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STRENGTHENING MEDICAID AND PRIORITIZING THE MOST VULNERABLE

WEDNESDAY, FEBRUARY 1, 2017

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Present: Representatives Burgess, Guthrie, Barton, Upton, Shimkus, Murphy, Blackburn, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Eshoo, DeGette, and Pallone (ex officio).

Also present: Representatives Flores and Ruiz.

Staff present: Ray Baum, Staff Director; Mike Bloomquist, Deputy Staff Director; Elena Brennan, Legislative Clerk, Oversight and Investigation; Karen Christian, General Counsel; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Paul Edattel, Chief Counsel, Health; Blair Ellis, Digital Coordinator/Press Secretary; Caleb Graff, Policy Advisor; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Director of Communications; Peter Kielty, Deputy General Counsel; Katie McKeough, Press Assistant; James Paluskiewicz, Professional Staff, Health; Mark Ratner, Policy Coordinator; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Health Counsel, Health; Luke Wallwork, Staff Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Olivia Pham, Minority Health Fellow; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; C.J. Young, Minority Press Secretary.

Mr. Burgess. My gosh, everything is new up here. I have got all kinds of buttons. I can actually silence you, Mr. Green, if I need to.

Mr. Green. Mr. Chairman, you know I don't need a mike.

Mr. Burgess. Well, I want to welcome everyone of course back to the 2123. It is the best room in the Rayburn Building. Welcome you to the first Subcommittee of Health hearing for this year. It is likely to be a very active term in the United States Congress on health care.

There are members of the full committee who have asked to waive onto this committee for the purposes of this hearing, so I will ask unanimous consent for Dr. Ruiz when he gets here, but right now I will ask for unanimous consent for Mr. Flores to be on this committee. Without objection, so ordered.

I will recognize myself 5 minutes for the purpose of an opening statement. Medicaid, a state and federal partnership designed as a safety net for the country's most vulnerable has grown at a very rapid rate. Today's Medicaid program is three times larger by enrollment and by spending than it was in 1997 under President Bill Clinton. This safety net program will cover up to 98 million people this year and will cost the taxpayers more than $600 billion.

As a physician I have had the privilege of providing health

care for hundreds of Medicaid patients. I have looked into their eyes, I have listened to their concerns, I have held their hands, I have delivered their babies, and I know of their stories. Now I have the privilege of trying to help many patients like this by holding this chair and by working with each of you on the subcommittee and the full committee to improve and modernize the Medicaid program.

As we embark on a new Congress together, while I know we will have real differences, I hope we can agree on some shared goals to improve the Medicaid program to provide access and high quality care to those who truly need it. Today we will start by examining targeted common sense steps that can be taken to cut states' cost and prioritize care for vulnerable patients who are awaiting access to Medicaid services.

One of the bills we will consider addresses an area of concern that states have repeatedly requested to Congress that they examine. Individuals seeking Medicare coverage for long-term care must have assets below established thresholds to be eligible. Medicaid's treatment of married couples' resources has resulted in a loophole that allows the community spouse to shield assets by purchasing an annuity that is not counted against asset thresholds.

Representative Mullin has written the Close Annuity Loopholes in Medicaid Act to put a stop to this gaming of the

system. His bill would make half of the income generated from an annuity purchased by a community spouse within the 60-month look-back period that would count toward the institutionalized spouse's financial eligibility.

Another bill we will consider today originated with the state emailing the committee to express a concern. The Affordable Care Act required states to use the modified adjusted gross income for income calculations for determining Medicaid eligibility. Eligibility for Medicaid applicants is based on a monthly household income. Irregular income received as a lump sum such as a lottery or gambling winning, one-time gifts or inheritance is counted as income only in the month received. This means that lottery winners have been allowed to retain taxpayer-financed Medicaid coverage.

Representative Upton's bill would close this loophole. This bill would require states to consider monetary winnings from lotteries as if they were obtained over multiple months for the purposes of determining eligibility. This provides a scalable approach so individuals with high-dollar winnings are kept off the program for an appropriate time.

Finally, each of these bills we are considering allocate some portion of the dollars saved into the Medicaid Improvement Fund to be used for the purposes of improving access to care for the vulnerable and needy individuals currently on Medicaid waiting

lists.

While we will have additional hearings on Medicaid in the weeks and months to come, this hearing is focused on narrow issues and will cover bills that have been introduced in prior congresses. We all agree that it is important to secure care and keep our commitment to vulnerable Americans; I hope that we can begin by taking these small steps forward to put Medicaid spending on a sustainable path.

I would now like to yield the remaining time to Representative Flores to speak about his bill that we will be considering today.

[The statement of Mr. Burgess follows:]

**********COMMITTEE INSERT 1**********

Mr. Flores. Thank you for yielding, Chairman Burgess. Chairman Burgess and Ranking Member Green, thank you for having me here this morning for this important hearing. I appreciate the opportunity to work with you to strengthen Medicaid and prioritize health care for our most vulnerable citizens. I also want to thank each of our witnesses for being here today. It is crucial that we work to identify and prioritize the populations that stand to benefit most from reform to our current health care system.

Today a growing number of hardworking Americans are on Medicaid enrollment waiting lists in all 50 states. At the same time, other populations who do not qualify are enrolling in Medicaid and hurting access for our nation's truly vulnerable populations. The Verify Eligibility for Coverage Act before us this morning addresses this issue. This bill prioritizes our neediest Medicaid populations by not forcing states to provide coverage for new applicants in Medicaid until those applicants have provided satisfactory documentation of lawful presence in the United States.

Again I thank the chairman and ranking member. These Medicaid improvement bills before us today are reason for great optimism for our most vulnerable populations. Mr. Chairman, I yield back.

[The statement of Mr. Flores follows:]

**********COMMITTEE INSERT 2**********

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. It is not lost on me that we are meeting today, well, of course this is the Dingell Committee Room, but also known unofficially as the Green Room. So it is now the chair's privilege to recognize the subcommittee ranking member, Mr. Green, 5 minutes for an opening statement, please.

Mr. Green. Thank you, Mr. Chairman, and I appreciate that. I wish I could have -- it was my decision but I want to thank the previous chairman and the current chairman for leaving the beautiful green walls. Thank you, Mr. Chairman, and congratulations on your chairmanship. I look forward to continuing to work with you on issues. We have done that over the years.

Medicaid is a lifeline, the safety net for more than 74 million Americans who depend on it for coverage. One in every five Americans receive health coverage from the Medicaid including 12 million people who now have health insurance thanks to the Affordable Care Act's expansion of Medicaid for low-income adults. It is the primary health insurer for ten million Americans with disabilities, finances more than half the births, and is a main source of long-term care coverage. In fact, one in seven seniors on Medicaid and 70 percent of all nursing home residents rely on the program.

Today's hearing is entitled Strengthening Medicaid and

Prioritizing the Most Vulnerable. Medicaid is both strong and protects the vulnerable, and this idea of covering one population deemed less vulnerable as done at the expense of another more vulnerable population is just wrong both morally and factually. Health insurance is a right and coverage and benefits are not a zero-sum game.

The idea of pitting one population or one benefit in a program against another is a red herring. It is in a poorly disguised plot to limit access/benefits and punish low-income Americans by undermining the effectiveness of the program. Medicaid is a health care safety net for coverage and this notion of one group being more vulnerable and thereby we should take money away from the other types of beneficiary goes against the intent of the program.

Medicaid is strong. It provides comprehensive care at a lower cost than private insurance. It is true that total Medicaid spending has grown significantly, but increased coverage has been overwhelmingly the driver. Enrollment growth is a cause for celebration not a reason to undermine the program. It is baffling that we have a debate on whether a person having health insurance is a good thing.

A part of the enrollment growth is driven by the ACA's Medicaid expansion which has helped drive the uninsured rate to 8.6 percent, the lowest in our history. States that expanded

Medicaid have not only increased, seen increase in health coverage, but has also seen savings in their health budgets. Medicaid beneficiaries, those under a hundred percent of the federal poverty level and the expansion population which fall between 100 and 135 percent of federal poverty level, are not fat cats draining the system. For the overwhelming majority of them private insurance is not an option financially and Medicaid allows them to work more hours and care for their families and seek higher paying jobs.

More than 550,000 of my constituents fall into the Medicaid expansion gap because Texas refused to almost a $100 billion in federal money over a decade left them without an option. The idea that being uninsured is somehow better than having Medicaid flies in the face of simple logic. Being uninsured is a terrible situation. One illness can mean bankruptcy and the only point of access to care is through the emergency room.

But even if that doesn't persuade you, having a large number of uninsured population is bad for everyone, for folks with coverage through their employers by driving up premiums, physicians and hospitals and state budgets. I hear from constituents every day about how coverage has literally saved their life and would hear from more in Texas if it would stop engaging in legislative malpractice and act in the state's best interest.

Last Congress and the congresses before we worked together on meaningful strengthening of Medicaid, expanding benefits, shoring up program integrity, and streamlining the program. The proposal before us today score a savings because they will delay or deny coverage to some or redirect funds to states that choose to operate waiting lists for Medicaid home and community based services.

The idea that states have waiting lists because resources had to be diverted to expand Medicaid doesn't hold water. It is absolutely no correlation between states' coverage levels and waiting lists for home and community based services. Texas has the biggest waiting list in the country but didn't expand Medicaid, while 12 of the states that did expand operate no waiting lists for these services of any kind.

The right way to truly strengthen Medicaid for the future is to build on the ACA with expanded coverage, promoting program integrity and transparency and advanced delivery system reform in the program. I think every member of our committee is a problem solver. If we have a problem we want to deal with it. I am glad to work with anyone to solve problems, but we will fight with all our means to save the safety net of our low-income and oldest and youngest Americans.

I thank you, Mr. Chairman, and I yield back my time.

[The statement of Mr. Green follows:]

**********COMMITTEE INSERT 3**********

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair would ask unanimous consent that Dr. Ruiz be waived onto the subcommittee for the purpose of this hearing. Without objection, so ordered.

The chair now recognizes the chairman of the full committee, Mr. Walden, 5 minutes for an opening statement, please.

The. Chairman. Well, Mr. Chairman, thank you. And before the clock starts I just want to commend former Chairman Upton, I guess, on the color choice. And Mr. Green, I know that makes you happy. I hope what comes up next makes everyone happy because we have this new -- we have new electronics. Oh, look at that, the University of Oregon. That will now be a permanent feature since I thought it actually went with the green. Are you okay with that?

I would like to yield to the gentleman from Clackamas County. Is that all right, Kurt? I mean I can't get an orange one.

Mr. Schrader. Yes. No, I think this is a good example of how this committee is very bipartisan, sir.

The. Chairman. That is right. All right, thank you very much, Mr. Chairman. Thanks for your leadership. This does mark the first hearing of the Health Subcommittee in this new Congress with a physician heading the subcommittee and with other professional physical and mental health care providers in key roles. Let there be no mistaking our intention. We will

modernize America's health care laws by putting what is best for the patient as our top priority.

The days of putting overbearing, unaccountable Washington bureaucrats and their tens of thousands of pages of regulations first are over. Today we embark afresh on our efforts to strengthen, improve and modernize America's Medicaid program. We share a common goal of making sure that those most in need of medical services in our communities get better quality affordable care. That is our shared goal.

We are committed to protecting patients and to supporting innovative patient-centered solutions at the state and local levels. We recognize the Medicaid program is critically important. It is a safety net for millions of Americans, Americans who are elderly, Americans who are low-income, or Americans who are blind or have disabilities. Individuals and families served by Medicaid are not just program enrollees, they are our neighbors. They are our friends.

Today we begin our work to modernize Medicaid and we turn to experts who have researched creative strategies to give us guidance on what is working and what is not. We should view our states as partners in a common cause to bring about a fresh approach to a big government program that began a half a century ago or more when Washington bureaucrats thought they knew what was best.

I want to commend our Health Subcommittee who worked hard last Congress to identify and adopt measures which would improve access to care for patients, empower states with more flexibility and tools, and yield better care for patients, but no, that was just scratching the surface. Our talented and experienced witnesses today offer us a set of new ideas and they offer us their counsel and how we can improve our own members' bills. Thank you for your input.

You can sense an eagerness among governors whom I have met with, and state Medicaid directors and think tanks who for the first time in a long time realize they actually have a partner who is serious about hearing from them and working with them to transform the most expensive health care system in the world into the most modern patient-centered, outcome-based model known around the globe. That is our opportunity here. They are overflowing with better ways to deliver health care to our most needy citizens.

I have read all of your testimony, it is terrific, and I hope you have only just begun to give those ideas to us. We have an obligation to improve Medicaid. We can make it more than just our country's safety net that catches people when they are down and out. We can do better than that. We can empower states to innovate, to harness savings and enhance the actual health of the patients who have been waiting years for a Washington bureaucrat

to decide to throw the kill switch on every new idea.

The legislation we will consider today originates from our members listening to their constituents and state leaders back home who believe we have not done enough to root out waste, fraud and abuse. Our committee was reminded of that yesterday in the Oversight Subcommittee chaired by Mr. Murphy where we heard from the GAO and the HHS Office of Inspector General that for 14 years Medicaid has remained on the list of high-risk programs and that those tasked with identifying and preventing waste, fraud and abuse are still frustrated in their jobs because they cannot get the data, and the program's lack of transparency.

Prioritizing the most vulnerable and those in need necessarily requires setting priorities, so today we consider three proposals which make common sense changes to close loopholes, root out abuses and target savings to help patients most in need. A portion of those savings from each of these reforms would go to help individuals on Medicaid waiting lists for home and community based services.

These bills improve Medicaid. They help patients by scrapping outdated rules or correcting unintended consequences from existing federal policy. Consider this just the start of our work as we identify other red tape and outdated requirements that add costs and deny care to those truly in need. So in the months and weeks ahead we look forward to hearing from you and

others in our work because we want to give states more choices, more tools, more flexibility, all toward the goal of improving health care choices and affordability for patients.

With that I would yield to Markwayne Mullin the remainder of my time.

[The statement of The Chairman follows:]

**********COMMITTEE INSERT 4**********

Mr. Mullin. Thank you, Mr. Chairman. It is an honor to sit on the Health Subcommittee and I am looking forward to reforming health care with my colleagues in Congress. Our Medicaid system is in drastic need to reform. In my bill, Close the Annuity Loopholes in Medicaid, or the CALM Act, closes an obvious loophole. The CALM Act makes sure that individuals with significant means do not take advantage of Medicaid by hiding some of their assets.

Currently, some married couples are allowed to mask their assets by purchasing an annuity that pays out to their spouse. This also allows a couple to hide their true net worth when applying for Medicaid coverage. My bill closes the loophole and directs the savings to help those who are waiting for home and community based services. It is an easy loophole to close and I look forward to passing this with other Medicaid reform legislation to make Medicaid stronger. Thank you, Mr. Chairman, and I yield back.

[The statement of Mr. Mullin follows:]

**********COMMITTEE INSERT 5**********

Mr. Burgess. The chair thanks the gentleman and the gentleman yields back. The chair now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement, please.

Mr. Pallone. Thank you, Mr. Chairman. Since 1965, the Medicaid program has been an invaluable resource to poor families, pregnant women, children, seniors, and now thanks to the Affordable Care Act low-income working adults. It is also the program that individuals with disabilities depend on to maintain independence in the community. In 2016, over 97 million Americans depended on Medicaid at some point during the year. Together, Medicaid and CHIP cover one in three children in this country and nearly half of all births. It is undeniable that Medicaid coverage pays us back as a society tenfold and that is why improving and strengthening Medicaid for generations to come continues to be one of our primary goals.

