RPTR ALLDRIDGE

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EXAMINING THE EXTENSION OF

SAFETY NET HEALTH PROGRAMS

FRIDAY, JUNE 23, 2017

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:23 a.m., in Room 2123, Rayburn House Office Building, Hon. Michael Burgess, M.D. [chairman of the subcommittee] presiding.

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

Also Present: Representatives Costello, Dingell, and Ruiz

Staff Present: Zachary Dareshori, Staff Assistant; Jordan

Davis, Director of Policy and External Affairs; Paul Edattel, Chief Counsel, Health; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Clerk, Health; Peter Kielty, Deputy General Counsel; Alex Miller, Video Production Aide and Press Assistant; Mark Ratner, Policy Coordinator; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Counsel, Health; Jacquelyn Bolen, Minority Professional Staff Member; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Health Counsel; Jerry Leverich, Minority Counsel; Rachel Pryor, Minority Health Policy Advisor; Tim Robinson, Minority Chief Counsel; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

Mr. Burgess. The Subcommittee on Health will now come to order. The chair wishes to observe that today's hearing was originally scheduled to occur last Wednesday morning. But on that Wednesday morning, the Capitol Hill family and the entire country was shocked and horrified to learn about an awful attack that took place against our own. This past week has been sobering and difficult for all of us in many different ways, a number of friends, indeed. A member of this very committee is still in the hospital. They continue to need our prayers and best wishes as they fight to heal, to recover, and, in coming days, join us again. Last week's awful tragedy reminds us that what unites is more important than what divides us. We are not first Democrats or Republicans, we are Americans. We love our country, and we respect our colleagues. We are saddened, but we are strong. We are troubled, but we will unite around our common duty and our common service to our fellow countrymen that spirit of unity.

Pause for just a brief moment of quiet reflection for those, especially the member of the committee who is not able to be here today. But, of course, we still have other people who are recovering from their injuries.

The chair will recognize himself 5 minutes for an opening statement.

In 2015, this committee passed the Medicare Access and CHIP Reauthorization Act -- you are welcome -- which extended funding for many of the Nation's safety net programs, including the community health center funding and the State Children's Health Insurance

Program. With funding for both the community health center fund and the SCHIP program set to expire yet again at the end of this fiscal year, our committee has the responsibility of taking a critical look at how these programs operate, and setting out a long-term path to funding, and, perhaps, reauthorization.

The Community Health Center Fund plays an important role in supplementing the services that federally qualified health centers are able to deliver to underserved communities by providing care to all Americans regardless of income, regardless of ability to pay. Additionally, the Community Health Center Fund provides resources for the National Health Service Corps which actually provides scholarships and loans -- and loan repayment opportunities to new doctors willing to serve in medically underserved areas. This program has proven effective at placing providers, providers who are young and energetic and willing to work hard in some of the most medically unserved and challenging areas.

The State Children's Health Insurance Program provides healthcare coverage to over 8 million children across the Nation through flexibility capped allotments to States. The program has been able to successfully support children while providing States with opportunities to tailor their respective programs as to best meet the needs of their populations. However, the programs are not without challenges. In regards to the Community Health Center Fund, we are interested in seeing how federally qualified health centers can best maximize this investment. Succeeding in underserved areas can be

difficult, and I look forward to learning more as to how the federally qualified health center can continue to deliver results and where improvements might be made.

As for the State Children's Health Insurance Program, there are multiple points for consideration. As is the case with other Federal insurance programs, there are considerable concerns regarding the long-term sustainability of the program. Following the passage of the Affordable Care Act, the program's Federal match rate rose an unprecedented 23 percent, providing some States with as much as a 100 percent Federal match. This increase in funding has challenged the program by both shifting the nature of shared responsibility of the State Children's Health Insurance Program to the Federal Government and making States more dependent on Federal dollars.

The issue is further complicated by concerns raised by the Congressional Budget Office on the efficacy of the enhanced match rate. According for the Congressional Budget Office, an elimination of the enhanced match rate would basically not impact coverage rates for children in the country, while a continuation of the enhanced funding would add another $7-1/2 billion to the deficit over the next 5 years if no other policies were undertaken to offset its cost.

So today's hearing should focus on how to best proceed with the Affordable Care Act's increased funding for the State Children's Health Insurance Program, the increased funding rate, and what a continuation of this funding would mean for taxpayers, and what it would mean for covered children.

With these challenges before us, I would like to welcome our witnesses and thank them again for joining us today, thank them for their forbearance as the hearing got rescheduled twice.

On the CHIP front, we have Ms. Jami Snyder who serves as the Associate Commissioner for Medicaid and CHIP in my home State of Texas, and Ms. Cindy Mann who served the administration as the administrator and director of the Center for Medicaid and CHIP services at the Center for Medicare and Medicare Services from 2009 to 2014. I am interested in hearing today how each of your experiences on both sides of this partnership has worked, and where you believe we can improve the ability of States to meet the needs of children in the program.

And finally, Mr. Michael Holmes serves as the CEO of Cook Area Health Services, which I believe is in Minnesota. And as the treasurer for the National Association of Community Health Centers, Mr. Holmes, I look forward to your testimony today on the role that the Community Health Center Fund has played in supporting your work. There is much to discuss today. I look forward to our conversation. Both the Community Health Center Fund and the State Children's Health Insurance Program provide State and local opportunities to improve access to care in the United States.

I yield back the balance of my time, and recognize the ranking member of the subcommittee, Mr. Green of Texas, 5 minutes for an opening statement, please.

Mr. Green. Thank you, Mr. Chairman. And, again, we appreciate the loss we had, the injuries you had, and particularly to our committee

member, last week. But I am glad he is progressing very well. The Children's Health Insurance Program, CHIP, and Federally Qualified Health Centers, FQHCs, are critical components of our healthcare safety net. Funding for both expires at the end of this fiscal year, and timely reauthorization is utterly critical. That said, we cannot talk about either without talking about Medicaid, and, literally, the elephant in the room. The American Health Center Act, or TrumpCare, guts Medicaid, makes structural changes that would inevitably lead to the rationing of care after seeing the House Republican's bill to kick off 14 million enrollees on Medicaid, cut 834 billion from programs, the Senate plan to kick even more kids off of Medicaid over time, and make even steeper cuts somehow managing to be more mean than even the House bill.

In 3 years, the Senate bill will start the process of kicking millions off their Medicaid coverage. And then as if that wasn't enough, starting in 2025, the plan leads to even more Medicaid cuts that every year becomes deeper cuts than the year before. CHIP is designed to sit on top of a strong Medicaid program, and reauthorizing it while simultaneously destroying Medicaid is simply unacceptable.

TrumpCare jeopardizes coverage for millions of kids with Medicaid and CHIP, and the Trump budget doubles down on cuts that directly hurt kids. To make matters worse, the Trump administration's budget proposals, an additional $610 billion cuts to Medicaid, eliminates enhanced CHIP matching for States, rolls back the requirement on States to maintain current kids' eligibility in CHIP, and cuts support for

CHIP kids over 250 percent of the Federal poverty level.

More than 1/3 of all children in the U.S. and almost half the kids under age 6 are covered by Medicaid or CHIP. The vast majority of these children, more than 90 percent, are covered by Medicaid.

I strongly support CHIP and will continue to urge my colleagues to fully extend the program for 5 years. And I have long championed community health centers and want to see the health center fund extended for the same amount of time. Without an extension of funding, the health center program will be decimated. Given all the uncertainly my colleagues are introducing in the health insurance programs, a clean extension of these two pillars of the healthcare safety net is utmost important. But, again, extending these programs without destroying Medicaid is unacceptable. CHIP stands on the shoulders of a strong Medicaid program. And in fiscal year 2016, Medicaid provided more than 40 percent of the community health center's funding. They are tied together as three legs on a stool that helps children get healthcare they need. No child should be left off worse because of Congress's actions.

With that, Ms. Chairman, I would like to yield 1 minute to my colleague from Massachusetts, Joe Kennedy. And after Congressman Kennedy, I yield the remainder to my time to Congresswoman DeGette.

Mr. Kennedy. Thank you to the ranking member.

Ladies and gentlemen, anybody who has welcomed a child into this world knows that moment when you lock your eyes with your son or daughter the first time, the promise that you make to protect them under any

circumstance. You learn quickly, sometimes far too quickly, that no matter how hard you try, nature will test the strength of that promise because children are not immune to an unexpected accident or a life-altering diagnosis. Facing that tragic reality, we as a country and as a community invest in their care through CHIP, through Medicaid, through a ban on lifetime caps into a strong community health center program. It is that recognition that our children are society's most precious resource that brings us together here this morning. But Trump Care threatens the fundamental guarantee of compassion for our kids. It segregates and stigmatizes children not just for their illness, but for their fate and fortune of their family. And that is a vision that, for our healthcare system on our Nation, that we should never accept.

Thank you, and I yield back.

Ms. DeGette. Thank you.

You know, we used to all agree in this country that every child, regardless of his or her parents' income, should have a chance at a healthy start. That is why we have been working in a bipartisan way to make this country get closer to that goal. I worked on the very first CHIP bill in 1999. And because of the bipartisan collaboration, 95 percent of Americans children have coverage. That is an all-time high. So why would Congress pass this TrumpCare bill which will take coverage away from over 3 million children? There would be an unprecedented $834 billion cut in Medicare which covers more than 35 million kids. Half of the 9 million children in CHIP are actually in Medicaid. And so, Mr. Chairman, it is really hard for me to see how

we can have a bipartisan reauthorization of CHIP by the end of September without a strong bedrock foundation of Medicaid.

I yield back.

Mr. Burgess. The gentleman from Texas yields back his time. The chair thanks the gentleman. The chair recognizes the gentleman from Oregon, Mr. Walden, 5 minutes for an opening statement, please.

The Chairman. I thank the chairman.

Today marks a really important step forward in this committee's work to strength our healthcare safety net by examining the extension of two very important safety net programs. Both the Children's Health Insurance Program, CHIP, the Community Health Center Program, have enjoyed strong bipartisan support for many years. Under current law, Congress needs to renew funding for these important programs, since the current funding streams will soon expire. We recognize that CHIP and community health centers play a significant role in the Nation's safety net for millions of Americans, for millions of American children, and pregnant women who are generally low- to moderate-income, and millions of individuals who may be medically underserved or face other barriers to care.

Individuals and families served by these programs are not just program enrollees: They are our neighbors. They are our friends. In my district alone, there are 12 federally-qualified health center organizations with 63 delivery sites leveraging more than $41 million in Federal money in order to serve over 240,000 patients. In many parts of rural eastern Oregon, a health center can serve as the main primary

care provider in the communities that face a shortage of private practice doctors. And in three of my counties, there are no physicians, and there are no hospitals. The Student Loan Repayment Incentive offered through the National Health Service Corps also helps staff those centers and ensure patients in those communities can see a provider in a timely manner. So I am glad to be here and join my colleagues, hopefully on both sides of the aisle, in moving this process forward. We are united in the effort to protect patients and to support innovative patient-centered solutions at State and local levels.

As a result, there are strong bipartisan recognition that CHIP and the health center program play key roles in our Nation's healthcare delivery system by providing health coverage and medical care for millions of low income Americans.

Both programs have demonstrated successes in helping reduce cost for patients and families, improve health outcomes, and deliver cost-effective care. We view our State and local partners in these programs as key allies in the common cause of putting patients first. This is a shared responsibility.

In my State of Oregon, our health centers partner with local providers, health systems, and the patient community through coordinated care organizations that work to provide comprehensive services focusing on prevention, chronic disease management, and locally controlled patient-centered care.

Today, we start our funding extension discussion by hearing from experts who have firsthand experience running CHIP programs and health

centers. We want to better understand if these programs face barriers to innovation. We want to hear creative strategies to deliver quality care, and we seek your guidance on what is working and what is not.

As we move forward, this committee also faces important considerations regarding extending funding for these programs. There are decisions to be made regarding how much funding should be provided, for how long, and how Congress should pay for it so as not to burden the next generation with additional debt.

Particularly, the committee will closely examine the question of whether the 23 percent bump for a State's match for CHIP is appropriate to continue as we look at funding questions. I have concerns the 23 percent increase upends the traditional financial Federal-State partnership.

As we embark on this effort, I know we all share the goals reducing cost and ensuring patients served by these programs have the peace of mind that they can continue to access timely, high quality care. And it goes without saying that this needs to be bipartisan. We look forward to working with our colleagues on the other side of the aisle. And it is important to note as well that CHIP is one of those programs that is actually a block grant to the States that seems to perform quite well when we rely on our State partners in this effort.

