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# MEDICAID AT 50: STRENGTHENING AND SUSTAINING THE PROGRAM

WEDNESDAY, JULY 8, 2015

House of Representatives,

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:14 a.m., in Room 2322 of the Rayburn House Office Building, Hon. Joe Pitts [Chairman of the Subcommittee] presiding.

Members present: Representatives Pitts, Guthrie, Barton, Whitfield, Shimkus, Murphy, burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Brooks, Collins, Green, Capps, Schakowsky, Butterfield, Castor, Sarbanes,

Matsui, Lujan, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff present: Graham Pittman, Legislative Clerk; David Redl, Counsel, Telecom; Michelle Rosenberg, GAO Detailee, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Traci Vitek, Detailee, Health; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Una Lee, Democratic Chief Oversight Counsel; Rachel Pryor, Democratic Health Policy Advisor; and Samantha Satchell, Democratic Policy Analyst.

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Mr. {Pitts.} Good morning, and welcome to this hearing, entitled Medicaid at 50: Strengthening and Sustaining the Program. Subcommittee will come to order. Chairman will recognize himself for an opening statement.

At the end of this month, Medicaid will turn 50 years old. It was created as a joint Federal/state program to provide health care coverage to certain categories of low income Americans. But today Medicaid is now the largest health insurance program in the world. Now more than 70 million Americans are covered by Medicaid, which is more than are covered by Medicare. No doubt Medicaid is a critical lifeline for some of our nation's most vulnerable patients. Medicaid provides health care for children, pregnant mothers, the elderly, the blind, and the disabled. It is safe to say that every member of this Committee wants to see a strong safety net program that protects the most vulnerable, regardless of how they feel about its recent expansion.

But, as we all know, the current trajectory of Medicaid spending is problematic. In the next decade, program outlays are set to double. That means that, in a decade, Medicaid is going to cost Federal taxpayers what Medicare costs today. And that is not even counting the fact that the Medicaid program is already the fastest growing spending item in most

state budgets. So, without Congressional intervention, Medicaid will continue to consume a larger and larger portion of Federal and state spending. This is not ideology. This is arithmetic. According to CBO data, by 2030, the entire Federal budget will be consumed with spending on mandatory entitlements and service on the debt.

And this is not only a budgetary problem, though such levels of spending would crowd out funding for other important Federal and state policy priorities. This is also not only a fiscal problem, though CBO has warned that running up our national credit card could trigger financial crisis. Perhaps most importantly, this spending trajectory threatens the quality and access of care for the millions of vulnerable patients who depend on Medicaid.

But reaching the breaking point is entirely preventable. Policymaking is about setting priorities and making choices, and that is why, and many of my colleagues were dismayed by some of what we learned at a recent Health Subcommittee hearing regarding some of the projects funded through waivers. With budgets growing, is it too radical to suggest we simply prioritize needed medical care over lower priority projects?

Since 2003 Medicaid has been designated a high risk program by the GAO because of its size, growth, diversity

programs, concerns about gaps, and fiscal oversight. More than a decade later, these issues are amplified by recent changes to the program. Our aging population will also increase demands on the program. But today Federal oversight of the program is more imperative than ever.

Each administration has a responsibility, with Congress, to ensure that taxpayer dollars used for Medicaid are spent in a manner that helps our neediest citizens. Thus, I am pleased that we have a distinguished panel of witnesses today to help inform us on the challenges facing Medicaid in the coming decade. I am especially pleased that CMS, who was unable to attend--to join us for our recent hearing is here today, along with GAO and MACPAC.

In order to preserve and strengthen this vital safety net program for the most vulnerable, I believe that Congress will be increasingly forced to take steps to modernize the Medicaid program. So we are eager to hear our witnesses' recommendations for ideas, and any efforts underway to enhance Medicaid program efficiency, reduce program costs, and improve quality.

[The prepared statement of Mr. Pitts follows:]

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Mr. {Pitts.} And, with that, I yield the balance of my--or I yield back, and recognize the Ranking Member, Mr. Green, 5 minutes for his opening statement.

Mr. {Green.} Thank you, Mr. Chairman, for holding the hearings, and I too want to welcome our panel. It is not very often that we get an all-female panel. I appreciate you all being here.

The Medicaid program has served as a critical safety net for the American public since its creation in 1965, 50 years ago this month. Today, over 70 million low income Americans rely on Medicaid for comprehensive and affordable health insurance. It is a lifeline for millions of children, pregnant women, people with disabilities, seniors, and low income adults. Medicaid covers more than one in three children, pays for nearly half of all births, accounts for more than 40 percent of the nation's total costs for long term care. One in seven Medicare beneficiaries are also Medicaid beneficiaries. The Medicaid accounts for a quarter of behavioral health care services.

The Affordable Care Act expanded coverage, made improvements to promote program integrity, transparency, and advanced delivery system reform. Since the enactment of the Affordable Care Act, the overall rate of health care spending

growth has slowed, reducing projected growth in Medicaid programs by hundreds of billions of dollars, according to the Congressional Budget Office. This is primarily due to lower than expected growth in costs per Medicaid enrollee.

The need to address the growth of health care spending is an issue, we all agree. We must remain committed to building on the progress made by the ACA in ensuring patients have access to quality, affordable care, and that we are getting the best value for our health care dollars. Medicaid is an extremely efficient program, covering the average enrollee at a lower cost than most comprehensive benefits, and significantly lower cost sharing then private insurance. 95 percent of Medicaid beneficiaries report having a regular source of health care, a medical home in today's terms, which they consistently rate as highly as private insurance.

As we examine ways to further strengthen and improve the program, we need to advance policies that better leverage dollars to pay for value, promote efficiency and transparency, and advance delivery system reforms, and extend innovative strategies within Medicaid, and across the health care system. For example, one improvement would be for the Centers of Medicaid and--Medicare and Medicaid Services to finalize the agency's proposed regulation that would better enforce the Medicaid's equal access provision. This

provision ensures that care and services are available to Medicaid enrollees, and that providers are paid a fair Medicaid reimbursement rate.

Another one would be the require 12 month continuous enrollment--eligible Medicaid and CHIP beneficiaries to address the issue of the churn, a concept that MACPAC has supported in several reports to Congress. Churn is bad for patients, providers, and health plans, and wastes taxpayers' dollars. I worked with my colleague Joe Barton for several Congresses on this legislation--on this issue, and I thank him for his leadership, on behalf of low income Americans.

Today we look at a broad--look at the Medicaid system, the past, present, and future. Throughout its 50 year history, Medicaid has served as an adaptable, efficient program that meets the health care needs of millions of Americans. I want to thank our witnesses again for their ongoing efforts and recommendations for additional ways to advance the program. I look forward to working with my colleagues on the Committee to strengthen the program in key areas, including the enrollment process, delivery system reforms, managed care, data collection, and behavioral health.

With that, Mr. Chairman, I would like to yield the balance of my time to my colleague from California,

Congresswoman Matsui.

[The prepared statement of Mr. Green follows:]

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Ms. {Matsui.} Thank you very much for yielding to me, and I would like to welcome our witnesses here today also. This year, as we know, we celebrate the 50th anniversary of both the Medicare and Medicaid programs, essential programs for the security of our nation's seniors, people with disabilities, children, and families. The Affordable Care Act took vital steps to reforming our health care system by increasing coverage and moving toward rewarding value, instead of volume. We know the ACA made improvements in the private insurance market, and it also made improvements for public programs like Medicaid. Now is the time that we need to build upon those improvements, and keep the momentum going for our health care system, and for the millions that rely on Medicaid as an important safety net.

Thank you, and I look forward to hearing from our witnesses today, and I yield time to whoever needs it.

[The prepared statement of Ms. Matsui follows:]

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Mr. {Green.} Anyone else want 40 seconds, or--I yield back.

Mr. {Pitts.} The gentleman yields back, and now the Chair recognizes the Ranking Member of the full Committee, Mr. Pallone, 5 minutes for an opening statement.

Mr. {Pallone.} Thank you, Mr. Chairman. I just want to say, obviously, this is a very important topic. Medicaid's 50 years of efficient, comprehensive, and sometimes life-saving health coverage of our most vulnerable populations is certainly something that is crucial. A fiber, you know, basic fabric of our health care system.

As members of Congress, I believe the government can help all Americans succeed, including seniors and low income families, and improving and strengthening Medicaid for generations to come continues to be a primary goal. Medicaid provides more than one in three children with a chance at a healthy start in life, and one in seven Medicare seniors are also actually Medicaid seniors. In fact, the overwhelming majority of the 71 million current Medicaid beneficiaries are children, the elderly, the disabled, and pregnant women.

We often talk about Medicaid as an entitlement program, though I don't believe this is true--a true reflection of the program. Medicaid is a bedrock safety net that ensures all

Americans have protection against the negative economic effects that undisputedly come with lack of health coverage. Medicaid's inherent structure was designed to ensure that health coverage will be there for those who need it, when times are hard, jobs are lost, or accidents strike. And the fundamental tenet of the program is that it can expand and contract according to need. In fact, Medicaid was first proposed as part of a set of economic policies by President Truman.

And the Affordable Care Act built on these same goals by strengthening Medicaid and expanding its coverage, and states that have expanded Medicaid have already realized significant qualitative and economic benefits as uncompensated care rates drop, and more people gain coverage. Meanwhile, Medicaid coverage lowers financial barriers to health care access, increases use of preventative care, and improves health outcomes. In addition, states have been successful in managing their Medicaid programs through broad latitude and flexibility to ensure access to critical health care services for their populations at low cost.

No program is perfect. For instance, I believe that we need to remain vigilant on access to specialty and dental care, and we continue to refine transparency and evaluation of Medicaid waivers, and ensure that Medicaid is successfully

integrated with Medicare in the health insurance marketplaces. We should think more about how to advance some of the innovations in delivery systems reform. The Medicaid program has some of our best successes, with some of the toughest to treat populations.

Mr. Chairman, I hope to hear--to not hear more today of the same assaults on the Affordable Care Act or Medicaid. Inaccurate and ideological representation of what Medicaid is and who it serves I think are outdated. Instead, I believe that there are many policy areas in Medicaid where members on both the Democrat and Republican sides could share an interest, and I look forward to learning about ways that Congress can help to build on an already strong Medicaid program, refining and modernizing this critical safety net for the next 50 years and beyond.

I would like to yield the 2 minutes--or the remainder of my time to Mr. Lujan.

[The prepared statement of Mr. Pallone follows:]

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Mr. {Lujan.} Thank you very much, Mr. Chairman, and Ranking Member Pallone, for scheduling this hearing. And I am glad that we are here, coming together to reflect on the success of this program as we celebrate its 50th anniversary.

Medicaid is a critical program across the nation, and especially in my home state of New Mexico, where we have had a 53 percent increase in enrollment since we expanded Medicaid. This represents 240,000 additional people who have gained coverage as a result of the Affordable Care Act's Medicaid expansion in New Mexico. Behind each of these statistics are real stories of New Mexicans whose lives have improved because of Medicaid. I believe deeply in Medicaid's mission of improving access to health care, better health outcomes, greater financial security, and that we have a responsibility to ensure that our constituents are not only covered, but also receive quality care.

I look forward to the testimony and discussion about how we can continue to enhance this program for the next 50 years and beyond, and I also have some very serious specific questions about New Mexico's behavioral health program, and I look forward to exploring those as well. So, Mr. Chairman, Ranking Member Pallone, I thank you for the time, and I yield back.

[The prepared statement of Mr. Lujan follows:]

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Mr. {Pitts.} Chair thanks the gentleman. As usual, all the members' written opening statements will be made part of the record. I have a UC request, would like to submit the following documents for the record. Statements from 3M, the National Association of Chain Drugstores, the Infectious Disease Society of America, and U.S. Department of Health and Human Services Office of Inspector General, HHS/OIG. Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} We have one panel today, and let me introduce them in the order of their presentations. First, Vikki Wachino, Deputy Administrator, Centers for Medicare and Medicaid Services, CMS, and Director of the Center for Medicaid and CHIP services, CMS. Then Carolyn Yocom, Director, Health Care, Government Accountability Office, accompanied by Katherine Iritani, Director of Health Care, GAO. And finally, Anne Schwartz, Executive Director, Medicaid and CHIP Payment and Access Commission, MACPAC.

So thank you all for coming. Your written testimony will be made part of the record, and you will each be given 5 minutes to summarize your testimony. So, at this point, Ms. Wachino, you are recognized for 5 minutes for your summary.

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^STATEMENTS OF VIKKI WACHINO, DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES, CMS; CAROLYN YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE (GAO), ACCOMPANIED BY KATHERINE IRITANI, DIRECTOR, HEALTH CARE, GAO; AND ANNE SCHWARTZ, EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC)

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^STATEMENT OF VIKKI WACHINO

} Ms. {Wachino.} Chairman Pitts, thank you. Ranking Member Green, thank you. Thank you members of the Subcommittee. I am happy to be with you here today to talk about the importance of the Medicaid program, and its success in meeting the needs of the low income population over the past 50 years. Pleased to be joined here today by my colleagues from MACPAC and GAO, whose work helps us to continue to strengthen the program for the future.

I am Vikki Wachino, and I will introduce myself, building on the Chairman's introduction, as Deputy Administrator and Director of the Center for Medicaid and CHIP Services. Since it is my first appearance here before the Subcommittee, I have served in this role since April, and

really look forward to working with the Subcommittee going forward to make the program as strong as possible.

