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``THE EXTENDERS POLICIES: WHAT ARE THEY AND HOW SHOULD THEY CONTINUE UNDER A PERMANENT SGR REPEAL LANDSCAPE?''

THURSDAY, JANUARY 9, 2014

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 of the Rayburn House Office Building, Hon. Joe Pitts [Chairman of the Subcommittee] presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Lance, Cassidy, Griffith, Bilirakis, Ellmers, Pallone, Dingell, Capps,

Matheson, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Gary Andres, Staff Director; Noelle Clemente, Press Secretary; Brenda Destro, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Amy Hall, Democratic Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; and Anne Morris Reid, Democratic Professional Staff Member.

Mr. {Pitts.} The subcommittee will come to order. The chair recognizes himself for an opening statement.

This subcommittee has played an integral role in advancing a permanent repeal of the SGR and implementing a replacement policy for Medicare reimbursement to physicians. We reported out Dr. Burgess's Medicare Patient Access and Quality Improvement Act of 2013, H.R. 2810, by voice vote, and the full committee reported it out favorably by a vote of 51 to 0 last July.

As we move ahead with a permanent SGR fix, we also need to examine the expiring Medicare/Medicaid Children's Health Insurance Program--CHIP--and Human Services' provisions that have traditionally moved with the SGR.

The purpose of today's hearing is to look at these extenders and evaluate whether some of these short-term provisions should be made permanent and, if so, how best to accomplish this.

The list of extenders includes the following: the Floor on Geographic Adjustment, or GPCI, for physician fee schedule, Ambulance Transitional Increase and Annual Reimbursement Update; Therapy Cap Exceptions Process, Special

Needs Plans, Medicare Reasonable Cost Contracts, National Quality Forum--NQF; Qualifying Individual--QI program; Transitional Medical Assistance--TMA; Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals; Medicare-Dependent Hospital--MDA program; Medicaid and CHIP Express Lane Eligibility; Children's Performance Bonus Payments; Child Health Quality Measures, Outreach and Assistance for Low-Income Programs, Child Health Quality Measures, Family-to-Family Health Information Centers, Abstinence Education, Personal Responsibility Education Program; Health Workforce Demonstration Program; the Maternal, Infant, and Early Childhood Home Visiting Programs; and Special Diabetes Program.

In our current budget climate, and with the Medicaid trustees predicting insolvency as early as 2026, hard decisions will have to be made. A determination that a policy should be made permanent must be based on data-driven analysis that justifies the extenders' continued existence.

I am looking forward to hearing from our witnesses today, particularly MedPAC, which has come up with its own criteria for evaluating these provisions, which includes the effect possible action would have on program spending

relative to current law, whether such action would improve beneficiaries' access to care and quality of care, and whether action would advance delivery system reform.

This is a time for us to be very prudent, even skeptical, given the enormous cost of these policies and do our job on behalf of the taxpayers to ensure every dollar spent is reviewed for efficacy.

Thank you, and I yield the remainder of my time to Dr. Burgess, vice chairman of the subcommittee.

[The prepared statement of Mr. Pitts follows:]

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

Dr. {Burgess.} Thank you, Mr. Chairman, and I do appreciate that you started your opening statement with the acknowledgment that the reason we are here today is because of the real progress that has been made on the repeal of the Sustainable Growth Rate formula, which has been a problem for a lot of us for a long time, so the cake is literally in the oven baking and today we are going to talk about what else may go into that before the process is completed.

There are certainly a number of Medicare- and Medicaid-related policies that every year plague providers because of the uncertainty that it brings to the program participation by provider payment each year. Not all of these policies are under our jurisdiction. Many are some that have proven successful but many of these programs are under our jurisdiction and many of them have proven successful such as the Special Diabetes programs and the Special Needs Plans. Others are essential to guaranteed access to care in States like Texas with large rural areas such as the Medicare-Dependent and Low-Volume Hospital programs. Still other extenders are necessary to block misguided policies like the Medicare therapy cuts. Capping rehabilitative access made no

sense when it was first passed several years ago, and guess what? With the passage of time, nothing has improved. It still makes no sense. Doctors should be able to provide their patients with the option of therapy and never fear that either prior to or after surgery a patient will not be able to access the therapy services that they require.

So certainly, Mr. Chairman, I am appreciative of the work that this subcommittee did in moving the SGR reform along as we were the initial subcommittee that passed real, meaningful Sustainable Growth Rate reform out of subcommittee on to full committee. Other jurisdictions have taken up that matter but it all started here with you, Mr. Chairman, and I am appreciative of that.

I would also ask unanimous consent to submit the testimony of the American Hospital Association for the record as well, and yield back.

[The prepared statement of Dr. Burgess follows:]

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Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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

Mr. {Pitts.} The Chair now recognizes the ranking member of the subcommittee, Mr. Pallone, 5 minutes for opening statement.

Mr. {Pallone.} Thank you, Chairman Pitts.

I am pleased we are having this hearing today to discuss the temporary payment policies and programs we typically extended every year alongside the SGR. I thank our witnesses also for being here today to contribute to the discussion.

This subcommittee has an important role in reviewing and evaluating health care policies and the extenders provisions that will contribute to the health care communities' abilities to better serve beneficiaries under Medicare and Medicaid.

In many ways, extenders support the health care framework envisioned in the Affordable Care Act. They work through various mechanisms to support increased access to health care and to encourage higher quality and more efficient patient care.

In spite of all that, we move beyond the unworkable process of legislating extenders policies year to year. We need to set these policies up for success by providing a

better sense of stability, and that is not to say that I think we should every provision permanently but moving towards a 3- to 5-year end date in some cases will better enable the subcommittee to conduct proper oversight and consider making changes periodically based on data collected over a sufficient amount of time.

In addition, we look to make changes to some of these policies but, more importantly, as we look to offset the costs associated with both the SGR and extenders, we must not cost-shift onto vulnerable patients who rely on these programs.

I just wanted to take a moment to highlight some extenders and how they help our Medicare and Medicaid programs, and this is not an exhaustive list, but certainly they are ones that I would like to work to urge this committee to extend. One is the Qualifying Individual, or QI, program in Medicare, which assists certain low-income Medicare beneficiaries by covering the cost of their Medicare Part B premium. This program helps reduce financial burdens and thereby improve access to needed health care services for low-income Medicare beneficiaries who do not quality for Medicaid. In New Jersey, 40,000 people were able to get this

needed financial assistance in 2013.

Another is the Transitional Medical Assistance, or TMA, program, which allows low-income families on Medicaid to maintain their Medicaid coverage for up to one year when their income changes as a result of transitioning into employment. The TMA program helps keep people continuously insured, allowing for consistent access to primary care and prevention services.

I also wanted to highlight two payment policies that we implemented in the ACA. The Medicaid Primary Care Physician Bonus Payment augments the low physician rates in Medicaid compared to Medicare. Research has shown that higher Medicaid payments increase the probability of beneficiaries having usual source of care and at least one visit to a doctor. This is an important policy that I believe should be extended because, unfortunately, we still need time to understand the impact of the program in a meaningful and empirical way. I also believe that there are physicians who are essential to the Medicaid program such as neurologists, psychiatrists and OB/GYNs that aren't included in the bonus payment but should be.

We also included in the ACA performance bonuses for

States that increased enrollment of children in Medicaid and streamlined enrollment procedures for Medicaid and CHIP. New Jersey was one of 23 States that received a bonus payment in 2013 through this program. Minimizing barriers to enrolling in coverage makes a difference in how many children are enrolled each year and ultimately whether they receive their prevention services and medical care they need.

And finally, I want to mention the Family to Family Health Information Centers, or F2F grant program. F2Fs assist families of children and youth with special health needs in making informed choices about health care, which in turn promotes improved health outcomes and more effective treatments. So F2Fs provide a unique service in that they are staffed by family members who have firsthand experience in navigating special needs health care services and that is why I have sponsored a bill, H.R. 564, to extend F2F funding through 2016 and will continue to advocate for its inclusion in any SGR package.

These are just a few examples of the many extender provisions that we must discuss as we move forward with an SGR fix. I have been pleased by the recent progress made on SGR, Mr. Chairman, and I stand ready to work with my

colleagues on both our committee and Ways and Means and with our Senate counterparts to permanently repeal and replace the SGR and continue these important extender provisions.

I don't know if Ms. Capps would like my last 30 seconds. All right. Then I yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

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

Mr. {Pitts.} The Chair thanks the gentleman. Our Chair is not here, so the Chair recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

Mr. {Waxman.} Thank you very much, Mr. Chairman.

My colleagues, this Congress seems to be, I hope, poised to eliminate the SGR and make it a program that will no longer be in existence so every year we don't have to go through the torture of trying to make sure that the harmful consequences of not extending it would be averted. All three committees, two in the House and one in the Senate, have voted--our Committee voted unanimously--on the SGR. I hope we can get it across the finish line and let us get this job done.

The SGR issue has often served as a vehicle to address Medicare, Medicaid, the Children's Health Insurance Program and additional public health-related programs, which contain similar time limits. These provisions have been collectively referred to as extenders or extender policies. When we permanently repeal and replace the Medicare SGR policy, we must also address these associated extender policies. These

policies seek to protect vulnerable patient populations and the providers and health programs that serve them, so we can't afford to leave them out in the cold and in jeopardy of being terminated.

In Medicare, we have policies that need to be extended relating to therapy caps and Special Needs Plans. Those have been discussed; they are well known. There are six public health extenders, some which have a long history of bipartisan support, and I am generally supportive of these public health programs, but I do want to note my reservations about extending the Abstinence Only program.

But I want to focus on the Medicaid and CHIP issues, which are often overlooked. Those policies help secure affordable coverage, boost enrollment of eligible children, and streamline administrative processes for States. For example, there is an Express Lane program. It gives States the option of relying on income data already in use for other federal programs, helping reduce bureaucracy and lower State administrative costs. This should be a permanent option for the States. The Transitional Medical Assistance and Qualified Individual programs are indispensable for low-income families. We must end the annual extender roller

coaster and ensure this coverage is secure going forward. The CHIP bonus payments have been successful at getting States to adopt simplifications and find and ways to get people enrolled, get kids enrolled. Twenty-three States, more than half of them with governors who are Republicans, have qualified under this program. We should continue it through the current CHIP reauthorization. And also, I have heard a great deal from family doctors and pediatricians about the Medicaid primary care bonus. It is something that would provide stability and adequate payment for physicians comparable to what we do in Medicare, and there is no better way to assure access and provide an alternative to the emergency room for care than making sure that doctors, especially family care and pediatricians, will have the extra payment to allow them to see these patients.

So I am glad we are holding this hearing, and I want to yield the balance of my time to my friend and colleague from California, Ms. Capps, who has a number of public health provisions that are in this bill that are very meritorious.

[The prepared statement of Mr. Waxman follows:]

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

Mrs. {Capps.} Thank you very much. Thank you, Waxman.

And I want to just simply add my thanks to the chairman and Ranking Member Pallone for holding this very important hearing today.

You know, we have had many discussions of how to move past the flawed SGR system, and I have frequently shared my views that we can't and must not ignore the important health care extenders, many of which have been mentioned already. These typically go along with SGR patch legislation, small technical but critical policies that make a world of difference for health care providers and their patients.

