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7 EXAMINING THE ADMINISTRATION'S APPROVAL OF MEDICAID

8 DEMONSTRATION PROJECTS

9 WEDNESDAY, JUNE 24, 2015

10 House of Representatives,

11 Subcommittee on Health

12 Committee on Energy and Commerce

13 Washington, D.C.

14 The Subcommittee met, pursuant to call, at 10:02 a.m.,
15 in Room 2123 of the Rayburn House Office Building, Hon. Joe
16 Pitts [Chairman of the Subcommittee] presiding.

17 Members present: Representatives Pitts, Guthrie,
18 Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith,
19 Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex

20 officio), Green, Capps, Castor, Schrader, Kennedy, Cardenas,
21 and Pallone (ex officio).

22 Staff present: Clay Alspach, Chief Counsel, Health;
23 Leighton Brown, Press Assistant; Noelle Clemente, Press
24 Secretary; Graham Pittman, Legislative Clerk; Michelle
25 Rosenberg, GAO Detailee, Health; Chris Sarley, Policy
26 Coordinator, Environment and Economy; Traci Vitek, Detailee,
27 Health; Dylan Vorbach, Staff Assistant; Greg Watson, Staff
28 Assistant; Tiffany Guarascio, Democratic Deputy Staff
29 Director and Chief Health Advisor; Rachel Pryor, Democratic
30 Health Policy Advisor; Samantha Satchell, Democratic Policy
31 Analyst; and Arielle Woronoff, Democratic Health Counsel.

|
32 Mr. {Pitts.} The subcommittee will come to order. The
33 chairman will recognize himself for an opening statement.

34 Medicaid is a lifeline for some of our Nation's most
35 vulnerable patients. The Administration and Congress have a
36 duty to ensure that taxpayer dollars used for Medicaid are
37 spent in a manner that promotes its core objectives and helps
38 our neediest citizens. Unfortunately, a recent report from
39 the nonpartisan government watchdog agency, the Government
40 Accountability Office (GAO), again raises serious concerns
41 about the Administration's management and oversight of
42 Medicaid funds.

43 Under Section 1115 of the Social Security Act, the
44 Secretary has the authority to approve Medicaid demonstration
45 projects that are likely to promote program objectives.
46 However, the GAO found that CMS did not have explicit
47 criteria for determining whether, and did not clearly
48 articulate how, demonstration projects met the statutory
49 requirement to promote Medicaid objectives. GAO also
50 reported that several state programs approved for federal
51 Medicaid funds appeared, on their face, to be only
52 tangentially related to improving health coverage for low-
53 income individuals.

54 This Committee has a duty to ensure that taxpayer

55 dollars used for Medicaid are spent in a manner that promotes
56 its core objectives and helps the most vulnerable patients.
57 Yet, GAO's findings raise significant questions about the
58 degree to which the Administration is consistently complying
59 with its own criteria. These criteria were not even
60 articulated by CMS until GAO asked. And these criteria do
61 not exist anywhere in CMS's regulations. They are not even
62 listed on their Web site.

63 When CMS has a process that is not transparent nor
64 predictable, a process in which CMS often approves a
65 demonstration for one state but denies a similar demo for
66 another state, that process is, understandably, perceived by
67 states and other stakeholders as inconsistent, unfair, and
68 unaccountable. It is unfortunate that CMS declined to
69 participate in this important hearing, despite our best
70 efforts. We gave the agency 2 weeks' notice, offered 2
71 different potential hearing dates. Nevertheless, despite all
72 the people that work at CMS, the Administration declined to
73 make anyone available to testify.

74 CMS's refusal to come today would be unfortunate under
75 any circumstance, but it is particularly concerning since
76 roughly one in three Medicaid dollars, nearly \$150 billion in
77 fiscal year 2014, are spent on 1115 demonstrations. CMS has
78 a responsibility to Medicaid patients, to states, to

79 taxpayers, to be transparent with their criteria for
80 approving or disapproving state demonstrations. And yet,
81 they declined to come before a committee of jurisdiction to
82 explain their criteria or their process. The agency's
83 absence from this hearing is really striking. Accordingly,
84 yesterday, we extended another invitation to CMS to testify
85 before this committee on Medicaid on July the 8th, and we
86 look forward to their participation.

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

88 ***** COMMITTEE INSERT *****

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89 Mr. {Pitts.} With that, I would like to welcome all of
90 our witnesses for being here today. I look forward to your
91 testimony, and I yield the remainder of my time to the
92 distinguished gentleman from Louisiana, Dr. Bucshon.

93 Mr. {Bucshon.} Thank you, Mr. Chairman.

94 I wanted to briefly highly that the State of Indiana
95 recently received an 1115 waiver for the Medicaid to
96 implement to help the Indiana Plan 2.0. As many of you know,
97 the Healthy Indiana Plan was a very successful program
98 implemented under former Governor Mitch Daniels, and rather
99 than expand traditional Medicaid, Governor Pence created HIP
100 2.0 to cover our state's most vulnerable population, but not
101 require that they go on traditional Medicaid.

102 There are over 283,000 Hoosiers to this point enrolled
103 in the program, and actually 71 percent of those opt to pay
104 in and pay more to get dental and vision coverage. This
105 program can be a model used across the country on how to
106 provide coverage to our most vulnerable population.

107 However, this waiver almost didn't happen. We are going
108 to hear from our witnesses about how complicated this process
109 can be. It took the State of Indiana 2 years; that is one
110 congressional term, to get the waiver. This was not a new
111 program; this was an extension of an already successful

112 program. Not only did it take 2 years, but it took Governor
113 Pence directly reaching out to President Obama several times
114 to get an answer. We received the waiver for 3 years. Let
115 me repeat again, it took 2 years and several conversations
116 directly with the President to get the waiver in place.
117 Something needs to change in this process.

118 I hope that going forward, CMS is going to learn from
119 the hoops that they made Indiana jump through, and make it
120 easier for states like Indiana to do what is already working.
121 I look forward to ensuring Indiana can continue HIP 2.0 when
122 this waiver expires, and to hearing--I look forward to
123 hearing the testimony today.

124 I yield back.

125 [The prepared statement of Mr. Bucshon follows:]

126 ***** COMMITTEE INSERT *****

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127 Mr. {Pitts.} The chair thanks the gentleman.

128 Now recognize the ranking member of the subcommittee,
129 Mr. Green, 5 minutes for an opening statement.

130 Mr. {Green.} Thank you, Mr. Chairman. Good morning and
131 thank our witnesses for being here today. I would like to
132 thank the chair for having this hearing on the topic of
133 Medicaid demonstration waivers, and I long--and look forward
134 to today's discussion.

135 Medicaid provides healthcare coverage for more than 70
136 million Americans. It is our Nation's most vital healthcare
137 safety net program. Today, it covers more than one in three
138 children, and is a critical component of care for seniors.
139 One out of every seven Medicare beneficiaries is also a
140 Medicaid beneficiary. For millions of American families, the
141 Medicaid Program is the only way they can gain access to
142 coverage for appropriate healthcare services. It is a simple
143 truth; our state and Federal Government save money by
144 investing in health care, and Medicaid coverage is a key
145 component of such investment.

146 The joint state-federal nature of Medicaid structure is
147 the defining feature of the program. Since its creation,
148 states have had the flexibility to design their own version
149 of Medicaid within the basic framework of broad federal

150 rules, in order to receive matching funds. If a state wishes
151 to change its Medicaid Program in ways that depart from some
152 federal requirements, it may seek to do so under the
153 authority of approved demonstration or a waiver. Section
154 1115 waivers are a very broad type of Medicaid waiver.

155 In recent years, these waivers have become increasingly
156 utilized by the states. In fiscal year 2014, Section 1115
157 demonstration waivers accounted for almost 1/3 of all
158 Medicaid spending. While each 1115 waiver is different in
159 scope and focus, they all must promote the objectives of the
160 Medicaid Program and be budget-neutral for the Federal
161 Government.

162 Over the last 2 decades, the Government Accounting
163 Office, the GAO, has raised concerns about Medicaid waiver
164 policy. Many of the GAO's longstanding recommendations were
165 included in the Affordable Care Act, and I want to thank CMS
166 for the agency's commitment to improving transparency
167 throughout the approval process. Per a requirement of the
168 Affordable Care Act, CMS has issued a final rule to ensure
169 meaningful public input in the waiver process, and enhanced
170 transparency. Today, we will hear from GAO about its body of
171 work on Medicaid waivers and additional improvements that can
172 be made.

173 While the Supreme Court made Medicaid expansion

174 voluntary for each state, expansion authority provides an
175 explicit, almost entirely federally funded pathway for states
176 to offer coverage for all nonelderly adults living below 138
177 percent of the poverty line. Because of this, states have a
178 clear option and do not need to use 1115 waivers to expand
179 eligibility for this population. Waivers are still being
180 used to make other programmatic changes, especially as states
181 continue to consider expanding Medicaid. Some of these
182 proposals have sought to impose premiums, cost-sharing
183 charges, and work requirements on beneficiaries. Robust
184 research does not support the arguments for such provisions.
185 Premiums have been shown to deter participation in coverage,
186 and lead to high administrative costs. Work requirements
187 have no place in a safety net healthcare program, and ignore
188 the fact that the vast majority of new eligible adults--
189 beneficiaries already work but do not have access to
190 affordable care through their employer. States have
191 flexibility--considerable flexibility under existing Medicaid
192 authority. Enacting punitive, unsubstantiated policies like
193 work requirements under the guise of flexibility does not
194 advance the conversation about improved transparency and
195 innovative care models. When people have access to regular
196 health examinations, immunizations, and preventative care,
197 they are dramatically more likely to be healthy and

198 productive adults. Coverage rather than uncompensated care
199 pools is the best way to promote the health of the American
200 people, and the viability of our healthcare system at large.
201 CMS has maintained that this will be one of the three guiding
202 principles moving forward.

203 That said, 1115 waivers retain the vital purpose of
204 affording states with a way to pursue innovative delivery
205 programs, expand eligibility to individuals not otherwise
206 eligible for Medicaid and CHIP, and pilot initiatives that
207 supports the objections of the Medicaid Program. Medicaid is
208 a safety net for everyone because we are all one medical
209 crisis away from financial ruin, and more people who have
210 coverage and access to necessary care, the better the system
211 works.

212 I look forward to hearing today's panelists about the
213 important topic, and working with my colleagues on the
214 committee. We have a great opportunity to build on success,
215 and continue to strengthen the Medicaid Program for current
216 and future beneficiaries.

217 And I yield back my time.

218 [The prepared statement of Mr. Green follows:]

219 ***** COMMITTEE INSERT *****

|
220 Mr. {Pitts.} The chair thanks the gentleman.

221 Now recognize the chairman of the full committee, Mr.
222 Upton, 5 minutes for an opening statement.

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

224 This year, the Medicaid Program turns 50. Over that 1/2
225 century, Medicaid has provided critical health coverage for
226 some of our Nation's most vulnerable populations. Medicaid
227 is the world's largest health insurance program, with as many
228 as 72 million people being covered by the program for at
229 least some period of the current year. And in the next
230 fiscal year, \$344 billion federal dollars will be spent on
231 Medicaid, and by 2024, federal-state spending on Medicaid is
232 expected to top \$1 trillion.

233 Today, roughly one in three Medicaid dollars is spent
234 through an 1115 waiver approved by the Secretary of HHS.
235 Section 1115 of the Social Security Act authorizes the HHS
236 Secretary to waive certain federal Medicaid requirements and
237 allow costs that would not otherwise be eligible for federal
238 matching funds for demonstration projects that are likely to
239 assist in promoting Medicaid objectives. These are critical
240 tools for states to experiment and evolve their Medicaid
241 Programs as they seek to modernize and improve them to better
242 serve patients. For example, Michigan has used a waiver to

243 successfully provide HSA-like health accounts to encourage
244 participants to become more active health care consumers.
245 Yet today we will hear from the nonpartisan government
246 watchdog, GAO, which has repeatedly raised questions about
247 CMS' approval process for those waivers.

248 Whether it is GAO's concerns about budget neutrality,
249 approval criteria, or the process for approvals and renewals,
250 these are indeed important and fair questions to ask. We
251 need a better understanding about how the billions of dollars
252 CMS is approving promote Medicaid's core objectives.

253 I want to thank the second panel, in particular, former
254 Governor Barbour, for being here to share his ideas about how
255 to improve CMS's management of the funds. I know that nearly
256 every member of this subcommittee has heard frustrations from
257 state officials at one point about the uncertainty and
258 timeframes surrounding the approval or renewal of an 1115
259 waiver. While state leaders are trying to balance their
260 budgets, pass legislation, it is essential that CMS's process
261 is transparent and certainly predictable.

262 Recent analysis and media coverage has raised questions
263 over the degree to which CMS is effectively picking winners
264 and losers in the waiver review process. CMS has a duty,
265 both to patients and taxpayers, to states, all stakeholders,
266 to do more to increase the transparency, accountability, and

267 consistency of their approval process. In fact, if CMS is
268 doing a decent job, increased oversight and scrutiny will
269 only bring their good efforts into the light. However, if
270 there are shortcomings, this subcommittee will play its role
271 in making the process more transparent, accountable, and fair
272 for all involved. At the end of the day, it is about
273 ensuring our most vulnerable receive the care that they
274 deserve.

275 I yield the balance of my time to Dr. Burgess.

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

277 ***** COMMITTEE INSERT *****

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278 Mr. {Burgess.} I thank the chairman for yielding. And
279 I just want to underscore what he said. And, Governor
280 Barbour, it is going to be good to have you before our panel
281 again. I know you have been here before. And I think one of
282 the failings when we initiate discussions on healthcare
283 policy is our failure to include the governors in the
284 discussion because, after all, our governors are the ones who
285 have the principle role in a shared federal-state program,
286 like Medicaid. Our governors are the ones who actually have
287 the responsibility of the deliverable for their citizens, as
288 well as they have to administer their own healthcare programs
289 for their state employees, and they have great expertise in
290 this area, and too often, we overlook that expertise. So I
291 am grateful you are here with us today.

292 The topic itself is one that holds a great deal of
293 interest for me, and I am, therefore, glad, Chairman Pitts,
294 that we are holding this hearing. Back home in Texas, we do
295 have an 1115 waiver, had it for a number of years, and it has
296 allowed a positive transformation in care delivery.

297 Conserving state flexibility within Medicaid allows
298 states to structure their programs in a way that best meets
299 their population's needs. Every Administration uses the 1115
300 negotiations to further their particular objectives, and

301 thus, maybe a discussion on more transparency is warranted.
302 But for this Administration, Medicaid expansion has been the
303 leading factor, the number one factor, in negotiations. It
304 has been publicly noticed that even though the Supreme Court
305 has ruled that the Administration may not coerce a state into
306 expanding its Medicaid under the ACA, that maybe, in fact,
307 what is happening when the state comes to talk about an 1115
308 waiver.

309 In April, the Center for Medicare and Medicaid Services
310 explicitly linked funding for Florida's low-income pool to
311 Medicaid funding, although progress has been made recently.
312 Expansion is not a viable option in Texas, where it was
313 previously estimated that it would cost the state as much as
314 \$27 billion over a decade.

315 Mr. Chairman, I am grateful we are holding the hearing
316 today, and look forward to the testimony of our witnesses and
317 their answering our questions.

318 I yield back.

319 [The prepared statement of Mr. Burgess follows:]

320 ***** COMMITTEE INSERT *****

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321 Mr. {Pitts.} The chair thanks the gentleman.

322 The ranking member of the full committee, Mr. Pallone,
323 has sent me a message. He said he would be late to get to
324 the hearing, would miss opening statements. He has asked to
325 designate Ms. Castor to have his opening statement time. So
326 without objection, Ms. Castor, you are recognized for 5
327 minutes for your opening statement.

328 Ms. {Castor.} Well, thank you, Chairman Pitts and
329 Ranking Member Green, and thank you for calling this
330 important hearing on the Medicaid demonstration projects.

331 It was the Congress, through amendments to the Social
332 Security Act and laws relating to Medicaid, that granted
333 states new and broad flexibility to test what works. All
334 states are different. Through what are called the Section
335 1115 waivers, or demonstration projects, states have great
336 flexibility to deliver care in more efficient ways. But each
337 waiver has a time limit, because demonstration projects are
338 intended to be analyzed to ensure they are working, and that
339 they are using taxpayer dollars wisely. And there are a
340 couple of important parameters. These are typically 5-year
341 demonstration projects with certain extensions, 3-year
342 extensions. You negotiate with CMS. And we say that the
343 states, and these are some of the principles, states and the

344 Federal Government cannot spend more than they would have
345 spent without the waiver. And that is an important safeguard
346 on taxpayer dollars.

347 So I appreciate the GAO and your thoughtful analysis of
348 these waivers. It is very opaque to the average person. You
349 have advocated for more transparency and accountability.
350 Congress responded in the Affordable Care Act, and CMS has
351 followed through with that direction, but I think we can all
352 agree we still have more to do. So I will look forward to
353 your testimony today on how we can continue to work to make
354 these demonstration projects and waivers more transparent.

355 Now, many states have experimented with low-income
356 pools, these uncompensated pools of cash, where the local
357 governments; state governments, Federal Government, pools
358 the--pools money to pay for uncompensated care. Now, the
359 uncompensated care pools are intended to support healthcare
360 providers that provide uncompensated care to uninsured and
361 underinsured state residents. They are not healthcare
362 programs. They don't allow people to get primary and
363 preventative care, and they don't protect people from
364 financial harm resulting from medical debt, and that is why
365 they have come under great scrutiny. They were very
366 important before the adoption of the Affordable Care Act
367 because the uninsured levels across America were so high.

368 Hospitals, doctors, community health centers simply couldn't
369 cover the costs of uncompensated care without the help of the
370 low-income pool dollars. And these were especially vital to
371 the State of Florida as we transition from traditional
372 Medicaid to Medicaid managed care. And I was an advocate in
373 past years for very healthy, uncompensated care pools.

374 But now we are in a whole different world. With the
375 broad expansion of coverage under the Affordable Care Act,
376 these billions of dollars in pools of cash don't make
377 financial sense anymore. So CMS put states on notice some
378 years ago. They put Florida on notice in 2011 that the low-
379 income pool would not survive in its current form, because it
380 doesn't make sense to simply write a check to a hospital or a
381 state that isn't as financially responsible as providing
382 coverage to your citizens. After being on notice since 2011,
383 Florida got a 1-year extension of LIP until June 30, 2015,
384 with the understanding that it would conduct an independent
385 review of its payment system intended to allow for the
386 development of a sustainable, accountable, actuarially sound
387 Medicaid payment system, and that LIP would be different.
388 Florida knew that it was expected to change the way it pays
389 providers, and provides health services to its low-income
390 residents. They got into trouble this spring because the
391 governor, even though he was on notice, included the full LIP

392 uncompensated care pool number in his budget, and the
393 Republican-led State senate wanted a coverage model, so they
394 went into a budget impasse. And fortunately, they have
395 resolved it. Unfortunately, they did not adopt a coverage
396 model, and we are on notice that the LIP funds are going to
397 diminish over time. This will be an important lesson for
398 other states across the country. And we need to be--we need
399 to focus on coverage that is more financially secure for
400 states, the Federal Government, and eliminate this risk of
401 unnecessary expenditure of taxpayer dollars. So I will look
402 forward to the discussion on that today as well.

403 Thank you very much. I yield back my time.

404 [The prepared statement of Ms. Castor follows:]

405 ***** COMMITTEE INSERT *****

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406 Mr. {Pitts.} The chair thanks the gentlelady.

407 That concludes the opening statements. As usual, the
408 written opening statements of the members will be included in
409 the record.

410 We have two panels today. And on our first panel we
411 have Ms. Katherine Iritani, Director of Health Care, the
412 Government Accountability Office. Thank you very much for
413 coming. Your written will be made a part of the record. You
414 will have 5 minutes to summarize your testimony before
415 questions. And so at this point, you are recognized for 5
416 minutes for your opening statement. Press the button on
417 that, yeah.

|
418 ^STATEMENT OF KATHERINE IRITANI, DIRECTOR, HEALTH CARE,
419 GOVERNMENT ACCOUNTABILITY OFFICE

420 } Ms. {Iritani.} Chairman Pitts, Ranking Member Green,
421 and members of the subcommittee, I am pleased to be here to
422 discuss GAO's work on Medicaid demonstration spending.
423 Demonstrations comprise a significant and fast-growing
424 component of the over-\$500 billion Medicaid Program. With
425 the broad waiver and spending authority conferred upon the
426 Secretary of HHS under Section 1115 comes responsibility for
427 ensuring that demonstrations further Medicaid objective and
428 do not increase Medicaid costs.