As you well know, Medicaid provides health insurance coverage to more than 70 million low income Americans, and the beneficiaries we serve are children, low income adults, people with disabilities, seniors, and pregnant women, some of America's most vulnerable populations. We work in partnership with states, and, as a partnership, both we and states have vital roles as program stewards in ensuring the program's future. Within Medicaid's structure, Medicaid provides vital financial support, and also significant flexibility within program rules that help us and states continue to improve and innovate in the program for the future.

The impact in success of Medicaid coverage is clear from the research. Just last month researchers at the Commonwealth Fund found that adults covered by Medicaid coverage continuously for a year have very high rates of obtaining regular sources of care. We also know, from research released earlier this year, that children who are covered by Medicaid or CHIP earn higher wages when they grow into adults, and those examples make both the health and the economic impact of Medicaid coverage clear.

There is a lot more we can do, though, and are doing, in

our work with states to strengthen the program for its next 50 years and beyond. As many of you have noted, the Affordable Care Act gives states the opportunity to provide Medicaid coverage to low income adults in their states, at their option, and supported by a substantially enhanced Federal matching rate. 28 states and the District of Columbia have worked with us to provide Medicaid coverage to these low income adults, and the benefits of that expansion are clear. And we are prepared at CMS to work with every state to develop an approach to expansion that works for the state, meets its specific needs, and meets the needs of its low income residents as we work together to close the coverage gap and insure more low income Americans.

The need for modernization in our eligibility enrollment process was clear to us several years ago, and we have modernized it. We have made it substantially easier for people to apply using a single streamlined application, the same application that people applying for marketplace coverage use, and we have supported that with electronic verification. And as a result, states are able to make eligibility decisions that are fast, and accurate, and in close to real time.

Another major area of our focus is delivery system reform, and working with states to promote innovations that

achieve better health, and better care, at lower cost. We carry that work out through a variety of mechanisms. Whether it is major delivery system reform initiatives, like Strong Start that is--that is aimed at improving prenatal and maternal health, new authorities, like Health Homes for people with chronic conditions, new models, like the state innovation models that help states undertake multi-payer delivery system reforms, or pioneering delivery system reforms through our 1115 innovations. In addition to that, a year ago, at the recommendation of the governors, we launched the Innovation Accelerator Program, which is designed to continue to advance in as many states as care to work with us, payment and delivery system reform.

As has been referenced, we have proposed major advances in managed care. Medicaid is no longer a fee for service delivery system. Managed care is the delivery system that provides care to the majority of our beneficiaries, and we want to maximize its potential to ensure coordination and quality of care. Our regulations had not been updated in more than a decade, and in May we proposed to update them to strengthen quality, accountability, transparency, the beneficiary experience, and also to align our roles with those that work in Medicare Advantage and in the private market, and that rule is out for public comment now.

We have been substantially advancing the ability of fragile seniors and people with disabilities to live in their communities and to self-direct their care. And underpinning all of these improvements are a commitment to program integrity that we have advanced over the past 5 years, and that span a range of mechanisms from reviewing states' program integrity programs to ensure that they are strong, to ensuring that states, and we, dedicate our resources and coordinate our resources to screen out high risk providers.

With that I will conclude, and again thank the Subcommittee for your interest in the Medicaid program, and to state once again how much I am looking forward to working with each of you.

[The prepared statement of Ms. Wachino follows:]

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Mr. {Pitts.} The Chair thanks the gentlelady. I now recognize Ms. Yocom, 5 minutes for your opening statement.

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^STATEMENT OF CAROLYN YOCOM

} Ms. {Yocom.} Chairman Pitts, Ranking Member Green, and members of the Subcommittee, I am pleased to be here today with my colleague, Katherine Iritani, to discuss the key issues that are facing the Medicaid program. Today Medicaid is undergoing a period of transformative change as enrollment grows following the passage of the Patient Protection and Affordable Care Act. Under this Act, more than half of the states have elected to expand their Medicaid programs and cover low income adults who were not previously eligible for the program.

At the heart of Medicaid is a Federal/state partnership. Both the Federal Government and the states play important roles in ensuring that Medicaid is fiscally responsible and sustainable over time, and effective in meeting the needs of its population that it serves. We designated Medicaid as a high risk program in 2003, and our statement highlights some of the significant oversight challenges that, based on our work, exist today.

Our statement highlights four key issues. First, access to care, second, transparency and oversight, third, program integrity, and fourth, Federal financing. Congress and HHS

have taken some positive steps related to these four key issues, and continued attention is critical to ensure that the Medicaid program is effective for the enrollees who rely on it, and also accountable to the taxpayers who pay for it. Accordingly, our work recommends additional steps to bolster efforts in each of these areas.

First, maintaining and improving access to care is critical to ensuring that Medicaid operates effectively. Our analysis of national survey data suggests that access to care in Medicaid is generally comparable to that of individuals with private insurance. However, our work also shows that Medicaid enrollees can face particular challenges accessing certain types of care, such as mental health and dental care.

Second, increased transparency and improved oversight can help improve the Medicaid program. For example, CMS lacks complete and reliable data about the sources of funds that states use to finance the non-Federal share of Medicaid, and it also lacks complete data on payments to providers, which hinders oversight. Gaps in HHS's criteria, process, and policy for improving state spending on demonstration projects also raises added questions about tens of billions of dollars in Federal spending.

Third, improving program integrity can help ensure the most appropriate use of Medicaid funds. Improper payments

are a significant cost to Medicaid, totaling an estimated 17.5 billion in fiscal year 2014. Our work suggests that an effective Federal/state partnership is a key factor in improper payments and combating them, not only to oversee spending in both fee for service and managed care, but also to set appropriate payments rates for managed care organizations, and ensure that only eligible individuals and providers participate in Medicaid.

Fourth, since its inception, efforts to finance the Medicaid program have been in odds with the cyclical nature of its design and operation, particularly during national economic downturns. We suggested that Congress consider enacting a Federal funding formula that would provide automatic, targeted, and timely assistance to states during national economic downturns. We have also described revisions to the current Federal funding formula that could more equitably allocate Medicaid funds to states by better accounting for each state's ability to finance the program.

In conclusion, continued focus on these challenges is critical to ensure that continued access to care for the tens of millions of Americans who are in the Medicaid program. It is also critical to ensuring the sustainability. Chairman Pitts, Ranking Member Green, and members of the Subcommittee, this concludes our prepared statement. We would be pleased

to respond to any questions you might have.

[The prepared statement of Ms. Yocom follows:]

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Mr. {Pitts.} The Chair thanks the gentlelady. And, again, as noted, Ms. Yocom's accompanied by Ms. Iritani, who testified before us a couple of weeks ago. She is back for-- to help answer questions for GAO. The Chair now recognizes Dr. Schwartz, 5 minutes for an opening statement.

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^STATEMENT OF ANNE SCHWARTZ

} Ms. {Schwartz.} Good morning, Chairman Pitts, Ranking Member Green, and members of the Subcommittee on Health. I am Anne Schwartz, Executive Director of MACPAC, the Medicaid and CHIP Payment and Access Commission. As you know, MACPAC is a Congressional Advisory Body charged with analyzing and reviewing Medicaid and CHIP policies, and making recommendations to Congress, the Secretary of HHS, and the states on issues affecting these programs. Its 17 members, led by Chair Diane Rowland and Vice-Chair Marsha Gold, are appointed by GAO. The insights I will share this morning reflect the consensus views of the Commission itself, and we appreciate the opportunity to share the--MACPAC's views as this Committee considers the future of Medicaid.

As others have already noted, Medicaid is a major and important part of the U.S. health care system, covering 72 million people, and almost half of the nation's births. It pays for more than 60 percent of national spending on long term services and supports to frail elders and other people with disabilities, and it accounts for more than a quarter of spending on treatment for mental health and substance use disorders. In total, it accounts for about 15 percent of

national health expenditures, 8.6 percent of Federal outlays, and 15.1 percent of state spending.

While we often compare Medicaid's performance as a payer with other sources of coverage, it is important to recognize Medicaid's unique roles. In addition to providing health insurance to individuals who otherwise might have access to coverage, it is also a major source of revenue for safety net providers serving both Medicaid beneficiaries and the uninsured. It covers enabling services, such as non-emergency transportation and translation services, which help beneficiaries access needed health services, and it wraps around other sources of coverage, including both employer sponsored insurance and Medicare, in its role for 10.7 dually eligible beneficiaries.

Since the early 1990s the Medicaid program has changed in significant ways. During this time period the country weathered two economic recessions, and states responded to budgetary pressures by undertaking modernization efforts and cost containment strategies. As a result, as has been noted, managed care has now become the dominant delivery system, with more than half of all beneficiaries enrolled in comprehensive risk-based managed care arrangements, and another 20 percent receiving benefits through a more limited managed care arrangement.

The Olmstead Decision, requiring that people with disabilities be served in the least restrictive environment, resulted in a major shift in the provision of long term services and supports from nursing facilities to home and community based settings. Congressional action in the 1990s brought in children's coverage through Medicaid and CHIP, and encouraged states to reach out to people who are eligible, but not enrolled in coverage. And, of course, more recently the Affordable Care Act created new dynamics not just by allowing states to expand coverage to certain non-disabled adults, but also by providing new options to states for the delivery of home and community based services, and by changing eligibility processes to allow for one-stop shopping for individuals seeking health care coverage.

The 20 years ahead are likely to be a similar dynamic, as states experiment with different approaches to delivery system reform and payment, and seek to provide care more efficiently and effectively to high cost, high need individuals. Pressure on Federal and state budgets create challenges to ensuring the sustainability of the program, as well as to ensuring that beneficiaries have access to high value services that promote their health and their ability to function in their communities.

MACPAC's analytic agenda for the year ahead reflects

several of these challenges. We will extend the work published in our recent June report on Medicaid's role for people with behavioral health disorders, focusing on how to improve delivery of care. We will continue to focus on understanding the impact of value-based purchasing initiatives, and the extent to which these bend the cost curve and improve health.

In the area of access, we will be determining how to effectively measure access, and looking closely at the extent to which different groups of Medicaid beneficiaries are at risk of access barriers, and the extent to which such barriers can be addressed through Medicaid policy. Our analyses on the impact of the ACA will include, at the request of Congress, a study to model the impact of payment cuts, and we will also consider how different approaches to Medicaid expansion affect expenditures and use of services. At the request of members of this Committee, and others in Congress, we will analyze spending trends and evaluate policy options to restructure the program's financing, and we will be moving ahead to the next chapter of our work on children's coverage, looking ahead before CHIP funding expires in Fiscal Year 2017.

Finally, we will continue to highlight the importance of having timely and complete data for both policy analysis and

program accountability. MACPAC has also expressed concerns about administrative capacity constraints that affect the ability of both Federal and state administrators to meet program requirements, provide oversight, and promote value to beneficiaries, and to the taxpayer.

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

[The prepared statement of Ms. Schwartz follows:]

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Mr. {Pitts.} The Chair thanks the gentlelady. That concludes the opening statements. We will begin questioning, and I will recognize myself for 5 minutes for that purpose.

Ms. Wachino, the part of the Federal statute on the 1115 waivers is very short, just four pages. So the Secretary of HHS has tremendous latitude under the law to fund some demonstration projects, while denying others. It is well known that some states get CMS approval for a specific proposal, while CMS will deny another state for a very similar proposal. My first question is, are there any statutory criteria requiring consistency related to the Secretary's review and approval of demonstration projects?

Ms. {Wachino.} Chairman, thank you for the question. CMS works with all states in the 1115 process, and outside of it, to develop approaches that meet the objectives of the Medicaid program, and take into account state-specific needs in surveying and meeting the needs of their low income population. We approach that process consistently across states, and we work with each state to identify the extent to which their proposal meets the objectives of the program, and improves the health of lower/low income residents.

We have been very transparent in our decision-making on 1115s. We issued transparency regulations implementing

provisions to the Affordable Care Act several years ago, and have bene posting all of our approval documents on medicaid.gov for states to see, and we welcome proposals from additional states, and will consider them on their merits.

Mr. {Pitts.} The question was, are there any statutory criteria requiring consistency?

Ms. {Wachino.} The statutory criteria is that a proposal meet the objectives of the Medicaid program.

Mr. {Pitts.} Does CMS have regulations or guidance to ensure that it is being consistent and equitable?

Ms. {Wachino.} There--we have guidance implementing our transparency requirements. Those were regulations that were implemented in 2012. We identified, subsequent to the GAO report, broad criteria that we used in considering every state's waiver to determine whether it meets the objectives of the Medicaid program, and those were criteria like expanding access to coverage, strengthening delivery systems. So, yes, we have developed a set of principles by which we review 1115 demonstrations.

It is also important to us, though, to be able to take into account state specific circumstances. States come to us with a wide array of proposals, and if you look across waivers you will see that they serve purposes as diverse as expanding eligibility to new populations, to providing

limited benefits, like prescription drugs, to reforming state delivery systems.

Mr. {Pitts.} Dr. Schwartz, in April several Chairmen of the Committees of Jurisdiction sent you a letter requesting that MACPAC undertake serious and sustained analytical work to advise Congress about potential policies and needed financing reforms, and incentives, to ensure the sustainability of Medicaid. Can you please explain to the Committee, in specific detail, how you are responding to that request, and when you--we can expect to start seeing the results of your work?

Ms. {Schwartz.} Yes. Since the Commission we--received the letter in April, we have had one public meeting in May. At that May meeting we presented analyses that were already underway on Federal and state spending trends that we are currently turning into a publication that should be out later this summer.

In determining our--we are now currently determining our next agenda for the next report cycle, bringing to fruition work on understanding innovative approaches that states are taking to build more sustainable programs. For example, the use of accountable care organization, bundled payments, patients at our medical homes, managed long term services and support, and trying to look at these designs and see what the

potential is for savings in both the short and the long term.