Last Congress this committee worked together on targeted policies that generally strengthen and improve the Medicaid program for beneficiaries. Unfortunately the bills before us today do not share these priorities. In fact, one piece of legislation continues the Trump administration's assault against our legal permanent resident population and naturalized citizens.

The Republican strategy to strengthen Medicaid is to remove or exclude certain people from the program and then apply those

resources to another person and this is a meaningless approach to resource management. There is no evidence to suggest that some beneficiaries take away resources from others or that excluding some beneficiaries will benefit others.

In today's hearing we will discuss three bills that are based on this very falsehood, bills that target specific beneficiaries for exclusion, bills that ultimately incentivize and reward those states that choose to operate waiting lists for home and community based services. In order to truly strengthen the Medicaid program we should expand coverage, protect against fraud and implement advanced delivery system reform, and the Affordable Care Act did just that. Thanks to the Affordable Care Act, 31 states and the District of Columbia have adopted expansion and dramatically lowered the uninsured rate.

All 50 states are testing innovative models of care and Medicaid eligibility and data collection systems have been modernized. Medicaid has always been under attack by Republicans, but the threat to this program and to its beneficiaries is more dangerous than ever before. Republican policies to cap or turn the program into a block grant would result in the rug being pulled out from under millions of children, elderly, individuals with disabilities, and low-income working adults.

These policies are nothing but bad for our providers and our

state economics. In fact, one analysis by the Kaiser Family Foundation found that block-granting Medicaid would lead states to drop between 14.3 million and 20.5 million people from Medicaid, an enrollment decline of 25 to 35 percent, and would lead states to cut provider reimbursements by more than 30 percent.

Now I know my Republican colleagues keep saying they have a plan and that Americans will not lose their health coverage. But I think it is clear today that the Republicans' only game plan right now is to sabotage health coverage for tens of millions of Americans. I yield the remaining time to Mr. Lujan from New Mexico.

[The statement of Mr. Pallone follows:]

**********COMMITTEE INSERT 6**********

Mr. Lujan. Thank you, Mr. Pallone. Hypocrisy isn't a term that I use lightly. Unfortunately today hypocrisy is the word that readily comes to mind. Let's start with the Republican title of this hearing, Strengthening Medicaid and Prioritizing the Most Vulnerable. Actions speak louder than words. Let's talk about what this hearing is really all about. My Republican colleagues are holding this hearing to lay the groundwork for ripping health insurance from millions of Americans.

Now I believe that access to affordable and quality health care is a right for all, not a privilege for some. We would be never be having a conversation like this if the topic wasn't Medicaid. If we were having a hearing on Medicare we would be talking about real ways to better serve beneficiaries, yet when it comes to health care for working families struggling to make ends meet, mainly those on Medicaid, all my Republican friends do is talk about how to cut-cut-cut and strip away access to care from millions of Americans.

Gutting Medicaid would be a disaster for 74 million Americans including nearly a million New Mexicans. Why would anyone want a less healthy country? And just listen to the argument my Republican colleagues are making, fewer people having health insurance and access to care is good for America. It is bad for America, a country with fewer health care jobs and a country with more working class families that could lose everything because

of a health emergency like a car accident or a cancer diagnosis.

I have to believe this comes down to the fact that the leaders of the Grand Old Party don't think that some people are grand enough to deserve health care. That is wrong. And that is why the cloud of hypocrisy hangs over these discussions today and every day that we continue to discuss Medicaid solely through the lens of what Republicans can cut and how we can improve things for those millions of seniors and working families served by this program. With that I yield back.

[The statement of Mr. Lujan follows:]

**********COMMITTEE INSERT 7**********

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. This concludes member opening statements. The chair would remind members that pursuant to committee rules, all members' opening statements will be made part of the record.

And we do want to thank our witnesses for being here this morning taking of your time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement and this will be followed by a round of questions from members. Our witnesses this morning are Dr. Avik Roy, the president of the Foundation for Research on Equal Opportunity; Mr. John McCarthy, the former director of the Ohio Department of Medicaid and the former deputy director of the DC Department of Health Care Finance; and Ms. Judith Solomon, vice president for health policy at the Center on Budget and Policy Priorities.

We do appreciate each of you being here today. We will begin the panel with Dr. Roy, and you are recognized for 5 minutes for the purpose of summarizing your opening statement, please.

STATEMENTS OF AVIK S. A. ROY, PRESIDENT, FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY; JOHN McCARTHY, CEO OF UPSHUR STREET CONSULTING; AND JUDITH SOLOMON, VICE PRESIDENT, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF AVIK S. A. ROY

Mr. Roy. Thank you, Mr. Chairman, Chairman Burgess and Chairman Walden, Ranking Member Green, members of the Health Subcommittee of the Energy and Commerce Committee. Thanks for inviting me here today for your premier hearing as chairman.

My name is Avik Roy. I am the president of the Foundation for Research on Equal Opportunity, a nonpartisan, nonprofit think tank focused on expanding economic opportunity to those who least have it. In my remarks I will discuss Medicaid's poor health outcomes. I will describe why the program's outdated design is directly responsible for those outcomes and I will explore some avenues for reform.

Studies consistently show that patients on Medicaid have the worst health outcomes of any insurance program in America, far worse than those with private insurance and, strikingly, no better than those with no insurance at all. It seems inconceivable that we could spend $450 billion a year on Medicaid without any improvement in health outcomes on average, but the evidence is overwhelming and it is detailed in my written testimony.

Why do patients fare so poorly on Medicaid? The key reason is that Medicaid pays physicians far below market rates to care for Medicaid beneficiaries. In 2008, according to CMS, Medicaid paid physicians approximately 58 percent of what private insurers pay them for comparable services. These disparities have only increased over the ensuing decade. Surprisingly, a 2007 study by MIT economists Jonathan Gruber and David Rodriguez found that doctors fare even better treating the uninsured, economically, than they do caring for those on Medicaid because getting paid in cash by the uninsured is better than getting paid through Medicaid.

As a result of these disparities in reimbursement, fewer physicians accept Medicaid enrolled patients. Internists are 8.5 times as likely to refuse to accept any Medicaid patients relative to those with private insurance. Physicians are six times more likely to deny an appointment to children on Medicaid suffering from serious medical conditions like a broken arm or an acute asthma attack relative to those with private insurance. Without consistent access to physicians, Medicaid enrollees don't get their cancer diagnosed until it is too late, they don't receive adequate care for problems like diabetes and heart disease until it is too late.

So why is it that Medicaid's reimbursement rates are so low? It is because of the flawed way in which the program was designed

in 1965. Medicaid as you know is jointly funded by state governments and the federal government, but because neither states nor Washington have full responsibility for the program both parties have engaged in irresponsible behavior.

As Medicaid has grown over time, state budgets have come under increasing strain. States' Medicaid obligations now crowd out spending on teachers, police and roads. But it is mostly illegal for states to increase co-pays, deductibles or premiums for Medicaid enrollees. Moving people off of the Medicaid rolls is highly controversial, and most attempts by state governments to enact minor programmatic changes must survive as you know this lengthy waiver process with HHS.

Federal law in some cases forces states to spend Medicaid dollars on people who don't need the help. For example, lottery winners who receive a lump sum payment in 1 month but have zero income for the rest of the year are eligible for Medicaid 11 months out of 12. Individuals whose spouses receive large annuities remain eligible in some cases for the Medicaid long-term care program.

Federal law also requires states to provide Medicaid funds to new enrollees for a period of time even if they have not documented that they legally reside in the U.S. and are therefore eligible for such funds. These provisions put additional pressure on states to reduce Medicaid spending and reimbursement

rates for the vulnerable populations that the program was designed to help. The vast majority of states have responded to these constraints in exactly that way by reducing Medicaid's reimbursement rates to health care providers, paying hospitals and doctors less for the same level of service.

The Health Subcommittee is considering legislation that would address some of these problems and I look forward to exploring those ideas with you at this hearing. I know that many of you believe as I do that we can do much more to improve the quality of care and coverage for Americans below the poverty line.

At the Foundation for Research on Equal Opportunity, we have published a detailed and wide-ranging health reform proposal called Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency. We estimate that the plan would cover 12 million more people than current law, dramatically improve health outcomes for the poor by taking the dollars we spend on acute care Medicaid and giving them to patients in the form of refundable tax credits that can be used to purchase private coverage and build Health Savings Accounts.

Per capita caps, a reform contemplated by this subcommittee, can also be structured in a similar way. Aside from the fact that private coverage is superior to Medicaid coverage, integrating Medicaid enrollees into an individual health insurance coverage

will ensure that as their incomes go up and down they can remain in one insurance plan in one physician network and thereby gain a continuity of care that they do not have in today's system.

This Congress has a once-in-a-generation opportunity to transform the quality of coverage and care that we offer to the neediest amongst us. I look forward to your questions and to being of further assistance to this committee. Thank you.

[The statement of Avik S. A. Roy follows:]

**********INSERT 8**********

Mr. Burgess. The chair thanks the gentleman and the chair recognizes Mr. McCarthy 5 minutes for your opening statement, please.

STATEMENT OF JOHN McCARTHY

Mr. McCarthy. Good morning, Chairman Burgess, Ranking Member Green and distinguished members of the subcommittee. I am John McCarthy, currently the CEO of Upshur Street Consulting. I recently stepped down from the position of Medicaid director for the State of Ohio and previous to that was the Medicaid director for the District of Columbia. I appreciate this opportunity to share my recommendations for strengthening the Medicaid program.

The three bills that are up for discussion began to address some common sense reforms to eligibility requirements for the Medicaid program. Having recently served as the vice president on the board of directors for the National Association of Medicaid Directors, I know that it is important to Medicaid directors that the integrity of the program is maintained to make the program financially viable to serve those who qualify. These three bills promise to move the program in that direction.

First, the discussion draft of Prioritizing the Most Vulnerable Over Lottery Winners Act of 2017 would place reasonable exclusion periods for Medicaid eligibility when a person wins the lottery. Limiting Medicaid eligibility for lottery winners is an eligibility change that many support and a policy change I advocated for the last few years.

Second, the discussion draft of the Close Annuity Loopholes in Medicaid Act requires a state to apply half of an annuity's payout to the spouse that is not institutionalized to the income of the spouse that is institutionalized and applying for Medicaid. Ensuring that Medicaid eligibility is limited to people without resources to pay for long-term services and supports, or LTSS, instead of also covering those who can shelter their resources would be an important improvement.

For most states the greatest spending per person is for the aged, blind and disabled population who are the greatest users of LTSS, so this is an important area to carefully explore. However, the bill does have some technical issues that need further examination. For example, the institutionalized spouse could purchase the annuity and then name the spouse the annuitant and avoid assigning half of the payment to the institutionalized spouse. Because this area of Medicaid policy is so complex, a very close analysis of this issue is needed to ensure the problem is fully addressed.

Lastly, the Verify Eligibility for Coverage Act eliminates federal dollars being used on services before a person proves their citizenship or immigration status. This change would provide the person requesting eligibility with an incentive to produce documentation as quickly as possible and help to ensure federal dollars are not spent on individuals who do not qualify

for the program.

All the bills include the creation of the Medicaid Improvement Fund. The main stated goal of this fund is to reduce waiting lists for home and community based service waivers. I agree that this is an important issue. It was one of the goals of the first Kasich administration budget to eliminate the wait list for the PASSPORT waiver which serves people over the age of 60.

We eliminated that wait list and reduced the number of nursing home bed-days that were paid for which in turn led to over $1 billion in savings over 4 fiscal years. A small initial investment was needed, but in the long term this offered a cost savings. However, this cost savings is only realized for cases in which there is a diversion from an institution.

If the person who is on the wait list is never institutionalized, the Medicaid program is likely to have lower expenditures than HCBS would entail. That does not necessarily mean that the person does not have the care he or she needs, the person may be enrolled in the Medicaid program and receiving some amount of state plan services at home and additional services may be provided by non-paid caregivers or from services paid by local dollars. This program therefore will need to be carefully managed so that costs do not grow uncontrollably. In particular, in caution I offer that since this bill creates a competitive

program with priority given to states with the highest number of people on wait lists that provides an incentive to a state to have higher wait lists.

Other methods for determining the appropriate funding level per state should be explored in order to manage the cost of the change. One alternative may be to tie the proposal to the Money Follows the Person program and provide financial incentive to states to move people out of institutions and back into the community. Another option may be to have the dollars proposed -- the Medicare program needs reform. There is simply too much unneeded and overly burdensome regulation that has been promulgated over the last few years and that does not provide a benefit to beneficiaries.

The new Access to Care Regulation and the Managed Care Mega Rule are just two examples. The Access to Care Regulation was a backdoor method to take away the ability for a state to set reimbursement rates for providers by putting that authority in the Centers for Medicare and Medicaid Services' hands. The amount of information that is requested by CMS, such as surveys of providers and private sector rate data, is not a true measure of adequacy of the proposal. Additionally, the staff time needed to complete this work pulls the staff away from more impactful tasks such as implementing value-based purchasing.

The areas in need of reform that I have laid out above are

only a subset of issues that are currently not working optimally in the Medicaid program. I do not have enough time today to go through all the areas. A good resource to use on what reforms are needed is the document published by NAMD, the National Association of Medicaid Directors legislative priorities for 2017. However, for real reform the fundamental role of CMS must be rethought. Currently it acts as a regulator for states. It should shift into the role of a payer and oversee the program. Instead of telling a state how much a state should reimburse providers, CMS should monitor health outcomes.

With that, in conclusion, the Medicaid program is in need of reform. We need to think of new ways to oversee this program, and I am happy to answer any questions.

[The statement of John McCarthy follows:]

**********INSERT 9**********

Mr. Burgess. The chair thanks the gentleman and the gentleman yields back. Ms. Solomon, you are recognized for 5 minutes for the purpose of an opening statement.

STATEMENT OF JUDITH SOLOMON

Ms. Solomon. Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee. I am really happy to be here to testify today. I am Judith Solomon, vice president for health policy at the Center on Budget and Policy Priorities. I am going to cover three things in my statement, provide some background on home and community based service waivers which I will refer to as HCBS, talk about how they work, explain why there are waiting lists, and briefly discuss how waiting lists should and should not be addressed.

HCBS waivers became available in Medicaid in 1981 to give states a way to provide long-term care in people's homes. Up until then because skilled nursing care and home health have been mandatory services in Medicaid there was a bias towards institutional care. Families often had to face the dilemma that the only way they could get their loved ones the care they needed was to put them in a nursing home.

HCBS waivers gave states new ways to address the needs of children, adults with disabilities and seniors. States can make people eligible for Medicaid who would only be eligible in a nursing home and create packages of services specifically designed to allow them to stay at home. These include home modifications, respite care and enhanced home health services.

Progress has been dramatic. In 2013, for the first time over half of long-term services and supports were for HCBS rather than for institutional care, and there is Figure 1 in my testimony shows that trajectory.

So why are there waiting lists? Well, HCBS waivers are the epitome of flexibility in Medicaid. States can target waivers to people with intellectual and developmental disabilities, seniors, people with HIV/AIDS and people with traumatic brain injury, and they can create packages of services that are specifically designed for the group they select. According to CMS there are now over 275 waiver programs nationally serving well over a million people.

Part of the flexibility states have is to limit their waivers to a defined number of slots and create waiting lists. The flexibility was important to states when these waivers were created because the waivers are expensive and states were concerned that the demand would just put them in the red. So the number of people on waiting lists shows that demand. They have grown every year going back to the data I have in my testimony to 2005, well before the Medicaid expansion. They have grown it an average rate of 14 percent a year and there is significant variation across states.

