare is also a participant.

The health home model is an extension of the medical home that integrates physical health, behavioral health, long-term services and supports to meet the needs of the most complex populations. A dozen States are pursuing these integrated models with support from the Federal Government under the Affordable Care Act.

Back in 2006, when Massachusetts reformed its healthcare system, it took a blended personal health and public health approach to smoking cessation services for Medicaid enrollees. In Massachusetts, smoking prevalence among Medicaid enrollees dropped by 26 percent in just 2 years, with significant health cost savings as an added benefit.

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Around the country, Medicaid programs are pursuing new models of accountable care that encourage health care providers to organize and coordinate care as they accept financial risk and accountability for health outcomes. The structure of these programs is as varied as the States that are pursuing them: New Jersey, Minnesota, Illinois, Colorado, Oregon. The States are taking approaches that meet their own needs. Twenty-five States have received support to test or further develop comprehensive multipayer payment and delivery system reforms through funding from the Centers for Medicare & Medicaid Innovation State Innovation Model cooperative agreements. These States are pursuing the shared aim of better care and improved population health at a lower cost, using their Medicaid programs as a catalyst for system improvements that embrace not just Medicaid, but Medicare and private payers and private providers as well.

Medicaid is surely a complex program, but it is also a very dynamic program. It is also surely open to improvement, as is anything that we have created. But fundamentally, as I look out at the experience of the States and what is going on out in the field, I see a program that works for America's most vulnerable.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

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[The prepared statement of Mr. Weil follows:]

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Mr. Pitts. And now recognize Mr. Bragdon for 5 minutes for an opening statement.

STATEMENT OF TARREN BRAGDON

Mr. Bragdon. Thank you, Mr. Chairman, members of the committee. I serve as the CEO of the Foundation for Government Accountability. We are a Naples, Florida-based free market think tank specializing in State health and welfare policy solutions.

Medicaid in its current form, or Old Medicaid, represents, as you have heard, the single largest and fastest growing line item in State budgets, consuming about one in four State dollars. At the Federal level, Medicaid spending represents about a quarter of deficit spending and is projected to double over the next decade.

Given these cost projections, Medicaid is failing the American taxpayer. But more importantly, it is failing the patients that it is supposed to represent. Poor access to specialists, the inability to personalize care, and perverse eligibility requirements keep too many Americans poor and sick and rob them of the hope of a better life. And for many Americans, Old Medicaid is not a safety net, but it is a tightrope, and patients are falling off every day.

Because of the Affordable Care Act, many States are debating whether or not they should expand their broken Old Medicaid systems.

This debate is a misguided priority. The real priority for States should be not expansion, but rather to make Medicaid work for the most vulnerable. And Congress can help State leaders by creating more flexibility at the Federal level to do that.

When States have flexibility to innovate and reform Old Medicaid, truly patient-centered care can be a reality. And one of the many pro-patient strategies working in the States are giving Medicaid patients the power to choose from several different competing private plans. Old Medicaid typically forces patients into one or two government-run plans, and this government-centered approach ignores that Medicaid patients have unique needs and individual concerns. But in States where Medicaid patients have a robust choice of plans, such as Florida, Kansas, and Louisiana, patients are our priority. For example, in Florida's Medicaid Reform Pilot, patients can choose from 13 different private plans and 31 different customized benefit packages. A commonsense funding formula in these States features risk-adjusted capitated rates so these private plans earn more money to enroll sicker patients and have the incentives to improve health and disincentives to cherry-pick.

Because plans compete for patient enrollment, they also are constantly striving to improve access to specialists, offer more specialized services, and enhance their customer service. And patients like this choice, with 70 to 80 percent of Medicaid patients

proactively choosing a plan rather than being automatically assigned to one.

This choice structure also promotes better health outcomes. Again, in Florida's Reform Pilot, the private plans in the reform outperformed Old Medicaid on 22 of 33 widely tracked health outcomes, and 94 percent of those health outcomes had improved since 2008. And when this reform goes statewide in Florida, taxpayers will save a billion dollars a year. And similar savings are occurring in Kansas -- a billion over 5 years -- and Louisiana -- $150 million in the first year. My written testimony includes details of other strategies that States have embraced, including integrating work with health outcomes, promoting specialty plans, and unleashing innovation to better serve patients.

But Federal rules and regulations can make it difficult for States to innovate, including the slow and inflexible waiver process, new taxes on private Medicaid plans, and additional cost shifts to the States. Luckily, this committee is exploring ways that Congress can make State reform easier and grant additional flexibility, and many of these reforms are detailed in my testimony, including allowing proven waivers to become seamlessly incorporated into State plan amendments, providing greater flexibility on mandatory and optional services, and creating an off-ramp that lets patients safely transition off Medicaid toward self-sufficiency in the hope of a better life.

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To make Medicaid work for the most vulnerable, Congress should recognize that proven pro-patient, pro-taxpayer solutions are out there. And there are strategies that can make it easier for State leaders and for patients to make Medicaid work for both patients and taxpayers. And I am happy to discuss that more in the questions. Thank you.

Mr. Pitts. The chair thanks the gentleman and thanks the witnesses for their opening statements.

[The prepared statement of Mr. Bragdon follows:]

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Mr. Pitts. We will now begin questioning. I will recognize myself 5 minutes for that purpose.

For the Nation's vulnerable citizens, having Medicaid does not always result in good health care. Studies have shown that while enrollment is growing rapidly, with more than 70 million Americans enrolled in Medicaid at some point in 2012, access to quality care is still a struggle for most. The new health care law proposes the largest expansion of Medicaid in history, an expansion that is clearly built on a framework that is already failing to meet current obligations in helping our most vulnerable citizens.

Mr. Bragdon, in your testimony you note that States should be cautious in opting into Medicaid expansion. At this point, the majority of States are either not expanding or are still undecided. What are some considerations you would raise with States that are still deliberating the decision to expand in 2014?

Mr. Bragdon. Thank you for the question.

When you look at States that have expanded Medicaid in the past, the two States that have most closely replicated the expansion of the Affordable Care Act are Maine and Arizona. And the realities of those States were much higher per-person cost, much higher per-enrollee cost, and many more people enrolling than originally projected. And what happened was, as that safety net was stretched further and further, those States proposed and did cut services to the most vulnerable.

Arizona stopped covering heart and lung transplants. Maine proposed cutting services to folks with brain injury and stopped paying their hospitals altogether, mounting $400 million in unpaid bills dating back over 5 years.