So with that, Mr. Chair, unless others on our side seek the balance of my time, I am more than happy to yield back to get on with the hearing.

Mr. Burgess. The chair thanks the gentlemen. The gentleman

yields back.

The chair would observe that there is a vote on the floor. There is still almost 9 minutes left. So with the committee's permission, I am going to recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement, after which we will recess for votes until votes have concluded on the floor. Mr. Pallone, you are recognized for 5 minutes, please.

Mr. Pallone. Thank you, Mr. Chairman.

A little over a month ago, House Republicans voted to repeal the Affordable Care Act and gut the Medicaid program in order to give tax cuts to the rich and privileged few. The result, 23 million people could lose health insurance, 3 million of them children. And then yesterday, Senate Republicans finally made public their bill where they proposed even steeper cuts to Medicaid. And now, today, Republicans will talk about the importance of our safety net programs, the Children's Health Insurance Program, CHIP, and the Community Health Center Fund. I agree wholeheartedly about the importance of extending these programs. But what our Republican colleagues seem to ignore is that our safety net is interconnected. To tear down Medicaid, which is supported by CHIP and community health centers, is misguided and hypocritical. Mr. Chairman, I believe we should judge a Nation by how it treats its children. CHIP covers 8.9 million kids. It stands on the shoulders of a strong Medicaid program that covers 37.1 million more children. Every single one of those kids deserve access to a doctor and access to good healthcare, yet every Republican on this

committee voted for a bill in committee that capped health coverage for kids in every one of our communities. And as a result of that vote, 3 million children would lose their health insurance, and that is simply not right.

Today we will have a conversation about community health centers also, that providers that serve so many of our most vulnerable children, the Community Health Center Fund provides 70 percent of the funding for the health center program, which accounts for 20 percent of revenue for community health centers. According to estimates, failure to reauthorize this funding will result in the closure of approximately 2,800 health centers, and 50,000 clinicians and other staff losing their jobs, and most importantly, 9 million patients losing access to care.

So I strongly believe in a swift reauthorization of this funding for community health centers. At the same time, I will remind my Republican colleagues again that Medicaid is the largest single funding source for community health centers, providing more than 40 percent of their revenue during fiscal year 2016. We can't ignore the devastating consequences that Republican efforts to cut Medicaid by $834 billion over the next 10 years will have on community health centers and millions of Americans. And this includes four in 10 children living in poverty nationwide who currently receive care at community health centers.

So, Mr. Chairman, GOP efforts to repeal the ACA and jeopardize the Medicaid program will harm children significantly. So I urge my

colleagues to first immediately reverse course and stop the dismantling of the Medicaid program.

I yield the remainder of my time split between Ms. Castor and Mr. Lujan. I guess we will start with Ms. Castor.

Ms. Castor. Thank you, Mr. Pallone.

We are at a remarkable place here in America after decades of bipartisan work. The overwhelming number of American children have health coverage, 95 percent. That is something to celebrate. And I wanted to thank you all of the policymakers, the doctors, the nurses, folks back in our local communities that have worked to achieve a 95 percent coverage rate. This is smart policy. This makes America stronger. Kids are healthier, they do better in school, they miss fewer days of school, they are more likely to attend college, and they earn higher wages. But all of this progress is at risk because the GOP has produced bills -- one here in the House, one that is even worse in the Senate that came out yesterday, that will rip coverage away from America's kids.

All of the progress we have made is at risk. Why? Just to give massive tax cuts to wealthy special interests? Those are not our values. Our values are reflected in the fact that we work together in a bipartisan way to make sure kids can see a doctor and get the care that they need. But what the GOP bills do is the most radical detrimental restructuring of children's healthcare ever proposed under the 50 years of Medicaid. And it must be rejected. And, in fact, it is wholly inconsistent for us to be talking about CHIP reauthorization,

because Medicaid and CHIP are so closely interconnected. You cannot have a CHIP reauthorization without a strong Medicaid initiative. So let's jettison those plans and work together to cover the remaining 5 percent of kids that don't have healthcare coverage.

And I am happy to the yield the balance to my colleague, Mr. Lujan.

Mr. Lujan. Medicaid is the single largest health insurer for children. Because of Medicaid, the CHIP program, and ACA, 95 percent of all children now have health coverage at an all-time high. Sadly, Medicaid is in the crosshairs of our Republican colleagues. And you have heard the numbers: 37 million kids who depend on Medicaid nationwide, half a million in New Mexico alone; the 3 million of the 23 million people who will lose coverage are children. It is simple. A strong CHIP program depends on a strong Medicaid program. You can't reach out with one hand in the guise of reauthorizing CHIP while cutting $1 trillion from Medicaid with the other. You just can't have it both ways.

I yield back.

Mr. Burgess. The chair thanks the gentleman. Does the gentleman from New Jersey yield back?

The gentleman from New Jersey yields back.

The chair thanks the gentleman. Chair makes a technical observation that SCHIP is authored until the end of fiscal year 2019 as was accomplished in the Affordable Care Act. It was only funded through fiscal year 2015. This is the second funding bridge that has had to occur because of the fiscal cliff that was built into the ACA.

We now stand adjourned until immediately after the -- in recess until immediately after the last vote.

[Recess.]

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[11:07 a.m.]

Mr. Burgess. The chair would remind members pursuant to committee rules all member's opening statements will be made part of the record. And we do want to thank our witnesses for being here today taking time to testify before the subcommittee on this important issue. Each witness will have the opportunity to give an opening statement, followed then by questions from members. Again, as previously mentioned our witnesses, but today we will hear from Mr. Michael Holmes, Chief Executive Officer, Cook Area Health Services; Ms. Jamie Snyder, Associate Commissioner for Medicaid SCHIP Services, Health and Human Services Commission State of Texas; and Ms. Cindy Mann, partner in Manatt Health. We appreciate you being here today.

Mr. Holmes, you are now recognized for 5 minutes for an opening statement, please.

STATEMENTS OF MICHAEL HOLMES, CHIEF EXECUTIVE OFFICER, COOK AREA HEALTH SERVICES; JAMI SNYDER, ASSOCIATE COMMISSIONER FOR MEDICAID/SCHIP SERVICES, STATE OF TEXAS, HEALTH AND HUMAN SERVICES COMMISSION; AND CINDY MANN, PARTNER, MANATT HEALTH

STATEMENT OF MICHAEL HOLMES

Mr. Holmes. Thank you, Chairman Burgess, Ranking Member Green, members of the subcommittee. My name is Mike Holmes. I am the CEO of Cook Area Health Services, a Federally qualified community health center providing medical, dental, behavioral healthcare in nine locations to more than 12,000 patients in rural northern Minnesota. On behalf of the more than 1,400 community health center organizations nationwide, I wanted to thank the subcommittee for the longstanding bipartisan support you have consistently shown for community health centers.

Since 1979, Cook Area Health Services has provided critical healthcare access to patients and communities who would otherwise go without. Our service area covers more than 8,300 square miles, and many of our patients travel 50 miles or more to access care. Each one of our sites is located in a town where the population of fewer than 600 people.

As with many rural community health centers, we are the only game in town. Our health center story is just one part of a much larger

national story. For more than 50 years America's community health centers, also known as FQHCs, have served as the medical home for our Nation's underserved communities and populations.

Today, health centers represent the Nation's largest primary care network, providing high quality care to more than 25 million patients. Our record of success would not be possible without the ongoing support of Congress. And I am here today to urge you to continue that support by extending your investments in the health center program, and specifically, the community health centers fund, which provides enormous value to patients, communities, the health system and the taxpayer.

Our success is reflected in the core requirements every health center must meet, each health center must be open to all. We must serve our medically underserved area of our population; we must offer comprehensive ranges of primary care services; and each health center is governed by a consumer majority board which works closely with health center leadership and clinicians to develop innovative responses to community needs.

In 2010, Congress created a dedicated source of funding to sustain and grow the national investment in health centers, with an initial 5-year authorization, the CHC fund directed resources to both operational expansion and capital investment in health centers. As a result of this investment, new health center sites were added in more than 1,100 communities, health centers are serving approximately 6 million additional people, and they have expanded services like

behavioral and dental care.

At our health center this funding allowed us to add new access points in Tower, Minnesota, and helped us expand dental services in three other communities and to significantly expand our care coordination services. In 2015, Congress extended the Community Health Center Fund for 2 additional years alongside CHIP and a number of other programs. With that extension nearing its expiration date, we strongly urge you to renew these investments and to do so for at least 5 years so that health centers like mine can continue to provide reliable access to our patients.

Without action by the end of the fiscal year, health centers and our patients face major disruptions in care. HHS has estimated that should Congress not act by September 30th, it would lead to the closure of 2,800 health center sites, loss of over 50,000 jobs, and, more importantly, a loss of access to care for some 9 million patients.

In conjunction with my testimony today, the Minnesota delegation has given me a letter, noting their support for health centers and the impact on Minnesota CHCs. In my written testimony, I have highlighted several other programs which fall under the subcommittee's jurisdiction. Two key workforce programs are set to expire on the same timeline as the health centers' fund.

The National Health Service Corps, which provides scholarships and loan repayments to clinicians willing to work in underserved areas, is a key tool health centers use as we recruit and retain clinical staff. Fifty-four percent of National Health Service Corps clinicians

practice in health centers today. Additionally, the Teaching Health Centers Graduate Medical Education program brings physician residency training right into community based settings like FQHCs where providers are needed the most.

And finally, I would like to note that the Medicaid program is extremely important to health centers and those we serve. And every State the program works hand in hand to turn the promise of coverage into the reality of care. Nearly half of all health center patients are covered by Medicaid.

This is a time of rapid change in our health system. Health centers probably help with that change, even though as we remain committed to our basic founding principle, ensuring that every American in need has a place to go for high quality care. That purpose is made into reality every day for 25 million patients because of the support of Congress. And that support begins here in this subcommittee. I urge you to continue that support by extending these critical programs on a timely basis, and appreciate the opportunity to testify before you today and thank you for making health centers an ongoing priority.

[The prepared statement of Mr. Holmes follows:]

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Mr. Burgess. Thank you, Mr. Holmes. The committee thanks you for your testimony.

Ms. Snyder, you are recognized for 5 minutes for an opening statement, please.

STATEMENT OF JAMI SNYDER

Ms. Snyder. Good morning, Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health. Thank you for the opportunity to provide testimony on the Children's Health Insurance Program. My name is Jami Snyder, I serve as the director of the Medicaid and CHIP programs for the State of Texas.

This morning, I would like to provide insight into how CHIP has worked for the State of Texas in response to the subcommittee's inquiries concerning the reauthorization legislation. The Texas Health and Human Services Commission implemented the State's CHIP program in 1998. The program currently serves approximately 380,000 children. Since implementation, the State has seen a notable reduction in the overall rate of uninsured children below 200 percent of the Federal poverty level, from 18 percent in 1998 to 6 percent in 2015.

CHIP statute allows States the flexibility to operate CHIP as a Medicaid expansion program, as a separate State program, or as a combination of the two. Texas has historically operated CHIP as a separate program, which has afforded Texas the freedom to design a

system that aligns with the State's philosophy of ensuring accountability in the management of public funds, and increasing personal responsibility for program participants.

Unlike the Medicaid program, which offers an extensive and prescriptive medical benefit for children, CHIP regulations offer States flexibility to tailor the CHIP benefit package to meet the unique needs of the populations served. This allows CHIP to function as a nimble program that is more easily able to respond to changes in the States fiscal outlook, emerging Federal legislation, as well as the evolving needs of beneficiaries.

Since the onset of the program, Texas has delivered CHIP services through a managed care model. The State currently contracts with 17 managed care organizations, delivering services to CHIP members Statewide. The managed care delivery system offers additional advantages as MCOs are incentivized through a risk-based, capitated payment system to contain costs while implementing innovative service delivery and provider payment mechanisms to improve health outcomes for their members.

Medicaid regulations make it difficult for States to implement cost-effective, or effective cost-sharing mechanisms for the full range of Medicaid beneficiaries. In contrast, CHIP offers States greater flexibility to design programs in which families retain a measure of responsibility for the cost of their child's care.

Most families in CHIP pay an annual enrollment fee, and all families in CHIP make copayments for office visits, prescription

medications, inpatient hospital care, and nonemergent care provided in an emergency room setting.

CHIP is a critical part of the health care safety net in Texas, offering a healthcare benefit to children who do not qualify for the Medicaid program. Texas' overall experience is that CHIP simply works. It provides reliable medical and dental benefits to the covered population at a rate of $156 per member, per month, which is $67 less on a per-member basis than the cost for coverage for the State's Medicaid population.

