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EXAMINING LEGISLATION TO IMPROVE MEDICARE

AND MEDICAID

TUESDAY, NOVEMBER 3, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Joe Pitts [chairman of the subcommittee] presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Collins, Green, Castor, Sarbanes, Schrader, Kennedy, and Pallone (ex officio).

Also present: Representative Loebsack.

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Staff present: Clay Alspach; Chief Counsel, Health; Rebecca Card, Staff Assistant; Karen Christian, General Counsel; Graham Pittman, Legislative Clerk; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Christine Brennan, Press Secretary; Jeff Carroll, Staff Director; Tiffany Guarascio, Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Health Policy Advisor; Samantha Satchell, Policy Analyst; and Arielle Woronoff, Health Counsel.

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1 Mr. Pitts. Okay. I will ask our guests to please take their
2 seats and the subcommittee will come to order. The chair will
3 recognize himself for an opening statement.
4 Today's hearing will examine five bipartisan legislative
5 bills designed to make common sense improvements to the Medicare
6 and Medicaid programs.
7 First, the committee is happy to have with us one of our own
8 colleagues, Rep. Lynn Jenkins from Kansas. Rep. Jenkins will be
9 testifying on our first panel about a bill she is sponsoring, H.R.
10 2878.
11 This bill would simply prohibit Medicare contractors from
12 enforcing supervision requirements for outpatient therapeutic
13 services and critical access in small rural hospitals for another
14 year.
15 The Senate companion to this bill was approved by the Senate
16 Finance Committee in June so we are pleased to be able to review
17 this bill today.
18 On our second panel, we will hear from representatives of
19 the Government Accountability Office, GAO, and the Medicaid and
20 CHIP Payment and Access Commission, MACPAC.
21 GAO and MACPAC will help us in our review of four bipartisan
22 bills to improve Medicaid. The first Medicaid bill is an updated
23 version of H.R. 1362, the Medicaid Reports Act, by Vice Chairman

1 Guthrie.

2 This bill seeks to address GAO and MACPAC findings that the
3 Centers for Medicare and Medicaid Services, CMS, does not collect
4 accurate and complete data from all states on the various sources
5 of funds to finance the nonfederal share.

6 This bill requires states to submit a report at least once
7 a year on sources of funds used to finance the nonfederal share
8 of expenditures in the Medicaid program.

9 This issue is important policy because state financing
10 approaches affect Medicaid payment methodologies and payment
11 amounts, which may affect enrollees' access to services.

12 The next Medicaid bill is H.R. 2151, sponsored by our
13 colleague, Rep. Chris Collins, the Improving Oversight and
14 Accountability in Medicaid Non-DSH Supplemental Payments Act,
15 would improve the calculation, oversight and accountability of
16 non-DSH supplemental payments under the Medicaid program.

17 This is important because GAO founds gaps in federal
18 oversight of high-risk supplemental payments including a lack of
19 information on the providers receiving them, inaccurate payment
20 calculation method and a lack of assurances the payments were used
21 for Medicaid purposes.

22 In 2014, MACPAC recommended that the HHS collect and make
23 publically available provider label non-DSH supplemental payment

1 data in a standard format that enables analysis.
2 Thirdly, the updated version of H.R. 1361, Medicaid Home
3 Improvement Act, sponsored by Rep. Guthrie, would establish a
4 federal cap on the home equity allowance consistent with the
5 current federal default of $552,000.
6 This bill would preserve existing beneficiary protections
7 but help protect taxpayers by updating the limit of allowable
8 equity interest a beneficiary can have in their home.
9 This is a common sense step to prevent cost shifting from
10 the private to the public sector. And finally, the Quality Care
11 for Moms and Babies Act, sponsored by Reps. Engel and Stivers,
12 seeks to improve the quality, health outcomes and value of
13 maternity care under the Medicaid and CHIP programs by developing
14 maternity care quality measures.
15 This bill would authorize the appropriations of $16 million
16 for HHS to identify and publish quality measures for maternal and
17 infant health.
18 Together, these five bills continue the commitment that this
19 Congress has to strengthen the Medicare and Medicaid programs to
20 help sustain these important safety net programs for those most
21 relying on them.
22 I want to thank all of our witnesses for agreeing to testify
23 today and I yield back and now recognize the ranking member of

1 the subcommittee, Mr. Green, 5 minutes for his opening statement.
2 Mr. Green. Thank you, Mr. Chairman, and welcome our
3 colleague from Kansas. Thank you for being here today.
4 We are here to examine five legislative proposals. One
5 impacts the Medicare Part B program and the other affect the
6 Medicaid program. As we know, the Medicaid program has served
7 as a critical safety net for the American public since its creation
8 on 1965, 50 years ago this year.
9 Today, over 70 million low-income Americans rely on Medicaid
10 for comprehensive affordable health care. Medicaid covers more
11 than one in three children, pays for nearly half of all births
12 and accounts for more than 40 percent of the nation's total cost
13 for long-term care.
14 One in seven Medicare beneficiaries is also a Medicaid
15 beneficiary -- dual eligible. The Quality Care for Moms and
16 Babies Act, the discussion and draft put forth by Reps. Engel and
17 Stivers, will improve health outcomes for women and children who
18 depend on Medicaid.
19 This legislation will authorize funding for HHS to develop
20 quality measures for maternal and infant health and award grants
21 related to care quality and I support this important legislation.
22 I am concerned about the other legislation we are considering
23 such as the Medicaid REPORTS Act and proposals requiring

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1 additional auditing on states that are overly burdensome,
2 prescriptive, and likely intended to chip away at the Medicaid
3 program.
4 Additional transparency on Medicaid payments is a goal we
5 all share. My priority is always including ensuring Medicaid
6 beneficiaries have access to the care that they need by supporting
7 providers that serve beneficiaries who otherwise have nowhere
8 else to go for the necessary care.
9 However, these bills as structured will not achieve our goal
10 of fully understanding Medicaid payments and whether these
11 payments are adequate to guarantee equal access for beneficiaries
12 within the Medicaid program.
13 My state of Texas use supplemental and Medicaid DSH payments
14 in a unique way. These sources of funding are an incredible and
15 important revenue stream for hospitals and providers that serve
16 a large portion of Medicaid beneficiaries and the uninsured.
17 For example, in Texas supplemental payments are used for
18 DSRIP and I want to make sure we maintain the flexibility so CMS
19 and states can deliver each Medicaid program the best way for its
20 unique patient base.
21 Providers in a Medicaid program must be paid a fair rate.
22 Given the complexities and the 56 distinct Medicaid programs,
23 there is a nuanced way to address these issues.

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1 The question you need to ask is its full payment that a
2 provider receives for treating a Medicaid enrollee fair and
3 sufficient to ensure equal access.
4 Unfortunately, legislation like Medicaid Reports Act, H.R.
5 2125, won't get us the information we need to see the full picture
6 and it may actually put more burdens on the states. They are not
7 in line with the actions CMS has taken to improve in the area and
8 I look forward to learning more about this complex issue.
9 Reforms done for the right reasons and nuance in an
10 intelligence way can truly improve how CMS ensures that payments
11 to Medicaid providers are sufficient and enforce equal access to
12 Medicaid beneficiaries.
13 Such proposals should be a priority for our committee and
14 I look forward to a comprehensive discussion on ways we can improve
15 transparency, strengthen coverage and expand access to providers
16 and increase the quality of health care.
17 And Mr. Chairman, I will yield the remainder of my time to
18 my colleague from Iowa, Dave Loebsack.
19 Mr. Loebsack. I thank Mr. Green for yielding.
20 I also want to thank my colleague, Congresswoman Jenkins,
21 for testifying here today on our bill. I am happy to be the lead
22 Democratic cosponsor of H.R. 2878.
23 It has been a pleasure to work with her on this issue. As

1 a native Kansan, she truly understands the needs of rural
2 Americans and I thank her for her bipartisan work on the bill.
3 Basically, what 2878 would do is suspend the physician direct
4 supervision requirement for outpatient therapeutic services
5 furnished at critical access hospitals and small rural hospitals
6 until January of 2016.
7 I often visit critical access hospitals in my district.
8 There are many, given that I represent rural Iowa, and the
9 number-one concern I have heard about recently was this direct
10 supervision issue.
11 In 2009, CMS issued a rule that mandated direct supervision
12 for all outpatient therapeutic services at these hospitals.
13 In response to concerns over the implementation of this
14 policy they delay the enforcement through 2013, which was extended
15 by Congress to 2014.
16 Direct supervision requires that a physician is immediately
17 available when the service is provided. This is difficult in many
18 of these rural settings.
19 Many outpatient services such as continued chemotherapy,
20 administration of IV fluids or drawing of blood can be safely
21 administered under general supervision, a fact that CMS itself
22 recognized in its delay of the policy.
23 Further, small rural hospitals often face staffing and

1 workforce shortages that make direct supervision of these
2 services incredibly difficult.
3 There are a lot of challenges facing our rural hospitals,
4 as you know all too well, Congresswoman Jenkins. This
5 legislation, I think, would go some distance to remedying at least
6 one of those issues facing them and I thank you for introducing
7 this legislation. I am happy to be a part of it, and I yield back.
8 Thank you.
9 Mr. Pitts. Chair thanks the gentleman and now recognizes
10 the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for
11 an opening statement.
12 Mr. Guthrie. Thank you.
13 Thank you, Mr. Chairman, and I appreciate my classmate from
14 the 2008 class coming in, being here with us this morning, Ms.
15 Jenkins.
16 But thank you, and I appreciate you holding this hearing on
17 the number of important bills. Today, the committee is examining
18 two bills that I introduced -- H.R. 1361, the Medicaid Home
19 Improvement Act, and H.R. 1362, the Medicaid Reports Act.
20 These are both good government bills that help strengthen
21 the Medicaid program and protect valuable taxpayer dollars. H.R.
22 1361, the Medicaid Home Improvement Act, caps the maximum
23 allowable equity for beneficiaries to qualify for long-term care

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1 under Medicaid.

2 Currently, in some states those with home equities -- not
3 home values but home equities -- above $828,000 can qualify for
4 Medicaid assistance. My bill reindexes the maximum threshold of
5 $500,000, adjusted for inflation.