I just want to stand ready to work with my colleagues on each of these issues, especially those that have been already mentioned--the Medicare therapy cap, the Medicaid primary care bump, the many critical Medicaid and public health care extenders that we are considering today, and again, thank you for yielding your time and also for holding the hearing today. Yield back.

[The prepared statement of Mrs. Capps follows:]

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Mr. {Pitts.} The Chair thanks the gentlelady. That concludes the opening statements of the members.

I would like to thank all of the witnesses for coming today. We have one panel. On our panel today we have Mr. Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission, MedPAC. We have Dr. Diane Rowland, Chair, Medicaid and CHIP Payment Access Commission, MACPAC. We have Dr. Michael Lu, Associate Administrator, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. And finally, Dr. Naomi Goldstein, Director, Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Thank you for coming. Your prepared testimony will be made part of the record. You will have 5 minutes to summarize your testimony, and that will be placed in the record.

At this point I will recognize Mr. Hackbarth for 5 minutes for his summary.

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^STATEMENTS OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC); DIANE ROWLAND, SC.D., CHAIR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC); MICHAEL LU, M.D., M.S., M.P.H., ASSOCIATE ADMINISTRATOR, MATERNAL AND CHILD HEALTH BUREAU, HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND NAOMI GOLDSTEIN, PH.D., DIRECTOR, OFFICE OF PLANNING, RESEARCH AND EVALUATION, ADMINISTRATION FOR CHILD AND FAMILIES (ACF), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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^STATEMENT OF GLENN HACKBARTH

} Mr. {Hackbarth.} Thank you, Chairman Pitts, Ranking Member Pallone and Vice Chairman Burgess. I appreciate the opportunity to talk about MedPAC's recommendations on these issues.

As the chairman noted, there is a long list of Medicare provisions under discussion here and it is a diverse list. I won't try to summarize our substantive views on those provisions. Instead, what I will do is describe the criteria

that we used to evaluate provisions.

We looked at them in two batches. First, there was a 2012 request from the Congress focusing on some temporary Medicare extenders, as they are known. By definition, all of these provisions increase spending above the current law baseline. In evaluating those provisions, what we did was ask the question, whether there is evidence that provision in question improves access to care, quality of care or enhances movement towards new payment models.

We also had a 2011 request from the Congress to evaluate various special payment provisions that apply to rural providers. There we used a similar test. We asked whether the provision in question was targeted so that it provided support to isolated providers necessary to assure access to care for Medicare beneficiaries, whether the level of the adjustment provided was empirically justified and whether it was designed to preserve some incentive for the efficient delivery of care. These tests that we applied are admittedly stringent tests but we believe that they are consistent with our statutory charge to make recommendations to the Congress that are designed to assure access to high-quality care while also minimizing the burden on the taxpayers.

We think a stringent test is particularly appropriate in the current context of SGR repeal. As the committee well knows, we have been long-time advocates of SGR repeal, well over a decade now. We are heartened by the progress that has been made towards repeal and recognize an important part of the remaining challenge is the financing of repeal, so we think a stringent test on the extenders is an appropriate test in this context.

So I welcome questions from the committee. Those are my summary comments.

[The prepared statement of Mr. Hackbarth follows:]

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Mr. {Pitts.} The Chair now recognizes Dr. Rowland 5 minutes for her summary.

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^STATEMENT OF DIANE ROWLAND

} Ms. {Rowland.} Thank you, Chairman Pitts, Ranking Member Pallone and members of the subcommittee. I am pleased to be here today to share MACPAC's expertise and insights as the committee considers extension of several legislative provisions affecting Medicaid and the Children's Health Insurance Program, CHIP.

MACPAC was authorized in 2009 and began its work in 2010 to provide the Congress with analytic support on a wide range of Medicaid policy issues and CHIP issues. The focus of our work is on how to improve the efficiency, effectiveness and administration of Medicaid and CHIP, to reduce complexity and improve care for the over 60 million beneficiaries with Medicaid and CHIP coverage. During the coming year, we will be looking at the implementation of the Patient Protection and Affordable Care Act and the coordination of Medicaid, CHIP and exchange coverage. We will be looking at children's coverage and the status and future of the CHIP program, at cost containment and payment system improvements underway in the States for Medicaid, at issues for high-cost, high-need

enrollees, and on Medicaid administrative capacity. But today I will focus on the issues that are up for reauthorization and extension.

Specifically, one of the areas the Commission has looked at carefully is Transitional Medical Assistance, or TMA. TMA provides additional months of Medicaid coverage to low-income parents and children who would otherwise lose coverage due to increased earnings and helps to promote increased participation in the workforce, a goal of all of us. It was originally limited to 4 months and has since 1990 been raised to a 6- to 12-month period through the extenders we are discussing today. This provision applies to the lowest-income Medicaid beneficiaries who qualify under the welfare level guidelines and indeed helps to reduce churning between Medicaid, employer-based coverage and uninsurance. This churn is disruptive for the plans that service these patients, providers and the government entities that process these changes as well as for the beneficiaries themselves. MACPAC recommends eliminating the sunset date for the Section 1925 TMA that allows the 6- to 12-month coverage and also provides States with additional flexibility to do premium assistance as people transition from Medicaid to the

workforce.

We also have recommended that when States expand Medicare to the new adult groups under the Affordable Care Act, they be allowed to opt out of Transitional Medical Assistance because in that case there would be no gap between the end of their earning period and the coverage they would provide either through Medicaid under the new options or through subsidized exchange coverage.

With regard to Express Lane Eligibility, we looked at ways in which the program can be streamlined and which eligibility can be improved and see that the Express Lane Eligibility provides children with enrollment under CHIP and Medicaid with an express vehicle so that it eliminates some of the duplication that goes on in program determinations. Thirteen States have implemented this method of establishing eligibility, and we will continue to monitor the use and effectiveness of this approach and are in the process of reviewing the December 13th report by the Secretary of Health and Human Services and will provide our comments on that report to the Congress.

In terms of the CHIP program and outreach and eligibility, we see that bonus payments have provided a

strong incentive to the States to improve outreach and enrollment processes for children and now many of these strategies are required in the new eligibility and enrollment processes being implemented effective in 2014. So we will look at the restructuring potential of the bonus payments to try and see how those need to be restructured in light of the changes under the Affordable Care Act.

We also strongly support developing policies that will help us improve the way to measure the quality of care for children including the requirement in the extenders to develop a core set of child health quality measures. There is no other way to really be able to compare the quality of care being provided or to assess it without some standardization of the methods used, and we know that you will be looking for us to do such comparisons and really strongly support having the data and ability to do that.

With regard to the Qualifying Individual program and the Special Needs programs, we really have been looking very carefully at the importance of the role that Medicaid plays as a wraparound for Medicare beneficiaries, especially helping the very lowest income to not only afford their premiums but to get better and more integrated care, and we

will continue to try and work to assess ways in which we can improve the coordination and delivery of care for individuals who are duly eligible and very low income.

So in conclusion, we will continue to keep Congress informed of our progress in examining these issues. We look to try and find ways to reduce administrative burden and streamline the programs as well as provide better care to the beneficiaries for better investment of the dollars that this government puts into this care.

Thank you very much for having us today, and we look forward to continuing to share our work with you in the future.

[The prepared statement of Ms. Rowland follows:]

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Mr. {Pitts.} The Chair thanks the gentlelady and now recognizes Dr. Lu 5 minutes for a summary of his testimony.

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^STATEMENT OF MICHAEL LU

} Dr. {Lu.} Thank you, Chairman Pitts, Ranking Member Pallone and members of the committee. Thank you for the opportunity to testify today.

HRSA focuses on improving access to health care services for people who are uninsured, isolated or medically vulnerable. The agency collaborates with government at the federal, State and local levels to improve health and achieve health equity through access to quality services and a skilled health care workforce.

I am pleased to provide an overview and update on two of our programs: the Maternal, Infant and Early Child Home Visiting program, which I will just refer to as the home visiting program, and the Family to Family program.

The home visiting program, administered by HRSA, includes collaboration with Administration for Children and families, supports voluntary evidence-based home visiting services during pregnancy and to parents with young children up to age 5. Providers in the community work with parents who voluntarily sign up to participate in the program to help

them build additional skills to care for their children and family. Priority populations include low-income families, teen parents, family with a history of drug use or of child abuse and neglect, families with children with developmental delays or disabilities, and military families.

The strength of the overall program lies in an evidence-based approach, decades of scientific research which shows that home visiting by a nurse, a social worker or early educator during pregnancy and in the first year of life improves specific child-family outcomes including prevention of child abuse and neglect, positive parenting, child development and school readiness. The benefit of home visiting for the child continues well into adolescence and early adulthood. For example, previous work in this area has shown that among 19-year-old girls born to high-risk mothers, nurse home visiting during their mother's pregnancy and in their first 2 years of life reduce the 19-year-old's lifetime risk of arrest and conviction by more than 80 percent, teen pregnancy by 65 percent, and led to reduce enrollment in Medicaid by 60 percent.

In addition, a number of studies indicate home visiting programs have a substantial return on investment. The most

current one funded by the Pew Charitable Trust found that for every dollar invested in home visiting, $9.50 is returned to society.

Early data collected by HRSA found that within the first 9 months of implementation in 2012, the program provided more than 175,000 home visits to 35,000 parents and children in 544 communities across the country. Preliminary data from 2013 indicates that more than 80,000 parents and children are receiving home visiting services, and the program is now available in 650 counties across the country, which is 20 percent of all the counties in the United States. States and communities are the driving force in terms of carrying out this program. With our support, States and communities are building capacity in this area and have demonstrated improved quality, efficiency and accountability of their home visiting programs. States have the flexibility to tailor their programs to serve the needs of their different communities and populations. States are able to choose from 14 evidence-based models that thus fit their risk communities needs capacities and resources.

We have taken a number of steps to ensure proven effectiveness and accountability. HRSA and ACF provide

ongoing technical assistance to grantees and promote dissemination of best practices by supporting collaborative learning across States. Additionally, we closely monitor States' progress. The data are collected on an annual basis, and by October 2014, States are expected to demonstrate improvement in at least four out of the six benchmark areas.

Additionally, HRSA administers the Family to Family Health Information Center program with centers in all 50 States and D.C., which provides support, information, resources and training to families of children with special health care needs. These centers are staffed by parents of children with special health care needs. These parents provide advice and support and connect other parents to a larger network of families and professionals for information and resources. The centers also provide training to professionals on how to better support families of children with special health care needs and assists States in developing and implementing family center medical home and community system of care for these children.

HRSA closely monitors program effectiveness. A 2012 Family Voices report supported by HRSA on the activities and accomplishments of these centers indicated that between June

2010 and May 2011, so a 1-year period, approximately 200,000 families and 100,000 professionals received direct assistance and training from these centers. Greater than 90 percent of the families reported being able to partner in decision-making, better able to navigate through services and more confident about getting needed services.

I appreciate the opportunity to testify today, and I will be pleased to answer any questions that you may have.

[The prepared statement of Dr. Lu follows:]

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Mr. {Pitts.} Thank you. The Chair now recognizes Dr. Goldstein 5 minutes for summary of her testimony.

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^STATEMENT OF NAOMI GOLDSTEIN

} Ms. {Goldstein.} Thank you for the opportunity to be here today. I plan to speak about three programs my agency oversees as well as our collaboration with Dr. Lu and his colleagues on evaluating the home visiting program he described.