The State's quality data also offers evidence of the efficacy of the program, indicating a 21 percent increase in children age 3 to 6, accessing well child visits, and a 90 percent increase in children receives recommended vaccines in the first 2 years of life for measurement years 2011 through 2015.

A decision to not reauthorize the CHIP program would result in a loss of over $1 billion in funding annually to the State of Texas, and a corresponding loss of healthcare coverage for more than 380,000 children. If funding for the program is not extended beyond September 2017, it is estimated the State will exhaust remaining resources by February 2018. As such, Texas would be faced with the prospect of dismantling the CHIP program. And as mandated by the ACA, the State would also be expected to continue adherence to maintenance of effort requirements at a lower Medicaid Federal matching rate for over 250,000 children now served under the State's Medicaid program.

Through its routine budgetary planning process, Texas has assumed

continued funding for the CHIP program for fiscal years 2018 and 2019 at the enhanced Federal matching rate. Should Congress elect not to move forward in reauthorizing CHIP, the State of Texas will no longer be able to administer this critical program, which has a proven track record of success, stemming from its adherence to the fundamental principles of State administrative flexibility, personal responsibility, and innovation aimed at enhancing outcomes for beneficiaries.

[The prepared statement of Ms. Snyder follows:]

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Mr. Burgess. The chair thanks the gentlelady for her testimony. Ms. Mann, you are recognized for 5 minutes please for an opening statement.

STATEMENT OF CINDY MANN

Ms. Mann. Good morning, Chairman Burgess and Ranking Member Green, and distinguished members of the subcommittee. I am pleased to be here this morning, I am Cindy Mann, a partner at Manatt Health, and I work on matters primarily focused on public coverage, and particularly the Medicaid and the Children's Health Insurance Program. And as noted, prior to joining Manatt, I served as the director of the Center for Medicaid and CHIP services at CMS responsible for Federal policy, Federal oversight of Medicaid and CHIP and supporting statement implementation of these programs. I am going to focus today on my testimony on the role of CHIP in providing affordable coverage to children, the issues facing Congress on the expiration of the funding. But I also do want to note the strong support of the comments by Mr. Holmes in terms of the incredibly important value and critical function of federally qualified health centers.

With 20 years of experience with the CHIP program -- it is hard to believe it is 20 years behind us -- we know what has made this program successful, and we know what has put it in jeopardy. CHIP works when it has robust and stable funding, and when it has a strong Medicaid program with which to partner in covering children.

Let's look first at the CHIP's history on financing. When the program was first started, it was -- the funding was ample for States that were just ramping up their program, but very quickly by 2002, some States began to see shortfalls in their funding, and we saw a mismatch between the allotments and States' needs in terms of coverage of children. And that was not unexpected. In some respects, Congress didn't know how many States would pick up the CHIP program, what the participation rates would be, but it gives us an example of what happens when you have a mismatch in funding.

Georgia, for example, reluctantly froze enrollment from March to July of 2007, and only lifted a freeze after Congress passed a supplemental budget. Florida froze enrollment, it froze it for just 5 months, and during those 5 months, 44,000 children, CHIP children, were placed on a waiting list. When CHIP was reauthorized in 2009, there was strong support from the Congress to avoid those kinds of shortfalls and enrollment freezes. CHIP has provided ample funding and revamped the system for distributing dollars. It built in new adjusters; it built in contingency funding; and a new system for redistributing funds across States.

That funding formula has been maintained through the subsequent extensions. Going forward, adequate financing for CHIP must be assured. Beyond extending the basic program funding, Congress also needs to consider the issues that have been raised so far, the 23 percentage point increase in the match rate, and the maintenance of effort provision, both of which were in the Affordable Care Act.

As my colleague from Texas noted, the enhanced funding for the CHIP program is very much integrated into State budgets and helping a number of States to adopt a plan for program improvements. But we must also recognize that that enhanced funding goes hand in hand with the maintenance of effort provision. Without the maintenance of effort provision, millions of children will be at risk of losing coverage, or paying much higher costs for that coverage.

CHIP made affordable coverage available to millions of children, but given the marketplace changes, the uncertainties of the futures of subsidies and cost-sharing reductions, indeed, even the uncertainties in the Medicaid program. It is essential to protect not just the funding for the program, but children's eligibility for coverage. And I would suggest that it is unlikely we would continue the MOE requirement without also supporting State's ability to fund that requirement and that need for stable coverage for children.

Next, let me just circle back to my point about CHIP working, in large part, because of the foundation of Medicaid. Medicaid, of course, is the much larger program covering about 37 million children, the two programs depend on each other, kids go back and forth between the two programs all the time as family circumstances change. But even more fundamentally is that Medicaid supports CHIP by covering so many of the children with the greatest healthcare needs: lowest income children, children in poor health, kids in foster care, kids with disabilities.

CHIP wasn't designed to do that heavy lifting. It doesn't have

the financing structure, it doesn't have the benefit structure to do that. CHIP is an incredibly critical part of that coverage continuum for children, but it can't do the job alone.

Finally, I would say that Congress has much to be proud of, given its long-standing support of children's coverage. Together, Medicaid and CHIP have brought the uninsurance rate for children below 5 percent. It was over 15 percent in 1997 when CHIP was first enacted. It is a historic low, and it is a great achievement, but with sweeping changes to Medicaid now under consideration, and CHIP reauthorization outstanding, much is at stake for our Nation's children.

Thank you for your time and support.

[The prepared statement of Ms. Mann follows:]

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Mr. Burgess. The chair thanks all of our witnesses for their testimony today, and appreciate your being here and your being flexible with us as this hearing was rescheduled a couple of times.

I now want to go to vice chairman of the committee, Mr. Guthrie, 5 minutes for his questions, please.

Mr. Guthrie. Thank you very much. Before I get into my questions, I know we have had some comments from some of my colleagues, and the others on Medicaid and the way the AHCA dealt with Medicaid. As we know, Medicaid is a program that is growing rapidly and could implode. So what we decided to do, and we very carefully sat down and walked through the AHCA was how are we going to move forward? And the principled way of moving forward, I know there is a block grant option in the bill, but the principle way we decided to move forward was on an approach to Medicaid, that in the 1990s, was bipartisan. As a matter of fact, every sitting Member of the Senate who was in the Senate in the 1990s on the Democratic side signed a letter to President Clinton supporting an option of going to per capita allotments, some being key ranking members and then leadership on the other side.

Medicaid, over the next 10 years, under our proposal, will grow, not cut, will grow by 20 percent, so I just want to make sure the record reflects more than some of the rhetoric we have heard.

First, Ms. Snyder, in addition to basic medical benefits, Texas' CHIP program include behavioral health services; vision exams and corrective lenses; hearing exams and hearing aids; physical, occupational and speech therapy; and durable medical equipment. There

is also limited dental benefit. In your testimony, you seem to contrast this with Medicaid extensive, yet prescriptive medical benefit for children. I believe every member of this committee wants to ensure low-income children have adequate access to healthcare, whether in Medicaid or CHIP. But it sounded like you might have some ideas on the way Medicaid could better serve children. Do you have any ideas you would like to share with us?

Ms. Snyder. Thank you, vice chairman. Absolutely, we are a fundamental believer in Texas in both the Medicaid and CHIP programs. I think, as is evidenced by my testimony, we enjoy the flexibility that the CHIP program offers to States in designing a benefit that actually is responsive to the population that served under the CHIP program, which is a population of children that don't qualify for Medicaid. Certainly, you know, we always in Texas are, and like many other States, looking at opportunities to infuse elements of personal responsibility into programs such as Medicaid, and clearly, we already have done so with CHIP. But we do realize that the populations that are served under those programs are distinctly different, and so want to be cognizant of those differences in terms of the populations as we consider cost-sharing opportunities, benefit limitations, and so forth.

Mr. Guthrie. Thank you. Mr. Holmes, also, the reliance community health centers is very important in our safety -- health safety net. And in 2015, we extended the community health center fund for 2 additional years. In your testimony, you call on us to do a longer-term basis for at least 5 years. Maybe some of the reason for

that is self-evident, but would you like to describe what is better for you in a longer extension over a 2-year extension, the things you can do differently, or maybe more efficiently?

Mr. Holmes. Thank you, Mr. Vice Chairman. Two years is a short period of time for safety net providers to go into the workforce and recruit new providers. One of the more difficult conversations any safety net provider has when they are trying to bring in new physicians, new dentists, is to have that discussion about, if the lead time to recruit these providers is 1 to 2 years, to say, we hope to have a job for you in 2 years. It really limits our ability to have realistic conversations with new providers that we need to help serve our patients. Two years is a short planning cycle for any small business to try and address changes in the environment, and certainly, in a healthcare environment that is changing rapidly. And a longer planning cycle just would make us more effective in how we deliver care to our patients.

Mr. Guthrie. Thank you. Also, every health center must meet statutory-defined criteria to receive in HRSA, section 330 grant. One of the conditions that must be made in order for health centers to receive one of these grants, and how does an applicant demonstrate to HRSA the need for health services? And I have a 30-second time left.

Mr. Holmes. There are 19 basic requirements to fund to be eligible to receive health care center funding. Each one of those areas must be defined and documented in a competitive grant application which occurs every 3 years at the current time.

Mr. Guthrie. And what you do is critical, so we really appreciate your efforts. We appreciate it.

I yield back.

Mr. Holmes. It is critical for us to show Congress that we do what we say we are doing, and that we are who we say we are. And without that, it -- we want to have a process that is transparent for all organizations to say, this is what we do, this is who we serve, and this is how can we care for our patients.

Mr. Guthrie. Thank you. I yield back.

Mr. Burgess. I thank the gentleman. The gentleman yields back. The chair recognizes the gentleman Mr. Green for 5 minutes of questions please.

Mr. Green. Thank you, Mr. Chairman. I would like to ask unanimous consent to place in the record letters from both a number of associations encouraging a 5-year extension on funding for the Children's Health Care Program.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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Mr. Green. One thing I think is really important and I highlight that Medicaid and CHIP are linked together, and many our CHIP kids receive Medicaid benefits. In fact, two-thirds of the CHIP kids actually receive the more comprehensive Medicaid benefit package, because States have recognized how important coverage is for children. That is why I am disturbed by what the House has done passing TrumpCare, and what the Senate looks like they are poised to do next week.

The conversation about children's coverage is something that this committee should have before passing legislation, capping, and blocking, granting coverage for 37 million children. This morning, I read that 3 million children will lose coverage under the House bill, and Senate cuts to Medicaid are even deeper over time. Every one child losing coverage in our country -- even one child losing coverage in our country is unacceptable. We can do better for our children.

Ms. Mann, can you start off with some of the important contexts we should have as we consider the reauthorization in CHIP, which I want to be clear, I strongly support and believe Congress must immediately do. What do people mean when they say CHIP stands on the shoulders of Medicaid? And can you discuss the history of CHIP and how it worked with Medicaid programs to bring us to the highest rate of coverage for children in our history?

Ms. Mann. Thank you. I would be glad to address that question. CHIP was established to extend coverage to children who otherwise weren't going to be eligible for Medicaid, and States could cover those children, either in Medicaid or in separate CHIP programs. So the idea

that CHIP sits on top of Medicaid is, in fact, exactly how it is designed by Congress, and how it is operated in the program. And why CHIP needs that support is that Medicaid really does, as I noted, much of the heavy lifting. Both in terms of numbers, Medicaid covers about 37 million children, CHIP covers over 8 million children. Medicaid covers the children who are the poorest, often in the poorest health, foster care kids, kids with disabilities. Those children -- any child, when they get a disability, when they get a chronic illness, they often have to turn to Medicaid, even if they are eligible for the CHIP program. It is not necessarily designed to be that robust a benefit package. They work hand in hand.

And at the same time, what CHIP has done is really helped modernize the Medicaid program over the years. When CHIP was started, it really got a lot of energy around children's coverage, and people started to look at not just how to design the new CHIP program, but what should we do to improve the Medicaid program? So simplified applications made it easier for families to enroll. That had a lot to do with the success and the uninsured rate that we have seen. So the two really are side by side and complement each other, and are needed for the continuum of coverage for children.

Mr. Green. Let me ask you a question about the -- following up on my colleague from Kentucky. Do you have anything to say about the flexibility of Medicaid in -- between States, different States with different Medicaid programs?

Ms. Mann. There is a great deal of flexibility in Medicaid. In

fact, often you hear from Members of Congress and others, oh, my God, it is such a complex program, in part, because there are 56 jurisdictions that administer it, and there is quite a bit of distinction and differences among them because of the flexibility accorded to States in the program.