6 With an average home sale in the United States at $221,000,
7 the current limits allow those not truly in need to access Medicaid
8 dollars, draining federal and state dollars.

9 H.R. 1362, the Medicaid REPORTS Act, requires states to
10 submit an annual report that identifies the sources and amounts
11 of funds used by the state to finance the nonfederal share of
12 Medicaid.

13 With the growing burden the Medicaid program is placing on
14 the federal budget and those of each of our states, it is important
15 that we know how states are coming up with the dollars necessary
16 to meet their Medicaid match.

17 Again, Mr. Chairman, I appreciate you holding this hearing
18 to examine these and other important issues and I look forward
19 to talking more with our witnesses and yield back the balance of
20 my time.

21 Anybody seeking time? I yield back.

22 Mr. Pitts. Chair thanks the gentleman.

23 As usual, all written opening statements of the committee

1 will be made part of the record and we will proceed to our first
2 panel.
3 On our first panel today we have the Honorable Lynn Jenkins,
4 Second District of Kansas, and we thank you for coming to talk
5 about your legislation.
6 You may proceed.

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1 STATEMENT OF THE HON. LYNN JENKINS, A REPRESENTATIVE IN CONGRESS
2 FROM THE STATE OF KANSAS
3
4 Ms. Jenkins. Chairman Pitts, Ranking Member Green,
5 honourable members of the committee, thank you for holding this
6 hearing and inviting me to speak on H.R. 2878, a critical piece
7 of legislation.
8 The bill would delay Medicare's physician direct supervision
9 requirement for outpatient therapeutic services in critical
10 access and small rural hospitals until 2016.
11 In January of 2014, the Centers for Medicaid and Medicare
12 Services began enforcing a requirement that physicians must
13 supervise outpatient therapy at critical access hospitals and
14 other small rural hospitals.
15 CMS' decision meant that routine outpatient procedures such
16 as drawing blood or undergoing active therapy would have to be
17 directly supervised by a physician.
18 This decision by CMS would have put a severe strain on
19 providers, particularly those in rural areas, while providing no
20 quality improvements for the patients they serve.
21 Most of these outpatient procedures are relatively simple,
22 are very safe and would not benefit from a federal mandate that
23 that physician always be in the room, and as a practical matter

1 in rural hospitals across Kansas such a requirement is simply not
2 feasible.
3 I was proud to introduce legislation last Congress that
4 delayed this Medicare direct supervision requirement through 2014
5 and it was signed into law with bipartisan support.
6 It has been widely recognized as an effective tool to improve
7 care in rural hospitals and keep the regulatory burden in check.
8 Unfortunately, rural hospitals are once again staring down
9 the threat of this federal mandate from CMS. The existing law
10 delayed enforcement action from CMS has expired.
11 Accordingly, I have now reintroduced similar legislation
12 this Congress, further delaying enforcement until 2016. It is
13 about this legislation, H.R. 2878, which this committee has
14 graciously invited me to speak today.
15 When I think about the health care needs facing my district,
16 there is nothing more challenging than ensuring access to quality
17 and accessible rural health care.
18 Rural America is struggling and the 84 critical access
19 hospital in Kansas are the lifeblood of our rural communities.
20 The presence of facilities such as a critical access hospital
21 in a community could be the deciding factor in whether or not the
22 next generations of children decide to raise their family in their
23 home town or perhaps whether or not a business decides to locate

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1 there.

2 Easy access to emergency care can be a life and death

3 situation and we cannot threaten the existence of these facilities

4 by piling on the regulatory burden from Washington.

5 Earlier this year I invited the CEO of Holton Community

6 Hospital to testify about this issue before the Ways and Means

7 Committee Subcommittee on Health.

8 Holton Community Hospital happens to be responsible for

9 serving my hometown, Holton, a community of just over 3,000

10 Kansans.

11 She explained in great detail that direct supervision would

12 be extremely burdensome, costly and is simply unrealistic at a

13 hospital serving rural America. The result of enforcing this

14 mandate would be to severely limit the type of services rural

15 health care hospitals could offer and it would threaten their

16 financial stability at a complicated and uncertain time in our

17 nation's health care system.

18 H.R. 2878 will correct this problem. It will do so by

19 reinstating the moratorium on enforcement of this unnecessary

20 regulation. It has broad bipartisan support in Congress and the

21 support of key stakeholders including the American Hospital

22 Association, the National Rural Health Association and the Kansas

23 Hospital Association.

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1 As a small town girl, I feel strongly that folks in rural
2 communities deserve access to quality health care. I can't
3 emphasize enough that rural hospitals -- rural communities in
4 Kansas and across the country depend on access hospitals like
5 critical access hospitals which are directly threatened by CMS's
6 action.
7 I hope the members from both parties can come together once
8 again to ensure high quality and timely care is available to you
9 no matter where you live in America. Companion legislation was
10 introduced by Senators Thune, Moran and Jon Tester.
11 It has passed the Senate back in September. I also want to
12 thank my lead cosponsor on the legislation, Congressman Dave
13 Loebsack and for all his hard work and advocacy on the issue as
14 well.
15 I urge my colleagues to support the legislation and move it
16 forward in a timely fashion.
17 Thank you all for allowing me to join you today.
18 [The statement of Ms. Jenkins follows:]
19
20 ********** INSERT 1 **********

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1 Mr. Pitts. Chair thanks the gentlelady. Really appreciate
2 you taking time out of your busy schedule to come and present
3 testimony to us today.
4 As usual, we will not have any questions for our members
5 presenting testimony. So we will excuse the gentlelady with our
6 thanks and call our second panel to the witness table. And while
7 they are setting up the table I would like to submit the following
8 document for EC request for the record. It is a statement from
9 the American College of Obstetricians and Gynecologists.
10 Without objection, so ordered. I will introduce our second
11 panel in the order they will testify. First, Ms. Katherine
12 Iritani, director of the Health Care Government Accountability
13 Office, and then Ms. Anne Schwartz, Ph.D., executive director,
14 Medicaid and CHIP Payment and Access Commission.
15 Thank you very much for coming today. Your written
16 testimony will be made a part of the record. You will each be
17 given five minutes to summarize your testimony.
18 So with that, Ms. Iritani, you are recognized for 5 minutes.

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1 STATEMENTS OF KATHERINE IRITANI, DIRECTOR, HEALTH CARE TEAM, GAO;
2 ANNE SCHWARTZ, PH.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP
3 PAYMENT AND ACCESS COMMISSION
4
5 STATEMENT OF KATHERINE IRITANI
6 Ms. Iritani. Chairman Pitts, Ranking Member Green and
7 members of the subcommittee, thank you for this opportunity to
8 be here today as you consider ways to strengthen the jointly
9 financed federal and state Medicaid program, now the largest
10 health care program in the nation by enrollment.
11 My testimony today will cover a body of GAO work from recent
12 years on two complex topics -- federal oversight of certain large
13 payments states often make known as supplemental payments and how
14 states finance the nonfederal share of their programs.
15 Supplemental payments are above and beyond regular payment
16 rates for services and states have considerable flexibility for
17 making them. States can distribute them to only a small number
18 of providers, often hospitals.
19 Congress and CMS have taken important steps to enhance
20 Medicaid program integrity through better oversight of these
21 payments. We believe there are opportunities for even more
22 improvements.
23 Our recent work on certain Medicaid supplemental payments

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1 that states often make has shown that better federal information
2 is needed to understand and oversee them.
3 The payments have been growing in size and now total over
4 $20 billion a year and can amount to tens or hundreds of millions
5 a year to a single provider.
6 CMS and others need better information to understand whose
7 states are paying, how much they are paying and how such payments
8 relate to services provided to Medicaid beneficiaries.
9 Many states have made supplemental payments that greatly
10 exceed the provider's cost of providing Medicaid care. In 2012,
11 we found that 39 states had made supplemental payments to over
12 500 hospitals that resulted in total Medicaid payments exceeding
13 the hospitals' cost of providing Medicaid care by $2.7 billion.
14 Payments are not limited to costs under Medicaid but payments
15 that greatly exceed costs may not be economical and efficient as
16 required by law.
17 Now, let me turn to our work on state financing, which has
18 concluded that better information on state sources of funds to
19 finance Medicaid is also needed. States are allowed within
20 certain limits to seek funds from providers and local governments
21 to fund Medicaid payments.
22 States can, for example, tax providers or seek
23 intergovernmental fund transfers from local governments to help

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1 finance the nonfederal share.
2 We have found that states are increasingly depending on local
3 governments and providers for financing, which can ultimately
4 shift Medicaid costs not only to providers and local governments
5 but to the federal government.
6 On the basis of our national survey of state Medicaid
7 programs, in 2012 about $46 billion or 26 percent of the nonfederal
8 share of Medicaid was financed with funds from providers and local
9 governments, a 21 percent increase from 2008.
10 Taxes on health care providers almost doubled in size during
11 that time from $9.7 to $18.7 billion. Such taxes are subject to
12 certain restrictions, for example, to ensure that taxes are broad
13 based and uniform.
14 Cost shifts to the federal government can occur through
15 financing arrangements that concentrate financing of the payments
16 on those providers who receive the payments.
17 For example, a state can increase payments for Medicaid
18 providers such as hospitals, impose a tax on those providers for
19 the nonfederal share and draw down federal matching funds for the
20 payments.
21 CMS and other stakeholders are not well positioned to assess
22 payments states make to individual institutional providers.
23 Federal data on certain supplemental payments states often make

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1 is not complete, reliable, uniform or accessible.
2 CMS has important initiatives underway but CMS has reported
3 that legislation is needed to compel states to report such
4 payments uniformly and to subject them to audit.
5 CMS also lacks good data on state financing sources. Such
6 data are needed to ensure financing is appropriate and to
7 understand how payments affect beneficiary access to care.
8 In conclusion, a needed step towards strengthening the
9 Medicaid program is to make payments and financing more
10 transparent.
11 For this large and growing program, CMS and others need to
12 know whose states paying and in what amounts and right now CMS
13 lacks sufficient data to know this.
14 We have suggested that Congress consider requiring CMS to
15 require states to report not at these payments. We have also
16 recommended that CMS develop a strategy for improving information
17 on state sources of funds for Medicaid.
18 In view of growing costs in enrollments, such transparency
19 can help ensure the program is efficiency and effectively meeting
20 the promise of providing medical assistance to our nation's
21 low-income populations.
22 Mr. Chairman, this concludes my testimony. I am happy to
23 answer any questions.

