Summary of House Energy and Commerce Subcommittee on Health Hearing
"Medicaid at 50: Strengthening and Sustaining the Program"
Washington, DC – July 8, 2015

Overview and Insights

The Energy and Commerce Committee's Subcommittee on Health held a hearing to discuss how to strengthen and sustain the Medicaid program as it turns 50 years old on July 30, 2015. The hearing broadly examined the Medicaid program, and touched upon Medicaid's role within the larger health care system, eligibility for the program and its benefits, federal and state financing of Medicaid as well as the increased use of managed care, beneficiary access to care and quality, and the use and approval of Section 1115 waiver demonstration authority and projects. The Subcommittee, which heard testimony from representatives of the Centers for Medicare and Medicaid Services (CMS), the Government Accountability Office (GAO), and the Medicaid and CHIP Payment and Access Commission (MACPAC), is chaired by Rep. Joe Pitts of Pennsylvania and the ranking member is Rep. Gene Green of Texas. Here are the majority and minority background memoranda.

Republican members of the Subcommittee, on the whole, focused their comments and questions on financial issues facing Medicaid, certain legislation to reform the program, and waiver demonstration project criteria and approvals.[1] Democratic members of the Subcommittee discussed Affordable Care Act (ACA) changes to Medicaid, including program integrity efforts and the Medicaid expansion option, as well certain state-specific issues and concerns. [2] Several Subcommittee members discussed and were interested in learning more about the notice of proposed rulemaking (NPRM) for Medicaid and CHIP managed care.

Member Opening Statements

Chairman Pitts, in his opening statement, argued that federal oversight of the Medicaid program is essential to its overall success. He noted that Congress needs to reform Medicaid since it "will continue to consume a larger and larger portion of federal and state spending," calling the program "the fastest growing spending item in most state budgets." Chairman Pitts stated it is the Subcommittee's duty to ensure taxpayer money used for Medicaid is spent on helping the neediest and most vulnerable Americans.

In his opening statement, **Ranking Member Green** said Medicaid is a critical and efficient safety-net program covering almost 70 million individuals, including nearly a third of all children, half of all births, and more than 10 million dually-eligible Americans. Though 95% of Medicaid beneficiaries report having a regular source of health care, according to Rep. Green, he would like to leverage funds to ensure better value and advance other reforms, including mandatory 12-month continuous eligibility for Medicaid- and CHIP-eligible individuals. Ranking Member Green also said CMS should finalize its proposed rule enhancing and bolstering Medicaid equal access provisions.

Witness Testimony

In her testimony, **Vikki Wachino**, CMS's Deputy Administrator and Director of the Center for Medicaid and CHIP Services (CMCS), reflected on the achievements of the Medicaid program, CMS's work to improve access and quality of care for beneficiaries, and "federal financial support and flexibilities in program rules, along with new tools and options made available through the ACA." Ms. Wachino said CMS modernized the Medicaid application and eligibility process, which has allowed states to make accurate and prompt eligibility determinations. She also noted that CMS is working with states to encourage innovation, including multi-payer delivery reforms like the State Innovation Models (SIM) demonstrations and also health homes and other new

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[1] The Subcommittee on Health held a hearing on Medicaid Section 1115 waiver demonstrations on June 24, 2015.

[2] The Subcommittee on Oversight and Investigations held a hearing on Medicaid program integrity on June 2, 2015. Full Committee Chairman Fred Upton of Michigan and Subcommittee Chairman Tim Murphy of Pennsylvania sent a letter to CMS on program integrity and the Medicaid payment error rate on July 1, 2015.

authorities under the ACA. Ms. Wachino mentioned the recently-launched Innovation Accelerator Program (IAP), which is designed to support states as they improve their Medicaid payment and service delivery systems, and the financial alignment initiatives that seek to better integrate Medicare and Medicaid services for dually-eligible beneficiaries. Ms. Wachino also discussed the NPRM for Medicaid and CHIP managed care, highlighting CMS's belief in achieving greater alignment across Medicaid, Medicare Advantage, and commercial insurance. In closing, she noted that Medicaid is no longer a fee-for-service (FFS) system but rather a robust and comprehensive managed care system whose potential must be maximized.