429 My testimony today is based on GAO's April report
430 examining HHS' approvals of new costs approved for 25 states'
431 demonstrations. I will also discuss a body of work from 2002
432 to 2014, examining HHS' review process for ensuring that
433 demonstrations do not raise federal costs.

434 Based on this work, we have three main concerns with HHS
435 approvals. First, with transparency. HHS' bases for
436 approvals of new costs not otherwise eligible for Medicaid
437 were not always apparent in recent approvals. Nor have been
438 the bases for approved spending limits for the demonstrations
439 which govern total allowed spending. Second, accountability.

440 HHS has not issued specific criteria for how it determines
441 that approved spending is furthering Medicaid objectives, nor
442 has HHS issued specific criteria for how it reviews and
443 approves demonstration spending limits. Without criteria,
444 stakeholders and overseers may not share a common
445 understanding of how major decisions occur. The third
446 concern, fiscal impact. Based on our reviews and multiple
447 demonstrations approvals, we have longstanding concerns that
448 the Secretaries approve spending limits that could
449 potentially increase federal Medicaid costs by tens of
450 billions of dollars.

451 I will turn now to our report findings. In April, we
452 reported that HHS has approved states to obtain federal
453 Medicaid funds for a broad range of purposes. Two prominent
454 types of new costs not otherwise eligible for Medicaid were
455 approved. The first was for state-operated programs. HHS
456 allowed five states to spend up to \$9.5 billion for more than
457 150 state-operated programs that, prior to the demonstration,
458 were funded by the state and potentially other federal
459 sources. The programs were wide-ranging in nature. They
460 included workforce education and training, insurance subsidy,
461 housing, licensing, loan repayment, and a broad array of
462 public health programs. The federal Medicaid funds the
463 states received could replace some of the states'

464 expenditures for the programs, and free-up state funding for
465 other purposes. HHS' approval documents were not always
466 clear about what the state programs were for or how they
467 related to Medicaid. Further, approvals did not always
468 provide assurances that new Medicaid funds for these programs
469 would be coordinated with other funding streams.

470 The second prominent type of spending approved was
471 funding pools to make new payments to hospitals and other
472 providers for broad purposes. HHS approved six states to
473 spend up to \$7.6 billion for funding pools for uncompensated
474 care costs. Five states were allowed to spend up to \$18.8
475 billion for incentive payments to providers to improve health
476 care delivery and infrastructure. Again, approval documents
477 were not always clear regarding how the spending would
478 further Medicaid objectives, and not duplicate other federal
479 funding streams.

480 Now let me to turn to our work on budget neutrality,
481 which examined the extent HHS has ensured that demonstrations
482 will not raise federal costs. Our longstanding body of work
483 examining over 20 demonstrations found that HHS allowed most
484 states to use questionable assumptions and methods to project
485 how much their Medicaid program would cost without the
486 demonstration. Such projections, once approved, become the
487 basis for total spending allowed under the demonstration. In

488 our most recent reports in 2013 and '14, we estimated that
489 HHS approved spending for five states' demonstrations that
490 was about \$33 billion higher than what the documentation
491 supported.

492 In conclusion, Medicaid demonstrations provide HHS and
493 states a powerful tool for testing and evaluating new
494 approaches for improving the delivery of services to
495 beneficiaries. Medicaid demonstrations can also set
496 precedents that are adopted by other states, and raise
497 potential for overlap with other funding streams. Given the
498 fast-growing and significant amount of federal spending
499 governed by these demonstrations, we believe there is an
500 urgent need for improved accountability and transparency in
501 HHS' review and approval process.

502 Mr. Chairman, this concludes my statement, and I am
503 happy to answer any questions.

504 [The prepared statement of Ms. Iritani follows:]

505 ***** INSERT 1 *****

|
506 Mr. {Pitts.} The chair thanks the gentlelady. I will
507 begin the questioning, and recognize myself 5 minutes for
508 that purpose.

509 Ms. Iritani, in your testimony you indicated that CMS
510 has four general criteria against which it reviews Section
511 1115 demonstrations to determine whether the Medicaid
512 Program's objectives are met. However, did anyone outside of
513 CMS know about these criteria until the GAO did its report?

514 Ms. {Iritani.} No. The first time we saw those
515 criteria was when CMS and HHS responded to a draft of our
516 report.

517 Mr. {Pitts.} So to be clear, these criteria are not
518 even in regulation?

519 Ms. {Iritani.} Correct.

520 Mr. {Pitts.} So did CMS create them out of thin air, or
521 where did they come from?

522 Ms. {Iritani.} We asked for CMS' criteria during the
523 course of our review, and that criteria were not provided
524 until they reviewed a copy of the report.

525 Mr. {Pitts.} Now, you raised concerns that the criteria
526 that CMS enumerated for its review of the demonstration
527 programs are far too general. Can you please elaborate on
528 these concerns, explain the risk associated with the lack of

529 more specific and transparent criteria?

530 Ms. {Iritani.} The general criteria that CMS said that
531 they used included things like increasing and strengthening
532 coverage for low income and Medicaid, increasing access to
533 and stabilizing providers and provider networks available to
534 Medicaid and low income, improving health outcomes for
535 Medicaid and low income, increasing efficiency and quality
536 care. We did not believe that these criteria were
537 sufficiently articulated in terms of the link to Medicaid,
538 and the documentation that we reviewed regarding the
539 approvals was not clear as to how they made their decisions
540 about what to approve.

541 Mr. {Pitts.} Now, the part of the federal statute on
542 1115 waivers is very short; just four pages. So the
543 Secretary of HHS has tremendous latitude under the law to
544 fund some demonstration projects, while denying others. Are
545 there any statutory criteria requiring the Secretary to be
546 consistent?

547 Ms. {Iritani.} There are not. The statute is quite
548 broad with regard to the Secretary's authority for approving
549 purposes that, in her or his judgment, further Medicaid
550 objectives.

551 Mr. {Pitts.} What is to stop the agency from playing
552 favorites; picking winners and losers, via the waiver

553 process?

554 Ms. {Iritani.} Well, we believe that more transparent
555 criteria and standards for approvals are needed, and more
556 oversight.

557 Mr. {Pitts.} Now, one of the worries that I and many of
558 my colleagues have is that the Medicaid Program too often
559 promises coverage, but effectively denies care. An NPR story
560 this week entitled, California's Medicaid Program Fails to
561 Ensure Access to Doctors, told the story of Terry Anderson.
562 She signed up for California's Medicaid Program earlier this
563 year, hoping she would finally get treatment for her high
564 blood pressure, but she faced challenges accessing care in a
565 timely manner. Would it make more sense for CMS to stop
566 spending money on the low-priority items, and free-up more
567 federal dollars for better oversight and direct care for
568 patients?

569 Ms. {Iritani.} We would agree that Medicaid funds
570 should be spent for Medicaid purposes. And the approval
571 documentation that we reviewed for the demonstrations did not
572 articulate how many of the approved expenditures were
573 furthering Medicaid objectives, which is why we have
574 recommended that the Secretary issue criteria as to how he or
575 she assesses whether or not approved spending is furthering
576 Medicaid purposes.

577 Mr. {Pitts.} The chair thanks the gentlelady. My time
578 has expired.

579 The chair recognizes the ranking member of the
580 subcommittee, Mr. Green, 5 minutes for questions.

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

582 Thank you again for your testimony. We hear a lot of
583 criticism of the lack of flexibility of CMS for waivers, but
584 what I heard in your testimony and seen in multiple reports
585 going back decades is that many actually--maybe actually too
586 much flexibility in how the budget neutrality and other
587 features of waivers have been administered. My question is,
588 GAO is asking for clearer standards and more transparency,
589 just like CMS has recently taken steps to provide in its
590 approach to Florida and other states with uncompensated care
591 pools. Is that correct?

592 Ms. {Iritani.} That is correct.

593 Mr. {Green.} In reviewing the GAO's recommendation over
594 the last--recommendations over the last 20 years, it appears
595 as though your recommendations have remained the same until
596 only recently. Isn't it true that the majority of these
597 recommendations were not acted upon up until the Obama
598 Administration and the Affordable Care Act, which placed many
599 of your recommendations into action?

600 Ms. {Iritani.} That is correct.

601 Mr. {Green.} Okay. Given the large amount of federal
602 dollars at stake in waivers, would you agree that it is
603 important for CMS to make it--to take its time in evaluating
604 the proposals and getting additional information from the
605 states to ensure that state--each state's proposal is for a
606 project that is in line with the objections--objectives of
607 the statute?

608 Ms. {Iritani.} We would agree that there is more need
609 for transparency for criteria around how they make their
610 decisions, around better methods allowed for predicting how
611 much the Medicaid Program would cost without the
612 demonstration, which becomes the basis for the spending
613 limits allowed.

614 Mr. {Green.} Well, and I don't think any up here would
615 disagree with we need more transparency in dealing from CMS
616 I want to clarify a point in your testimony that may be
617 misleading to some of colleagues. GAO mentions that some of
618 the funds that go to the designated state health programs has
619 been supported by both political parties for more than a
620 decade, could have received funding from other federal
621 support--sources--could that--the designated state health
622 programs receive funding from other federal sources. As you
623 may know or may not know, it is very common for small
624 programs to leverage multiple funding streams to provide

625 services. However, that is concern--what is concerning is in
626 this case, from my understanding, the lack of documentations
627 and potential, therefore, for Medicaid federal matching
628 dollars to be given based on other federal funding not as a
629 match for the state dollars as is appropriate under the
630 Medicaid Program. That duplication of funds is the issue
631 that GAO is concerned about. Is that correct, Ms.--

632 Ms. {Iritani.} That is correct.

633 Mr. {Green.} Okay. The GAO is not determining what is
634 or is not appropriate for Medicaid objective because that
635 determination lies with the Secretary of HHS. And our
636 states--rather, the GAO is recommending that better
637 documentation reflect the tide of Medicaid objectives for
638 these funds, and that CMS ensure that states are not drawing
639 down federal matching funds based on the input of other
640 sources of federal funds. Is that pretty accurate?

641 Ms. {Iritani.} Yes, that is correct. I think our
642 concern with the approval documentation around potential
643 duplication was that there was variation in the level of
644 protections in the approval documentation with regard to
645 assuring that if programs were receiving federal funds from
646 other sources, that they were offsetting those against the
647 Medicaid funds that they received.

648 Mr. {Green.} Okay. Thank you, Mr. Chairman. I yield

649 back my time.

650 Mr. {Pitts.} The chair thanks the gentleman.

651 Now recognize the gentleman from Illinois, Mr. Shimkus,
652 5 minutes for questions.

653 Mr. {Shimkus.} Thank you very much, Mr. Chairman. Ms.
654 Iritani, it is great to have you here.

655 And I have been focused on this budget waiver neutrality
656 debate, to the chagrin of some of some of my friends, and
657 actually I think my own state, because the concern has been,
658 since there is no transparency or clear answer, the premise
659 is, which I agree, properly done, that give states their
660 authority to meld their own program, you also get better
661 outcomes and you will get a savings. I mean that is what we
662 are always told. And if not a savings, there is an implied
663 aspect in 1115 that says at least it should be neutral, but
664 for the past 10 years you all have looked at this, and what
665 have you found?

666 Ms. {Iritani.} Yeah, we have found that the
667 documentation did not support that spending limits were
668 budget neutral. We found that it is likely that federal
669 Medicaid costs could be increased significantly for Medicaid
670 based on these demonstration approvals.

671 Mr. {Shimkus.} So just using the facts of dollars, the
672 claims, they are not being substantiated by the facts. The

673 facts don't substantiate the claims that states have made
674 that we can build a better mousetrap, provide better care,
675 and actually have a savings to the Medicaid system.

676 Ms. {Iritani.} Yes.

677 Mr. {Shimkus.} So--and again, to the chagrin of even my
678 state, because as--the State of Illinois, we are almost a
679 failed state these days. Our pension obligations far
680 outstrip per capita any in the union. Medicaid is also a big
681 driver. So there is sometimes an intent, I--so I am not
682 being encouraged, let me put it this way, to ask these
683 questions on budget neutrality because of, I think, a desire
684 for the states to be able to gain the system a little bit,
685 based upon the vagueness of what CMS is doing. And I hate to
686 kind of tell--weave the story this way, but it is--I think it
687 is just a--it is a fact, based upon the numbers.

688 So we have dropped a bill, H.R. 2119, I don't know if
689 you are familiar with it, and I know your position of not
690 commenting on legislation, but the intent of the bill is to
691 do at least an analysis and have the chief actuary of the CMS
692 certify that the proposed budget neutrality or implied
693 savings is actually there. I mean it is a guess, but at
694 least it has actuaries doing the number crunching to say,
695 yeah, we believe the state, we think there is going to be a
696 savings, at a minimum there is going to be budget neutrality.

697 If we brought in and had that actuary analysis before a
698 decision was rendered, do you think that would be helpful?

699 Ms. {Iritani.} Yes, I think that what I can say is
700 that, in a recent--we have noted that the actuary isn't
701 involved in the process typically. In our most recent report
702 in 2014, the--which was looking at the budget neutrality of
703 one state's approval, we did note that the actuary was asked
704 to review the state's proposal, including the proposed
705 spending limits and the basis for it, and had raised
706 questions with it, but was--but--and asked for further
707 documentation that was not provided by the state. And the
708 spending limit was approved, and we found that it was likely
709 going to raise federal costs.

710 Mr. {Shimkus.} So, you know, that story kind of just
711 supports our concern and the reason why we dropped the bill,
712 and it is a very--it is very short. But what we require then
713 is a certification process by the actuaries which would then,
714 I think, empower them to make sure they get all the
715 information they need to be able to make a--to certify based
716 upon the best available information that this is going to be
717 budget neutral or, in essence, an implied savings.

718 So I appreciate you being here. It is a tough issue.
719 Money is always what you fight about. So thanks for coming.

720 I yield back my time.

721 Mr. {Pitts.} The chair thanks the gentleman.

722 Now recognize the gentlelady from California, Mrs.

723 Capps, 5 minutes for questions.

724 Mrs. {Capps.} Thank you, Mr. Chairman, for holding this

725 hearing, and to our witness for your testimony. I am happy

726 we have this opportunity to come together to talk about these

727 important Medicaid waivers; something that has really, truly

728 helped my state respond creatively to its challenges and

729 provide healthcare coverage to many more than before.

730 Our Nation faces a significant challenge of caring for

731 our growing patient population with limited resources, and as

732 was mentioned, the challenge even with the number of

733 providers available to meet the needs. We must ensure that

734 the Medicaid Program has the flexibility through these

735 waivers to address these needs. As has been said, these

736 waivers are negotiated between the state and CMS, but

737 especially as we have seen in California, the agreement

738 affects many more stakeholders once it is in place.

739 Recognizing this fact, the ACA included an important

740 provision to encourage broader stakeholder input during the

741 waiver process. Now there is a formulized process for the

742 broader coalition of stakeholders to contribute, and I think

743 that range of perspectives has created better and more

744 effective waiver programs. I think both sides of the aisle

745 agree that this aspect of transparency is so vitally
746 important.

747 Ms. Iritani, can you talk more about how public comments
748 have helped and will help to increase transparency throughout
749 the Medicaid waiver process?

750 Ms. {Iritani.} Certainly. Yes, we raised concerns with
751 the lack of transparency in the approval process, dating back
752 to the early 2000s. In a report in 2002, we talked to a
753 number of different states and advocacy groups and others
754 about demonstrations that had been recently approved that
755 significantly affected beneficiaries, and found that there
756 are great concerns about groups even being able to see a copy
757 of the proposal prior to the approval. In some cases, I
758 think that there were FOIAs involved to try to get
759 transparency over what was being approved. And the Patient
760 Protection Affordable Care Act did require a public input
761 process at the federal level, which we think greatly enhances
762 transparency of what is being proposed, and provides for
763 input to the process prior to the approval. So we would
764 agree that that is an important reform.

765 Mrs. {Capps.} And so you have seen progress since this
766 has been initiated?

767 Ms. {Iritani.} We have not looked at public--

768 Mrs. {Capps.} You are not--

769 Ms. {Iritani.} --input since--

770 Mrs. {Capps.} --measuring it.

771 Ms. {Iritani.} --since the law was passed. But--

772 Mrs. {Capps.} Okay.

773 Ms. {Iritani.} But we--

774 Mrs. {Capps.} Do you intend to?

775 Ms. {Iritani.} --we agree that it has increased
776 transparency.

777 Mrs. {Capps.} I mean how are states responding to these
778 kind of comments?

779 Ms. {Iritani.} We have looked at that. In terms of how
780 are states responding to the proposals?

781 Mrs. {Capps.} The proposals and the process of the
782 whole transparency issues.

783 Ms. {Iritani.} We have not looked at that, at how
784 states are responding to the process.

785 Mrs. {Capps.} Do you see this as part of your overall
786 objective, or is it up to somebody else to do this piece of
787 it?

788 Ms. {Iritani.} Well, we would be happy to look at that.
789 The work that we have been requested to do in recent years
790 has focused on budget neutrality and the new costs that were
791 approved in the demonstrations.

792 Mrs. {Capps.} Which is a lot to be assigned to and be--

793 Ms. {Iritani.} Yes.

794 Mrs. {Capps.} --grappling with in light especially, in
795 my view, of the total, I won't say overwhelm, but increase in
796 volume. I mean there has really been a sea change. You want
797 to explain--I have a few more seconds left, and what are some
798 of the issues that you have faced, or how has this process
799 been received?

800 Ms. {Iritani.} The public input process?

801 Mrs. {Capps.} Right.

802 Ms. {Iritani.} Well, you know, as I say, we haven't
803 looked at it since it was implemented, but we did look at the
804 regulations that implemented it and agree that it was
805 responsive to our recommendations that they provide for a
806 federal input process.

807 Mrs. {Capps.} Um-hum. So we are on the path, but it is
808 early yet to interpret any results, is that what I am hearing
809 you say?

810 Ms. {Iritani.} I would say it is an important step to
811 improving transparency, yes.

812 Mrs. {Capps.} Right, but we need to keep checking back
813 and--do you have the means by which you can accomplish some
814 of these goals?

815 Ms. {Iritani.} I would be happy to work with the
816 subcommittee on work--

817 Mrs. {Capps.} Thank you.

818 Ms. {Iritani.} --looking at that.

819 Mrs. {Capps.} I thank you for the time. I yield back.

820 Mr. {Pitts.} The chair thanks the gentlelady.

821 Now recognize the gentleman from Pennsylvania, Dr.

822 Murphy, 5 minutes for questions.

823 Mr. {Murphy.} Thank you. I am over. Good morning. It
824 is good to be with you, and thank you for your work.

825 I want to ask about one demonstration project that was
826 authorized in the Affordable Care Act that relates to the
827 Institution for Mental Disease exclusion, IMD exclusions, for
828 emergency care for people with psychiatric conditions. As
829 part of comprehensive mental health reform, this committee
830 will be deciding and considering modifications in these IMD
831 exclusions to increase access to timely and cost-effect
832 short-term psychiatric care as opposed to boarding in
833 emergency rooms, and that is what I understand is the
834 demonstration report that is--was worked on for that study.

835 Can you tell the committee, if you are aware of this,
836 what CMS has learned from current Medicaid emergency
837 psychiatric demonstrations, and which created an exception
838 for this IMD exclusion for adult Medicaid enrollees who have
839 been determined to have emergency psychiatric conditions?
840 Are you aware of any of this?

841 Ms. {Iritani.} I am not. That demonstration was not
842 within the scope of our work.

843 Mr. {Murphy.} Is that something that you would be able
844 to look at, because it is--was one of the demonstration
845 programs? Is it totally excluded from your work to review
846 that?

847 Ms. {Iritani.} I believe that that is a separately
848 authorized--not under the 1115--

849 Mr. {Murphy.} Well, let me ask a little bit more about
850 this because I mean I value your input on this--

851 Ms. {Iritani.} Um-hum.

852 Mr. {Murphy.} --but I understand the final evaluation
853 though for the demonstration will be completed in the fall of
854 2016, so it is still ongoing. Do you have any advice or
855 suggestions you could make to this committee to help us shape
856 how we review these to make the most effective policies, for
857 example, on these IMD exclusions? Is that something you
858 would be able to advise us on?