Specifically to the items mentioned in your letter, we do have analyses underway to review the past work of blue rhythm--ribbon commissions and think tanks so as not to reinvent the wheel, and we will use those to inform our analyses of technical and design issues associated with some of those proposals, as well as more recent approaches that have been put forward by members of this Committee and others.

So the letter speaks to a sustained work plan, and you can expect to see some of this work coming together over the course of the fall to inform our March and June reports, and follow-ons after that.

Mr. {Pitts.} Thank you. Ms. Wachino, has CMS determined an eligibility error rate for the Obamacare expansion population, and how does the error rate vary for those determined Medicaid eligible through the Federally facilitated marketplace versus those whom states determine eligibility?

Ms. {Wachino.} Mr. Chairman, I--within CMS there are other parts of the organization that have responsibility for the error rate measurement. I can say that I know that we have piloted approaches to measuring eligibility errors with states in order to ensure that we are measuring eligibility

effectively as we move to the new rules under the ACA, and we would be happy to get back to you with a report out for the record on what we know from those pilots so far.

Mr. {Pitts.} Thank you. My time is expired. The Chair recognizes the Ranking Member, Mr. Green, 5 minutes for questions.

Mr. {Green.} Thank you, Mr. Chairman. This year marks the 50th anniversary of Medicaid. It is a vital program that is served as a lifeline for millions of Americans that--when they need it the most. It is important to recognize the successes that it made, innovations that are working well, and improvements that could be implemented. We have seen some outstanding success ensuring the overwhelming majority of Medicaid beneficiaries have access to primary care. More than 95 percent of the Medicaid beneficiaries not only have access to primary care, but are satisfied with that care.

The Committee has made substantial investments in the Community Health Center Program, particularly when it comes to grant funding intended to cover the uninsured. One aspect that is not talked about as frequently is that of the unique role and intertwined nature of community health centers and Medicaid.

Ms. Wachino, could CMS comment on the role that community health centers, and--a crucial source of primary

care have played to bring along--about the level of success of Medicaid beneficiaries?

Ms. {Wachino.} Thank you for the question. Community centers play a really vital role in serving our populations and meeting the needs of a diverse range of Americans, whether it is--it was particularly focused on primary care. Community health centers are playing a growing role in meeting low income Americans' oral health care needs, which are important to us, and we continue to work with them to make their payment systems as strong as possible.

Mr. {Green.} Okay. Thank you. And I know we still have work to do on--to ensure equal access to dental and specialty care. In particular, access to behavioral health providers is an issue this Committee has considered, and all three of our witnesses know well.

Ms. Wachino, CMS is working hard with states to promote innovative care delivery, integrating physical and mental health, or promoting oral health, as part of the comprehensive primary care. Can you provide the Committee with a few examples of how CMS work on Medicaid delivery system reform is helping to promote access to these specialty providers?

Ms. {Wachino.} Sure, I would be happy to, thank you. Through our Innovation Accelerator Program, which, as I

mentioned earlier, is our new delivery system reform initiative aimed at providing program to--support to states that would like to improve their payment and delivery system, we identified four areas that--in particular, and this was--these were established with the input of states and stakeholders that were priorities of our program, substance use disorder, physical and behavioral health integration, community integration, moving away from institutional care to community care, and meeting the needs of complex, high cost beneficiaries.

The first two I think, Ranking Member Green, are responsive to your question. And as--and the area in which we have done the most work so far in this new program is substance use disorder, and we are working actively right now with seven states to help expand the range of providers who can provide substance use disorder supports, and we expect to bring a similar approach to physical and behavioral health to really help ensure that there is access to mental health--to community based mental health services for the people who need it.

Mr. {Green.} Okay. I was impressed to see provisions on adequate--or quality and actuarial soundness and network adequacy in the new Medicaid managed care regulation. Can you describe how, if CMS's proposed managed care regulation

would be implemented, access to quality care would improve beneficiaries in the managed care?

Ms. {Wachino.} Sure. I will highlight a couple of examples of how our new proposed rule could improve quality and actuarial soundness and access for our populations. With regard to quality, there are a number of provisions. I think one of the most significant is giving Medicaid beneficiaries the ability to understand how quality compares across plans through a new quality rating system, so that beneficiaries can shop, and they can form choices about their plan selections.

As you referred to, Ranking Member Green, we also substantially have improved our approach to ensuring that plan rates are actuarially sound. There is a body of work reviewing those rates that is going on now, even in advance of the regulation, to really make sure that we are paying the right amount to ensure adequate access to Medicaid beneficiaries, and ensuring appropriate stewardship of funds.

And with respect particularly to access, the proposed rule establishes for the first time--or proposes to establish that there will be state developed network adequacy standards for many key services for the Medicaid population, which, given that, as recently as 3 years ago, nearly 60 percent of our beneficiaries were enrolled in managed care, I think is a

really substantial advance in access for our program.

Mr. {Green.} Okay. Mr. Chairman, I have one last question for Ms. Schwartz. Has MACPAC looked at how changes to streamline eligibility have improved the continuity of care?

Ms. {Schwartz.} We haven't--we have not specifically analyzed that issue. It is one we are very interested in, and the data are not yet available for us to do so. And as data become available, that is something that we will be keeping our eye on.

Mr. {Pitts.} The Chair thanks the gentleman. I recognize the Chair Emeritus of the full Committee, Mr. Barton, 5 minutes for questions.

Mr. {Barton.} Thank you, Mr. Chairman, and thank you for the hearing. These microphones kind of have an echo to them. I will be as softly as I can.

Ms. Wachino, could you give us the status of the Texas request for re-approval of its 1115 waiver?

Ms. {Wachino.} Yes, I can. The Texas waiver expires next year. I know that the state has been working on a request to extend that demonstration, which we approved in 2011, but they have not yet sent it to us yet. We have had some initial conversations with them, but are waiting for them to submit their full request, and look forward to

working with them on it.

Mr. {Barton.} So the--there have been some rumors that because Texas is such a red state that that application is going to be frowned upon. That is just rumors? There is no validity to that?

Ms. {Wachino.} Congressman Barton, we work with all states through the waiver process to try to achieve the objectives of the Medicaid program, and try to take into account state specific needs, and we are looking forward to reviewing with the State of Texas how the initial demonstration went. There were some areas of the--of their programs that were new to us when we initially approved it. We will want to review very closely with them how the different provisions of the waiver are working. And we are looking forward to that discussion.

Mr. {Barton.} With Mr. Green here, my ally, make sure we are bipartisan, you will--

Mr. {Green.} Would you yield to me just for a minute?

Mr. {Barton.} I will be happy to yield.

Mr. {Green.} Even though we are a red state, we sure have a lot of poor people, and Medicaid is for that, whether you are red or blue, or--

Mr. {Barton.} That is true.

Mr. {Green.} --whatever. Thank you, Joe, for your

leadership on what we are trying to do.

Mr. {Barton.} Of course, those of us that are red, in that sense, you know, if they would listen to us more, we would have less of those people. See, we would get them into the--where they didn't need to be a part of it, but that is a different discussion.

So we have your word that the Texas 1115 waiver application is going to be fairly reviewed?

Ms. {Wachino.} Again, we work with all states, you know, and we apply the same process to all states. We look to review the extent to which a waiver achieves the objectives of the Medicaid program and how it is advancing the health of the low income population in the state. And I--

Mr. {Barton.} So that is a yes?

Ms. {Wachino.} I know that the team in Texas is working hard, and we are looking forward to working with them.

Mr. {Barton.} Okay. I am going to take that as a yes. We are going to put it in the record as a yes, that it is going to be fairly reviewed.

Let us look at a program, Ms.--that Ms. Castor and I are very supportive of, the Ace Kids Act. It would allow states to set up programs across state lines for special needs children, create a medical home in these anchor children's

hospitals, where a parent could bring a child, and if the child qualifies, they get the full range of services, whatever those services need to be. This is a bipartisan bill. We have got--I can't remember how many co-sponsors, but it is well over 100. Are you familiar with that bill?

Ms. {Wachino.} Congressman Barton, I can't say that I have looked at the particulars of that bill, but clearly approaches that advance the quality of care and coordination of care for children particularly are of interest to us, so I am happy to take a look at it, and CMS stands ready to provide any technical assistance to you on it.

Mr. {Barton.} Well, the advocates of it, and I am an advocate for it, believe that it would save money for Medicaid. You wouldn't have to have a parent try to create their own network, and in some states you don't even have the type of care that is--that that child needs. So it has got a lot of support, and I would encourage you and your staff to take a look at it, and hopefully, at the appropriate time, be supportive of it. And with that, Mr. Chairman, I yield back.

Mr. {Pitts.} The Chair thanks the gentleman. I now recognize the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. {Capps.} Thank you, Mr. Chairman, and I appreciate the presence of our witnesses today, and your testimony. It

is very appropriate that we are here during this anniversary year to talk about the largest source of health coverage in our country, Medicaid, and the Children's Health Insurance Program, CHIP. These programs now provide health care--or opportunities for health for over 70 million Americans, and I am happy that our Committee was able to ensure that CHIP is re-authorized for 2 more years, and I hope that we continue to actively support and ensure the continuation of something I have known, as a school nurse, as an incredibly successful program.

As a Committee, we have a responsibility to make our best faith effort to build upon the success of these programs. First, it is important to recognize how far the Medicaid program has come in the last 50 years. It is remarkable. Perhaps most notably, in the past few years, the program has been very much strengthened through the provisions in the Affordable Care Act based on the needs of our communities.

Medicaid is a safety net, of course, for these people who are otherwise shut out of private insurance, either because it is unaffordable, or is unavailable to them. And thanks to Medicaid expansion in the states where they have access to it, the program could be there for any of us, including here, in this room, who fall down on our luck and

needed support.

Most people in the coverage gap are working. They are working poor, employed either part time or full time, but still living below the property line. While the promise of coverage is there, unfortunately, nearly four million hard working low income Americans cannot receive the health coverage they need because they live in states that have chosen not to expand Medicaid, despite the economic benefits that are now demonstrated, well demonstrated, of doing so. However, for those who do have Medicaid coverage, there have been substantial changes to the delivery of Medicaid that aim to increase access, and also quality of care. I am particularly proud of all the progress in my home state of California made in the areas of patient center medical homes and care coordination.

This has been discussed by you already in a response to a question, but can you talk about, Ms. Wachino, some of the other new and innovative delivery system reforms that you have seen states starting to take up, and have been working with states to make sure it happens?

Ms. {Wachino.} Sure, I am happy to, thank you. We have a variety of really promising work underway with states to strengthen their delivery systems. And, as I said briefly in my oral testimony, there are many different modalities.

Mrs. {Capps.} Um-hum.

Ms. {Wachino.} Some states, you know, use existing state plan authority. States like Arkansas are taking up shared savings for their providers, building off of a Medicare model. Missouri is using our new health homes option, created under the Affordable Care Act, to really move forward with improvements for people with chronic diseases. And in Missouri we have seen reductions in the use of hospital care, and improvements in key measures, like measures of diabetes care, which are very, very promising.

There are other states who have taken even more far reaching approaches. Oregon, under 1115 authority several years ago, launched coordinated care organizations, which were designed to be community rooted approaches to coordinating the entire spectrum of care for Medicaid beneficiaries and piloting new approaches, like using community health workers. Other states have created delivery system reform incentive payments to really propel movement forward on key payment goals. We approved New York last year for a new 1115 waiver, and New York is committed to very concrete and measurable objectives for increasing the number of their providers who are using value-based payments.

Mrs. {Capps.} Thank you.

Ms. {Wachino.} So I think we are changing the landscape

of Medicaid care delivery in a number of ways.

Mrs. {Capps.} I don't mean to cut you off, but I think you could go on and on, and maybe you would like--

Ms. {Wachino.} I am afraid I can, so I thank you for the stop.

Mrs. {Capps.} You could submit any other examples you would like for the record, because, as we have discussed in this community 2 weeks ago, we have seen over 300 state flexibility waivers to create state solutions within the Medicaid framework. And that--this is an exciting time to see those come forward. There is substantial state flexibility. I think it is important to recognize this innovation and flexibility, what it looks like. Before considering any changes to our program, we must be mindful about what exactly--who will be impacted by the decisions that we might make, and if we are truly improving care, or just passing the buck to states.

So we want to be working with you--with the different states with respect to persons with disabilities, seniors, and struggling families. Right now we know that the Medicaid program works. Individuals with Medicaid are more likely to receive preventative health care, which is cost savings, and less likely to have medical debt than their underinsured counterparts.

Dr. Schwartz--I will have to save that question for another panel--another round. Thank you.

Mr. {Pitts.} Or you can submit it in writing. Thank you. The Chair thanks the gentlelady. I now recognize the Vice Chair of the Subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. {Guthrie.} Hey, thank you. Thank you all for coming this morning. And, first, to either Ms. Yocom or Ms. Iritani, I hope I said that correctly, in your testimony you noted that CMS lacked complete and reliable data about the sources of funding states used to finance the non-Federal share of Medicaid, which can shift costs to the Federal Government. What information have you recommended that CMS collect, and how will having this information help CMS monitor the program to ensure the appropriate use of Federal funds?

Ms. {Iritani.} Yes, we have made recommendations that CMS develop a data collection strategy regarding sources of funds that states use for financing the non-Federal share. We have recently surveyed states about how they are financing the non-Federal share, and identified that states are relying more heavily on providers, such as through provider taxes and local governments, through inter-governmental transfers, for example.

Provider taxes, I think, doubled during the course of the 2008 to 2012 time period that we looked at, and these can shift costs to the Federal Government to providers. We think it is important that CMS have data needed for oversight.