Each of these programs uses knowledge from past research, and in keeping with direction from Congress, we are carrying out evaluations to continue to learn about effective approaches for meeting the goals of these programs. We aim to make our evaluations rigorous so the results are sound and credible and also relevant and useful for policymakers and practitioners.

First, the Health Profession Opportunity Grants program funds training in high-demand health care professions for low-income people. It uses a career pathways framework based on past research. The program has funded 32 grantees including five tribal organizations. Of those people completing a training program, over 80 percent have become employed. The most common training is preparation for jobs

such as nursing assistant or orderly, short courses that can be the first step in a career pathway. Last year we published three reports on the implementation of these grants and the outcomes for participants. Grantees are using a range of creative strategies. For example, one grantee in Pennsylvania is using Google Hangouts for real-time tutoring in a highly rural service area. We plan to release additional reports this year and next. We are also studying how the program affects participants' education, employment and earnings.

Second, the Personal Responsibility Education program is designed to educate youth on both abstinence and contraception. The statute reserves the majority of funds for program models that are evidence-based or substantially so. All models must provide medically accurate information. HHS sponsors a systematic review to identify programs with evidence of impacts. So far, 31 program models have met the review criteria. We continue to learn about what works. We recently released a report describing State choices about program design and implementation such as how they define and how they reach target populations. Further findings from the national evaluation will be released over the next couple of

years. We are also studying the impacts of four local program approaches to address gaps in the evidence base.

Third, in the Abstinence Education program, States are encouraged to use models that are evidence-based, and again, all models must provide medically accurate information. In 2007, HHS completed an evaluation of four local abstinence programs, which found no effects on abstaining from sex. The study also found no effects on the likelihood of unprotected sex. However, three abstinence models are among the 31 teen pregnancy prevention models that meet HHS evidence criteria. The Abstinence Education statute provides no funding for research and evaluation. However, HHS is supporting evaluation of abstinence education through some of its broad teen pregnancy prevention activities. For example, one Virginia grantee of the Personal Responsibility Education program is evaluating an abstinence curriculum.

Finally, Dr. Lu mentioned our collaboration on the home visiting program. The statute reserves the majority of funding for home visiting models that meet evidence criteria. The statute also requires continual learning through a national evaluation and other activities. HHS sponsored a systematic review of evidence similar to the review of teen

pregnancy prevention evidence. So far, 14 home visiting models have met the review criteria.

The design of the national evaluation has been informed by an advisory committee of experts required by the statute. Most recently the committee reviewed and endorsed plans for a report to Congress due in March 2015. The evaluation is using a rigorous random assignment design to assess the effectiveness of the program overall and of the four home visiting models most commonly chosen by the grantees.

I hope these brief descriptions convey some sense of the accomplishments of these programs and of our ongoing efforts to learn and improve.

Thank you again for inviting me to testify. I would be happy to address any questions.

[The prepared statement of Ms. Goldstein follows:]

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Mr. {Pitts.} The chair thanks the gentlelady for her testimony and now we will begin questioning. I recognize myself for 5 minutes for that purpose.

Mr. Hackbarth, I believe that this committee needs to be diligent in its spending priorities and consider every one of these policies carefully before deciding whether they warrant extension. Many constituencies are advocating for making these extenders permanent. In your testimony, you lay out a set of criteria to use when considering these extenders. Using your criteria, do you believe that all or the majority of these extenders warrant extension?

Mr. {Hackbarth.} Certainly not all. I haven't done a count so I would be reluctant to say whether a majority are not, but we think many should not be extended.

Mr. {Pitts.} In your opinion, based on your criteria, do you have a couple of programs that Congress needs to look at with a very critical eye as we begin this review?

Mr. {Hackbarth.} Well, we just focus on the world of payment provisions, some of which are permanent and some of which are temporary and under consideration here. As I said in my opening comments, we did an extensive review of

Medicare rural health issues, which was published in June 2012, I believe, and part of that was to examine the special payment provisions against the criteria I mentioned in my opening comments, namely are they targeted to isolated providers, are they empirically justified and do they retain some incentive for efficiency, and we found a number of those provisions to not.

So let me focus in on one in particular. There is a temporary Low-Volume Adjustment in the Medicare program. This is a hospital payment adjustment for providers that have low volume. There are a couple serious problems with that adjustment. First of all, it is based only on Medicare discharges. If the issue we are trying to address is small size and a lack of economy of scale, the appropriate index of that is total discharges, not Medicare discharges. In addition to that, it looks to us like the magnitude of the adjustment is too large. And then finally, it is not directed only at isolated providers so hospitals that are in close proximity to, say, a Critical Access Hospital can qualify for the Low-Volume Adjustment. In fact, there are some hospitals like Sole Community Hospitals that can in effect double-dip, get special payments as Sole Community

Hospitals and also low-volume payments as well.

Mr. {Pitts.} Thank you. I want to commend you for putting forward the criteria you referenced in your testimony. I believe it will be helpful to me and others on this committee as we consider the extenders before us today.

Dr. Rowland, like MedPAC, does MACPAC have a similar set of established criteria by which to weigh the Medicaid extenders that consider issues like cost and taxpayer burden against current benefit that the policy delivers to beneficiaries? And if not, how do you take into account issues of cost and other important considerations that MedPAC is advocating?

Ms. {Rowland.} Well, we are obviously a much newer body than MedPAC so have begun to try to establish the criteria by which we would look at the various policies. One of the strongest criterion is, does this promote efficiency, effectiveness and reduce complexity in the programs. So we looked at these various extenders in terms of their role. The only area in which we have made strong recommendations is around Transitional Medical Assistance, or TMA, and we are continuing to look at the others both in terms of their cost but also in terms of their impact on beneficiaries on State

administration and on federal dollars and spending.

Mr. {Pitts.} Thank you.

Dr. Goldstein, we only have 30 seconds, but I understand that ACF provides technical assistance to grantees on a number of issues. However, very little of that assistance includes how to encourage more teens to choose abstinence or sexual risk avoidance. Please describe the technical assistance that you provide on abstinence compared to other topics such as contraceptives.

Ms. {Goldstein.} I am actually not prepared to address that but I will be glad to take that question back to my program colleagues and provide an answer for the record.

Mr. {Pitts.} All right. Now, the committee published a report that analyzes abstinence or sexual risk avoidance programs, and it describes over 22 peer-reviewed studies that show statistically significant evidence of the positive impact of these programs. Are you familiar with that report?

Ms. {Goldstein.} I am.

Mr. {Pitts.} And have you, or would you share it with grantees as part of the technical assistance?

Ms. {Goldstein.} Again, I will take that back to my program office colleagues and provide an answer for the

record.

Mr. {Pitts.} Thank you. I have gone over time. I now recognize the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. {Pallone.} Thank you, Mr. Chairman.

I have a number of documents on the extenders that I wanted to ask unanimous consent to enter into the record. I am not going to read them all because it would take up my whole 5 minutes but I can maybe hand you the sheet here.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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

Mr. {Pallone.} Thank you.

I had a question initially of Dr. Lu. I have been a strong supporter of the Family to Family Health Information Center program in the past and the program has helped so many families in my State and across the country manager their special health care needs, and that is why I introduced a bill that would extend the funding for these centers into 2016. I was also pleased to see the Senate went even furthering their SGR bill by extending the program until 2018 and included $1 million increase.

So my question is, in addition to helping families with special health care needs, I was wondering if you could talk a bit more about some of the contributions that the F2F program has made to our overall health care system.

Dr. {Lu.} As you mentioned, Congressman Pallone, these centers are unique in that they are staffed by parents of children with special health care needs, so as parents, they understand the challenges, the issues that other parents face. They know the system. They can provide advice and support and they can connect other parents to this larger network of families and professionals for support. They can

help the families find the best health care providers. They also partner with providers, and in doing so they can really improve on the outcomes as well as cost-effectiveness of the care for a very vulnerable population of children.

Mr. {Pallone.} I think you kind of answered my second question, but could you just talk a little bit more about how the Family to Family Health Information Center program is different from other HRSA programs and how the staffs are uniquely qualified to help families with special care needs? I know you kind of answered that but--

Dr. {Lu.} Yes, that is right, and because it is unique in the sense that they are staffed by parents themselves, and in terms of the support, the information, the resources, the training that they can provide from their firsthand experience, I think that is irreplaceable.

Mr. {Pallone.} All right.

Mr. Chairman, the work of these Family to Family Centers has long been supported by members on both sides of the aisle so I am hopeful that the program can be continued when the committee addresses the extenders.

I wanted to ask Ms. Rowland a question also about the CHIPRA bonus payments. CHIP enrollment performance bonuses

established by CHIP have incentivized States to more effectively administer their CHIP programs as evidenced by the growing number of States receiving these bonuses each year. For the fiscal year 2009, 10 States received bonuses for a total of $37 million. In fiscal year 2013, 23 States received bonuses for a total of $307 million. So I think it is important to continue providing incentives to States to more effectively administer CHIP. In order to qualify for these bonus payments, States have to implement five of eight enrollment best practices or simplifications. While the ACA has now required some of these best practices, States have not uniformly adopted all of them, and there is a lot more work to do. Express Lane Eligibility, Presumptive Eligibility and 12 Months Continuous Enrollment are all very important for enrollment and retention of children in coverage, in my opinion.

So I just wanted to ask you, wouldn't you agree that working to encourage States to adopt these simplifications is critical and that the availability of the enrollment bonus is in part responsible for getting States interested in adopting these best practices?

Ms. {Rowland.} Well, I think we have learned a great

deal about the quality of these best practices and that is why some of them are now required and I think to continue to look at ways to encourage States to do outreach and effective enrollment of the eligible but not enrolled children is an important way to reduce the uninsurance of children. So certainly being able to maybe look at some other incentives to provide in the bonus payments that perhaps if the State chooses to eliminate its waiting period for CHIP, for example, that that would be another thing that you might want to add on to qualifying for the bonus payments. But I think that really gives you the ability to give States a true incentive to go out and find many of these eligible but not enrolled children, and we really just need to look at ways to structure those bonus payments so that we are trying and testing all of the ways to smooth and streamline enrollment.

Mr. {Pallone.} Thank you.

You know, I just wanted to mention, Mr. Chairman, currently the CHIP is authorized for 2015 but I believe we should extend the bonus payments for the life of the program, and I agree, as we get evidence from the ACA, we want to retool and qualify the threshold but for the time being to encourage States to keep making gains in coverage. It would

make sense to keep the program going. And it is also true that of the States that have qualified, more than half are led by Republican governors, so this is a program that has good results in both red States and blue States. I hope we can continue it. Thank you, Mr. Chairman.

Mr. {Pitts.} The Chair thanks the gentleman. I would also like to do what you did, and I will just give you the list. I have a number of letters that I would like to submit for the record. Without objection, so ordered.

[The information follows:]

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

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Mr. {Pitts.} All right. The Chair recognizes the vice chair of the subcommittee, Dr. Burgess, 5 minutes for questions.

Dr. {Burgess.} I thank the chairman.

Dr. Rowland, let us stay on the issue of Transitional Medical Assistance for a moment. Now that the Affordable Care Act has been implemented and we are all lying in the elysian fields of Obamacare, is the TMA even necessary any longer?