Eleven states and the District of Columbia have no waiting lists, and of these states without waiting lists only two haven't

expanded Medicaid, Maine and Missouri. The two states as was mentioned with the longest waiting lists are Texas and Florida which have not expanded Medicaid. Another fact that is often overlooked is that people on waiting lists, the vast majority, are actually getting Medicaid so they are getting other services. The specialized services are very important to them but they aren't being left without the core services that Medicaid provides.

So how do we deal with waiting lists? We all, you know, certainly at CBPP we join the goal of people here to decrease them, but we think there are better ways to address the waiting lists than by taking savings from the three bills before you today to provide enhanced federal funds for states with the longest waiting lists.

It would be much fairer to all states to provide incentives to enhance the provision of home and community based services which could include metrics to measure state progress. This could include continued funding for the Money Follows the Person program and the balancing incentive programs for which both the funding has expired. These were initiatives that have allowed states to make progress. The concern, and I think Mr. McCarthy said it as well is, you know, by rewarding states with the highest waiting lists with higher match you really almost encourage states to grow their waiting lists.

So in closing though I would like to note what I think the real threat to Medicaid is and to home and community based services specifically. The most recent House budget plan would have given states the choice of a block grant or per capita cap to achieve cuts in federal Medicaid funding of $1 trillion over 10 years, cutting the program by 30 percent in the 10th year and then even more in the decades after this. Cuts of this magnitude would likely lead to huge increases in waiting lists or elimination of the programs altogether because these are optional for states.

I thank you, I look forward to answering your questions about this and also about the bills. I can talk about those as well.

[The statement of Judith Solomon follows:]

**********INSERT 10**********

Mr. Burgess. The chair thanks the gentlelady. I really thank all of our witnesses for being with us today. This brings us to the question portion of the hearing and I am going to begin the questioning by recognizing myself for 5 minutes.

Dr. Roy, Mr. Flores has a bill before us today that would require individuals to provide documentation of their citizenship or lawful status before the states begin covering them. Is this in fact a problem? Is this an area where regulation needs to be perhaps tightened up a little bit?

Mr. Roy. If you talk to state Medicaid directors and other people at the state level they will say that this is a significant expenditure for them. And I am not aware of a CBO score for the previous -- I know there has been a bill that has been scored previously along these lines, but I want to say at least several hundred million dollars potentially could be saved by ensuring you are dedicating Medicaid resource to people who are legally resident of the country and you don't have these windows where people who aren't documented are getting those benefits.

Mr. Burgess. And just as a consequence of that there is no way to retrieve those dollars once they have been spent, once they go out the door they are gone?

Mr. Roy. They are gone. And as I mentioned both in my written testimony and my oral testimony, to me the biggest challenge is what we see is most states when they face a cost crunch

what do they do, they lower reimbursement rates to providers, particularly physicians, which ends up in particular harming access to care for the people who are enrolled in the program who are eligible for the program in reality.

Mr. Burgess. And I appreciate your comments on that.

Mr. McCarthy, under the Affordable Care Act of course expanded Medicaid and the expansion populations were eligible for a federal match of 95 percent this year, tapers down to 90 percent in 2020 under current law. And there has been a concern expressed because a state that expanded is paying a smaller portion of the cost for care of the expansion population, in times of a budget crunch the incentive would be for a state to reduce services or benefits for the traditional population. Can you talk about the degree do you think that this is a fair concern?

Mr. McCarthy. Mr. Chairman, every state is different. They all make their different decisions. I would say that depending on where a state is and the number of advocates in that state for different services you would have to look at those things.

I would agree with Dr. Roy that the first place a state would probably look is at reimbursement rates rather than looking at eliminating services for individuals. It partially goes back to what I was talking about on home and community based services. If you, for instance in Ohio where we had a waiting list for our PASSPORT program, which was our waiver for individuals who are

aged above the age of 60, the service that they could get is nursing home. But we had a 20 percent nursing home vacancy when I began that role, so where a person would end up is just in that higher cost service anyway so just further driving up the cost of the program.

So that is the home and community based services we wanted to keep in place because that actually saved us a large amount of money. Actually, if you look at the Ohio program and you look at the number of people age 65 or older in January of 2011 when the Kasich administration came into office and you just looked at how that actually grew the number of the people in the program and then you plotted against that a line of the number of nursing home bed-days that we paid for, that line actually went down.

So that is what generated that savings in there so we used that savings to go back into the program to do that. So I understand your question of, well, it is only ten percent and we wouldn't get savings but at the same time the other costs are pretty large also. You know, we hadn't talked about duals population. That was for us in Ohio was a huge portion of the costs and growing costs. Also the Medicare growing costs that we had, so our Part D and Part B expenditures for this budget that just got put in ate up almost our entire growth of the Medicaid state share of the budget.

So there is a lot of moving pieces in there. I am not sure

of going to where there would be cuts in services would be the first place probably would be in provider reimbursement.

Mr. Burgess. Which in turn has a deleterious effect downstream which Dr. Roy has detailed. Let me yield back my time and I will recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for questions, please.

Mr. Green. Thank you, Mr. Chairman. Multiple studies show that Medicaid is a lean and high-performing program that provides access to quality health care for those who need it the most. Unfortunately the bills we are discussing here today are rushed and not well thought out and could undermine the program and its beneficiaries. Medicaid matters and it works. I think we have been in an audience to alternative facts and skewed in some of the testimony we have heard.

I would like to use my time to ask Ms. Solomon questions to help set the record straight. Ms. Solomon, what are the benefits of having Medicaid coverage? I read in a recent study that the folks are literally dying while waiting for Medicaid expansion, yet we hear from some that it would be better to be uninsured than have Medicaid. I would like to see if you can debunk that myth that it is better to be uninsured than to have Medicaid.

Ms. Solomon. Thank you. I think that it is very clear and the data on access show that Medicaid patients have a usual source of care at rates approaching that of privately insured and double

that of uninsured people. I think the studies that Dr. Roy has cited are really looking at people with serious illness and comparing people on Medicaid to others, and it is really unclear where they were. Were they insured before they got sick? And the expansion, what the expansion has done has allowed that to happen. So if we look at this, you know, 10, 20 years from now assuming we stay steady, I think we would see a very different picture.

And I think what has happened in Louisiana where they are really documenting it is amazing. They have a dashboard that shows kind of how many cases of breast cancer have been diagnosed from their expansion that just started actually last year, how many cases of colon cancer, how many cases of diabetes and hypertension. You can look at that up to the minute.

And what you are seeing is that in that expansion population that now has access to care, people are getting the exams and they are finding those things so that when people do have cancer and need surgery their outcomes will likely be better because they were covered up until the time that they got sick. Before the expansion you either had to be a very, very low income parent, a senior, a person with a disability, a severe disability. So what the expansion does is really open the door to allow access to care for everybody who can't afford to purchase coverage on their own.

Mr. Green. Can you describe access to care in the Medicaid program, for instance the timeliness in which Medicaid patients are able to make an appointment with a primary care doctor? Are Medicaid patients generally satisfied with their care? Have there been studies on that?

Ms. Solomon. Yes. I mean I think there is high levels of satisfaction. And again, a study from researchers at the Urban Institute showed that timely care was at about 78 percent of people reported they could get care in a timely manner. And that again compared favorably with patients that were insured, and people that were uninsured had obviously a much harder time getting care they needed when they needed it.

Mr. Green. Do you believe that the Medicaid program will be able to serve the same number of people with the same quality and same benefits if the program were converted to a capped or a block grant program? How would states adjust to a capped or block grant system?

Ms. Solomon. It is impossible. With the level of those cuts the Urban Institute -- and a prior proposal -- estimated a loss of 14 to 21 million people covered by the program by the, you know, after a few years. It is just impossible to serve the same number of people when you are making a cut of that magnitude. And I think over time, you know, you would see cuts in provider payments. You would see, but you would see other things as well.

You would see cuts in eligibility, you would see cuts in benefits.

And I think, you know, when we are talking about home and community based services you have to think about it from the perspective of you have people in nursing homes that is not, you know, you are not going to be able to turn those people out of nursing homes so where are the cuts going to be made? I think the home and community based services are particularly vulnerable as the topic of today that it is worth highlighting.

Mr. Green. Thank you. Mr. Chairman, given some of Ms. Solomon's answers I would like to submit to research studies for the record. The first study, the research that covers reducing mortality as evidence from states that expanded Medicaid prior to the ACA; and second, Mr. Chairman, illustrates the bipartisan support of the Medicaid program in the ACA expansion by both Republicans and Democratic governors. I ask unanimous consent to put those in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 11**********

Mr. Green. And I yield back my time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the chairman of the full committee, Mr. Walden, 5 minutes for questions, please.

The. Chairman. Thank you very much, Dr. Burgess, appreciate it.

Dr. Roy, I was intrigued by your, well, all of your testimonies, I read it all. It was all very helpful. I am curious, Dr. Roy, do you think it is appropriate for millionaires, maybe billionaires, to receive Medicaid while at the same time we do have people waiting for care? I mean I know we heard that there is nothing to that, but indeed we have heard from states.

I have heard from Medicaid directors, I have heard from governors. They would just like the flexibility to close what some would say is a loophole that allows somebody to get a windfall. It is not just the lottery winner but it could be and it is in some cases, and then the way the rules are written they still qualify for Medicaid when actually they are flush with money. Do you think we ought to close that loophole? Does that harm somebody?

Mr. Roy. I entirely agree with that Mr. Chairman, and let me take a minute to respectfully correct the record in terms of what Mr. Green did to characterize, how he characterized my remarks. I didn't say that Medicaid beneficiaries were worse off

than people with private insurance, I said they were no better off based on the gold standard research which comes from work that was published in the New England Journal of Medicine not known as a sort of alternative facts.

The. Chairman. It is actually a peer-reviewed journal of high renown, right?

Mr. Roy. Absolutely. And my written testimony contains 14 footnotes from peer-reviewed journals that discuss Medicaid help, how it comes in and the challenges thereof.

The. Chairman. See, and I approach this from the fact that why aren't we looking at the science, why aren't we looking at the peer-reviewed journal and saying, okay, what is wrong there and how do we fix it?

Mr. Roy. Absolutely. And, you know, this is one of the things that I hope that this committee can do in a bipartisan way is say look, this is not about a debate about whether we should provide and subsidize and help people who need --

The. Chairman. Correct.

Mr. Roy. -- health insurance who are poor, it is what is the best way to do that.

The. Chairman. Right.

Mr. Roy. And I firmly believe that the best way to do that is through giving those patients more control over the health care dollars that are spent on their behalf. You get less waste and

fraud, more accountability and more innovation in the delivery of health care.

The. Chairman. And, you know, in the meetings I have had with governors, just to continue this, they are begging for that flexibility at the state and local level. They are the ones that are managing and helping these patients. They have talked to me about really impressive things like, what was it, the high-risk assessments where they get around a person and say this is a person with a lot of issues going on.

They may need this kind of health care, this kind of mental health care, they may actually need some modification of their house and yet they have to come beg Washington and some bureaucrat back here to get a waiver to do this that or the other thing or they can't plow the savings in to continue to expand and improve the patient's health.

I have always approached this having been on a local hospital board and then working on this stuff in Oregon that you start with the patient and if you get your hands around it that is where I see it is going trying to devolve some of the decision making back to the states. Are there other examples that you have run across in your work where states have had innovative ideas and yet can't get past somebody back here in Washington to be able to implement it that would improve, improve patient care?

Mr. Roy. We could spend all day talking about innovative

ideas at the state level that have been stymied by CMS. One I can bring up is the Healthy Indiana program in Indiana. When it was first installed by then governor Mitch Daniels, they tried to do some very simple things to install a larger co-pay if you use the emergency department for non-urgent medical needs and instead they tried to create financial incentives for Medicaid enrollees to go to urgent care clinics or primary care physicians for those issues. They couldn't do it because it is contrary to the Medicaid statute passed by Congress in 1965. They can't even get a waiver for that because the statute itself forbids those practices.

I can tell you it is not just policymakers at the state level who are concerned about these problems. If you have ever spoken to a patient who has spent a week trying to get a doctor's appointment for their child or for themselves and can't do it because so many physicians don't take Medicaid, those are heartbreaking stories.

The. Chairman. And don't your peer review data also show that?

Mr. Roy. Yes.

The. Chairman. That the wait times are longer for Medicaid patients than for others, it is a fairly significant wait-time differential, right?

Mr. Roy. Absolutely. And again in my written testimony I

have referenced to some of that literature.

The. Chairman. I know in conversation I had with Governor, I think it is Governor Herbert from Utah talked about trying to be able to communicate with Medicaid patients in Utah by email, apparently some new and novel communication technique. He had to appeal to Washington to get a waiver, waited months, only to get an email from Washington saying no, sorry, you can't do that.

Now I don't know what else was all involved there, but I assume they would have a backstop. If they didn't have email you would still do other ways to communicate because not everybody does, but that struck me as something pretty bizarre. Do you run into those sorts of things? Is that -- is he unique?

Mr. Roy. I mean every Medicaid director, Democrat or Republican, has stories like that. It is a huge problem. And again this is why it is not only important to give states more flexibility in how they manage these populations, but it is also important to give individuals more flexibility --

The. Chairman. There you go.

Mr. Roy. -- in how they use their health care dollars.

The. Chairman. Back to a patient-doctor, patient-provider system. I have used up my time. Thank you very much, all of you, for your comments, counsel and testimony. I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from New

Jersey, Mr. Pallone, 5 minutes for questions, please.

Mr. Pallone. Thank you, Mr. Chairman. My questions are to Ms. Solomon. There is a lot of misinformation, or maybe alternate facts is a better word, about Medicaid that continues despite all evidence to the contrary, so I would like you to help us set the record straight, Ms. Solomon. What do you say to claims that the Medicaid expansion funding threatens the truly vulnerable? Can you clarify why that is not the case?

Ms. Solomon. Yes, thank you, Mr. Pallone. As I said in my written testimony, there really is just no correlation. And I think this was explored at the hearing yesterday and resolved that the states with the biggest waiting lists have not expanded. The states that don't have waiting lists in large part have expanded.

Another metric is the state option that the Affordable Care Act gave states to actually provide HCBS services without a waiver. Eighteen states have taken that up. The option actually doesn't allow waiting lists, so this is opening up programs to everyone who qualifies. Eighteen states, fourteen are states that have expanded. So I think what you see, you know, Texas unfortunately has one-third of the people, all the people on the waiting list is really no correlation between wait lists and the decision whether or not to expand. They are totally independent.

Mr. Pallone. All right. And in a similar vein, Mr. Roy claims that Medicaid is simply fiscally unsustainable due in part

to the Medicaid expansion under the ACA. Can you clarify why this is not the case? Why have most states that have expanded Medicaid for instance actually experienced net budgetary savings associated with the expansion?

Ms. Solomon. I mean it is true and they have documented them. New Jersey, for example, has put out reports and they have saved money in a variety of ways, primarily by lowering their payments for uncompensated care through hospitals and other providers as Medicaid has picked that up. They have also been able to better utilize the services that they have already been providing to people with behavioral health conditions, mental health and substance use disorders.

And that is where the expansion -- and I know it is really true in Ohio -- has been particularly helpful in dealing with the opioid epidemic in allowing states to use their own dollars more effectively to wrap around services for people, for example, who are chronically homeless, and address the social determinates of health recognizing that health care is only a small part of what is going to keep very low income and vulnerable people healthy.