Carolyn Yocom, Health Care Director at GAO, identified her agency's four key concerns and issues facing the Medicaid program in her testimony: access to care; transparency and oversight; program integrity, and; federal financing. In so doing, she noted that "Medicaid enrollees report access to care that is generally comparable to privately-insured individuals" and that a lack of data exists on states' financing of the non-federal share of Medicaid and the program's payments. Ms. Yocom's written testimony, which resulted from a study of GAO's more than 70 reports and 80 recommendations on Medicaid, highlighted specific concerns and suggestions for the Subcommittee's consideration:

- CMS should take steps to improve its data collection from states to help assess Medicaid enrollees' access to care, including specialty and dental care, and to evaluate whether beneficiaries actually received such services (e.g. state reporting on access to and receipt of care).
- CMS lacks complete and reliable data about program payments to providers and the sources of funds states use to finance the non-federal share of Medicaid, including data needed to monitor states' reliance on providers and local governments to finance the non-federal share, which can also shift more costs to the federal government.
- The Department of Health and Human Services (HHS) has allowed states to use questionable methods and assumptions for their demonstration spending estimates without providing adequate documentation to support them. HHS has not issued explicit criteria determining how demonstration spending is approved nor how such spending furthers Medicaid program objectives.
- Congress should consider requiring CMS to improve reporting of certain high-risk Medicaid payments and subject them to independent audit in addition to improving the demonstration approval process.
- CMS should consider requiring states to conduct audits of payments to and by managed care organizations (MCOs), and updating guidance on Medicaid managed care program integrity practices.
- Congress may want to consider changing the statutory Medicaid funding formula, including revisions that distribute Medicaid funds more equitably to states by better accounting for states' ability to fund Medicaid, and/or enacting a federal funding formula that provides automatic, targeted, and timely assistance to states when they are affected by national economic downturns.

Ms. Yocom's written testimony also includes a detailed appendix with several of her agency's recommendations listed by GAO report as well as a listing of GAO Medicaid-focused reports organized by the agency's four larger issue areas.

In her testimony, **Dr. Anne Schwartz**, MACPAC's executive director, focused on the Medicaid program's evolution since its enactment and MACPAC's upcoming analytical agenda for this year and 2016. Dr. Schwartz noted that Medicaid, which covers more than 20% of the U.S. population and has "grown as a share of the federal budget from 1.4% of federal outlays in FY 1970 to 8.6% in FY 2014," has spending per enrollee "lower or comparable to Medicare and private insurance since the early 1990s." She also described Medicaid as a significant funding source for safety-net providers, as a wrap-around program for individuals with other primary sources of coverage such as Medicare and employer-sponsored-insurance (ESI), and as a source of funding for more than 60% of national expenditures on long-term services and supports (LTSS). MACPAC, Dr. Schwartz, said, will focus on access to care, value-based purchasing initiatives, and the impact of disproportionate share hospital (DSH) payment reductions. MACPAC will also examine how "different approaches to Medicaid expansion affect expenditures and use of services."

Questions, Answers, and Comments

Chairman Pitts asked Ms. Wachino about HHS's approval of and criteria regarding Section 1115 waivers and the Medicaid program payment error rate. Ms. Wachino said CMS approaches the waiver approval process "consistently across all states," emphasizing that she believes CMS has been transparent in their decision making. She also said CMS has developed a set of principles when reviewing Section 1115 waivers, but noted the diversity and complexity of waiver requests CMS receives. Ms. Wachino said she would discuss the Chairman's payment error rate questions with the relevant HHS departments and submit CMS's findings from certain payment pilot programs.

Chairman Pitts asked Dr. Schwartz about the bicameral April 29th letter to MACPAC's Commissioners. Dr. Schwartz said MACPAC is preparing its response, which will be developed over the course of this fall, and mentioned that MACPAC staff will conduct a literature review and discuss technical, design, and other issues related to certain Medicaid reform proposals. MACPAC will also examine accountable care organization (ACO) models, managed LTSS, patient-centered medical homes (PCMH), and other types of programs and their projected savings. She noted many of the questions asked in the letter will also be addressed in the MACPAC March and June 2016 reports to Congress.

Ranking Member Green inquired about Medicaid beneficiaries' access to care and the role of community health centers in providing care to beneficiaries. Ms. Wachino said community health centers play a vital role in meeting beneficiary needs, including their oral health needs, but CMS needs to work with community health centers in improving their payment systems.

Ranking Member Green also asked how the NPRM for Medicaid and CHIP managed care will improve access, quality, and actuarial soundness standards. Ms. Wachino referenced several proposals included in the NPRM such as the quality rating system and new network adequacy standards.