So what happens as States expand is the most vulnerable, who tends to be higher cost, as was mentioned, the services are cut back on those individuals first.

Mr. Pitts. Ms. Owcharenko, would you respond to that question as well?

Ms. Owcharenko. Sure. I think the primary caution I would give to the States is you have to take the long view of what the future of Medicaid is going to look like versus just the short view. I think the temptation of the bump in Federal dollars to the States is a tempting offer, but it has a very short-term impact. And I think States need to take the longer view, not only for their own State taxpayers, but for Federal taxpayers who their constituencies are as well. So looking at what are the implications at the Federal level, understanding that our country cannot survive on the spending path that we have today.

Mr. Pitts. Now, in your testimony you mention some of the innovations States are pursuing. From your experience, what are some of the barriers that States face in pursuing new innovative delivery models, such as those outlined in your testimony?

Ms. Owcharenko. Well, I think one of the things that has been

mentioned by many of the folks here is the lack of flexibility at the Federal level. Too many times the States have to figure out which holes to jump through, how to get things done. Even if we think that they are making progress today under current rules, imagine what States could do if they had greater flexibility to do more innovative projects without having to have the constraint of all the Federal requirements on there. I think that would probably be the best direction for the States to take and the Federal Government to enable them to.

Mr. Pitts. Each of you have highlighted the value of managed care and increased care coordination in the Medicaid program that moves us away from Medicaid's flawed fee-for-service history, and it improves care and reduces costs. If given one opportunity, what would be an important policy reform to pursue that would allow for States to more easily pursue managed care models for Medicaid? If each of you would respond. Start with you, Ms. Owcharenko.

Ms. Owcharenko. I think expanding without having to do so many waivers on the populations that could be included. I would argue that the States know best when they are trying to develop and deliver care to the most vulnerable, which groups they think are best suited for the managed care approach.

I would also note, though, that it is not just good enough to have one managed care plan. What you want is insurers competing against each other. And so making sure that there is competition and giving

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the patients the choice to choose I think will alleviate concern that there may not be a plan that is best suited for the most vulnerable.

Mr. Pitts. Mr. Weil.

Mr. Weil. The rapid movement of States in their Medicaid population toward managed care makes it hard for me to see that there is a major Federal barrier to reliance on managed care. The primary area that remains a challenge is integration with the Medicare program. We do have some demonstrations going on right now designed to enable alignment of managed care plans between Medicare and Medicaid. I think we are going to have to see how that evolves. But that, to me, is the population that faces the largest barriers in that movement.

Mr. Pitts. Mr. Bragdon.

Mr. Bragdon. Thank you. I think there are a few different things. One, looking at the robust competition among private plans. Nobody is suggesting that Medicaid not set the floor of benefits that should be available in those private plans. But as the plans build on top of that, you can provide much more comprehensive care that Old Medicaid does not. For example, Kansas added a dental benefit when they moved to a private plan. GED services so that individuals could ultimately get the best safety net, which is a good-paying job. Florida shows how when you give people choice and choice counseling, which I think is an important component, so that patients understand the differences among those private plans.

I think lastly, there is this debate over mandatory versus voluntary private care. But when you look at how patients vote with their feet, patients appreciate having robust choices of several different private plans. In Kansas, Native Americans are given a choice of whether to choose from one of the three different private plans or opting back into Old Medicaid. Out of 4,000, only 12 stayed in Old Medicaid. Louisiana, 0.3 percent of people voluntarily chose Old Medicaid versus five different private plans.

Mr. Pitts. Thank you.

The chair recognize the ranking member, Mr. Sarbanes, for 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman. I want to thank our panelists today.

Mr. Weil, Ms. Owcharenko mentioned challenges to the Medicaid program. And I didn't hear that that necessarily formed an indictment of the program overall, but it just laid out what some of the challenges are. I wanted to get maybe your reaction to those challenges, whether you think the Medicaid program can handle them.

So the first one obviously is the demographic challenge that is coming at us, particularly the baby boomer generation and the implications that has for the Medicaid program, and this notion of competition within the diversity of the pool of beneficiaries that is covered by the Medicaid program. These are realities we are going to

have to deal with. My sense is an expanded Medicaid program that we are trying to make better every day is going to be best equipped to handle that challenge.

She spoke of structural challenges -- for example, relating to payment rates. Did acknowledge that in 2013 and 2014 there is an attempt made to achieve 100 percent parity with Medicare rates for primary care. That is a good step in the right direction. And then spoke of the fiscal challenges ahead of us, with entitlement programs or, as I often refer to them, earned benefit programs in some instances.

But your testimony suggested that in some ways Medicaid is on the cutting edge with respect to innovations that not only can improve care, particularly care that one might put under the heading of sort of public health. When you look at children, developmental screening, where what the Medicaid program does is really cutting edge, ahead of both the commercial arena and potentially even Medicare there. The dental care for children and patient-centered medical homes. Among many examples you gave, these are things -- particularly the last one I mentioned -- that can improve efficiencies and save costs over the long run. And it is really because of ACA that we are going to see some opportunities for that.

So can you address these challenges, the demographic, structural, fiscal, and other challenges you see, and why an expanded Medicaid program in some ways may be best equipped to handle them?

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Mr. Weil. Thank you, Mr. Sarbanes, for the question.

The demographic challenges are real. They affect Medicare as well as Medicaid. We can't ignore the reality that we are aging and they will increase the average cost per person.

But I think against that backdrop it is worth noting that despite aging of the population, the Medicaid nursing home census has stayed flat despite the aging of the population, that our use of home- and community-based services grows, and some leading States have really shown us how to not just prevent people from going into nursing homes in the first place but help them come home even after they have been resident there for some time. Washington State is a leader in that regard.

With respect to your question about expansion, I think we need to be careful about what I heard the repeated use of the term able-bodied adults, as if somehow they don't need health insurance. If they are not sick, then the good news is they won't cost us any money. So we shouldn't be so worried about providing them with coverage. But everyone gets sick, sometimes more than others, or they may have chronic conditions that are untreated, that getting them early care will actually reduce the overall cost. And we know there is growing prevalence of chronic conditions, particularly among the target populations in the Medicaid expansion.

The issue here is, are we going to move this population into a

system where there is someone responsible for managing their care, a State and Federal Government responsible for paying, and usually a private plan -- and I should note, most States offer their Medicaid enrollees a choice of plans -- a private plan that is interested in maintaining health or do we just leave them the alternative? The only alternative I am aware of is that they are uninsured and no one is accountable for improving results.