Mr. Pallone. And Ms. Solomon, over the past 2 days in this committee we have heard from some sources that Medicaid expansion discourages work. It is my understanding that numerous studies have disproven the myth that Medicaid expansion diminishes work incentives and I want to know if that is correct. But also,

furthermore, several states that expanded Medicaid have found that the expansion populations have not experienced greater job losses or work reduction, so would you comment on those?

Ms. Solomon. That is absolutely right. And I think what the Medicaid expansion has been shown to do is allow people to work and to have greater earnings knowing that they can then transition to the marketplace and get subsidies or, you know, assuming their employer doesn't provide work. The other thing that is really important particularly for people who have mental health and substance use disorders is that states are creating supported work programs so that they are able through Medicaid to provide the supports that people need to help them get a job and stay employed.

And Medicaid has been able to do that not only for people with disabilities in the disability category but also for people in the expansion. You know, most of the people that are getting expansion coverage actually are people who are working but they are working in low wage jobs or part-time jobs or multiple part-time jobs that don't provide coverage. So Medicaid allows them to get the care they need to stay employed and to remain healthy, so it is a work support not a work discourager, I would say.

Mr. Pallone. And then also the studies have found that Medicaid expansion likely improves the financial situation of

those who gained Medicaid coverage under the ACA including reducing unpaid bills and medical debts. Just a few seconds left, if you could comment on that.

Ms. Solomon. Absolutely. A National Bureau of Economic Research study shows that a dramatic fall-off in people with debt sent to third-party collections in states that have expanded Medicaid compared to states that haven't.

Mr. Pallone. Thank you. Thank you, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The chair recognizes the gentleman from Kentucky, the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thanks. My first question is for Mr. McCarthy. There is a new CRS memo, CMS Collections of Information from States under the Medicaid Program that tallies the burden states face when complying with CMS requirements under current law. Mr. Chairman, I request unanimous consent this be placed in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 12**********

Mr. Guthrie. This new memo shows that the reporting burden is higher than many people probably appreciate. One thing I have heard a lot over the past year is that CMS collects information from states but it is often focused on the wrong issues and it is not clear what CMS even does sometimes with the information reported. I mean we don't even have good data matching expenditures by category of service to beneficiaries, and everyone knows how bad Medicaid data is.

I strongly believe in accountability for states, but I wonder if CMS has been focused on the wrong things at times. What reporting requirements do you think add costs and not value and what could we cut back on without negatively impacting accountability?

Mr. McCarthy. I think what needs to be done is going through all of those reports that are identified in there to determine what information it is needed and how it will be used going forward. It is the same thing we did at the state when we came in. We looked at all the different reports we had and decided one way, should we keep the report or should we get rid of the report or is there something in there that we need?

Often at the state level the report that we requested was partially due because a legislator at some point had asked for information and so you gathered that information and you just kept on gathering it. There is two reports from CMS that we always

had to turn in. It was the CHIP report and also the EPSDT report, and I was unclear always of how CMS used those two reports. Our federal matching percentage isn't changed because of those. It doesn't go up or down. There is no penalties or rewards for those things.

So I think that is a part of looking at those reports and saying okay, what information do we need? Information, giving that to CMS is very important. They get questions, you are talking about transparency especially on demonstration projects I know there is a number in there. We need to turn over that information, but the question is then how do they use that and if it is not good information or it is not used then let's let it go.

Mr. Guthrie. So in your testimony you talked about CMS should be more focused on outcomes for patients in Medicaid and less prescriptive on how states get there, and I agree with the sentiment and direction. Can you think of a few concrete steps to move incrementally that direction?

Mr. McCarthy. So we, many states I should say, use managed care plans, private sector managed care plans to help provide services to the population. You hold them accountable and it is often called pay for performance for the managed care plans. And what you do is you hold back a percentage of their capitation rates from one percent to five percent, and some of that is changing

right now. So it provides that incentive and then you use some type of measure. We often use NCQA HEDIS measures to be able to then measure those plans. The better they did they could get that money back.

So one of my ideas has always been, well, why doesn't CMS do the same thing with states and back off some of the command and control and instead hold states accountable for healthy outcomes. Dr. Roy brought those up. So if you have bad outcomes maybe a state should be penalized for that, but if you have good outcomes why isn't there, you know, an increase in funding for that state to provide that incentive. States do what we are incentivized to do. Right now the incentive is how do you draw down the maximum amount of federal dollars that you can get, so it is how do you move from that to something else that can be measured?

Mr. Guthrie. Okay, thank you. And just from some of the other things that we have talked about, I am from Kentucky and Kentucky is an expansion state, elected a new governor recently. And at some political peril to himself he decided we are going to try to figure out how to keep the expansion and make it work.

And it is kind of news, it would be news to Kentucky that expansion has made the budget better. Maybe when the previous governor expanded it was a hundred percent federal, but the Medicaid program is going to take up 100 percent of the new

additional revenues grown to Kentucky over the next biennium which means it is going to sacrifice what we can pay teachers, what we can do to colleges and universities.

So our governor is actually trying to -- and he is hearing some of the same rhetoric that we have heard in some of the opening statements. And when he is really trying to keep the program and make it better a lot of people say, well, keep it and make it better and he is trying to, and one of the things he is trying to do is co-pays.

So there is people in the expanded population, so he has the traditional Medicaid, the disabled and the traditional Medicaid, looking at the expanded population -- and he gets a lot of negative rhetoric for this. He says maybe they should pay $1 minimum to $15 maximum for health care per month, and the other one is a work requirement. And he says that, you know, people are in the expanded population working. There are working poor in the expanded population, but some people aren't.

And he says if you are able bodied and you are not, you should work at least 20 hours a week, volunteer, work, and I think you can even classify maybe taking care of your grandchild. You can get it certified that as long as you are doing that 20 hours a week so somebody else can go work then you get credit for that. And so there are people trying to make this better and it is not sustainable the way that it is. And I know no one has offered

a big tax increase to make Medicaid balance in states and at the federal level and so that is what we are trying to do. We are trying to be serious with it and have people covered and move forward.

And I have ran out of time so I will yield. I was going to ask a question but I ran out of time so I will yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Florida, Ms. Castor, for 5 minutes for questions, please.

Ms. Castor. Thank you, Mr. Chairman. Mr. Chairman, many people in organizations are speaking out about the difference that Medicaid coverage makes in the lives of millions of Americans and they have contacted the committee this week to make their views on Medicaid known. And I would like to ask unanimous consent to submit some of their letters from the record including a letter from the National Coalition on Health Care opposing the defunding or repealing of the Medicaid expansion.

The coalition represents nearly 90 of America's leading associations of health care providers. A letter from the Asian & Pacific Islander American Health Forum which works to improve the health of 20 million Asian Americans and nearly one million native Hawaiians and Pacific Islanders; a letter from the AARP representing 38 million seniors in all 50 states; a letter from the Save Medicaid in Schools Coalition representing more than 25

organizations invested in the education of our kids; and a letter from the Association of American Medical Colleges representing the nation's medical schools and major teaching hospitals.

This is just a sampling of the diverse array of groups that proactively have reached out to this committee just recently to express support for the flexible federal-state partnership that is Medicaid and to offer their ideas to truly strengthen and protect vital Medicaid services.

Mr. Burgess. Will the gentlelady yield to accept her unanimous consent request?

Ms. Castor. Yes, I will.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 13**********

Ms. Castor. Thank you very much.

Ms. Solomon, the fear is palpable across the country among families that the Republicans aim to devastate care that is provided through the Medicaid partnership, families that relied on skilled nursing and home and community based services, families with an Alzheimer's patient, children's health care especially kids with complex medical conditions, people with disabilities, and now according to many news sources at the start of the Trump administration it appears that yes, indeed, they intend to target families who rely on Medicaid for elimination of care and services disguised by the terminology of per capita caps and block grants.

And this committee has put out a press release as recently as last night Republicans also plan to target Medicaid through reconciliation so we are gearing up for that. I want to get it clearly on the record what American families can expect if Republicans try to change Medicaid to block grants or per capita caps. It looks like a real draconian process.

I have served on the Budget Committee the past few terms as a representative of the Democrats on the Energy and Commerce Committee and we have seen those budgets. And we have always had this backstop of President Obama and the White House and senators that said no way are we going to devastate care for families, but I think it is really at risk. You have studied these budgets that have passed the past couple of terms; is that right?

Ms. Solomon. Yes, I have.

Ms. Castor. And could you describe the impact on health services for American families that rely on Medicaid if that approach is enacted into law?

Ms. Solomon. Yes. I mean in my testimony Figure 3 shows the trajectory of cuts over 10 years from the latest proposal, the proposal for fiscal year 2017 and it is enormous. And it is very clear that what these proposals do is basically pull federal funds out of the program and shift not only the cost to states but the responsibility to deal with the cuts and it is the states that then have to decide where those cuts should fall. They have to figure out whether they can put more of their own money in at the expense of education and other vital areas of the budget. But these are cuts. These are cuts in federal funds changing the partnership dramatically.

Ms. Castor. And how many Americans would be left without health care services?

Ms. Castor. Well, as I said, the estimate from a previous proposal was somewhere between 14 and 20 million and the cuts get bigger over time. And they also can get bigger if things happen that are not anticipated. So the trajectory in my testimony shows what would happen based on expenses growing as expected.

Ms. Castor. And we even have Republican governors speaking out against this approach. For example, Governor Charlie Baker

of Massachusetts wrote recently we are very concerned that a shift to block grants or per capita caps for Medicaid would remove flexibility from states as a result of reduced federal funding. States would most likely have to make decisions based on fiscal reasons rather than the health care needs of vulnerable populations.

Isn't that true that when you devastate care and take a hammer to the federal-state partnership you are really saying to states you have less flexibility to care for your citizens?

Ms. Solomon. You certainly can innovate. States have been innovating and they have been getting flexibility to provide some upfront funding to build the technology they need to coordinate across providers and deliver care in a more coordinated way. That is gone under these proposals.

Ms. Castor. Thank you. Mr. Chairman, I will yield back my time.

Mr. Burgess. The gentlelady's time has expired. The chair thanks the gentlelady. The chair recognizes the gentleman from Texas, the vice chair of the full committee, 5 minutes for questions, please.

Mr. Barton. Thank you, Mr. Chairman and thank you for holding this hearing. I was a little surprised to hear the tone and the tenor of our friends on the minority side. I have been on this committee 30 years. I missed the memo apparently where

it said we were trying to gut Medicaid, destroy the program.

The memo I got said that we have a budgetary crisis and we need to find ways to strengthen the program to reform and improve it and make sure that we get the money to the most vulnerable, and in doing that hey, we might give the states a little bit more flexibility. We might change the waiver process which is fairly bureaucratic. Again I am only the vice chairman and the past chairman and I have only been on the committee for 30 years, so maybe there is some things that have happened behind my back and if so I will take that up with Chairman Walden and make sure it doesn't happen.

I do know that the federal budget is about $4 trillion, Mr. Chairman. I know that the federal government is right now spending about $350 billion on Medicaid and that is supposed to double in the next few years. In total, state and federal spending is going to be about a trillion dollars. I also know that the expansion of Medicaid, which the Affordable Care Act engendered, added about ten million people to the rolls and we are spending in the neighborhood of $60 billion to cover those people and that as the federal hundred percent match is phased out the states are scrambling to find ways to continue to cover this.

So I guess my first question to Dr. Roy, do you think it is possible to maintain the existing growth rate in Medicaid spending

at the state and federal level and actually do it in a way that the hardworking taxpayers of America can afford?

Mr. Roy. No, Mr. Barton. And, you know, I will go back to something that Ms. Castor said. There is no state in America that does not make decisions about care and coverage for the Medicaid population based on fiscal consideration today. Every single state does that today. Every single state did that last year and the year before that and the year before that because for every state in America Medicaid expenditures are either the number one or number two line item in their budget.

So fiscal considerations are dominant in the way states have to manage their Medicaid programs and they don't, they simply don't have the flexibility to focus their resources, their limited resources on the needs of their populations.

Mr. Barton. So you could say that the states right now are capitating Medicaid spending.

Mr. Roy. They effectively are and in very ineffective ways by reducing reimbursement rates to physicians and to other providers. And if we gave them full flexibility, particularly if we gave individuals the flexibility to control the dollars that are being spent on their behalf for the health care needs that they have, we could dramatically improve their access to primary care, their access to specialist care and their access to high quality hospitals in a way that would substantially improve their

health outcomes.

We have been talking a little bit today about health outcomes for people in Medicaid versus being uninsured. The most important point I could make today is that health outcomes for people on private insurance are dramatically better than those for people on Medicaid. And so more --

Mr. Barton. Well, we have three, this is called a legislative hearing so we have three bills before us. One of them has the radical idea that you should count lottery winnings. Now there are not very many of these lottery winners, 6,000 I think nationwide. Would that gut Medicaid if we actually counted lottery winnings as part of the income test?

Mr. Roy. Not in the least. If someone can afford private coverage or otherwise is not the kind of person who the Medicaid program is designed for it just defies common sense why we would devote those scarce resources to subsidize those individuals as opposed to the individuals who need the help.

Mr. Barton. Congressman Flores has a bill that would say we give the states the discretion on covering undocumented workers or illegal aliens. They could cover it with their dollars but the federal government wouldn't have to automatically cover them; now that is a little bit more controversial. These are people that have come into country illegally, don't have the proper documentation. Do you think that the majority of the citizens

and the taxpayers of the country would support that idea?

Mr. Roy. As the child of immigrants to this country from this country from India I find it very puzzling that we are even having this debate. It seems entirely commonsensical that we would restrict Medicaid funding and resources to people who are legally resident in this country.

Mr. Barton. In my congressional district if I did an opinion poll it would be about 95/5, 95 in support of restricting Medicaid to citizens or legal residents. With that Mr. Chairman, I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman Mr. Lujan, 5 minutes for questions, please.

Mr. Lujan. Thank you, Mr. Chairman. And Ms. Solomon, at the Center on Budget and Policy Priorities have you had a chance to review the Republican proposal, some of which was listed in Speaker Ryan's Better Way document on --

Ms. Solomon. Yes.

Mr. Lujan. -- what they would do to Medicaid? Can you talk about that?

Ms. Solomon. Yes. I mean I have mentioned it. It would really just shift huge amounts of costs to the states, as I said, along with the decisions of how to absorb the major cuts and also leave states shorthanded, essentially, if things that were not

anticipated happened such as an epidemic. We have had, you know, the Zika threat, drugs, new blockbuster drugs, the ability to provide those to people, the aging of the population; all of the proposals are based on what the population looks like now.

And we have that bulge of the Baby Boomers which right now are at the sort of lower end of the seniors, 10 years from now that is an older population and 20 years even more so. So none of that is really taken into whatever the formula would be that we would have a lot more people who are very old and need a lot more care. So basically states would have to figure out how to deal with that.

Mr. Lujan. So Ms. Solomon, I know this is a complex issue as we are trying to better understand it to do our due diligence to make a difference to keep this program strong. The way that I understand, when the federal government shifts costs to the states that means that the federal government is going to cut the federal investment and put that burden on the state. Is that a fair assessment?

Ms. Solomon. That is it. I mean that is exactly what these, we call them block grants, we call them per capita caps, but they are cuts. They are cuts in federal funds when it is very easy for Congress to do it because it really leaves the states with the hard decisions of how to absorb that change in the partnership between the federal and state government.

Mr. Lujan. I appreciate that Ms. Solomon. So if there is any question associated with the Republican plan, I think Speaker Ryan has something called a Better Way that everyone can go take a look at that pamphlet. And when we are talking about what is happening here, if you are saying and using terminology to shift the cost from the federal government to the states that means you are cutting the program. I mean I don't know why we are parsing over this. It is what it is. Let's just accept the programs that both sides are putting forward here.