Mr. {Guthrie.} Okay, thank you. And, Ms. Wachino, I have introduced a bill H.R. 1362, which would require states to report how they finance. I know you share that we need more transparency in the way states--how states report how they finance Medicaid. And what actions has CMS taken in response to the GAO recommendations?

Ms. {Wachino.} Mr. Guthrie, thank you for the question, and for your interest in transparency and accountability. I think GAO's work in this area has been very helpful, and we are making improvements, and continue to make more. We are looking much more closely at the sources, and reviewing more closely the sources of the non-Federal share. We are working on getting additional levels of data for a variety of different kinds of payments, and we are conducting more active oversight. We have also issued several forms of guidance to states, making sure that our rules are clear with respect to provider taxes and donations. So I think we are strong in this area, and continue to get stronger.

Mr. {Guthrie.} Yeah, and I used to be in state government, before I got here on the Budget Committee, in

Kentucky, which has a substantial Medicaid population. Actually one out of four now are on Medicaid, and so I understand that states are being creative because of the budget pressures they are facing, so that is something we all need to work together to move forward.

And, Ms. Wachino, in your written statement you described numerous CMS initiatives aimed at innovation in achieving better health outcomes at a lower cost. And how is CMS assessing these--or evaluating these initiatives to determine if they are meeting goals?

Ms. {Wachino.} We are conducting--a lot of these delivery system reforms are very important to us, and we want to know how they work for ourselves, as stewards of taxpayer dollars, and also to inform developments in other states. We are evaluating many of the delivery system reform improvements that we undertook with states through our 1115 waivers. Right now that is very important to us. MACPAC's also done some very helpful work in this area. And we also will be evaluating the effectiveness and results of the work we are doing through our Innovation Accelerator Program in areas like substance use disorder, promoting community integration, improving physical and behavioral health, and meeting the needs of complex, high cost populations. And, again, all of that is designed to help us, and to help states

be smarter and better purchasers of care.

Mr. {Guthrie.} Well, good. Is there some timeframe when some of the original--or early evaluations will come forward?

Ms. {Wachino.} You know, I can get back to you on that question for the record.

Mr. {Guthrie.} All right, thanks. And then one more. I understand that OIG has found significant and persistent compliance, payment, and fraud vulnerabilities related to the provision of personal care services in Medicaid, and--including payments for services not rendered. Has CMS taken action to address the OIG recommendations to improve integrity in personal care services?

Ms. {Wachino.} Yeah. Thank you for the question, and for the work that IG and GAO have done looking at our personal care services. We have taken steps to ensure the integrity of personal care services. We recently engaged a contractor to look at data and provider compliance--

Mr. {Guthrie.} Um-hum.

Ms. {Wachino.} --in that area. We issued a quality informational bulletin with respect to personal care services in our 1915(c), which, apologies for the jargon, are home and community based services waivers. And also, as I think staff of this Committee knows, we have made a very substantial

effort in data systems modernization. We call it our TMSIS System, and that is going to provide us a level of programmatic data that we are very eager for, and will help our program integrity, program management, ability to evaluate states in a number of areas, including for personal care services.

Mr. {Guthrie.} Thank you, my time has expired. I appreciate your answers. Appreciate your answers.

Mr. {Pitts.} The Chair thanks the gentleman. I now recognize the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. {Castor.} Well, thank you, Mr. Chairman, and thank you to all of our witnesses for being here today to discuss Medicare on its 50th anniversary. You know, the passage of Medicare and Medicaid 50 years ago, through amendments to the Social Security Act, really are something to celebrate. They are landmark safety net laws in this country that really demonstrate our values. We--if--in Medicare, you work hard all of your life, and you retire, you are not going to fall into poverty because of a health condition. The same with Medicaid. Under Medicaid, we are not going to allow children across America, no matter what station they are born in in life, to suffer the consequences of a debilitating disability, or just being able to see a doctor.

So we have something to celebrate here. And then when you add on the impact of the Affordable Care Act, feels like we are kind of out of the woods, and now we can begin to work on bipartisan solutions to improve it together. I think the future is bright so--this is also an important time for Medicaid, because at this point in time we are dealing with Medicaid expansion and delivery system reform, and that will help improve the lives of so many of our neighbors all across the country. So I look forward to hearing your thoughts on these transformations.

I want to especially thank Ms. Wachino for her extensive work with the State of Florida over the past few months, few years. We had a very contentious legislative session, where we had Republican State Senators, and the business community, hospitals, clamoring for a coverage model in Medicaid expansion. We had a governor who flip-flopped. He was for Medicaid expansion when he ran for re-election, then he changed after the election. He devised a budget with certain low income pool monies that were--he was on notice that--just weren't going to happen, and you came through it very well. We still have challenges in Florida. I hope we can move to Medicaid expansion. But you stayed true to the values and the intent of the Medicaid program, so thank you very much.

I would like to ask about the agency's proposed rule for

Medicaid managed care organizations that were issued earlier this year. Given the growing number of Medicaid beneficiaries who receive care through managed care arrangements, it is crucial that we strengthen Federal oversight of these programs to ensure that Federal dollars are being spent wisely. This has my attention especially because a Federal Court Judge in Florida found that Florida's Medicaid program was in violation of Federal law because of low reimbursement rates, failure to provide prompt service and adequate service, failure to provide outreach services as required by the law. Then you had a Supreme Court Decision involving the State of Idaho that said that you can't-- private providers cannot challenge low reimbursement rates. So that puts the impetus on HHS to follow through with oversight.

Ms. Yocom, GAO has issued a number of recommendations to CMS to improve Federal oversight of the managed care rate setting process, is that correct? And why does this feel-- why does GAO feel that this is necessary?

Ms. {Yocom.} Well, it goes back in part to transparency issues, understanding that, you know, where the money is going and for what purposes. We also did do work just recently that spoke to the fact that neither the Federal Government nor the states in our sample were actually

conducting audits of Medicaid managed care organizations, and we recommended that that be changed. We--that CMS requires states to conduct audits both to and by managed care organizations.

Ms. {Castor.} And Ms. Wachino, do you agree?

Ms. {Wachino.} I think we were--I think GAO's concerns helped us really inform some of our thinking about our proposed rule. Ensuring accountability in managed care is vitally important to us because it is where most of our beneficiaries get their care. Medicaid is no longer a fee for service program, and managed care has great potential to offer care coordination and meet the needs of low income Americans, but we really want it to be as strong as possible.

So, to Ms. Yokom's point, part of the proposed rule does include greater auditing by Medicaid managed care plans. We have also proposed new rules with respect to provider enrollment to ensure that providers go through the same screening process when they enroll in a Medicaid managed care plan that they do in a fee for service program. And we are making substantial advances in the soundness of the rates that states pay plans.

Ms. {Castor.} Yeah. For example, the Federal--I will--I am going to submit these further questions into writing, Mr. Chairman, and I would also like to thank Chairman

Emeritus Barton for raising the issue of the Ace Kids Act, and we will look forward to working with CMS on a medical home for children with complex conditions. Thank you very much. I--

Mr. {Pitts.} The Chair thanks the gentlelady, and now recognizes the gentleman from Kentucky, Mr. Whitfield, 5 minutes for questions.

Mr. {Whitfield.} Thank you very much, and thank the four of you for joining us today, and we appreciate your responsibilities and involvement in the health care delivery system in America. As you know, or maybe you don't know, there are about 67 different programs in the Federal Government relating to climate change. And whenever--EPA has been particularly active in that area, and on their regulations they talk about some of the primary benefits relate to health care. Asthma conditions, premature deaths, whatever. And we know that Medicare, 500 billion a year, Medicaid, 330 billion a year, community health centers, around 5 billion a year, I don't know what the cost of Tricare is, but it is primarily about access to health care, which is vitally important.

But one area that I have been reading more and more about recently that disturbs me a great deal relates to antibiotic resistant bacteria. And it is turning out that it

is a more significant issue not only nationally, but internationally. And I read an article recently that last year alone in America there were 37,000 deaths relating to infections that could not be treated by antibiotics. And some of the experts are saying that that figure is much lower than reality because the identification system is not sophisticated enough to determine when someone has died because of the bacteria being resistant to antibiotics.

And I have been told that 44--that hospitals in 44 states have had outbreaks of bacteria resistant to antibiotics. Even NIH, our premier research and development institute, has had deaths because of this issue. And I would like to know--you all are involved in the very core of CMS, and HHS, and CDC. Are you aware of some specific programs that are trying to address this problem that faces the American people today?

Ms. {Wachino.} Congressman Whitfield, thanks for raising the concerns. I think we--that HHS shares your concern about making sure that people remain healthy. I would like to go back and consult with my colleagues in--particularly in CDC and get back to you for the record about what we are--what they are doing, because I think when it comes to things like surveillance, that is really a primary responsibility of theirs, with Medicaid coverage supporting

people, when they unexpectedly fall ill, to make sure they get the services--

Mr. {Whitfield.} But you--well, I appreciate that, because I tell you, I do get upset about it, because we see a plethora of executive orders and regulations relating to asthma, and other things like that, but I am not aware of one executive order or regulation to address this issue, and this is an issue that can really destroy a lot of people in this country and around the world. And the experts that I have heard from, the hospitals that I have talked to, and others, say that this is an epidemic that can be quite serious not only for America, but for the world.

Ms. {Wachino.} Thank you for the concern. I am happy to go back and consult with our experts and circle back with you to provide you more information with how we are approaching it.

Mr. {Pitts.} The Chair thanks the gentleman, now recognize the gentlelady from California, Ms. Matsui, 5 minutes for questions.

Ms. {Matsui.} Thank you, Mr. Chairman. As we know, California is the forefront of innovation of many areas, not the least of which is health care. California was an early implementer of Medicaid expansion, and the first state to implement the delivery system reform incentive payment. As

we know, Medicaid is a State/Federal partnership, and the ability for the state to implement pieces of the program as it sees fit within Federal guidelines is essential to its success. Of course, the main way that states are able to exercise this flexibility is through the waiver process.

Now, just 2 weeks ago California was the first state to be approved for a 5 year renewal of a different waiver, for specialty mental health services. Previously these types of waivers were only allowed to be renewed in 2 year intervals, but the ACA changed that to allow for 5 year renewals. This is a huge step forward for the nearly one in six California adults, and one in 13 California children with mental health needs.

I am also so pleased that California is also moving forward to apply for new community behavioral health funding in the Medicaid program, which will be available in the form of demonstration projects based on the Excellence in Mental Health Act that I co-authored with my colleague on this Committee, Representative Leonard Lance. This demonstration will support California's efforts to integrate mental and physical health. This is so important, as we all know that the head is connected to the body, and we need to treat it that way.

Ms. Wachino, how is a Medicaid program, especially

through waivers and demonstration projects, making a difference in the mental health system?

Ms. {Wachino.} Thank you for the question. We are working actively on supporting mental health services in a number of areas, and thank you for mentioning the community mental health services program that we released the planning grant announcement for just a few months ago. We were very happy to have that legislation. As you well know, it allows us to pilot approaches in partnership with health centers to advance community based mental health care, and we are very much looking forward to seeing states apply for those grants. We have had a high interest level so far, and we will look forward to continue working with them.

I think, in addition to that, we have a number of initiatives underway, and a very strong interest level from states in moving towards greater physical and behavioral health integration, and clearly community based mental health care is a key part of that, and we will be working actively with California, and with other states, to ensure appropriate provision of community based care.

Ms. {Matsui.} Well, thank you. Now, Ms. Wachino, under your leadership CMS recently released the first major proposed update to Medicaid and CHIP managed care rules since 2003, and one of the provisions of the proposed rule would

provide flexibility for Medicaid managed care on the so-called IMD exclusion, which prevents Medicaid from paying for inpatient mental health services and facilities with more than 16 beds. Can you please elaborate on that policy, and how it is intended to strike the right balance between the ability to provide inpatient services and emphasis on community based care?

Ms. {Wachino.} Thank you for the question. We have spent a lot of time thinking, and I know many members of Congress have as well, about how to ensure access to mental health services, particularly community mental health services, and we have become aware of a growing need for access to mental health services.

However, we are also trying to approach it cautiously, and very aware of the risk that if we move too far forward, and too fast in moving forward, in terms of allowing Medicaid funding for services to adults in institutions of mental disease, which, as you know, Congresswoman Matsui, is prohibited by statute, that we would risk undermining the progress we have made in serving Medicaid beneficiaries in communities, rather than institutions. So our proposed rule tries to strike the balance by proposing to allow states and plans to cover, as part of their capitation rates, short term stays in institutions of mental disease.

Ms. {Matsui.} Okay. Thank you. Dr. Schwartz, during your testimony today you noted the importance of Medicaid on our health system safety net. I was particularly interested in your comment that Medicaid often acts as a wraparound insurance for long term services and supports, as well as employer sponsored insurance and Medicare. Can you please expand on this wraparound role that you described in 10 seconds?

Ms. {Schwartz.} Yes. I think the primary way is Medicare does not cover long term services and supports, although it is the primary source of coverage for medical care for the elderly and disabled. Those services have very few sources of private coverage, and Medicaid plays a key role for those populations. It also provides wraparound services for employer sponsored coverage, primarily for children with disabilities, who have very high costs, particularly for prescription drugs. That may be what their parents' plans pay for.

Ms. {Matsui.} Okay. Thank you, and I will submit my other questions.

Mr. {Pitts.} The Chair thanks the gentlelady. I now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. {Shimkus.} Thank you, Mr. Chairman, and welcome--we

have two competing, as you probably heard, hearings going up and down, so I apologize for missing some of the testimony. But to my friend from Kentucky, we do have 21st century cures. Bill is going to be on the floor. Adapt is part of that. It is going to build on gain. This is on the antibiotic resistance issues, which we hope to get, you know, more drugs into the--or to be able to compete. So I do think there is a legislative response. I think his issue was, you know, where is the government's response? So--but I just throw that out there for information.