And similarly, I will readily admit that Medicaid payment rates are below commercial and in some instances below Medicare rates. But again, I think we have to ask, compared to what? These are people who would otherwise be uninsured. There would be no payment source for them. There are mission-driven providers and other providers that have a broad cross-section of patients that understand that they are going to subsidize care for some in order to serve others. And Medicaid helps alleviate the burden, although it does not completely eliminate it.

So these are challenges. But my experience is that States observe them, look ahead, and are doing what they can to tackle them within the design of the current program.

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

Mr. Pitts. The chair thanks the gentleman.

Now recognize the vice chairman, Dr. Burgess, for 5 minutes of questioning.

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Dr. Burgess. Thank the chairman for the recognition.

Ms. Owcharenko, let me ask you, we have heard it mentioned several times in the opening statements and I believe in your testimony about low provider rates and how that affects access for Medicaid patients. So low provider reimbursement rates. Medicaid is a shared Federal and State responsibility. So how can the Federal Government ensure provider rates are set at levels that will encourage participation?

Ms. Owcharenko. Well, I think one of the points is that you have to contrast it with the fiscal challenges. So if you have provider payment issues, you are not paying providers enough, then the easy solution is to say, well, just pay them more. Well, to pay them more you have to pay for that, and so someone is going to have to pay for that. The States have decided in many instances they are not willing to spend the money to the Medicare levels; otherwise, they wouldn't have had the Federal Government come in for the temporary boost.

The challenge is, what happens when that boost is gone? Can the Federal Government continue to provide that type of a level of reimbursement? I think that is the whole problem we have with Medicaid in the long term, is it sustainable from a fiscal standpoint?

Dr. Burgess. Well, let me just ask you, for that 2-year interval, who is responsible for paying those increased rates?

Ms. Owcharenko. Well, the Federal Government. Well the Federal taxpayers are paying that.

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Dr. Burgess. Then past 2015?

Ms. Owcharenko. It will go back to the States. And as the MACPAC study said, many States are already saying that it is doubtful that they will be able to keep and sustain that level. So the challenge will be, the States will be back here in Washington saying, we need more Federal dollars, and we don't want them temporary, we want them permanent. Well, then, the Federal Government is going to have to find the money, if they are going to go down that road. And I just would argue that the Federal Government doesn't have the money today to be continuing that type of spending.

Dr. Burgess. We have actually seen that movie before. The stimulus, in February of 2009, provided an 18-month bump-up in Medicaid reimbursement rates, as it was about to run out in August of 2010. As I recall, we had to have an emergency meeting of Congress in the middle of the August recess -- one of the few times that has happened, except for war and pestilence -- and the purpose of that was to pass a supplementary stimulus bill to augment those Medicaid rates. For the record, I voted against it both times.

Let me just ask you a question, because we are looking at the -- you have States that have agreed with Medicaid expansion and some that have not. Now, the Supreme Court in their wisdom said that you could not make acceptance of the standard Medicaid, regular Medicaid contingent upon the acceptance of the expansion. So States

actually have some leeway there. The deadlines for the exchanges, since this expansion of Medicaid was not set in Federal statute but rather by a court directive, there are no dates, there are no drop dead dates for the States. So actually, wouldn't a State be well advised to see what happens in a few other States before they jump into this?

Ms. Owcharenko. I think with the complexity that we see the healthcare law facing, I think it would be wise for States to think again for the long term and see how this plays out. I think this will be an annual debate I think moving forward as well.

Dr. Burgess. But at this present time, there is no penalty for a State that says, not now.

Ms. Owcharenko. That is correct. That is correct.

Dr. Burgess. And they can always revisit it in subsequent legislative sessions in the future.

Ms. Owcharenko. That is correct.

Dr. Burgess. When you get back to getting the providers to get back into the system, I can remember in Texas in the early 1990s, the State said, look, we will cover your first $100,000 in medical liability claims for Medicaid patients if you agree to see a certain number. That program did not last very long. I presume it was a cost-related factor. But it seems that something along those lines, to encourage providers to come back into the system, would make a great deal of sense.

Is there flexibility built into this Medicaid expansion that

would allow States to do that?

Ms. Owcharenko. I am not familiar with any at this time. But the other panelists may know more than I do on that.

Dr. Burgess. Mr. Weil, let me ask you a question, because you mentioned something about the Center for Medicare & Medicaid Innovation and the use of -- what did you describe it as, multipayer systems? Could you provide us a reference for that? I would be interested in what the data was that CMMI used to make that determination, how much money was forwarded in those grants. Do you have that information available? If not today, could you make it available to us?

Mr. Weil. Yes, Mr. Burgess. I would be happy to. That is public information. We are quite early in these cooperative agreements. But the States that were awarded them, what they intend to do with the funds, that is all public. It is available from CMS, and I am happy to supply it to you.

[The information follows:]

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Dr. Burgess. All right. I would appreciate you making that available. My experience with CMMI has not been that great. It seems to be a bureaucracy that not even a bureaucrat could love. But I would be interested in what you base those statements on.

Thanks, Mr. Chairman. I will yield back.

Mr. Pitts. Chair thanks the gentleman.

Now recognize the distinguished ranking member emeritus, Mr. Dingell, 5 minutes of questions.

Mr. Dingell. Mr. Chairman, I thank you for your courtesy, and I commend you for holding this important hearing today.

Medicaid is a critical program. It provides health insurance to the most vulnerable in our society. Many States, including my own State of Michigan, are currently deciding whether to expand their Medicaid programs under the Affordable Care Act. I believe expanding the program was the right thing to do because it is going to expand health care to millions of Americans who desperately need it.

These questions are for Mr. Weil of the National Academy for State Health Policy.

Mr. Weil, in your testimony you note that Medicaid is a source of insurance coverage for one out of three children. Is that correct? Yes or no?

Mr. Weil. Yes, sir.

Mr. Dingell. Now, Mr. Weil, children and their parents account

for 75 percent of Medicaid enrollees. Is that correct? Yes or no?

Mr. Weil. Yes, that is correct.

Mr. Dingell. And this population accounts for only 34 percent of the spending in the program. Is that correct? Yes or no?

Mr. Weil. Yes.