Ms. {Rowland.} Well, sir, I think it depends on what the option that the State chose to pursue. So certainly in the States that have chosen to do the expansion of coverage, there is a way to eliminate the gap as earnings go up because the coverage can be continuous. But as you know, half of the States have not opted to pursue the extension of eligibility for adults that is coming through the Affordable Care Act, and in those States, Transitional Medical Assistance is particularly important because it would enable individuals to really get the ability to go into the workforce.

Dr. {Burgess.} I thank you for the answer. So if I understand you correctly, the extension of Transitional

Medical Assistance should only be for those States that are non-participating in the Medicaid expansion, as is their right under the Supreme Court decision.

Ms. {Rowland.} Well, Transitional Medical Assistance at the 4-month level exists for all States. This is about whether it should be extended to the 6 to 12 months, which also provides States with some additional flexibility to do premium assistance as people transition into the workforce. So it gives States the ability to really move people from Medicaid into private insurance, and I think that is a very important provision in the Transitional Medical Assistance.

Dr. {Burgess.} Yes, I think that was actually--I have to interrupt you for a minute because my time is limited. I think that was actually a flaw in the Affordable Care Act. We can talk about that. But for continuation of Transitional Medical Assistance, really it seems to me that that is only necessary in those States that did not participate in the Medicaid expansion, again, which was their right under a Supreme Court ruling.

Ms. {Rowland.} Correct, except if you are concerned about the cost, there actually is a higher cost for the federal government to individuals in the States that do the

transition to the Affordable Care Act coverage because there it is 100 percent federal financing as opposed to the shared financing that goes on for Transitional Medical Assistance. So the--

Dr. {Burgess.} Again, forgive me for interrupting, but that is a temporary state also and we all know that the FMAP for those States that are participating is going to have to change at some point in the future. There is a limit to how much money the Chinese will loan us for that program.

Now, you mentioned churning, and I think that is an important issue and one that I don't think was ever completely well thought through as the Affordable Care Act was discussed because you are going to have people that continuously earn at different levels during the course of a year, and 137 percent of federal poverty level may sound great when we talk about it here in a committee or in a federal agency, but in real life, there are people whose income may fluctuate wildly throughout the course of the year. When we had the hearings on the people affected by the blowup of the Deepwater Horizon, we had a hearing down on the Gulf Coast of Louisiana. We heard from a shrimper who earned a fantastic amount of money during the month of May but the

rest of the year he is flat broke. So he is going to transition from Medicaid into an exchange and then back into Medicaid. That seems terribly inefficient as a way to structure that. So your program prevents that from happening?

Ms. {Rowland.} It would help maintain coverage throughout the period so that during these lapses where one month there is a lot of income and the next month there is less, you have continuous eligibility during that period so it eliminates having to transition and really helps managed-care plans to be able to more effectively provide continuous care as well as reduces State administrative burden.

Dr. {Burgess.} Forgive me. I don't think it is our role to help managed-care plans.

Dr. Lu, let me just ask you a question because in both your spoken and your written testimony, you talk about a study amongst 19-year-olds. Their lifetime risk of arrest was significantly lowered. What period of time did this study comprise?

Dr. {Lu.} The study, I believe, was a longitudinal follow-up of these children and families over a two-decade period.

Dr. {Burgess.} Correct. It would have to be two decades if you are dealing with a population of 19-year-olds who received home visits during their gestations with their mothers, but you cite a lifetime arrest risk as being diminished. I mean, most of us expect to live longer than two decades when we are born, so how actually have you compiled those figures? Is there some way to project the lifetime risk of arrest or conviction at age 19?

Ms. {Goldstein.} I can speak to that. The lifetime arrest record that Dr. Lu referred to is as long as their life had been so far, so it was through the age of 19. It was not a projection beyond that point.

Dr. {Burgess.} Very well. I thank you for clarifying that.

Mr. Chairman, I will yield back.

Mr. {Pitts.} The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for questions.

Mr. {Waxman.} Thank you very much, Mr. Chairman.

Dr. Rowland, I want to draw your attention to a provision that was enacted into law this past December that I fear will have serious consequences for access to care in

Medicaid. We all agree that Medicaid should not pay for care that someone else is liable for, and the statute has protections to ensure that States can recoup when other parties are liable financially. But for pediatric and neonatal care, for more than 20 years the law had required States to pay promptly and chase other sources of payments later. This is to ensure children, infants and pregnant women could get access to care promptly with no delay. The law was changed in December to say that States must delay payments to those providers for up to 90 days while they chase other potential sources of payment. Congress would be outreached if anyone proposed delaying payments to Medicare physicians for 90 days for a service provided. I am concerned this change in law will have a negative impact on providers' willingness to participate in Medicaid and will harm access to care for children and infants. Could you comment on this?

Ms. {Rowland.} Well, as you know, this committee has long been concerned about access to care for Medicaid beneficiaries and the willingness of physicians to participate in the program. One of the areas that MACPAC has been looking at is, what are the barriers that prevent more

primary care and specialists to participate in the program, and we learned from that that payment delays and inability to get payments processed is one of the identifiable issues that doctors raise about why they are unwilling to participate in these programs. So I think one really needs to look at whether such a delay in payment would affect the access to care that is so important given Medicaid's substantial role today in paying for nearly 50 percent of all births in the country and a high share of the neonatal care. This is critical to look at.

Mr. {Waxman.} It seems just logical, and we should expect that that is going to happen if we are going to delay payments just to delay payments when we don't it anywhere else and there is no reason to delay it.

Mr. Hackbarth, last month this committee held a hearing where we heard from a number of stakeholders about how the changes to the Medicare Advantage program under the ACA were affecting patients, and if you listened to some of the testimony you would think that Medicare Advantage was withering on the vine and that beneficiaries are no longer able to choose among private plans as they had before. I would be interested to hear MedPAC's perspective on the

current state of the Medicare Advantage plans. Are plans really in such dire straits?

Mr. {Hackbarth.} Well, enrollment in Medicare Advantage continues to grow and last year increased about 9 percent. Medicare beneficiaries continue to have a large choice of different options. The average per county is now 10, which is down slightly from the year before. Just this week, the CMS actuaries reported that in 2012, for the population newly aging into the Medicare program, over 50 percent of the new Medicare enrollees chose a Medicare Advantage plan, which I think is a potentially significant milestone.

Mr. {Waxman.} Let me ask you about the parity between an Advantage plan and Medicare fee for service. Can you tell us, did the Affordable Care Act set Medicare on a path to parity between FFS and Medicare Advantage or do you believe that Congress should stick to the ACA reforms and continue moving forward, or is there any justification for repealing these reforms?

Mr. {Hackbarth.} We have long advocated, Mr. Waxman, going back more than a decade that there be financial neutrality between Medicare Advantage and traditional Medicare. We continue to believe that that is the wise

course. The Affordable Care Act moves in that direction, and we would encourage Congress to stick with that course. We expected that with fiscal pressure resulting from the reduction in benchmarks that in fact plans would respond in part by lowering their costs if in fact the bids have fallen concurrent with tightening of the benchmarks. So it is evolving pretty much as we expected and we urge you to continue on this path.

Mr. {Waxman.} I know there was a recent recommendation for additional changes to Medicare Advantage payments from the Commission. This deals with how Medicare Advantage plans offered by employers to retirees are priced. Could you describe this recommendation and why you believe it is important?

Mr. {Hackbarth.} We haven't quite yet made the recommendation. It is up for consideration at our meeting next week where we will be voting on recommendations for our March report to Congress. The issue here is that the bidding system used for employer-sponsored plans is different, and there is basically no incentive for plans to bid low in the employer-sponsored area, which results in higher payments for Medicare. So we are looking to options for using market bids

that come from the rest of Medicare Advantage programs to set payments for the employer-sponsored plans that would reduce Medicare outlays somewhat by using those market-based bids.

Mr. {Waxman.} Thank you, Mr. Chairman.

Mr. {Pitts.} The Chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. {Shimkus.} Thank you, Mr. Chairman, and welcome. It is a great hearing and it is important to remember extenders and of course tied with the SGR.

So I have got a chart. It is the budget numbers for, I think if we do this right, 2012 just to keep this debate in perspective. And if you look at it, the budget is $3.45 trillion. Of that, Medicare is $251 billion--no, Medicaid is $251 billion, Medicare is $466 billion. Those are 2012 numbers.

So my first question is to Mr. Hackbarth and Dr. Rowland. We don't move any of these extenders, and they lapse. What happens to the solvency debate of Medicare and Medicaid? How much does that improve the extended life of these programs and how many days or months? Mr. Hackbarth?

Mr. {Hackbarth.} Mr. Shimkus, I don't have in my head

what the total spending impact of all of the various temporary provisions is. I don't know if my colleagues have it here. If not, we could get you that number.

Mr. {Shimkus.} Okay. But you understand where I am headed to with this question, I am sure.

Dr. Rowland, do you--and I am going to go back to you in a minute but do you have a response to that?

Ms. {Rowland.} The only estimate that we have is that the Congressional Budget Office has estimated that making the Transitional Medical Assistance provision permanent would save Medicaid spending dollars.

Mr. {Shimkus.} But in the billions, in the hundred billions or in--

Ms. {Rowland.} In the $1 to $5 billion over a 5-year period.

Mr. {Shimkus.} Okay. So the point being is this. These programs, and we can debate the relevancy, in our federal budget, mandatory spending is driving our national debt. These will really hardly affect the solvency debate on both Medicare and Medicaid. Mr. Hackbarth, would you agree with that?

Mr. {Hackbarth.} They are not large relative to these

numbers. Another potential reference point is how do they compare to the cost of repealing SGR, in other words, how much do they add to the challenge of financing SGR repeal. That is a number where it looks a lot more significant relative to--

Mr. {Shimkus.} Obviously, because proportional.

Dr. Rowland?

Ms. {Rowland.} Yes, these are compared to total Medicaid spending. These are very small, but they still represent obviously spending that helps--

Mr. {Shimkus.} So the overall debate, which we try to raise all the time and I have been talking about since 1992, if we don't get a handle on our mandatory spending programs, they will end up consuming the small blue portion, which is our discretionary budget. We will continue to have these budget fights. We will continue to try to squeeze because the red areas are going to continue to grow unless substantial, significant reforms occur, which is--and we, since I have been here since 1996, I started talking about this in 1992, we are unwilling to make those tough choices to have a Medicare program for future generations and to have a Medicaid program. And I fear for the future. That is just

the macro debate. I am glad we are having this debate, but it gives me the opportunity to put real numbers on the board because real numbers matter for our children and our children's children, and as Dr. Burgess said, who is subsidizing our debt, also foreign countries.

Let me go then to, I represent about a third of the State of Illinois, pretty big area, 33 counties. I would hope in these evaluations that we understand distances, the importance of rural health care providers in 30 to 45 miles and what is that cutoff. So in essence, the Medicare-Dependent Hospitals and the Low-Volume Hospitals, I understand these reforms, but the importance of this debate for rural America is, there is nowhere else to go. They are it. And if they don't have the volumes, as you mentioned, to justify their existence, we need to figure out how to make sure that those doors stay open.

Mr. {Hackbarth.} We emphatically agree, Mr. Shimkus, that we need to preserve access for Medicare beneficiaries that live in areas that are not sparsely populated. Our point, though, is what need to do is make sure we target our assistance to those isolated providers, and if we target it well, we can actually provide more assistance, more effective

assistance than if we spread our available dollars loosely over a larger number of providers, many of whom are not necessary to assure quality care.