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1 [The statement of Ms. Iritani follows:]

2

3 ********** INSERT 2 **********

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1 Mr. Pitts. Chair thanks the gentlelady and now recognizes

2 Ms. Schwartz 5 minutes for her opening statement.

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1 STATEMENT OF ANNE SCHWARTZ

2

3 Ms. Schwartz. Good morning, Chairman Pitts, Ranking Member

4 Green and members of the Subcommittee on Health.

5 I am Anne Schwartz, executive director of MACPAC, the

6 Medicaid and CHIP Payment and Access Commission.

7 As you know, MACPAC is a congressional advisory body charged

8 with analyzing and reviewing Medicaid and CHIP policies and making

9 recommendations to Congress, the secretary of HHS and the states

10 on issues affecting these programs.

11 Its members, led by Chair Diane Rowland and Vice Chair Marsha

12 Gold, are appointed by GAO and the insights I will share this

13 morning reflect the consensus views of the commission itself

14 anchored in a body of analytic work conducted over the past five

15 years and we appreciate the opportunity to share our views this

16 morning.

17 My comments today will focus on reporting of provider level

18 data on non-DSH supplemental payments and contributions to the

19 nonfederal share, the subject of two bills being considered by

20 the subcommittee -- H.R. 2151 and H.R. 1362.

21 The commission shares the objective of transparency

22 reflected in these two bills. There are several compelling

23 reasons that providers' specific data should be reported. First,

1 these data are necessary for assessing whether state payments and
2 rates are consistent with federal statute.
3 While states have considerable flexibility in setting rates
4 and payment methods, Section 1902(a)(30)(a) of the Social
5 Security Act requires that Medicaid payments be consistent with
6 efficiency, economy, quality and access and that they safeguard
7 against unnecessary utilization.
8 But information on the base Medicaid payments that providers
9 receive that is the per case or per diem payment associated with
10 the delivery of specific services to specific Medicaid
11 beneficiaries provides only a partial picture of how much Medicaid
12 is paying a given provider.
13 To assess payment fully, policy makers need to know the
14 amount of Medicaid payment that providers receive including both
15 claims-based and supplemental payments less the amount that
16 providers contribute towards the nonfederal share of Medicaid
17 expenditures.
18 The level of payment can be considered the most basic measure
19 of economy and is essential to an assessment of patient
20 efficiency. A measure of value that compares what is being spent
21 -- economy -- to what is obtained -- quality, access, use of
22 specific services.
23 Typically, an analysis if whether a health care payment is

1 economical includes comparison to the cost to provide a given
2 service and in comparison to what other payers pay for a comparable
3 service in a given geographic area.
4 Other health care payers including Medicare commonly conduct
5 such assessments. In Medicaid, however, federal policy makers
6 and program administrators do not have complete data to make such
7 assessments and therefore to ensure that payments are consistent
8 with the delivery of quality necessary care to beneficiaries.
9 The second reason for collecting provider level data is that
10 Medicaid spending for supplemental payments is substantial and
11 growing.
12 In fiscal year 2014, states reported making $24.2 billion
13 in non-DSH supplemental payments to hospitals, more than 20
14 percent of total Medicaid fee for service payments to hospitals
15 nationally and more than 50 percent in some states.
16 The amount of funds raised through providers and local
17 government contributions is also significant and increasing.
18 As such, the federal government has a reasonable expectation
19 of having complete payment and financing data that permit it to
20 understand and oversee states' use of Medicaid funds.
21 In light of these concerns, in March 2014 MACPAC recommended
22 that the secretary of HHS collect and report data on non-DSH
23 supplemental payments at the provider level and just last week

1 in deliberations on a report on disproportionate share hospital
2 payments that is due to Congress on February 1st, the commission
3 voted unanimously on a recommendation focused on reporting of data
4 for both payments and the nonfederal share.
5 Specifically, MACPAC recommends that the secretary collect
6 and report hospital-specific data on all types of Medicaid
7 payments for all hospitals that receive them.
8 In addition, the commission recommends that the secretary
9 collect and report data on the sources of nonfederal share
10 necessary to determine net Medicaid payment at the provider level.
11 Efforts to fully understand provider payment levels are more
12 relevant now than at any time in the program's history. Use of
13 supplemental payments is growing, particularly to hospitals
14 through Section 1115 expenditure authority.
15 In addition, interest and payment reforms that incentivize
16 greater value in the delivery of health service is also growing.
17 Even so, lack of solid data on net payments makes it extremely
18 difficult to assess the effectiveness of these efforts.
19 MACPAC shares this subcommittee's interest in ensuring that
20 taxpayer dollars are spent appropriately on delivery quality
21 necessary care and preventing and reducing fraud, waste and abuse.
22 Provider level data on supplemental payments and
23 contributions to the nonfederal share would provide greater

1 transparency and facilitate Medicaid payment analysis including
2 assessments of Medicaid payment adequacy and analysis of the
3 relationship between payment and desired program objectives.
4 Again, thank you for this opportunity to share MACPAC's work
5 with the subcommittee and I am happy to answer any questions.
6
7 [The statement of Ms. Schwartz follows:]
8
9 ********** INSERT 3 **********

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1 Mr. Pitts. The chair thanks the gentlelady -- both of the
2 witnesses for your testimony. I will begin the questioning and
3 recognize myself 5 minutes for that purpose.
4 This is for both of you. We will start with you, Ms. Iritani.
5 What data does CMS currently collect about the sources of the
6 nonfederal share Medicaid funding?
7 Ms. Iritani. CMS collects some data on the sources of funds
8 on a case by case basis. When states submit a new request for
9 approval for a state plan, CMS asks several questions about the
10 sources of funds.
11 It is not very accessible -- this data -- and it is not in
12 a uniform manner. CMS also collects some data on provider taxes.
13 But CMS acknowledges that the data are unreliable and incomplete.
14 Mr. Pitts. Anything to add, Ms. Schwartz? Let me ask you,
15 what additional data do you think they need and how will having
16 this data improve CMS's ability to oversee states' financing of
17 Medicaid? Both of you.
18 Ms. Iritani. Additional data that CMS needs includes data
19 on all sources of funds used to finance the Medicaid program.
20 Currently, CMS does not collect this data.
21 In order to understand net payments to providers, as Ms.
22 Schwartz has discussed the need for understanding, we need to
23 understand whether or not the financing of payments is being

1 concentrated on certain providers that also receive payments and
2 in order to understand this we need to collect complete data on
3 how states finance the nonfederal share of payments.
4 Ms. Pitts. Ms. Schwartz, do you want to add anything?
5 Ms. Schwartz. Just to add that our primary concern in
6 conducting this analysis is to get provider-specific data on their
7 contributions to the nonfederal share, which would allow us then
8 to net those contributions out from the total payments that they
9 are receiving Medicaid to get a true picture of what they are being
10 paid.
11 Ms. Pitts. Okay.
12 Now, Ms. Iritani, in your written testimony you indicate that
13 HHS acknowledged that additional data was needed to ensure that
14 states comply with federal requirements regarding how much local
15 governments may contribute to nonfederal share.
16 But despite this, HHS has said that no further action is
17 needed. Can you explain these seemingly contradictory
18 statements, explain why GAO believes that additional data is
19 necessary to properly oversee the program?
20 Ms. Iritani. Yes. We made a recommendation to CMS that
21 they collect -- develop a strategy for collecting better
22 information and I think CMS disagreed because they did not believe
23 that information on the sources of Medicaid financing was needed

1 on a payment specific basis.

2 They collect information in the aggregate but they don't
3 collect information that would enable us to ascertain how much
4 individual providers are collecting, as Ms. Schwartz discussed
5 a need for.

6 Mr. Pitts. Now, what does the required reporting and
7 auditing of DSH payments tell us about the utility of requiring
8 similar reporting and auditing for non-DSH supplemental payments?

9 Ms. Iritani. The DSH payments are subject to complete
10 reporting of both the financing of the payments and this -- the
11 information for non-DSH payments is lacking.

12 And I am sorry, could you repeat the question?

13 Mr. Pitts. Yes. What does the required reporting and
14 auditing of DSH payments tell us about the utility of requiring
15 similar reporting and auditing for non-DSH supplemental payments?

16 Ms. Iritani. Right. So the required reporting and
17 auditing of DSH payments has been very important for understanding
18 the -- who the payments are going to and at what levels and the
19 non-DSH payments are currently not subject to similar
20 requirements.

21 Mr. Pitts. Okay.

22 Ms. Iritani. We have suggested that non-DSH payments really
23 need to be comparable to the DSH payments in terms of the extent

1 of the reporting.

2 Currently, one cannot tell with the non-DSH payments the net

3 payments that providers are actually receiving because you cannot

4 tell on a provider specific basis what a provider is actually

5 contributing to the financing of a particular payment.

6 So the financing of a payment could be, for example, 100

7 percent concentrated on the providers who receive the payments.

8 Therefore, you know, the net payments that the providers receive

9 is actually much lower.

10 Mr. Pitts. My time is expired. The chair recognizes the

11 ranking member of the subcommittee, Mr. Green, 5 minutes for

12 questions.

13 Mr. Green. Thank you, Mr. Chairman, and I would like to ask

14 the panel to provide information on how Medicaid payments work.

15 I think Medicaid payments are so complicated. Even as I was a

16 state legislator in Texas it was tough.

17 I know that we would appreciate a little more information

18 about how this actually works. Ms. Schwartz, given that the issue

19 of rate setting is so complicated, explain how states set these

20 rates and what types of payments are provided to providers and

21 what is recorded to CMS.

22 Ms. Schwartz. Yes. Setting payment rates and

23 methodologies is one of the parts of the Medicaid program that

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1 varies the most.

2 Hospitals -- pay hospitals in very different ways. Some of
3 them use a system similar to the prospective payment system in
4 Medicare where they make a per case payment at the diagnosis level
5 for a number of different services that are provided in the
6 hospital.