859 Ms. {Iritani.} Well, I need to see more specific
860 information, but yes, we would be happy to talk to the
861 subcommittee about new work in this--on this--

862 Mr. {Murphy.} Thank you.

863 Ms. {Iritani.} --issue.

864 Mr. {Murphy.} And also with CMS support, extending the

865 current Medicaid emergency psychiatric demonstration until at
866 least the final evaluation is available. The--because we
867 have an initial 2013 report, but we don't have--I mean the
868 rest is going to take some more time. And what we see is in
869 the states involved, because we limit hospitals to have less
870 than 17 beds because it seems to only cover people who are
871 suicide or the most severe cases, it still leaves us in a
872 position where we are having problems putting these pieces
873 together. We want to provide effective care for people, we
874 want to do it in the most cost-effective way, but also
875 recognizing that you can be cost-effective--you can do cost
876 care without providing anything. We don't want to do that.
877 We want to make sure we are providing effective services.
878 And believe that the Government Accountability Office is a
879 record of really helping us look at and analyze those
880 numbers, so I would be grateful if that is something you
881 could help us with. It is a key issue that this committee
882 has got to deal with, because otherwise what happens with
883 Medicaid, for people ages 22 to 64, is they have nowhere to
884 go. We had a recent hearing in this subcommittee where
885 Senator Creigh Deeds of Virginia was here. His case was one
886 where he took his son to a hospital in Virginia, and the
887 hospital said we don't have any beds. And what happens so
888 often is these men and women are--they may be boarded in an

889 emergency room, they may be tied to a bed, if they are
890 assaultive they may be given chemical sedatives, and they say
891 there is just no room, and it is this Medicaid rule which was
892 based upon closing down those old institutions and hopefully
893 having some other support services. If we close the
894 institutions down, we don't have enough hospitals because
895 Medicaid has said you can't have them. And so in his case,
896 he took his son home. His son took a knife and tried to kill
897 his father. Slashed him up pretty bad. Father escaped.
898 Luckily, some driver picked him up as he was running up, but
899 unfortunately, his son killed himself.

900 Now, I know that these aren't the cost-effective
901 measures that GAO looks at, but it is something we all care
902 deeply about. How do you put a number on that? How does he
903 put a number on his son's life? And given the 40,000
904 suicides that occurred in this country last year, given the
905 43,000 drug overdose deaths that occurred in this country
906 last year, those numbers are staggering and they are getting
907 worse every year, so we have to effect this.

908 So your input, GAO's input, I would value greatly as we
909 help address this to find--to look at these numbers and costs
910 and saying this is not acceptable to this committee, it is
911 not acceptable to this country. Quite frankly, it is not
912 acceptable to the human race that we have done this, and the

913 outcomes too often are death.

914 I yield back.

915 Mr. {Pitts.} The chair thanks the gentleman.

916 And now recognize the gentleman from Oregon, Mr.

917 Schrader, 5 minutes for questions.

918 Mr. {Schrader.} Thank you, Mr. Chairman.

919 Ms. Iritani, what is the rate of Medicaid reimbursement
920 compared to private insurance coverage in general?

921 Ms. {Iritani.} That is going to vary by service and
922 state. Oftentimes, I--for fee for service Medicaid rates may
923 be lower, but again, it is going to vary.

924 Mr. {Schrader.} They are pretty--they are always lower,
925 and significantly lower. I know in my state it is very
926 dramatic. It is hard to get providers sometimes to see
927 Medicaid patients unless they are a mix because the rate is,
928 you know, almost 1/2, and sometimes not even covering the
929 cost of these services.

930 What is the rate of--well, is there a general rate of
931 medical inflation that GAO uses to estimate savings when they
932 are evaluating these different programs and--

933 Ms. {Iritani.} We apply HHS' own criteria for how
934 states should develop spending limits, and that criteria is
935 that states should project what Medicaid will cost, which
936 becomes the basis for the spending limit, based on the lower

937 of either the state's historical spending trends in recent
938 years, or the President's budget projections of Medicaid
939 growth for the Nation in--as used in the President's budget.

940 Mr. {Schrader.} But wouldn't you say it is always more
941 than the general rate of inflation?

942 Ms. {Iritani.} I--

943 Mr. {Schrader.} Medical inflation is generally higher
944 than regular inflation.

945 Ms. {Iritani.} I cannot--

946 Mr. {Schrader.} Well, the answer is yes.

947 Ms. {Iritani.} Okay.

948 Mr. {Schrader.} I mean there is not a state in this
949 country that--

950 Ms. {Iritani.} Um-hum.

951 Mr. {Schrader.} --doesn't budget for a higher rate of
952 medical inflation for its healthcare programs compared to
953 services and supplies--

954 Ms. {Iritani.} Uh-huh.

955 Mr. {Schrader.} --you know. My state was easily 3, 4,
956 or sometimes 5 times, historically--

957 Ms. {Iritani.} Um-hum.

958 Mr. {Schrader.} --prior to the advent of the ACA, which
959 has now driven down healthcare expenditure increases
960 dramatically. A little shocked that GAO doesn't have this

961 information, actually.

962 Isn't it correct that, for these designated state health
963 programs, that these have been around a long time? Not
964 recent--

965 Ms. {Iritani.} Some of the approvals--

966 Mr. {Schrader.} --figment of this--

967 Ms. {Iritani.} Some of the original approvals of the
968 demonstrations we reported on in our recent report had been
969 approved years ago, yes.

970 Mr. {Schrader.} So prior to this Administration?

971 Ms. {Iritani.} Yes.

972 Mr. {Schrader.} Okay. Good. Good. And isn't it
973 accurate that CMS, with your latest report, has agreed with
974 most all of your recommendations and is inclined to
975 supposedly work to improve them?

976 Ms. {Iritani.} Yes, we had three recommendations around
977 issuing criteria about how to further Medicaid demonstration
978 objectives around improving the documentation about how they
979 apply that criteria, and about making sure that they
980 consistently provided assurances and approvals that there
981 wouldn't be duplication of funding.

982 Mr. {Schrader.} Good.

983 Ms. {Iritani.} And they agreed with two of those,
984 documentation-related recommendations. They partially agreed

985 with the first one, indicating that they had general criteria
986 that they used. They did not commit to issuing criteria.

987 Mr. {Schrader.} And I guess I have a concern as I
988 listened to your testimony and some of the queries by some of
989 my colleagues. I am a little concerned we are--you are
990 encouraging CMS to actually get into the micromanagement of
991 these state waivers, and I think that is a big concern.
992 Criteria defining how states have to have, or have to have
993 certain procedures in place, and--shouldn't we be outcome-
994 based, shouldn't we be outcome-focused, don't we just want to
995 see more coverage for more people, better healthcare
996 outcomes? I mean that is something that my colleagues and I
997 can evaluate. Some of my medical physician colleagues, they
998 perhaps have the greater degree of understanding, but for
999 those of us in the lay field, I feel more comfortable
1000 evaluating the outcomes, not defining criteria by which these
1001 states, who we are trying to give more flexibility to give
1002 better coverage to more people over the long-haul. That
1003 really should be the goal. I am concerned that CMS may
1004 interpret, or my colleagues may interpret, your queries as to
1005 wanting to micromanage these states, and I think that is the
1006 wrong way to go. I think that is really the wrong way to go.
1007 Don't you feel that outcomes are the most important criteria
1008 by which we should judge success in these programs?

1009 Ms. {Iritani.} I would agree that outcomes--improved
1010 outcomes for federal spending is important. Healthcare costs
1011 are increasing and we are concerned about the long-term
1012 sustainability of the Medicaid Program. The--our work has
1013 really focused on the spending aspect and the approvals of
1014 the spending. And certainly, I think the goal of many
1015 demonstrations is to improve outcomes, but given the
1016 longstanding policy that they not raise federal costs, I
1017 think that has been the focus of our work, and that is where
1018 we think reforms are needed because it is the long-term
1019 sustainability of the program that is--could be at risk.

1020 Mr. {Schrader.} I yield back. Thank you, Mr. Chairman.

1021 Mr. {Pitts.} The chair thanks the gentleman.

1022 Now recognizes Dr. Burgess 5 minutes for questions.

1023 Mr. {Burgess.} Thank you, Mr. Chairman.

1024 And just picking up on Representative Schrader's
1025 questions, and the observation of outcomes versus
1026 micromanagement at CMS, we as physicians are always held to
1027 the standard we are going to pay for performance, and we are
1028 going to pay for value not volume. Do you ever provide or
1029 look to a pay-for-performance standard for CMS when
1030 evaluating these programs?

1031 Ms. {Iritani.} We have not looked at that, but I know
1032 some of the demonstrations I think are evaluating that.

1033 Mr. {Burgess.} Well, it just seems like, again, we are
1034 all too willing to burden every physician across the land
1035 with new requirements, and yet never ask the same of the
1036 bureaucracy, and really, we ought to be for patients before
1037 we are for the bureaucracy.

1038 I do have a question, it may require an answer in
1039 writing, but let me pose it to you. And I will get it to you
1040 in writing because the answer may be longer than time will
1041 permit us to do here. But we have heard several times this
1042 morning that applying for one of these waivers, an 1115
1043 waiver, can be burdensome, time-consuming. I know it
1044 happened in Texas. Mr. Bucshon referenced Indiana. Can you
1045 discuss ways in which the Department of Health and Human
1046 Services could streamline the approval process for the 1115
1047 waiver?

1048 Ms. {Iritani.} Our work is really focused on the
1049 approval processes for the spending, and we have examined the
1050 approval times, which vary greatly among demonstrations.
1051 There are many factors that we have been told contribute to
1052 that.

1053 Mr. {Burgess.} Well--but I would like, if you would,
1054 and I apologize for interrupting because--but time is short,
1055 I would like your evaluation of why that variability exists.
1056 Again, we in health care, if we had that degree, or when we

1057 have that degree of variability, people are always willing to
1058 ask questions and point fingers at us, just like that same
1059 standard applied to CMS when issuing these waivers. Just
1060 very briefly, according to your report, the Department of
1061 Health and Human Services actually did not have specific
1062 criteria for these 1115 waivers. Now they do, but do you
1063 have a sense of what the criteria was before you issued your
1064 report?

1065 Ms. {Iritani.} They did not have any written criteria
1066 regarding how they made these approvals.

1067 Mr. {Burgess.} So it was flip a coin, draw straws, just
1068 how I feel that morning when I get up? No criteria at all?

1069 Ms. {Iritani.} Officials told us that it wasn't within
1070 the Secretary's interests to specify criteria.

1071 Mr. {Burgess.} Well, that brings up the point, because
1072 we kind of watched what is happening down in Florida, and now
1073 that expansion of Medicaid is the number 1 issue for the
1074 Obama Administration going forward, this is the sine qua non
1075 of President Obama's legacy is the expansion of Medicaid. It
1076 really does seem like that power is being brought to bear on
1077 a state that had a functional 1115 waiver for their low-
1078 income pool, now it needs to be re-upped but the pressure is
1079 coming that you have to do something different that you
1080 haven't been doing before. Am I wrong to get that

1081 impression?

1082 Ms. {Iritani.} Well, we would agree that transparency
1083 is needed in the approvals and approval process, and the
1084 criteria that is used, and our concerns have been
1085 longstanding based on reviews of many, many states'
1086 demonstrations.

1087 Mr. {Burgess.} Well, the good news for both of us is
1088 that this is the most transparent Administration in the
1089 history of the country, so we, I guess, can take some degree
1090 of solace on that.

1091 The question about the neutrality, and you brought that
1092 up a couple of times, when approaching and approving these
1093 1115 waivers, but GAO has had some concerns about this,
1094 actually going back into the--into 2008, into the Bush
1095 Administration. Center for Medicare and Medicaid Services
1096 has consistently asserted the policies are adequate and
1097 applied consistently, but really, to me, they are not. Could
1098 you share with us, and again, this may be an answer in
1099 writing because of time, but can you share with us ways that
1100 you think Congress could use to remedy this issue?

1101 Ms. {Iritani.} Yes, we believe congressional
1102 intervention would be helpful in this case. As I mentioned
1103 in my statement, our concerns about the approvals are
1104 longstanding. I think we have a report dating back to the

1105 mid-'90s on the budget neutrality process raising concerns,
1106 and the Secretary has consistently disagreed with our
1107 recommendations to reform the criteria and process around
1108 approving the spending limits. So we have elevated the
1109 recommendations that we made to the Secretary about improving
1110 the process as a matter for congressional consideration.

1111 Mr. {Burgess.} Well, I thank the gentlelady for her
1112 testimony. I will submit those questions in writing.

1113 And, Mr. Chairman, if I could, if you would yield to me
1114 for a unanimous consent request?

1115 Mr. {Pitts.} The gentleman may proceed.

1116 Mr. {Burgess.} Chairman, I have--request unanimous
1117 consent to enter into the record a letter by my attorney
1118 general in Texas, Ken Paxton, several others attorneys
1119 general, about the issue of the 1115 waivers. And I would
1120 ask--

1121 Ms. {Castor.} And, Mr. Chairman--

1122 Mr. {Burgess.} --for its inclusion in the record.

1123 Ms. {Castor.} --I reserve the right to object.

1124 Mr. {Pitts.} All right. The--

1125 Mr. {Burgess.} Again, I make the unanimous consent
1126 request--

1127 Mr. {Pitts.} He has made--

1128 Mr. {Burgess.} --as a matter of--

1129 Mr. {Pitts.} --the unanimous consent request. Do you
1130 object?

1131 Ms. {Castor.} I would just like to make a short
1132 statement, and then I would--

1133 Mr. {Pitts.} All right, the chair recognizes the
1134 gentlelady.

1135 Ms. {Castor.} I just want to point out that part of
1136 that letter is inaccurate when it comes to the State of
1137 Florida and what transpired there, since the State of Florida
1138 was on notice since 2011 that it was unlikely that the low-
1139 income pool was likely to survive in its current form, and
1140 due to the fact that CMS and the State of Florida have, in
1141 fact, negotiated the matter. The state did not expand
1142 Medicaid, and the LIP does survive. This simply points to
1143 the fact that we have all got to work harder to make sure we
1144 are working on behalf of the taxpayers. GAO has been
1145 critical of not allowing federal waivers to spend extra
1146 money, and we have all got to be mindful of that. And if we
1147 take this tact that states get--have coverage, but they get
1148 these uncompensated care pools that don't have much
1149 accountability and transparency, that is not going to serve
1150 Medicaid patients very well, and the congressional intent to
1151 be strict and wise with taxpayer dollars.

1152 But at this time, I will remove my objection. Thank

1153 you.

1154 Mr. {Pitts.} Thank you.

1155 Without objection, the letter is entered into the

1156 record.

1157 [The information follows:]

1158 ***** COMMITTEE INSERT *****

1159 Mr. {Pitts.} The chair thanks the gentleman.

1160 Now recognizes the gentlelady, Ms. Castor, 5 minutes for
1161 her questions.

1162 Ms. {Castor.} Yeah, I just have a quick question. The
1163 transparency regulations also require states to be more
1164 transparent; have hearings, have comment periods, but this is
1165 so difficult for folks who rely on Medicaid services back
1166 home, because remember, Medicaid really it serves primarily
1167 children, the disabled population, elderly in nursing homes,
1168 especially for states that have an expanded Medicaid. They
1169 have transitioned now, many states, to Medicaid managed care.
1170 And what I hear from folks at home is it is very difficult to
1171 have any real idea on where accountability lies, where they
1172 can go for recourse when they have an issue. For example, I
1173 had a woman in my office from Florida last week who has a
1174 severely autistic son, and she--under managed care, they have
1175 changed providers and she hasn't had the ability to weigh-in
1176 with policymakers on how care is going to be delivered to her
1177 son and other families.

1178 Here is another example, doctors are extremely
1179 frustrated. I had a pediatric dentist in my office just a
1180 few weeks ago from Florida. He does the Lord's work in
1181 taking care of hundreds and hundreds of children across my

1182 state and their dental health care needs. And that is smart
1183 because you take care of dental health needs and you save the
1184 state and Federal Government money down the road. But they
1185 do not have any recourse into inquiring at the state level
1186 what is happening with changes in demonstration projects and
1187 waivers. Can the GAO take a closer look at how states can do
1188 a better job? Have you done that and what recommendations do
1189 you have to help these families, patients and providers, have
1190 more access to what is happening?

1191 Ms. {Iritani.} We haven't looked at the public input
1192 process since the year 2000s. We haven't been asked to, but
1193 we would be happy to work with your staff regarding re-
1194 examining how things are working.

1195 As I said earlier, we thought that the federal input
1196 process that was provided for in recent legislation was a
1197 very good step because, before, it was really just up to the
1198 states to get input, and that was often difficult for
1199 beneficiaries and others to weigh-in.

1200 Ms. {Castor.} I will look forward to doing that with
1201 you.

1202 Thank you. I yield back my time.

1203 Mr. {Pitts.} The chair thanks the gentlelady.

1204 Now recognize the gentlelady from North Carolina, Mrs.
1205 Ellmers, 5 minutes for questions.

1206 Mrs. {Ellmers.} Thank you, Mr. Chairman. And thank
1207 you, Ms. Iritani, for being here today with us.

1208 You know, based on your testimony and some of the
1209 questions and discussion today, it looks like CMS is creating
1210 overlap and duplication through its funding of state health
1211 programs. Under Section 1115, basically, CMS is authorizing
1212 federal matching funds for state programs, despite the fact
1213 that other federal agencies already provide funding for these
1214 causes. It would seem that we are duplicating billions of
1215 dollars.

1216 With that, could you discuss the steps that CMS is
1217 taking to ensure that the funding of these state-based
1218 programs does not result in overlap of duplication of federal
1219 funding?

1220 Ms. {Iritani.} We found really mixed results in what
1221 CMS was doing in the documentation around--providing for
1222 assurances that the new spending that they were approving for
1223 the demonstrations would not duplicate other federal funding
1224 sources. There were some states where the documentation
1225 would actually provide for a specific weighing-out of the
1226 different funding streams--

1227 Mrs. {Ellmers.} Um-hum.

1228 Ms. {Iritani.} --and requirements on how to offset--

1229 Mrs. {Ellmers.} Um-hum.

1230 Ms. {Iritani.} --the Medicaid funds with other federal
1231 funding streams, but in many cases, there wasn't such a
1232 requirement, which raised concerns to us.

1233 Mrs. {Elmers.} In your report, it lists that 150 state
1234 programs for which CMS authorized federal Medicaid funding,
1235 while many of the programs, based on their name, appear to be
1236 worthwhile and for good causes. I would like you to expand
1237 on how some of these programs promote Medicaid's objectives.
1238 And I want to give you three examples, and if you can just
1239 help us understand how this fits into the Medicaid space and
1240 should be approved for funding. How about licensing fees in
1241 Oregon?

1242 Ms. {Iritani.} Yes, we--you know, the point of our
1243 report is that we could not tell how that and other examples
1244 of the state programs that were approved actually related to
1245 Medicaid objectives.

1246 Mrs. {Elmers.} So the other two, now, one sounds--that
1247 I--one example I have, healthcare workforce retaining in New
1248 York. Now, certainly, we need a good, strong health, you
1249 know, workforce. Do you feel that that fits into the
1250 Medicaid space as well?

1251 Ms. {Iritani.} We felt like many of the approvals that
1252 CMS had approved were on their face only tangentially related
1253 to Medicaid.

1254 Mrs. {Ellmers.} Um-hum. Um-hum.

1255 Ms. {Iritani.} And without any criteria about how the
1256 Secretary was making these decisions--

1257 Mrs. {Ellmers.} Um-hum.

1258 Ms. {Iritani.} --we could not--

1259 Mrs. {Ellmers.} Determine--

1260 Ms. {Iritani.} --make an assessment.

1261 Mrs. {Ellmers.} Yeah. And then the last one I have is
1262 Fisherman's Partnership in Massachusetts. I am like you, I
1263 am just going to assume that you are going to say that also
1264 fits into that same characterization.

1265 Ms. {Iritani.} Yes.

1266 Mrs. {Ellmers.} And lastly, I just want to ask a little
1267 bit about the broad authority of the 1115 statute. What are
1268 the outer boundaries that the Secretary has to approve
1269 Medicaid funding?