Mr. Dingell. One area where Medicaid has been very innovative is the area of developmental screening for children which helps promote early detection and prevention of healthcare problems? Mr. Weil, how many States require Medicaid providers to perform developmental screenings on children as a part of routine exams? I believe the number is 14. Is that right?

Mr. Weil. That sounds right.

Mr. Dingell. They are not, however, required to require this kind of work. Is that correct?

Mr. Weil. That is right.

Mr. Dingell. Now, Mr. Weil, recently we have seen the national percentage of children receiving developmental screening rise from 19.5 percent in 2007 to 30.8 percent in 2012. Is that correct?

Mr. Weil. Yes, sir.

Mr. Dingell. This is a great improvement, and I believe Medicaid's innovation in this area has helped increase the number of children that undergo developmental screening tests. Mr. Weil, is it correct that a child with public health insurance is now more likely

to receive a developmental screening than a child with private insurance? Yes or no?

Mr. Weil. Yes, it is.

Mr. Dingell. Now, Mr. Weil, oral health is another area where State Medicare programs are successfully implementing innovative programs and are seeing positive results. Isn't that so?

Mr. Weil. Yes, it is.

Mr. Dingell. Now, Mr. Weil, do you believe that the reforms in North Carolina and Washington, with which I think you are familiar, which you described in your testimony, have led to positive health outcomes and are models for other States to follow. Is that right or wrong?

Mr. Weil. Yes, it is.

Mr. Dingell. Now finally, a recent study in the New England Journal of Medicine studied the impact that expanding Medicaid has on mortality rates. So, Mr. Weil, do you agree with the conclusion of this study that expanding Medicaid will lead to lower rates within the States that do it? Yes or no?

Mr. Weil. I believe the strongest evidence says that expanding Medicaid will reduce mortality. That is correct.

Mr. Dingell. I very much thank you for this.

I believe Medicaid brings real health benefits to our vulnerable populations. The States are currently coming up with new, innovative

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strategies to improve access to care.

As States across the Nation, including my own State of Michigan, are debating whether to expand Medicare or not, I hope they will look at this evidence as how the program is working to improve health outcomes for millions of Americans. States should also consider the financial benefits for expanding Medicaid as well. Michigan alone could save $1 billion over the next 10 years if they chose to expand Medicaid, which I hope they will do.

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DCMN ROSEN

[5:00 p.m.]

Mr. Dingell. I hope this committee will continue to examine this issue in a bipartisan manner.

Mr. Weil, you have been most helpful to us.

Thank you, Mr. Chairman. I yield back 1 minute and 15 seconds.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questions.

Dr. Gingrey. Mr. Chairman, thank you.

Let me -- I want to address the first question to Ms. Owcharenko. Much has been said that the Medicaid waiver program offers States all the flexibility that they need to improve and reform their programs, the existing waiver program.

As you know, this administration is a strong supporter of the Medicaid population expansion, you said up to 138 percent of the Federal poverty level. May there be an opportunity for the administration to intentionally withhold waiver determinations if the State does not get with the program and expand?

Ms. Owcharenko. I can't speculate, but we do know the waiver process is long and cumbersome, and you don't know when, there is no time limit on how long a process may take or the complexity of the

waiver. But we also need to recognize, too, that the waiver is dictated by the statute. There are only certain things that can be waived and so to the point that you want to do something above and beyond what the statute allows you to, that still is a limitation, but I can't speculate.

Dr. Gingrey. Well, Mr. Chairman, we have seen this administration continually use almost coercive methods to aid implementation of the law. Allowing Medicaid waivers as the only process for States to innovate seems to offer the administration a situation ripe for abuse. This is why we need to repeal the Medicaid and CHIP maintenance of effort provisions and give States a chance to truly innovate.

Continuing along that line, the maintenance of effort provisions in Obamacare have not only been costly, but they have been a barrier to reforms. That is why I introduced H.R. 1472, the State Flexibility Act to repeal PPACA Medicaid and CHIP provisions in the President's health care law, repeal the maintenance of effort.

In these difficult fiscal times, States often must make cuts to other non-mandated programs, such as education, because they don't have the flexibility to improve their existing Medicaid programs. In other words, get rid of people that are on the rolls that shouldn't be there that maybe 2 years ago, 3 years ago, prior to PPACA, these people were eligible but now they are making $75,000 a year, and they are frozen

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on the program.

Would you please explain to the panel how these provisions increase costs to both the States and the Federal Government and actually hamper patient outcomes?

Ms. Owcharenko. I would say that the maintenance of effort freeze really does take a tool out of the toolbox that States have to work within their budgets within their means and within their budgets to provide the care to who they feel are the most vulnerable and the most needy. Again, getting back to the flexibility for the States, I think the closer the policymakers are to what is going on on the ground at the State level, the better are suited in deciding who should get the care, where the adaptation should be, where we can scale back maybe, or where policy should be increased.

Dr. Gingrey. Well, I'm just thinking that if they didn't have that maintenance of effort provision and they were able to kind of clean up the rolls, if you will, then maybe some of these States would be willing to expand, because they wouldn't be throwing money at people that really don't need it. Mr. Bragdon, would you care to comment on that as well?

Mr. Bragdon. Thank you. I think that you are touching on an important point that when you look at how States can customize their Medicaid programs, that you need different solutions for different populations, and you also need a very dynamic toolkit, if you will.

In Florida, for example, the average single mother who is on welfare, or on TANF and receiving Medicaid is on the program for 5 months. And so for those individuals, it is also about creating some sort of off-ramp, because what happens now is you are on Medicaid, you may be in a private plan you like, but there is no ability to keep that private plan once you go off the program, there is no ability to even become aware of what is available to people --

Dr. Gingrey. I'm going to interrupt you because I just have 30 seconds left. I want to make this comment. And I thought about this of course 3-1/2 years ago right here when we were in the minority on the side when this bill was being developed, and this Medicaid expansion, up to 138 percent of the Federal poverty level, where would those people get their care if they were not eligible for Medicaid? They would get it on the exchanges and the provision that goes to them would be all Federal dollars. They wouldn't be State dollars. So it is really a game of moving the hat around to see where the pea is.

You clearly, that was a setup so that there would be less Federal costs and more burden on the backs of the States. And I yield back.

Mr. Pitts. The chair thanks the gentleman.

The chair now recognizes the gentlelady from Florida, Ms. Castor.

Ms. Castor. Thank you very much, Mr. Chairman.

Thank you to the panel.