Ms. Wachino, on--in 2008, in a--Mr. Waxman, Dingell, and Mr. Pallone sent a letter to GAO expressing concerns on the--on CMS's implementation of its own policy on 1115s, and we have talked about these today, demonstrations that they be budget neutral. Years later those concerns are still there. GAO has found billions of dollars in increased costs to the Federal Government as a result of waivers that were not budget neutral, a concern that crosses party lines. Can you please explain CMS's process for assessing the budget neutrality of waivers, and how the CMS actuaries are involved in this process?

Ms. {Wachino.} Sure. I--our approach to budget neutrality, which, as you know, is designed to ensure that costs with the waiver are not higher--

Mr. {Shimkus.} Well, the states have been making promises that they are going to have this new ramped up program that is actually going to be a savings, and we are finding out that they are not.

Ms. {Wachino.} Yeah. As we work with each state, we try to find a solution. As we have worked them, particularly on budget neutrality, we have made our 1115 waiver approval process more transparent. We have improved our monitoring and evaluation. And particularly with respect to transparency, we put all of our approval documents on medicaid.gov. We also, as you probably know, developed a template for waiver applications that includes a structure for budget neutrality reporting, and we have worked to be consistent in our approaches to budget neutrality across states.

Mr. {Shimkus.} Wouldn't it be prudent to have you all and your actuaries sign off on each demonstration to ensure that it is budget neutral?

Ms. {Wachino.} I think we have worked hard to ensure consistency in budget neutrality, and will continue to work hard.

Mr. {Shimkus.} So that brings me to H.R. 2119, which is the bill I dropped, just to really say sign off on it. Have your actuaries actually sign on the dotted line, and put

their reputation on the line that, based upon the analysis they have in front of them, that this is going to be--right now, yeah, you could put all this stuff out there, but it is not a strong enough signal to say--because we--it is been proven it has not been working. I mean, we are just spending more than what the projected savings would be on the program.

Let me go to one last issue, which I do have time for. If the staff would put the chart up? I talk about this all the time. CBO recently issued a 2015 long term budget outlook, and has noted that a little--that, in a little more than a decade, all the Federal budget will be consumed with entitlements and service on the debt. With respect to Medicaid it said many state governments will provide--will respond to growing costs for Medicaid by restraining payment rates to providers and managed care plans, limiting the services that they choose to cover, or tightening eligibility for those programs so that it serves fewer beneficiaries than it would have otherwise.

This reaffirms a long term concern of mine that our biggest threat to access to care for our nation's most vulnerable is the budgetary pressures that states and the Federal Government face in financing our entitlement programs. Yet, in your testimony today, you did not mention the fiscal sustainability of the program at all. Aren't you

concerned that unless we make changes our fiscal situation will put beneficiaries' access to care at risk, or do you agree with--disagree with CBO's warnings?

Ms. {Wachino.} We are very committed to being strong fiscal stewards of the Medicaid program. I think Medicaid has proven to be a very cost efficient program. As you saw in some of my colleagues' testimony--

Mr. {Shimkus.} But the point is this, here--that is our budget.

Ms. {Wachino.} Um-hum.

Mr. {Shimkus.} The red is mandatory spending. One of those is Medicaid. And the CBO says it is going to grow, so it is going to keep shrinking the blue, which is the discretionary budget, which is all these other things we do, NIH, and all these other things. The CBO report also says that states--and we have seen this. This is not new. States, when they are in budgetary pressure, they start restricting access to Medicaid. Isn't that a threat that you ought to be mentioning when we are doing this let us talk about Medicaid hearing?

Ms. {Wachino.} Congressman, we work, again, actively to ensure the sustainability of the program so that it--

Mr. {Shimkus.} So how--what are--what proposals are you going to provide to us to make this program sustainable?

Ms. {Wachino.} Congressman, in the President's budget we proposed proposals around changing the drug rebate--

Mr. {Shimkus.} And that is not in your testimony.

Ms. {Wachino.} That is right. My testimony did not address every proposal in the President's budget, but I think it is important to note for the record that there are proposals with respect to changes for durable medical equipment, and to spending for prescription drugs. And we think approaches like that, together with our approaches to strengthening delivery system reforms, are the ways to ensure the sustainability of the program for the future.

Mr. {Shimkus.} Thank you, Mr. Chairman. I will just say actuary changes in entitlement programs. You have to make actuary changes, not nibbling around the edges. And I will yield back my time.

Mr. {Pitts.} The Chair thanks the gentleman, and now recognize the gentleman from New Mexico, Mr. Lujan, 5 minutes for questions.

Mr. {Lujan.} Thank you very much, Mr. Chairman. Ms. Wachino, as you are aware, I have had conversations with you, and with Secretary Burwell about concerns with the behavioral health system in New Mexico. At the moment is CMS concerned that New Mexicans enrolled in Medicaid have adequate access to behavioral health services?

Ms. {Wachino.} Congressman, thank you for working with us, and for your continued interest in this issue, and you know that we share concerns about ensuring appropriate access to behavioral health services in New Mexico. We have worked very closely with all states, including New Mexico, to ensure appropriate access to behavioral health care. Specifically with respect to New Mexico, as you and I have discussed previously, we are working with the state to develop a comprehensive plan to continue and to ensure access. The state has provided us data, which we are reviewing now, and we hope to be able to report out on soon.

Mr. {Lujan.} So, Ms. Wachino, in 2013 CMS asked the State of New Mexico for a network development plan. Is that the plan you are referring to?

Ms. {Wachino.} We asked them for a plan. We have actually taken a step back and asked them to go a little bit further than that, and to go--review their past plans and their future plans, and provide to us a plan that we haven't--that provides us an assurance that there will be adequate access to mental health services throughout the state.

Mr. {Lujan.} So in 2014 you followed up with a request letter, the same one that you submitted in 2013 to the State of New Mexico, reminding them--it says, we remind the state

to submit a network development plan. Has that plan been submitted to CMS?

Ms. {Wachino.} I will have to go back and check, and I could submit that for the record. I can tell you, Congressman, that we met with the state as recently as June to talk about the need to continue progress forward in this effort. We still have some additional information we are awaiting for the state, and we continue to work with them actively, and look forward to having more to report to you soon.

Mr. {Lujan.} So I appreciate very much that CMS shares concerns. It is also stated in your 2013 letter that CMS continues to be concerned about the transition of behavioral health providers and centennial care. In 2014 the state again worked with the State of New Mexico to ask for some data to be released associated with behavioral health stakeholders.

And there was a letter that was sent to the State of New Mexico in which the State of New Mexico's behavioral health responded to CMS, September 23, 2014. In the letter it says, ``As we discussed in our meeting with CMS''--and I am quoting --``and the BHS stakeholders, HSD is anxious to share BH utilization data with the public, but we need to be sure that the data we report is accurate. We are close to confirming

the utilization data, and within the next few weeks we expect to release BH utilization data for the first two quarters of centennial care. We understand the importance of data transparency.'' So it said within the next few weeks. Again, this letter was written September 23.

In an article in the Albuquerque Journal, which is a local paper, published September 24, which is the next morning, at 12:02 a.m.--and I know the press is good, but they can't write an article in a minute, so it probably was written the day before--the spokesperson for HSD says that the data will be presented to the Legislative Finance Committee today. Was someone not being honest with CMS when they sent this letter to you on September 23?

Ms. {Wachino.} Congressman, we continue to work as closely as we can with the state to ensure adequate access to behavioral health services. I can go back with my staff and review what the state submitted, and report back to you.

Mr. {Lujan.} Ms. Wachino, has CMS been receiving adequate data yet?

Ms. {Wachino.} We have a variety of data sources from the state. We are comparing them to each other, and trying to identify trends and issues with respect to access to behavioral health care.

Mr. {Lujan.} Did CMS receive the data that was publicly

reported in the Albuquerque Journal, that was also shared with the New Mexico Legislative Finance Committee on September 24 of 2014? Has CMS received that data?

Ms. {Wachino.} Congressman Lujan, I know that we have received data, including data that is reported to the legislature from the state. I am going to have--and, as you know, many of the developments that you have just informed me of precede my tenure at CMCS, so let--if I could, I would like to go back and examine the record with my staff who have been working on this.

Mr. {Lujan.} And, Ms. Wachino, with all due respect, these issues were brought up with the meeting with the delegation 6 weeks ago. This is--these are not new questions. The reason I am asking them in this hearing today is because we have not received any answers, and it is frustrating. Especially when it seems that the paper has more access to data than the delegation and CMS does, at least than what is--reporting to us. The way that this information came out was through a FOIA request through a local network of individuals that were concerned in New Mexico. Do--does--do members of Congress have to seek Freedom of Information Act requests to Federal agencies to get data?

Ms. {Wachino.} Congressman, as we have committed to

you, we would--we are obtaining data from the state, and we have agreed to make it transparent for everyone. And let me say again, we met with the state as recently as early June to try to ensure continued progress in this area, and we are going to continue to work with them and with you to ensure appropriate provision of behavioral health services in the state.

Mr. {Lujan.} All right. Mr. Chairman, I--as you can see, there is some frustration from the delegation in the State of New Mexico in this issue, and it is one that we hope that we can continue to work with the staff and everyone that--from CMS that has been working with us recently. But we need to get these answers to questions that have been asked, and to try to get to the bottom of what is going on. And I certainly hope that you can share with us.

I will submit into the record more questions, Mr. Chairman. A deadline that has been established for when this report were--in 2013--2014. It is now 2015. When is a deadline going to be established to get this report in? So I thank you, Mr. Chairman, for your indulgence, and I yield back.

Mr. {Pitts.} The Chair thanks the gentleman, and now recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. {Murphy.} Thank you, and good morning. I am going to follow up on some of the questions my colleagues and friends have asked from New Mexico and California, the behavioral thing. I know the GAO report said that behavioral health is a serious problem.

Ms. Wachino, you made reference to the word progress. What progress is being made on the IMD exclusion issue?

Ms. {Wachino.} We have been looking very carefully at this issue from the standpoint of wanting to ensure that there is access--appropriate access to inpatient mental health services, and at the same time trying to arrive at an approach that doesn't undermine the progress that we have made--

Mr. {Murphy.} That is what I am asking--

Ms. {Wachino.} --supporting people in the--

Mr. {Murphy.} --what you mean by progress--

Ms. {Wachino.} --communities.

Mr. {Murphy.} --is what--

Ms. {Wachino.} What I--the most tangible sign of progress is in our proposed managed care role, where we have proposed to give states the flexibility, and plans the flexibility, to cover, through their capitation rates, short term stays in their--

Mr. {Murphy.} Short term meaning?

Ms. {Wachino.} Short term meaning--I think the standard is up to 15 days. I can tell you that we reviewed preliminary data from the Medicaid emergency psychiatric demonstration, which I know you are familiar with, and use that to base the standard for the short term stay.

Mr. {Murphy.} Some things about that have been--I am concerned that a short term stay of 15 days is insufficient, because it may take a couple weeks to get off of one medication, couple weeks to get back on another one. But we don't--but that is different from residential care. I am looking at things that I think are valuable at a less than 30 days average rate.

But when you are looking at these issues, and helping states do that, are you looking at other dependent variables, such as suicide rates, drug overdose rates, arrests, incarcerations, homelessness, ER boarding costs, are any of those things you are looking at?

Ms. {Wachino.} I think, Congressman, your question points to--at the end of the day we should be looking at health outcomes.

Mr. {Murphy.} Um-hum.

Ms. {Wachino.} When we fund Medicaid services, I believe that the evaluation of the Medicaid emergency psychiatric demonstration will inform our policy in this area

significantly. We don't have evaluation results yet.

Mr. {Murphy.} And I just want to make sure, as you are pursuing that--and this is what I want to find out, what your dependent variables are in your study. A recent report that was just--I just read from the Arkansas legislature, might want to look that up. It looked at states like Oregon, Georgia, Texas, and found that the rates--the cost of incarcerating someone with mental illness could be 10 times higher than the rate of serving them in the community.

Obviously this would be a huge issue, especially if you have the revolving door of people in and out of jails, show up in emergency rooms, back in the community, we are not serving anybody well that way. I am sure you would agree. That is heartless, and that is--we don't do that in this country. Unfortunately, we do that, but it is a serious concern.

But with regard to that, I also want to talk about legislation I have that this Committee's--has been dealing with my legislation, Helping Families in Mental Health Crisis Act. We are trying to reform the whole system. And one of the ways that we look at this is to help--is through promoting stronger enforcement of mental health parity. And recently CMS proposed a rulemaking that would apply purely to beneficiaries served by Medicaid and managed care, which have

far reaching positive implications, if complied with.

On another area, though, I have strong concerns about the proposed rule's exclusion of long term care services from MHPAEA, parity protections. Long term care services, inpatient and community based, are critical to many individuals with mental health and substance abuse disorders, particularly the medicated CHIP population. And CMS has clear authority and statutory obligation to apply parity to all covered benefits under these programs, yet the proposed rule doesn't even define long term care services, or identify the types of services that apply. Can you address this flaw in the proposed rule with regard to the definition of that?

Ms. {Wachino.} As you know, the comment period on our proposed mental health parity rule, which we think is a very substantial advance in coverage of mental health services in the Medicaid program, just recently closed. We are reviewing the comments now, and I would fully expect that the question of whether these protections also extend to long term services is something that will be actively--that we will receive a lot comment on, and that we will actively consider as we finalize the rule.