They have -- States have a lot of flexibility to design their delivery system as a managed care, is it fee for service? Accountable care organizations? They design their payment system; they design their care management system. The area where Medicaid is clear, however, is on the benefit protection for children. It is actually 50 years, almost to the day, where Congress adopted the early periodic screening and diagnostic treatment program to make sure that all kids in Medicaid get screened for vision, hearing, developmental delays, other problems. And if they have a medical problem, the benefit requirement in Medicaid is that they get treated.

Mr. Green. I am almost out of time. Texas receives a 1115 waiver that, I think, bipartisan, we supported. There is flexibility in States. Although -- I also, before I was elected to Congress, served 20 years in the State legislature, and I watched how we were funding Medicaid back then. And my concern is that the flexibility -- we also vote this Federal money, in Texas, our match is two-thirds Fed, one-third State, of course, Louisiana gets a little better than that. Someday maybe we will get to that level. But we also need to have guidelines for what we know that funding will go through.

Ms. Mann. Absolutely.

Mr. Green. So I want flexibility, but I also make sure it is spent on the healthcare for poor people, including children.

Ms. Mann. Absolutely.

Mr. Green. Thank you, Mr. Chairman.

Mr. Burgess. The gentleman yields back.

The chair thanks the gentleman. The chair recognizes the chairman of the full committee, Mr. Walden. The gentleman from Oregon, for 5 minutes, please.

The Chairman. I thank the chairman. And I want to thank our witnesses for your testimony. We appreciate what you do in our States, and communities, and what those you represent here today do.

Mr. Holmes, in your testimony, you say that many of your patients travel over 50 miles off and over secondary roads to access care in your health center, and that oftentimes, you are the only provider in the communities you serve. In addition to isolation and distance, what other challenges exist that we should know about in care and delivery that are unique to rural areas? And I would just preface that by saying my district would extend from the Atlantic Ocean to Ohio. And so it is bigger than nearly every State east of the Mississippi River. So I am used to pretty remote, rural, extreme remote, whatever the furthest-out remote nomenclature is, we got it in my district. But can you speak to some of those issues and the reimbursement issues?

Mr. Holmes. Delivery of care in a service area that is almost the size of New Jersey is challenging. It is challenging because we are in small communities. Two of our health center sites are attached

to critical access hospitals. And the critical access hospitals are small. They are 14 beds, and 16 beds, they have attached long-term care units. We have to be able to recruit providers to see these patients. I mean, we are in a frontier area, and it is long distances between sites. If we are not there, no one else is there. The next level of care for our system, or our health delivery system, is 40 to 50 miles away to an entry point.

When we look at rural areas, it is where we have our agriculture; it is where we have our forest products; it is where we have our mining; and we can't relocate those jobs to urban areas. We have to deliver care to the people that are working in those industries, and it presents challenges of distance, and time, and access. Payment reimbursement methodologies that come to FQHCs help on a per-visit basis to subsidize or offset some of the infrastructure costs. I could be much more economically efficient if I had all of my patients and all my providers in a single site, but I can't, because I can't have patients traveling 60, 70, 80 miles in.

The Chairman. Let me ask, I am thinking about the clinic I have in Fossil, Oregon, it is 92.2 miles to The Dalles, Oregon, where Mid-Columbia Medical Center is. That would be most likely the nearest hospital, so more than 90 miles away. This is one of three counties where we have physician assistants, but beyond that, no other access and no hospital in this three-county region.

Talk to me about telemedicine and what role it can play and what you encounter. I understand the recruitment issue, and some of that

goes back to the States because they want to do their board certification. So I have had various health centers and providers say, we can wait 6 months to a year to get through the process from the State of Oregon to get approval to get somebody here, and meanwhile, they go somewhere else, perhaps. We are not as bad as some, not as good as others. Can you talk about telemedicine?

And then, I had an amendment before it came law and then it expired on sort of bonus payment for home healthcare, because it is more expensive to go out and back 90 miles each way to take care of somebody in a remote area. Perhaps you could address those things?

Mr. Holmes. We have a common electronic medical record platform across all of our sites. We have some clinics that are mid-level provider sites only. They are staffed by nurse practitioners or physician's assistants. If they have issues or questions about care of a patient, they can route that chart to one of our physicians in one of our other sites for assistance in care delivery.

We have some telemedicine capabilities. We have telemental health services with the University of Minnesota, Duluth, where we can have patient's access, some psychiatric and psychology care. And we do have some telederm setups. But part of the problem we have with telemedicine is that in the rural areas, there is not a significant infrastructure for high speed internet.

The Chairman. Right.

Mr. Holmes. So we can't do home monitoring, because in many places, there is not even a cell service, cell phone signal. And so

we end up having patients coming into our sites, which is the closest access point they can. And we will work with the patient there, whether it is with direct hands-on care, or through some telemedicine.

The Chairman. That is helpful. We also have jurisdiction over spectrum and broadband buildout, it is a big bipartisan effort on our committee to get access. We just had a hearing this week, as a matter of fact, on getting access to unserved areas first with the Federal support, and then underserved after that, and how we mapped that and really figure out where those areas are. So thank you all for the work you do and for your testimony today.

I yield back.

Mr. Burgess. The gentleman yields back the chair. The chair recognizes the gentleman from New Jersey, the ranking member of the full committee, Mr. Pallone, 5 minutes for questions, please.

Mr. Pallone. Thank you, Mr. Chairman.

I believe deeply in the CHIP program. I want to see a full 5-year extension of current CHIP policy. However, I also believe deeply in the Medicaid program. And I know that a lot of our success with the CHIP program is due, in part, because it bills so seamlessly on top of the Medicaid program in its current form. And as virtually every stakeholder agrees, the TrumpCare bill passed by the House would decimate coverage for 23 million people, 3 million of them children. What is worse is that the Senate's own TrumpCare bill doubles down against kids. And it is a fact that these proposals are bad for kids.

So with that in mind, Ms. Mann, I wanted to ask you some questions.

First, why is the current full 5-year extension of the CHIP program with the maintenance of effort in the so-called 23 percent bump in payments for States so critical now more than ever?

Ms. Mann. Thank you. MACPAC, the pediatricians, and NGA have all recommended a 5-year extension. MACPAC with 23 percentage points and the maintenance of effort, and I think for good reason. And I think it goes back to the points that Mr. Holmes made about health center funding. These 2-year cycles are just not sufficient for States to be able to really do the kind of planning and improvements that make sense for kids. And I also think the other side of that is to look at what is going on broadly in the healthcare marketplace right now. If CHIP were to end more abruptly, then children will be at risk of not having coverage, or if they find coverage, they will have significantly higher out-of-pocket costs.

This is really a time of great uncertainty in our healthcare marketplace, small "m", and it is really a time, given the bipartisan support for children's coverage, to give CHIP 5 years to be stable and to do the job it needs to do for children.

Mr. Pallone. Well, I obviously agree with you and the importance of an immediate and full extension, but I also share the same belief about reauthorizing the community health center fund. I think we need to do it immediately. But again, when you talk about the health center program, a lot of success due, in part to the Medicaid program, which provides more than 40 percent of community health center revenue each year. And unfortunately, all that success, I think, is jeopardized

with TrumpCare. And yet my colleagues argue that a cap on the Medicaid program is not a cut at all. In fact, the administration was up here testifying on the budget of the Ways and Means chair arguing that TrumpCare was not a cut to Medicaid at all. So I would like to hear from someone who knows a lot about Medicaid and CHIP, many have likened the capping of the Medicaid program to be just like managed care, which, in Medicaid, is quite widespread. Is the cap in Medicaid like managed care?

Ms. Mann. Well, I will jump in and answer that. And I am sure Ms. Snyder also has a view on that. It is very unlike managed care. States use managed care largely for CHIP programs and for their Medicaid programs. They set rates, they set rates at a regular period of time. They adjust rates based on the acuity and the needs of the population that are served. They take into account policy changes, healthcare cost changes, and they are constantly reexamining their rates.

In the cap in the bill, is it is set based on spending from years back, moved forward, adjusted by a national trend rate that is not related to the actual needs and cost of serving people in that State. And it doesn't adjust based on acuity of the needs; it doesn't adjust based on the healthcare costs in that community.

Mr. Pallone. So what is going to happen to benefits and provider revenue with a capped or block granted Medicaid program?

Ms. Mann. Well, States have three major levers to do significant reductions of spending in the Medicaid program: enrollment, provider payment rates, and benefits. I think likely, with the kinds of changes

that are proposed, all three will be relied on by States. But if you think about going to provider rates, which is maybe the first place States will turn, we worry a lot about access for kids. Access is in good shape for kids right now in our Medicaid program, but if we thin out the payment rates for providers, if we lower our payment rates for managed care organizations, we are going to have access issue and problems of serving children, as well as seeing some children who are on optional kinds of programs, kids with brain injuries and other types of HCBS services, Home and Community Based Services may be losing their coverage and services all together.

Mr. Pallone. Are there any winners for this policy, regardless of what States are carved out? And is it going to matter?

Ms. Mann. Well, no States are carved out, and I think it is just a fact of math that when there is a Federal and State partnership to share all costs and the Federal Government is saying, I am pulling out of that partnership, and I am setting my limits at a certain amount, and the State is responsible for everything above that, every State becomes a loser in that formula.

Mr. Pallone. All right. Thank you. Thank you, Mr. Chairman.

Mr. Guthrie. [Presiding.] Thank you. The gentleman from New Jersey yields back. The gentleman from New Jersey is recognized.

Mr. Lance. Thank you, and good morning to the distinguished panel.

Is it the view of the panel that the current formula for Medicaid, which is open ended, as I understand it, should continue as it exists

permanently without any analysis of a potential modification? I ask the question legitimately and I was one of 20 Republicans not to vote for the healthcare plan on the floor of the House of Representatives. Ms. Mann, I will start with you.

Ms. Mann. I think the shared commitment, the shared partnership around underlining financing of the program is critical and needs to be retained. I think there are always areas of improvement. There has been years of complaints about how the FMAP itself, how that share is actually the formula for that. That could be looked at, though it is a quagmire of political complications when one does.

Mr. Lance. I think that is the understatement of the day. As I understand it, the costs have increased relatively significantly in the last decade. Is that accurate?

Ms. Mann. The costs per enrollee, actually, in the Medicaid program, have grown much more slowly than either commercial insurance or Medicare. Medicaid costs have grown, but that is because it is covering many more people.

Mr. Lance. Others on the panel who would like to address the issue?

Ms. Snyder. I would be happy to respond to the question.

Very similar to Ms. Mann, I think we can all agree that there is always opportunity for improvement when we look at the funding formula for Medicaid as it currently stands. As a State, I can tell you Texas is looking very closely at the implications of the ACA, as well as the proposal that has been advanced by the Senate, specifically for the

implications for the State of Texas and how the proposed funding formulas would play out for the program, versus the funding formula that we are now working with.

Mr. Lance. Yes.

Mr. Holmes. From a rural standpoint and a small safety net provider standpoint, I think it is important to recognize that not all Medicaid patients are evenly distributed across all payer types and across all providers. In the rural areas, there is a higher level of Medicaid population and where nursing home care paid by Medicaid may be 64 percent nationally. In the nursing homes that I am familiar with, their Medicaid population is 90 percent. And so there is a disproportionate percentage in some of our communities that rely on Medicaid. And so any time we have a change in that system, I worry about unintended consequences and how the rural providers, and rural safety net providers, and all safety net providers adapt to those changes.

Mr. Lance. Regarding rural America, is this particularly important as it relates to those in nursing homes, as opposed to children and other populations served by Medicaid?

Mr. Holmes. In the rural areas, we still have a significant nursing home population, a long-term care population, but we have a disabled population, and we have a population of moms and kids.

Mr. Lance. Well, that is true across the country, obviously. Is there a disproportionate percentage in rural America in one of the cohorts you have just mentioned?

Mr. Holmes. I believe that there is a disproportionate share in the rural areas for long-term care, because we have an aging in rural parts of the country. A lot of the younger people have moved out of the rural areas to urban areas where the jobs are. And so we have a graying of the population in these rural communities. Along with that graying of the population, I think there is a greater reliance on some of the programs to help provide care.

Mr. Lance. Thank you. I think that this is an issue that deserves a great deal of attention, and I am not one who wants to make this a partisan issue. I think that it is a very difficult issue, and we have to examine it, in my judgment, based upon the facts that we want to cover as many Americans as possible. We also have a responsibility to the tax-paying public with a rising Federal debt. And I hope that we can examine these very difficult issues in a bipartisan capacity moving forward, because I do not think that this is an issue that should be politicized.