This is a very important topic, and as Mr. Weil testified, there

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are so many exciting innovations going on all across the country when it comes to Medicaid that is the lifeline for families and seniors and children and disabled.

I have wanted to, I think it is very important that we share and understand what is happening in these innovations. We do this on a regular basis for those that are interested in the children's health care caucus that I co-chair with Republican Congressman Dave Reichert from Washington State where we educate staffers across Capitol Hill, other policymakers, Members, and we have another of our Medicaid matters for kids sessions this Friday here in the Rayburn building at 12 o'clock, and I would like to thank First Focus Campaign For Children, all the children's hospitals across the country, the pediatricians, the Kaiser Family Foundation for helping to organize these very important Medicaid educational sessions. The one on Friday is called "Unlocking Ideas to Improve Care For Kids on Medicaid."

One of the most exciting innovations I know of in Florida in my home town at St. Joseph's Hospital is their complex, their chronic complex clinic for children. It has been running for 12 years now. It provides continuous comprehensive and coordinated care for the most medically needed children in our community. The clinic was organized after years and years of watching children cycle through the emergency room without a real focus on their ongoing health care needs. The hospitals desperately wanted someone to provide them with coordinated

care. So the clinic came together. It now serves over 1,000 children in the Tampa Bay area with a great team of pediatricians, pediatric nutritionists, nurses, social workers and many others. The families in my area love this clinic. And we also appreciate the fact that it saves $6,000 per patient per year in hospital costs alone and some national studies say that we are saving closer to 10,000 a year. That is one of the innovations that I am excited about.

Mr. Weil, name another one where you, where things are going right under Medicaid, this important Federal/State partnership.

Mr. Weil. Well, I think some of the most exciting work is in the area of patients in medical homes and health homes where what we are trying to do is take a health care system, not just in Medicaid but in the system at large that primarily sends its resources to the most expensive settings for care for hospitals, for institutional care and build out, as you described in the scenario you described, build out an infrastructure of the kind of care people need at a better touch, it is closer to the community, it is less expensive, it is less episodic, it is more continuous, and also, and I think some of the best innovations going on now are about bringing in mental health into how we think about delivering health care. We have traditionally had very strong lines and barriers between these systems, different funding streams, different programs, and we are understanding that people with untreated mental health conditions cost more in physical health, and that the

relationship between the two requires a different model of care. We are seeing it in oral health. I including included a few examples in my written testimony.

And what is great about these kinds of innovations is that Medicaid is a part, sometimes it is a leader, sometimes it is a follower, but most providers of services within Medicaid also provide services to privately covered folks, and if they are, if it is not pediatric care, they are usually in Medicare as well.

So the interesting exciting innovation, the most interesting exciting, from my perspective, is when Medicaid is part of a broader conversation across public and private payers and providers, physicians and hospitals and others to fundamentally rethink how people get care, and then pays in a way that supports that as opposed to just writing checks for services that people need.

Ms. Castor. I think you are right. I think you are right.

And Mr. Bragdon, I know you did not mean to mislead this committee by heralding the great success of Florida's Medicaid privatization. The statewide waiver was just approved a couple of weeks ago. So be careful when you testifying in front of Congress. And then the pilot program of Medicaid privatization was known as a real disaster. The State's own study condemned the results. We had patients unable to gain access. We had providers, private providers leave the State.

So be careful when you testify before Congress and saying this

is a great success when the evidence and everyone across the board has really condemned what has happened. We are more hopeful with the new waiver and privatization, it is like night and day. There are broad new conditions for consumer protections. Providers, if they back out and leave, are going to be penalized, their medical loss ratios.

So those are some of the innovations that can happen with that important Federal/State partnership. But you have got to, you really have to do your homework on what has happened in the past and what is actually happening moving forward. Thank you.

Mr. Pitts. The gentlelady's time has expired. The chair recognizes gentleman from Louisiana, Dr. Cassidy 5 minutes for questions.

Dr. Cassidy. Thank you, Mr. Chairman. Mr. Weil, I am a doctor who takes care of Medicaid patients in a public hospital clinic, so I am very familiar that Medicaid can actually have a beneficial effect. But I think there are some things kind of in the interest of Ms. Castor's kind of fact check sort of thing.

Let's first talk about the paper that Mr. Dingell referenced that showed an all-cause decreased mortality after Medicaid expansion. Now, I happened to have read that article and I happened to know and I looked it up just to confirm. In Maine, actually mortality increased after Medicaid expansion. The authors point out only in New York was there a statistically significant effect of decreased mortality, and

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that overwhelmed the increased mortality in Maine and the no significant effect in Arizona.

So would you disagree with that table which I am looking straight at or would you acknowledge that, indeed, it is only one-State specific and indeed, if we were to look at Maine, we would actually see an increase in mortality after Medicaid expansion?

Mr. Weil. I will happily defer to you looking at the table and say that as you know as a clinician, you never want to take your conclusions too far based on one or two studies and I think we are right now in an environment where people are looking at one or two studies and using it to caricature a program. So I appreciate your clarification very much.

Dr. Cassidy. Secondly I also point out and you were very careful in your testimony to say that Medicaid prevents people from having financial duress, but you did not make the claim that it improves health. And again, as you and I both know the National Bureau of Economic Research found in their Oregon study that when, and I am quoting from their conclusions, this randomized controlled study showed that Medicaid coverage had generated no significant improvements in measured physical health outcomes in the first 2 years, but it did reduce financial strain.

So it also make its clear that the best study from NBER has shown that Medicaid expansion did not improve health outcomes.

And lastly I will say that in your -- by the way, I enjoyed everybody's testimony and I don't mean to challenge, I am just trying to point this out, you seem to suggest in your testimony that the choice is dichotomous, either somebody is uninsured or they are on Medicaid. But then I will quote another National Bureau of Economic Research study, again, by Mr. Gruber, who is a big backer of Obamacare, who points out that 60 percent of the children that go on to a public insurance program actually formally had private insurance but the expansion of the public insurance crowded out, if you will, the private insurance so it is not the employer or the family paying the bill, it is now a taxpayer paying the bill. And that is 60 percent.

Any comments upon that because again, it is not -- you know where I am going with that.

Mr. Weil. Well, I do have to begin by commenting on your characterization of the first study. First of all, there were, as you know, demonstrated positive effects on depression, so the physical health word is important. But I don't think it shows that it did not improve outcomes. I think it didn't show that it improves outcomes. And I think those are actually quite different. We don't --

Dr. Cassidy. But if question take the no hypothesis we really cannot claim a benefit unless the benefit was shown.