7 Some states still pay hospitals per diem. The range is all
8 over the place in both how they pay, the special adjustors they
9 have for that and the actual payment rate. We have collected some
10 of this information from MACPAC and it is a rather unwieldy
11 spreadsheet that gives you a sense of the complexity of those
12 payments.

13 One of the things that MACPAC is most interested in is trying
14 to get a sense of how payments can be used to leverage proper
15 appropriate greater value care and as part of that we need to be
16 able to know both the methods and the payment rates and to be able
17 to net out these additional payments.

18 So it is quite complex with considerable state flexibility
19 reflecting historical practices and the local markets.

20 Mr. Green. Okay. Ms. Iritani, my understanding is it is
21 very hard to gather Medicaid data and indeed to compare Medicaid
22 data, given the time lag on availability of that data and how
23 different all these programs are from one another.

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1 Is that a problem that you encounter regularly in your work
2 at the GAO?
3 Ms. Iritani. Regular payment data is available to us. But
4 the supplemental payments that states often make are not reported
5 in the claims data that go to the CMS.
6 So states really have all the data that shows who those
7 payments are going to and so that is part of the transparency that
8 we believe is needed is more data at the federal level on whose
9 supplemental payments are going to and for what purposes and in
10 what amounts.
11 Mr. Green. Ms. Schwartz, I thought your point about linking
12 other sources of data to better understand a full picture of the
13 payments was interesting.
14 Can you expand on that recommendation?
15 Ms. Schwartz. Well, as Ms. Iritani says, claims are
16 available and are reported up to the federal level. So we know
17 on a per case or per diem level what hospitals are making.
18 Supplemental payments are not paid associated with claims
19 and what is reported by the states to the federal level is the
20 aggregate amount across all institutions in a particular class
21 and we can't associate that big chunk of dollars that is being
22 reported to the particular institutions that receive them.
23 States, clearly, know this information because they are

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1 making the payments. But states also have many different data
2 systems and approaches to making those payments and so you can't
3 just go out and ask every state report this information and get
4 the right answer.
5 So that is the desire to have the secretary specify a method
6 by which those data would be reported so that they could be
7 consistently reported and available to analyze both at the
8 national level and across states.
9 Mr. Green. Okay. Both -- Ms. Iritani, both you and Ms.
10 Schwartz mentioned that CMS is actually taking quite a number of
11 steps on the issue and I am glad the administration is taking those
12 steps in recent years to shed light on.
13 I know there has been a GAO recommendation through
14 administrations on both sides of the aisle. Can you talk about
15 CMS work on nonsupplemental payments in recent years?
16 Wasn't that work based in part on longstanding GAO
17 recommendations and isn't it true that CMS hasn't even finished
18 rolling out the new actions on the supplemental payments?
19 Ms. Iritani. Yes. CMS has taken some significant steps,
20 we would agree, to try to improve the transparency and
21 accountability of supplemental payments.
22 Recently, CMS has, for example, had initiatives to try to
23 require states to submit reports that would provide information

1 on the financing and payments for supplemental payments.
2 This information is more than what they have had before. It
3 is extensive. CMS has provided that information to a contractor
4 to assess how they can use it to improve oversight, for example.
5 CMS also has a initiative known as T-MSIS, Transform Medicaid
6 Information System reforms to try to collect better information
7 on claims. That would include supplemental payments.
8 Mr. Green. Okay.
9 Thank you, Mr. Chairman. I yield back.
10 Mr. Pitts. Chair thanks the gentleman.
11 I recognize the vice chair of subcommittee, Mr. Guthrie, 5
12 minutes for questions.
13 Mr. Guthrie. Thank you, Mr. Chairman, and my questions to
14 Ms. Iritani will be directed at you, and I know you have talked
15 about some of the things I am going to ask you about but I would
16 like to give you a chance to elaborate with -- through the question
17 I am going to move forward.
18 So in your testimony you point out that states generally use
19 general revenue funds for their Medicaid share but you point out
20 that states can use other financing options, specifically that
21 states are increasingly relying on providers and local
22 governments to finance their Medicaid share.
23 Can you discuss some of the ways states are financing their

1 Medicaid share? It is not just general revenue?

2 Ms. Iritani. What we have reported on are apart from the

3 general revenues, which is the majority of how states finance,

4 are -- is the growing reliance on taxes on health care providers,

5 for example, to help finance the nonfederal share of payments.

6 Intergovernmental transfers, which can be used between units of

7 government to --

8 Mr. Guthrie. Can you give an example of one -- an example?

9 Ms. Iritani. So, for example, a local government may

10 operate a hospital and an intergovernmental fund transfer might

11 be a transfer from the local government to the state that it is

12 in to provide the nonfederal share of a payment that is going to

13 the provider.

14 And other method is known as certified public expenditures,

15 which is basically certifying that an expenditure was made for

16 Medicaid. That can also be used as a nonfederal share.

17 Mr. Guthrie. Okay. And I think every member of this

18 committee wants to ensure that vulnerable beneficiaries are

19 protected and receive the Medicaid benefits, which are eligible.

20 But I know many of us also want to ensure that federal

21 Medicaid policy doesn't unnecessarily crowd out private sector's

22 role.

23 Medicaid long-term care is the largest chunk of Medicaid

1 spending and represents one of the biggest challenges to the
2 program's sustainability over the long term.
3 My bill, H.R. 1361, the Medicaid Home Improvement Act, seeks
4 to address the concerns of GAO in this area and requires states
5 to submit an annual report identifying the sources and amounts
6 of funds used to -- as the Medicaid report items are -- use funds
7 to finance their nonfederal share of Medicaid.
8 Can you talk about how that will be beneficial as we move
9 forward?
10 Ms. Iritani. Yes. Currently CMS does not collect data on
11 the sources of funds that states use for Medicaid and there are
12 several reasons why we believe that information is needed.
13 One is just to enforce Medicaid requirements on limits that
14 are set on the extent that states can rely on providers and local
15 governments.
16 There is a limit that states cannot -- it is called the 60/40
17 rule that states can only obtain a certain proportion of funds
18 from local governments and providers.
19 The other is just to understand net payments that providers
20 actually receive. Without having better data on the extend that
21 payments are being financed by the providers who receive the
22 payments, we can't really understand net payments to providers.
23 Mr. Guthrie. Okay. Also a bill I have today is the Medicaid

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1 Home Act that changes the equity requirement to $500,000 plus --
2 I mean, plus inflation.
3 Can you talk about if this policy were adopted how
4 individuals could access the equity interest in their home through
5 a variety of legal means such as reverse mortgages, home equity
6 loan or other financial vehicles?
7 Ms. Iritani. I am not prepared to answer that question but
8 I would be happy to get information for you -- for a question for
9 the record.
10 Mr. Guthrie. Okay. All right.
11 And can you talk about there is an exception under current
12 law which my bill does not change which allows an individual with
13 any level of home equity to qualify for Medicaid if an individual
14 spouse, child under 21 or child that is considered blind or
15 disabled also live in the home? Are you familiar with that
16 provision?
17 Is that -- maybe, Ms. Schwartz, you have a -- checking in
18 on that -- do you have a --
19 Ms. Schwartz. Yes, that is correct.
20 Mr. Guthrie. That is correct. Okay.
21 And given that -- there are few seconds here -- given the
22 aging of the Baby Boomers and the growth of long-term care, have
23 MACPAC or GAO conducted any analysis about the challenges

1 unrestrained growth in this part of the program imposes on federal
2 and state budgets?
3 For example, CBO estimates that federal spending alone on
4 Medicaid long-term care will be $77 billion this year. So is GAO
5 or MACPAC looking at the long-term care and ensuing Baby Boomer
6 arrival, not just at retirement but also older in life so that
7 more demands on long-term care?
8 Ms. Iritani. We have several engagements underway around
9 long-term care and Medicaid.
10 Mr. Guthrie. Thanks.
11 Ms. Schwartz. Yes, and MACPAC is engaged in a long-term work
12 plan on analyzing spending trends and different aspects of the
13 Medicaid program and we are just beginning that work, and since
14 long-term care is such a significant part of the program it will
15 be included as part of that area of work.
16 Mr. Guthrie. Thank you. My time is expired and I yield
17 back.
18 Mr. Pitts. Chair thanks the gentleman.
19 I now recognize the ranking member of the full committee,
20 Mr. Pallone, 5 minutes for questions.
21 Mr. Pallone. Thank you, Mr. Chairman.
22 I want to follow up on my colleague's discussion of long-term
23 care.

1 Dr. Schwartz, I would like to discuss how the proposed
2 Medicaid Home Improvement Act would affect beneficiary
3 eligibility for long-term care services.
4 As you know, the Medicaid program is the backbone of our
5 country's long-term care system. Sadly, even with Medicaid as
6 the safety net, the majority of Americans lack the options or
7 resources to sufficiently plan for future long-term care needs.
8 And, you know, my questions relate to, obviously, to the
9 spend down provision, which I think is a terrible way to pay for
10 long-term care -- actually shameful, in my opinion.
11 The last thing I want to do is to take someone's home to pay
12 for their long-term care. Could you briefly describe the purpose
13 of the home equity exemption?
14 Ms. Schwartz. I think there is two purposes. One is to
15 allow living family members to remain in the home while the
16 beneficiary is in an institution and the other is to -- there is
17 the limit that exists on there to ensure that the government is
18 seeing a contribution of assets to their care. So that is the
19 purpose of the act.
20 Mr. Pallone. Thank you.
21 And states are allowed the option of maintaining a higher
22 home equity threshold. What is the purpose of allowing states
23 to choose between different equity allowances?