I yield back 17 seconds.

Mr. Guthrie. The gentleman yields back his 17 seconds. The lady, Ms. Matsui from California, is recognized.

Ms. Matsui. Thank you very much, Mr. Chairman.

CHIP and the Community Health Centers' Fund are critically important programs for serving children and families in our communities. And I do look forward to working with my colleagues to continue their funding in the future, and hopefully far into the future. However, we all know we can't have a conversation about safety net that

CHIP and community health centers provide without including Medicaid as their foundation, because Medicaid is the foundation of our Nation's safety nets.

Forty-one per of children in California are on Medicaid and CHIP. That is about two in every five kids. I say 41 percent on Medicaid and CHIP because you can't separate the two. CHIP eligible children in California, in fact, receive services through the Medi-Cal program. The CHIP and community health centers programs and the children and families they serve, will be devastated by the Medicaid cuts proposed by the TrumpCare bill.

Ms. Mann, I know that -- I am going to ask you this, because the way it looks now, if the TrumpCare bill goes through, billions of dollars will be cut from Medicaid. Would States be able to continue to cover the same number of people? Would they be able to cover the same type of services? Where might they cut? And are there examples of difficult choices States have had to make when budgets were squeezed?

Ms. Mann. Sure. The Medicaid program, I think, certainly as CBO has projected, the reductions in Medicaid funding $834 billion over 10 years would result in about 14 million people in the Medicaid program losing coverage. That will grow over time due to the impact of the caps, and how the caps get tighter and tighter over time just because of the way the math works. And, so, we will see necessarily, I think, lots of impacts to the program, both on that coverage number, but also in terms of whether we see limitations on the kinds of benefits to people are able to access. States will have to look, for the first time, I

think, really closely at so-called outlier cost people: people who are elderly people, children who are in special waiver programs, for example, who are -- whose expenditures are so much higher than the cap would be. Every time they enroll somebody in that situation, the State will lose a lot of money under the way the caps are designed.

We also see big concerns about access, whether lower payments to providers, lower payments to health plans will narrow networks, children won't be able to get access to specialty care, and the kind of services that they need in a timely way.

Ms. Matsui. So it seems to me you will be rationing care here. It seems to me they would have to make very difficult decisions as to what population will get the care that they need.

Ms. Mann. What you will have even more than you have now, there is always issues at the State level about funding the Medicaid program. It is a big expenditure. States do not just spend their money without a lot of examination. But under a capped environment, you will have both cuts and a limit. And that will increase the competition between populations and between providers inside the State.

Ms. Matsui. Okay. Thank you.

I would ask you also about in California, children receive full EPSDT, which is Early and Periodic Screening, Diagnostic and Treatment services through Medi-Cal. Can you talk about the impact of access to these services on children and families? And can you talk about the differences in the benefits and resulting health outcomes?

Ms. Mann. EPSDT was really designed initially because of concern

about low-birth weight babies, about children growing up, even children being -- going into the Armed Forces, and as young adults and not being in healthy shape. It is really a very sensible benefit package that says there should be screening, diagnostic testing. And then it simply says that when a child needs treatment, as recommended by their doctor, they get the treatment that they need. That is an incredibly important service that is available to children, and, I think, the kind of standard we all want for our children. With reductions in spending, that might be a hollow promise; you might have the promise even for EPSDT if it is still there, but can a child find a provider, can a child get to a dentist, can that child get to the specialist that they might need for a particular kind of circumstance.

Ms. Matsui. I see I am out of time and I would like to submit my questions for the record.

Thank you. I yield back.

Mr. Guthrie. The gentlelady yields back. The gentleman from Virginia, Mr. Griffin, is recognized for 5 minutes.

RPTR ALLDRIDGE

EDTR ZAMORA

[11:56 a.m.]

Mr. Griffith. Thank you, Mr. Chairman. I appreciate it very much.

Mr. Holmes, you have been talking about some of the rural issues, and I appreciate that, because my district is larger than the State of New Jersey. And you indicated that your -- territory that you cover is about the size of New Jersey, or a little bit less than that. And one of the things that I have been -- that has been rattling around in my head is that -- the telemedicine issue that you touched on earlier is that we ought to be able to figure out a way to save money longterm, maybe not initially but longterm, by using telemedicine and not only save some money but increase the effectiveness of the care in the rural areas or at least make it more accessible. For example, I have a bill in that deals with making sure that folks, by telemedicine, talking to the appropriate neurologist, et cetera, can get a quicker response on getting the tPA, in the case of a stroke. Because, obviously, if you are in a rural area, sometimes you can't get to the hospital where the right doctor has to look at you currently to give that medication. But we can speed it up.

You mentioned that you all are providing some services for mental health. I think that is extremely important, because if we can catch that, just like with the stroke, instead of having somebody in long-term

care, which we have talked about and how expensive that is, tPA can stop a lot of that. Likewise, with mental health, if we catch it early in a regular clinic and -- what we found -- we are doing that a little bit in my district now. What we found is that people are much more likely to go to the clinic, the community center, if they can just step into the other room and get the mental health, even if it is by telemedicine, because we don't have the ability to have population to have psychologists or psychiatrists in every one of those communities. But they also -- there is still a certain stigma. Maybe that is not the way it is supposed to be, but there is, particularly in rural areas, to getting mental health services. If they can just step into another room in the clinic, nobody knows whether they are getting their foot looked at for toe fungus or whether they are getting a mental health evaluation.

So just some comments on that, and do you believe that there might actually be some savings there longterm, particularly in rural settings, because we prevent folks from having more serious maladies.

Mr. Holmes. I believe there are opportunities for cost savings by integrating behavior health into primary care, along with medical services. We have a couple of rooms set up in some of our clinics that have the telemedicine capabilities, the hookups for behavioral healthcare. Those patients are scheduled routinely. There is no indication that it is a specialty behavioral health visit for that patient when they are in the waiting room.

And some of the other things we do is that we do have some

behavioral health specialists that come in from some of the local mental health agencies to our clinics. And they have office space and exam room space embedded right into other space. So we try and care for the patients in the best way that we can within the local situation, within the local facilities.

There still are reimbursement challenges with telemedicine. The originating facility is not usually a part of the reimbursement methodology. So you have to build the infrastructure without having payment for that infrastructure. You have to maintain it. You have to have enough bandwidth to have interactive television in those interactive conversations.

Mr. Griffith. All right. Let me springboard off of that. And I believe I have got my names right. Sometimes I get them wrong. But the Stark Act, currently, if I understand correctly, prevents us from using some of our facilities in conjunction with a hospital that might be willing to pay for some of that infrastructure, because at one time, they were worried about collusion and raising the bills. Today, I have got underserved areas. I could use some space in a nursing home, long-term care facility, and put in some telehealth stuff, even if it was in conjunction with the hospital, because, in all fairness, I only got one hospital that's really in competition if you are talking about somebody having a heart attack. But my folks have to travel about 45 minutes to get there.

So do you think we need to also look at maybe relaxing some of that, particularly when we can get into underserved areas?

Mr. Holmes. Antitrust issues are certainly an issue for medical delivery, especially now when we are seeing the development of large systems of care and yet we have small providers that are trying to deliver services in a cost-effective way. Small areas don't have the depth of resources to have competitive services. We have to find the best way to deliver that care to our populations. But we have to be, at this point, careful of antitrust issues. And it is always something that is in the back of our minds.

Mr. Griffith. So what you are saying is we have to try to figure out the balance. We would prefer to have competition, but where there is no competition, maybe we need to take a look at giving some flexibility on the antitrust issues to make sure that we are getting services there.

Mr. Holmes. Yes, sir, I agree.

Mr. Griffith. All right. I yield back, Mr. Chairman. Thank you.

Mr. Burgess. Thank you. The gentleman's time has expired.

And now recognize Mr. Lujan from New Mexico.

Mr. Lujan. Thank you.

Mr. Burgess. Five minutes.

Mr. Lujan. Thank you, Mr. Chairman.

Ms. Mann, I keep hearing on the news that TrumpCare doesn't cut Medicaid, yet the CBO said that is just not true. And I am looking at these quotes from different stakeholders. The American Academy of Pediatrics says, I quote, The U.S. and its healthcare legislation fails

to meet children's needs. There is too much at stake for those of us who care for children to be silent. Pediatricians will continue to speak out for what children need until we see legislation that reflects it. The Children's Hospital Association are unified in calling on the Senate to reject the bill. They say, at its core, the bill is a major step backwards for children and their health. And the American Academy of Family Physicians say that this legislation would have a profoundly negative impact on Americans.

So, Ms. Mann, can you set the record straight? Is TrumpCare a cut for children, families, and for everyone in the Medicaid program?

Ms. Mann. Yes.

Mr. Lujan. That is a pretty straightforward answer. Just so that I am clear, you respond to that question with a resounding yes.

Ms. Mann. With a resounding yes. There is $834 billion taken out of the program. There is 14 million people, by CBO standards, losing coverage. There is countless other changes that States will have to make if those cuts are imposed. And children will suffer both from the caps, from their parents losing coverage, from the loss of the expansion. There is enormous ramifications to the Medicaid program. Negative ramifications.

Mr. Lujan. I appreciate that clarification, Ms. Mann. When I asked that question during our 27-hour markup in this committee, I was responded to several times that Medicaid was not cut. I appreciate the clarification of the reduction, the cut of $834 billion from the Medicaid program.

Ms. Mann, as we have heard today, the Children's Health Insurance Program is an important provider of health insurance coverage for nearly 9 million American children. However, the Medicaid program is a primary source of coverage for low-income children covering four times as many kids as CHIP. In New Mexico, for example, there is over 414,000 kids that rely on Medicaid and 15,000 kids that rely on CHIP.

Can you please describe the role that Medicaid plays in children's coverage?

Ms. Mann. Sure. And that ratio that you have in New Mexico is pretty much what the national average looks like. It is, first of all, a much larger program, as you noted from your New Mexico figures. Medicaid just covers so many more children. And it covers infants. It covers newborns. It covers kids at school age. It covers adolescents. It covers 100 percent of a State's foster care kids, for example. Any child who has been determined disabled under the Social Security definitions, they go into the Medicaid program. They don't go into the CHIP program. Covers early intervention services for very young children. Covers school-based healthcare services. It is a very -- it is a program with lots of different functions and lots of different ways in which it serves the child population.

Mr. Lujan. And I think you addressed the next question I had, which was what would the concern be associated if the Senate passed their bill or the House-passed Republican repeal bill, otherwise called as TrumpCare, would pass and how it would affect CHIP. I think you eloquently described that.

Our Nation's leading children's health providers advocates, including the American Academy of Pediatrics, Children's Defense Fund, Family Voices, First Focus, March of Dimes have all spoken out against the Republican repeal bill. And in a March 22 statement, they wrote: In addition to the bill's initial proposal to fund Medicaid through per capita caps, the Republican bill would allow States to choose a block grant model, which would eviscerate existing protections afforded to children and pregnant women in the Medicaid program. Comprehensive EPSDT benefits would no longer be required for children, allowing States to ration limited dollars by drastically cutting back pediatric services.

And, Mr. Chairman, I would like to ask for unanimous consent to submit their statement for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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

Mr. Lujan. And just as I close, Mr. Chairman, I appreciate the conversation about the concerns, Mr. Holmes, with the impact in rural communities. I represent a district that takes about 8-1/2 hours to drive across. This is critically important. When we talk about the concerns to these rural healthcare facilities, the conversations that were taking place about the importance of mental and behavioral health programs in these small clinics, if these bills become law that would eliminate the Affordable Care Act, we would see those programs get eliminated, if not disappear.

And when it comes to getting broadband access across America, I certainly agree. I have said it once, I will say it again: If there is a debate taking place with TSA about being able to have a phone conversation on an airplane once you board in Los Angeles, California, and you can stay on that phone till you get to New York, then we should be able to have broadband coverage all across rural America in every part of our beautiful country. We once electrified rural America. Now let's make sure that we connect rural America with affordable, fast Internet. Everyone should have it. We can get it done. And I am glad to hear it being talked about today.

Thank you, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman.

The chair can see a downside to you being on the telephone between Albuquerque and New York. But nevertheless, your comments are appreciated.

The chair recognizes the gentleman from Georgia, Mr. Carter, 5

minutes for questions, please.

Mr. Carter. Thank you, Mr. Chairman. And thank all of you for being here. This is a very important program, certainly very important in my State. In the State of Georgia, SCHIP is the PeachCare program. We are very proud of it. It has been a very good program that has benefited many, many recipients.