Mr. {Shimkus.} And Mr. Chairman, if I could just make this final statement. It is not a question. But Dr. Hackbarth, you are only one who raised the ground ambulance extenders, and I think you raised the point, and I think as we look at that, there has to be a time frame by which we get real data and reevaluate that data.

Mr. {Pitts.} Mr. Dingell for questions.

Mr. {Dingell.} Good morning, Mr. Chairman. Thank you for your courtesy and for holding this hearing today. It is very important. And I want to thank our panel members for being here. I am not going to be asking questions today because I want to make a few observations about the urgent need to get SGR reform over the finish line.

I would like to observe that SGR reform is urgently necessary because without it, the whole problems of Medicare and our taking care of health care in this country in making the Affordable Care Act is going to suffer terribly as will the people.

Now, every year for the last decade, the Congress has

stopped in to reverse severe cuts in reimbursements for physicians wisely mandated under Medicare as mandated by the SGR. Due to our failure to fix this fatally flawed payment system, doctors and other medical providers have experienced enormous uncertainty and have been able to plan for the future, and the country and medical system has suffered because of it. Last year the Congress made bipartisan, bicameral progress in repealing and replacing the SGR with a new system that provides stable payments for doctors in the short term and incentivizes them to move the alternative payment models forward in the long term.

It is really a shame that we weren't able to put this in because of budget matters without having to address the question of how we are going to pay for it because it solves a problem that was created by some very unwise actions by the Congress. The legislation is going to make a significant contribution to the change in our efforts to provide health care for our people and it will award doctors for their performance rather than for the quantity of the work and begins to take steps away from the fee-for-service system, parts of which are so badly broken.

I am confident that the three bills passed by this

committee, the Ways and Means Committee, the Senate Finance Committee can be reconciled and sent to the President's desk before March 31 deadline but there are still hurdles to be overcome.

I want to commend the members of the committee, the leadership of the committee and the other committees in the House and Senate for the leadership which they gave in this matter and for the vision and for their hard work and for the decency with which they worked. This hearing is an important contribution to resolving the problem, and I want you to take my commendations, Mr. Chairman, for your part in all that has been done, and I want you to appreciate not only what you have done but what others have done to bring us to this point.

I want to observe that it would be a terrible calamity if we don't carry this thing across the finish line. I want to make it very clear that Medicare beneficiaries should not have their benefits reduced or cost increased to pay for the reform of SGR. Both sides must be willing to compromise and all persons must understand that the resolution of this problem will probably not be perfect from anybody's view but at least we will make progress in getting rid of something

that is causing us vast difficulty in achieving our purposes. So our goals must be responsible compromise, and I have observed over the years, compromise is an honorable activity and it is something which will make this institution work.

Second, I am very pleased that the so-called extenders and the policies that are traditionally considered a part of the short-term Medicare physician payment formula patches are the focus of today's hearing. You have been very perceptive in doing that, Mr. Chairman, and I thank you.

I am also pleased that the Senate Finance Committee included many of these critical extenders in their permanent SGR bill. Many of the extenders provide critical benefits to Americans across the country, especially Medicare and Medicaid beneficiaries, people who have great need of these things. We must not forget about these critical programs as Congress moves forward with SGR reform. Specifically, the Qualifying Individual program, Transitional Medical Assistance, Express Lane Eligibility and CHIP bonus payment programs must not be allowed to expire and should be extended as part of the long-term SGR bill. Congress should consider extending many of these programs on a permanent basis, given their proven track records and the fact that the annual SGR

patch will not be available as a vehicle in the future.

Furthermore, I hope that the Congress will consider reinstating Section 508 wage classification that expired in 2012. I also believe that the Medicare primary care payment increase should be extended as well.

In closing, I hope we can build off the momentum we generated last year to get a long-term SGR bill across the finish line while not leaving extenders beyond. I look forward to continue to working with you and all my colleagues, the leadership on this committee and the leadership in the House and Senate to get this bill to the President's desk before the March 31 deadline.

Mr. Chairman, there are great accomplishments that have been made in this matter. We have taken major steps to solve a terrible problem which has been inhibiting responsible consideration of health care for the American people, and I hope that we don't lose this opportunity because we let some kind of partisan or other misfortune create difficulties for us.

Again, I commend you. This is an example of how oversight should work, and I thank you for your leadership.

Mr. {Pitts.} The Chair thanks the gentleman and thanks

him for his leadership and cooperation on this issue of repeal and reform of the SGR. Thank you for the sentiments you have expressed, and I share those with you.

Now the Chair recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. {Murphy.} Thank you, Mr. Chairman. I thank the panel here.

Mr. Hackbarth, you have talked about a number of things with quality, and quality and value are of great concern to all of us, but I want to talk about some of the issues of readmission rates and also deal with some of the measures. For example, reports have come out from Medicare about readmission rates for such things as heart attack, pneumonia, hip and knee replacements. I don't think we have those same things on a pediatric level, do we, Dr. Lu or Dr. Goldstein? Do we look at readmission rates for pediatrics? Okay.

But on the Medicare level, what we have to be concerned about is that when people have a chronic illness, we know a small portion of folks on Medicare, for example, make up a large portion of the cost, particularly those with chronic illness. I think 90 percent of the cost is caused by chronic illness. And when you have a lot of chronic illness, you

also have a 50 percent higher rate of depression. You have untreated depression and chronic illness, you double the cost.

So along those lines, MedPAC has recommended new criteria for payment to rural hospitals. Now, under MedPAC's criteria recommendations, should a facility with fewer than 100 beds and approximately 60 percent of discharges under Medicare qualify for the Medicare-Dependent Hospital Payments program?

Mr. {Hackbarth.} Mr. Murphy, we think that the Medicare-Dependent Hospital program suffers from some of the issues that I have referred to earlier. For example, it is not targeted at isolated hospitals, and so a Medicare-Dependent Hospital can receive these higher payments, these subsidies, if you will, even when it is in close proximity to say, a Critical Access Hospital.

Mr. {Murphy.} But I think some of those are in danger of being changed. One of my concerns with Medicare is how it does not pay for coordinated care. For example, Southwest Regional Medical Center in Greene County, Pennsylvania, used its Medicare-Dependent Hospital funding to provide case management services for patients upon discharge. So if you

were to eliminate those payments, could it not lead to readmissions of patients who had trouble following their discharge orders?

Mr. {Hackbarth.} Well, we absolutely share your concern about better care for complicated patients, many of whom have multiple--

Mr. {Murphy.} I just want to make sure there is funding to help them.

Mr. {Hackbarth.} Well, we don't think that this sort of program is the best way to attack that problem. We think that mechanisms like accountable care organizations where an organization assumes responsibility for a full range of conditions.

Mr. {Murphy.} This hospital I am talking about is way outside of a 25-mile boundary from a Critical Access Hospital, and when I look at what is happening here--and let me go to something that was recently in the Baltimore Sun. They talked about 500 patients in the State of Maryland with psychiatric problems account for $36.9 million a year with regard to psychiatric services because one of the problems that occurs is when someone has a psychiatric problem such as psychosis and they have a co-occurring symptom of that called

anosognosia, which means they are not aware they have a problem. That also occurs, for example, in stroke victims who may have a right-sided problem in a stroke, and if the left side of their body doesn't work, they do not even work that the left side of the body doesn't work. And with psychiatric symptoms, they may not realize their hallucinations or delusions are not real.

So what happens when they are discharged from ma hospital, they stop taking their medication, and it is essential in these cases that there is someone who is working with them. Now, that is in Baltimore, but the example I am giving is hospitals in a very rural area. I just want to make sure we have mechanisms in place to look at coordinated care, and the reason for that is, as long as we are using measures such as readmission, readmission alone can't be the criteria because sometimes readmission is a symptom of the disorder where we are not maintaining that coordination. So what advice, where could we go with this in improving this?

Mr. {Hackbarth.} Well, again, I think the clinical problem that you are raising is a really important one, not just for the individual patient but for the program. Our goal is to address the needs of the patient in the most

effective way possible. We don't think that poorly targeted subsidies, some of the money from which might be used for good purposes, is the best way to deal with a systemic problem such as you have identified. So if we have a finite amount of money to spend, which we do, we need to be very careful. So one thing that has been done recently in post-discharge care is to create a code where clinicians will be paid for coordinating care post discharge. That is a much more targeted response to the clinical problem as opposed to paying more for Medicare-Dependent Hospitals.

Mr. {Murphy.} Well, let us continue to work on that together.

Thank you, Mr. Chairman.

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

Mrs. {Capps.} Thank you, Mr. Chairman, and thank you, witnesses, for your testimony today.

Drs. Lu and Goldstein, the Affordable Care Act established several new programs that you described in your testimonies, the Personal Responsibility Education Program, or PREP, and also the Maternal, Infant, Early Childhood Home

Visiting program, as well as the Health Workforce Demonstration Projection for Low-Income Individuals. I am interested in all of these.

You mentioned hat comprehensive evaluations are ongoing. From your testimonies, even as we await results of these comprehensive evaluations, early indications seem to me that these programs are successful, and importantly, they are grounded in sound evidence. Could you each just say a word, if you will, a very brief description on the successes of these programs thus far and how these three programs are informed by available evidence? Let us start with you, Dr. Lu, but also Dr. Rowland just for a minute each.

Dr. {Lu.} I can share about the home visiting program. As I mentioned, the home visiting program is built on decades of evidence on its effectiveness, and as of 2013, we are now reaching and serving more than 80,000 parents and families in 738 communities, and that is two-thirds of all the communities identified by the States to be in the highest risk for adverse health outcomes in the country.

Mrs. {Capps.} Let me just turn to you, Dr. Rowland, for one of the other programs, if you would.

Ms. {Rowland.} We mostly looked at the way in which

Medicaid care can be coordinated and clearly have looked at the fact that case management and integration of services is really critical, especially for coordinating the care for people with behavioral problems.

Mrs. {Capps.} Okay. Dr. Lu, I was a long-time visiting nurse, and I know firsthand of the benefits home visiting can have on high-risk pregnant women, children and families, helping them be healthy, make healthy choices, accessing critical health care services and supports needed to have healthy babies. I am referring now to a program in my district. The San Luis Obispo Department of Health delivers a nurse family partnership model, which has shown long-term improvements in child health and educational achievements as well as family economic self-sufficiency. The home visiting program supports States in expanding these programs and services to reduce poor birth outcomes, preventable childhood injuries, all the good things that happen along with these home visits, issues that affect all of us as taxpayers. So I just want to get on the record what is at stake if this program is not continued, Dr. Lu.

Dr. {Lu.} Well, if the program is not continued, families will be losing services that are proven to improve

maternal-child health outcomes and have all the positive benefits on positive parenting, children's cognitive, social, emotional and language development as well as school readiness. Also, the investments that States and communities have made to build up the service systems and capacity will be lost if the program is not continued.

Mrs. {Capps.} Right. Dr. Goldstein, in your testimony you mentioned that States receiving Title V funding for Abstinence Only Until Marriage Education programs are encouraged but not required to use evidence models that are medically accurate. This differs from the statutory requirements in PREP hat say these programs which teach both abstinence and contraception must be evidence-based and medically accurate. Could you elaborate on the difference in the evidentiary standards for these two programs?