Mr. {Murphy.} Thank you. I hope--what is important to all these rules, in looking at behavioral health, is when--you also talk about progress in this issue is--I think we are

also--so all--you have the IMD exclusion. A lot of people can't get care for the crisis, period. We don't want people--we don't ever want to bring back the asylums, but we want people to have an option for crisis, instead of being boarded in an emergency room. We have had testimony in my Oversight Committee that boarding would take place for hours, days, weeks, and months. Terrible place for a person to be strapped to a gurney as these things go on.

But part of the concern also is that there are just simply not enough providers. Not enough psychiatrists, not enough clinical psychologists, not enough clinical social workers, who deal with the severely mentally ill. And so I am hoping that is also something you are looking at as well. It has an impact upon the reimbursement and--provision of these. As you are looking at working out these partnerships with states, we have to have ways of getting more people out there, because nothing is worse than telling someone, there is just no room for you, and there is no one to see you. I yield back.

Mr. {Pitts.} The Chair thanks the gentleman. I now recognize the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. {Schrader.} Thank you, Mr. Chairman, I appreciate it. Ms. Wachino, could you comment a little bit on Medicaid

spending per beneficiary compared to private insurance over this past decade?

Ms. {Wachino.} Sure. I think--thank you for the question. When you look at per capita--per beneficiary costs, Medicaid costs have been recently growing more slowly than the per beneficiary costs in private insurance. And I believe I saw in my colleague's testimony projections that, on a per beneficiary basis, Medicaid costs are expected to grow more slowly than private insurance. Of course, we are putting a number of tools in place focused on delivery system reform to ensure that we continue to do the best possible job of maintaining Medicaid's cost efficiency.

Mr. {Schrader.} CBO would apparently agree with you on that. Ms. Yocom, just a quick comment. I--as we celebrate the 50th anniversary of Medicaid, the program is changing. We are moving past the old fee for service, pay for, you know a widget, or a particular service and going to this managed care type of model, where we are treating the whole patient a little bit, I think to answer Dr. Murphy's concerns, and others. Is GAO prepared to audit outcome based results versus just how the money is spent?

I mean, in our last hearing Ms. Iritani and others in GAO talking about how the money is spent. And certainly when you are just monitoring, you know, individual dollars going

out, that is appropriate. But, as a policymaker of the 21st century, I would rather monitor outcomes. I am not sure I can evaluate the appropriateness of an expenditure, but I can evaluate whether or not we are getting results. Is GAO prepared to work along those lines?

Ms. {Yocom.} We would be glad to work with you on putting together work in that area. We have also done some work looking at managed care utilization rates, and did find a wide variety of utilization rates across the 19 states that we looked at. And some of this did appear to be related to whether or not a beneficiary was enrolled in Medicaid for the full year versus a partial year.

Mr. {Schrader.} All right. That will be fun to work with you on. I know my own state, much like I guess Kentucky, the Medicaid expansion--what was occurring before this was going on, before the ACA, and with the ACA, last year and a half we added 400,000 people to the Medicaid rolls. Big active outreach by folks in our state. We also have 25 percent of our population on Medicaid. It is not a--at least they have access--that great a portion of the population, I think.

Ms. Wachino, pleased to see you reference Oregon's program in your testimony. It is a fairly innovative outcome based approach, where we are trying to keep costs down.

Actually, half of the projected rate for Medicaid growth nationally, from four percent down to two percent, in the same time get better outcomes.

Or--already seeing--we--or I commented last year about results from a year ago, and I guess just recently new data came out, with emergency room visits down 22 percent amongst these coordinate care organizations that deal with mental health, hopefully dental health, as well as the fiscal health of the people. Short term complications from diabetes down 27 percent with this coordinated care approach. Hospital admissions from COPD, chronic obstructive pulmonary disease, down 60 percent. You know, and that is one of the long term cost drivers, unfortunately, of a lot of health care in this country, whether you are on Medicaid, Medicare, or private insurance. Can you comment a little bit on what CMS may be learning from what you are seeing in Oregon, and how you might evaluate future waivers from different states?

Ms. {Wachino.} Sure. I think we will be looking very carefully at the results of the Oregon demonstration. And I am not yet familiar with the results you just shared, so thank you for that, and improving the population health. Oregon Committed is part of the 1115 waiver to very robust cost quality goals. And as we review the success of the waiver with them, and of their coordinated care in serving

Medicaid beneficiaries, we will want to look at cost, and quality, and how it is achieving those goals.

Mr. {Schrader.} Good, good. Well, I think it is the future of medicine. Frankly, the future of Federal budgeting in general, rather than trying to dictate to different agencies or different providers around the country how to do things. Let us talk with them, share concerns about outcomes and where we are trying to go, monitor those and spend money there, hopefully a little more efficiently. With that I yield back. Thank you, Mr. Chairman.

Mr. {Pitts.} The Chair thanks the gentleman. I now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. {Lance.} Thank you very much, and good morning to you all. And I apologize for shuttling between two Subcommittees. I think this is a very interesting hearing, and I want to learn more about Medicaid.

To Ms. Wachino, what--when the program began 50 years ago, I assume that greater expenditures were in Medicare than Medicaid, is that accurate, 50 years ago?

Ms. {Wachino.} Congressman, I would have to go back and look at the history--

Mr. {Lance.} Well--

Ms. {Wachino.} --to--

Mr. {Lance.} Well, perhaps someone else on the panel. I presume at some point the line crossed, and the greater expenditure was on Medicaid than Medicare. Can anybody on the panel enlighten me on that?

Ms. {Yocom.} I know that, and I attended a conference a couple of years ago where it was mentioned that on a-- combined Federal and state spending on Medicaid had just exceeded that of Medicare, total Medicare spending, and that would have been maybe a year or 2 ago.

Mr. {Lance.} Combined Federal/state on Medicaid?

Ms. {Yocom.} Correct.

Mr. {Lance.} Whereas Medicare, of course, is primarily a Federal program. I wonder whether this was anticipated. The figures I have is that 70 million people utilize Medicaid, is that right, in this country? We have 200--310, 315 million people? Is that right? 70 million people?

Ms. {Yocom.} Yes.

Mr. {Lance.} And has that increased because of the terrible recession? I know it increased as well because of the ACA. I am familiar with that, and the fact that some states have expanded Medicaid, and others have not, and that is a great debate in this country. And New Jersey is one of those states with a Republican governor that expanded Medicaid. But do you think that the numbers have increased

as well due to the fact that we are not in as robust economic times as we all would like?

Ms. {Yocom.} We have done work looking at the effects during the economic downturns, and Medicaid enrollment does go up during an economic downturn. It also recovers--it is related to unemployment, of course--

Mr. {Lance.} Yeah.

Ms. {Yocom.} --and it is--unemployment, it tends to be a lag in indicator, so the recovery is also slower. And so you tend to get people on Medicaid more quickly, and they stay--

Mr. {Lance.} Now, the unemployment rate is whatever it is, 5.3 percent. It is lower than it was. Is there a correlation as well with the labor participation rate?

Ms. {Yocom.} Yes, there is.

Mr. {Lance.} Um-hum.

Ms. {Yocom.} Yeah.

Mr. {Lance.} Yeah. I mean, people cite the lower unemployment rate. I think that is half the picture. There is also a dramatically lower labor participation rate in this country. So there would be a correlation between Medicaid and the labor participation rate?

Ms. {Yocom.} Right. Our work relied on the employment to population ratio.

Mr. {Lance.} Um-hum. And that is significantly lower than it has been in the last 50 years, isn't--would that be an accurate statement?

Ms. {Yocom.} Well, I couldn't answer that.

Mr. {Lance.} I think it is the lowest it has been since at least 1980, something like that. Thank you. Well, I want to learn more about this, because it is such an important part of the public policy of this country for the last 50 years.

To CMS in particular, and this is a long and complicated question, and has lots of jargon in it, CMS has indicated the oversight of a program the size and scope of Medicaid requires robust, timely, and accurate data to ensure efficient financial and program performance, support policy analysis and ongoing improvement, identify potential fraud, waste, and abuse, and enable data driver decision making.

Work conducted by the OIG in 2013 raised questions about the completeness and accuracy of the Transformed Medicaid Statistical Information System, TMSIS, data upon national implementation. CMS has since stated its goal of having all states submitting data in the TMSIS file format by 2015. Could you please describe the actions you are taking to ensure that this occurs?

Ms. {Wachino.} Sure. If it helps with the jargon,

Congressman, we call it TMSIS, and it is a data--

Mr. {Lance.} TMSIS?

Ms. {Wachino.} TMSIS.

Mr. {Lance.} I have learned something this morning.

Ms. {Wachino.} And it is CMS's investment in getting stronger, better, more comprehensive, and faster data, and how our program is working.

Mr. {Lance.} Um-hum.

Ms. {Wachino.} We have made substantial advances in TMSIS implementation this year. Our first state started submitting data in May, and we expect to have nearly all states submitting data by the end of the year. So we are moving forward and very eager to start sharing the data with external stakeholders for analysis, and using it for our own program management.

Mr. {Lance.} Thank you. My time has expired, and I look forward to working with all of you.

Mrs. {Ellmers.} [Presiding] The Chair now recognizes Mr. Sarbanes from Maryland for 5 minutes.

Mr. {Sarbanes.} Thank you, Madam Chair. Thank you all for your testimony. I am very interested in the money following the person initiative, and I wanted to hear a little bit more about that. When I was in private practice as a health care attorney, I had the opportunity, in

Maryland, to work on a program where Medicaid--the Medicaid program assigned a certain number of slots where assisted living facilities could qualify for Medicaid reimbursement, which doesn't typically happen when you have skilled nursing care, which is covered, but doesn't extend into the assisted living arena.

But the observation was there were sort of people in that inner section who could actually be treated in assisted living facilities, as opposed to going into skilled nursing, and could--that could be done at much less cost, and so why not try and explore that opportunity, potentially broaden it. And if we can continue to design that expansion or initiative going forward, it could produce tremendous savings, as well as being better for patients. And that can include exploring what sorts of treatments or reimbursement can occur in the home, right? So you are not even getting into institutional care of any kind.

So I was just curious, what is the status of exploring this--what I consider a new frontier, particularly as the demographics of the wave of our seniors is coming at us full force?

Ms. {Wachino.} Congressman, thank you for the question. We have spent a lot of time at CMS moving towards approaches that promote care--the most community based care possible.

And there is, as you note, a spectrum of different types of providers that can serve those individuals. Money Follows The Person is one vehicle by which we have worked with states towards that goal. We also have worked with them through the balancing incentive programs, and through their home and community based service waivers.

Currently we are--we have been assessing some of the things we have learned from our work with states through Money Follows The Person, and similar programs, and using it to inform our efforts with all states moving towards greater community integration, and would be happy to follow up with you on some of the particular things we have learned, and in particular the interaction with assisted living facilities.

Mr. {Sarbanes.} Are you--I mean, are you seeing some real potential savings opportunities there?

Ms. {Wachino.} I would like to look back more carefully at the fiscal impacts. I can say with certainty that we are seeing high rates of satisfaction from our beneficiaries as they move forward with greater community care. So we will circle back with you and provide evidence and impact on the cost.

Mr. {Sarbanes.} I would love to get more information about that, and maybe collaborate with you--

Ms. {Wachino.} We will follow up--

Mr. {Sarbanes.} --going forward.

Ms. {Wachino.} --with you. Thank you for the question.

Mr. {Sarbanes.} Thank you very much. I yield back my time.

Mrs. {Ellmers.} The gentleman yields back. The Chair now recognizes Mr. Bilirakis from Florida for 5 minutes.

Mr. {Bilirakis.} Thank you, Madam Chair, I appreciate you very much, and I want to thank you for your testimony.

Ms. Yocom, in your statement you--for--to your report titled Medicaid Demonstrations, Approval Criteria and Documentation Needs To Show How Spending Furthers Medicaid Objectives, you highlight how HHS has approved questionable methods and assumptions for spending estimates without providing adequate documentation. You also mentioned HHS does not have explicit criteria explaining how it determines how spending in the demonstration program furthers Medicaid objectives.

You also note their approval documents are not always clear on what expenditures are for, and how it will promote Medicaid objections--objectives. Can you talk about what recommendations have GAO made in this area that have not been accepted or implemented by HHS or CMS?

Ms. {Iritani.} I will answer that question. Yes, we have made several recommendations to CMS around those issues

that you point out. One is to issue criteria regarding how CMS assesses whether or not approved new spending under demonstrations will further objectives. A second is to apply that criteria in the documentation and make the documentation transparent. And a third relates to providing assurances in the documentation that approved spending will not duplicate other Federal funding sources. CMS agreed with the second two, the latter two, and partially agreed with our recommendation to issue criteria on how they assess spending.

Mr. {Bilirakis.} Have these recommendations been implemented, and then why not, Ms. Wachino?

Ms. {Wachino.} We have implemented the GA's--GAO's recommendations with respect to ensuring our approval documents are clear with respect to the criteria we use, with ensuring that there is no duplication of Federal fundings, and ensuring that we are consistently and clearly articulating when we meet the objectives of the--when we determine that a particular authority meets the objectives of the Medicaid program.

We move forward with that implementation, with implementing those policies while the report was still in draft, and so have worked very actively over the past several months to ensure that our approval documents are clear.

Mr. {Bilirakis.} Ms. Yocom, what do you have to say

about that? Do you agree?

Ms. {Yocom.} I really have to defer to Ms. Iritani. She is the expert in this area from GAO.

Mr. {Bilirakis.} Please.