I want to ask you, I will start with you, Ms. Snyder, and then, Mr. Holmes, I will also want you to address this, but I know that, in my district alone, we have got six federally funded health centers, and they serve over 55,000 patients. Very, very important. One of the things that we require, the Federal statute requires, is that States reimburse these federally qualified health centers and rural health centers using prospective payment system. And there have been groups who said this could be done better. And let me quote real quick. The National Association of Medicaid Directors has said: This distinct reimbursement system limits Medicaid's ability to use the full range of value-based purchasing strategies in this care delivery setting, including models that incorporate financial risk. It also prevents many States from comprehensively transforming the healthcare system across all providers. The directors have said States need to be allowed to align value-based purchasing approaches.

How do you feel about that? Ms. Snyder, what do you think?

Ms. Snyder. Congressman Carter, I am happy to answer question to the degree that I can.

What I can tell you is that the State in Texas is well aware of

the requirement around a prospective payment system and very committed to working with all of our managed care and provider partners in the advancement of value-based purchasing initiatives. Unfortunately, I cannot answer specific questions in regard to FQHC reimbursement at this time, because the State is in the midst of active litigation on the matter.

Mr. Carter. Oh, do tell about that.

Ms. Snyder. I wish I could, but I can't.

Mr. Carter. Okay. We will give you a pass.

Mr. Holmes?

Mr. Holmes. Over the years, payment methodologies have changed across all provider types, whether it has been a cost-based payment, whether it is a discounted fee-for-service payment, or whether it is prospective payment system payment. FQHCs are currently reimbursed under an FQHC prospective payment methodology for both Medicare and Medicaid.

A couple of years ago, Medicare updated their payment methodology. And I think it is important to note that Medicare, in that payment methodology update, retained the payment-per-visit methodology where a bundled set of services is reimbursed under that methodology.

We are looking at a change to value-based purchasing for all provider types. I think the question that comes in with value-based purchasing is how do you determine value? We have seen, in Minnesota, for instance, we have clinical outcome disclosures for outcomes of care

for all medical groups. And the medical groups will range from Mayo Clinic down to the smallest safety net provider. And there are different ratings for optimum care and for under diabetic -- for diabetic care or optimum cardiovascular care.

But what concerns me about value-based payments is whether or not that value truly reflects the skill and the care of the provider or if it reflects the patient population that provider served. If I was going to a value-based system, I would be -- I would wonder whether or not the best value is perceived in the suburban areas where there is high levels of income, there is high levels of poverty -- or low levels of poverty and high education. I think we have to be careful that value does not reflect our patient populations but more accurately reflects the care that is delivered by the provider.

Mr. Carter. Okay. All right. Very quickly. I have just a few seconds left. But I want to ask you, Mr. Holmes, if you have experienced the 340B program? Do you all use that at all and what has been the impact on your systems there?

Mr. Holmes. We use the 340B program. We have some savings under 340B. In turn, we use those savings to pay for some of our care coordinators and some of our patient assisters where we can align our patients into the pharmaceutical manufacturers patient assistance programs, because free is better than discounted.

Mr. Carter. Okay. Ms. Snyder, you all use 340B?

Ms. Snyder. We do.

Mr. Carter. And the impact?

Ms. Snyder. I think it is a very valuable tool, in terms of influencing reimbursement in regard to pharmaceuticals.

Mr. Carter. Okay. And what do you use the savings for? Can you identify it specifically?

Ms. Snyder. Yeah. I would be unable to identify it specifically. But certainly, I mean, I think we are always looking at opportunities to maximize savings that we are seeing in our system through various means, including --

Mr. Carter. Okay. Well, we are looking at that closely on this committee --

Ms. Snyder. Okay.

Mr. Carter. -- and on the O&I Committee. So be prepared on that. Okay?

Ms. Snyder. Absolutely.

Mr. Carter. All right. Thank you.

Mr. Chairman, I yield back.

Mr. Burgess. The gentleman's time has expired. The chair thanks the gentleman.

The chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions, please.

Ms. Castor. Thank you very much, Mr. Chairman. And thank you to our witnesses and the role that you all have played with your organizations and hitting this historic mark of 95 percent of America's kids with health coverage now. And it certainly isn't the time to go backwards. We need your expertise in how we maintain that level. And

anyone who cares about making sure kids are on a pathway to success in life really need to focus on this devastating TrumpCare bill and the most radical change to health services for kids under Medicaid in the 50-year history.

At the same time, we do need to reauthorize the Children's Health Insurance Program. And there are a few portions of it that I think are vital to maintaining that 95 percent an upwards coverage rate. One of them is the enhanced 23 percent bump. I have heard some people say that the 23 percent bump in the match did nothing to improve children's coverage. Well, I can tell you, coming from the State of Florida, and this happened in many other States last year, we were able to eliminate the 5-year Medicaid CHIP waiting period for children by using that bump up. It has been a major win for children and families.

In Florida, approximately 17,000 children were now able to come onto the rolls. I know in Arizona they were able to lift their enrollment freeze in CHIP, in KidCare, allowing 30,000 kids to receive healthcare coverage.

Ms. Mann, how important is it, as part of the reauthorization, to maintain the 23 percent match, or bump up?

Ms. Mann. I think, as you note, it really has triggered in a number of States. And the National Academy of State Health Policy did a report looking -- talking to CHIP directors about the impact. But also, as Ms. Snyder said, it really is integrated into State budgets. And a new Kaiser survey of State budgets done by Health Management shows that 26 States are experience -- is not a terrible time economically,

but 26 States are experiencing budget cuts. So I think if we pull those dollars out from the CHIP program, we will definitely see repercussions. And as I noted before, I think it is very much tied to the maintenance of effort --

Ms. Castor. Exactly. That was my next question, because I have heard folks say that that maintenance of effort that has been in place for 7 or so years and then was extended, in a bipartisan way, in the MACRA, some folks say that has limited State flexibility and innovation, and it should be allowed to expire. But, boy, that maintenance of effort has been vital to the continuity of care.

So is that as it is important? Do they go hand-in-hand, the 23 percent go hand-in-hand?

Ms. Mann. They go hand-in-hand. I mean, you could have a maintenance of effort requirement continuing to protect children's coverage and pull the money out from States, but I think there would be a lot of unhappy States with that arrangement. They really do go hand in hand. And I think even more now than 2 years ago, in terms of the stability of coverage is just critically important for children.

Ms. Castor. So that would lead -- if we didn't do that as part of the reauthorization, do you think we would see the return of waiting lists and lost coverage for kids?

Ms. Mann. I think we would. We definitely would see a pullback.

Ms. Castor. One of my great fears, and I know it has been intimated that, way back in the 1990s, Bill Clinton and the Democrats fooled around with block grants. And I can tell you, right now, this

is very dangerous to the ability of our kids to be successful in life when you move this direction. And I am particularly frightened for my home State of Florida, because Florida spends about $1,880 per child Medicaid enrollee. It is the lowest rate in the country, Ms. Mann. If we went to Medicaid caps, it appears that that would lock in Florida's low spending rate. But we are a high growth State, and our needs change over time.

What would a cap do to lock in -- what would happen to our State's ability to take care of kids and the elderly and people with disabilities?

Ms. Mann. I think Florida is a good example of many States' experience where they would be what is referred to as a relatively low spending State. They would be locked into those dollars, modified only by a small trend rate over time. And if they chose to add benefits, if they chose to put different care management in to help kids with asthma, kids with diabetes, they would either have to do that at State dollars or by cutting something else in the program.

Ms. Castor. Like education or --

Ms. Mann. As you know, in Florida there is not a lot of give --

Ms. Castor. I mean, where would we go? Would it be folks in nursing homes? They are very expensive. Or would it be special needs kids or children's hospitals?

Ms. Mann. Absolutely. And nationwide, we spend about a third of our dollars on long-term services and supports for the elderly, for people with disabilities. Populations will be vying for those limited

dollars just to be able to keep steady, never mind lose ground.

Ms. Castor. Thank you for helping to explain what is at stake. Thank you very much.

I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for questions, please.

Mr. Schrader. Thank you very much, Mr. Chairman. I appreciate it.

Mr. Holmes, I would love to get into a discussion with you on value based. You may have some good points if it was still a silo-based delivery system in modern medicine. But I point out, in the ACA, there were some risk adjustments to take some of that issue way. And in Oregon, most of our physicians, nurse practitioners in Medicaid/CHIP arena now use coordinated care organizations. We get bundled payments so that it is not just the doctor being responsible for the outcome. But you had a social worker, a dentist, you know, mental health provider. And, frankly, they take it upon themselves to make sure they have ultimate success. But I won't belabor that point. That is another discussion.

What percentage of your community health centers' budget comes from Medicaid?

Mr. Holmes. Nationally, it is just under 50 percent.

Mr. Schrader. Okay. So that is a pretty big number. The plans

we have heard from our Republican colleagues would pretty much devastate the funding for community health centers, because it would be tough to make up that 50 percent.

What would happen to your expansion -- you talk about your expansion of services -- if the Republican plans went into effective and you were cut significantly, and particularly if you have any rural areas?

Mr. Holmes. Certainly, if we have an immediate reduction, it places us in a difficult position. We have 10 different medical and dental delivery sites in nine different communities. There is no way for us to be able to sustain all of those sites with a significant reduction in resources. That means we are faced with which sites do we close, which staff do we lay off, how do we reconfigure our providers. And it all affects access to care for our patients.

Mr. Schrader. All right. Thank you.

Ms. Mann, I guess I will preface my comment. I am like a lot of my Republican colleagues, I have got huge swaths of rural Oregon in my district. And so I am a little surprised, because 25 percent -- well, no, actually, half of the kids in rural Oregon get their healthcare through Medicaid. It is so critical to the success and health of these communities. It is a key portion. The rural hospitals are a key component and portion of our economic growth in employment in these communities.

So I am very concerned about how these reductions in Medicaid reimbursement, certainly over the long haul, will affect them. Can

you talk a little bit more about what might happen in rural areas if the Medicaid expansions roll back like we are talking about?

Ms. Mann. I think one of the things we have been talking about so far in this hearing about ways to modernize our system of delivering care, ways to integrate behavioral health and physical health, ways to bring in telehealth, changing care practices, expanding our electronic health records, those all require investments. And so the first thing that will go will be any of those investments. And States will be scrambling to bring their spending down below the caps that are set by the Federal Government if the bill passes just because any dollar spent over that cap will be wholly State dollars, and any Federal dollars brought down over the cap will be clawed back the next year and really harm the State.

So we will not see investments for sure, but we will likely see reductions in funding for community providers and other specialty providers that allow that fragile fabric of access in rural areas to be able to work.

Mr. Schrader. All right. Thank you.

Ms. Snyder, you talk about the reduction in uninsured rate for kids, I think 16 to 6 in Texas and stuff. What will happen to that uninsured rate in Texas if some of the Republican healthcare plans go through as currently envisioned? Will it go up or down?

Ms. Snyder. So what I can tell you is the CHIP program, clearly, in Texas precedes the advent of the ACA, the AHCA, or the Senate proposal that was advanced yesterday. The CHIP program in Texas is highly

successful. As I mentioned, it has resulted in a reduction in the percentage of --

Mr. Schrader. What about the Medicaid piece? If the Medicaid reimbursement for Texas is cut as proposed, is your children's uninsured rate going to go up or down?

Ms. Snyder. So we are, right now, looking at the implications of the legislation that has been proposed on the House side, as well as the proposal that was advanced yesterday, to determine how that is going to impact the State. What I will tell you, as a State --

Mr. Schrader. You are not sure quite yet?

Ms. Snyder. We are still looking into that, yes.

Mr. Schrader. All right. Well, I appreciate that, and that is a good answer, given where you all are coming from. And I feel sorry for a lot of your providers. I know rural hospitals in your State, in many states, that did not do the expansion are facing some pretty tough times.

I think there is some middle ground here, to be quite honest with you. I too am in favor of making sure that Medicaid is put on a budget, but a budget that is realistic and doesn't result in tons of uninsured children, children that we should not be balancing the budget of this country on. I worry about that. But I look forward to work with my Republican colleagues to fix this system overall.

And I yield back.

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

The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. Eshoo. Thank you, Mr. Chairman. And thank you to the witnesses.

I just want to start out by speaking about what is racing through me throughout this hearing, and that is that I have lived my life for my children. And I think everyone here has as well. We are talking about something that couldn't be more sacred: our children, my children, your children, the children of our Nation.