Ms. {Goldstein.} Certainly. The statutes require that grantees in both programs provide medically accurate information. The PREP program also requires that services be evidence-based or substantially incorporate elements of evidence-based programs. The Abstinence Education program does not have such a requirement although we have encouraged grantees to use evidence-based approaches, and as I noted,

there are evidence-based models for a range of approaches to teen pregnancy prevention including both comprehensive sex education and abstinence education.

Mrs. {Capps.} Thank you. I was very much involved with a school-based program for teen parents when I was in my community as a school nurse, and I have such vivid images of these young women and parents incredibly strong and hardworking but if they had had appropriate medically accurate information, education, empowerment, they could have delayed these pregnancies and they could have still been really good parents but they would have had time to complete their preparation for the future, setting up a more viable economic future for their families and children, and that is why I believe our investments in PREP are so critically important.

I thank you again, all of you, for your testimony today, and I yield.

Mrs. {Ellmers.} [Presiding] The gentlelady yields back. I now call on Dr. Cassidy from Louisiana for 5 minutes.

Dr. {Cassidy.} I was 15 minutes behind, so anyway. Oh, my gosh, Madam Chair, can I defer and come back because I was

thinking I had two more people head of me?

Mrs. {Ellmers.} Okay. That would be fine. The gentleman yields back for a later time. Mr. Griffith from Virginia, 5 minutes.

Mr. {Griffith.} Thank you, Madam Chair. I appreciate that.

As we prepare to permanently repeal and replace the SGR, I believe we must also address two vital centers, and we have talked about these previously in testimony today, the Medicare-Dependent Hospital and the Low-Volume programs, which are critical for my constituents and my rural hospitals in southwest Virginia. If these programs are not extended, Virginia hospitals in total will lose about $10 million and most of the hospitals that qualify are in my district, but $10 million in Medicare reimbursements next year at a time when they are already being hit hard by new costs, deep cuts to Medicare, other programs, and an economic crisis which is exacerbated by the Administration's new regulations and what many of us refer to us as their casualties in the war on coal. These combination of factors have already resulted in one of my rural hospitals closing in Lee County and at least eight of the remaining hospitals in my district benefit from

these two essential programs. They keep the hospital doors open in some economically distressed areas that are pivotal to vital access to care for my rural constituents. I have got Smith County, Russell County, the Lonesome Pine Hospital in Big Stone Gap, and I invite you all to go see the soon to be a major motion picture based on the book of the same name, Mountain View in Norton, Pulaski, Buchanan, Tazewell and Wythe. These are not hospitals that are necessarily close to a lot of other hospitals.

Mr. Hackbarth, let me go ahead and ask you something. I was reading your testimony, and you talked about several programs that were based on how many miles one hospital was away from another. Do you know, is that done on a map or is that done on road miles? And the reason that is important of course is because when you come from a mountainous district, if you just look at the flap map sitting in your office, two hospitals might only be 15 miles away but it might be a 45- to 50-minute trip.

Mr. {Hackbarth.} I will have to check this, Mr. Griffith, but I am pretty sure that it is road miles, and my recollection is that the regulations also take into account unique conditions like mountains and difficulties and certain

times of the year, but I will verify that and get back to you.

Mr. {Griffith.} And I appreciate that because oftentimes we see that in the areas. People say well, yeah, there is another pharmacy just down the road if one closes. Well--

Mr. {Hackbarth.} I come from a mountainous area also.

Mr. {Griffith.} --it may be just down the road but it might not be easy to get to.

Knowing a little bit about my background, do you think that that district and other districts like mine would be hurt if the provisions were not extended or made permanent, particularly talking about Medicare-Dependent Hospital and Low-Volume programs?

Mr. {Hackbarth.} Well, I can't obviously address the circumstances of your district. I don't know it. But again, our emphasis is on maintaining access for beneficiaries in remote areas. I think we are in complete agreement on that. And what we want to do or what we urge the Congress to do is with that goal in mind focus the subsidies on the institutions that are truly necessarily to provide care in isolated areas, and right now we are concerned that some of

these provisions including the Medicare-Dependent Hospitals and the Low-Volume Adjustment are not well targeted, and I would emphasize again in particular the Low-Volume Adjustment is problematic because even if you accept the premise, which we do, that there are economies of scale in the hospital business, in small institutions, many therefore have difficulty keeping their costs down. The right measure of that is not just Medicare discharges, it is the total discharges. This adjustment is based on Medicare discharges alone. So a hospital that has relatively few Medicare discharges can get a big adjustment whereas a smaller institution as more of an economic problem doesn't get the adjustment because it is a different mix of public and Medicare discharges. That is not fair, in addition to not being--

Mr. {Griffith.} And that may very well negatively impact my hospitals because we have a disproportionate number--based on the rest of the country, we have a lot of older folks that live in our communities. We have had some counties that have depopulated of mostly the younger folks and so there is a disproportionate number of senior citizens in a number of the counties that are also rural and

underserved. So I look forward to working with you on these formulas.

My concern is, as you might imagine, as we negotiate this, I don't want to lose anymore hospitals. We are hoping that we can replace the one that is gone but the parent company of two of the eight that I mentioned has announced today that they are looking for new ways to do things in the future and may even be seeking out a strategic partner because they are having some difficulties dealing with the new environment we are in, with the new laws passed in health care, with the economic situation in southwest Virginia and east Tennessee, and with lots of other things that are putting pressure on the hospitals and so anything that we can do as we find a better formula, that is great. I just don't want to see us taking away one of the items that is helping these hospitals survive in these small communities.

Mr. {Hackbarth.} Well, if I could make a suggestion, the Low-Volume Adjustment that we are discussing here today is a temporary provision. There is a permanent Low-Volume Adjustment that already exists, and we believe it is structured in a way that is much better targeted, and so that is the foundation to build on for the committee.

Mr. {Griffith.} I thank you, and I yield back.

Mrs. {Ellmers.} The gentleman's time is expired. The Chair now recognizes Mr. Green from Texas.

Mr. {Green.} Thank you, Madam Chair, and I appreciate our panel being here. In fact, I know I met and worked with Dr. Hackbarth and Dr. Rowland on the commonwealth retreat that you do every year, and I would encourage my colleagues to consider that. It is in February. Now, I have to admit, it is not the south of Florida this year but it is in Houston, Texas. But you will hear, it is bicameral, bipartisan and by committee, because we typically in our committee don't deal with Ways and Means or Education and Workforce but you will have different members, and we can really come and problem-solve in an informal setting.

The Affordable Care Act takes a number of important steps to broaden access to health care, especially for people who are working and are unable to receive employer-sponsored insurance or afford individual market plans. While the number of uninsured is already decreased, some challenges remain, and I want to follow up on my colleague, Dr. Burgess, talking about the Transitional Medical Assistance churn. That churn is due to a small change in income and an

individual will be switched from being eligible for Medicaid and be eligible for now subsidized coverage in exchanges. Switching back and forth between insurance coverage can mean a change in benefits, participating providers and pharmacies and out-of-pocket expenses, not to mention the administrative paperwork for the State or an insurance company or a doctor's office.

One of the programs to help reduce churning is the Transitional Medical Assistance, and Ms. Rowland, I understand that MACPAC has recommended Congress make TMA permanent in part because of this churn factor. Could you elaborate? And I know I am following up and I want to address some of Congressman Burgess's issues, but is that the reason because the recommendation from MACPAC?

Ms. {Rowland.} Well, we have tried to look at how to make transitions between coverage smoother and more streamlined, and one of the ways clearly is to help the lowest-income Medicaid beneficiaries who qualify through the 1931 provisions, which are the old welfare-related categories be able to maintain coverage, and we have looked at the time period, and the 6-12-month period really does provide for continuous coverage that allows them to go into the workplace

and back and forth and the income volatility of individuals at that very low income and the income spectrum is very important to take into account to try to keep care continuous so that people don't have to end treatment and so that the States don't have to continually re-administer the benefits.

Mr. {Green.} Because it raises administration costs plus the cost to the patient.

And Dr. Burgess talked about in States, for example, Texas didn't expand their Medicaid and also does not have a State exchange. The TMA is really important in those States to make sure it happens, but even States that have their own state exchange or use the Medicaid expansion could use transition assistance.

Ms. {Rowland.} We believe that the Transitional Medical Assistance is critical in the States that have not expanded coverage to keep people from going to uninsurance from one dollar of increased income. In the States that have elected to go forward with the expansion, the expansion will provide for a way to transition from Medicaid coverage on the income side to either the exchange or to the new Medicaid coverage options. So the Commission has recommended there that we consider giving States the ability to opt out of TMA if they

are able to assure that transition, and that is an issue that we will be looking at in the future as well.

Mr. {Green.} And I know one of the concerns is a 12-month continuous eligibility to make sure there is not a gap in coverage, and I know in States like Texas, who has a 6-month for Medicaid and SCHIP also but Congressman Barton and I both have legislation to make sure that continuous coverage would be 12 months because if you have people that are low wealth, they are not going to come in every 6 months, and particularly if they are ill, they will have that lapse in coverage and they will show up at one of my emergency rooms and cost much more than having that continuous coverage.

The Medicaid primary care bump helps ensure that sufficient access to Medicaid providers as enrollment increases. The ACA requires States to raise their Medicaid fees to Medicare levels at least for family physicians, internists, pediatricians and primary care. Can you comment on the impact of that that lack of this parity between Medicare and Medicaid provider rates on physician participation. I know particularly because, for example, in Texas, TRICARE pays the lowest, Medicaid pays a little more and then Medicare pays more. Of course, private sector pays

more. But to have that Medicaid and Medicare would help us actually have more physicians accept more Medicaid patients, I think.

Ms. {Rowland.} Well, one of the things that the Commission has looked at is in fact what are the incentives for physicians to participate within the Medicaid program and what are the barriers, and clearly, low payment rates and delayed payments are two of the issues that prevent many of the primary care doctors as well as specialists especially to participate in the program. So I think that looking at the wages that are paid or the payment levels for Medicaid are a very important piece. We have to look at the role managed care is now playing and so we really need to understand more about the payment levels within managed care plans, and we believe that improving access to primary care is of course a critical part of the Medicaid program and one that is very important to make sure we get full participation there. But the--

Mrs. {Ellmers.} The gentleman's time is expired.

Mr. {Green.} Thank you, Madam Chair. I know we ran over time, but I appreciate the committee having this hearing today so hopefully we will come back and visit it again.

Thank you.

Mrs. {Ellmers.} Thank you. Now the Chair recognizes Dr. Gingrey for 5 minutes.

Dr. {Gingrey.} Madam Chair, thank you very much. I would like to also thank the witnesses. One very famous person once said there is nothing more permanent than a temporary federal government program. I think that was probably President Reagan, but of course, it could have been my good friend, Chairman Emeritus Dingell. I did like what he said this morning in regard to SGR and the bipartisanship and all the work that has gone into that, and we continue to push to try to get that across the finish line in the next couple of months hopefully. I agree with him 99 percent of the time but I am not sure I agree completely with his remarks, don't leave the extenders behind.

As I said, there is nothing more permanent than a temporary federal government program. Our constituents need to realize that one of the most important things we do other than passing legislation is oversight of current legislation and temporary programs and indeed maybe even all programs that probably should be looked at every 10 years, every 5 years, and say hey, you know, do we need to continue to do

this, is it serving its purpose or is it time to end this program, even if it was permanent, but certainly on these temporary programs like these extenders, I think we need to look at a lot of them and question whether or not we need to go forward.