Now there is a lot of conversation, Ms. Solomon, associated with one of these areas and a term that we are learning more about called the reasonable opportunity period which is being talked about in one of these bills. It is my understanding that there is a verification process that has been established when someone applies for these programs that you have to submit your Social Security Number or documentation.

In cases maybe where Social Security doesn't exist, but where it does exist you submit that that is verified Social Security Administration whether someone is eligible or not. If they don't have their Social Security Number or their Social Security Number process is not one that is recognized by the Social Security Administration then an applicant would submit paperwork to show that they are citizens and then they would be put in this what is called an ROP. So can you tell me if there is challenges for

naturalized citizens?

Ms. Solomon. Yes.

Mr. Lujan. Do they have to submit additional paperwork and then would they land up in an ROP? Would citizens born outside of the United States fall into that situation and have to fall into an ROP and namely children born on military bases outside of the United States, would their number fit into that process and would they fall into this ROP?

Ms. Solomon. Yes, those are the groups that would be most affected by the bill that is before you because that bill if you look at the language it talks about aliens declaring that they are citizens. It actually affects the verification process for people who are attesting to being citizens or U.S. nationals. A vast majority of those individuals have their citizenship verified electronically pretty instantly by the Social Security Administration.

There are several groups, the groups that you mentioned, naturalized citizens, people who are born abroad, say, to military parents and some newborns who have to provide documentation because Social Security can't verify it quickly. The reasonable opportunity period was put into the law after we saw large numbers of children and others not being able to get through this without delays so that they could get benefits while they were submitting their documentation.

Mr. Lujan. Thank you, Ms. Solomon. And as my time expires, Mr. Chairman, I think that we all want to make this system work, but citizens of the United States should not be left out. Thank you very much.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions, please.

Mr. Shimkus. Thank you, Mr. Chairman. It is great to be here, great new hearing room and so I get to do the inaugural chart through this new technology. Obviously we are talking about the budget and we are talking about spending. I think you can see it.

[Chart]

Mr. Shimkus. You should be able to see it right -- can't they see it in front? All right, see, it is all new to us. So you got it right in front of you. Does anyone dispute this as a federal budget pie in 2015? No. Mr. McCarthy?

Mr. McCarthy. No.

Mr. Shimkus. Ms. Solomon? No, that is it. Now, so we are debating -- I always -- look, this is an important budget chart to show that we fight our budget on the blue area which is the discretionary numbers. The red is the mandatory, the red is spending out of control and as that continues to grow it squeezes the blue portion.

And Ms. Solomon, you mentioned it on Medicaid, or someone, Mr. McCarthy, you mentioned it on Medicaid. As Medicaid in the states expand it squeezes schools, public health, state budgets, so the debate on reforming the process to make it solvent, I think, is a very fiscally responsible debate, but people have to see the whole chart. So really, our challenge here is try to address the mandatory spending and make it fiscally sustainable and then we don't have these discretionary budget fights. So that is just a good way to start.

Now I want to go to specific questions. Mr. Guthrie just returned. He kind of talked a little bit.

You can take that chart down now unless we want to keep it up just for the allure of it.

But Mr. Guthrie at the end of his filibuster kind of started talking a little bit about the, what we call the work requirement. So I know, Mr. Roy, you have done some research on that. Can you talk about that quote-unquote work requirement as far maybe some possible reforms?

Mr. Roy. Yes. So let me highlight, Mr. Shimkus, one of the things that we in the health policy community support about a work requirement and that is that there is a lot of emerging research that shows that individuals who have health insurance and who have health care needs who have work, who have a job are much more engaged in their actual health care and just the wellness that

comes with having a job, going to work every day, feeling needed.

A lot of these things are subtle, but the research is quite compelling in showing that people who have jobs do a much better job in terms of health outcomes versus people who don't. Not because of income because you can stratify these results for income, but because of their engagement in their own lives and their own health. And so a lot of what I think our ambition is is to see a work, a relationship between work and the Medicaid program and other programs that help low-income individuals so that there is an encouragement for those individuals to be engaged in their lives and engaged in their health.

Mr. Shimkus. And these are not, the elderly or the disabled are not involved in this work requirement discussion, correct?

Mr. Roy. Correct.

Mr. Shimkus. And Mr. McCarthy, having your experience in the state you know that the 1115 waiver supposedly has that ability to do that. Can you talk about how a requirement that an individual not just take from the Medicaid program but actually give back to the community can help that individual?

Mr. McCarthy. So from the standpoint of what we saw in Ohio as many of the people on the program were working so we believed -- and we had a Healthy Ohio waiver which we turned into CMS that was disapproved -- that having people participate not only in their health care but in just making their lives better would be

something that would be beneficial to everyone.

I think one of the things that we get distracted on, and somebody brought this up earlier, was the issue just simply work. There was a discussion of could it be education or other things that are going on, just engagement of a person to say here is the things we need to do. Many people are already doing it. There is a subset that is not, so let's engage them to figure out what that is that they can do to better themselves.

Now there was --

Mr. Shimkus. Let me in my last 45 seconds ask, don't we do this already for TANF, for the Temporary Assistance for Needy Families, isn't there some quantification right there already and that could be used in that same process?

Mr. McCarthy. Yes.

Mr. Shimkus. I yield back my time.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions, please.

Mr. Kennedy. Thank you, Mr. Chairman. I appreciate the opportunity here. I want to thank the witnesses for being here, discuss an important topic to our health care system and the underpinnings for how we try to make good on a promise that everyone in this country gets access to the care that they need when they need it and that is a fundamental, I think, bedrock for

not just our medical community but our society. No one wants to be checking a health insurance card after you get hit by a bus, or a passport or for a green card.

So the question then is, getting back to the pie chart Mr. Shimkus put up, is yes, there is issues on the discretionary spending and the mandatory spending side, and the focus of this hearing is looking at that smallest piece of the mandatory side and taking out that side interest on the debt and squeezing out efficiencies there, which I would point out is close to 50 percent of the Defense Department budget.

So I think it is also important to put these reforms in context and to put a human side on them too. As we consider these reform bills that we go through we should remember that there is by some estimates 32 million Americans that are on the cusp of losing health insurance depending on what this committee decides to do.

I toured a series of community health centers last week in my district and you heard the same message from their doctors, from their patients, from their advocates, from their staff which was don't sabotage the Affordable Care Act, don't gut Medicaid expansion and don't jeopardize the progress that we have made in our health care system. It is not as simple as redirecting that funding.

As more and more people lose coverage and access to

preventive care which many of them can get from a community health center they turn to emergency room treatment, then uncompensated costs go up at hospitals and premiums increase with them. One of the health centers I visited, the North Shore Community Health Center, Medicaid makes up 60 percent of the total patient service revenue. Statewide community health centers serve over one-fifth of all Medicaid beneficiaries in the Commonwealth of Massachusetts and account for less than two percent of our Medicaid expenditures.

So yes, while we need to look for innovative ways to deliver new care we should dismiss catchy ways to kick people off of Medicaid. We should be debating reforms that would replicate those efficiencies that we have seen across the country. And a state -- in Massachusetts by the way -- that has a 2.8 percent unemployment rate and a 2.8 percent uninsured rate, the idea that the Affordable Care Act is somehow a job killer is demonstrably false as we have seen in Massachusetts.

So we also know that going forward the immediate repeal of the Affordable Care Act would result in a loss of three million jobs worldwide, would lead to $165.8 billion in hospital losses over the next 8 years, Medicaid expansion would, in fact the progress we have made on lowering marketplace premiums would be gone, and repeal without a replacement would lead to nearly 44,000 deaths annually by conservative estimates. There is a reason why

Republican governors, many of them represented in states that my colleagues here represent, are begging Congress to try to defend that Medicaid expansion.

And I would like unanimous consent, Chairman, to submit for the record a letter by my governor, Republican Charlie Baker, in response to a solicitation put out by leader Kevin McCarthy, detailing some of the reforms that he would like to see going forward as a health care executive, former health care executive.

And he mentions in here, Chairman, that maintaining state health care safety nets including retaining existing federal health subsidies and uncompensated care pools that support health care coverage and charity care providers, avoiding proposals that only offer more flexibility and control in exchange for shifting costs to states, providing flexibility with then pulling back money does not solve the problems that we have heard from today.

Mr. Burgess. Will the gentleman yield for action on his unanimous consent request?

Mr. Kennedy. I will for that. Thank you.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 14**********

Mr. Kennedy. Thank you, Mr. Chairman. So I realize I filibustered there for a little while, apologies. But Ms. Solomon, two very simple questions and then just so I leave with, do you support repealing the Medicaid expansion and do you believe that health outcomes improved in states with expanded Medicaid versus those that did not?

Ms. Solomon. I totally support, obviously support the expansion and do believe that it has made a huge difference in the states that have expanded in addition to lowering the un-insurance rate, more people getting care, its evidence is indisputable.

Mr. Kennedy. And then very briefly since we have about 30 seconds left, the largest payer of mental health services in this country is Medicaid. There has been in this committee a bipartisan commitment to look at some of the issues around mental health. How can we possibly address the systemic failures of our mental health system without addressing Medicaid?

Ms. Solomon. You can't because it really is providing the foundation for things such as the initiatives that were in the CURES bill and elsewhere. Those are going to wrap around the foundation that is provided through Medicaid for behavioral health services.

Mr. Kennedy. Thank you and I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks

the gentleman. The chair recognizes the gentleman from Pennsylvania, Mr. Murphy, 5 minutes for questions, please.

Mr. Murphy. Thank you, Mr. Chairman. First, Dr. Roy, you were talking about how people who are on Medicaid don't really differ much from people who have no insurance at all and cited a few studies, looked at things like cancer, diabetes rates and things like that. And I just want to make sure I got it on the record you are not implying that being on Medicaid causes cancer.

Mr. Roy. Of course not.

Mr. Murphy. That being on Medicaid worsens cancer or reduces life span, and you also say that people who are on Medicaid, the doctors are paid below market rates, and you are not saying that when doctors are paid less that reduces life span, but you are talking about an access to care.

And I believe one of those studies, I looked it up here, is also Kwong, et al, University of Pittsburgh, my alma mater. But what is happening is that people actually come in worse. They put off care. And this is where I agree with some of my colleagues on the other side of the aisle, when people don't have insurance they put off care.

And it has actually been some of the problems of the Affordable Care Act. It was supposed to have been that it would increase outpatient visits and actually reduce inpatient and emergency room visits and it has had the opposite effect because

what people have found they have high co-pays and deductibles. Does that make sense?

Mr. Roy. That is correct. Emergency room volume has increased through the Medicaid expansion and it has not increased the rate of primary care physician access relative to what Medicaid's performance was previously.

Mr. Murphy. Mr. McCarthy, I want to understand. You had made some references in your comments about co-pays and premiums that were reasonable and enforceable which should keep -- is that meant to keep people from the emergency rooms and keep those costs down?

Mr. McCarthy. It is designed, the purpose of it is to have a person actually make a choice of where they are going to go and make a reasonable choice to say --

Mr. Murphy. I understand. And the same thing with formularies and drug -- for drugs there, because initially we were trying to grapple with that when dealing with the cost of drugs that formularies and negotiated drug prices in selecting one can be part of a cost savings, correct?

Mr. McCarthy. Right. The problem with the Medicaid program right now is that a state is forced to cover every FDA-approved drug and it leaves you with no negotiating room for new drugs.

Mr. Murphy. Okay. And part of the issue we dealt with here

on another hearing was that when a state chooses, for example, a formulary in mental health drugs that assumes that all anti-depressants are anti-depressants the same and all anti-psychotics are the same just because they have that same function, they are not the same because they have different side effects and because of different side effects people may not take them. When they don't take them their situation gets worse.

And I know that Ms. Solomon, you also made some comments about when people have to make a choice about care and they are on waiting lists to get into long-term care. And I am assuming you would be supportive that if there was an option for an alternative payment model and if someone could be cared for in-home that would save money and probably be more preferable to that patient. Am I correct?

Ms. Solomon. Absolutely. And there are multiple options and flexibilities for states that want to do that including the new state option for home and community based services. This is where there is enormous flexibility in Medicaid for states to pick up different ways of doing that.

And as Figure 1 in my testimony shows, the result has been that --

Mr. Murphy. I have to cut you off. I am trying to get to another point here, but if you can get me that I want it because here is the thing I want you to think, although I think we are

not there yet. We are talking about moving around how things are paid for, whether doctors are paid more, whether -- what is happening there. A number that keeps coming up to us is that five percent of the people on Medicaid account for 55 percent of Medicaid spending and they are not a homogeneous group.

One thing I would like to submit, Mr. Chairman, is an article by Gregorio, et al., on inflammatory bowel disease in medical homes, talking about this in an op-ed that I wrote called A Better Model for Healthcare in America from the Washington Examiner that when you actually wrap service around something and you identify the over utilizers versus someone who just is a high utilizer you can make a massive difference.

So not all of those people on Medicaid are the same, and it isn't just paying doctors more. This is where I want to know, I am not sure the bill, I mean the bills we are dealing with today have some effects here on spending but they don't have an effect on changing medical models. So now Ms. Solomon, if you can complete your thought, how do we change an alternative spending model that saves money in Medicaid and provides better care? You have 30 seconds.

Ms. Solomon. It is going on today in multiple states that have done exactly what you are saying, identify those high utilizers. The health home program that was in the Affordable Care Act, things like the programs at the Camden Coalition which

has become a national model --

Mr. Murphy. Very important. Can we do more to incentivize those, because as some of those even worked it is kind of state by -- the Camden model is a great model, but the question is, and this is where I would like all of you to get back to this committee, it is extremely important that we find ways of effectively helping those and it isn't just going to be raising their co-pays and deductibles to do that.

With that Mr. Chairman, also one other thing I want to ask unanimous consent to submit for the record. It is a letter from the National Association of Psychiatric Health Systems too, on these models too.

Mr. Burgess. So just to clarify the gentleman had two unanimous consent requests?

Mr. Murphy. Three.

Mr. Burgess. Was there one embedded in that previous discussion?

Mr. Murphy. There is three. One is an article by Gregorio, et al., where --

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 15**********

Mr. Burgess. The gentleman's time has expired. The gentleman yields back. The chair recognizes the gentlelady from California, Ms. Eshoo, for 5 minutes for questions, please.

Ms. Eshoo. Thank you, Mr. Chairman. Glad to be back on the subcommittee. I am a returning member because I did serve on this subcommittee for several years. Thank you to the witnesses. Let me just do -- there is an advantage to coming in a little later in terms of asking questions because we have been listening to both questions, answers, comments of members.

My takeaway on the three bills here is that they, all three of them, change Medicaid eligibility requirements, and when eligibility requirements narrow some Medicaid beneficiaries who previously qualified for coverage will no longer qualify and will lose their Medicaid coverage. So the results in coverage are essentially being taken away from these people, so this is subtraction. This is subtraction. That is my take on the three bills. I could say more about them. I am just fascinated with some of the things that have been said.

Now I want to go to you first, Dr. Roy. I am not familiar with your organization, the Foundation for Research on Equal Opportunity. Who funds you?

Mr. Roy. We are a nonpartisan, nonprofit think tank that has donors from --

Ms. Eshoo. Yes, but who funds you? Where does the money

come from?

Mr. Roy. The money comes from donors just like every other think tank who are individuals.

Ms. Eshoo. And who are they? Who are your major donors?

Mr. Roy. We don't disclose our donors. We are 4-1/2 months old.