And I really am overwhelmingly sad by what is happening. I can't believe that this is taking place in our country. There is some sort of conflation that is going on here today. It is important for us, obviously, to reauthorize the CHIP program and the other, and with all of everything that should be a part of it. But to have the evisceration of Medicaid as the top issue, top line headline of today that is going on in the Congress, what are we doing?

Children need patriots in the Congress. I don't know what has happened to the Republican party. I don't recognize it. Republicans that are in my district don't support any of this. And a strong CHIP program depends on a strong Medicaid program. So there is like a pretend thing going on here. CHIP this, CHIP that. CHIP, CHIP, CHIP. What about the chipping away at or the destruction of Medicaid? Does anyone here think that we are going to be able to care for, provide what our children need in our country if we rip away $834 billion out of Medicaid for tax cuts that were taking care of them?

I mean, there are myths that are swimming around. The myth that 23 percent bump in the ACA did nothing to improve children's coverage. Since the enactment of the enhanced 23 percent bump and the matching payments for CHIP, the States have used those additional dollars to improve the care and expand coverage for kids in our country. There is a myth that CHIP is the primary insurer of low-income children in the United States. Medicaid is the primary insurer of low-income children in the United States.

So, yes, CHIP is important, but let's not let all these myths creep in around it. This is a shameful thing that is taking place in our country. It really is a shameful thing, and it is hurtful. What is going to happen to children that are disabled? Anyone examined their conscience on that?

So I would like to go to Ms. Mann and ask you to expand on the issue of disabled children. It is one thing for children to get the basic care that we all provided for our children. I mean, I think these families that have disabled children are amongst the most courageous people in our country in what they need to deal with. They get up earlier in the morning because they have a lot of things to do for that child. It costs more money, more doctors, more complications in their lives, more complexities. And they try to balance their affections too, because the other little ones may end up feeling that this one other child is getting more attention from the parents. This is what takes place in people's lives every single day across our country.

And we are sitting here in some insulated, air-conditioned,

green-painted room as if this one thing that we are going to reauthorize, and we should, is just going to take care of everything, and that anyone that is involved in it and votes for it has absolution. They don't, in my view. They don't, in my view.

So, Ms. Mann, would you just say a few words about disabled children and these programs that are knitted together.

Ms. Mann. Yes. Certainly. Thank you for your comments. So Medicaid has many different eligibility pathways, and there is many different definitions of what is a disabled child. There is a category in the Medicaid program that if you have been determined disabled by the Social Security Administration of the State, then you automatically get Medicaid. In that circumstance, there is about 1.9 million children around the country who fit in that category. And based on that medical necessity standard that we talked about before, they get the care that they need, and they get the kind of care that really is not otherwise available in the commercial market. And some of them get special waiver service. They will get respite care for that caregiver who, as you say, is going, you know, 20 hours a day in terms of taking care of their child. They will get a wheelchair refitted as they age and as they grow. So it is a very important program.

And then there are other kids within the other categories of the Medicaid program. They may be foster care kids, they may be just low-income kids. They might not have a disability that meets that level of disability, that gets them into the category of disabled, but they are kids with very significant healthcare needs. And they too

have their needs met very strongly by the Medicaid program, which is, I think, why you see those statements from organizations like Family Voices, Parents of Kids with Special Healthcare Needs.

Ms. Eshoo. Thank you so much.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady's time has expired.

The chair recognizes the gentleman from Texas, vice chairman of the full committee, Mr. Barton, 5 minutes for questions, please.

Mr. Barton. Thank you, Mr. Chairman. I apologize. I, after votes, took a group of Members and staffers out to the hospital to see Matt Mika, one of the individuals that was shot in the incident last week at the congressional Republican baseball practice. So I am a little bit late getting back.

I think it is obvious --

Ms. DeGette. How is he doing? Give us a report.

Mr. Barton. He is up and --

Mr. Burgess. Do not violate HIPAA, come on. This is a Federal -- yeah.

Mr. Barton. He is doing very well, Diane. I can't go into details, apparently. But he is excited, and hopefully he is going to be out of the hospital within a week.

Mr. Green. Did the chairman invoke HIPAA?

Mr. Barton. Yeah, I am not a doctor. I can just tell you what I saw. Okay? I saw a breathing, happy young man who is wearing the cap of his employer, which I am not going to publicize. But they sell

a lot of chicken and they are headquartered near Arkansas.

Now, to the purpose of this hearing, Mr. Chairman, we want to talk about CHIP reauthorization and community health centers. And I think the last CHIP reauthorization I was one of the chief cosponsors of. So we are obviously for CHIP and the community health centers. My family foundation has bought a building in my hometown and donated it to the Hope Clinic, which is a community health center for Ellis County, and the Nel Barton annex is providing services for low-income citizens in Ennis, Texas, and is doing very, very well. And so we are strong supporters of the community health centers and SCHIP.

I have two questions that I have been asked to ask our distinguished panel. This one is for Ms. Snyder and Mr. Holmes. This committee earlier this year passed a bill to charge millionaires, people who have won the lottery, a little bit more if, in fact, they have come into some extra money. To put it in perspective, this policy change would mean millionaire Medicaid beneficiaries would only pay approximately $70 more each month. That would save apparently several billion dollars.

Would you two support making millionaires on Medicare to pay their fair share to help pay to extend the SCHIP and the health center funds? That was supposed to have been asked by Mr. Walden, but he is not here to ask it.

Ms. Snyder.

Ms. Snyder. Congressman Barton, I am happy to answer the question. As I have mentioned in my testimony earlier and in some of

my responses over the course of the hearing, in Texas, we are very much in support of personal responsibility and infusing a level of personal responsibility into the programs that we administer. Certainly, this, I think, is a good example of an opportunity to infuse that personal responsibility into one of our programs in a way that is commensurate. Ultimately, we hope, with the earnings, that each of those individuals is lucky enough to be a beneficiary of lottery winnings is able to draw down as income.

So we would support a measure such as that and would support that it ultimately reflect the earnings in a way that holds individuals accountable.

Mr. Barton. Mr. Holmes.

Mr. Holmes. Certainly, the expenditures of the Federal Government are important to its people. It is also important to where those expenditures are directed. We have common things that we need to do as far as defense, but we also need to look at the care of our most vulnerable populations. And in order to do that, we need money. That money is coming from the taxpayers. And we have to make sure that it is a fair system and that it is a system that has good return.

I will say, from a health center perspective, we are concerned about the return on investment that the taxpayer is making in health centers and that we use those dollars wisely to lessen the burden on the taxpayer, and that we show a return for those dollars in the savings and the Medicaid programs and the Medicare programs and throughout all of our patient population.

Mr. Barton. My time has expired, Mr. Chairman. I will submit the other question for the record.

I do want to say that we are working on a bipartisan basis. We have a bill called the ACE Kids Act. And we had it in the last Congress with over 200 cosponsors. Ms. Castor, who just left, Mr. Green, I think everybody in the room right now who is a Member was a cosponsor in the last Congress and hopefully will be in this Congress. We are going to reintroduce that very quickly.

But it is a bill for these special needs children that have complex medical conditions to create a medical home so that their care can be coordinated with Medicaid across state lines. And it is a voluntary optional program for the States to participate in. But if they choose to participate, it apparently is a piece of legislation that will make the care much better and also save money for the taxpayers. And we hope to reintroduce that bill in the very, very near future. And we have a commitment to have a hearing on it. And hopefully, we are going to have a commitment to move that bill.

With that, I yield back.

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

The chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DeGette. Thank you very much, Mr. Chairman.

We have been talking a lot today about -- at least on this side of the aisle -- our concerns about what this TrumpCare bill would do

to Medicaid and how it would interface with the CHIP program, because CHIP is something that we have all agreed is important for the children of this country, but it really does ride on the foundation of Medicaid. I want to talk a little bit about that.

The $840 billion cut to Medicaid and converse of the program into a per-capita cut, under TrumpCare, it would then be combined with President Trump's budget, which cuts CHIP funding by $3.4 billion by eliminating this so-called 23-point bump. So Medicaid covers 37 million children, and nearly 9 million additional are covered under CHIP. I am trying to figure out what would happen if both the TrumpCare cuts to Medicaid and the budget cuts to CHIP went through.

Ms. Mann, can you discuss, from your knowledge, how these proposed Medicaid cuts and the CHIP proposal under the Trump budget would affect children in the States?

Ms. Mann. Certainly. Thank you for your question. The House provision around setting caps for the program would have a -- fundamentally change the commitment that the Federal Government makes to the children, to people with disabilities, to parents, to pregnant women, to people, elderly, who are served by that Medicaid program. And they would force States to have to significantly reduce their spending in order to stay within the caps, unless they were going to spend only their State-only dollars.

And so the kinds of things that States would end up doing, no doubt reluctantly, would be things that would reduce access to care, things that would potentially look at some of these specialized programs for

kids with brain injury and special healthcare needs, pull out funding around children's school-based services and early intervention care. A number of different ramifications we think that that would have.

In addition, it would pull out the funding for the expansion population. And this often talks about the so-called childless adults in the expansion population -- I say so-called, because my -- I would be a childless adult. My children are grown. I am not a childless adult. But many of those individuals covered under the expansion are parents.

Ms. DeGette. Right.

Ms. Mann. And children do better when their parents are healthy. So between those cuts and the budget cuts, I think we would see a really devastating change for children's coverage.

Ms. DeGette. Let me follow up and ask you, do you think of the children who would lose their insurance or lose some of those specialized benefits under the cuts, could they be covered by CHIP?

Ms. Mann. CHIP is not designed, both in its financing and in its benefit structure, to pick up those children.

Ms. DeGette. To pick up those kids. That is right.

Ms. Mann. And if you are pulling the 23 percentage points away from CHIP, we are going to see a ratcheting down of CHIP.

Ms. DeGette. But CHIP is really designed to be in addition to Medicaid.

Ms. Mann. That is right.

Ms. DeGette. It is not as a substitute.

Ms. Mann. It needs the foundation of Medicaid in order to operate well.

Ms. DeGette. Now, the administration has said they might allow States to lower the bar on Medicaid benefits, cost sharing, and other attributes. And I think you alluded to this, but if those programmatic changes go into effect, then how is that going to impact kids in light of the proposed cuts?

Ms. Mann. Well, there is, you know, many ways in which whether it is increased cost sharing and premiums for children and families at very low incomes, we talked about lottery winners, but most of the children on Medicaid have incomes below the poverty line. You know, for a family of three, that is about $1,700 a month to support three people every month for rent, food, utilities, all that they need. So those kinds of responsibilities may be hard for families to bear.

In addition, if there are reductions in the benefits. If there is waivers to EPSDT and kids can't get dental services or kids can't get transportation. We have talked about some of the problems that children face in rural areas. They need help getting transportation to medical care. So those are all of the kinds of ways besides just absolutely cutting a group of children who are high-needs children off the program that States may have to turn to under caps and further budget cuts.

Ms. DeGette. And, you know, States have their own set of budget issues too. In my State, we have a constitutional prohibition against raising taxes without a vote. So it is not like States have huge pools

of money they are going to pour into this.

Thank you so much, and I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for your questions, please.

Mr. Shimkus. Thank you, Mr. Chairman. I'm sorry I wasn't here. I was with Coach Barton as we went up to the hospital. So I haven't been able to follow all the activities that have been going on in the hearing.

And I think it is safe to say, bipartisanwise, that we support the Medicaid program and we support CHIP. So the real debate, from what I am gathering, is, you know, tied into whatever the Senate is doing, whatever we did. So let me just ask a question. Does anyone at the panel know our national debt?

Mr. Holmes, do you know how much our national debt is?

Mr. Holmes. I believe that it is close to $20 trillion.

Mr. Shimkus. Ms. Snyder?

Ms. Snyder. That is my understanding as well.

Mr. Shimkus. Ms. Mann?

Ms. Mann. 19.6, I think. And a little over 13 is public.

Mr. Shimkus. And what is debt? I mean, when we say that, what is that? Is it safe to say it is our promises to pay future services either -- because we know what drives our national debt. It is the mandatory spending programs. People don't like to say this, but it

is just true. It is Medicare, Medicaid, Social Security, and our interest payments.

I will point everybody up to the pie chart, which has been -- I use this a gazillion times. So that is 2015 spending. And when we find on our budget, we are fighting that blue area, which is the discretionary. And we are going to be going through that. Does anyone reject that pie chart as being an accurate depiction of our Federal spending?

No. Okay. I am seeing everybody believing that what we put up there is accurate.

So in the red, we have automatic spending and Social Security, Medicare, Medicaid, which means we are not engaged in determining those costs. They are automatic, other mandatory interest payment. And the blue is what we call discretionary spending.