And let me then direct my question to Mr. Hackbarth. I will direct all my questioning to you. As an example, one such program, group of programs, are in the Medicare ambulance add-ons. In reviewing the data around ambulance service availability in the Medicare program, what have you found? For instance, have you found growth in the number of providers or has there has been a decrease, or to put it another way, has there been any evidence of service inadequacy in regard to the ambulance program?

Mr. {Hackbarth.} Yes, we found no evidence of inadequate service. We found on the contrary evidence of growth in service, both in terms of the number of trips paid for but also significant new entrants, a lot of private capital, some big private equity firms buying into the ambulance business. This is one area where we do not have Medicare cost reports, and one of the things that we do when we don't have cost report information is look at the market

for signals. When big money, smart money is buying into an area, it is usually a sign that--

Dr. {Gingrey.} So you are getting some ominous signals in regard to that. And I want to draw your attention to the ambulance extender title temporary increase for ground ambulance services under the Social Security Act. My office has been approached by a number of constituencies who want to make this extender permanent, and my staff confirms for me that this provision and its spending was never, never intended to be made permanent. Can you tell me, Mr. Hackbarth, if Congress intended this extender to be a temporary provision and do you believe the data supports making the policy permanent?

Mr. {Hackbarth.} Dr. Gingrey, are you referring to the 2 and 3 percent add-on payments for urban and rural ambulance providers?

Dr. {Gingrey.} Yes.

Mr. {Hackbarth.} That is a temporary provision and one that we don't think needs to be extended based on our analysis. We have suggested, however, that the rates paid for non-emergency transport be decreased and then use that money to fund higher payments for emergency transport, and

the reason for that change is, we see a lot of this new entry that I referred to is really being targeted at non-emergency ambulance transport.

Dr. {Gingrey.} Yes, but, you know, with urban transports accounting for 76 percent, an increasing share of claims, and non-emergency ambulance transport most common in the urban areas, do you still believe that urban adjustments are needed?

Mr. {Hackbarth.} No, we do not but we do recommend that there be this recalibration of the rates for emergency and non-emergency rates.

Dr. {Gingrey.} Mr. Hackbarth and all of the panelists, thank you. I want to yield the remaining 22 seconds to my colleague from Tennessee, Ms. Blackburn.

Mrs. {Blackburn.} Well, I thank the gentleman for yielding, and since the time is so short, I will just say, reliable ambulance services are very important to our district. We have watched very closely the add-on payments. We think they are necessary for rural districts like mine, and the Low-Volume Hospital Adjustment is something for our rural hospitals we are very concerned about. Those are things that in my district we would like to see those made

permanent, and with that, I yield back to the gentleman from Georgia.

Dr. {Gingrey.} I yield back.

Mrs. {Ellmers.} The gentleman yields back. The Chair recognizes Dr. Christensen from the Virgin Islands for 5 minutes.

Dr. {Christensen.} Thank you, Madam Chair, and thank you all for being here with us this morning to discuss these important extenders.

I want to follow up on Congressman Green's questioning about the primary care bonus. The ACA boosted payment for primary care services for 2 years so that it would equal the Medicare payment rates, and I think that is an important step, and I believe it is something that is worth continuing into the future.

Dr. Rowland, the Commission doesn't have a recommendation yet on this policy, and I know there has been some concern that it is has been difficult to set up the payment changes, especially for policy, which at the moment, at least, is only short term, and to me, this further illustrates why important policies like the primary care bonus shouldn't really be temporary, it should be permanent.

Could you comment on how the short-term nature of some policies can cause a disincentive for action?

Ms. {Rowland.} Well, clearly, the 2-year period for the bump-up in primary care payments is an important test of what the increase in payments will do to access to care, and that is something that it is too early to really evaluate but also what we know from programs is that it takes time to change incentives and so in that the short 2-year period, they really have not given enough incentive to many of the physicians who participate knowing that it may expire after 2 years. So I think it is very important to both look at what the effect of it has been, and then there has been some concern within the Commission about whether that payment bump limited to primary care physicians is really getting at some of the other gaps in participation, especially among specialty care, and especially among mental health and behavioral health people.

Dr. {Christensen.} Yes, I would share that concern. You know, as you said, it is too early to really evaluate what impact those bonuses have had on access to care, and I am worried that some people would argue that we need more data before we decide to go forward with continuing this

policy, which might set up a catch-22 because under current law, the policy will end before we might have adequate data. Given what we know about underpayment in Medicaid, it would seem highly unlikely that payment parity would cause a decrease in access or cause beneficiary harm. Can you comment on that?

Ms. {Rowland.} Well, clearly, we do need time to look at what the effect of this has been but we also know that Medicaid payment levels have been extremely low in many areas and that this increase is likely to be one that will continue to be there for physicians and attract them, and we really need to look at the availability of primary care services and how to boost that as we try to decrease the use of emergency rooms.

Dr. {Christensen.} Dr. Goldstein, as we know, disparities exist in different teen population groups for sexually transmitted disease and teen pregnancies, so we are really pleased that under PREP, there is a focus on those vulnerable populations to reduce the incidence of both the pregnancy and the SDIs. Could you comment on the kinds of populations that PREP prioritizes and within that, what populations of States chosen to target?

Ms. {Goldstein.} Yes, the most common targeted population among States is in high-risk areas that have above-average rates of teen birth or sexually transmitted infections. Some States are also focusing on specific vulnerable populations such as Hispanic youth, African American youth, youth in foster care and in the juvenile justice system.

Dr. {Christensen.} Okay. And PREP specifically sets aside a small portion of funding to implement and evaluate innovative strategies in order to expand the menu of effective programs among the vulnerable or marginalized young people. What is the process for evaluating these emerging strategies and the associated timeline for findings?

Ms. {Goldstein.} All of the grantees in the Personal Responsibility Education Innovation Strategies program are being evaluated. A few of them are included in a federal evaluation project, and reports on impacts are expected in 2016. The rest of the grantees are conducting their own evaluations. HHS is providing technical assistance to ensure that these evaluations are rigorous. The evaluations are designed to meet the HHS evidence standards, so when they are finished, the results can be reviewed for evidence of

effectiveness, and we expect the grantees' evaluations will have impacts in 2016 as well.

Dr. {Christensen.} Thank you. I yield back.

Mrs. {Ellmers.} The gentlelady yields back. The chair recognizes Dr. Cassidy from Louisiana for 5 minutes.

Dr. {Cassidy.} Thank you, Madam Chair.

Mr. Hackbarth, just to follow up briefly on what Mr. Waxman said, in fairness, the cuts to the MA program, only 4 percent of them have actually been implemented so far. This is not a question; it is a statement. I gather the demonstration projects, which GAO criticized the kind of worth of, nonetheless have mitigated the cuts as of up to now and they actually don't begin to be implemented until frankly substantially this year and by 2019 there is estimates of decreased enrollment in MA plans because of this. That is not a question per se. It is just a kind of useful correction to Mr. Waxman's misleading.

Now, next, as regards the fully integrated Medicare Advantage programs, I see Senate Finance only wants to continue those D-SNPs which are fully integrated. You make the recommendation that we continue all of these programs. Is that a fair statement?

Mr. {Hackbarth.} No, we recommend continuation of the fully integrated, those that assume both clinical and financial responsibility.

Dr. {Cassidy.} Got you. So if they are two-sided risk, they would then be allowed to continue?

Mr. {Hackbarth.} Well, all Medicare Advantage plans--

Dr. {Cassidy.} Are two-sided risks, right? So tell me, when you say fully financially integrated, what do you mean by that? I am sorry.

Mr. {Hackbarth.} Well, that they assume under a global payment responsibility for providing all of the covered services.

Dr. {Cassidy.} But from what we just said, that would be all of those plans, correct?

Mr. {Hackbarth.} In the Medicare Advantage program, yes, they are by definition all assuming financial risk. The issue on D-SNPS is, do they assume responsibility for both Medicare and Medicaid benefits.

Dr. {Cassidy.} Correct.

Mr. {Hackbarth.} And what we see is evidence that organizations that assume responsibility for both types of benefits actually can improve care and reduce costs. If

those two are separate and there isn't that integrated responsibility--

Dr. {Cassidy.} I see. So when you say integration, you mean between Medicaid and Medicare, the dual-eligible population?

Mr. {Hackbarth.} Exactly.

Dr. {Cassidy.} Got you. That makes sense to me. I agree with that, and I think that is a positive policy.

Let me move on to the ambulances. My colleagues have addressed this. But when I turn one ambulance service, they said the growth in the non-emergency services is because basically they are going out, finding somebody who has had a hypoglycemic episode, they do a finger stick, they find their glucose is low, they give them sugar, if you will, of some sort, they wake them back up. They don't transport them; they leave them there. And actually they are providing some basic services and saving money on the ER visit, if you will. Now, have you been able to look globally to see, one, if this is true, and two, if they are providing these services, does it decrease the Part A amount, for example?

Mr. {Hackbarth.} I don't know about the specific example that you have described. My understanding of the

Medicare payment rules for ambulance is that Medicare only pays if the patient is transported, so in the example you describe, if the ambulance goes out and doesn't transport the patient anywhere, then I don't think it is covered under the ambulance policy at all.

Dr. {Cassidy.} Got you. And you also mentioned the difference between certain geographic locations as regards the frequency of transport for things like end-stage renal disease.

Mr. {Hackbarth.} Absolutely.

Dr. {Cassidy.} That seems like that would be variable upon poverty rates, upon degree of MA penetration that might provide services.

Mr. {Hackbarth.} I am sure that there are a lot of factors that go into that variation but the variation is--

Dr. {Cassidy.} But can we understand that unless we actually do some sort of statistical analysis correcting for rates and poverty, for example--

Mr. {Hackbarth.} Well, we have not tried to do any sort of multi-variant analysis of the variation but I would be very surprised if poverty alone explained the sort of variation that we are talking about. We are talking about,

you know, 20-, 30-fold variation across States.

Dr. {Cassidy.} I get that. I will just say, coming from a State in which there is high levels of poverty, some of the poorest regions in the country are in Louisiana, I can understand how your rate of poverty may be 30-fold relatively to a suburb in New Jersey, a rural suburb.

Dr. Rowland, I am very intrigued by this integration of Medicaid and Medicare, the dual-eligible population, and I know that you referenced that, and you referenced that in your testimony. Can you give any preliminary results as to whether aggregating, or what are the preliminary results in terms of aggregating payment in terms of increasing coordination of care?

Ms. {Rowland.} Well, clearly, there are efforts at the State level to try to integrate Medicaid services with the Medicare services. We also have the financial demonstrations that are now out in the field but there are no results back from them. In fact, most of them are just in the process of being launched.

What we have been looking at is how do you provide for better coordination of care, and as Mr. Hackbarth has noted, there is some evidence that when a plan integrates both of

the services, that they are more able to maintain them. We are particularly concerned about how to merge the behavioral health aspects together with the medical care in plans and have been looking not so much just at the dual-eligible population but at Medicaid's responsibility for people with disabilities, which includes many individuals who need that merger.

Dr. {Cassidy.} If you have preliminary data on that, I would love it if you would share that with us.

Ms. {Rowland.} We will share it with you whenever we have it.