1270 Ms. {Iritani.} The 1115 authority is very broad, and
1271 gives the Secretary discretion to waive certain Medicaid
1272 requirements in 1902, i.e., the Social Security Act, and
1273 approve new costs that are not otherwise eligible for
1274 Medicaid that, in the Secretary's judgment, are likely to
1275 promote Medicaid objectives. It is a broad authority.

1276 Mrs. {Ellmers.} So--and I think that probably is about
1277 the best characterization. It is quite a broad authority,

1278 and gives quite an incredible amount of discretion.

1279 Well, thank you, Ms. Iritani.

1280 That is all I have, Mr. Chairman. Thank you. I yield
1281 back the remainder of my time.

1282 Mr. {Pitts.} The chair thanks the gentlelady.

1283 Now recognize the gentleman from California, Mr.
1284 Cardenas, for 5 minutes for questions.

1285 Mr. {Cardenas.} Thank you very much, Mr. Chairman.

1286 Appreciate this opportunity to go through these issues, Ms.
1287 Iritani.

1288 I hear of some of the concerns about budget neutrality,
1289 but I also understand that CMS has taken new steps to make
1290 their approach to budget neutrality more transparent and
1291 enhance understanding between CMS and the states. On October
1292 5, 2012, the released a Section 1115 template for states to
1293 use in order to clarify the requirements and simplify the
1294 application process. This template includes instructions and
1295 an accompanying budget worksheet that provides guidance on
1296 some of the most commonly used data elements for
1297 demonstrating budget neutrality.

1298 That being the case, is this a step in the right
1299 direction?

1300 Ms. {Iritani.} We would still maintain that much more
1301 is needed. That template that was issued provides guidance,

1302 but it is a voluntary--it--states do not need to use it. And
1303 CMS' written policy is quite outdated in terms of their
1304 typical practices for what they review and how they review
1305 things and what data they require, and we believe that more
1306 reforms to those things are needed to ensure that there is
1307 more consistency and approvals.

1308 Mr. {Cardenas.} Is it the case that, prior to October
1309 2012, that HHS had not issued anything like this?

1310 Ms. {Iritani.} As far as I know, yes.

1311 Mr. {Cardenas.} Okay. Well--so hopefully, what that
1312 means is HHS recognizes the--that they need to have a better
1313 transparency and understanding, and--with everybody involved
1314 when it comes to their responsibilities in giving the states
1315 this flexibility, correct?

1316 Ms. {Iritani.} I--the Secretary has consistently
1317 disagreed with our recommendations that any sort of reforms
1318 to their process for reviewing are needed, and this dates
1319 back to the early 2000s when we first made recommendations to
1320 the Secretary around transparency. And we have multiple
1321 reports, there is a list attached to my testimony statement,
1322 dating back to the mid-'90s. And regarding our
1323 recommendations to the Secretary on transparency and
1324 accountability in the review and approval of spending limits,
1325 the Secretary has consistently disagreed that anything is

1326 needed.

1327 Mr. {Cardenas.} Can you give us an example of one of
1328 those statements of disagreement, based on your reports?

1329 Ms. {Iritani.} We have recommended that the Secretary
1330 issue criteria for how they review and approve the spending
1331 limits, and provide for better documentation regarding the
1332 basis for approvals of the spending limits and make that
1333 publicly available, as well as ensure that states are
1334 required to use appropriate methods for projecting Medicaid
1335 costs.

1336 Mr. {Cardenas.} Um-hum.

1337 Ms. {Iritani.} And the Secretary has indicated that--
1338 generally has disagreed with--that any of those reforms are
1339 needed to the process. And that is why we have elevated our
1340 recommendations to the Congress as a matter for consideration
1341 to require the Secretary to do these things.

1342 Mr. {Cardenas.} So those objections on behalf of the
1343 Secretary based on those recommendations, are--was there any
1344 indication that it is something that they couldn't do, or
1345 just something that they disagree with? Because one of the
1346 problems that I have experienced being a policymaker for 18-
1347 plus years now is that it is one thing to make
1348 recommendations to a department or a government entity, and
1349 it is another thing for them to admit that if we had the

1350 resources, maybe we would do so, but we don't have the people
1351 power or the resources to actually implement those
1352 recommendations. Is there any indication whatsoever that
1353 resources are an issue as well, on behalf of the department?

1354 Ms. {Iritani.} That has not been something that the
1355 Secretary has said. I think that their response has
1356 generally been that they are--they use consistent criteria,
1357 and that they have treated states consistently, and that they
1358 believe that their current policy and practices do not need
1359 reform.

1360 Mr. {Cardenas.} And overall, are you aware of any--of
1361 states overall on balance not appreciating that flexibility,
1362 or that they do, in fact, want to continue that flexibility
1363 relationship with HHS and the individual states?

1364 Ms. {Iritani.} We have not, you know, discussed with
1365 states the spending limit process particularly but, you know,
1366 given that the Secretary has authority to approve new costs
1367 not otherwise matchable, and to approve spending limits that
1368 may be much higher than what, you know, the state has
1369 justified, I would think states would actually embrace it.
1370 But our concern, again, is with the long-term fiscal
1371 sustainability of Medicaid and, you know, how this affects
1372 the federal budget and federal taxpayers.

1373 Mr. {Cardenas.} Thank you. I yield back the balance of

1374 my time.

1375 Mr. {Pitts.} The chair thanks the gentleman.

1376 Now recognize the gentleman from Indiana, Dr. Bucshon, 5
1377 minutes for questions.

1378 Mr. {Bucshon.} Thank you, Mr. Chairman.

1379 As a physician who has taken care of Medicaid patients
1380 for, you know, a couple of decades, this hearing is very
1381 valuable to me today. I want to point out that, you know,
1382 Medicaid is a critical program that we need to--that our
1383 citizens need and--but clearly, we need more oversight. I do
1384 want to point out that, in my view though, the traditional
1385 Medicaid is not good insurance coverage, and that has been
1386 shown already with the Medicaid expansion, under the
1387 Affordable Care Act where emergency room visits are actually
1388 up, not down, across the country. That is not my opinion,
1389 that is factual. And when I was a practicing physician, when
1390 I first came to Evansville, Indiana, there wasn't a single
1391 fellowship trained OB/GYN that would take a Medicaid patient
1392 in our community. Now, that has changed some now that
1393 physicians have been essentially kind of forced into being
1394 employed by hospitals, especially in that area. In one of
1395 the surrounding states surrounding Indiana, some of the
1396 anesthesiologist in my hospital didn't even both to bill
1397 Medicaid for the care that they provided for those patients

1398 because the state ran out of money before the end of the
1399 year, and the reimbursement was so low it didn't even make
1400 sense to spend the administrative costs to bill them.

1401 So that said, some of the things you pointed out about
1402 where waivers are using--it appears to be given with no
1403 specific approval criteria. It is not in a rule, it is not
1404 in a statute, it is not in a law, and that has resulted in
1405 some money, billions of dollars, being spent on non-Medicaid
1406 really type spending that should be associated with that
1407 program. Further, spending money that could be used for
1408 direct patient care, as has been pointed out by a number of
1409 members. So it seems to me that specifically legislation
1410 likely is needed. Would you agree or disagree with that?

1411 Ms. {Iritani.} Well, we would agree that congressional
1412 intervention would--and oversight is--would be important to
1413 addressing these issues.

1414 Mr. {Bucshon.} Yeah. And some states, as you probably
1415 know, have been operating under an 1115 waiver for decades,
1416 and some have suggested that as part of that process,
1417 Congress create a process where longstanding core elements of
1418 an 1115 waiver can effective be grandfathered into the
1419 state's state plan amendment, which directs the operation of
1420 the program. Do you have any thoughts on that?

1421 Ms. {Iritani.} I do not have a comment. Our work has

1422 not looked at that kind of process.

1423 Mr. {Bucshon.} Because it seems to me, I mean if you
1424 have a program in your state that is working, and you have
1425 been getting waivers for decades sometimes, that--during the,
1426 you know, how we utilize the Medicaid Program, we should just
1427 change it so that we don't have to continue to ask for these
1428 waivers. And, you know, Healthy Indian Plan 2.0, which was
1429 put into place after the original Healthy Indiana Plan was
1430 successful, and has data to prove so, you know, we had to
1431 fight for 2 years to get a waiver for something that has been
1432 shown to be effective, and also that the patients, over 90
1433 percent, approve of. And it actually saved probably 2 or 3
1434 percent in our Medicaid budget in our state, and has allowed
1435 us to cover individuals with a--low-income individuals with a
1436 program not--that is not traditional Medicaid, that actually
1437 reimburses providers at a level that they can accept. And so
1438 it actually is increasing access to patient care.

1439 So I don't have a specific question, other than those
1440 comments. I think that many of the questions I have asked--I
1441 were--was going to ask have been answered, but just to say
1442 that, you know, it really is hard to believe that after
1443 decades of recommendations from you all, that we are still
1444 wasting money in the--it seems, in the Medicaid Program, at
1445 the same time where the reimbursement rates to providers is

1446 limiting access to direct care for patient. And it seems to
1447 me, Mr. Chairman, that we are going to need legislative
1448 action.

1449 I yield back.

1450 Mr. {Pitts.} The chair thanks the gentleman.

1451 Now recognize the gentleman from Virginia, Mr. Griffith,
1452 5 minutes for questions.

1453 Mr. {Griffith.} Thank you, Mr. Chairman. Thank you for
1454 being here this morning.

1455 Despite the fact that CBO has indicated that under
1456 ObamaCare, ACA's Medicaid expansion would, on balance, reduce
1457 incentives to work, and that a work requirement component for
1458 the able-bodied would increase available resources for
1459 Americans. To date, CMS has refused to approve work
1460 requirements as a part of a--of Republican state
1461 demonstration waivers. Is there anything in the Section 1115
1462 statute that would prevent CMS from approving work-related
1463 requirements?

1464 Ms. {Iritani.} We have not encountered that kind of
1465 proposal in the work that we have done, so I can't comment on
1466 the Secretary's authority in that case. But as I mentioned,
1467 the 1115 does provide the Secretary with quite broad
1468 authority.

1469 Mr. {Griffith.} So a cursory view would not be

1470 unreasonable for some of us to think that that broad
1471 authority would not preclude a work component requirement for
1472 the able-bodied?

1473 Ms. {Iritani.} As I said, we haven't encountered that
1474 kind of requirement in our work, so I can't comment on that.

1475 Mr. {Griffith.} I appreciate that.

1476 Since 1115 demonstration programs are intended to be
1477 experimental or pilot projects to test new ways of providing
1478 services, it is my understanding that each demonstration is
1479 to be evaluated. Has GAO reviewed the evaluations of
1480 demonstration programs, and if so, what have those
1481 evaluations taught about the ways to reform the Medicaid
1482 Program to provide better access and services to
1483 beneficiaries?

1484 Ms. {Iritani.} We have not been asked to look at that
1485 component of the demonstration, but you are correct, these
1486 demonstrations are supposed to be evaluations and have an
1487 evaluation component. We did, in the mid-'90s, in a report,
1488 discuss the major impact that some of these demonstrations
1489 had on beneficiaries and other things, and looked at the
1490 progress reports that states were submitting to CMS and also
1491 the planning for the evaluations, and found both were
1492 lacking. We made recommendations to the Secretary to improve
1493 both those things, and we have not since been asked to look

1494 at that.

1495 Mr. {Griffith.} Did they ever get back to you and say
1496 that they had implemented your recommendations that you made
1497 back in the mid-'90s?

1498 Ms. {Iritani.} They agreed with the recommendations at
1499 the time, and then at some point, and this is years ago, I
1500 think they said they were no longer--reform was no longer
1501 needed.

1502 Mr. {Griffith.} Thank you. I know that as a part of
1503 waiver renewal, some states send CMS evaluation reports that
1504 may be posted on the CMS Web site. Do you know if CMS also
1505 conducts its own analysis?

1506 Ms. {Iritani.} We haven't look at evaluations for
1507 years, so I can't comment on that.

1508 Mr. {Griffith.} All right. So you don't know if they
1509 are doing their own evaluations--

1510 Ms. {Iritani.} Well, what I do--

1511 Mr. {Griffith.} --because of what the state says?

1512 Ms. {Iritani.} What I do know from our work from the
1513 mid--

1514 Mr. {Griffith.} Yes, ma'am.

1515 Ms. {Iritani.} --2000s is that, you know, the
1516 demonstration terms are typically 5 years, but they can be
1517 less, and that, you know, CMS required at the time that the

1518 state plan an evaluation and that they also, because they
1519 wanted to understand how the demonstrations were working and
1520 if information was being collected to actually do the
1521 evaluation, they required progress reports. But, you know,
1522 that is, again, where we found that the progress reports
1523 weren't always, you know, complete or being turned in timely,
1524 et cetera. So we feel like the evaluation component of the,
1525 you know, the demonstration is--already is an important one.

1526 Mr. {Griffith.} And, of course, if CMS doesn't do their
1527 own evaluation of those demonstrations, it is kind of hard
1528 to--for them to really assess it if they are just relying on
1529 the states.

1530 I do appreciate you being here today. Appreciate your
1531 testimony. Thank you so much for answering my questions.

1532 And, Mr. Chairman, I yield back.

1533 Mr. {Pitts.} The chair thanks the gentleman.

1534 Now recognize the vice chairman of the subcommittee, Mr.
1535 Guthrie, 5 minutes for questions.

1536 Mr. {Guthrie.} Thank you very much. Thank you, Mr.
1537 Chairman, for yielding. And thank you for being here today
1538 and answering the questions.

1539 I want to talk about the budget neutrality policy. In
1540 your testimony, you indicated that one of the problems with
1541 CMS' implementation of its budget neutrality is that it

1542 allowed some states to include hypothetical costs. Can you
1543 provide--define hypothetical costs that CMS has implemented
1544 and some examples of that?

1545 Ms. {Iritani.} Sure. There are two main components to
1546 basically the budget neutrality process and projecting the
1547 cost of Medicaid without the demonstration, which becomes a
1548 basis for the spending limit that would be allowed. One is a
1549 spending base, which is by the policy supposed to be based on
1550 actual historical expenditures for Medicaid in the state for
1551 the recent year. The other is the growth rates that project
1552 costs over the course of the demonstration.

1553 CMS has, since we first started looking at this issue in
1554 the mid-'90s, allowed hypothetical costs that is in the
1555 spending base, so they would allow states to project or use
1556 baselines based on not what they were actually covering,
1557 historical costs, in their Medicaid Program, but what they
1558 could potentially cover, for example, populations,
1559 hypothetical populations that they could cover under the
1560 flexibility under the Medicaid Program, but were not
1561 covering, or payment rates. In more recent demonstrations we
1562 found that CMS has allowed states to assume that they would
1563 be paying providers more than they were actually paying, as
1564 part of their baseline for developing the spending limits.

1565 Mr. {Guthrie.} And then so is there anything that stops

1566 CMS from applying budget neutrality to one state but not
1567 another state? Could they favor one state over another in
1568 the way they apply budget neutrality? Anything to stop them
1569 from doing that? And could this cost--you know, this seems
1570 to cost--could cost billions by allowing hypothetical costs.

1571 Ms. {Iritani.} There are tens of billions of dollars
1572 being approved in these demonstrations, and a lack of
1573 transparency over the basis.

1574 Mr. {Guthrie.} So they could favor one state over--
1575 there is nothing to prevent them from favoring one state over
1576 another in that--they make the decision on a state-by-state
1577 basis I guess is--and so they could--

1578 Ms. {Iritani.} I think oversight--

1579 Mr. {Guthrie.} Needs to be--

1580 Ms. {Iritani.} Oversight.

1581 Mr. {Guthrie.} Okay. And then--so GAO--what would GAO
1582 say to the charge that some have made that budget neutrality
1583 would prevent CMS from making an important investment in
1584 state innovations?

1585 Ms. {Iritani.} Could you repeat the question?

1586 Mr. {Guthrie.} So what would GAO say to the charge that
1587 some have made that budget neutrality prevents CMS from
1588 making important investments in some state innovations?

1589 Ms. {Iritani.} Well, the whole concept of budget

1590 neutrality is that states would figure out how to innovate
1591 and get flexibility from traditional Medicaid rules, but
1592 within their current constraints of what they have been
1593 spending for Medicaid. I think it is one thing to innovate
1594 when you are getting a lot more money to do so.

1595 Mr. {Guthrie.} Um-hum.

1596 Ms. {Iritani.} It is another thing to innovate with,
1597 you know, with flexibility around Medicaid's traditional
1598 requirements, but creating efficiencies in doing so and not
1599 raising costs for the program. And we think that is a very
1600 important concept again--

1601 Mr. {Guthrie.} Um-hum.

1602 Ms. {Iritani.} --getting back to the long-term
1603 sustainability of the program.

1604 Mr. {Guthrie.} But if one state is receiving X amount
1605 of dollars and they want to innovate, and they say you can
1606 innovate within that X amount of dollars, but if one state is
1607 receiving X amount of dollars and CMS says you get X amount
1608 of dollars plus hypothetical cost dollars, that could be
1609 applied on a state-by-state and not consistent, correct? So
1610 that eventually--essentially, a state is getting more money
1611 to innovate, is that--am I reading that wrong--

1612 Ms. {Iritani.} Well--

1613 Mr. {Guthrie.} --or understanding that wrong?

1614 Ms. {Iritani.} Yeah, different states ask--develop
1615 their spending limits different ways.

1616 Mr. {Guthrie.} Well, thank you.

1617 I yield back, Mr. Chairman.

1618 Mr. {Pitts.} The chair thanks the gentleman.

1619 And now recognizes the gentleman from Florida, Mr.
1620 Bilirakis, 5 minutes for questions.

1621 Mr. {Bilirakis.} Thank you, Mr. Chairman. Appreciate
1622 it very much. Thank you for your testimony.

1623 In Florida, we recently finished getting an 1115 waiver
1624 with CMS. I am sure you are aware. It was a long hard
1625 process that included a state law suit against federal--
1626 against the Federal Government over the process. Florida has
1627 had an uncompensated care fund which we call the LIP, the
1628 Low-Income Pool, for our Medicaid Program for almost a decade
1629 now. What should have been a simple process, in my opinion,
1630 to renew that fund turned into a long, drawn-out affair by
1631 CMS who decided to change the rules this year.

1632 Ms. Iritani, when HHS reviews and issues 1115 waivers,
1633 do they follow precedent established with other approvals, or
1634 is every application reviewed from the beginning?

1635 Ms. {Iritani.} If I understand the question, is it when
1636 HHS approves a demonstration, does that set precedent for
1637 others?

1638 Mr. {Bilirakis.} Yeah, for others and maybe previous
1639 applications for that particular state as well. Or is that--
1640 do we have to start from the beginning?

1641 Ms. {Iritani.} Well, we have--

1642 Mr. {Bilirakis.} First with others. Yes.

1643 Ms. {Iritani.} Well, we haven't look at differences in,
1644 you know, how HHS approves new approvals versus extensions
1645 versus amendments, which are all different ways that HHS can
1646 approve things. That said, you know, I think HHS, with every
1647 new approval, does set precedents for other states to follow.
1648 And there are many demonstrations that have been operating
1649 for many years--

1650 Mr. {Bilirakis.} Right.

1651 Ms. {Iritani.} --as someone mentioned.

1652 Mr. {Bilirakis.} Okay, next question. HHS provides GAO
1653 with four general criteria, you stated that, that state
1654 programs must meet to receive the funding through the 1115
1655 Medicaid waiver. However, the criteria are so broad that
1656 they can be interpreted many--in many different ways. The
1657 question, is such activity fair to states and stakeholders,
1658 and does GAO think that HHS needs to issue regulatory
1659 guidance explaining these criteria?

1660 Ms. {Iritani.} Well, we believe that more specific
1661 criteria--written criteria are needed and--otherwise we

1662 believe that many questions about the basis for the
1663 decisions, as well as the consistency of approvals, will
1664 continue to rise.

1665 Mr. {Bilirakis.} And I understand that GAO was not even
1666 aware of these criteria, is that correct?

1667 Ms. {Iritani.} Yes, correct.

1668 Mr. {Bilirakis.} Okay, next question. GAO's work
1669 suggests that there is likely significant duplicative federal
1670 funding streams for state programs and the waivers and other
1671 HHS programs. Do we know if HHS reviews for duplicative
1672 payments prior to or after approval? If not--mechanism for
1673 HHS to prevent duplication or at a minimum recoup duplicative
1674 funding, save billions of dollars for us.