Rep. Joe Barton of Texas, full committee chairman emeritus, asked about Texas' forthcoming Section 1115 waiver and whether CMS will consider it objectively. Ms. Wachino answered in the affirmative. Rep. Barton also discussed his Advancing Care for Exceptional Kids, or ACE Kids Act (H.R. 546 and S. 298). Ms. Wachino said she was not familiar with the legislation, but offered to analyze it and provide technical assistance and input. Rep. Barton was appreciative, and asked for CMS to support the legislation.

Rep. Lois Capps of California asked about CMS's delivery system reform initiatives. Ms. Wachino said CMS is working on variety of "really promising" delivery system reform projects, noting the development of a Medicaid shared savings model in Arkansas, Missouri's use of health homes, and Oregon's deployment of Coordinated Care Organizations (CCOs). Ms. Wachino also cited Delivery System Reform Incentive Payments (DSRIP) in New York and five other states.

Subcommittee Vice Chairman **Rep. Brett Guthrie** of Kentucky inquired about the lack of data on states' sources of funding to finance the non-federal share of Medicaid. Katherine Iritani, who accompanied Ms. Yocom and is the director of GAO's Health Care program, said CMS should develop a data collection strategy to understand states' sources of funding for the non-federal share, highlighting that states are increasingly relying on provider taxes and intergovernmental transfers (IGTs). She stated that the number of provider taxes doubled from 2008 to 2012. Ms. Wachino said CMS has issued "several forms of guidance" to states regarding provider taxes as well as beginning to collect better data from states. Rep. Guthrie also discussed his proposal (H.R. 1362) to require states to report how they finance the non-federal share of Medicaid funding.

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Rep. Kathy Castor of Florida asked about the NPRM for Medicaid and CHIP managed care, specifically regarding the managed care rate setting process and MCO audits. Ms. Yocom said CMS and states should conduct and be required to conduct more MCO audits. Ms. Wachino said the NPRM includes several sections focused on MCO oversight, including regular auditing of MCOs, new rules for provider enrollment, and updated actuarial soundness standards. In closing, Ms. Castor expressed her support of the ACE Kids Act and stated she looked forward to working with CMS on the legislation.

Rep. Doris Matsui of California inquired about DSRIP, waivers for specialty mental health services, and strategies to integrate physical and mental health services. She also discussed new language related to the Institutions for Mental Diseases (IMD) exclusion from federal financial participation (FFP) included in the NPRM for Medicaid and CHIP managed care. Ms. Wachino said CMS is approaching the IMD exclusion cautiously, hoping not to undermine the progress CMS has made in serving beneficiaries in home and community-based settings.

Rep. John Shimkus of Illinois discussed the approval and implementation of Section 1115 waivers and HHS budget neutrality policy. He also discussed his legislation (H.R. 2119) to require that state Medicaid waiver applications, as a condition of approval, be budget neutral. Additionally, the legislation prohibits the HHS Secretary from determining the budget neutrality of a demonstration project unless CMS's chief actuary certifies that a demonstration project is budget neutral.

Rep. Kurt Schrader of Oregon focused on per beneficiary costs in Medicaid as compared to private insurance. He also questioned Ms. Yocom about GAO's future audits, asking if GAO's audits include outcomes-based results in addition to financial and other audits and reports. Ms. Yocom said GAO would be happy to collaboratively work on this area. She also said they continue to look at MCO utilization rates and the relationship between full-year and partial-year beneficiary enrollments.

Rep. Gus Bilirakis of Florida asked about CMS's approval criteria for Medicaid demonstration projects. He also asked about GAO's recommendations and whether they were accepted, completed, or rejected by CMS. Ms. Iritani answered that CMS should issue criteria and make approval documentation more transparent. Ms. Wachino said CMS has updated their approval documents and transparency around such documents, but Ms. Iritani said she has not seen those changes referenced by Ms. Wachino. Rep. Bilirakis also inquired about the proposed quality rating system language included within the NPRM for Medicaid and CHIP managed care and also the Medicare Advantage five-star rating system and its relationship to socio-economic status. Ms. Wachino said a quality rating system would help beneficiaries, and that CMS, if the NPRM is finalized, will have "pretty lengthy implementation schedules and a very substantial public input process" for the proposed quality rating systems to account for low-income populations and to examine the strengths of other quality rating systems. In so doing, she noted that Medicaid serves different and unique populations compared to Medicare and commercial insurance.

Viohl & Associates will continue to monitor, analyze, influence, and report on the work of the Energy and Commerce Committee. Please let us know if you have any questions, concerns, or would like to discuss further.