Dr. {Cassidy.} I yield back. Thank you.

Mrs. {Ellmers.} The gentleman yields back. The Chair recognizes Mr. Matheson from Utah for 5 minutes.

Mr. {Matheson.} Thank you, Madam Chair, and thanks for holding this hearing.

I think we all want to have a permanent fix to the SGR issue, and our committee has passed out a bill last year, and we have had Ways and Means and Senate Finance look at this as well and move legislation, and I think we all desire that outcome of fixing this problem with SGR but it is really important we are having this hearing because we have to

figure out how we are going to handle a lot of these extenders that have always been associated with these temporary one-time fixes, 12-month advances, 6-month advances, SGR. We had all of these extenders, and what are we going to do if we don't have that regular process on SGR anymore? How are we going to handle these? So I applaud this committee for holding the hearing today.

I have heard from so many providers and patient groups about their concerns about specific programs in a world where the SGR issue has been permanently fixed, and I want to say that I am actually going to keep my comments pretty brief, and I don't even have any questions for you. I just want to raise a couple of quick issues and I will yield back after that.

I do think that there are a number of these extenders that have been traditionally attached, as I said, to the SGR patch and we ought to talk about how important they are and what we do to fix them, critical programs like the Special Diabetes program, which has widespread, bipartisan support to providing funding for diabetes research, or the Maternal, Infant and Early Child Home Visiting program, which we have heard about earlier in this hearing. It helps provide

coordinated resources to expectant new parents, improves newborn health and works to increase economic self-sufficiency. I think those are just a couple of examples of many of these programs in our discussion today which work to save money. They remove potential cuts to providers. They are going to maintain better access to beneficiaries and they provide really important services to certain at-risk populations.

So I am glad we are going through regular order, Mr. Chairman. Again, I applaud you for holding this hearing and I appreciate our panel coming here today and I look forward to continuing to work on these extenders, and I will yield back my time.

Mr. {Pitts.} The Chair thanks the gentleman, and with unanimous consent would like to enter into the record a statement by the Rural Hospital Coalition. Without objection, so ordered.

[The information follows:]

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

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Mr. {Pitts.} The Chair now recognizes the gentlelady from North Carolina, Ms. Ellmers, for 5 minutes for questions.

Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you to our panel today on this very important issue regarding SGR.

Dr. Hackbarth, I have a question in relation to some of the situations with the 2014 CMS changes that are coming with the physician fee schedule. In 2013, MedPAC reported to Congress that ``if the same service can be safely provided in a different setting, a prudent purchaser should not pay more for that service in one setting than in another'' and then it goes on to discuss some of the payment variations.

But in the 2041 CMS Medicare fee schedule, it seems to be doing the exact opposite. Can you expand on that and explain the thinking behind that?

Mr. {Hackbarth.} Mrs. Ellmers, is there a particular example in the CMS proposed rule that you--

Mrs. {Ellmers.} I am particularly concerned with oncology services, but certainly any of the outpatient services that can be provided in a hospital or outside in an

outpatient setting or ambulatory care, the difference.

Mr. {Hackbarth.} Yes. So you correctly stated what our principle is, which is that we shouldn't pay higher rates for hospitals if the same service can be safely provided in lower-cost settings, and we are in the process of making recommendations to the Congress to move Medicare policy in that direction. We made a recommendation about evaluation and management services a couple years ago. At this upcoming meeting next week, we are looking at an additional batch of services, many cardiology services, for example. CMS doesn't always agree with our perspective on issues, and this is an example where I think there have been some differences of opinion.

Mrs. {Ellmers.} Okay. And too, you know, I cited oncology services and some of the outpatient services but I am also concerned about reimbursement for some of the Medicare therapy services. Now, earlier--and I actually kind of crossed this off my list because I think you really referred to those changes coming more in the accountable care organizations. Is that true as far as the therapy cap issue?

Mr. {Hackbarth.} So what we have recommended on outpatient therapy, we don't believe that there should be

hard caps imposed on therapy services. That said, we do think that after some point, additional services should be subject to review before they occur, which is an approach very similar to what private insurers typically use in outpatient therapy.

Mrs. {Ellmers.} Okay. And just lastly, and this is really more of a comment and a question for you as well, you know, I continue to be concerned about the physician reimbursement in relation to Part B payments through hospitals or Part A payments through hospitals with the upcoming CMS changes. I am afraid that with the trend that is moving forward that this is going to affect the viability of Medicare to our seniors, and I just want to get your reassurance if you can commit to continue to work with my office on making sure that MedPAC, that we work in conjunction to make sure that reimbursement is--

Mr. {Hackbarth.} I would be happy to

Ms. {Ellmers.} Thank you. Thank you, sir, and I yield back the remainder of my time.

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

Ms. {Castor.} Well, thank you, Mr. Chairman. I would like to thank you as well for organizing this hearing today and I would like to thank all of our witnesses for your service and attention to the health and well-being of American families and to our ability to provide health services in the most efficient manner.

I think most people understand that children have a better chance of success in life if they are healthy and they have consistent access to a pediatrician and the doctor's office and those important checkups, and health services provided under Medicaid have simply been fundamental to ensure that millions of American children do get those vision tests, the wellness checkups, immunizations in a consistent fashion, whether they are growing up healthy or they have certain special needs.

I want to make sure everyone is aware that in the Congress, we have a very active Children's Health Care Caucus. I co-chair the Children's Health Care Caucus with my Republican colleague, Representative Reichert of Washington, and with the help of the Children's Hospital Association, First Focus, the American Academy of Pediatricians and others, over the past 2 years we have had educational

sessions on Medicaid for members and for professional staffers here on Capitol Hill, and I wanted to extend the invitation to all of my colleagues and to everyone in attendance today to attend those sessions, and we get into a lot of the detail that we are discussing here today.

A number of members have brought up the issue of access to Medicaid. We know that over time there has been a real problem with enough providers to serve the population, and one good thing the Congress did a couple of years ago was to bump up the Medicaid reimbursement to doctors. Implementation didn't go as quickly as we wanted it to for primary care providers. Fortunately, HHS finally finished that, and we were able to include pediatricians and pediatric specialists, which I think is very important to children's health care.

But Dr. Rowland, can you tell us the status of implementation across the board now that HHS has that complete? Have States been able to implement it?

Ms. {Rowland.} Well, we think that most States have been moving forward with implementing it. The condition is in the process of obviously looking at what can be learned from the State experiences and we will be going out to re-

interview some of the States that we talked to earlier about how implementation has been proceeding. Unfortunately, data is always delayed beyond where we would like it to be. There isn't any specific data yet on what the impact has been on changes in terms of participation of physicians in the program.

The one issue that the Commission, however, has discussed and raised is whether that provision needs to also be broadened either providers who help provide those primary care services and do not fall within the definition in the statute and especially to look at some of the specialists that are so important especially to some of the programs where there are intense pediatric needs where there are real shortages.

Ms. {Castor.} I think that is going to be a very important challenge for us moving forward and we should at least extend it now, and then based upon your data and recommendations go further to make sure that people are getting the care they need under Medicaid.

And we all have the goal of improving the overall efficiency of Medicaid and the Children's Health Insurance Program. One tool States have to assist them towards this

goal is the Express Lane Eligibility. This efficiency simplifies and streamlines the application and renewal process by allowing States to use eligibility information obtained from other income checks like the School Lunch program or SNAP, and we all get annoyed when government or you go to the doctor's office and they are asking you to fill out paperwork again and again, the same information, and the Express Lane Eligibility helps reduce that duplicative paperwork. So I understand now that 13 States have proven to be real leaders in cutting paperwork and were able in doing that to reach thousands of more children and make sure they can get to the doctor's office.

This sounds very promising, but 13 is still pretty low. I know the Commission has not formally opined on Express Lane Eligibility but there is promising evidence. Could you tell us in terms of increasing enrollment as well as reducing State administrative costs how effective the Express Lane Eligibility has been?

Ms. {Rowland.} From what we can learn so far, it has been an effective way of shifting people from one program's eligibility determination process into the Medicaid program itself, so it has boosted enrollment in those States. It is

now being looked at for adult eligibility in two States to try to see if under the waivers they have been granted through the ACA they can facilitate getting parents into coverage as well, and I think that the more we can simplify and streamline our eligibility processes and use electronic transfers to get more people covered without having to go through, as you say, reapplying, reapplying and reapplying, the better off both beneficiaries will be as well as the States that try to administer these programs.

Ms. {Castor.} Thank you very much.

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

Mr. {Bilirakis.} Thank you, Mr. Chairman. I appreciate it. Thanks for holding this hearing, and I want to thank the panel for their testimony as well.

Mr. Hackbarth, the March 2013 MedPAC report included recommendations to permanently reauthorize integrated dual-eligible Special Needs Plans which include the fully integrated dual-eligible Special Needs Plans and a second successful model for integration. In the second model, one managed-care organization administers a Medicaid plan and a

dual-eligible Special Needs Plan. The same dual-eligible beneficiaries are enrolled in both plans, and integration occurs at the level of the managed-care organization across the two plans.

Questions. Why is it important that we retain this model in addition to the FI D-SNP, and can you tell us about the benefits of this model and why MedPAC included a more broad definition of integration?

Mr. {Hackbarth.} well, the ultimate goal, as you say, is to get somebody to assume the responsibility for integrating Medicare and Medicaid both financially and clinically, and we allowed different paths to that because there are various types of issue that arise at the State level that may not make the fully integrated single plan model work in every State. Plans approached us and said that this dual plan model where the same beneficiary is both in the Medicare SNP and the Medicaid plan and they do the integration can work as well. In trying to be flexible, we wanted to accommodate that.

Mr. {Bilirakis.} Thank you. Second question for you, sir. Does the current star rating system penalize Special Needs Plans by rating them against all Medicare Advantage

plans rather than against the SNPs?

Mr. {Hackbarth.} We have not looked specifically at that question. I would think the answer is probably not but again, we haven't studied that.

Mr. {Bilirakis.} Would creating a more appropriate star rating system that is tailored to the specific population D-SNPS be more representative of their quality performance and provide more accurate information to beneficiaries?

Mr. {Hackbarth.} We can look at that. As I say, we haven't studied that.

Mr. {Bilirakis.} When do you plan to?

Mr. {Hackbarth.} We don't have any specific plans. I am saying we can take a look at that.

Mr. {Bilirakis.} Can you please follow up with me on that?

Mr. {Hackbarth.} Sure, I would be happy to do that.

Mr. {Bilirakis.} I think that is very important. Thank you. I appreciate it very much.

Thanks, Mr. Chairman. I yield back.

Mr. {Pitts.} The Chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, for a UC request.

Mr. {Griffith.} Thank you, Mr. Chairman. I would ask for unanimous consent to submit a statement from the Federation of American Hospitals for their support of the rural extenders that I talked about.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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

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Mr. {Pitts.} That concludes the questions of the members who are present. We will have some additional questions, the members will, and we will send those to you. We ask that you please respond promptly.

It was a very important hearing today. Thank you for the testimony that you have given to the members.

I remind members that they have 10 business days to submit questions for the record, and so they should submit their questions by the close of business on Friday, January 24th.

The Chair thanks everyone for their attention, and without objection, the subcommittee is adjourned.

[Whereupon, at 12:07 p.m., the subcommittee was adjourned.]