1675 Ms. {Iritani.} We have not looked at how HHS monitors
1676 spending post-approval. We have looked at, you know, what
1677 protections they provided in the terms and--of the
1678 demonstrations regarding preventing duplication and found
1679 variation and, in some cases, no assurances that the new
1680 spending for Medicaid would not duplicate other purposes.

1681 Mr. {Bilirakis.} Okay, next question. In my
1682 estimation, there is a clear lack of uniformity in CMS
1683 decision-making. I think it is pretty obvious from the
1684 testimony. Are there criteria that could explain why 2
1685 states of a similar nature get uncompensated care pools

1686 approved for different lengths of time? And I know my
1687 friend, Mr. Guthrie, touched on this as well.

1688 Ms. {Iritani.} There are no criteria that would explain
1689 that, and that is part of why we are recommending that there
1690 be criteria. We feel like that is important for transparency
1691 and for a common understanding of why the Secretary is making
1692 certain approvals.

1693 Mr. {Bilirakis.} Thank you. One last question, if you
1694 don't mind. I have a couple--few more seconds. Have you
1695 ever encountered an instance when CMS would force a state to
1696 take an action that their governor and the legislature did
1697 not want to take in order to renew the 1115 waiver that was
1698 already in existence?

1699 Ms. {Iritani.} I am not aware of that kind of
1700 circumstance, but we typically haven't--have looked really at
1701 the approvals at the federal level.

1702 Mr. {Bilirakis.} All right, very good. I yield back.
1703 Thank you, Mr. Chairman.

1704 Mr. {Pitts.} The chair thanks the gentleman.

1705 Now recognize the gentleman from Missouri, Mr. Long, 5
1706 minutes for questions.

1707 Mr. {Long.} Thank you, Mr. Chairman.

1708 Doctor, we--if we are facing serious budgetary
1709 challenges, wouldn't it be better for us to prioritize

1710 medical care for patients in Medicaid rather than some of the
1711 questionable projects being approved for federal spending in
1712 these 1115 waivers?

1713 Ms. {Iritani.} We would agree that many of the approved
1714 new costs in the recent demonstrations, that documentation
1715 was lacking as to how they related to Medicaid purposes. And
1716 our position has always been that Medicaid funds should be
1717 for, ideally, covered Medicaid services for Medicaid
1718 beneficiaries. You know, the demonstrations give authority
1719 to the Secretary to approve new costs for purposes of the
1720 demonstration, but they should be furthering Medicaid
1721 objectives, and that is why we think there needs to be more
1722 articulation on the Secretary's part of how she makes the
1723 decisions.

1724 Mr. {Long.} So you do agree that it would be better to
1725 prioritize medical care for patients in Medicaid?

1726 Ms. {Iritani.} We would agree that, yeah, Medicaid
1727 objectives should be the driving--is within--the 1115 is--
1728 should be the driving factor for decisions, and it is just
1729 not clear how the Secretary defines those.

1730 Mr. {Long.} Okay. One of my big concerns about the
1731 growth of the Medicaid Program is there is the temptation to
1732 just cover more people. Everybody always wants to be
1733 philanthropic and, oh, let's cover more, cover more people,

1734 without ensuring that the access is timely and meaningful for
1735 these patients that they are wanting to cover. But from what
1736 I understand of GAO's work, CMS said they define low-income
1737 patients as 250 percent of the federal poverty level. 250
1738 percent, that is a fairly decent income in several districts
1739 around the country. And do you think it is appropriate for
1740 CMS to approve spending Medicaid dollars on what would be
1741 middle-class income in a lot of areas?

1742 Ms. {Iritani.} One of the things we were looking for
1743 when we looked at what new costs that CMS was approving was
1744 whether or not those costs, for example, with the state
1745 programs in the low-income pools, were for providers that
1746 were serving low income and Medicaid individuals. And
1747 didn't--found that some of the programs were for the general
1748 public and--or not clearly linked to low-income populations,
1749 and we find that questionable.

1750 Mr. {Long.} But do you think--so you do find it
1751 questionable, the 250 percent mark?

1752 Ms. {Iritani.} We have--you know, states have great
1753 flexibility to define how they define low income. You know,
1754 the poverty level--levels that they cover under Medicaid vary
1755 greatly. So we don't--we feel like it is the Secretary's
1756 decision and discretion to define what she considers to be
1757 Medicaid purposes--

1758 Mr. {Long.} Which apparently--

1759 Ms. {Iritani.} --we just don't know what they are.

1760 Mr. {Long.} --is 250 percent.

1761 Ms. {Iritani.} It is, you know, within the authority of
1762 the Secretary to define how she defines low income and
1763 Medicaid--

1764 Mr. {Long.} Okay, I have about a minute left here. So
1765 1115 waivers are supposed to further Medicaid's objectives.
1766 Medicaid is a program which exists to provide access to
1767 medical care for vulnerable populations, so how does the
1768 Administration get away with justifying some of these
1769 spending approvals?

1770 Ms. {Iritani.} The Secretary--and it is--and the
1771 response to our draft report, said that they had general
1772 criteria that we discussed earlier that they applied, and
1773 that they apply criteria consistently and treat states
1774 consistently. And that is the general response they had.

1775 Mr. {Long.} Okay, thank you, Dr. Iritani.

1776 And I yield back, Mr. Chairman.

1777 Mr. {Pitts.} The chair thanks the gentleman.

1778 Now recognize the gentlelady from Indiana, Mrs. Brooks,
1779 5 minutes for questions.

1780 Mrs. {Brooks.} Thank you, Mr. Chairman.

1781 I think you have already heard a little bit about the

1782 Healthy Indiana Plan, and at the beginning of 2015, Indiana
1783 was fortunate enough to have its demonstration approved by
1784 CMS. Now, the Healthy Indiana Plan 2.0, or what we call HIP
1785 2.0 as we call it, is really an extension, an expansion, and
1786 some changes made to a very successful Healthy Indiana Plan.
1787 Started under Governor Daniels, and then expanded and changed
1788 slightly under Governor Pence. It provides 350,000 uninsured
1789 Hoosiers with access to healthcare services, but what was
1790 very different about it, and I thought what was really so
1791 effective, started under the first HIP plan, was that
1792 individuals would pay small contributions, and this was a
1793 huge sticking point for CMS, ranging from \$1 up to \$27 a
1794 month based on their income level, into power accounts. And
1795 POWER accounts stand for personal wellness and
1796 responsibility--responsible accounts. Now, this allows
1797 people to create a sense of personal responsibility for their
1798 own health care, put in \$1 a month, up to \$27. And it took
1799 our state years, as the gentleman from my delegation has
1800 already stated, to get this type of plan approved. And it
1801 has had--demonstrated tremendous success. So after it was
1802 finally approved, after our governor had to speak with the
1803 President personally about a very successful program in order
1804 to get it approved, the governor sent--Governor Pence sent
1805 out entire delegation a letter suggesting that the manner--

1806 celebrating the success of finally getting it approved, but
1807 also the delay in the approval process itself caused so much
1808 stress and anxiety among the Hoosiers who were on the plan
1809 that it is just completely unnecessary. And it was all about
1810 the timing, quite frankly, that I am complaining about, and
1811 the manner in which the approval process took place.

1812 It is my understanding CMS has no set time period, is
1813 that right, Ms. Iritani, about how to approve these requests
1814 for waivers. Is that true that there is no time period in
1815 which the CMS director has to provide their decision on these
1816 requests, even of programs that are already in place?

1817 Ms. {Iritani.} I believe there is a time limit on
1818 extensions, but otherwise, no.

1819 Mrs. {Brooks.} And so if any changes or improvements
1820 want to be made to--really speaking of the fact that we
1821 haven't evaluated or delved into the evaluations, the
1822 evaluations, as I understand, of our HIP program were
1823 outstanding--

1824 Ms. {Iritani.} Um-hum.

1825 Mrs. {Brooks.} --and that is why we chose to expand it
1826 for more Hoosiers, and to change it to try to bring more
1827 Hoosiers into the program. The Upton-Hatch, Making Medicaid
1828 Work Blueprint included a proposal for a waiver clock. Would
1829 it make sense for a timeframe to be implemented related to

1830 these Section 1115 waivers, and what kind of guidance should
1831 we have from you and from your study of the waiver process,
1832 what should Congress be taking into consideration as we try
1833 and tighten the timeframe for these waivers for CMS to
1834 approve or to not approve these programs, because they keep
1835 our state legislators in knots, those who are receiving the
1836 benefits of these programs, what kind of factors should we
1837 consider in trying to put a timeframe around these decisions?

1838 Ms. {Iritani.} Yeah, other than the 2013 report that I
1839 mentioned where we looked at the variation in the timeframes
1840 and the factors that CMS told us contributed, including the
1841 complexity and comprehensiveness of the proposals, we haven't
1842 addressed timeframes in our work. We have really focused on
1843 the spending limits and new spending approved, that has been
1844 the scope of our work.

1845 Mrs. {Brooks.} Do you agree though that the timeframe
1846 issue is a significant issue for the states?

1847 Ms. {Iritani.} Some of the factors that CMS said
1848 contributed to the more lengthy approval times included
1849 things like how comprehensive the proposal was. You know,
1850 some states operate their entire Medicaid demonstrations--or
1851 Medicaid Programs under the demonstrations, so it effectively
1852 changes the entire program. It could be the states need to
1853 go back to the legislatures to get new legislation, and when

1854 they do, then there may be changes to the proposal that CMS
1855 has to review. It is very complicated to sort out why things
1856 take so long.

1857 Mrs. {Brooks.} Thank you. Thank you for your work.

1858 I yield back.

1859 Mr. {Pitts.} The chair thanks the gentlelady.

1860 Now recognize the gentleman from New York, Mr. Collins,
1861 5 minutes for questions.

1862 Mr. {Collins.} Thank you, Mr. Chairman. And thank you,
1863 Ms. Iritani. Is that correct?

1864 Ms. {Iritani.} Yes.

1865 Mr. {Collins.} Yes.

1866 Ms. {Iritani.} Thank you.

1867 Mr. {Collins.} For all your testimony. This is an
1868 area, I guess you could say, of overall concern when, as I
1869 understand it, the CBO recently issued their 2015 long-term
1870 budget outlook, and in that, said that in just a little more
1871 than a decade our entitlement spending will consume, along
1872 with service on our debt, 100 percent of the inflow of monies
1873 into the U.S. Government. If we look back 40-some-odd years
1874 ago, it was \$1 in \$3; today, these same programs are \$2 in
1875 \$3, and it is truly a major concern when it would hit \$3 in
1876 \$3.

1877 So something is going to have to give, and unfortunately

1878 in Congress, all too long the kick-the-can mindset of let me
1879 get past my next election is very much alive. And so here we
1880 have the CBO which should be--send a chilling effect to all
1881 of us that we have to make some changes. And Medicaid is
1882 certainly a major contributor on the expense side of those
1883 entitlement programs.

1884 So my question really comes down to maybe asking you do
1885 you have some suggestions for Congress, and as we are looking
1886 at these 1115 waivers, and in particular I think your
1887 testimony indicated that some of these waivers really didn't
1888 go to the core proposition of what Medicaid is there for, but
1889 very tangentially associated with it, and it is even hard to
1890 get your arms around how some of these waivers are
1891 benefitting or could benefit us in the long-term. Do you
1892 have any idea how much--how many dollars are in that kind of
1893 bucket, and do you have any recommendations for anything
1894 Congress could do, however small that might be, to at least
1895 try to stem some of these expenses that we wouldn't have to
1896 have?

1897 Ms. {Iritani.} Yes, we share your concerns about the
1898 impact of these waivers. The spending trends of the funds
1899 that are governed by the terms of demonstrations are rising
1900 significantly. In 2011, we reported that about 1/5 of
1901 Medicaid spending was governed by the terms and conditions of

1902 demonstrations. In 2013, we said it was about 1/4. In our
1903 most recent report it is almost 1/3 of Medicaid spending,
1904 the--over \$500 billion program. So we believe that, given
1905 that the Secretary has disagreed with the need for reforms,
1906 that the Congress should consider requiring the Secretary to
1907 take certain steps to reform the process.

1908 Mr. {Collins.} Well, I think we agree, and I certainly
1909 appreciate you being very forthright in that observation, and
1910 I really do thank you for your testimony.

1911 And with that, Mr. Chairman, I yield back.

1912 Mr. {Pitts.} The chair thanks the gentleman.

1913 Now recognize the vice chair of the full committee, Mrs.
1914 Blackburn, 5 minutes for questions.

1915 Mrs. {Blackburn.} Thank you, Mr. Chairman. And in the
1916 spirit of the College World Series, I am here to bat cleanup,
1917 and I am going to be fast so we can move to our second panel.

1918 I am going to pick right up where Mr. Collins left off.
1919 \$344 billion program, and 1/3 of that is now in the 1115
1920 waivers, correct?

1921 Ms. {Iritani.} Well, total spending including federal
1922 and state, is actually over \$500 billion.

1923 Mrs. {Blackburn.} So in total, over \$500 billion, with
1924 that once they do the state match to the federal.

1925 Ms. {Iritani.} Yeah, \$304 billion--

1926 Mrs. {Blackburn.} Okay.

1927 Ms. {Iritani.} --federal, correct.

1928 Mrs. {Blackburn.} All right. And one of the things

1929 that we are looking at with this, if I have my notes right,

1930 and I want to be sure that we have it right for the record,

1931 is that you have a lot of gray area here on how decisions are

1932 being made--

1933 Ms. {Iritani.} Um-hum.

1934 Mrs. {Blackburn.} --that meeting the objectives has

1935 become very subjective, and that you have not gone in, if I

1936 understood your response to Mr. Bilirakis, you said that you

1937 all have not looked at spending post-approval, or looked at

1938 the outcomes, you have just looked at that process of pushing

1939 the money forward. Am I correct on that?

1940 Ms. {Iritani.} Yes.

1941 Mrs. {Blackburn.} Okay.

1942 Ms. {Iritani.} We have only looked at the approvals of

1943 the spending limits and the basis for them.

1944 Mrs. {Blackburn.} Okay.

1945 Ms. {Iritani.} And--

1946 Mrs. {Blackburn.} But not the outcomes--

1947 Ms. {Iritani.} Correct.

1948 Mrs. {Blackburn.} --of the delivery. All right, and so

1949 that is something that we definitely need to circle back and

1950 do some oversight on. Let me go back to Ms. Castor's
1951 question. Did I understand you to say you have looked and
1952 reviewed the federal end, but you have not looked at the
1953 public input process--

1954 Ms. {Iritani.} Not--

1955 Mrs. {Blackburn.} --on the 1115 waivers?

1956 Ms. {Iritani.} Not since the mid-2000s. We--

1957 Mrs. {Blackburn.} Okay.

1958 Ms. {Iritani.} --that is when we raised concerns about
1959 the lack of a federal public input process that was then
1960 addresses in the recent House reform legislation.

1961 Mrs. {Blackburn.} Okay, and I think that gets to part
1962 of Mrs. Brooks' question also. There have been mixed
1963 results, and you have mentioned that. You have states as
1964 diverse as what Indiana has done, you have Arizona which was
1965 one of your first 1115s. I am from Tennessee. We have a
1966 very mixed result history, if you will, with the 1115 waiver
1967 process. So I--it concerns me that you all have not done a
1968 deep dive, if you will, on looking at the outcomes, reviewing
1969 these results, looking at that public input process, going
1970 through that, because if I am following what you are saying,
1971 we--a conclusion would be that when you set up a
1972 demonstration project, and there are four criteria that have
1973 to be met for this to move forward, and with the subjective

1974 nature of the decision-making process, a state can meet 1 of
1975 four criteria and be approved and be considered a success.
1976 Is that correct?

1977 Ms. {Iritani.} I believe so. That is the--

1978 Mrs. {Blackburn.} So they could have a failing grade,
1979 if you will. If you are on a grading scale of 100, and you
1980 meet one of four criteria, you are at 25 percent
1981 effectiveness, but CMS would consider that a success.

1982 Ms. {Iritani.} The criteria--the first time we saw them
1983 again was just in CMS' response to our report. They were not
1984 issued, you know, in any written guidance. And we have not
1985 since circled back to CMS to see how they apply it, but the
1986 way that they stated it in their response was that,
1987 basically, one of these criteria is--

1988 Mrs. {Blackburn.} Okay, and--

1989 Ms. {Iritani.} --you know, basically what we apply.

1990 Mrs. {Blackburn.} And then setting the spending limits,
1991 they pretty much make it up as they go along, and are
1992 subjective in that approach, if I understood you correct in
1993 your response to Mr. Bucshon.

1994 Ms. {Iritani.} There is a lack of transparency,
1995 definitely--

1996 Mrs. {Blackburn.} Okay.

1997 Ms. {Iritani.} --how they are set.

1998 Mrs. {Blackburn.} With that, Mr. Chairman, I yield
1999 back. And I thank you, Madam Director, for your time today.

2000 Ms. {Iritani.} Thank you.

2001 Mr. {Pitts.} The chair thanks the gentlelady.

2002 And now recognize the ranking member of the full
2003 committee, Mr. Pallone, to bat cleanup, 5 minutes for
2004 questions.

2005 Mr. {Pallone.} Thank you, Mr. Chairman. And I
2006 apologize that I wasn't able to be here until now.

2007 And, you know, I may be repeating some things that
2008 already have been said or have been asked, and so, you know,
2009 forgive me for that. I just wanted to say that after close
2010 to 20 years of recommendations for more transparency into the
2011 Medicaid waiver process, the Affordable Care Act included a
2012 bipartisan provision to improve the transparency of Medicaid
2013 waivers in line with longstanding recommendations from GAO.
2014 Today, because of this provision, the public has meaningful
2015 opportunities to provide input into the waiver process of
2016 both the state and federal level, and waivers are now
2017 evaluated on a periodic basis, and states submit reports on
2018 implementation, and this is a huge step in the right
2019 direction, in my opinion.

2020 I am further encouraged by CMS' concurrence with GAO
2021 recommendations, specifically in their April 2015 report for

2022 better ongoing and transparent documentation of how states
2023 spend Medicaid dollars. This is a recommendation that prior
2024 Administrations had refused to correct, and I continue to
2025 believe it is the right thing to do, ensure dollars are
2026 following our Medicaid beneficiaries.

2027 But let me ask a couple of questions, if I can. In
2028 reviewing the GAO recommendations over the last 20 years, it
2029 appears as though your recommendations have remained the same
2030 until only recently. Isn't it true that the majority of
2031 these recommendations were not acted upon until Obama
2032 Administration initiatives and the Affordable Care Act, which
2033 placed many of your recommendations into action?

2034 Ms. {Iritani.} Well, we have made many--over a dozen
2035 recommendations over the course of this time, and only a
2036 couple have been implemented, including the public input
2037 process that you mentioned that was implemented in 2012.

2038 Mr. {Pallone.} Okay. And, of course, that was under
2039 the--under President Obama, 2012. Based on the GAO reports,
2040 it appears that GAO recommendations on the budget neutrality
2041 accounting principles have remained unchanged since as far
2042 back as the 1990s. So is it true to say that this
2043 fundamental disagreement between HHS and GAO has remained the
2044 same, regardless of which political party has controlled the
2045 presidency?

2046 Ms. {Iritani.} Yes.

2047 Mr. {Pallone.} Okay. And then the last thing I wanted
2048 to ask, and to follow up on that, isn't it true that GAO went
2049 so far as to issue a letter to HHS from GAO's chief legal
2050 counsel regarding budget neutrality issues in the prior
2051 Administration--I mean under the last President Bush?

2052 Ms. {Iritani.} It is true in 2007, our legal counsel
2053 did issue a letter to the Secretary at the time, raising
2054 concerns with two states' approvals, yes.

2055 Mr. {Pallone.} And have you had to take such action
2056 under the current Administration, under the Obama
2057 Administration?

2058 Ms. {Iritani.} We have not.

2059 Mr. {Pallone.} Okay. All right, thanks a lot.

2060 Again, Mr. Chairman, I am not going to take up too much
2061 time because I came in at the end here, but thank you for the
2062 opportunity here.