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1 I know for New Jersey, you know, in our state it is much
2 higher. We have chosen the option of the higher equity.
3 Ms. Schwartz. Well, I am not an expert in this area and it
4 is not an area where MACPAC has done any significant work.
5 But in general, states exercise flexibility in definitions
6 within the program to reflect local circumstances in their
7 communities and I do believe New York and New Jersey are two of
8 the states that have allowed a higher exemption, presumably
9 reflecting the higher market value of real estate in those areas.
10 Mr. Pallone. I mean, that is absolutely the case. I mean,
11 it is not unusual at all for, you know, a person of average income,
12 you know, to be living in a home that is worth $800,000, which
13 I think would qualify in New Jersey under the higher -- because
14 New Jersey has opted for the higher equity but might not -- but
15 I think wouldn't qualify if this bill became law because they
16 wouldn't allow states to have a higher threshold.
17 Would you expect the Medicaid Home Improvement Act to have
18 different effects in different states because it wouldn't allow
19 this higher threshold?
20 Ms. Schwartz. Well, certainly, to the extent that states
21 have a higher threshold now would affect those states more than
22 those who have a threshold similar to what is in the bill.
23 Mr. Pallone. Thank you.

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1 I mean, my concern, Mr. Chairman, you know, I find this
2 proposed piece of legislation to be very concerning with regard
3 to this home equity threshold and not allowing states to raise
4 the threshold.
5 I mean, our country, we know, has still not implemented a
6 thoughtful comprehensive approach to long-term care yet this bill
7 would only serve to restrict eligibility to long-term services
8 and supports and I would -- you know, I can't stress enough that
9 in states, you know, like New Jersey where, you know, real estate
10 -- you know, you have this much higher ability -- it costs a lot
11 more, essentially, to have a home in New Jersey. And I -- I mean,
12 the last thing I would want to see is people to have to, you know,
13 sell their home because the threshold is reduced.
14 Let me ask you, Dr. Schwartz, I understand that Medicaid and
15 CHIP have experience in quality performance measures through the
16 Pediatric Quality Measures Program and this program was
17 established in 2009 with the goal of improving the quality of care
18 delivered to our nation's pediatric patients.
19 Could you briefly describe the Pediatric Quality Measures
20 Program and the effect it has had in advancing pediatric care for
21 Medicaid patients? I think you have a minute.
22 Ms. Schwartz. Sure.
23 The core set of measures, as you mentioned, was developed

1 in 2009 and all states are reporting at least two of the measures.
2 The median is 14 measures, and there are things like the share
3 of kids between the ages of 3 and 17 with an outpatient visit to
4 a primary care practitioner, the share of children up to the age
5 of 2 are up to date on their vaccines, share of births at low birth
6 weight.
7 These are areas that are agreed have a clinical definition
8 as being meaningful from the purposes of high quality care.
9 MACPAC has commented on the importance of improving the
10 number of states reporting those measures and increasing the
11 number of measures and also strengthening the capacity of CMS to
12 calculate those measures for states from claims data to the extent
13 that it is possible.
14 Mr. Pallone. Do you have any suggestions for improvement?
15 I know my time is almost up but if you had to mention one or two.
16 Ms. Schwartz. To the extent that data from claims that
17 states submit up to CMS that those data can be used and that require
18 no additional data collection on the part of the states that would
19 be a really valuable way to get more information on the performance
20 of different states in providing quality pediatric care.
21 Mr. Pallone. Thank you.
22 Thank you, Mr. Chairman.
23 Mr. Pitts. The chair thanks the gentleman and now

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1 recognizes the gentleman from Illinois, Mr. Shimkus, five minutes
2 for questions.
3 Mr. Shimkus. Thank you, Mr. Chairman. And welcome back,
4 it is good to see you. This question would be for both of you
5 as I begin. Many of us are familiar with the Disproportionate
6 Share Hospitals, or DSH, supplemental payments. However, can you
7 please explain what non-DSH supplemental payments are, who they
8 go to and what purpose they serve? Ms. Iritani, why don't you
9 start?
10 Ms. Iritani. Yes, the non-DSH payments are a type of
11 supplemental payments that states often make under the upper
12 payment limit that is established under Medicaid or under Medicaid
13 demonstrations. The purposes are largely unknown, which is part
14 of why we believe there is a need for more reporting so we can
15 understand who these payments are going to and for what purposes.
16 Mr. Shimkus. Ms. Schwartz, do you want to comment on it?
17 Ms. Schwartz. Sure. I can just say that the non-DSH
18 supplemental payments are calculated by a state looking across
19 a class of providers, say, public hospitals, nonprofit hospitals,
20 looking at the total payments under fee-for-service that are paid,
21 and then the difference between that payment amount and what would
22 have been paid under Medicare principles, which is generally more.
23 So the difference there is the amount that the state can make in

1 non-DSH supplemental payments, and it uses those funds presumably
2 to target different types of hospitals.
3 But again, as Ms. Iritani said, that is one of the reasons
4 we would like to be able to get the provider-specific data to see
5 the relationship between the specific payments and which
6 hospitals are receiving them.
7 Mr. Shimkus. So in the question previously, Ms. Iritani,
8 you talked about -- we were talking about general funds payment
9 and I think you did raise the issues of taxes. So some states
10 use provider taxes to finance the non-federal share of Medicaid
11 cost which has been used to shift cost to the federal government.
12 Can you kind of talk through that?
13 Ms. Iritani. Yes, so to the extent that financing of large
14 payments is concentrated on the same providers receiving those
15 payments, there can be a cost shift. For example, when we looked
16 at this issue in a recent report, we looked at certain new
17 arrangements that states put in place where they increased
18 provider payments but they at the same time imposed a tax on those
19 providers, the same providers, to pay for the non-federal share.
20 And so then they drew down the federal matching for that
21 payment, for those payments, and in the end the federal government
22 paid much more, hundreds more, or tens of millions for those new
23 payments. The providers who received the payments funded the

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1 non-federal share and the state ended up not having to pay more
2 for those payments.
3 Mr. Shimkus. Ms. Schwartz, do you want to comment? No.
4 That is fine.
5 And last for Ms. Iritani, GAO has had longstanding
6 recommendation for CMS to require additional reporting and
7 auditing of non-DSH supplemental payments. Why don't you think
8 CMS has implemented those recommendations?
9 Ms. Iritani. CMS has agreed with our findings, but with
10 regard to that particular recommendation they said that they would
11 need to be required to do so; that because of the effect on states
12 that they would need legislation to be ordered and to be able to
13 do that.
14 Mr. Shimkus. Okay, very good. I yield back my time. Thank
15 you, Mr. Chairman.
16 Mr. Pitts. The chair thanks the gentleman. I now recognize
17 the gentle lady from Florida, Ms. Castor, five minutes for
18 questions.
19 Ms. Castor. Great. And that is where I want to pick up.
20 So CMS says that they do not have the authority to go out and
21 collect all of the data from states on their supplemental
22 payments. Do you agree with that, that legislation is needed?
23 Ms. Iritani. We defer to CMS on that. We believe that in

1 the past when CMS has tried to require states to report information
2 that states didn't necessarily want to report or want to report
3 at the level that CMS needed it, CMS needed legislation.
4 Ms. Castor. Ms. Schwartz, do you agree with that?
5 Ms. Schwartz. CMS is collecting information from states to
6 demonstrate compliance with the upper payment limit regulations.
7 And for the purposes that MACPAC is interested in, the payments
8 on provider-specific data on the non-DSH supplemental payments
9 from those regulations might be sufficient. We don't have any
10 access to those data. CMS does not share at a lot of details.
11 We do know that they have been talking about a regulation
12 on supplemental payments, so it does seem that there is activity
13 going on and that as part of its oversight activity it does have
14 the ability to collect the payment information. I believe an
15 audit is another level in which I think it is probably fair to
16 say that they would need legislation to conduct an audit as they
17 had to do the additional --
18 Ms. Castor. And it certainly would give them the leverage
19 to say to states we need it to be accessible and we need it to
20 be uniform, because these supplemental payments go to all 50
21 states, correct? So oftentimes I imagine the data comes back in
22 different forms. What impact now has Medicaid expansion in some
23 states and not in others had on supplemental payments?

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1 Ms. Schwartz. I am not sure that we have done the analysis
2 of the supplemental payments of expansion versus non-expansion
3 states and it is something we could do. In any case, it would
4 still be at the aggregate state level and not give you a picture
5 of what is happening to individual providers.
6 Ms. Castor. How about with the expansion of the 1115 waivers
7 and supplemental payments? Has the trend towards states having
8 those Medicaid waivers changed the format of supplemental
9 payments at all?
10 Ms. Schwartz. Many of those waivers have allowed states to
11 continue making supplemental payments, and so we do know that
12 those payments under the 1115 waivers are increasing.
13 Ms. Castor. So, and in the Medicaid managed care rules that
14 were proposed recently, did those rules propose any type of
15 standardized reporting for supplemental payments through the
16 waivers or --
17 Ms. Schwartz. I am not sure if the rules specifically
18 mention that, but in general supplemental payments are not
19 permitted under managed care because in managed care the plan is
20 making a payment to the institution not the state.
21 Ms. Castor. So it is more applicable to the 1115 waivers
22 to states than in managed care rules for sure.
23 Ms. Schwartz. That is my understanding.