Mr. Weil. I completely agree with you. We cannot claim a benefit unless the benefit is shown. That does not equate with the

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absence of benefit, it simply means we were unable to show a benefit. And since you are being very careful, I am going to ask that we be equally careful in that regard.

The literature on crowd-out which used to be a very hotly debated topic and has faded from view for some time has great complexity about what you count as the numerator and the denominator. We know that low and moderate income people and families, their income fluctuates and they do gain different sources of coverage, although the prevalence of private coverage --

Dr. Cassidy. I only have a minute left.

Mr. Weil. I am sorry. My sense would just be, I don't think that we can state on the basis of the Gruber study that 60 percent of those children would still have private coverage if they did not public coverage.

Dr. Cassidy. Maybe. I will say they had 400,000 observations, and Gruber obviously is, one, respected and, two, a big backer of the Obamacare, so it is not like he is trying to find something to trash himself.

Lastly, is there a philosophical difference if a State is going to manage care and they are going to capitate payment to the insurance plan, is there any difference in facts that if the Federal Government gives only a set amount of money to the State, which, in turn, gives a set amount of money to the insurance plan? Is there any kind of

difference in that?

Mr. Weil. Well, yes, a plan organizes and finances the delivery of care. A State organizes the policy environment for that finance and delivery, so they are akin, but I think they have different effects.

Dr. Cassidy. But if you give $100 to the State to care for somebody and the State gives 90 to the insurance plan, that really is the same mechanism, the capitated payment in each case.

Mr. Weil. If 100 percent of the cost were through capitation, and it was just who wrote the bill, then I would agree it is the same, but that is not how I see the program.

Dr. Cassidy. Okay, that may be an issue of perception. I yield back.

Mr. Pitts. Mr. Bragdon, did you want to respond to Ms. Castor's remarks regarding Florida reforms? I apologize that she had to leave, but I wanted to give you an opportunity to respond quickly. Please.

Mr. Bragdon. Thank you, Mr. Chairman, I appreciate the opportunity.

In my testimony, I referred to the Florida reform pilot. The facts are very clear: The Florida reform pilot outperformed on health outcomes in 64 percent of the cases. It had higher levels of patient satisfaction in 82 percent of the cases. But perhaps the best validation of how this approach of patient-centered pro-patient/pro-taxpayer is working is the fact that the Obama

administration approved the waiver.

This is a proven bipartisan approach that saves money, improves health and produces more satisfied patients. And would be happy to provide further information to the Congresswoman so she can understand that.

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

Dr. Christensen. Thank you, Mr. Chairman, and thank you for the hearing, and welcome to our panelists.

And Mr. Weil, my first question was really about Medicaid flexibility, but I think your testimony and the answers that you have given really have demonstrated that flexibility and innovation are not only possible, but they are happening in different States across the country and improving access and actually in some of the cases you cited, improving outcomes as well. Improved outcomes is what we are all looking to achieve here.

I am sure that all of you are familiar with the 2002 IOM Report on Unequal Treatment, a report that demonstrated bias and discrimination in health care, in the health care of racial and ethnic minorities, still in other studies, more recent studies since that have demonstrated the same as it relates to cardiac care and other medical conditions.

We know that racial and ethnic minorities make up at least 58 percent of non-elderly Medicaid enrollees. And in addition to that, the prior low reimbursement rates, limited accesses to providers, and even when there were providers, some of the needed ancillary services were not available in the neighborhood because of how Medicaid was paid for before the Affordable Care Act.

So Mr. Weil, don't you think these factors have some impact and import on whether, even with Medicaid being available and access to health care being available, don't those factors parallel? We haven't even talked about the socio and economic determinants of health that are not changing in those communities.

Mr. Weil. Well, I appreciate the question and the observation. I am struck by how frequently I hear people repeat the phrase that Medicaid is a lousy, broken program because people on it, and then they fill in the blank. The people on it are poorer and sicker and disproportionately nonwhite, and as you indicated there is a strong evidence based in all of those areas that health outcomes are worse regardless of source of coverage, and very rarely do people make an effort to actually control for it, because it is impossible to control --

Dr. Christensen. Even regardless of income level and education level.

Mr. Weil. So we know, for example, that lower income Americans

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are less likely to use health care services whether they have private or public coverage because they are less comfortable -- on average, they are less comfortable with the system, less able to navigate it, and providers seeking payment are less likely to locate in the places where they live. To indict the Medicaid program for the outcome of that seems to me a bit odd.

Dr. Christensen. I agree and thank you because when those inequities are addressed then the socioeconomic determinants of health when they are addressed in poor and racial and ethnic minority communities and rural communities, and some of the reforms that you have cited in the different States are more widely adopted, I think we will see those changes. And we are seeing changes where those things are happening. They are really making a difference in improved care for vulnerable patients for whom Medicaid has been their lifeline.

The Affordable Care Act recognizes that we needed to begin to make Medicaid a stronger safety net. The law, along with State changes, is already beginning to make a difference. The Republican-recommended reforms really are not designed, as I see it, and I am a practice, I was a practicing family physician to help the vulnerable. I think they run the risk of reducing access to care and leaving some of our most vulnerable out of the health care system entirely.

Let me see if I can fit in one other question.

The Affordable Care Act includes a provision which will provide

additional payment to certain Medicaid providers for primary care services. What impact on access to primary care do you believe that this policy will have? And what other steps can we take to improve access to these important services for our most vulnerable? Dr. Weil.

Mr. Weil. Well, higher payment is certainly a positive, although its temporary nature I think is going to limit the behavioral response on the part of physicians. It is unlikely they are going to fundamentally change where they practice or how they practice for an incentive that they know will last a short period. I think it is important to think of that as a step, as an imperfect step in broader efforts to reorient health care system spending toward primary care and it, in and of itself, is not going to achieve fundamental --

Dr. Christensen. It is 2 years probably because we had to reduce the cost of the bill, and we had to reduce the cost of the bill because we could not score the prevention, the savings from prevention which is something we still need to do. Thank you, Mr. Chairman.