2063 Mr. {Pitts.} The chair thanks the gentleman.

2064 That concludes the questions of members present. We
2065 will have follow-up questions in writing. I know some of the
2066 members not here have questions. We will send those to you
2067 in writing. We ask that you please respond promptly. Thank
2068 you very much--

2069 Ms. {Iritani.} Thank you.

2070 Mr. {Pitts.} --for your testimony this morning.

2071 Now, as our staff sets up the table for the second
2072 panel, we will take a 3-minute recess.

2073 The committee stands in recess.

2074 [Recess.]

2075 Mr. {Pitts.} Okay, the time for recess having expired,
2076 we will convene--reconvene the subcommittee. And I will
2077 introduce our second panel in the order of their
2078 presentations.

2079 We are delighted to have today the Honorable Haley
2080 Barbour, former Governor of Mississippi, and Founding Partner
2081 of BGR Group, with us this morning. Mr. Matt Salo, Executive
2082 Director, National Association of Medicaid Directors. And
2083 Ms. Joan Alker, Executive Director, Georgetown University
2084 Center for Children and Families. Thank you each for coming
2085 today. Your written testimony will be made a part of the
2086 record. You will each be given 5 minutes to summarize your
2087 testimony. There is a series of lights on--so when the
2088 yellow light goes on, that is 1 minute left, and red light
2089 means you can wrap up at your convenience.

2090 And at this point, the chair recognizes Governor Barbour
2091 5 minutes for your summary.

|
2092 ^STATEMENTS OF HALEY BARBOUR, FORMER GOVERNOR OF MISSISSIPPI
2093 AND FOUNDING PARTNER, BGR GROUP; MATT SALO, EXECUTIVE
2094 DIRECTOR, NATIONAL ASSOCIATION OF MEDICAID DIRECTORS; AND
2095 JOAN ALKER, EXECUTIVE DIRECTOR, GEORGETOWN UNIVERSITY CENTER
2096 FOR CHILDREN AND FAMILIES

|
2097 ^STATEMENT OF HALEY BARBOUR

2098 } Mr. {Barbour.} Thank you, Mr. Chairman. When I last
2099 testified before the committee, I was actually governor. I
2100 want to make plain that I am not governor anymore. I don't
2101 speak for the governors or the Republican governors, or even
2102 the Governor of Mississippi. This is what I think.

2103 You know, states are trying to juggle demands of
2104 increasing health care costs while trying to balance their
2105 budget. Most of our states actually literally balance the
2106 budget every year, and this is a huge part of it. In 2014,
2107 the Federal Government spent \$300 billion on Medicaid; \$344
2108 billion this year as I understand it, but also the states
2109 spend a ton of money on Medicaid. Medicaid expects in the
2110 next 10 years that that budget for the Federal Government is
2111 going to go to \$575 billion. And when you put in what the
2112 states do, it will be about \$1 trillion. About \$1 trillion.

2113 So this is a big burden on the states' budgets and on the
2114 federal budget. I think we all ought to remember that about
2115 2/3 of all federal spending is mandated for entitlements or
2116 payments on the national debt. That is--and that percentage
2117 is growing. Any discussion of Medicaid and our healthcare
2118 programs must include some mention of our ability to pay the
2119 bills that we are accumulating, because what we do today
2120 affects future generations' ability to pay the debt that we
2121 burden them with, and affects their chance to experience the
2122 American dream that we have been blessed to experience.

2123 Since January of 2009, the federal debt has gone up 73
2124 percent, and that can't continue. We have to provide quality
2125 health care for the truly needy in a cost-effective manner,
2126 and one way to help do that is to give each state the
2127 flexibility to run its Medicaid Program in the manner that
2128 best meets the needs of its population. I personally believe
2129 Congress should give states authority to adjust their
2130 programs without any CMS waiver, as long as it is within the
2131 law. But at a minimum, the waiver process needs to be
2132 improved.

2133 For instance, should states be able to ask some
2134 nondisabled adults if they prefer to pay a small copay if it
2135 better ensured their being able to see a doctor. Not really
2136 a problem in Mississippi. Eighty-three percent of our

2137 doctors take new Medicaid patients. But you all have already
2138 cited a story in California where somebody got on Medicaid
2139 and then couldn't see a doctor. In New Jersey, about 38
2140 percent of doctors take new Medicaid patients. Wouldn't our
2141 patients be better off if they really did have a way to get
2142 care, even if it meant paying voluntarily, on their own
2143 choice, a small copay? I believe copays really help make the
2144 system work. When people miss an appointment, there ought to
2145 be a copay because they have cost somebody else an
2146 appointment, they have cost another Medicaid person or some
2147 other patient. I believe states should be allowed to do work
2148 requirements, or job training and retraining, for able-bodied
2149 adults who are on Medicaid. CMS is standing in the way of a
2150 lot of state innovation by not approving commonsense waivers,
2151 and taking long, long periods of time to improve--to approve
2152 the ones they do.

2153 It has been talked about already about the opacity that
2154 this is not transparent, inconsistent standards, and the
2155 concerns about favoritism or about using waivers as a way to
2156 coerce states. CMS has reached an agreement principle with
2157 Florida on the Florida LIP program. The bottom line though
2158 is Massachusetts got theirs last year in October, about the
2159 same time that Florida was applying. The Medicaid Program in
2160 Florida asked CMS in the fall, and just now there is an

2161 agreement in principle. By the way, that agreement in
2162 principle cuts the contribution to the program by more than
2163 1/2 in the first year, and by 2/3 in the second year for what
2164 Florida will receive.

2165 We do need transparency so that the states understand
2166 the process, how to get things approved, and I would say to
2167 you, not only should there not be different rules for
2168 different states, I believe when a state like Indiana
2169 institutes a program and it works well, and we test whether
2170 it is working well and find that the results are good, it
2171 ought to be an easier process for another state to adopt
2172 that. Things that work, we ought to encourage. If Oregon
2173 has something that works and we think it fits Mississippi, it
2174 ought to be easier to get a waiver for that than starting at
2175 scratch. So I would encourage the committee to go to block
2176 grants, but I would certainly encourage you to adopt a waiver
2177 clock, to adopt some rules about transparency, and remember,
2178 a successful program under a 1115 also ought to be allowed to
2179 become permanent if we see that the results are such, why
2180 should they have to go back every couple of years?

2181 I--sorry, I ran 14 seconds over. Pretty good with my
2182 accent.

2183 [The prepared statement of Mr. Barbour follows:]

2184 ***** INSERT 2 *****

|

2185 Mr. {Pitts.} You are pretty good. Thank you.

2186 The chair recognizes Mr. Salo 5 minutes for your

2187 summary.

|
2188 ^STATEMENT OF MATT SALO

2189 } Mr. {Salo.} All right, thank you, Mr. Chairman, Ranking
2190 Member Green, members of the committee.

2191 I represent the 56 state and territorial Medicaid agency
2192 directors. We have talked a lot about how big Medicaid is.
2193 I don't want to belabor that, but I do want to underscore how
2194 complex it is, and I think a lot of people don't fully
2195 appreciate that.

2196 We cover, yes, a lot of children, lot of pregnant women,
2197 lot of low-income families, but we also cover a lot of
2198 individuals with disabilities; intellectual, developmental,
2199 physical, as well as a lot of people who need long-term
2200 services and supports. In fact, we are the largest payer in
2201 the healthcare system of long-term care, of mental health, of
2202 HIV/AIDS care, et cetera. It is a complex, it is a difficult
2203 program.

2204 Our members are responsible and accountable for the
2205 program. They are striving to provide the best possible
2206 health care to the citizens we serve, and also be wise
2207 stewards of the taxpayer dollar. They are also hard at work
2208 actively driving program reform.

2209 Now, less people think that driving program reform means

2210 that the underlying program is broken. I would say
2211 unequivocally, no. And, in fact, I would posit to you the
2212 challenges of the broader U.S. healthcare system, which is
2213 failing us. Take a look at this. Costs--health care cost
2214 inflation has exceeded CPI for decades. Health care is now
2215 18 percent of the Nation's GDP. We have suboptimal outcomes
2216 to show for that. We also have profound political division
2217 about what the future is--of health care is. But I think an
2218 important piece here is that we have also had decades of
2219 either proactive or passive policies in this country of
2220 either ignoring or actively shifting responsibility for many
2221 of these difficult populations directly to Medicaid, and that
2222 is why we are the largest payer for the most complex, the
2223 most expensive, and the most difficult to serve populations
2224 in this country.

2225 So what are we doing about it? We are actively trying
2226 to reform a healthcare system, a fee-for-service system that
2227 does not serve these populations well. As Dennis Smith once
2228 said, fee-for-service, FFS, ought to stand for fend for self,
2229 because that is what we are requiring of the sickest, the
2230 frailest, and the most complex patients.

2231 This--but this is hard, and part of the challenge is
2232 that the statute at 50 does not allow us to do what we need
2233 to do, so we rely on waivers. And we have been relying on

2234 waivers for decades to drive program improvement. In Arizona
2235 in 1982, in a number of states in the mid-'90s, with the
2236 private option in Arkansas and other states who have done the
2237 expansion recently. With Indiana, as we have heard, and with
2238 many other states that are doing DSRIP or other types of
2239 programs. We have a long history of success with this, and
2240 accountability does exist. There are evaluations, there is
2241 reporting, and even though GAO may not particularly like it,
2242 there are budget neutrality calculations. And finally, there
2243 is significant public input.

2244 Which is not to say we think the system is working
2245 perfectly. We think there are a number of changes that can
2246 and should be made. We have been fairly vocal in what these
2247 kinds of things should be. Our short--is the system should
2248 be more of an HOV program, and the HOV for us stands for
2249 healthy patients, outcomes, and value to the taxpayer and
2250 value to the healthcare system. These principles ought to
2251 drive what we are doing and how we are able to do it.

2252 We have a number of ideas that we--I am more than happy
2253 to talk about; ways that we can get there. Some are
2254 incremental, some are bigger, some of them will require
2255 congressional input. One of those, as Governor Barbour
2256 referenced, is sort of a pathway to permanency, and we can
2257 talk more about how that might play out. But I do also think

2258 there is a--we need more--we do need more timely approvals
2259 and renewals. We can talk about what that might look like,
2260 but I think a big challenge, in all honesty, is capacity;
2261 capacity at CMS to be able to do the reviews in a timely
2262 manner. And I think we need to keep in mind that there needs
2263 to be a balance between transparency and flexibility. The
2264 flexibility--we do need transparency, but we do need the
2265 flexibility to innovate, and I think we need to be careful
2266 about proscribed definitive checklists of what can or what
2267 cannot be done because that sets a ceiling for what can be
2268 innovated, not a floor. And I think we need to be very
2269 mindful about how do we spread the innovation once we know
2270 that it works.

2271 So let me close on this and just say that I think a lot
2272 of states spend a lot of time, energy, resources, on chasing
2273 paper trails, on trying to, you know, prove to everyone's
2274 satisfaction budget neutrality or other types of process
2275 requirements, too much time arguing about the cost per unit
2276 of widgets that do not contribute to the overall value of the
2277 healthcare experience, and that we need to start investing
2278 more in state capacity to actually drive the changes that we
2279 seek. And I would be happy to talk about some solutions to
2280 that as well. Thank you.

2281 [The prepared statement of Mr. Salo follows:]

2282 ***** INSERT 3 *****

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2283 Mr. {Pitts.} The chair thanks the gentleman.

2284 Now recognizes Ms. Alker 5 minutes for her opening

2285 statement.

|
2286 ^STATEMENT OF JOAN ALKER

2287 } Ms. {Alker.} Thank you so much, Chairman Pitts, Ranking
2288 Member Green, and members of the committee.

2289 I really appreciate the opportunity to be here today
2290 because I have been studying Medicaid waiver policy for many,
2291 many years now, and while I find it fascinating, many think
2292 it is sort of boring. So I am thrilled that you are
2293 interested in this issue.

2294 I would also like to commend the GAO for their long
2295 history of excellent work on this issue. It has been 20
2296 years now that GAO has been writing reports that I have been
2297 reading, raising questions and concerns about Medicaid waiver
2298 policy, and these issues have arisen regardless of which
2299 party; Democrats or Republicans, have controlled the
2300 Executive Branch.

2301 And today, I am going to focus on two areas of concern
2302 raised by the GAO; the need for transparency and robust
2303 public input, as well as the question of budget neutrality.
2304 And the good news from my perspective is that after 20 years
2305 of scrutiny by GAO and others on these issues, I think we are
2306 finally making significant progress on both of these issues,
2307 but there is still some work that needs to be done.

2308 So first on the issue of transparency, I do believe it
2309 is vitally important to have a very strong and robust process
2310 for public comment at both the state and the federal levels.
2311 This is an idea that has long bipartisan support. Senators
2312 Grassley and Baucus worked on this on the Senate side. And
2313 language was included, as you heard, in the Affordable Care
2314 Act, and that was implemented through regulations in 2012 by
2315 the Obama Administration.

2316 So these changes have led to dramatic improvements in
2317 the public comment process, but I would like to make a few
2318 suggestions to the committee for you to consider that might
2319 lead to greater transparency and better public input in the
2320 waiver process.

2321 The first suggestion is that current public input
2322 requirements only apply to new Section 1115 applications or
2323 renewals, but not to amendments to existing Section 1115
2324 waivers. Since so many states already have Section 1115
2325 waivers, there are many important changes that occur through
2326 the amendment process. So I believe it would be a valuable
2327 amendment to the law to ensure that amendments were also
2328 subject to the public input requirements.

2329 Second, while significant progress has been made with
2330 respect to having waiver applications and approvals online at
2331 Medicaid.gov, there is more work to be done here. Many

2332 important documents such as operational protocols, quarterly
2333 and annual reports, and other significant deliverables often
2334 required in terms and conditions that come with Section 1115
2335 waivers are not always publicly available on Medicaid.gov,
2336 and I would urge you to urge CMS to make sure those are
2337 publicly available as soon as possible.

2338 And then finally I will just say, I think the suggestion
2339 came up from a number of committee members earlier in the
2340 day, I think it would be terrific to have GAO do a report
2341 that looks specifically at how the public comment process is
2342 working, particularly at the state level.

2343 Now, let's turn to budget neutrality. Again, GAO has
2344 found that administrations of both parties have approved
2345 budget neutrality, Section 1115 agreements, which in GAO's
2346 judgment were not adequately supported by sound documentation
2347 and adequate methodology.

2348 So budget neutrality is very complex and, of course,
2349 when the Secretary makes decisions about what state programs
2350 to include or how to assess budget neutrality, the Secretary
2351 is responding to state requests. CMS is not just making
2352 these things up; CMS is always responding to a state's
2353 request. And so by definition, every state's request is
2354 different. But I think in the past few months we have seen
2355 some encouraging signs from the Obama Administration with

2356 respect to how Secretary Burwell plans to approach budget
2357 neutrality agreements going forward. In particular, on April
2358 14, 2015, CMS Director, Vikki Wachino, sent a letter to the
2359 State of Florida indicating three principles by which they
2360 would approach their review of Florida's low-income pool,
2361 which has been discussed here today. In addition to sending
2362 this letter to Florida, press reports indicated that CMS also
2363 made calls to eight other states that currently have some
2364 kind of uncompensated care pool through a Section 1115 waiver
2365 agreement. These were both states that have done Medicaid
2366 expansion and states that have not done Medicaid expansion,
2367 and they have shared the same principles to signal their
2368 intent to apply these criteria across states. Even more
2369 recently, I understand CMS has started including specific
2370 ways in which expenditures authority, and I believe this is
2371 part of the Oregon health plan extension that was just
2372 approved, where they tie, in the Secretary's judgment, how
2373 those expenditure authorities are linked to the objectives of
2374 these programs.

2375 So both of these actions that I have just described,
2376 something that I have never seen before in the last 20 years,
2377 so that is encouraging to me, but I do think we will need to
2378 continue to monitor this issue very closely.

2379 So thank you very much for the opportunity to testify.

2380 [The prepared statement of Ms. Alker follows:]

2381 ***** INSERT 4 *****

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2382 Mr. {Pitts.} The chair thanks the gentlelady, and
2383 thanks all of you for your testimony.

2384 We will begin questioning now. I will recognize myself
2385 5 minutes for that purpose.

2386 Governor Barbour, yesterday, 10 Republican attorneys
2387 general wrote Chairman Upton expressing their concern over
2388 CMS' coercion to try and get Florida to expand Medicaid under
2389 the Affordable Care Act. As you know well, the Supreme
2390 Court's NFIB v. Sebelius ruling made such an expansion
2391 voluntary for states. Do you believe the Administration's
2392 actions here are legally problematic?

2393 Mr. {Barbour.} I do. These attorneys general are there
2394 because of something we have been talking about; the lack of
2395 transparency, the lack of real hard rules so you don't--you
2396 have so much discretion. And certainly, states see it as
2397 coercion because they did not choose to expand Medicaid under
2398 the ACA. So that appears to be the case. We will see what
2399 the court decides. But I will say this, it is--for a lot of
2400 states, this idea of 115--1115 waivers would affect them
2401 tremendously, and they think they are not getting their
2402 waivers treated the same, and there is some evidence of that.
2403 If you look at the low-income pool program in Massachusetts
2404 and the one in Florida, both of them have been in effect for

2405 a long time, yet Massachusetts was approved last year, well
2406 before the time needed so that they could plan for their
2407 budget. Florida got really hung up, ended up going through a
2408 special session because they didn't get approved the same
2409 time as Massachusetts. So I think that is why these people
2410 are thinking that.

2411 Mr. {Pitts.} Thank you, Governor. And I will let each
2412 of the others also respond to this. It is my understanding
2413 that CMS has no set period of time for reviewing and
2414 responding to a request for an 1115 waiver, but CMS has to
2415 review and respond to other waivers for managed care and home
2416 and committee-based services within a certain timeframe. So
2417 my question is, would it make sense for a timeframe to be
2418 implemented related to the Section 1115 waivers?

2419 Mr. {Barbour.} Yes, sir.

2420 Mr. {Pitts.} Mr. Salo?

2421 Mr. {Sale.} I think conceptually that makes sense
2422 because I do think the challenge is that you are correct,
2423 there is a lot of frustration that sometimes approvals and--
2424 or renewals can take a very long time to get. I would
2425 caution though that in practice, I would worry that a
2426 definitive clock might just--if we don't have the rules in--
2427 if we don't have the structure in place to ensure that CMS
2428 has the capacity to look through these, that a short clock

2429 might just get them to know faster--

2430 Mr. {Pitts.} Ms. Alker?

2431 Mr. {Salo.} --which is not what we want. We want to be
2432 able to get to yes faster, and I think we need to focus on
2433 that. But certainly, to speed the process up.

2434 Mr. {Pitts.} Ms. Alker?

2435 Ms. {Alker.} So I would say a few things. First of
2436 all, I think many of the recent substantial waiver approvals,
2437 like Arkansas and Iowa, happened pretty darned quickly. And
2438 we have to balance the committee's interest and the need for
2439 transparency and public input with this desire to have quick
2440 approvals, and I think we have to find kind of the sweet spot
2441 where you allow sufficient time for public input and comment
2442 with adequate time for CMS to review this very complex policy
2443 and make decisions. And I will just give one example. The
2444 GAO in, I believe, 2007 did a report criticizing approvals at
2445 that time by the Bush Administration of the Florida waiver
2446 and the Vermont waivers, and underscored the lack of public
2447 input. And I believe the world record approval for Section
2448 1115 went from Governor Bush to President Bush, and it was 8
2449 business days. So that wasn't great because, clearly, a lot
2450 of that was sort of wired out of the public eye. So again, I
2451 think we need to balance the need for timely and efficient
2452 government action with the need for appropriate public

2453 comment and oversight by yourselves, as well as the public.

2454 Mr. {Pitts.} Mr. Salo, you mentioned in your testimony
2455 the length of waiver process. You indicate it took nearly a
2456 year on average from the time a waiver application is
2457 submitted until it is approved. My understanding is that
2458 there are often months of negotiations that occur even before
2459 the application is submitted. Can you please discuss a
2460 little bit more the difficulty that such a lengthy process,
2461 nearly 1/4 of a governor's term, nearly 1/2 of a term of the
2462 member--of a Member of the House, like myself, creates for
2463 states and for Medicaid Program beneficiaries?