1 Ms. Castor. Okay. In one example, I wonder if GAO has
2 looked at states that have taken supplemental payments and done
3 things with them that really are outside the bounds of the intent
4 of the Medicaid laws. Do you know of any cases where states have
5 said, okay, we are going to provide, use supplemental payments,
6 that revenue, and pay providers that don't serve the Medicaid
7 population?
8 Ms. Iritani. Years ago in prior reports, we have looked at
9 how excessive supplemental payments were used by states and did
10 find that the payment revenues could be used for non-Medicaid
11 purposes. And in more recent years, we have just been looking
12 at the level of the supplemental payments and how that they relate
13 to costs of the providers for providing Medicaid and that is where
14 we have found that many states are making payments that are much
15 --
16 Ms. Castor. In Florida we had that crop up where the state
17 went in and said, here, we are going to take some of the
18 supplemental payments and give it to some providers that were not
19 serving the Medicaid population. And that is a real worry in my
20 home county that has a half cent sales tax that they use as an
21 intergovernmental transfer and to bring down their Medicaid
22 match.
23 So I think this is a very good idea for us to standardize

1 the reporting from states and get all the data so we can ensure
2 the funds are being spent accordingly. Thank you, and I yield
3 back.
4 Mr. Pitts. The chair thanks the gentle lady. I now
5 recognize the gentleman from Missouri, Mr. Long, five minutes for
6 questions.
7 Mr. Long. Thank you, Mr. Chairman. And Ms. Iritani, what
8 factors prompted CMS to require audits and reporting of the DSH
9 payments?
10 Ms. Iritani. CMS identified concerns with states making
11 excessive payments over the limits, and Congress had required them
12 to also establish reporting and auditing requirements. And some
13 of our work also found concerns with excessive payments and also
14 requirements on providers to return the non-federal share to the
15 state, so effectively reducing the net payments that some
16 providers received. So CMS did, and now requires DSH payments,
17 Disproportionate Share payments to be reported on a
18 facility-specific basis and subject to audit.
19 Mr. Long. Okay. These overpayments, were they an anomaly,
20 or do you know what percentage they found, find or think are
21 overpaid?
22 Ms. Iritani. Well, what I can say is the original, the very
23 first DSH audits found that the majority of states, I believe it

1 was 41, had overpaid at least one hospital. And one of our reports
2 reported on the findings of the DSH audits and 41 states had paid
3 over 500 hospitals 2.7 million on the non-DSH side, but they also
4 reported on significant noncompliance on the DSH side in terms
5 of --
6 Mr. Long. Significant. Do you have any idea what
7 percentage when you said significant?
8 Ms. Iritani. So the DSH payments, payments that were in
9 excess of the hospitals' uncompensated care and/or not calculated
10 with acceptable data and methods, 41 states that made DSH payments
11 exceeded the hospitals' --
12 Mr. Long. Yes, but that doesn't tell me what percentage.
13 Ms. Iritani. So 24 percent of the hospitals were found to
14 have received DSH payments that were noncompliant.
15 Mr. Long. Twenty four percent across the board.
16 Ms. Iritani. Twenty four percent of hospitals.
17 Mr. Long. Okay. Okay, thank you. And Dr. Schwartz, on
18 Thursday, MACPAC commissioners recommended that the secretary of
19 HHS should collect and report hospital-specific data on all types
20 of Medicaid payments for all hospitals that receive them. In
21 addition, they said the secretary should collect and report data
22 on the sources of non-federal share necessary to determine net
23 Medicaid payments at the provider level.

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1 As I have been told, HHS said legislation was necessary to
2 implement reporting and auditing requirements for DSH payments
3 and that legislation would be needed to implement similar
4 requirements for non-DSH supplemental payments. So why did
5 MACPAC target its recommendations to the secretary?
6 Ms. Schwartz. Sure. We have not asked for nor received a
7 review from CMS of our recommendations, so I don't know what CMS
8 will say about our specific recommendation. MACPAC's
9 recommendation was for reporting of payment information, which
10 we know from what CMS already is asking of states in the UPL payment
11 demonstrations that it is already asking for similar types of
12 information, and that is why we believe that the secretary had
13 the authority to do this. Auditing is a different step, and
14 auditing is a much more intense activity as seen in the DSH audits
15 and that is not what MACPAC was asking for. MACPAC was asking
16 for collecting and reporting payment data, and so we believe that
17 the secretary has the authority to do that.
18 Mr. Long. Okay, thank you. With that I yield back, Mr.
19 Chairman.
20 Mr. Pitts. The chair thanks the gentleman and now
21 recognizes the gentleman from Oregon, Dr. Schrader, five minutes
22 for questions.
23 Mr. Schrader. Thank you, Mr. Chairman. I guess for GAO,

1 have you evaluated what the cost-benefit might be in changing from
2 reporting classes of overpayments versus going to the individual
3 providers?
4 Ms. Iritani. We have evaluated the cost-benefit, but we
5 would note that this is required on the DSH side. So, and non-DSH
6 payments are now higher in amounts than DSH payments, but the
7 non-DSH payments are not subject to reporting and auditing as with
8 DSH.
9 Mr. Schrader. Has there been any consideration of just
10 increasing the Medicaid payments as opposed to going with the DSH
11 and non-DSH supplemental payments that we have got?
12 Ms. Iritani. Well, ideally, Medicaid payments would be
13 sufficient to ensure access in a local area comparable to what
14 others outside of Medicaid would be receiving.
15 Mr. Schrader. Like everyone in this committee and Congress
16 fully realizes, Medicaid payments are not sufficient and as a
17 matter of fact are so low that many providers can't accept Medicaid
18 patients. We have the same problem with Medicare. I think a lot
19 of folks need to be aware that that is a very, very low
20 reimbursement rate compared to the private insurance market.
21 Ms. Iritani. Yes, our work has found that Medicaid payments
22 are lower generally for certain services than private.
23 Mr. Schrader. Has there been any move to just fund Medicaid

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1 to the various states and providers based on outcomes? There has
2 been a lot of talk in health care recently about outcomes, quality
3 based health care.
4 Ms. Iritani. What I can say is that I think that there are
5 some demonstrations that are trying to incentivize outcomes by
6 making payments for that.
7 Mr. Schrader. MACPAC have any comments on that?
8 Ms. Schwartz. I think there is a lot of activity at the state
9 level to try and link payment to outcomes through different
10 approaches such as health homes, bundling of payments, different
11 approaches. We don't know very much yet about the outcomes and
12 whether they have affected outcomes. That is something we would
13 be very interested to know.
14 And it is also very difficult to conduct that research
15 because you have to be able to control for everything else that
16 is going on in the health system and in the patients' lives to
17 be able to attribute the outcomes to specific actions on the part
18 of the beneficiary and the provider.
19 Mr. Schrader. Well that is interesting and that is always
20 true whether it is an education bill or anything we do. But we
21 are doing that right now in Medicare. We are trying to get at
22 that in Medicare. We are doing that under the Affordable Care
23 Act. So I don't think it is impossible, and certainly there could

1 be risk based reimbursement to accommodate the types of
2 socioeconomic factors that people have.
3 And I would argue respectfully that rather than us trying
4 to micromanage all the states and the different providers, it
5 would be a heck of a lot easier for us, particularly non-doctors,
6 although I guess I am a veterinarian but I wouldn't want to be
7 the guy in charge of your healthcare, that we go to an outcome
8 based reimbursement system where we could easily judge whether
9 or not the people are staying healthier, staying out of the
10 hospitals, getting that quality based healthcare.
11 That should really be what we are about, then our task here
12 would be pretty easy. We would just be able to have a common set
13 of outcomes, and your job would be a little bit easier and we could
14 see whether or not things are doing well or not.
15 Another question. In the REPORTS bill why do we have the
16 40/60 rule? Why is that significant? What is the goal of having
17 that rule?
18 Ms. Iritani. I can't speak to the legislative history
19 around that rule, but I think that the concept generally is that
20 states should share in the non-federal share of the financing that
21 --
22 Mr. Schrader. Well, why do we specify it can't be more than
23 40 or more than 60? What is the point of that? Who cares? Why

1 do we care? I am the federal government. As long as someone is
2 paying their fair share, why do I care?
3 Ms. Iritani. Well, I think that to make sure that the
4 incentives are for sufficient and economical payments that the
5 state should be sharing in the cost of the payment.
6 Mr. Schrader. Yes, but who cares if it comes from the local
7 government or a private enterprise or the state? Who cares?
8 Ms. Iritani. The concern around the reliance on providers
9 and local governments for financing the non-federal share is when
10 the burden on financing Medicaid rests with, for example, the
11 providers who are serving the beneficiaries. From the providers'
12 standpoint, the payment they receive from Medicaid is the net
13 payment. It is not the full payment, it is the payment less the
14 taxes or other contributions they might be making for the payment
15 that they receive.
16 Mr. Schrader. Mr. Chair, I would just respectfully suggest
17 we are micromanaging and should let the states do what they do
18 best and just regulate the outcomes. I think that would be a
19 smarter proposal. And I yield back. Thank you, sir.
20 Mr. Pitts. The chair thanks the gentleman. I now recognize
21 the gentleman from Indiana, Dr. Bucshon, five minutes for
22 questions.
23 Mr. Bucshon. Thank you, Mr. Chairman. I would agree with

1 what you just said and I think we are micromanaging. And I can
2 tell you why CMS wants to know the information, because they want
3 to decrease payments to the Medicaid program. They want to save
4 money. And I was a provider before I was a surgeon and you can't
5 have access if you continue to decrease Medicaid payments.
6 Because you have a program that needs fundamentally restructured
7 in my view. You can't have both.
8 And so now, states, including Indiana with the Healthy
9 Indiana Plan 2.0 which is a HSA based way to manage the Medicaid
10 population, now what basically your testimony is telling me that
11 wow, you guys came up with a great system but we don't want you
12 to do it because we are concerned it is going to cost the federal
13 government more money and we are trying to save money here.
14 So the question -- I mean, I am playing a little devil's
15 advocate here. The question I have is why does the federal
16 government care? I mean, for example, Healthy Indiana Plan 2.0
17 uses hospital taxes to, as you probably know, to help fund the
18 expanded state share of the expansion under the Affordable Care
19 Act.
20 Why does that matter to the federal government? Because
21 what they are doing then is they are reimbursing providers at a
22 higher level than traditional Medicaid. Guess what that does?
23 It gets the providers to take Medicaid patients so that we get

1 access so low-income people actually can see a doctor. So why
2 does that matter to the federal government? Does that cost the
3 federal government any more money than it would if they did it
4 in a traditional way?
5 Ms. Schwartz. I think the most fundamental reason that the
6 federal government pays is that when you look at the financing
7 federal, non-federal, the federal government is still paying on
8 average 57 percent of the cost of the Medicaid program and much
9 more than that in many states --
10 Mr. Bucshon. So?
11 Ms. Schwartz. -- notwithstanding how --
12 Mr. Bucshon. So what?
13 Ms. Schwartz. So the interest is ensuring that that amount
14 of money is being used consistent with the aims of the statute.
15 Mr. Bucshon. Okay, so they want to micromanage the Medicaid
16 program just like Dr. Schrader said. The basic, and what I am
17 getting is that the reason is, is because the federal government
18 wants to micromanage the states. I mean that is my view on that
19 and again I am all for reporting, and I think people, states should
20 be compliant with coverage and make sure people are getting
21 adequate coverage.
22 But other than that, I mean the question I have is why does
23 it matter to the federal government? That is why I support