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

Mrs. Ellmers. Thank you, Mr. Chairman, and thank you to our panelists today. I do want to talk a little bit about the North Carolina programs that are moving forward. I am very proud of the work that they are doing in North Carolina. Over, it has grown 90 percent

over the last decade from less than 8 billion annually just a decade ago to more than 14 billion annually as of 2012. North Carolina spends more per person on Medicaid than any of its Southern State neighbors. Recognizing North Carolina's Medicaid failures, Governor McCrory has proposed reforms outlining the State's partnership for a healthy North Carolina. And I commend him for his work, and also, North Carolina Health and Human Services chairwoman, Dr. Aldona Wos, for the work that she has done, and I echo the words of Representative Bert Jones in North Carolina calling it a win-win-win situation because it benefits the patients, it benefits the health care providers, and the taxpayers of our State.

With that, I do want to expand a little bit on the Florida issue, because North Carolina is looking at Florida.

And I do have a question, Mr. Bragdon, for you in relation to some of the discussion that has already gone on. Is it not true that Florida's Medicaid reform demonstration was approved 8 years ago, but only last month did the State receive final approval to go forward with the State reforms? Is that part of the situation that we are talking about?

Mr. Bragdon. Thank you for the question, Congresswoman.

Florida started a reform pilot in five counties, it covered 300,000 individuals, moms and kids as well as those who are on SSI. And then 2 years ago, the legislature voted and the Governor submitted

a waiver to expand that reform pilot to all 67 counties.

Mrs. Ellmers. So it was expansion?

Mr. Bragdon. Correct.

Mrs. Ellmers. Great. So basically obviously we are talking about tough times here, scarce resources, drastically growing enrollment levels. States need to know that they can move forward with reforms, and I know that is part of the discussion that we have been having today.

Unfortunately, they are currently forced to live under the "maybe" or wait-and-see approval Federal agency process that takes years to find out whether or not their demonstration projects can be approved.

From your perspective, Mr. Bragdon, what can be done to improve the Medicaid reform review process by CMS? I am sure that is kind of a broad answer, but if you can give a couple of pointers.

Mr. Bragdon. Thank you for the question. I think first and foremost, States need predictability. You have in the State plan amendment, which is an administrative filing, you have predictability, there are set time frames, if the Federal Government does not act, it is deemed approved. What happens with a waiver is there is no time limit and therefore CMS can drag its feet. In the case of Kansas, CMS approved the waiver 2 days before implementation began.

So what we are seeing is States are playing a game of chicken with

the Federal Government moving forward with implementation with the hope that CMS will act at the last minute, otherwise there will be all this wasted effort.

Mrs. Ellmers. Ms. Owcharenko, I have been practicing your name. Do you want to expand on that at all? Is there anything that you would like to add to that?

Ms. Owcharenko. I think that Tarren made a great point about predictability, and I think that this is one of the things that does have bipartisan or nonpartisan issue which is, how can you improve the innovations that are happening in the State faster so that you get more results so that people can study the results to say does this work? Does this not work? And I think that that is one thing I think that people can come together to look at is how do you speed up the process, and allow a lot more innovation at the State level without having the barriers.

Mrs. Ellmers. Keeping that in mind, right now with Medicaid enrollment at over 70 million, one in four Americans expected to become a Medicaid beneficiary as a result of the ACA, do you believe there are measures in place to ensure proper eligib -- after a week being back in North Carolina I can't speak today -- eligibility verification?

Ms. Owcharenko. I think that it is actually even before the Affordable Care Act, the trend has been going in the opposite direction with presumptive eligibility, express lane eligibility, those things

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kind of move in the opposite direction. I think with the massive complexity of this health care law, I think it is important that there are some stronger eligibility processes in place, not only for Medicaid, but on the exchange side as well.

Mrs. Ellmers. Thank you so much. Mr. Bragdon, I have about one second. Is there anything you would like to add?

Mr. Bragdon. Ditto.

Mrs. Ellmers. Thank you, and I yield back the remainder of my time.

Mr. Pitts. The chair thanks the gentlelady and now recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. Bilirakis. Mr. Chairman, I thank you for holding this hearing, and I thank the panel for the testimony.

Mr. Bragdon, under the current law the system seems to be rigged to maintain the status quo in my opinion. If a State tries to reform the system to increase outcomes and reduce costs, they typically don't see most of the savings. How can we transform the system to incentivize States and allow them a greater share of the savings?

Mr. Bragdon. Thank you for the question, Congressman.

I think that this is really a key factor that is holding States back from innovating. States get to keep only about 40 cents of every dollar that they save, or in the case of expansion, 10 cents out of every dollar that they save. What I think would be a better approach

to promote innovation would be to have shared savings. One of the things that private Medicaid plans do is they share the savings that coordinated care contributes with providers, so providers have an incentive to save money as well as the plan.

It should be the same with the Federal Government to States. Why not allow the States to keep one out of every three, or one out of every two Federal dollars that they save through innovation?

Mr. Bilirakis. Very good. For the panel, what reforms are needed to help beneficiaries transition off Medicaid and on to private insurance? What are the challenges that beneficiaries face? For the panel.

Ms. Owcharenko. I would say, first of all, it is prioritizing the population that not everyone on Medicaid is treated the same, and I think that is for a benefit for the beneficiary. The higher up the income scale, the more access you would likely have to private health insurance and that should be encouraged. The same rules that apply at the higher income should not apply at the lower income and vice versa.

Mr. Weil. I would agree that Medicaid's reliance on private plans makes that transition easier when it occurs, and that States are currently making significant efforts to try to ensure smooth transitions between Medicaid and the exchange. Unfortunately, the biggest barrier to transitioning smoothly from Medicaid into private coverage is that the jobs most people move into when they move off of

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Medicaid don't offer health insurance. And so in the absence of that, there is nothing to transition to.

Mr. Bragdon. I would agree with both responses. I think that you, it is very important to look at for individuals who are on Medicaid, many of them are on Medicaid for a short amount of time, and yet those private plans are prohibited from marketing to them or reaching out to them and just making them aware of here are other options that are available.

And States need to be more creative to create transition products that aren't quite Medicaid private plans but aren't quite private insurance to give people some protection to not only catastrophic coverage, but also preventive services.

Mr. Bilirakis. Is it a good idea to provide diversity of plan options to consumers?

Mr. Bragdon. Thank you. Yes. And I think that the most strong evidence of that is consumers voting with their feet. When you give them a diverse group of plans with meaningful differences, 70 to 80 percent voluntarily pick a plan different than the one they were defaulted into.

Mr. Bilirakis. Mr. Weil?

Mr. Weil. I certainly see advantages to plan choice. It think there are two constraints I would put in that comment. One is that in less populous areas of the country, plan choice doesn't really mean

anything because the real challenge is finding providers and having different administrative structures over them doesn't really provide any value.