2464 Mr. {Salo.} Sure. And I think, you know, I do want to
2465 be careful to acknowledge the--and respect the dialogue that
2466 has to go on between the states and their federal partners on
2467 this. That dialogue is important. And, you know, and there
2468 is a certain amount of deference that we should allow the
2469 Administration, any Administration, as the payers of 1/2 this
2470 program. But as you pointed out, when you drag out these
2471 negotiations, oftentimes what you will have is amendments
2472 that need to follow, and other things that are related get
2473 backed up, and that can bring the effective, you know,
2474 functioning of good government to a slow crawl. And that is
2475 not going to be in the best interests of the patients, it is
2476 not going to be in the best interests of the healthcare

2477 system.

2478 Mr. {Pitts.} The chair thanks the gentleman.

2479 And now recognize the ranking member, Mr. Green, 5
2480 minutes for questions.

2481 Mr. {Green.} Thank you, Mr. Chairman.

2482 Ms. Alker, my home state of Texas is next in line for
2483 renewal of their waiver, and I want to be clear I am proud of
2484 what my state has accomplished through the delivery system,
2485 reform efforts have dramatically improved the quality of care
2486 for the Medicaid beneficiaries, and look forward to working
2487 with CMS and Texas to start the process. But I also want to
2488 make sure that, as a former state legislator, I think it is
2489 almost medical malpractice not to expand Medicaid in--for the
2490 states based purely on politics, which is what we are doing.
2491 And in Texas, I know every hospital executive I know has
2492 asked the legislature expanded, just like they have in other
2493 states, because people are not being served. And so--but
2494 that is, again, the states' decision by the Supreme Court.

2495 And I want to correct the record here because there is a
2496 lot of misinformation flying around about Texas is just like
2497 Florida. Isn't it true that some undeniable similarities
2498 that both of our states have so-called uncompensated care
2499 pools, but that part of their respective Medicaid waivers and
2500 that Florida seems to have a tough time with. Ms. Alker,

2501 isn't it true that no one state has the same type of so-
2502 called uncompensated care pool?

2503 Ms. {Alker.} That is definitely true, and Texas'
2504 waiver, I would say, is a lot more complicated than
2505 Florida's.

2506 Mr. {Green.} Okay. And wasn't there a fact that the
2507 longer term issues at play with the structure of Florida's
2508 pool?

2509 Ms. {Alker.} Yes, in 2008 actually, GAO issued a report
2510 that criticized the budget neutrality assumptions underlying
2511 Florida's low-income pool.

2512 Mr. {Green.} Is it true that Florida actually would
2513 have been able to get more federal dollars from the expansion
2514 plan that was under--than that that was under consideration
2515 by the legislature?

2516 Ms. {Alker.} That is definitely true, and of course,
2517 those matching dollars would come in at 100 percent match
2518 currently, as opposed to their regular match rate which is
2519 about 60/40, so they would get a lot better return on
2520 investments by taking up the expansion dollars.

2521 Mr. {Green.} Ms. Alker, Governor Barbour's written
2522 testimony is very critical in that--cost sharing in Medicaid,
2523 however, in 2013, CMS issued a final rule that revised
2524 Medicaid's cost sharing policies. The rule increased in the

2525 maximum allowable cost sharing amounts that the states can
2526 impose on Medicare beneficiaries, including individuals below
2527 the poverty line without a waiver. Ms. Alker, would you say
2528 that states have considerable flexibility to whether we agree
2529 or not with it--not here today implement cost-sharing
2530 policies for Medicaid?

2531 Ms. {Alker.} That is true, and I think one of the
2532 common misconceptions about Medicaid is that you have to get
2533 a waiver to do any--everything, and that is just not true.
2534 We see that time and time again. As you mentioned, states
2535 are allowed to impose nominal copays on the adult population,
2536 and they don't need a waiver to do so.

2537 Mr. {Green.} Okay. And again, in Governor Barbour's
2538 written testimony he noted that Medicaid providers should be
2539 able to charge beneficiaries a fine if they miss their
2540 appointments without notifying their doctors. And I am
2541 concerned that we are pushing ineffective policy we know
2542 don't work because, while CMS actually approved Arizona's
2543 request to impose a \$3 missed provider fine back in 2011, the
2544 state ultimately let the authority expire because there was
2545 so little provider participation. Is that correct?

2546 Ms. {Alker.} Yeah, I think that speaks to the issue
2547 that came up earlier, that we need really robust evaluations
2548 of waiver demonstrations that have happened in the past, some

2549 of which we already know that are not--simply not good
2550 policy.

2551 Mr. {Green.} One of the issues I know with Arizona
2552 findings, but also like Georgia's emergency room
2553 demonstration, goes unnoticed. Do you think it is--or it
2554 might be worthwhile to explore how we can evaluate and make
2555 publicly available the results of these demonstrations so
2556 that we might learn what strategies work to actually improve
2557 care and lower cost?

2558 Ms. {Alker.} Absolutely. I am certain, obviously, as a
2559 public policy professor, very much a fan of evidence and
2560 research base to inform our public policy decisions. I would
2561 say a couple of things about the evaluation process. I do
2562 believe that it would be a great question to ask CMS that
2563 they have commissioned an overall evaluation of some of these
2564 new Section 1115 waiver approvals--recent approvals, that
2565 that is in process. It would be great to learn more about
2566 that, because one thing I have observed is that sometimes in
2567 the evaluation process, particularly at the state level, that
2568 if you have the state paying the evaluator, that the
2569 researchers may not always be objective. So we need to
2570 ensure that we have independent evaluations to assess these
2571 policy choices going forward.

2572 Mr. {Green.} Okay. Mr. Salo, in balancing transparent

2573 flexibility, you noted that you fear strict guidelines for
2574 wavier approval might quickly become obsolete as our medical
2575 system advances. Would you agree that a set of broad
2576 principles should be--such as those put forth by the
2577 Administration is, in fact, the best balance to achieve these
2578 program goals?

2579 Mr. {Salo.} In short, I would say yes. I think it is
2580 more important to have broad guidelines than clearly
2581 delineated checklists because, let's face it, what is
2582 approvable today would not have been conceived of or
2583 approvable 15 years ago.

2584 Mr. {Green.} Yeah.

2585 Mr. {Salo.} And it is in all likelihood the innovations
2586 that are going to be driving real healthcare system
2587 improvement 10 years from now, many of which we probably
2588 haven't thought of today. So we are going to need the
2589 ability to think about things very different. This is an
2590 iterative process. Innovation is a dynamic and fluid
2591 process.

2592 Mr. {Green.} Thank you, Mr. Chairman.

2593 Mr. {Pitts.} The chair thanks the gentleman.

2594 Now recognize the gentleman from Indiana, Dr. Bucshon, 5
2595 minutes for questions.

2596 Mr. {Bucshon.} Thank you, Mr. Chairman. I think,

2597 again, it just strikes me the mere fact that we are talking
2598 about waivers shows you that maybe the program itself needs
2599 to be changed so we don't have to have so many waivers. Same
2600 thing is probably true in education with No Child Left
2601 Behind, it needs reauthorized in a different way. We are
2602 giving waivers to states because of poor policy that needs to
2603 be changed by Congress, and it seems like this may be an area
2604 that needs to be addressed. We are continuing to address
2605 today, and as a healthcare provider, I can say it is, you
2606 know, coverage and not really delving into cost. And I think
2607 some of you in your testimony have pointed out that, you
2608 know, the rising cost of health care and the inflation in
2609 health care is something that has to be addressed. I mean we
2610 are not going to keep up with the cost of the system going
2611 up, like the governor pointed out, if you don't start to
2612 address that as an issue and not just address coverage.

2613 And if you are going to address coverage, you should
2614 address good coverage. And as I pointed out in the previous
2615 panel, I can tell you from experience that the Medicaid
2616 Program, although critical, is financially strapped and
2617 doesn't necessarily guarantee access to physicians. Again,
2618 Governor Barbour pointed out that in New Jersey, only 38
2619 percent of physicians are taking new Medicaid patients.

2620 So that said, and the other thing I--someone mentioned

2621 earlier that hospitals in certain states are asking for
2622 Medicaid expansion. I would too because it means a huge
2623 financial gain for the hospitals, and the implication that
2624 that means that it is, you know, for all truism of covering
2625 people is not necessarily the case. And I just wanted to
2626 point that out.

2627 So with that, Mr. Salo, some have mentioned today that
2628 in recent years there has been greater transparency in the
2629 waiver process, such as through the adoption of requirements
2630 for public input both at the state and federal level. The
2631 ability for the public to provide input on proposed Section
2632 1115 waivers is very important, of course, but it sounds like
2633 there has been still a lack of transparency and consistency
2634 regarding CMS' criteria for assessing 1115 demonstration
2635 applications. How does this lack of transparency affect
2636 state Medicaid Programs, and what recommendations do you have
2637 for improving the demonstration application and approval
2638 process?

2639 Mr. {Salo.} So I think a couple of things probably need
2640 to be done. Again, we--several of us have referred to this
2641 pathway to permanency. Because 1/3, as we have heard from
2642 GAO, 1/3 of all program spending is now incorporated into an
2643 1115 waiver, pretty much--pretty soon that is going to become
2644 the norm, rather than the--than a different example. So--and

2645 a lot of the things that we have been doing, Arizona has been
2646 doing this for 30 years. Tennessee and other states have
2647 been doing it for decades. There are certain things we just
2648 shouldn't need to get a waiver for anymore, you know.
2649 Thoughtful managed care, coordinated care is one of them.
2650 Home and community-based alternatives to nursing home care is
2651 another example. If we can make the waiver process less
2652 necessary, if we can build some of those commonsense
2653 developments into the underlying program, we can free-up
2654 resources that can really be focused on real innovation, but
2655 I think it does still need to exist because as we are seeing
2656 with states like Massachusetts and New York and Texas and
2657 others where the delivery system incentive payments are being
2658 implemented, there are different things we need to try, and
2659 the system has to be accommodating to thinking outside of the
2660 box. And so I would say let's make the 1115 waiver process
2661 less necessary, but still nimble and fluid enough to be able
2662 to accommodate the innovations that need to happen, not just
2663 today, but tomorrow.

2664 Mr. {Bucshon.} Governor Barbour, you have some comments
2665 on that?

2666 Mr. {Barbour.} Yeah, Doctor, I agree with that. That
2667 is very in line with what I have said earlier. I would think
2668 for many things there shouldn't be any necessity for coming

2669 and seeking a waiver, particularly something that has already
2670 been proven to work well in other states. But one of the
2671 things that strikes me is, we ought to base this on results,
2672 and yet GAO's witness here told us that CMS doesn't even test
2673 the results, that they don't look at the outcomes, and that
2674 is news to me. I hope it is really--that that is not quite
2675 accurate. But certainly, that ought to be part of the test.
2676 Did it achieve what you said it was going to achieve, and
2677 budget neutrality wasn't within the money. I testified, Mr.
2678 Chairman, 4 years ago that if you would give us a block
2679 grant, we would take 1/2 the annual increase in Medicaid that
2680 our state would be entitled to because I thought we could
2681 save way, way more than that. I think if you have a budget--
2682 if you have a waiver, and you don't meet budget neutrality,
2683 the state ought to have to pay it. You will get very good
2684 programs if the state knows they are on the line. And most
2685 states, I believe, most states wouldn't prefer that, but if
2686 that was the difference, they would take it.

2687 Mr. {Bucshon.} I yield back.

2688 Mr. {Pitts.} The chair thanks the gentleman.

2689 Now recognizes the gentleman from Oregon, Mr. Schrader,
2690 5 minutes for questions.

2691 Mr. {Schrader.} Thank you, Mr. Chairman.

2692 A couple of comments, I guess. The course of the

2693 hearing, I find it astonishing that some states, some
2694 governors find it a burden to take care of the most
2695 disadvantaged people in our society, that Medicaid is not
2696 something--especially when the Federal Government is kicking
2697 in 90 percent of the cost. I mean I am a little budgeteer
2698 from Oregon, a small business person, if someone is going to
2699 pay 90 percent of the cost of something, I am going to find
2700 10 percent of the money to get it done, especially for this
2701 population. And who are these people? Who are these
2702 shiftless people on Medicaid? They are children, they are
2703 seniors, they are disabled people. Eighty percent of the
2704 Medicaid population is that group. I don't consider that
2705 shiftless. Seventy percent of the people that are able to
2706 actually work, they are all on Medicaid, that little 20--70
2707 percent of them working, and they can't afford health care.
2708 I mean Medicaid, 138 percent of poverty level, that is like,
2709 what, 14, \$15,000 a year? I challenge any of us to try and
2710 live on something like that. Afford health care? You can't
2711 do that. Oregon had a small demonstration project that at
2712 the time I thought was very good. Yeah, everyone should pay
2713 something for their health care. Let's see, we sort of do
2714 that under the ACA that is being demagogued on a regular
2715 basis. Yeah, people that are lower income but can afford
2716 some--yeah, we make them pay on a graduated basis, based on

2717 their income and their socioeconomic level, but somehow what
2718 we are hearing today, you know, we don't like that because it
2719 is Medicaid? Medicaid is tougher though. We had this
2720 demonstration project in our state and we found that those
2721 people that are on Medicaid, they have lots of issues, they
2722 have multiple risk factors, folks. It is not like you and I
2723 that just decide not to work. There may be a few of those
2724 but most have multiple issues. And, frankly, they are not
2725 going to pay \$5, you know. And enlightened self-interest
2726 ought to dictate to every one of us, even if we don't care
2727 about children, seniors, disabled, or the people that have
2728 multiple risk factors, that if we don't take care of these
2729 folks, their diabetes cost is going to go into our health
2730 insurance premium. And that has been proven. That is one of
2731 the predicates over healthcare reform. Whether you like the
2732 ACA or not, that is one of the predicates of why healthcare
2733 reform is so important; to get the costs aligned like they
2734 should.

2735 And there are some good projects out there though. I
2736 agree with the general sense of this panel that the whole
2737 waiver system, the whole Medicaid system itself seems to be
2738 antiquated, and we should update it to be, I believe, outcome
2739 and results-based. I agree with that 100 percent. That is
2740 the future; not micromanaging. Very concerned when I heard

2741 GAO talking about, well, we have more criteria here and a
2742 little more definition there, and count more waits that are
2743 being processed on--that is not the goal. The goal is to
2744 have higher quality health care at, frankly, less cost. And
2745 the way to do that, and it is in the ACA, and like it or not,
2746 even without the ACA, it is coordinated care. Aligning
2747 things so you don't have the duplication that GAO talks
2748 about.

2749 Oregon has a great demonstration project that they are
2750 doing right now that I think is very accountable. It is
2751 pretty gutsy. They say they got a bunch of money from CMS to
2752 develop this coordinated care organizations for Medicaid
2753 patients. That means that there are primary care docs,
2754 specialists, dentists, mental health professionals,
2755 coordinating the care for Medicaid patients so that they will
2756 know what each other is doing, they will have an
2757 accountability in there, and they get--they are--in return
2758 for this money, the goal was to keep--not only get better
2759 outcomes, but get better value, not just for the individual
2760 but for the taxpayer. Limit healthcare inflation to 2
2761 percent through the duration of it.

2762 And I--you know, as a health care--well, as a budget
2763 guy, I got--ran--helped run the budget back in Oregon back in
2764 the day. You know, healthcare costs for healthcare

2765 inflation, 6, 7, 8, 9 percent annually. It was a big deal.
2766 We always budgeted more than annual inflation on a regular
2767 basis, which was anywhere from, you know, 1 1/2 to 2 1/2
2768 percent. So Oregon is going to keep it at 2 percent. That
2769 is impossible. Well, the results so far are pretty amazing.
2770 We are under 2 percent. Under 2 percent inflation because of
2771 the coordinated care system. Emergency visits, I don't know
2772 about other states, emergency visits are down 21 percent from
2773 a couple of years ago. That is substantial. Complications
2774 from diabetes down 10 percent already. This is the early
2775 stages of coordinated care. And chronic obstructive
2776 pulmonary diseases, you know, hospital stays, down 50
2777 percent. That is what we are talking about. That should be
2778 the outcome-based type of information that every waiver
2779 should be judged by, and hopefully, ultimately, Medicaid
2780 reimbursement in general.

2781 I yield back.

2782 Mr. {Pitts.} The chair thanks the gentleman.

2783 Now recognize the gentleman from Florida, Mr. Bilirakis,
2784 5 minutes for questions.

2785 Mr. {Bilirakis.} Thank you very much, Mr. Chairman, I
2786 appreciate it.

2787 And good to see you, Governor.

2788 Mr. {Barbour.} I remember your dad, Congressman.

2789 Mr. {Bilirakis.} Good. Yeah, thank you. Governor,
2790 some states have been operating under an 1115 waiver. You
2791 mentioned Arizona has been operating, I believe, since 1982,
2792 well, at least 30 years. Some have suggested Congress
2793 created process where longstanding core elements of an 1115
2794 waiver can be effectively grandfathered into the state's
2795 state plan amendment. Do you have any thoughts on that? And
2796 I know that the Doctor had mentioned that too. I am just
2797 following up on his question.

2798 Mr. {Barbour.} Yes, sir. I think that is absolutely a
2799 step in the right direction. If you have a demonstration
2800 project that has demonstrated that it works, that you are
2801 able to do it in a budget neutral or better way, and that the
2802 outcomes are what you were expecting and what you told was
2803 going to happen, if that is the case, at some point--it
2804 shouldn't be years and years and years later, at some point,
2805 you ought to just be able to make that permanent. And I
2806 think importantly to your sister states, if we are the
2807 laboratories of democracy, and if Florida has got something
2808 that really works, it ought to be easier for us to go adopt
2809 what Florida is doing, make it--make some adjustments for us,
2810 but generally adopt what is proven to work in another state
2811 if we choose to, and not have to go through a big long
2812 process that takes 337 days.

2813 Mr. {Bilirakis.} Sounds good. Thank you.

2814 Mr. Salo, one of the things that the many Republican
2815 governors have been interested in, they are interested in
2816 using 1115 waivers to test consumer-directed accounts with
2817 modest copay structures to encourage health literacy and
2818 individuals participating in their own health care. I agree
2819 with that. CMS has approved a few demonstration programs for
2820 this but they have been stringent on the copays under the
2821 waiver program, I understand. How do you think that fact
2822 squares with the reality those consumers who make a few
2823 dollars more are suddenly expected to be shoppers on the
2824 exchanges, for example, at 133 percent of the federal poverty
2825 level you could be on Medicaid with no copay, but at 134
2826 percent of the federal poverty level, you would be on the
2827 exchange with no copays?

2828 Mr. {Salo.} Yeah, I think the issue there is--and again
2829 with deference to the Administration's priorities, every
2830 Administration is going to have priorities about what it
2831 wants to see done with its share of the Medicaid dollars.
2832 The current Administration is not a huge fan of copays in the
2833 Medicaid Program, but I think it is clear that a key point of
2834 what we need to do in the overall system to make health care
2835 better for people is that we have to have greater
2836 accountability, but for everyone. Yes, we need better

2837 consumer engagement, but we need to give--we need to make
2838 sure that consumers have the tools to be able to do that
2839 effectively. And we need to also make sure that providers;
2840 primary care physicians or what have you, are accountable.
2841 We have to give them the tools to be able to do that. And
2842 ultimately, whether it is a health plan or whether it is the
2843 state, we have to have the tools to create an environment
2844 where all of those other pieces can succeed. You know, we
2845 don't want to just leave anyone out there with, you know,
2846 here is a ticket, good luck out there. We have to create,
2847 you know, with--it is not the Peter principle, it is the
2848 Peter Parker principle. With great power comes great
2849 responsibility. We have a responsibility to be able to
2850 ensure that everybody within the system is going to succeed
2851 as we change it from a dysfunctional fee-for-service model to
2852 a better integrated, coordinated managed care model. And
2853 that is going to involve consumer engagement, provider
2854 engagement, and state engagement as well.

2855 Mr. {Bilirakis.} Thank you. Last question. Governor,
2856 CBO has indicated ObamaCare's Medicaid expansion would, on
2857 balance, reduce incentives to work, yet CMS has refused to
2858 approve work requirements as part of the Republican
2859 governor's state demonstration waivers. Are you aware of
2860 anything in Section 1115 that would prevent CMS from

2861 approving work-related requirements?

2862 Mr. {Barbour.} No, sir, I am not. And clearly, having
2863 a plan where more people work in our economy--today, only 48
2864 1/2 percent of adult Americans have a full-time job. The
2865 labor participation rates are about 62.9 percent; the lowest
2866 since the '70s, before women had really come into the
2867 workforce in the numbers that they have in the last 40-some
2868 years. So yeah, it is absolutely--now that we allow able-
2869 bodied childless people to be on Medicaid, there is
2870 absolutely no reason we shouldn't look back at Bill Clinton's
2871 welfare reform law, which had work or retraining
2872 requirements.