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1 fundamental Medicaid reform that gives the states a certain amount
2 of money and let them do what they need to do with it versus having
3 all these strings attached. I mean, I think we are just finding
4 today with this hearing why we need to fundamentally restructure
5 the Medicaid program, because people are spending literally
6 1,000s of hours trying to figure all this stuff out.
7 Like I said, I don't have a problem with needing to be
8 reporting if it has an impact on patient access. I mean, if there
9 is a concern that based on states using local or state funding
10 for the non-federal portion is having an impact on access and
11 people are not getting the services that is one thing. If it is
12 just because the federal government wants to say, well, look, we
13 don't have to pay you as much because you have found a way to use
14 local money or state money to help yourself, then I am against
15 that.
16 And so why does it matter if a state reports, for example,
17 in the aggregate versus an individual provider? Why would the
18 federal government care? It is the same amount of money.
19 Ms. Iritani. Well, as you point out, we want to make sure
20 that Medicaid payments are going for Medicaid purposes and then
21 prove access to Medicaid beneficiaries.
22 Mr. Bucshon. And I agree with that.
23 Ms. Iritani. Without knowing the amount that an individual

1 provider is contributing to the payment that they are receiving,
2 we can't actually understand whether or not the payment is being
3 used basically for fiscal relief for the state or actually serving
4 to improve access for Medicaid beneficiaries.
5 Mr. Bucshon. That is fair enough. But that there what you
6 just said is making the assumption that states are purposely
7 violating federal law for their own benefit. If you make -- I
8 am just saying that CMS needs to know this because they want to
9 prevent states from purposely violating the law by using Medicaid
10 dollars for non-, for example, giving payments to people who are
11 not providing coverage to Medicaid patients. Is that true or not
12 true?
13 Ms. Iritani. And it is not necessarily even violating the
14 law. States can make payments and receive federal matching up
15 to the upper payment limit, and there is no limit on Medicaid
16 payments in relation to costs. But this data is really needed
17 to understand the extent that payments are going to providers who
18 are actually financing the non-federal share, therefore reducing
19 the net payments to the providers because --
20 Mr. Bucshon. My time is expired. So again I will just
21 finish by saying who cares? Because it is the same cost to the
22 federal government, who cares? I yield back.
23 Mr. Pitts. The chair thanks the gentleman and now

1 recognizes the gentleman from Maryland, Mr. Sarbanes, five
2 minutes for questions.
3 Mr. Sarbanes. Thank you, Mr. Chairman. I had a question
4 about -- I am very interested in these demonstration projects to
5 explore alternative venues or settings for long-term care and the
6 financing of those. So I guess the obvious example of
7 experimenting with this is there are some waiver and demonstration
8 programs that have allowed for Medicaid reimbursement for
9 placement in, say, assisted living facilities as opposed to long
10 term in nursing care facilities. I don't know that there has
11 been, but you would know, I imagine, demonstration projects that
12 are reimbursing through Medicaid for placement in somebody's home
13 where they are getting some home care.
14 But my question is, as those kinds of alternatives are being
15 explored are there also alternative kind of financing structures
16 or formulas being looked at at the same time? So obviously you
17 would be looking at different kinds of reimbursement amounts
18 depending on this setting, but is there any reason, for example,
19 to look at some of these asset thresholds and other things
20 depending on -- my instinct would say no, but I am just wondering,
21 has that kind of analysis accompanied the experimenting of just
22 where you might reimburse for this kind of care?
23 Ms. Iritani. We have work plan to look at Medicaid payments

1 for assisted living. We have not done work looking at financing
2 of Medicaid payments necessarily directed to long-term care, if
3 that is your question.
4 Mr. Sarbanes. Okay. And are there, is it in your bailiwick
5 to tell me whether there are demonstrations that are actually
6 looking at Medicaid reimbursement for home care where somebody
7 is actually staying in the home?
8 Ms. Iritani. There are, increasingly, states moving from
9 a fee-for-service type of payment for long-term care services to
10 managed care which would be a capitated payment amount to cover
11 all services including long-term care.
12 Mr. Sarbanes. So in that instance there would be a capitated
13 payment for providing care along a continuum that could include
14 some component of home care along with institutional care; is that
15 what you are saying?
16 Ms. Iritani. Correct.
17 Mr. Sarbanes. Okay. All right, thank you. I yield back.
18 Ms. Schwartz. I can just add to that that about half of
19 payments for long-term services supports in Medicaid are now
20 occurring in a non-institutional setting, and this reflects a very
21 big shift over the past 20 years when it was primarily in
22 institutional settings. And that is primarily through 1915(c)
23 waivers that have allowed states to move, allow folks to stay in

1 their own homes and receive services if that is something that
2 is valuable to them.
3 And there have also been grants under the money follows the
4 person program to help states transition people from nursing homes
5 to homes settings or to allow people to stay in their homes and
6 not end up in a nursing facility.
7 Mr. Sarbanes. Thank you.
8 Mr. Pitts. The gentleman yields back. The chair now
9 recognizes the gentleman from Maryland, Mr. Bilirakis, five
10 minutes for questions.
11 Mr. Bilirakis. Florida.
12 Mr. Pitts. I mean Florida, sorry.
13 Mr. Bilirakis. That is okay. No problem. Well, I have a
14 couple questions here, but I wanted to say how much, with the
15 moving the patient from a long-term care facility to the home,
16 obviously quality of life is number one, but are we saving money
17 at the same time?
18 Ms. Schwartz. Those waivers require a demonstration of
19 savings and so yes. And in the managed long-term services and
20 supports area, I think that is also an area to increase the
21 predictability of the amount that is being spent on long-term
22 services and supports. So fiscal concerns are obviously a part
23 of both of those efforts.

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1 Mr. Bilirakis. Very good, thank you. A couple more
2 questions, Ms. Iritani and Ms. Schwartz. In your testimony you
3 talk a lot about non-state sources being used to fund Medicaid.
4 Can you explain what these non-state sources are such as provider
5 taxes and how they fund state Medicaid programs?
6 Ms. Iritani. States are allowed to use up to certain sources
7 of funds apart from state general revenues to finance Medicaid.
8 Provider taxes are an increasing method that states use to fund
9 Medicaid which would be a broad-based uniform tax on health care
10 providers, and it could be Medicaid providers to fund Medicaid.
11 And our governmental transfers and certified public
12 expenditures are other methods that are increasingly used to
13 finance the non-federal share of Medicaid. These would be
14 methods that local governments or a local government provider such
15 as county hospitals might use to, for example, in the case of
16 certified public expenditures, to certify that they had expended
17 a certain amount on Medicaid for purposes of getting federal
18 matching for the payment or the fund.
19 Mr. Bilirakis. Do you have anything else to add, please?
20 Ms. Schwartz. No, I don't have anything else to add to that.
21 Mr. Bilirakis. Okay, all right. Okay, federal law
22 requires that provider taxes must be broad based and uniformly
23 imposed and must not hold the providers harmless and cannot

1 provide a direct or indirect guarantee those providers will
2 receive all or part of the tax payment back. How does the
3 use of non-state funding sources such as provider taxes reconcile
4 with federal law?
5 Ms. Schwartz. It is permissible under federal law, and
6 changes have been made over time to clarify the circumstances
7 under which it is possible and the ones you just named are examples
8 of that. But it is a permissible activity. There is no
9 intimation that something shady is going on with these taxes and
10 they are clearly important in many states as a source of funds
11 to support the Medicaid program.
12 Mr. Bilirakis. Okay, next question. Ms. Iritani, in 2014
13 you asked CMS to ensure states report accurate and complete
14 information on all sources of funds used to finance the
15 non-federal share of Medicaid. What data did you want to capture
16 and what was CMS's response to your recommendations?
17 Ms. Iritani. Yes, we suggested that CMS come up with a data
18 strategy for obtaining complete and reliable information on
19 sources of funds. Currently CMS does not collect specific
20 sources of funding. CMS agreed that they needed better data for
21 oversight purposes, but disagreed with our suggestion that they
22 needed this data at the provider level for in particular
23 institutional providers.

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1 We felt like the data is needed at the institutional level
2 so that a net payment to the provider could be understood. For
3 example, if a hospital is getting 200 million from CMS in a
4 supplemental payment that CMS would also know that that provider
5 was being asked to finance a non-federal share, a hundred million
6 or more, whatever the non-federal share of the payment would be.
7 This is important not only for understanding the trends in
8 financing and the net impact on the provider and whether it would
9 be helpful to understand the extent the payments are actually
10 going to improve access to the beneficiaries as opposed to cost
11 shifting to the federal government or providing fiscal relief to
12 the states.
13 Mr. Bilirakis. So one final question, if I may, Mr.
14 Chairman.
15 Mr. Pitts. You may proceed.
16 Mr. Bilirakis. Okay, thank you. Ms. Iritani, Medicaid is
17 listed by GAO as a high risk program. Can you explain why this
18 program is listed as high risk?
19 Ms. Iritani. Yes. There are multiple contributing reasons
20 based on our body of work over the last years, but Medicaid is
21 a significant program in terms of size, in terms of the number
22 of enrollees now, the largest health care program in the country.
23 It is a diverse program. The federal-state nature of it makes

1 it very difficult for oversight. Our work has identified
2 concerns with gaps in oversight including the transparency of
3 supplemental payments and many other types of issues that
4 contributed to our putting Medicaid on our high risk list.
5 Mr. Bilirakis. Thank you. Thank you very much. I yield
6 back.
7 Mr. Pitts. The chair thanks the gentleman and now
8 recognizes the gentleman from New York, Mr. Collins, five minutes
9 for questions.
10 Mr. Collins. Thank you, Mr. Chairman. And I want to thank
11 our panel for being here. I think examining Medicaid programs
12 are very important and we have kind of been doing it many ways
13 today. I guess I would like to start by standing with Dr. Bucshon
14 in saying if we could block grant Medicaid back to the states I
15 don't even think there would be a need for today's hearing. But
16 unfortunately we haven't done that so that is one of the reasons
17 we are having this hearing, which I think is timely.
18 And maybe to respond a little bit to Mr. Guthrie's comments
19 earlier, Medicaid is all over the place when it comes to how states
20 administer them. And maybe to sum up a little bit, I am from New
21 York, which New York with 20 million Americans spends as much on
22 Medicaid as California and Texas combined with 60 million people.
23 That shows you how crazy this program is. Thirty six or so states,