And the second constraint is that unfettered choice or unstructured choices can be very hostile, actually, to consumers. The private industry knows very well how to structure choices in ways that help people make choices and not bewilder them. But in general, certainly choice is a key component of the drive to quality.

Mr. Bilirakis. Ms. Owcharenko.

Ms. Owcharenko. I would agree with the panelists and just say, though, that a slight difference a choice of the same product across without any differentiation is kind of choice with no choice, you are not really choosing anything different. So I do think there needs to be some sort of diversification or ability for insurers to offer different types of plans with additional benefits, et cetera, in order to really have what choices.

Mr. Bilirakis. Thank you. One last question if I may, Mr. Chairman. Mr. Bragdon and Ms. Owcharenko, the administration seems focused on expanding Medicaid as you know.

How many people are Medicaid eligible and are not enrolled? Shouldn't we focus on getting care to those groups before we focus on expanding Medicaid?

Also, this expansion of patients will increase the patient load

on the Medicaid system. Has there been an influx in doctors taking Medicaid? I don't think so. What will this patient surge do to the system? And we will start with Mr. Bragdon, please.

Mr. Bragdon. I think there are -- absolutely there are real challenges to access for individuals. A card is not access. And we need to look at can you actually provide access to care?

Ms. Owcharenko. I would just point out that with the question of there are many out there, knowing children, many children that are eligible but not enrolled in the program, raises the question of what is it that keeps those children out? Is it that they -- it is obvious they are eligible. They would qualify. The question is do their parents see that there is value in getting the Medicaid program. As Tarren has pointed out having a card may not be the type of care that best suits them.

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

Mr. Pitts. The chair thanks the gentleman. The chair now recognizes the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. Griffith. Thank you, Mr. Chairman. I appreciate it greatly. Mr. Bragdon, I was looking at your written testimony, and on pages 7 and 8, you go through a process -- you may want to refer to it, although you probably know it like the back of your hand -- where some of the Medicaid programs that rely on some private programs are going to be hit with the tax inside of Obamacare. Could you explain

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that to us more fully than just a one- or two-paragraph response might give to the American people?

Mr. Bragdon. Sure. One of the new funding mechanisms for Affordable Care Act is a new tax on private plans which falls on those private Medicaid plans as well. And so you have this perverse dynamic where the Federal Government is, on one hand, taxing itself and then at the same time, taxing States to raise revenue.

And what is going to happen is States either need to come up with the money or they have to cut services for individuals to pay the tax.

Mr. Griffith. Explain how that works if you can, because I was not here when the bill was passed and I have always been under the impression this was on the wealthier people and on plans that were private plans. Is this because some States have, or work with private-type plans to provide the coverage for their citizens?

Mr. Bragdon. This is not the tax on Cadillac plans. This is a different tax that is essentially a premium tax for private health plans, but those private plans within Medicaid are included within that tax, and that tax over the next decade is going to raise costs from 37 to $42 million for those private Medicaid plans only.

Mr. Griffith. And the number in your report said something like one-fifth of all the money raised by this new tax included in the Obamacare plan is actually a tax that we paid by Medicaid?

Mr. Bragdon. Correct.

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Mr. Griffith. Okay. I appreciate that.

Virginia is looking at a lot of reforms and things before they do the expansion. They set up a special committee, et cetera. And amongst those, I am going to go to a specific question instead of just reciting again the different things that Virginia is looking for, although I think those are good, but one of them is value-based purchasing, and I kind of like that idea that they are looking at. And I think we need to do this in an efficient way that it saves money and provides a greater flexibility to our States. Now obviously, there has to be a balance because you don't want to put a co-pay into that value pricing that keeps people from using services that they may need. So I would ask all of you, from your experience, where have States been able to use that successfully and where has it been not successful?

Mr. Bragdon start with you and then we will just go down the table.

Mr. Bragdon. I think it is key for States to look at value-based purchasing not only innovative things working directly with providers in how do you get better care for individuals, and there are great examples of States doing that to promote more providers participating in the Medicaid program, where you have private plans they pay if the Medicaid patient no-shows, or in some States the plan itself coordinates travel to make sure the patient can actually get to the doctor, but it also add benefits to attract patients. So for example, adding dental benefits, all within that same fixed price, but really

creating taking Medicaid like a floor and building on top of it, which I think is really key.

You have to also look at, are individuals actually getting healthier? Because that is what we want the safety net to do, is take somebody who is poor and sick and make them healthier so they have the hope of a better life. So ultimately, value based should look at, is it improving health?

Mr. Griffith. Absolutely. Mr. Weil.

Mr. Weil. States use their flexibility to set payment rates to promote plans that can demonstrate higher value through standard measures of quality and measures of access.

There is also movement towards what is known as value-based insurance design which is a specific form of value purchasing design to make it less expensive, for example, for people to get maintenance drugs for a chronic condition, maybe even free, because it is actually cheaper to give them free medication than to have them not take the medicine because of a $3 copayment. There is a whole center at the University of Michigan that is helping States and private payers in that area. It is a very active area.

Mr. Griffith. Obviously not easy answers.

Mrs. Owcharenko.

Ms. Owcharenko. Thank you. I think that it actually what has been said is great, and what it shows is that Medicaid has seen kind

of the failure of its past in trying to find ways to be more innovative and in doing things in a more efficient way. But I would caution like in the State of Virginia that those reforms should take place and those results should come through before deciding whether to now add a new expansion population into that making further the complexity of what reform is intended to achieve.

Mr. Griffith. Particularly in light of the fact that the Federal Government is going to reduce the amount of money it gives back to the States for the expansion as time goes by. I do appreciate that.

Mr. Weil, I also appreciate the fact that you are concerned about rural districts. I have a rural district, and while I like the idea of having multiple plans, if folks can't get there it doesn't do us any good. So I do appreciate all of your testimony this afternoon.

And with that, Mr. Chairman, I yield back.

Mr. Pitts. The chair thanks the gentleman. That concludes the questions from the members. Thank you very much, very informative testimony today. There will be questions that members have that will be submitted to you in writing. We ask that you please respond promptly to those questions.

I remind members that they have 10 business days to submit questions for the record, and members should submit their questions by the close of business on Monday, July 22nd.

Without objection, the subcommittee is adjourned.

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[Whereupon, at 5:40 p.m., the committee was adjourned.]