Ms. Eshoo. Does the committee require in the witness background to submit to the committee who funds organizations, et cetera that witnesses come here to testify on behalf of? If we don't I think that we should consider that.

Mr. Roy. I am not testifying on behalf of donors. I am testifying on behalf of the Foundation for Research on Equal Opportunity and myself.

Ms. Eshoo. Well, that is why I am asking about the Foundation because we have foundations and we have foundations. But since you don't wish to disclose, I think that the committee should for all witnesses make that determination and make it a requirement so that members do know.

Now did you support the ACA when it was passed?

Mr. Roy. We don't take institutional positions on legislation.

Ms. Eshoo. Do you support it today?

Mr. Roy. What I do support --

Ms. Eshoo. No, no, no. Answer it. I only have 5 minutes.

Mr. Roy. What I do support is universal coverage, and we have put out a plan to achieve universal coverage.

Ms. Eshoo. Do you support the elimination of Medicaid?

Mr. Roy. I don't support the elimination of Medicaid. I support covering everyone who needs financial assistance to afford health insurance.

Ms. Eshoo. Right. In your research -- the chairman of the full committee made mention of millionaires and billionaires who use Medicaid. In your research have you found anyone in those two categories that are in Medicaid, using Medicaid?

Mr. Roy. There are lottery winners who by law if they receive all their income in a lump sum in 1 month --

Ms. Eshoo. So it is lottery winners, and how many of those are there?

Mr. Roy. It is not merely lottery winners. It is anybody who receives a lump sum payment. So for example someone who received a financial bonus from work --

Ms. Eshoo. So if someone is in an automobile accident and there is a settlement then that makes them a millionaire or billionaire. I just think that this is -- I have to tell you that this is a bad rub when these things are thrown around that millionaires and billionaires are on Medicaid.

Mr. McCarthy, do you support eliminating the federal dollars of Medicaid and then have the states be the laboratories of

invention and be able to expand or contract or write their own rules with their own money and believe that people will still be served?

Mr. McCarthy. I believe that people can be served if the states are given the proper flexibilities in whatever --

Ms. Eshoo. No, I am asking about the federal dollars though, picking up on Ms. Solomon's testimony.

Mr. McCarthy. If the federal dollars change the states will --

Ms. Eshoo. No, if the federal -- do you support subtracting the federal dollars out and just have the states carry out with their own dollars whatever they want to design?

Mr. McCarthy. If you are asking if all federal dollars, no. That would be very difficult for a state to do.

Ms. Eshoo. Sure would. And at what point do you support the reduction of federal dollars? What level reduction are you --

Mr. McCarthy. It depends on what flexibilities are given to states. Those two things have to go hand in hand.

Ms. Eshoo. So you don't want to name the amount of dollars that you are willing to subtract as a former director of the program from a state, from a major state.

Mr. McCarthy. Again it would depend on what flexibilities come with it.

Ms. Eshoo. Ah-ha. So we want the money for sometimes, we don't know how much but someone is going to decide it. That is quite a proposition. Well, you know, what the conclusion that I have come to, and it is not hard to listening to the testimony, is that there is really not support for this program and so there is a nitpicking around the edges.

In anything we do there is always room for improvement, but this, I don't think today's hearing is about improvement. I think it is about elimination, subtraction and I don't --

Mr. Burgess. The lady's time has expired.

Ms. Eshoo. -- think your surveys and whatever you presented in your testimony are reliable or acceptable because I think they hurt people. Thank you.

Mr. Burgess. The chair would request that we respect other members' time, and I am now going to recognize Mr. Lance from New Jersey 5 minutes for questions. Mr. Lance lost interest. Mr. Griffith, 5 minutes for questions, please.

Mr. Griffith. Thank you very much. I appreciate our committee working hard on this. As you have heard we can always make things better. And one of the things that the American people want and my people that I represent in Virginia and my district want is folks to make sure that if they need the help they get it. But if they suddenly find themselves millionaires because they won the lottery or they have gotten some other lump

sum payment, they don't think those folks ought to necessarily be getting Medicaid.

And so while I have heard it said that, you know, throwing it around that millionaires are getting Medicaid is a bad rub, currently it is a bad rub the average hardworking American taxpayer is paying for it, wouldn't you agree, Dr. Roy?

Mr. Roy. My foundation, the Foundation for Research on Equal Opportunity is dedicated to expanding economic opportunity for those who least have it. Generally speaking, millionaires and billionaires are not people who at least have economic opportunity in this country.

Mr. Griffith. And in fact when I read the bill I noticed with some interest that I thought it was fairly generous because it basically allocates it out as roughly $40,000 a month for the first, say, hundred thousand and then it is more than that. So it is not like we are saying that if you win a million dollars you can never be on Medicaid again, it is fairly loose. Wouldn't you agree?

Mr. Roy. I mean to me it is very simple. If you can afford to buy health insurance yourself, please do so. If you can't afford health insurance on your own and you need the financial assistance and are eligible for the financial assistance that Medicaid provides then let's find a way to get you that assistance. It seems completely non-controversial and I really don't

understand why members of the minority find this problematic.

Mr. Griffith. And I am going to switch gears but stick with you, Dr. Roy, if I might. In your written testimony, and I don't believe you have had an opportunity and I apologize if I have missed it somewhere, but I don't believe you have had an opportunity to discuss it. On page 8 of your written testimony you start getting into issues about how, and I am going to quote, the interest of state and federal governments have diverged in Medicaid because of the way it is set up.

And I am not sure these bills directly get to that but I thought that was interesting testimony because it is one of the things that has been a bad rub for Virginia. And that you then go on to talk about how the federal government has done some things that maybe they ought not to have done and the state governments have responded and done some things where they came up with creative financing and you actually reference Medicaid hospital taxes. And in Virginia we rejected that concept because we saw it as a tax on the sick and that they wanted to create a bed tax where, you know, if you were a Medicaid patient you would get the money back as increased costs and you would receive as you said in your testimony whatever your match was, in Virginia it is 50 percent but you used 60 percent in your example, you would get that money back and so the states have actually gamed the system in some states to get more federal dollars from Medicaid and in

some cases like New York they have actually had to have reforms because they gamed it so much they had so much money floating around they were wasting millions of dollars. Isn't that true?

Mr. Roy. Absolutely. And, you know, a number of the states in fact nearly I would say a majority of the states that have expanded Medicaid under the ACA in theory there --

Mr. Griffith. Just a second. Mr. Chairman, I am having a hard time hearing.

Mr. Burgess. The gentleman is correct and the time will suspend. The chair notices a significant difficulty hearing the testimony of the witness even with amplification, so could I ask conversations be taken off the dais in respect to our witnesses who have agreed to be with us this morning?

Mr. Griffith. Thank you.

Mr. Burgess. The gentleman continues to suspend. Conversations off the dais to allow the witnesses a chance to be heard. The chair thanks the committee. The gentleman may proceed.

Mr. Roy. A majority of the states that have expanded Medicaid under the ACA have used provider taxes and health insurance premium taxes to fund the theoretical ten percent match that they are supposed to contribute. We have heard some descriptions of the so-called savings that states have achieved by expanding Medicaid. There are no so-called savings.

What has happened is that state governments have raised taxes on Medicaid providers and on managed Medicaid managed care companies and use those revenues to fund the Medicaid expansion in their states, in other words increasing the federal liabilities for the Medicaid programs in ways that the ACA did not contemplate.

That is not just true of the ACA. In my written testimony I cite the fact that on average the FMAP, the match rate at the federal level is around 58 to 60 percent. At least that is what it is supposed to be on paper, in reality it is closer to 70 percent because of these taxes that states use to game the system and attract raised costs in the Medicaid program and drive revenue to the states from the federal government that they otherwise wouldn't gather and aren't supposed to obtain.

Mr. Griffith. And I want to summarize and probably then have to conclude, but in summary, if the federal government gives the state $2 million and the state was only going to spend a million dollars, the state has not saved a million dollars, the federal government has spent a million dollars it maybe didn't need to.

Well, I support all three of these bills, but I would invite all of our witnesses if you have ideas on ways that we can improve these bills, please let us know because we are trying to make sure -- I agree with the philosophy, but if there is some way that we can make the bills better, please let us know and I would appreciate it very much if you will give that in writing. That

would be great. And with that Mr. Chairman, I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman and the chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DeGette. Thank you so much, Mr. Chairman, and it is good to be back on the committee, on the subcommittee, although this morning I can't help but feel like I am in a Lewis Carroll book because here we are talking about lottery winners and undocumented people getting Medicaid, but then the testimony particularly from the majority witnesses is all about the full Medicaid expansion.

We saw this yesterday in the Oversight and Investigations hearing on the Medicaid expansion and I think we really need to clarify what we are talking about. I don't think the biggest problems facing Medicaid are lottery winners getting Medicaid advantages, and also under current law although it may not be good from a health care policy standpoint, people who are not citizens or have documentation they can't get Medicaid right now under current law. And with respect to people who are vulnerable, as has been demonstrated by all of the evidence, if you expand Medicaid then you actually are more able to insure the vulnerable.

So let's talk about what we are really discussing today under the guise of these three bills. What we are really discussing today is the majority's intention to gut the Medicaid expansion for a variety of reasons. And that is what I want to talk about.

Ms. Solomon, I want to ask you, now I understand that in the Medicaid expansion under the Affordable Care Act 80 percent of the people who are getting that Medicaid expansion are actually working; is that right?

Ms. Solomon. That is right.

Ms. DeGette. What is the situation with the other 20 percent of the population?

Ms. Solomon. So it is varied, but you do have a large share of people if you think about who was not covered by Medicaid before and is picked up by the expansion you have the people we sort of shorthand call the childless adults. And these are people that didn't fit a category and we did away with the categories. So you do have people who are chronically homeless, people with substance use disorders, people with mental illness and then just a group of people who are caring for family members and, you know, low income, unable to work.

So it is probably a diverse population, but there really isn't -- the people that are mostly affected are the people who didn't have a pathway to coverage before and who were working because they were working in jobs without coverage.

Ms. DeGette. And how did those people get their health care before we had these Medicaid expansions?

Ms. Solomon. They didn't. I mean they didn't have insurance so they --

Ms. DeGette. Well, if they got sick what did they do?

Ms. Solomon. Yes. They went to the emergency room. They went to hospitals. They went to community health centers that would --

Ms. DeGette. Right, and eventually we the taxpayers paid for that, right?

Ms. Solomon. Correct.

Ms. DeGette. Now you heard Dr. Roy say that he did a study -- and Doctor, I read your testimony and also the article that you wrote that you cited in your testimony. And he said that the data shows that people on Medicaid have no better outcomes than people who are uninsured. Is that supported by the rest of the data?

Ms. Solomon. I don't think so. People are getting care. And I think again the studies are very, very narrow and they look at people with very serious illnesses, and I think Dr. Roy said that they came in late. They didn't have their conditions diagnosed, and that is exactly what the Medicaid expansion is allowing. I would just commend everybody to look at the dashboard in Louisiana where they are tracking the people that are being found through their pretty new expansion.

Ms. DeGette. Okay. So some of you who were at yesterday's hearing in O&I, I talked about some of the people I had last week in Denver. I had a listening session for people to come and talk

about their experiences in the ACA. And I had one woman, Lisa Scheim (phonetic) of Denver. She developed a neuroimmune illness and so she has only been able to work part-time. Because she works part-time she is not eligible for insurance through her employer, and before the ACA she was rejected for insurance because she had a preexisting condition.

We had a high risk pool in Colorado, but the premiums were so high she couldn't buy in. So then she got ulcerative colitis and an autoimmune disease, she couldn't even go in for a diagnosis because she couldn't pay for it. Finally she got a part-time job but she couldn't get insurance. In the meantime her medical bills went to collection and she even got a letter that said she was going to jail. So now she is on the Medicaid expansion. She works part-time, she gets her treatment, and if we eliminate this expansion she now won't have insurance again.

Mr. Chairman, those are the types of people who are getting health insurance now. I can't help but believe Lisa Scheim and all the other millions of people who are getting insurance are getting worse care now than no care before. I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it and I thank the panel for their testimony.

Mr. McCarthy, in your testimony you noted that giving priority to states with the biggest wait lists would only incentivize states to have high wait lists. I am from Florida and we are the number two when it comes to the size of our home and community based care waiting lists, and I understand Texas is number one. Right, Mr. Chairman?

You also mentioned tying funds to the Money Follows the Person program. There are 44 states that have that program, Florida does not. How do you propose allocating funding to promote more home and community based care, something I strongly support, and yet not disadvantage states such as Florida and Texas that have a greater need?

Mr. McCarthy. It has to do with how we provide that incentive. So the idea is like in Ohio what we -- our Money Follows the Person program, when we started we had about 600 people that we moved out of institutions. By the time I left that number was over 5,000 people. So in 6 years we were able to do it. We focused on how to get people out of institutions, looking at that to pull people out.

We also used the money that came to the state by the one percent increase for rebalancing, so we used that also. So my point of it was if you were to say that it only goes to the states with the highest wait lists, then in Ohio my incentive would be to let the wait list grow that I have so as to be able to access

that 90 -- that that funding was 90/10 in the bill, so that would be my incentive to get there.

So instead of doing that I was saying, how do you just tie it to programs that are out there and hopefully other states will be looking at what we have done in Ohio or other states and learning from that and that is where CMS can come in and do a better job of getting states to collaborate to figure those different pieces out to move forward in those areas.

Mr. Bilirakis. Thank you. Again for Mr. McCarthy, Medicare is moving towards value-based payments. Some forward-thinking Medicaid directors of programs have been adopting this model while others have been much slower. Can you talk about why value-based purchasing is important and what some of the existing barriers are both regulatory and statutory that need to be removed? How can we promote, really, generally how can we promote innovation?

Mr. McCarthy. So Ohio is a State Innovation Model grant winner and so that was a benefit to the state to move forward in that. And the reason value-based purchasing is important in Medicaid is because it rewards better health outcomes, it doesn't just put money into the program.

So in Ohio for instance even in this last budget that was introduced Monday, there weren't just simply for physicians putting money into increases in fee-for-service physician rates.

It was going into the per member per month amount going to doctors which then get rewarded for bringing down costs but having better outcomes.

And so that is why value-based purchasing is important. The barriers that you run into are all at the CMS level. I have talked to CMS about this. The Center for Medicare and Medicaid Innovation don't talk to CHDS at the Medicaid side. And for instance in Ohio we ran into a barrier. The only way we could do patient centered medical homes in the fee-for-service world was through a state plan and that meant then we had to bring up a PCCP program, which we didn't run in Ohio.

So there is this whole barrier of how do we get there? Those things need to be waived, because what we were trying to do is bringing more value to the program and increasing outcomes.

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

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for questions, please.

Mr. Schrader. Thank you, Mr. Chairman. I appreciate having the hearing, and some of these fixes to the Medicaid population issues and the Medicaid expansion issues I think are fine. I think unfortunately it doesn't get at the big gorilla in the room which is what do we do with the Medicaid expansion

population and how do we deal with Medicaid going forward.

And I apologize to Dr. Roy right off because I am going to ask you a few questions. When was study, the New England Journal of Medicine study done that cites some of the issues in the Oregon Medicaid program that you cite in your testimony?

Mr. Roy. The study was conducted in the late 2000s and early 2010s, and I believe it was published in 2014.

Mr. Schrader. Yes, so it predated the ACA.

Mr. Roy. It wasn't about the ACA expansion, but it was about --

Mr. Schrader. I understand, reclaiming my time. The problems you cite with outcomes, no better no worse, but no better than traditional Medicaid with the waiver program. Second question, do you think it is cheaper based on your information to give tax credits and subsidies for the federal government, for the federal taxpayer to do that rather than have eligible people be on Medicaid?