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1 as I understand it, absorb the Medicaid cost at the state level
2 and there is no local share. It is about 36 out of 50.
3 Well, the 14 states of which New York is certainly one, pushed
4 this back to the county level. In the case of Erie County where
5 I am from, Buffalo, I was the county executive, and 100 percent
6 of our property tax did not even cover our Medicaid share at the
7 county level; 100-plus percent of our county tax covered Medicaid,
8 which meant the county had to live on sales tax.
9 Well, when it gets to DSH it is worse. In New York State,
10 when the federal government makes a DSH payment the state pays
11 nothing. They force 100 percent of the match for DSH payments
12 down to the local level for the county. Erie County, Eric County
13 Medical Center, we are talking about $40 million in a year.
14 Now under the ACA, to speak to the folks on the other side
15 that was, the DSH payments were supposed to be reduced
16 dramatically by the expansion of Medicaid and Affordable Care.
17 Well, it hasn't happened. As I understand it now just maybe we
18 will see a DSH reduction in 2018, but that may go the same way
19 as SGR and just kicked down the road. And I just bring this up
20 to put into context how Medicaid is all over the place through
21 the country, and if you are living in Erie County, New York, it
22 doesn't get much worse when it comes to what we are having to bear
23 for that burden.

1 So briefly, the bill that I have put forth, H.R. 2151, really
2 addresses the non-DSH supplemental payments. And this came from
3 the GAO's own report on we need transparency. I have a sign in
4 my office, In God we trust, all others bring data. We don't have
5 the data on the non-DSH supplemental payments.
6 And so, Ms. Iritani, I am assuming the bill that I am putting
7 forth, I am simply asking states, or not asking, requiring states
8 to do audits and CMS to do audits on non-DSH supplemental payments
9 as something GAO would support.
10 Ms. Iritani. Yes, we would agree that that bill is
11 consistent with our recommendations.
12 Mr. Collins. And really in learning from that I think all
13 of us would support payments going where they are supposed to,
14 but do you also have any data on the 50 states? I understand it
15 is very inconsistent from state to state. And the crazy thing
16 I have heard is I don't think New York does as much non-DSH
17 supplemental. Is that true? Do you know?
18 Ms. Iritani. I cannot speak to that right now, but be happy
19 to --
20 Mr. Collins. Yes, if you could get back to us it would be
21 interesting just to see as a percentage or absolute or both on
22 the non-DSH supplemental payments, and then that would also beg
23 the questions, and I think we would see, why variances from one

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1 state to the other? And it would beg the question, why is one
2 state doing one thing and another doing something else, but
3 without the audits how do we know?
4 Ms. Iritani. There are great variations among states in how
5 they finance their programs and the extent of supplemental
6 payments.
7 Mr. Collins. And just from a common sense standpoint it
8 doesn't make any sense to me. So I would certainly urge all my
9 colleagues to support that bill, H.R. 2151, which is simply trying
10 to gather data in a way that would help us all better understand
11 state by state even what is going on. So again, Mr. Chairman,
12 thank you for holding this hearing, and I yield back the balance
13 of my time.
14 Mr. Pitts. The chair thanks the gentleman. Ms. Schwartz,
15 did you want to add anything to that?
16 Ms. Schwartz. Well, I have some data here that show that
17 nationally supplemental payments as a share of inpatient and
18 outpatient hospital payment is about 44 percent, and in New York
19 it is 36.8 percent so it is below the national average. But the
20 figures go all over the place from two percent to there is several
21 states in the 80s and one or two in the 90s. So you are slightly
22 below the average, but like all things Medicaid it varies by state.
23 Mr. Collins. And I think again we could use some data to

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1 understand why that variation would be what it is. Thank you very
2 much.
3 Mr. Pitts. The chair thanks the gentleman and now
4 recognizes Mr. Griffith for five minutes.
5 Mr. Griffith. Thank you very much, Mr. Chairman. As we
6 have discussed in some of the prior testimony, the state may impose
7 a broad based health care tax on providers and use the revenue
8 raised from that tax to pay for the Medicaid program. Virginia
9 looked at that a couple of decades ago and it was rejected because
10 it was considered a sick tax or a bed tax and why would we want
11 to put more burden on those people who are already sick by having
12 a broad based tax on folks who are in the hospital?
13 But because of the way the FMAP works, the Federal Medicaid
14 Assistance Percentage, the effect of this is that a state can draw
15 down more and more federal spending in its Medicaid program.
16 Currently these provider taxes are permissible, as we talked about
17 earlier, if they are applied at a rate that produces revenues less
18 than or equal to six percent of the provider's net patient
19 revenues. Now I know, Ms. Schwartz, you said that is not
20 cheating, but from a Virginia perspective even though it is legal
21 it seems a little bit dicey that you get more money because you
22 charge your sick people more taxes, therefore you can get more
23 money drawn down from the federal government.

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1 Can you talk about any work that either MACPAC or GAO has
2 done to explore provider taxes to see how they are utilized by
3 the states and how they drive up the spending or how provider taxes
4 can create what we believe in Virginia is a perverse incentive
5 in Medicaid? Either of you all want to tackle that one?
6 Ms. Schwartz. We have written about provider taxes and
7 described the statute as you have and we have expressed, there
8 has been an expression of interest in learning more. But it is
9 a topic that is difficult to study because you are having to look
10 at the finances of the entire state and their tax structure. So
11 it is not one that we have a lot to offer now, but I am hopeful
12 that in the future we will have more information to be able to
13 share on that.
14 Mr. Griffith. Well, as Mr. Bucshon said earlier, maybe we
15 would be better off if we just decided what was the right amount
16 for each state and sent it back to them, and then you don't have
17 all these little games being played about we are going to charge
18 our people a sick tax so that we can then draw down more money.
19 I have introduced a bill, the Medicaid Tax Fairness Act,
20 which is co-sponsored by some of my colleagues on the committee,
21 Blackburn, Bucshon and Guthrie. It doesn't get to the whole
22 problem, but it does reduce the current provider tax threshold
23 from 6 percent to 5.5 percent which is what it was just a few years

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1 ago. What do you all think of that concept? And there is a
2 follow-up question too.
3 Ms. Iritani. We have looked at provider, states' uses of
4 provider taxes at a broad level, at a national level, and have
5 found that states are increasingly relying on provider taxes as
6 a source of the non-federal share of Medicaid. And we looked in
7 three states at arrangements where indeed there was an increase
8 in the Medicaid payments and some sort of contribution, for
9 example, through provider taxes from the same providers that were
10 receiving payments.
11 And so we would agree that there needs to be much more
12 transparency on what is reported. And with regard to your
13 proposal about reducing the provider tax that I would just note
14 that there have been several bodies including CMS in its budget
15 that have also suggested reducing provider taxes as a way to
16 improve the fiscal integrity of Medicaid.
17 Mr. Griffith. Yes, my bill is actually the first step, I
18 think, but it is H.R. 1400 and then we can go forward from there.
19 And what is interesting is, as folks on the other side of the aisle
20 will recognize, is oftentimes I am in conflict with the
21 Administration. But in December 2010, President Obama's fiscal
22 commission said Congress and the President should eliminate state
23 gaming of Medicaid tax gimmick. They recommended restricting and

1 eventually eliminating this practice.

2 While this policy would obviously need to be phased in
3 incrementally, does GAO or MACPAC, and I think you have already
4 answered it in part, but do either of you have a position on that
5 policy, and if not can you comment on benefits of reducing the
6 use of the provider taxes over time? And you may have
7 already answered it in your previous answer and I recognize that
8 but did want to get it out there that this is a bipartisan thought.
9 It is not something that we own just on the Republican side or
10 just on the Democrat side. But gaming the system moves money
11 around but it doesn't really help the sick folk. Comments?
12 Agree, disagree?

13 Ms. Schwartz. I would just say that from the Commission's
14 perspective that interest at the moment has been on transparency
15 and you need those data to be able to then evaluate different
16 policy options. The Commission as of this time has no position
17 on that.

18 Mr. Griffith. And I would just say at some point, and I
19 haven't introduced a bill and maybe I should, but at some point
20 we need to look at helping folks out. I had a little concept when
21 I was in the state legislature in Virginia that would allow folks
22 who needed medical care maybe not as intense as a nursing home,
23 but needed at least two things a day that were of assistance, and

1 we passed a law that -- North Carolina has a similar law -- that
2 would allow a medical cottage to be placed, a temporary to be
3 placed in a family member's backyard, side yard, whatever, worked
4 under the regular laws but it created a zoning exemption for that.
5 It might be a way that we can save money for folks all the
6 way around because it is cheaper than a nursing home but the person
7 is still getting care and they are with their family. I
8 appreciate it, Mr. Chairman. I appreciate the time, and I yield
9 back.
10 Mr. Pitts. The chair thanks the gentleman, and that
11 concludes the questions of the members present. As usual,
12 members who are in other hearings on our committee may have
13 questions who will submit those too in writing along with any
14 follow-up questions. We ask that you please respond promptly.
15 And I remind members that they have ten business days to submit
16 questions for the record, so members should submit their questions
17 by the close of business on Tuesday, November 17th.
18 Very interesting hearing examining various Medicaid
19 programs, a very complex issue. Thank you very much for your time
20 and testimony today. Without objection, the subcommittee is
21 adjourned.
22 [The Bill H.R. 2878 follows:]
23

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1 ********** INSERT 4 **********

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1 [The Bill H.R. 2151 follows:]

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3 ********** INSERT 5 **********

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1 [The Bill H.R. 1362 follows:]

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3 ********** INSERT 6 **********

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1 [The Bill H.R. 1361 follows:]

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3 ********** INSERT 7 **********

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1 [The Bill H.R. Quality Care for Moms and Babies follows:]

2

3 ********** INSERT 8 **********

**This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.**

1 [Whereupon, at 11:54 a.m., the subcommittee was adjourned.]