2873 Mr. {Bilirakis.} Thank you very much.

2874 I yield back, Mr. Chairman.

2875 Mr. {Pitts.} The chair thanks the gentleman.

2876 Now recognize the gentlelady from Florida, Ms. Castor, 5
2877 minutes for questions.

2878 Ms. {Castor.} Thank you, Mr. Chairman. And welcome,
2879 panel.

2880 I would like to read from a Miami Herald article from
2881 about 6 months ago relating to Florida's Medicaid Program.
2882 It says, in a sweeping decision, the judge says Florida
2883 systematically has shortchanged poor and disabled children by
2884 providing inadequate money for their health care. A federal

2885 judge Wednesday declared Florida's healthcare system for
2886 needy and disabled children to be in violation of several
2887 federal laws, handing a stunning victory to doctors and
2888 children's advocates who have fought for almost a decade to
2889 force the state to pay pediatricians enough money to ensure
2890 impoverished children can receive adequate care. In his 153-
2891 page ruling, U.S. Circuit Court--Circuit Judge Adalberto
2892 Jordan said lawmakers had for years set the state's Medicaid
2893 budget at an all--artificially low level, causing
2894 pediatricians and other specialists for children to opt out
2895 of the insurance program for the needy. In some areas of the
2896 state, parents had to travel long distances to see
2897 specialists. The low spending plans which forced Medicaid
2898 providers for needy children to be paid far below what
2899 private insurers would spend, and well below what doctors
2900 were paid in the Medicare Program for a more powerful group;
2901 elders, amounted to rationing of care, the order said. And
2902 here are a few examples of what the judge found. Almost 80
2903 percent of children enrolled in the Medicaid Program are
2904 getting no dental services at all. By squeezing doctor
2905 payments, Florida health regulators left 1/3 of the state's
2906 children on Medicaid with no preventative medical care,
2907 despite the federal legal requirements. And this was true
2908 for both children paying fee-for-service or under managed

2909 care. In addition, the judge wrote, an unacceptable
2910 percentage of infants do not received a single well child
2911 visit in the first 18 months of their lives. Florida health
2912 regulators sometimes switch needy children from one Medicaid
2913 provider to another without their parents' knowledge or
2914 consent. So these sweeping violations of federal law within
2915 a demonstration project, and Medicare--Medicaid waiver raised
2916 a lot of questions.

2917 And, Governor, I heard you said, well, for Florida--for
2918 all states, if it is working, maybe we should keep it. But
2919 clearly here, if something is not working, they need to take
2920 a look at it. I think everyone would agree.

2921 So, Ms. Alker, you are fairly familiar with what has
2922 been happening in Florida. This is part of the reason that
2923 the low-income pool and these multibillion dollar--in
2924 Florida, the--these large uncompensated care pools have
2925 gotten a lot of attention over past years. A lack of
2926 transparency in the way the funds are distributed by the
2927 state. They are distributed not by--they don't follow
2928 beneficiaries, they go--depending on--the pool of money goes
2929 to--depending on what counties have contributed. And they
2930 have raised serious questions about provider rates that have
2931 been cut over the years. What is to be done in a waiver
2932 situation when you have these uncompensated care pools, and

2933 yet providers, doctors are not being paid adequately, and
2934 children aren't getting the care they need?

2935 Ms. {Alker.} So I think you raised a number of issues,
2936 and one of the really important questions is having, I think,
2937 strong oversight of Medicaid managed care, particularly in
2938 Florida; there has been serious problems over the years with
2939 your managed care companies. And so part of what, you know,
2940 if you build it into the waiver process or through the new
2941 Medicaid managed care regs that CMS has just issued, that we
2942 really are going to need accountability for the taxpayer
2943 dollar with respect to these managed care companies. And I
2944 worry because I think that states have lost personnel, their
2945 departments are often underfunded, and they don't have the
2946 ability to oversee these managed care companies, ensure that
2947 we really are paying for care for very vulnerable children
2948 and others.

2949 And I guess with respect to the uncompensated care pool,
2950 I think it is also important to emphasize, as you mentioned
2951 earlier, Representative Castor, that the low-income pool in
2952 Florida doesn't cover a single person, and uncompensated care
2953 pools don't cover people. They came out of a time when
2954 particularly states had very high uninsured rates, but
2955 coverage is really a better way to approach the healthcare
2956 needs of citizens of your state and others, because the low-

2957 income pool doesn't protect families from bankruptcy, it
2958 doesn't ensure that folks get primary and preventative care,
2959 and to my mind, it is a smarter use of taxpayer dollars to
2960 make sure that people get coverage so they get the primary
2961 and preventative care they need so they don't get sicker and
2962 have to wind up taking uncompensated care from your state's
2963 hospitals.

2964 Ms. {Castor.} Thank you. I yield back.

2965 Mr. {Pitts.} The chair thanks the gentlelady.

2966 And now recognizes the gentleman from New York, Mr.
2967 Collins, 5 minutes for questions.

2968 Mr. {Collins.} Thank you, Mr. Chairman. And I want to
2969 thank all of the witnesses today for your testimony on what
2970 we know is a major concern for all of us. And I may direct
2971 this to Governor Barbour. As the CEO of Mississippi, I can
2972 just tell you, in my past life, I was the county executive of
2973 the largest upstate county in New York, where Medicaid
2974 actually was 115 percent of our budget, of our property
2975 taxes. So every single dollar that we collected in property
2976 taxes, every single dollar we collected was not enough to
2977 cover our Medicaid burden, because in New York, the counties
2978 pay a portion of the fee. That is not true in a lot of
2979 states. I don't know what it was in Mississippi, but in New
2980 York our Medicaid costs are so outrageous that we pass a--you

2981 know, a big chunk of it down to the 62 counties, to the point
2982 in Erie County, one of the poorest counties in the State of
2983 New York, home to Buffalo, it was 115 percent of our property
2984 tax levy. So we lived on only sales tax. The entire--
2985 everything we did with highways and roads and supports of our
2986 culturals, our prisons, our holding center, 100 percent of
2987 everything we did outside of Medicaid was sales tax revenue,
2988 which is not a predictable source.

2989 So I will get back to commonsense. When commonsense
2990 meets good government, I think that is a good day for all of
2991 us. And I want to talk about how nominal copays can make a
2992 big difference. I mean we teach our kids, you know, you
2993 raise 50 cents, I will give you 50 cents. You want a new
2994 bike, you go raise this, I will do that. A fundamental part
2995 of America is teaching people at a young age the value of \$1,
2996 but in Medicaid, when there is no copay--let me tell you
2997 another story. I mean I can get pretty animated on this. We
2998 had in Erie County what we called the frequent fliers that
2999 use ambulances as a taxi service. They call 911, they climb
3000 in an ambulance, it takes them to the Erie County Medical
3001 Center, they get out and they start walking somewhere else.
3002 It was an--a free taxi cab, that is what it was, because we
3003 don't have a copay. I suggested why not a \$50 copay. Fifty
3004 dollars to get into an ambulance and take you to the

3005 hospital, and we would even have a way to potentially, for
3006 some of those, waive that, but that would be more expensive
3007 than a taxi cab. So if you are looking for a taxi ride, call
3008 a taxi, don't call an ambulance. And I was told absolutely
3009 not, this isn't going to go that way. I chaired a
3010 commission, County Executives for Medicaid Reform, asking
3011 that we would have the ability at the county level to set up
3012 our own programs, and I was turned down on that one. So I
3013 just have a fundamental belief that having some level of pay,
3014 however little it is, invests a person in what it is they are
3015 getting, and that nothing in life should be free.

3016 So, you know, do you have any comments, Governor?

3017 Mr. {Barbour.} We try very hard to get CMS to agree to
3018 let us make copayments enforceable, and could not--we were
3019 not allowed to do that. Governor Daniels is quoted in some
3020 of the material, when they started the HIP program he--you
3021 know, everybody is going to have to pay something, and I
3022 think the lady from Indiana said it starts at \$1 a month, but
3023 I remember him saying if you can afford a Big Mac you can
3024 afford the copayment. And for people to be--for patients to
3025 be participating in their health care, making decisions
3026 because of copays, the decision may be generic versus brand
3027 name, the decision may be something else, but as an old
3028 Scotch-Irish descendent, if it is a cash bar or a free bar, I

3029 know who drinks more. And if you--if it costs you something,
3030 if you have to be part of it, you are going to be a better
3031 healthcare receiver because you are going to be conscious
3032 about that. And the copays don't have to be very large, as
3033 you say, or as Governor Daniels says, where they have \$1, a
3034 \$1 copay. There is not anybody that can't afford \$1 a month.

3035 But anyway, I agree with you. My legislature we had
3036 Democratic majorities in both the House and Senate when I was
3037 governor. They were for copays and enforceable copays. It
3038 is just commonsense.

3039 Mr. {Collins.} Well, and that is what I would say. It
3040 is commonsense meets government. We should do something like
3041 this. In fact, to me, it should be part of the basic
3042 Medicaid Program because if we don't--if we teach our 6-year-
3043 old kids the value of \$1, and let's go out and do some work
3044 in the garage and clean up the house, and then you earn--and
3045 I will buy the--pay the rest of your bicycle, we
3046 fundamentally know that anything that is free has less value
3047 than something you even pay a nominal part for. So certainly
3048 within the 1115 program there should, in my opinion,
3049 definitely be a place for something for very small copays,
3050 and anyone who would debate otherwise I think is kind of
3051 leaving commonsense at the door, unfortunately.

3052 Well, thank you again for your testimony. My time has

3053 expired. I yield back, Mr. Chairman.

3054 Mr. {Pitts.} The chair thanks the gentleman.

3055 Now recognize the gentleman from Massachusetts, Mr.

3056 Kennedy, 5 minutes for questions.

3057 Mr. {Kennedy.} Thank you, Mr. Chairman. I want to
3058 thank the witnesses for coming today, and for your testimony
3059 on an extraordinarily important topic.

3060 I apologize, I was bouncing around a little bit and so I
3061 think I missed some comments earlier about the Massachusetts
3062 low-income pool. So, Ms. Alker, I was hoping you might be
3063 able to clarify--I know my colleague, Ms. Castor, brought up
3064 the Florida low-income pool, and I think there were some
3065 comparisons that were made earlier. In your assessment,
3066 ma'am, are there any noticeable differences between the way
3067 that the--Massachusetts has set up its low-income pool and
3068 that of Florida?

3069 Ms. {Alker.} I think there are. I am not as familiar
3070 with Massachusetts. I think though when you look at the 9
3071 states that CMS has identified with these kinds of
3072 uncompensated care pools, they are all different from each
3073 other. And as I mentioned before, one important step forward
3074 is that CMS, earlier this year, sent a letter to Florida
3075 about the principles they are going to use to apply to all
3076 states, excuse me, going forward as they consider their

3077 uncompensated care pool, and they are applying those
3078 principles both to states who have expanded Medicaid, like
3079 Massachusetts, and states who have not, like Florida.

3080 Mr. {Kennedy.} Excuse me. Right. So thank you for
3081 pointing out at least one important distinction. I also
3082 wanted to talk about--this has come up a couple of times
3083 today, but the work requirements, and with regards
3084 specifically to an issue that has come up also a couple of
3085 times today, mental health. One group that is particularly
3086 hit hard by unemployment are individuals that are suffering
3087 with mental illness. Committee had a hearing just a couple
3088 of days ago on improving our mental healthcare system in this
3089 country, and it is an issue that I know a lot of us care an
3090 awful lot about.

3091 In 2012, 17.8 percent of the seriously mentally ill were
3092 unemployed. This group of individuals could succeed at work
3093 if given the right opportunity for--excuse me, the right
3094 employment supports, which is why Medicaid coverage is so
3095 important. Medicaid--states to provide supportive
3096 improvements like skills assessments, assistance with job
3097 search, and completing job applications, job development and
3098 placement, job training, negotiations with prospective
3099 employers. And Medicaid dollars can be leveraged to support
3100 state training programs for mental health providers who, in

3101 turn, serve low-income beneficiaries. In fact, Mississippi
3102 and Massachusetts have something in common. Both states are
3103 taking advantage of these types of opportunities.
3104 Mississippi is, I think, a great example of using Medicaid
3105 support to help state health programs. And, Governor, your
3106 state goes so far as to provide services to help individuals
3107 start their own businesses, such as helping the with a
3108 business plan, finding potential financing, and ongoing
3109 guidance once the business has been launched. Massachusetts
3110 is doing some pretty outstanding work as well when it comes
3111 to treating mental illness and substance abuse. Flexibility
3112 in that waiver process allows Massachusetts to leverage state
3113 dollars to conduct community support programs, psychiatric
3114 day treatment, and acute treatment for children and
3115 adolescents.

3116 So, Ms. Alker, to start with you, do you agree that
3117 flexibility the states have today leverages Medicaid dollars
3118 to serve communities through the designated state health
3119 programs, and the--it is a hallmark of the Medicaid Program
3120 that should be protected?

3121 Ms. {Alker.} Well, so let me say two things, and then
3122 if it is okay, I would like to go back to the work
3123 requirement issue as well.

3124 So the kinds of programs that you are mentioning, I mean

3125 this has been a hallmark of Section 1115 waivers for many
3126 decades now. This is not something new that the Obama
3127 Administration has started doing, and also it is not
3128 something which the Obama Administration just simply says we
3129 are going to give you money for. The states come to them
3130 with ideas and, you know, I think we would all agree, if it
3131 is a good idea that supports the objectives of the Medicaid
3132 Program, that then that is the kind of thing exactly the
3133 Section 1115 waiver should test. And so I think again, if we
3134 look at it from that long-term perspective, it is exactly
3135 what Mr. Salo was saying is that, over time, there are more
3136 innovative ideas that emanate from states, and that is a
3137 hallmark of Section 1115 waivers.

3138 With respect to the work requirement question, because I
3139 think there is an intersection between the mental health
3140 issue and the work requirement that I would like to point
3141 out, work requirements strike me as a bad idea both from a
3142 policy perspective and they are possibly outside the purview
3143 of the Secretary's legal authority to approve, although I am
3144 not a lawyer so I am going to leave that to others to comment
3145 on it, but I think they are a bad idea for the following
3146 reasons. I think we all share the same objective here, which
3147 is we would like to see people work. We would like to
3148 maximize employment. But it seems to me that imposing the

3149 arbitrary work requirement may, in fact, have the precise
3150 opposite effect because you have folks perhaps who have a
3151 mental health condition that needs to be treated, and the
3152 health care--providing them with the health care will allow
3153 them to work in greater--there will be a greater chance of
3154 them becoming employed. So I worry very much that a work
3155 requirement would have precisely the opposite effect of what
3156 is intended.

3157 Mr. {Kennedy.} Thank you. And I am, unfortunately,
3158 over time, so I yield back 5 seconds.

3159 Mr. {Pitts.} The chair thanks the gentleman.

3160 Now recognize the vice chair of the full committee, Mrs.
3161 Blackburn, 5 minutes for questions.

3162 Mrs. {Blackburn.} Thank you, Mr. Chairman. And I want
3163 to thank each of you for your patience as we worked through
3164 the first panel, and then for staying with us. This makes
3165 for a long morning, we understand that, but as we look at the
3166 demonstration projects, we do want to come back in and review
3167 this, and maybe as the director said earlier in the first
3168 panel, be able to put some guidelines in place, and some more
3169 components for oversight and also for conduct, put these in
3170 the statute. So today is important for us.

3171 Mr. Salo, I want to come with--to you. In your
3172 testimony, you had said that simple accounting for Medicaid

3173 is extremely difficult, if not impossible. And we are
3174 talking about a program that is probably the world's largest
3175 health insurance program, and the spending is pretty much on
3176 autopilot at the federal level. Lot of problems with how
3177 this is playing out. And as a former state senator in
3178 Tennessee, and the experiment we had with TennCare, I fully
3179 understand the challenging nature of Medicaid and of working
3180 through these waivers in the 1115 program, but I want to give
3181 you a chance to explain this because surely, you are not
3182 suggesting that benefits cannot be quantified, and that
3183 dollars cannot be tracked effectively, or that accountability
3184 is not needed. So would you like to respond to that?

3185 Mr. {Salo.} I would love to, thank you.

3186 Mrs. {Blackburn.} Good.

3187 Mr. {Salo.} So I guess what I am saying is I think what
3188 the GAO is searching for here is akin to--there is an old
3189 joke where there is a policeman walking down the street and
3190 he sees a guy on his hands and knees, looking for something
3191 in the street under the streetlight, and it is dark. And
3192 policeman comes over, says, you know, what are you doing? He
3193 says, I am looking for my keys. I lost my keys. So the
3194 policeman helps him. And he is there for like 5 or 10
3195 minutes. He says, I can't find them, are you sure you
3196 dropped them here? He says, oh, no, I dropped them down the

3197 block, just the light is better over here. I think that is
3198 what is going on. I think the GAO is struggling for
3199 something that is really simple and really easy, that for the
3200 green eyeshade approach of, well, I can put this in a
3201 checklist, this is simple, this is simple, check, check,
3202 check. And I am here to argue that Medicaid is much more
3203 complex than that. I am not saying it doesn't need
3204 accountability. It does. It has. And I am not saying that
3205 we cannot--we should not track the dollars, track the
3206 benefits. You should, and we do. What I am saying is, I
3207 think what the GAO is pushing for may not actually be good
3208 for the ultimate value and health care--health of the program
3209 itself. That as we start getting into very narrow
3210 definitions--

3211 Mrs. {Blackburn.} Well, sir, I am--

3212 Mr. {Salo.} --of what budget neutrality is--

3213 Mrs. {Blackburn.} --going to interrupt you right there.
3214 If the program is too expensive to afford, it is not good for
3215 anybody. And what we need to make certain is that we are
3216 looking at this from access to affordable health care, and to
3217 approach it from a viewpoint that, well, this is too
3218 challenging, the problem is too big to solve so let's leave
3219 it on autopilot, that is not a responsible course of action,
3220 and that is something that we ought not to do, and it is

3221 exactly the reason we need to pull this back in and look at
3222 these 1115 waiver situations, and look at the subjectivity
3223 with which these waivers are being given.

3224 Governor Barbour, I want to come to you. Talking about
3225 the subjective nature of this, and looking back through these
3226 uncompensated care pools, and you look at what happened with
3227 Massachusetts and Hawaii, and they are being given a much
3228 longer period of time for their extension on their pool as
3229 opposed to Florida, and I--what I don't like where this--you
3230 look at how this is playing out and it seems like you have
3231 CMS treating states differently if they are friendly to the
3232 Administration as opposed to those that are not friendly to
3233 the Administration. And that is troubling to me. I think it
3234 is troubling to a lot of people that are looking at Medicaid
3235 and Medicaid delivery.

3236 Mr. {Barbour.} Certainly, that is the contention of the
3237 attorneys general law suit, that because their states did not
3238 expand Medicaid, they are being coerced or they are being
3239 punished in doing this. GAO did not say different states get
3240 different treatment, but they did publish a list of who got
3241 their waivers redone, and it is pretty politically
3242 consistent. If you look down the list, they all voted for
3243 the same candidate for President. They got two senators in
3244 the same party. They all expanded Medicaid. Now, I can't

3245 look into anybody's heart and say they are--that is why they
3246 made the decision, but that is why we need more transparency,
3247 not just in a Democratic Administrations, but in Republican
3248 Administrations, of why did the decision get made.

3249 Mrs. {Blackburn.} Thank you. Mr. Chairman, I have one
3250 other question for Governor Barbour. I will submit it, it
3251 has to do with eligibility, and get an answer from him
3252 relative to that.

3253 I yield back.

3254 Mr. {Pitts.} The chair thanks the gentlelady.

3255 That concludes the questions of the members present. We
3256 will have follow-up questions. We will send those to you in
3257 writing. We ask that you please respond promptly.

3258 I remind members that they have 10 business days to
3259 submit questions for the record. Members should submit their
3260 questions by the close of business on Wednesday, July the
3261 8th.

3262 Another very important, interesting hearing. A critical
3263 program needs attention of Congress. This has been very
3264 informative. We thank you for coming.

3265 And without objection, the subcommittee stands
3266 adjourned.

3267 [Whereupon, at 1:12 p.m., the Subcommittee was
3268 adjourned.]