Ms. {Iritani.} We have not reviewed the changes that Ms. Wachino has said that they have made, so we would need to do that in order to see how they are documenting their approvals. That said, you know, we still feel strongly that there should be more transparent criteria for how they assess whether or not new spending will further Medicaid objectives.

Mr. {Bilirakis.} Okay. Please get back to our Committee after a review of these objectives, okay? Please. I am sure most of the Committee is interested in this, not all.

Ms. Wachino, you probably know about Puerto Rico's financial challengers, which are rather severe, I am sure you will agree. A recent morning consult story highlighted the contrast in treatment that Puerto Rico receives under Federal health care programs. For example, Puerto Rico has a rather low spending cap on its program. Are you monitoring the rate at which Puerto Rico is spending its Medicaid funds, and do you worry it will exhaust those funds well before 2019?

Ms. {Wachino.} We are looking very closely at the overall situation in Puerto Rico, including its Medicaid

spending, very aware that there are a bunch--very strong concerns about the finances of Puerto Rico, and considering what approaches we might take. We--last year, in approving some of their benefits, we offered flexibility, and they took us up on it, and--with respect to their administration, and we are continuing to look at the spending in the program, and options for assisting the Commonwealth.

Mr. {Bilirakis.} In your estimation, will they exhaust the funds before 2019?

Ms. {Wachino.} I would have to go back and look at that, Congressman, but I am happy to submit a response for the record.

Mr. {Bilirakis.} Thank you. Ms. Wachino, CMS proposes to develop the Medicaid managed care quality rate system for managed care organizations in all states, which would presumably be similar to the Medicare Advantage five star rating system. However, research shows that CMS's current start system undervalues care provided to beneficiaries with low socioeconomic status. This is an area of growing bipartisan concern. So how does CMS plan to address this issue, especially since all the Medicaid beneficiaries are presumably low income?

Ms. {Wachino.} Congressman, thank you for the question. Our proposal to implement the quality rating system is

designed to make sure that low income people are able to compare quality across plans and select plans in the same way that individuals in the private market and in Medicare Advantage can. We think that is a substantial advance in quality for our program, and an assist to our consumers.

We do plan on--should we finalize the rule, which, as you know, is out for public comment now, we propose to have pretty lengthy implementation schedules, and a very substantial public input process so that we could identify the strengths of other quality rating systems, bring them to bear in ours, and make any needed adjustments that we need to to account, to your point, for the low income nature of our populations, and the fact that our populations differ in some very important respects from those of Medicare and commercial insurers.

Mr. {Bilirakis.} Okay. Thank you very much, and I yield back, Madam Chair.

Mrs. {Ellmers.} Thank you. The gentleman yields back. I now--the Chair now recognizes the gentleman from California, Mr. Cardenas, for 5 minutes.

Mr. {Cardenas.} Thank you very much, Madam Chairwoman. Appreciate the opportunity for us to dialogue with the witnesses. I just wanted to remind all of us that one of the main points of Medicaid was the--to eventually get to the

point where we have protection or security against the economic effects of sickness for all Americans. In addition to that, President Truman, one of his statements included the line that talks about health security for all.

On that note, as a result of the Affordable Care Act, our country currently holds the lowest rate of the uninsured in the history of this nation. In 2014 alone Medicaid helped reduce the number of uninsured Americans from 43 million to 26 million. Is that about right, Ms. Wachino?

Ms. {Wachino.} I do know that we have made really--very substantial advances in reducing the uninsured rate, and it is an accomplishment we are very proud of.

Mr. {Cardenas.} Okay. Well, I would like you to take it back to all of the hard working folks within your department, to let them know how much not only do those 43, down to 26, Americans who now have health care appreciate all of your good hard work, but also at the same time that it is a vision that hopefully we can see in our lifetime, where we could see that 26 million go down to nothing. In addition to that, one of the things that I noticed, as a politician myself, is that many people try to use the word entitlement program as though it is a bad word. But yet, at the same time, I prefer to call it a safety net, which is a good thing, because it brings dignity, and actually saves lives

for many Americans, especially hard working poor Americans.

Speaking of the hard working poor, my first question goes to you, Dr. Schwartz. Thank you very much for your testimony today. One of the issues that is very important to my constituents is the availability to health care to all constituents in my district. But my district being 70 percent Latino, a disproportionate representation of uninsured is within the Latino community in my district, and around the country. And this is despite the fact that among these uninsured Latino households, 82 percent of those households are part of a hard working employed family.

So we are not talking about people who choose not to work, we are talking about people who are the working poor, which it--which, in my opinion, is part of the backbone of what makes this country great, people willing to go to work every single day and be able to work for whatever meager means people are willing to pay them, yet at the same time they do it every single day, and then have to worry about whether or not somebody is going to get sick in their family, and if they are going to have a catastrophic change to their entire finances for maybe one or two generations to come.

On that note, has MACPAC undertaken any work looking specifically at barriers to enrollment that may still exist in the Latino community?

Ms. {Schwartz.} No, we haven't. Our work looking--we have done work looking at the experience of different minority communities in accessing services, and I believe Medicaid mirrors much of the rest of the health system in that different minority populations do experience higher barriers to care. And that is an area, as I said in my written statement, that we are interested in the experiences of groups within the Medicaid population, because they are so diverse, and how their different experience of care relate, and what policy solutions might be appropriate, given the different experiences.

Mr. {Cardenas.} Okay. Please keep in mind at all times that it is not just language barriers, cultural as well are some of the barriers out there.

Ms. Wachino, what types of initiatives are underway to help ensure that we reach Latino and other minority communities where individuals may be eligible for coverage, particularly in the wake of Medicaid expansion?

Ms. {Wachino.} Thank you for the question. I think we are very interested in making sure that Latino residents across the country get coverage. And clearly one of the--one way to do that is by taking up Medicaid expansion, as California has. We also are working actively to ensure that people that--eligible Latinos, working families, I mean, the

Latino community, enroll in coverage.

And frequently that requires outreach and application support, so we work with programs like our navigator programs to make sure that people have support in applying for coverage, provide the information they need to to get an eligibility determination and enroll.

Mr. {Cardenas.} Okay. Thank you. Ms. Wachino, with over 25 million low income Americans nationwide who are unable to see a primary care physician, I believe telemedicine could provide an incredibly effective way to improve the health care system for everyone. Could you expand on the particular benefits for using telemedicine with dual eligibles who are unable to visit their doctor due to illness or immobility? And not just in rural areas, but also in higher populated areas as well.

Ms. {Wachino.} We have moved forward with telemedicine in a number of states. It is an approach that a state can take to promote access to care without even seeking a state plan amendment for us. I can look at the particular use of telemedicine for the dual eligible population and circle back with you, and provide information for the record about specifics to that population.

Mr. {Cardenas.} Thank you very much.

Mrs. {Ellmers.} Thank you. The gentleman yields. I

am--the Chair now recognizes the gentlelady from Tennessee, Mrs. Blackburn, for 5 minutes.

Mrs. {Blackburn.} Thank you, Madam Chairman, and I am going to make Mr. Pallone's day, because I am going to say TennCare, and talk about TennCare with you all. And I know you are very familiar with it, Ms. Wachino. There is a lot of frustration with that program, but embodied in that in part is frustration that some of the states who have been under the waivers for years, and doing the same thing for decades, have to keep coming back to you every 3 to 5 years for permission one--once again. So would it not make sense to start to grant the states a longer reprieve, and give them a longer path to certainty or permanence on these issues?

Ms. {Wachino.} Thank you for the question, Congresswoman Blackburn. As you know, we work very actively with each state to try to develop--

Mrs. {Blackburn.} This is a yes or no.

Ms. {Wachino.} --for the state. We have been looking very actively, and I think Secretary Burwell spoke with the governors about this in February, about streamlining our renewal process. It is very important--

Mrs. {Blackburn.} Okay, it is a yes or a no question.

Ms. {Wachino.} I think that there are ways, and we are working on them now--

Mrs. {Blackburn.} Okay.

Ms. {Wachino.} --to--

Mrs. {Blackburn.} Thank you.

Ms. {Wachino.} --streamline--

Mrs. {Blackburn.} Ms. Yocom--

Ms. {Wachino.} --renewals.

Mrs. {Blackburn.} --you want to weigh in on that? No? Okay. All right. Well, maybe you want to weigh in on this one. CMS has all these rules, and again, this comes from my guys in--at the state level--on transparency and required timeframes for the states when they are applying for their waivers, but then CMS doesn't hold themselves to this own standard, and sometimes it can take forever to get an answer from you. So should you not be held to the same standard that you are foisting on the states, to meet deadlines and timelines and to give some certainty?

Ms. {Wachino.} Congresswoman, we are very committed to working with states quickly to evaluate waiver requests--

Mrs. {Blackburn.} Okay, let us pick up the pace, then.

Ms. {Wachino.} May I--

Mrs. {Blackburn.} --Yocom--no, ma'am. Ms. Yocom, you want to--or Ms. Iritani? Yeah. I am just short on time. You can expand in--

Ms. {Wachino.} I will.

Mrs. {Blackburn.} --form. Thank you. Mr. Iritani?

Ms. {Iritani.} Yeah, we have heard concerns, you know, from states about the lengthy time to get waivers--

Mrs. {Blackburn.} Yeah.

Ms. {Iritani.} --renewed and approved, and we have seen wide variation in approval times. You know, our concern is around the lack of standards and criteria, and we think that that would help bring more transparency--

Mrs. {Blackburn.} So, to be more definitive, lay out a timeline, give the states some certainty, and maybe not make them come back every 3 to 5 years. That makes some sense, doesn't it?

Ms. {Iritani.} We believe that there is more need for oversight--

Mrs. {Blackburn.} Okay.

Ms. {Iritani.} --so there is the--

Mrs. {Blackburn.} Let me go to a question on enrollment. States are required to enroll applicants who attest to being citizens, or to having legal immigration status, and then are thereby eligible for Medicaid. States receiving Federal matching funding for the care during this reasonable opportunity period. But, as a result, and I am hearing this from some of my state legislators, individuals who are not citizens or eligible permanent residents may be

enrolled, and receiving Medicaid. So does CMS think it is appropriate for Federal taxpayer Medicaid dollars to be expended on individuals who are neither citizens nor eligible residents? Ms. Wachino?

Ms. {Wachino.} Congresswoman, we think it is very important for us to make accurate eligibility determinations. When people apply for Medicaid coverage, they attest to their citizenship. We verify that electronically through the hub, which is a major advance for us in making accurate eligibility determinations. If someone is not able--

Mrs. {Blackburn.} Okay.

Ms. {Wachino.} --to--

Mrs. {Blackburn.} Then let me ask you this. Should we not withhold those benefits until such time as their--certainty and a verification process is completed?

Ms. {Wachino.} Congresswoman, the--under the statute, individuals have a reasonable opportunity--

Mrs. {Blackburn.} Okay.

Ms. {Wachino.} --period. They attest to citizenship, and then we, during that period, verify it.

Mrs. {Blackburn.} Okay.

Ms. {Wachino.} If they are found to be ineligible, they are determined ineligible.

Mrs. {Blackburn.} Okay. Let us look at billing

privileges. And Obamacare explicitly requires that states suspend the billing privileges of most providers that have been terminated or revoked by another state, or by Medicare. However, more than 5 years after enactment, banned providers are still receiving many of these Medicaid payments. So what steps is CMS taking to ensure, once again, that taxpayer dollars are not going to those that are prohibited, should be prohibited, from receiving this money? And are you taking steps to recoup Federal dollars paid to prohibited providers by state Medicaid programs?

And, in the same vein, how are you dealing--how does CMS deal with companies that have been found guilty of fraud, and should not be receiving taxpayer dollars, but they go out, and they sell themselves so they can be renamed, and still get taxpayer dollars? I would like to hear from you on this, and, Ms. Yocom, I would also like to--Ms. Yocom, let us start with you, as a matter of fact.

Ms. {Yocom.} Certainly. We have done work in this area, and we did identify, in terms of providers, issues where individuals who did have suspended or revoked licenses were receiving payments. We also have identified some providers who are dead who are receiving payments.

Mrs. {Blackburn.} And erroneous payments amounted to how much last year?

Ms. {Yocom.} I would have to get back--

Mrs. {Blackburn.} Okay.

Ms. {Yocom.} --with you on that. Yeah.

Mrs. {Blackburn.} Okay.

Ms. {Yocom.} Yeah.

Mrs. {Blackburn.} Okay. Ms. Wachino, you want to comment on that?

Ms. {Wachino.} Yes, Congresswoman. It is very important to us that we ensure--that the providers serving Medicaid beneficiaries are appropriate, both so that they get the care they need, and so that we are ensuring--

Mrs. {Blackburn.} That is not the question that I have asked you. I have asked you what you are doing about it. So why don't you submit for the Committee an answer about what you are doing about erroneous payments, and what you are doing about providers that are not eligible getting this money. I yield back my time.

Mr. {Green.} Madam Chair, can I just have 30 seconds? Ms. Wachinko, I understand that under law that--and California is the only state that expanded Medicaid to undocumented children, and--but they don't get the Federal match. Is that true? If it is a state decision?

Ms. {Wachino.} I am not familiar with the particular circumstances in California, but Medicaid generally does not

provide comprehensive coverage for immigrants. There is a limited provision for emergency care only.

Mr. {Green.} Okay. Thank you.

Mrs. {Ellmers.} Could--I would just ask that you provide us with that--the accurate documented material--

Ms. {Wachino.} I will happy to do that--

Mrs. {Ellmers.} --to the Committee, since this issue has been raised. Thank you.

Ms. {Wachino.} I will happy to do that for the record, as well as to respond to--

Mrs. {Ellmers.} Thank you.