Mr. Roy. In Transcending Obamacare, our health reform proposal, we propose taking the same dollars. So it is not about a reduction in dollars relative to the Medicaid program, but it is about taking the dollars that are spent, providing acute care coverage to the Medicaid population and giving them the option of having a tax credit that allows them to purchase --

Mr. Schrader. And the answer -- thank you, I appreciate

that. And the answer is it is unfortunately to put people in the Medicaid population for the American taxpayer. I am trying to be a little fiscally responsible as we look at the costs of all these people. I prefer not to have to take care of people that are unable to afford health care, but on the back end I don't want to pay for them in the emergency room or for long-term, serious, life-threatening issues at the end of their life.

Mr. Roy. If you buy an East German car it might be cheaper than buying a Toyota or a Ford but that doesn't mean you get more transportation out of it in the end.

Mr. Schrader. I totally agree.

Mr. Roy. So cheaper isn't necessarily better.

Mr. Schrader. So spending money -- I am a businessman. Spending money sometimes saves you money up front, right? So if you spend your money you can hopefully make it up on the back end. How many people do you think that are under 138 percent of poverty level or earning $16,000 a year are going to be able to afford to put money into an HSA account that you recommend in your proposal?

Mr. Roy. If it is subsidized through these tax credits they would be able to afford it.

Mr. Schrader. If it is subsidized. So in other words we need to have money in the Medicaid expansion population or whatever system we have to be able to make something go forward

in a reasonable way that Joe Sixpack could actually afford things.

Mr. Roy. Absolutely.

Mr. Schrader. The issue I have here right now is that, you know, the bottom line is the Medicaid expansion population has been an unqualified success. We have red states, red state governors, some of my Senate colleagues, some of my Republican colleagues who cross the aisle, you know, really excited about the opportunity to serve people. That is really the goal, right? People, you don't want them not to have health care. You don't want them not to show up to work. You don't want them to be a burden to the taxpayer, and health care is kind of a central way to make that thing happen.

I am very worried that the block grant math is unfortunately a death spiral. That has been talked about. It is a block grant. I don't care if it is a Medicaid expansion population, I don't care if it is Medicaid itself. I don't care if it is all these little bills that we are talking about that are supposed to fix, not repeal Medicaid or Medicaid expansion, you know, we need to make sure that these things are there at the end of the day. The block grant math doesn't do that.

Population in America is going increase. By definition 20 percent of Americans are on Medicaid, 25 percent in my district, 50 percent in the chairman's district are on Medicaid. You put that on a block grant with increasing population it is a death

spiral not just for the individuals, not just for the families, but for the taxpayers of this country.

Rural districts in particular benefit by the Medicaid expansion. In my district, in my state alone in rural parts of my district and the chairman's district, the coordinated care organizations are giving better care for less money. It doesn't always have to be this Hobbesian choice where you cut provider reimbursement. That is a medieval technology. That is a medieval technology, colleagues.

What you want to do is incentivize with block grant global payments like we have talked about with the SGR, you know, to give these local districts, local control to the states to create their own way to provide Medicaid services to these people. In Oregon, contrary to that study that you cite in your testimony, it has been an unqualified success. You know, emergency room admissions are down 20, 30 percent; primary care visits up 60 percent. Diabetes, one of the studies they are doing and looked at, much better outcomes, almost 60 percent better outcome than we see before. And I could on with COPD, all these.

If you give people the right incentives to get good health care, not burden them with financial burdens we can get this thing done. So I would urge my colleagues to think thoughtfully as we look at this Medicaid expansion issue going forward. And I yield back. Thank you, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman; precisely why we are having the hearing. The chair recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions, please.

Mr. Bucshon. Thank you very much, Mr. Chairman. Indiana expanded under the Affordable Care Act under current Vice President Pence, so obviously, you know, a state based program like HIP 2.0 is a flexible program but required a difficult to acquire waiver.

Mr. Roy, in House Republican health care proposal Better Way would allow states to use Medicaid to provide a defined contribution in the way of premium assistance or a limited benefit to work-capable adults who are working or preparing to work. States can do this now but require a waiver as in HIP 2.0. This would allow states to use this approach without a waiver so they can enroll more low-income adults in private coverage if they are working.

This is similar to the goals, as I mentioned, Healthy Indiana Plan 2.0 and in fact it is being implemented and I would like to explore this idea legislatively, so what are your thoughts on this type of policy reform?

Mr. Roy. Thank you for the question. I think it is better than nothing to have more flexibility for states to do the kinds of things you are talking about. As I alluded to earlier in response to a different question though, the Medicaid statute

severely limits the flexibility even if CMS grants waivers to states to do certain types of things with their Medicaid program.

So what is very important is to reform the statute so that individuals have more control over their healthcare dollars, they can buy the kind of insurance that really serves their needs, deploy Health Savings Accounts sometimes for example to use retainer based direct primary care so they can get much bigger and much more frequent access to primary cares and specialists when they need them. If you do that it will dramatically improve health care outcomes relative to the Medicaid program today.

Mr. Bucshon. Thank you. Mr. McCarthy, in your testimony you said the fundamental role of CMS should be rethought and we should focus less on command and control. There are nearly 400 staff at CMS and CHIP -- well, Centers for Medicaid and CHIP services at CMS. Do you know how many of them have worked in a state program for a health provider or a managed care plan?

Mr. McCarthy. I do not know how many of them worked in --

Mr. Bucshon. Well, let me, I will give you the data. Using LinkedIn to look at publicly available information it was examined in 2016 that about 40 percent of the staff had a bachelor's degree and nearly 15 percent had a law degree or Ph.D., but only four percent held a credential as a health care provider. The majority of the staff, 57 percent of the staff had spent their career in federal or state government, but only five percent had previously

worked for a state Medicaid program or fewer than 20 percent had ever worked for a health plan or provider.

Of course none of this is to suggest that, you know, these aren't great employees and are doing the best that they can, but it does raise the question of whether or not there is an unintentional institutional bias for individuals who are writing the rules and regulations for state Medicaid programs if you only have five percent of the people that have ever actually worked for a state Medicaid program.

What could be done to devolve CMCS authorities or assure there are more people at CMS that have more real-world experience in this area?

Mr. McCarthy. One of the things that often comes up is the fact that CMCS treats the National Association of Medicaid Directors as just another stakeholder group. They are no different than a hospital association or anyone else.

And so one of the things I have advocated for a long time is the Medicaid directors should be brought in earlier to talk about rules and regulations and what will work and not work. They should not be treated as just another stakeholder because they are part of the system that is putting up a bunch of the money, so they need to be talked about. For instance, the latest rules, the mega rule where you brought up that came up around the IMDs, Institutions for Mental Disease, in that final rule states cannot

implement what was put in and that was because CMCS didn't talk to states specifically around how could this be implemented.

So I don't know how to change getting people who work at CMCS to come from states because obviously they would have to move across the country there or you would just be some of my old staff from the district or Maryland would be the only two places that people would move there for. But the rules and regulations and how states are looked at have to be --

Mr. Bucshon. So I think what at the end of the day, which we see this across federal agencies, federal agencies should reach out to people who have subject matter expertise probably in a better way than they have. Not necessarily have those people with that expertise in the agency, but they should probably reach out more to people like yourself and others.

Ms. Solomon, do you believe that all citizens of the United States should be on Medicaid or on Medicare?

Ms. Solomon. All citizens, no. I mean the ones that --

Mr. Bucshon. Yes. That would be a single payer. Do you believe in a single payer?

Ms. Solomon. I believe in universal coverage. I think what we did in --

Mr. Bucshon. No, the answer is you do or you don't.

Ms. Solomon. No, I don't believe in single payer. I believe in whatever gets us there.

Mr. Bucshon. Yes.

Ms. Solomon. And the ACA made a big start in that.

Mr. Bucshon. Yes. Okay, thank you. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions, please.

Mr. Engel. Thank you, Mr. Chairman. We have heard Republicans describe their alternative picture of Medicaid before. In fact we have had a hearing on most of these bills before. I don't think anyone here would disagree with meaningful efforts to shrink waiting lists and afford Americans the services they need quickly, but that is not what these bills do. These bills represent yet another Republican attempt to gut Medicaid based on total falsehoods.

I think it would be helpful to talk about the real Americans for whom Medicaid is lifesaving. First, let's clear up any misconceptions about who Medicaid covers. Nearly a quarter of New Yorkers were covered by Medicaid or CHIP in 2015. The vast majority of New York's Medicaid beneficiaries come from working families. These Americans cannot afford private health insurance even with a full-time job. For them, Medicaid is a chance to stay healthy which means a chance to work longer hours and provide for their families.

Now I would like to debunk another misconception. My

friends on the other side of the aisle allege that Medicaid spending is out of control. In fact, Medicaid spending is lower than the spending growth rate of Medicare and private insurance, and again I will point to New York. Despite charges that Medicaid is inflexible, our state has dramatically revamped our program to improve program integrity, better care for patients and save money. These efforts have avoided costs to the Medicaid program in excess of $1.8 billion. New York achieved this while expanding Medicaid and cutting our uninsured rate in half.

There is one more issue I would like to address and that is the one before us today. A Republican's ideas to strengthen Medicaid entail delaying or denying coverage to Americans that need it to redirect funds to other parts of the program, specifically to those states that choose to operate waiting lists for Medicaid home and community based services. They are suggesting that if states have high coverage levels they are also letting Americans suffer on waiting lists.

Let me ask you this, Ms. Solomon. I am wondering if you can help us delve into that claim. You said in your testimony that 11 states and D.C. do not operate waiting lists. I believe my state of New York is among them. Is that correct?

Ms. Solomon. That is right.

Mr. Engel. Thank you. As I said a minute ago, New York cut its uninsured rate in half, thanks in part to its decision to

expand Medicaid. Now even with that major expansion of coverage zero New Yorkers, nobody, was forced onto a waiting list. So Ms. Solomon, let me ask you again. Would you say that New York's example is representative of most states without waiting lists?

Ms. Solomon. It is. As I said, only two of the states without waiting lists have not expanded, so there isn't a correlation there.

Mr. Engel. Thank you. And I have one final question for you, Ms. Solomon. Is there any evidence that refusing or holding up Americans' Medicaid coverage as these bills would do, would reduce waiting lists for home and community based services?

Ms. Solomon. I don't think they would because these are all state choices. States have made a choice whether or not to lower their waiting lists to provide more services to take up options. It is all state choices. It is not necessarily because another state has done something for other people.

Mr. Engel. Thank you very much. Let me say that if as this hearing title suggests my Republican friends are serious about strengthening Medicaid, and I quoted this is what this about, Strengthening Medicaid and Prioritizing the Most Vulnerable, unquote, well, let me suggest there is a way to do that. The Affordable Care Act strengthened Medicaid tremendously by modernizing it and promoting program integrity. The ACA also helped America's most vulnerable. Thanks just to the law's

Medicaid expansion, more than 12 million people gained insurance coverage.

So in short, let me say this. If you want to strengthen Medicaid, if you really want to strengthen Medicaid, strengthen the Affordable Care Act. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions, please.

Mrs. Brooks. Thank you, Mr. Chairman. I would actually like to talk about something that we have done in Indiana that my colleague from Indiana has talked about which I do believe will strengthen Medicaid, and that is Healthy Indiana Plan 2.0, which I might say the logo is health coverage equal peace of mind.

So we in Indiana do believe that health coverage equals peace of mind. And the Healthy Indiana Plan which was approved by our General Assembly prior to the Affordable Care Act being implemented had incredible difficulties with CMS getting waivers during the time that it has been in existence, and our new governor, Governor Holcomb, just resubmitted Healthy Indiana Plan 2.0 with some modifications just yesterday. And I have to just share some of the year one results, and this comes, some of this information comes from analysis of 2015 member surveys.

There are over 370,000 members approved for coverage.

Seventy percent of the members choose to make contributions into their POWER accounts, and we could go into more. Forty two percent emergency room visits lower, 42 percent emergency room visits are lower for individuals that have moved from traditional Medicaid into Healthy Indiana Plan. Eighty percent HIP plus members report satisfaction, so do providers. Three and four providers, and we started out the hearing talking about providers, believe HIP will improve health care in Indiana. And there is a gateway to work in trying to incentivize for the expansion population more and more people to seek work opportunities and to get them training.

So I would like to just focus a little bit on what your thoughts are about Healthy Indiana Plan 2.0, each of you, what do you think are the best things, and maybe a challenge very briefly in my 3 minutes, about what you know about Indiana's innovative, the first consumer-directed health care program in the country for the Medicaid population.

Dr. Roy.

Mr. Roy. So in my view the Healthy Indiana program and in particularly the initial version that was passed under Governor Mitch Daniels is the most innovative Medicaid program in the country. And I think it is very encouraging that Seema Verma who was one of the chief implementers of that plan has been nominated by the President to be the CMS administrator.

I think one thing we should mention about the Healthy Indiana Plan 2.0 is that under the Obama administration CMS there was lot of pushback on some of the important features of Healthy Indiana that made Healthy Indiana so attractive. So, for example, in the POWER accounts that Healthy Indiana, the program has, the Health Savings Account-like instruments in the Healthy Indiana program, there were certain requirements. To be eligible for the Medicaid expansion under HIP 1.0 you had to do very small things, provide a small premium payment of like a dollar in some cases.

Mrs. Brooks. A dollar a month.

Mr. Roy. Exactly, a dollar a month. Do some basic annual checkup tests like checking your cholesterol, checking your diabetes, your HbA1c, other basic checkups to make sure that you were engaging in the primary care and wellness health activities that would help people manage their care in a really good way.

A lot of those requirements were watered down in Healthy Indiana Plan 2.0 because the ACA Medicaid expansion is mandatory and so there isn't the same carrot opportunity to say, look, if you do these things we will give you the reward of expanded access to coverage under HIP 2.0 the way it was for HIP 1.0. So that is one of the very disappointing aspects of how the Obama administration --

Mrs. Brooks. Thank you. And Dr. Roy, because I would like to get Mr. McCarthy because my time is running out, I would

appreciate it if you would supplement your testimony with other responses if you might.

Mr. McCarthy.

Mr. McCarthy. I agree with what Dr. Roy said. It is really important to say that it was the pre-ACA versus post-ACA. And I would also point out that in Ohio under our Healthy Ohio program that we had with something similar we also hired Seema Verma to help us write that waiver. And that was called Health Savings Account, but we called it a BRIDGE account so that a person could take the money that was in that account with them when they moved off of Medicaid to help them pay for health care services when they weren't on Medicaid any longer.

Mrs. Brooks. Can you please quickly explain your concept? You mentioned in your written testimony about money following the person approach. Could you briefly touch on what that means?

Mr. McCarthy. Yes. So that is where people who are in home and community, well, basically people who are in institutions so they are institutionalized. And what you are doing is trying to get the person out of the institution back into the community and the issue is often that person doesn't have the money to do some of the very basic things and that is where Money Follows the Person works, like buy people pots and pans and help on the first month's rent.

The idea there was to use those dollars that would be

available to then also pay for home and community based services for a year or 2.

Mrs. Brooks. Thank you. I am sorry, my time is up. I yield back.

Mr. Burgess. The chair thanks the gentlelady. The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for questions, please.

Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. This has been a very informative session today and I appreciate all of your input.