Ms. {Wachino.} --Ms. Blackburn's question--

Mrs. {Ellmers.} Thank you.

Ms. {Wachino.} --about provider enrollment.

Mrs. {Ellmers.} Thank you. I now--the Chair now recognizes Mr. Pallone from New Jersey for 5 minutes, the Ranking Member of our Committee.

Mr. {Pallone.} Thank you, Madam Chairwoman. I was going to ask unanimous consent to include in the record two new health affair studies that just came out that found evidence that Medicaid expansion has made patients and hospitals' bottom lines healthier. I think you have copies of them.

Mr. {Pallone.} We have not had a chance to review that,

so I reserve--

Mr. {Pallone.} Let me hand them--

Mrs. {Ellmers.} --the--

Mr. {Pallone.} Let me hand them over to you, then, take a look.

Mrs. {Ellmers.} We will consider at a later date, and we will--before the hearing adjourns.

Mr. {Pallone.} Okay, thanks. I was going to say to Ms. Blackburn that I hadn't--she left, but that I hadn't heard about tin can--TennCare so often that I actually forgot about it, but she brought it up again, so--but she is not here, so, sorry.

All of our witnesses here today have an important and different perspective to share about Medicaid and its 50th anniversary. I wanted to ask first, Ms. Wachino, as we reflect on Medicaid's 50th year, what do you see as the most significant changes to the program from the standpoint of low income consumers?

Ms. {Wachino.} Well, Medicaid has grown and evolved over time. I think some of the biggest change--and you have--we have seen over time its role expand for a variety of populations. Coverage of pregnant women to ensure access to strong prenatal care, and promote lower rates of infant mortality, expansions to coverage of people with chronic

conditions, like HIV.

I think if I had to choose two developments just to single out, the first would be the coverage of low income children, that I know was led out of this Committee, through both Medicaid expansions, and later CHIP, which really built on that. And if you look at the record on the impact of that coverage, it is clearly been a critical support for low income families through thick economic times and thin.

The second would be the coverage expansion for Medicaid to low income adults under the Affordable Care Act, which I think really solidifies Medicaid's role as the base for a strong system of health coverage in the United States. And I think, as we work with more states to implement it, we will see that base firmly solidified.

Mr. {Pallone.} Thank you. And then, Dr. Schwartz, MACPAC was formed fairly recently, but the Commissioners and MACPAC staff have already proven to be an invaluable resource to both sides of the aisle. What, in your opinion, have been some of Medicaid's greatest advancements?

Ms. {Schwartz.} I think, to follow up on Ms. Wachino's comments, the program has really transformed over its lifetime from a program that provided medical care to a very small group of low income families who were receiving cash assistance to a much larger program that takes a much more

proactive and--role in the delivery system design, in payment initiatives to improve the delivery of care to a broader set of populations. Children, pregnant women, adults, and, of course, people with disabilities.

I think the other is the very significant shift in the delivery of long term care from institutions into homes and communities, allowing--and people with disabilities to remain in their homes and active in their communities.

Mr. {Pallone.} Thank you. Could I just ask, Ms. Wachino, if you would take--I have just got about a minute and 20 seconds of my time. Could you just talk about CMS's work over the last 5 years on program integrity as a result of the Affordable Care Act tools?

Ms. {Wachino.} Yes. We take our program responsibilities very seriously. I participate in them. They are led out of our Center for Program Integrity, but we work in concert. We have worked actively over the 5 years on a comprehensive Medicaid integrity plan. We have worked to do program integrity reviews of each state, because program integrity in Medicaid is a shared state and Federal effort. We both have responsibilities.

But one of the most tangible things we have done is improve the process of ensuring that high risk providers do not enter into our programs. We have employed and worked

with states on high risk provider screening, and we have given states access to the same data to screen out providers that Medicare uses. So I think we have made very substantial advances. I think some of the data you heard about earlier is from 2011, and predates some of our recent accomplishments.

Mr. {Pallone.} All right. Thank you very much. Thank you, Madam Chairwoman.

Mrs. {Ellmers.} Thank you to the Ranking Member, and, without objection, the documents that you provided will be submitted into the record.

[The information follows:]

********** COMMITTEE INSERT **********

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Mrs. {Ellmers.} The Chair now recognizes myself for 5 minutes. Thank you to our panel for being here. Ms. Wachino, in the most recent actuarial report on the financial outlook for Medicaid, CMS reports that the projected annual growth rate for Medicaid expenditures is faster than the projection of annual GDP growth. The actuary noted that, ``should these trends continue as projected under current law, Medicaid's share of both Federal and state budgets would continue to expand, despite any other changes to the program. Budget expenditures, or budget''--what happened to my microphone? Let me just--no. Thank you. Sorry. Sorry, it just went--it wanted to cut me off. Is this one? Is this--no, okay. Now? Can you--me.

I am going to go on, and maybe it will just pick up. Let us see, where did I leave off? Okay. ``Medicaid's share of both Federal and state budgets would continue to expand, despite any other changes to the program, budget expenditures, or budget revenues.'' As a representative from a state that has not expanded Medicaid in North Carolina, I have two questions. Given that this would crowd out other important fiscal priorities for both state and Federal Government, don't you think that the--that there are changes that need to be made to the program to alter this current

trend?

Ms. {Wachino.} Congresswoman Ellmers, thank you for the question. Can you hear me?

Mrs. {Ellmers.} No. Well, I can hear you, but the microphone is definitely not working.

Ms. {Wachino.} It is on, yes, so I think I have the same problem you--

Mrs. {Ellmers.} Okay.

Ms. {Wachino.} I will try to project, but tell me if you can't--

Mrs. {Ellmers.} No, you--I can hear you fine. I hope--okay, perfect. We--

Ms. {Wachino.} Yeah.

Mrs. {Ellmers.} The--she is the important one.

Ms. {Wachino.} We have worked very actively to ensure that the program is on a sound fiscal footing--

Mrs. {Ellmers.} Um-hum.

Ms. {Wachino.} --generally, and, you know, with respect to expansion in particular. I think we have put in common sense reforms to ensure accountability of funds through--

Mrs. {Ellmers.} Um-hum.

Ms. {Wachino.} --activities like reviewing our rates, and ensuring that we are not overpaying for services. I think, in addition to that, you see from the Administration

proposals like changes to the drug rebate that are designed to ensure that some of the major cost drivers in our program are addressed. So I think we can real--we can work, and we do work, and we look forward to working with you for really--

Mrs. {Ellmers.} Um-hum.

Ms. {Wachino.} --putting the program on a sound fiscal footing.

Mrs. {Ellmers.} Well, thank you for that. I would like to ask, do you know--have these changes, or proposed changes, resulted in any decreases in spending up to this point?

Ms. {Wachino.} We do know in some states that have embarked on delivery system reform that there have been reductions in things like hospitalizations--

Mrs. {Ellmers.} Um-hum.

Ms. {Wachino.} --that have resulted in cost savings. There are a couple of--

Mrs. {Ellmers.} How many states would you say that is?

Ms. {Wachino.} I think I can give you some state examples. The actual models used by states vary. States have significant flexibility in using things like health homes, the way--

Mrs. {Ellmers.} Um-hum.

Ms. {Wachino.} --Missouri did--

Mrs. {Ellmers.} Um-hum.

Ms. {Wachino.} --where they saw improvements in clinical outcomes and reductions in costs.

Mrs. {Ellmers.} Okay.

Ms. {Wachino.} So I can give you the examples of models that have worked.

Mrs. {Ellmers.} Okay. Ms. Yocom, would you like to expand on that as well, or comment on the same from your perspective?

Ms. {Yocom.} Well, our work has focused primarily on areas where transparency and better data are important.

Mrs. {Ellmers.} Um-hum.

Ms. {Yocom.} I think some of CMS's challenges are around not having accurate information with which to gauge the success of the program, and to gauge--to fine tune where improvements need to be made.

Mrs. {Ellmers.} Um-hum. So you see an effort for more transparency and more efficiency and accuracy to be moving forward?

Ms. {Yocom.} I think we have seen progress, particularly in efforts to control--

Mrs. {Ellmers.} Um-hum.

Ms. {Yocom.} --improper payments. There--

Mrs. {Ellmers.} So you have seen progress in that area?

Ms. {Yocom.} Right.

Mrs. {Ellmers.} Okay. Great. Ms. Wachinko, CMS authorized Federal Medicaid funding in five states for more than 150 state programs. Based on their names, many of these programs appear to be fully worthwhile causes. However, it is difficult to see how other funded programs promote Medicaid objectives. Let me ask just a few questions. There are a couple states--and we--I asked Ms. Iritani, when she was with us a couple of days ago. One of these issues--the licensing fees for Oregon, how does that affect patient care in regard to Medicaid? Do you see that as a worthwhile funding issue?

Ms. {Wachino.} Congresswoman, it isn't really important to us that we ensure that--what we--the spending we authorize promotes Medicaid objectives. As I had the opportunity to speak to earlier this morning, we have fully responded to many of GAO's recommendations, in terms of wanting to be very clear and straightforward in our approval documents when we determine that a program supports Medicaid objectives. I can't speak to the particulars of every program, but I do know that my staff has provided to the Committee extensive detail on the programs we--

Mrs. {Ellmers.} Okay. Well, then the--I will--what I will just say, the licensing fees in Oregon, the fishermen's partnership in Massachusetts, and the health workforce

retaining in New York, if I can get a response on how those actually are effective measures, that would be great, and I would appreciate it in writing. Thank you.

Ms. {Wachino.} I would be happy to do--

Mrs. {Ellmers.} And I will yield back, and I now recognize Ms. Schakowsky from Illinois for 5 minutes.

Ms. {Schakowsky.} I appreciate--providing long term care--

Ms. {Wachino.} Yeah, thank you for the question. As you spoke to, Medicaid is the nation's leading source of financing for long term care in the country. We pay for 64 percent of all nursing home residents in the United States, and we work very actively with states to ensure the quality of nursing home care. Because these are, as you know, very frail--we are back. Thank you.

Mrs. {Ellmers.} And we are back.

Ms. {Wachino.} Some of the nation's frailest residents and citizens, people who could have limited mobility, and a lot of complex health needs. We are working not just to ensure quality nursing home care, but also ensuring that people, whenever they are able to, are able to be cared for in--at homes and in their communities, to be--really remain active participants in their communities.

Ms. {Schakowsky.} I wanted to ask about that. One of

the most important elements of long term care has been community based care, and that does allow many elderly and disabled to remain in their home, or in assisted living facilities, rather than in institutions. In recent years CMS has worked to reduce its reliance on institutional care and transition individuals to community living. In fact, as you have mentioned earlier today, 51 percent of long term care spending under Medicaid is spent on community based services, compared to 10 years ago, when community based services only made up 33 percent of spending.

So why is it important, as you just said earlier, it-- that community based care be available to Medicaid beneficiaries?

Ms. {Wachino.} We hear consistently from beneficiaries that they want to remain in their communities, they want to remain active, and they want to remain with their families as much as possible. And we are lucky to have a number of tools in the Medicaid program to help support that. Things like home and community based waivers, and giving beneficiaries the ability to self-direct their care, to hire their direct service works, and to fire their direct care service workers if they are not happy. And if you look across the states, we see nearly every state is moving forward with some option.

But the proof is in the pudding, as you say, and seeing

the equalization of spending on institutional care versus home, community based care is a very major advance in modernization in our program, and we are going to keep at it, and move the needle further.

Ms. {Schakowsky.} All right. And, finally, as you mentioned in your testimony, since the beginning of ACA's first enrollment period, 12.3 million people have gained coverage through Medicaid or CHIP. According to The Urban Institute, the current uninsured rate nationwide for non-elderly adults is 10 percent down--10 percent, which is down from 17.8 percent, before the implementation of the ACA. Even more impressive, states have expanded Medicaid--that have expanded Medicaid have an uninsured rate of 7.5 percent compared to 14.4 percent in states that have not expanded Medicaid. Can you explain how Medicaid expansion helped to drastically reduce the uninsured rate?

Ms. {Wachino.} Well, I think we know that many low income Americans fall into the coverage gap that is created when states have an expanded Medicaid, and one of the things that we can do as a country to advance--to make further advances in covering the uninsured, and see even progress beyond what you have just described is to work with states on Medicaid expansion. And we are very committed to working with every state to finding an approach that provides its

lowest income citizens access to needed health care so we could start improving their quality, and so that those people can benefit.

Ms. {Schakowsky.} It seems to me the Medicaid expansion, because it was so public, also helped other enrollment, that people became more aware of Medicaid, so I think it even went beyond the new population.

Ms. {Wachino.} That is right. The benefits of expansion go beyond the newly eligible population because states that cover Medicaid expansion are able to convey a clear message to their lowest income residents that you are eligible for coverage. And we know that when there is that message, eligible people come and enroll, and get the health care they need.

Ms. {Schakowsky.} Thank you so much. I yield back.

Mrs. {Ellmers.} The gentlelady yields back. And, with that, I think we are finishing up. I would like to thank our panel for being with us today. I would like to remind members that they have 10 business days to submit questions for the record. And I will say to the panel, I know there are some very, very specific questions that members are going to be proposing in written form, and we would very much like to have very specific answers to these questions. You know, as we are addressing Medicaid and Medicare issues, we have to

remember that these--this is taxpayer dollars that we are spending, and so we need very specific answers on those questions, and in a prompt fashion, if you can accommodate us on that.

I would like to also say members should submit their questions by the close of business Wednesday, July 22. And, again, thank you very much for being with us today, and to everyone who was here for the hearing. And I call this Subcommittee hearing adjourned.

[Whereupon, at 12:33 p.m., the Subcommittee was adjourned.]