Dr. Roy, I want to start with you. First of all, I want to thank you. Today you have articulated the fact that Medicaid spending is climbing and that unfortunately the health outcomes in Medicaid are not what they should be and they are far worse than many other programs. So it seems like we are at an impasse. And my question is, you know, all of us want to improve care and we want to decrease costs and cut costs and decrease spending but, and we are looking for ways that we can do that and certainly the bills that have been presented here today that we are discussing will do that and we are thankful for that.

But what are some other solutions very quickly that you envision that perhaps could help us in this goal?

Mr. Roy. Absolutely. Thank you for the question. I think the most important thing is to maximize the flexibility that

individuals have and also states and localities to take the health care dollars and the financial systems that we are offering so that individuals can buy the health coverage and health care that they need.

The biggest problem with the Medicaid program and the reason why it doesn't work is not because we don't spend enough money or we spend too much money, it is because there is very little flexibility in how those dollars can be spent. And so a lot of the dollars have to be spent in massively inefficient ways that prevent people from getting the care that they need.

Mr. Carter. Where does personal responsibility come in and how do you legislate that? I mean it is difficult.

Mr. Roy. Well, I think when individuals are controlling more of those health care dollars they are naturally going to be much more responsible for their coverage and care, because they know that if they manage those dollars wisely they are going to have savings later on in a POWER account or something like that that cannot only accrue to their future health care needs but those of their children, their spouses, their descendants, the caregiver, the people they have to take care of.

So that is an important aspect of when you take the dollars out of the bureaucracy and give it to patients to control themselves; surely we can all agree that the more the patient controls the dollar the better that patient is.

Mr. Carter. Absolutely. Thank you for that. And I am going to stay with you, Dr. Roy, and I am going to ask you one more. In your written testimony you discussed the 2010 Simpson-Bowles report, and that of course took on the issue of creative financing and noted that many states finance a portion of their Medicaid spending by actually taxing the providers. We did this in the state of Georgia. I was in the state legislature for 10 years and we actually, I was on the Appropriations Health Subcommittee, I was on Health and Human Services, so I was right in the thick of it.

And we actually drew down, we were drawing down more federal dollars from Medicaid at a 1:2 ratio. In other words for every dollar we would put in we were getting two. Well, obviously we balanced our budget that way, and in fact the state of Georgia this year is reauthorizing that in this legislative session. How can we do this better? That just doesn't make much sense to me.

Mr. Roy. Thank you again for this question. What we propose in Transcending Obamacare, and it is an idea that we actually borrowed from the Urban Institute and a scholar there named John Holahan, a left of center think tank, is that the best way perhaps to reform the Medicaid program broadly is to restructure it so that instead of having both states and Washington offload these costs onto each other and split the responsibility in ways that don't work, have the states and

Washington divide the responsibilities up.

So for example what we propose is have the federal government say we are going to take over the part of Medicaid that is providing financial assistance to poor people who need acute care health insurance, just like we do for tax credits for the uninsured, et cetera, and then the long-term care, trade that and give that fully to the states to manage. If you do it that way, if you clean up the lines of responsibility -- states control one aspect, federal government supports the other -- you eliminate all these poor and bad incentives for mismanagement.

Mr. Carter. Okay. Mr. McCarthy, I have got about a minute and there is something that is very important to me. In your testimony you said that states are forced to cover all FDA-approved drugs and in turn receive rebates. However, for new high cost drugs the rebate is not high enough to offset the large increases in expenditures. Would we not be better off letting the states opt out of the rebate program and do it themselves?

I will be quite honest with you we used to do it ourselves in Georgia. We used to have our own rebate system before this started with the federal government. Dr. Bucshon can certainly attest to the fact that in the South we are in the Cardiac Belt. We utilize more of a certain type of drugs than they do in other parts of the country. Dr. Murphy mentioned the anti-psychotics, and of course as a pharmacist I understand all this. And how do

you think that idea would go if we let the states do their own rebate program?

Mr. McCarthy. As always if you let states have that option and don't force them to do something I would be in support of that because right now you can only negotiate on additional rebates.

Mr. Carter. Good. Okay, well, I am out of time, but thank all of you again for this.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from California, Dr. Ruiz, for 5 minutes for questions, please.

Mr. Ruiz. Thank you, Mr. Chairman. Thank you, panelists, for being here. I am not on this subcommittee, but I am still here because this issue is so very important to me personally, my patients and my constituents. I am an emergency physician and there is just so much to say about this conversation.

First, all doctors, Republican or Democratic doctors prefer health insured patients over uninsured patients. There is no doctor on this committee or anywhere in our nation that prefer their patients to be uninsured. Two, Medicaid patients have higher morbidity because they are a higher risk group. They are the sick, vulnerable and poor. That means that actually Medicaid is working because we are targeting those patients that it is intended to target.

Three, block grant and per capita block grants will create

more uninsured patients and physician reimbursement rates will worsen because states will choose to cut eligibility, reduce insured patients and cut reimbursement rates to physicians. Tax credits will not cover the full cost of health care, in fact it will have our vulnerable populations pay higher premiums and deductibles and therefore patients will have to pay more out-of-pocket.

Since the expansion of Medicaid under the Affordable Care Act, emergency departments around the nation including mine have seen a dramatic decrease in uninsured patients by 50 percent or more. That is good for the patient. That is good for the emergency department and that is good for hospitals and taxpayers. And the reason why emergency departments have seen an increase in patients is because there is not enough physicians to see the newly insured. The over 20 million newly insured patients in our nation now have insurance.

So these patients who have been putting off taking care of their chronic illness because they couldn't see a doctor because they couldn't afford it are now insured and they can't see physicians in their community because of the severe physician shortage crisis so they go to the emergency department.

Okay. I have concerns that the Verify Eligibility Coverage Act will hurt American citizens. This bill will prohibit federal funds until citizenship is proven. So let me give you a real-life

case of a citizen that this bill will hurt. At the Mass General Hospital where I was training in medical school I took care of a patient that arrived in the emergency department after a severe motorcycle accident and suffered severe multi-organ trauma including completely degloving of his face.

He was in the trauma ICU for 2 months without any identification of who that person was. He couldn't speak, he was intubated, and there was no information about him and nobody, no family was calling in to look for him. so we simply didn't know who he was. What do we do with them? What do we do with that citizen? Are we not allowed to pay for his care because he couldn't prove his citizenship?

So in regards to the lump sums and lottery winning legislation, Ms. Solomon, while I think it is safe to say that an overwhelming amount of millionaires aren't trying to qualify for Medicaid, I would like to clarify the impact of this legislation. It should be noted that this bill has changed since last Congress and reflects some additional nuances and protections that are very important.

This legislation is a prime example of why it is so critical that we slow down and take the time needed to truly consider a policy proposal and its impact on lives of millions of Americans. So is there any evidence that this bill actually solves a rampant problem?

Ms. Solomon. Thank you, Dr. Ruiz. This bill has changed considerably and I commend the drafters for filling in a lot of the problems that were identified initially, and now I think what it really will do is very modest and just create hassles for states.

It is really interesting to look at what has happened in Michigan which actually is recovering from lottery. In their Medicaid waiver they were given permission and over the 21 months that this provision has been live they have recovered $380, but they have a contractor that needs to track so it is not clear it does much of anything.

Mr. Ruiz. Let me ask you another question regarding tax credits. Can you explain why tax credits don't work in place of Medicaid coverage?

Ms. Solomon. Especially these tax credits that are being proposed that are flat and not based on income would clearly not work. But the other thing that we need to remember is that Medicaid is a very different program than private insurance that is specifically designed and very flexible to cover the multiple populations that are served. A tax credit isn't going to have that same flexibility that Medicaid has to provide the kinds of substance use treatment, behavioral health treatment, programs for kids with special needs; it just isn't going to work.

Mr. Ruiz. Thank you.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions, please.

Mr. Sarbanes. Thank you, Mr. Chairman, I appreciate it. I want to thank the panel for its testimony.

And Ms. Solomon, I wanted to ask you a question, but I also wanted before that just to say that it is unfortunate that our Republican colleagues seem to want to take parts of the Medicaid program that really do represent innovation and flexibility and then instead of identifying that as a real opportunity to build on a strong foundation in the overall program, they instead use it to distract from good parts of the program or actually go pull money away from that foundation.

So, you know, you talk about the home and community based waiver program which is a terrific innovation, I think. When I was still in the health care arena representing a lot of health care clients in Maryland, we were looking at a waiver program that would allow some Medicaid funding to flow to assisted living facilities where there is, you know, a lower need for care and less costly, but didn't usually qualify for Medicaid reimbursement.

So we wanted to explore that as an alternative to nursing home care which is very high cost, the home and community based care waiver is an extension of that thinking and so we ought to

pursue it in a meaningful way, but we shouldn't just then use it as a shiny object to be able to then argue that we should go take money from other important parts of the program.

In the same way the idea of flexibility is an important one. I think you do want to give state Medicaid programs flexibility to innovate and try other things, but then using the flexibility argument that our colleagues on the other side say, okay, that is why we should block-grant things because that is the ultimate flexibility, so again they go take a concept that could be a constructive one and they use to advance something which has the effect of undermining the core strength of the Medicaid program. And I think that is, it is unfortunate. It is a missed opportunity for us to talk about how we can continue to strengthen and improve a program that works pretty well already.

So I would like you to maybe speak to that idea of how you keep the foundation of the program strong even as you are looking at potential for innovation and flexibility. And in fact that if you did maintain the strength of the program and gauge states' flexibility, they would actually go identify sources of savings and you would probably achieve more savings than as what is being proposed by these three bills to take away from the existing beneficiaries.

So if you could speak to that because I think it is important if we want to get a more efficient program that provides solid

care and maintains a strong foundation that is the way flexibility and innovation ought to be pursued.

Ms. Solomon. I totally agree with that. And we have been actually cataloguing on our website examples of states doing exactly that and they have been given tremendous flexibility to innovate, including being able to use upfront dollars which often are necessary to build the communication system across providers, to increase provider capacity and then achieve the savings in the long run.

When I worked in Medicaid at the state level that was always the barrier, because as an advocate we would argue but you would be able to save money if you make this investment. And the money wasn't there. And if you look at the innovation through the SIM grants that Mr. McCarthy spoke of and other initiatives that have taken place that is exactly what has been going on.

And I really take issue with Dr. Roy's statement that Medicaid doesn't work. Medicaid works really well. And I think that is really the thing that we are trying to lift up through highlighting these innovative programs, targeting the high utilizers that are responsible for a great portion of the costs by providing better coordination with some of the alternative models that have been put forth in the Affordable Care Act and elsewhere. So I think, you know, we could go on for all day on how Medicaid works.

Mr. Sarbanes. Thank you for your testimony. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from California, Mr. Cardenas, 5 minutes for questions, please.

Mr. Cardenas. Thank you very much, Mr. Chairman. Don't let these people distract you from the big picture, ladies and gentlemen. They keep talking about less than six --

Mr. Bucshon. Would the gentleman yield?

Mr. Cardenas. Yes.

Mr. Bucshon. We are not these people, we are elected members of Congress that represent over 700,000 citizens.

Mr. Cardenas. Would you please give me back my time, Mr. Chairman? Thank you very much. Don't let these elected Congress members distract you from the big picture. They keep talking about less than 6,000 people. The big picture is the more than 74 million Americans today that have a life of dignity because they are using Medicaid and Medicare, 74 million, ladies and gentlemen, right now in the United States of America. Six thousand, let's deal with that.

Let me be very clear here, ladies and gentlemen, for the majority of Americans, middle class Americans, Medicaid is what gets you or your mother or your father into a nursing home. It is what allows you to have a nurse help you in your home with things you otherwise need to live a basic life of dignity. It is not

Medicare, ladies and gentlemen. It is Medicaid that provides that. Medicare doesn't even get you through the door.

Seniors, families with seniors who need help cooking, walking or even changing their clothes, I want you to be very clear about this. We are talking about you, ladies and gentlemen, we are talking about your loved ones. This is important here. Your long-term care doesn't come through Medicare. It comes through Medicaid. Many people don't understand the program. They want to demonize it to basically rip it out of your hands.

But Republican and Democratic governors are begging Republicans here in Washington, please don't do this Congress members, because if Republicans in Congress do, these governors know that their state, the people in their state are going to suffer. Governors are going to have to decide what to cut from your life. Ladies and gentlemen, they are going to turn their backs on Grandma and Grandpa and we are going to have sick people in the streets more than there are today and we will be right back where we were, and that is not the good old days, folks.

Today people on Medicaid walk into the doctor's office. If Republicans make these changes, people will be flooding emergency rooms. That will increase health care costs for everyone. Doctors and nurses and hospitals won't be able to handle the workload.

Now according to the study in the New England Journal of

Medicine, one of the oldest and most prestigious medical journals, if Republicans take away everyone's coverage over 43,000 people could die each year based on these actions. In California that means over 7,600 people could die in 1 year. In Texas that is over 2,400 people a year. I am sure my colleague chairman of the Health Subcommittee understands the value in saving lives and doing no harm. In Illinois that is over 1,400 people a year. I am sure my colleagues from Illinois think that is unacceptable. In Oregon that is over 1,200 people a year. I am sure the chairman of the committee doesn't want to see Medicaid dollars get slashed in his state.

We cannot accept this. We cannot allow Republicans to do this to seniors, to children and to the people with disabilities. These are hardworking Americans. Republicans in Congress want to take that care away, but they won't own up to it. Republicans say to you that they don't want to pay for Medicaid. What they don't want you to figure out is that they want to pocket your tax dollars. They are going to cut Medicaid while lowering taxes for the wealthiest people. They are going to lower taxes for Trump's billionaire friends, and in the committee down the hall, but raise taxes on everyone else. It is not fair. It is just another trade-off, and Republicans are sabotaging the American health care system.

Ms. Solomon, people in L.A. County where I am from have truly

benefited from the Affordable Care Act. I have seen it with my own eyes. Can you talk a little bit about what repealing the law and what kicking people off of Medicaid would mean for people in Los Angeles?

Ms. Solomon. I think, you know, you probably have as many people as many states do in your county. I have had the opportunity to meet the people from the community health centers across L.A. County. I think large numbers would just lose coverage as they would in every state, hospital uncompensated care would grow, same for other providers, and as you noted there would be real harm.

Mr. Cardenas. Thank you very much, my congressional colleagues. I yield back.

Mr. Burgess. The gentleman's time has expired. The gentleman yields back. Seeing that there are no further members wishing to ask questions, I do want to thank our witnesses for being here today.

The chairman would remind the committee that we all agree it is important that we secure the care and keep our commitment to vulnerable Americans. The very fact that we are holding this hearing today as the first Subcommittee of Health hearing, I think, is evidence of that fact and I hope we can continue to take these steps and have the discussion in a rational manner.

Pursuant to committee rules, I remind members they have 10

business days to submit additional questions for the record. I ask the witnesses to submit their response within 10 business days on the receipt of these questions, and without objection, the subcommittee is adjourned.

Mr. Green. Can you yield just for a second?

Mr. Burgess. One second.

Mr. Green. Okay.

Mr. Burgess. Time is up.

Mr. Green. Mr. Chairman, I think on our side we want to work with you and I will leave this, I think a start of a good hearing. So we will go from here and to see what we can do.

Mr. Burgess. Well, again, Mr. Chairman, the very fact that this was the first hearing of the subcommittee, I mean I know there are members on my side who actually resent the tone that this committee ended up on today. I regret that fact. I hope that we can keep this on a civil and unemotional level going forward. This is important work that we do and it is literally the future of our country.

Again I want to thank our witnesses for being here today, and without objection, the Subcommittee is adjourned.

[Whereupon, at 12:43 p.m., the Subcommittee was adjourned.]