So go to the next chart. So this is what has happened in our Nation since 1965. As you see that the mandatory spending continues to grow, squeezing out the discretionary budget, which are things like defense, education, HHS, Department of Energy, you name -- what is that?

Mr. Burgess. Roads.

Mr. Shimkus. Roads, bridges, infrastructure, and the like. And so if left unchecked, in 2026, we continue to start having big problems. And that is why we discuss it.

We don't discuss the debate on mandatory spending out of a desire to be mean, vindictive. We actually discuss this to save our country.

Admiral Mullen said in testimony before the Armed Services Committee, our debt is our national threat. The threat to our country relies in that depiction there.

So what we did in our healthcare bill -- and I am not sure what my colleagues on the other side ended up saying, but the fact is we have Medicaid spending and we have a percentage of growth, per capita growth. So as much as they want to say it is a cut, over the years, it has increased Medicaid spending at a slower rate than what would happen if you left it automatic. That is the reality of the state.

So if someone is something you are cutting Medicaid, in real dollars, they are not telling the truth. It is an inaccurate depiction of what we have done. And my guess is that is what has been going on today in the hearing. Where we are trying to get control of the threat to our Nation, which is our national debt, and we are trying to provide to our providers a stable funding stream that grows and let them, through the Medicaid program in the State, manage how best to provide for their citizens in the States. Empowering governors, who are actually closer -- and Medicaid is a -- so it just impels me to raise that.

And my time is almost over. But I would just end on this. This is from a report, and I can provide it to the minority. I am not asking for it to be submitted into the record. But current projections bear no resemblance to a picture in which people historically dependent on Medicaid would lose their benefits. To the contrary, CMS estimates that Medicaid enrollment would stay roughly constant at current levels

under the AHCA, while still be being substantially higher than projected before the Affordable Care Act was passed. Indeed, CMS finds that many States would still cover some of the ACA expansion population, even if lawmakers do away with the AC's inflated Federal matching payment rate. This would mean expanded coverage relative to pre-AC levels, while also being equitable for the ACA.

And my time has expired, and I yield back.

RPTR ZAMORA

EDTR ZAMORA

[12:47 p.m.]

Mr. Burgess. The chair thanks the gentleman. The gentleman's time has expired. The gentleman yields back.

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

Mr. Cardenas. Thank you, Mr. Chairman. I appreciate the opportunity to hear from the witnesses and also the opinions of our colleagues.

Unfortunately, my colleague, Mr. Shimkus, his time was expired, but I would like at least one of the witnesses to take an opportunity to respond to the narrative that we just heard for the last 5-plus minutes.

Ms. Mann, would you like to maybe enlighten us a little bit about the juxtaposition between the argument that was just made on expenditures versus healthcare?

Ms. Mann. Sure. I will take a stab at that. Thank you.

Let me say a couple of things. One is that the Medicaid reductions in spending in the bill largely are not being used to reduce the deficit. They are largely being used to finance new tax cuts in the bill. So the connection there is not as strong as it might otherwise seem.

But I think the bigger issue in terms of the healthcare debate

is there is no dispute, I think, among anyone, healthcare policy experts, hospital administrators, consumers, State Medicaid agencies, that we need to do what we can to bring down healthcare costs. And that has been, I think, what people have been engaged in, particularly in the last 4 or 5 years, the integration of behavioral health, the physical health, the care management, the telehealth. Those are all mechanisms to deliver better care and to do that in a way that lowers cost.

And what won't work is if you simply take one part of the healthcare system, the largest source of coverage for the lowest income people, and just say, on that program, we are going to put a cap, because that doesn't change the cost. That doesn't change the healthcare needs. It is a tougher job to do that.

Mr. Cardenas. In the long run, what you just described, if you just take away dollars and reduce benefits of being able to see a doctor or getting healthcare, in the long run, doesn't that set us on a trajectory to increase cost and reduce the health level of Americans?

Ms. Mann. I think that is absolutely right. When people don't get care at the right time at the right place, they go to emergency rooms, they have more inpatient admissions.

Mr. Cardenas. That is preventative care --

Ms. Mann. That is preventative care.

Mr. Cardenas. -- which, you know, "A stitch in time saves nine." I love that. You know, when I was a kid, I hated hearing that, but now that I am adult, gosh, makes a lot of sense, especially as a

policymaker.

Ms. Snyder, taking a swath of money, like $1 trillion away from our American healthcare system, and then -- I don't know if you agree with me, but having less people having direct access to care, doesn't that create -- in the long run, we put ourselves on charting the course of, oops, now per person long term we are probably spending more for healthcare and maybe not even having better care, just more emergency care, more last-minute care.

Ms. Snyder. So what I would say is I think the CHIP program actually provides us with a great opportunity to look at a program that does infuse some of those critical concepts into the program framework that can help to drive down costs. Those include State administrative flexibility, the inclusion of personal responsibility --

Mr. Cardenas. Yeah, but with all due respect, State flexibility is something that is thrown around a lot. But if you have more flexibility and a heck of a lot less money or resources to provide care for your State constituents, your people who live in your State, can that contribute to, oops, we are now setting ourself on a course where less care in time early on, less preventative care means that, oops, we are now snowballing for different reasons and having more expenditure need on care in the long run?

Ms. Snyder. So I think that is a great question, and I think --

Mr. Cardenas. Well, what is the answer? Is that an accurate narrative or I am just not seeing it right?

Ms. Snyder. What I would say is it is incumbent upon States, and

it is going to be more crucial than ever that States --

Mr. Cardenas. I used to be -- excuse me. I used to be a State legislator. I used to be the budget chairman. So I know what it is like to make those tough decisions, saying we have all the things that we love to do but just not enough money to do it. And then when the Feds go around saying we are going to block grant you, and all of a sudden we went from taking off a 0 of how much money the Feds give us, then we say, oh, my gosh, that didn't reduce the need to provide for our constituents. All it meant is we have less money to do it with.

Ms. Snyder. And I believe that is the case. And so what it is going to really call on us to do is to critically evaluate the data that we have on hand and ensuring that we are making informed and smart decisions --

Mr. Cardenas. Sure. But with all due respect, when I am a -- if I were a single mother with two children and people are telling me, reevaluate your family situation, and I have no healthcare coverage for my children, that analysis ain't going to do my diddly when my son gets really sick and gets a fever, and I don't have a clinic to go to, and I don't have coverage, and I am not part of CHIP anymore because I am on a waiting list, or I don't have Medicaid anymore because I am on a waiting list for my State.

And then all of a sudden, guess what I am going to do as that single mom? I am going to end up in the emergency room. And, gosh, darn it, I think it is going to cost the State more. It is going to cost that hospital more. It is going to tax them. It is not going to help my

challenge.

For Heaven's sakes, if my child has a fever because he has a more serious condition, and if I would have taken him to a doctor 2 years ago, they would have found it early, and all of a sudden now my child has fourth stage something else. Oh, believe me, we are going in the wrong direction.

And I appreciate your generosity, Mr. Chairman, for allowing some of us to go over our time on both sides of the aisle. Thank you. I am out of time.

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

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

Mr. Engel. Thank you very much, Mr. Chairman.

I want to make a statement and then I have a couple of questions for Ms. Mann.

Let me say at the outset that I strongly support CHIP, the Children's Health Insurance Program, and our Nation's community health centers. I was very proud to support the Medicare Access and CHIP Reauthorization Act back in 2015, and it most recently extended those two vital programs.

I would like to point out, though, that those reauthorizations passed the House in March of 2015 and was signed into law by mid-April, and yet here we are at the end of June without a plan to fund programs set to expire in September. It is certainly not right.

And in reality, our timeline is even tighter than that. Months before their funds are depleted, some States must start the process of shutting their CHIP programs down. And that means that if Congress doesn't act fast, it is entirely possible that children will see their coverage disrupted, and I think Mr. Cardenas pointed that out.

So why hasn't Congress acted yet? Why didn't we vote to extend funding for CHIP and community health centers in March as we did in 2015? And the answer is that TrumpCare monopolized the House's time and prevented us from doing all these important things.

And that is not the only thing that TrumpCare has endangered. TrumpCare will cut and cap care for the 37.1 million children on Medicaid. And on top of that, TrumpCare's radical restructuring of Medicaid has dangerous implications for the CHIP program. A strong CHIP program depends on a strong Medicaid program. They work in concert to afford children comprehensive coverage.

How? First of all, more than half of children with CHIP are actually enrolled in expanding Medicaid coverage that is financed by CHIP. These programs also work together to meet the needs of different populations of kids since Medicaid covers benefits that other insurers do not.

CHIP reauthorization is vitally important for America's kids. I don't dispute it. My Democratic colleagues don't dispute it. But in a discussion on this topic -- a discussion on this topic can occur in a vacuum. If TrumpCare becomes law and Republicans therefore succeed decimating Medicaid, there is no way to go around it. Children will

be much worse off.

I want to talk about President Trump's budget, which unfortunately exacerbates the problems that TrumpCare creates for kids. While we should enact a full, long-term extension of CHIP, this budget proposes harmful changes to the program.

What does it do? It will abolish the enhanced Federal funding match that States get now. It will overturn the requirement that States maintain children's current eligibility levels, turning back the clock on historic coverage improvements, and cut off support for CHIP kids above 250 percent of the Federal poverty level.

I want to talk more about this last point, because right now, 24 States have income eligibility for Medicaid and CHIP and are greater than 250 percent of the Federal poverty level. This includes my State of New York. You know, we are a high cost-of-living State. So what you buy in New York, you buy a lot less for the same money than you do in other States. It is ridiculous to penalize States like mine. The administration wants to cut off Federal dollars, give nearly half of all States the flexibility to cover children above 250 percent of the Federal poverty level.

We hear a lot about States' rights, and yet we want to take away the flexibility that States have, the programs that States deem are important for them. We want to tell them, the Federal Government, what they can and cannot do. So much for States' rights.

If this cut takes effect, I have to imagine that States will have no choice but to restrict eligibility for the CHIP program, thus cutting

off care for children who have CHIP coverage today. So it is bad enough that we won't be helping children who need this coverage; it will be throwing children off who have it today.

So let me ask you, Ms. Mann, since this provision would affect my district, where one-third of children are covered by Medicaid or CHIP, I am extremely concerned about its potential effects. Can you tell us what we can expect to happen if Federal support for CHIP kids above 250 percent of the Federal poverty level is cut off?

Ms. Mann. Thank you for the question. You are absolutely right. We have about 24 States that cover children at some income levels above 250 percent of the poverty line.

Most of the children actually in the program, 97 percent, have incomes below 250 percent of the poverty line. But those States that have increased their eligibility levels have made a determination, have exercised their safe flexibility because of cost in that State, because of market conditions in the State, for various reasons of concern for the kids in their States have decided that having CHIP as an option for those children is really important.

And I should say, New York, like every other State that covers children at higher income levels, requires the families to pay a portion for their care, so there is premiums and the premiums slide in accordance with the income.

If in a State like New York with high healthcare costs and high premiums for other kinds of coverage have to end their coverage, go down to 250 percent of poverty, those children will be scrambling for

other kinds of care. They will pay higher cost. Their benefits won't be as pediatric focused as they are in the New York CHIP program. And many of them, because of what is called the family glitch, won't be able to qualify for subsidies in the marketplace.

Mr. Engel. Well, I had a couple of more questions, but you have really answered them about how this in turn would effect coverage levels --

Mr. Burgess. That is good, because your time has expired. So the gentleman yields back, and the chair thanks the gentleman for his participation.

I want to recognize myself for questions. The chair would point out that the chair did delay his questions till the end to allow all other members to ask their questions and then accommodate their travel plans, if they had them. I may not use the entire 5 minutes, because this has been a very robust and insightful discussion.

We do have a task ahead of us, which is the funding for the State Children's Health Insurance Program, which concludes on September 30 of this year, the end of the fiscal year. That, of course, was a fiscal cliff that was set in motion under the Affordable Care Act, when the Affordable Care Act passed and was signed into law in 2010, as CHIP was reauthorized to the end of fiscal year 2019, funded only until the end of fiscal year 2015. Your chairman, as part of the SGR Repeal, managed to get 2 years of funding until fiscal year 2017, and that is the task that is ahead of us at this time.

So, Ms. Snyder, I need to ask you what is just a very practical

and Texas-focused question, but since the majority of the dais members now are from Texas, it will be appropriate. You said in your testimony, what you provided us in your testimony, that Texas -- of course, Texas has just concluded its legislative session. Is that correct?

Ms. Snyder. Exactly.

Mr. Burgess. And Texas, the legislative session is every 2 years. So your budget is now set until the next legislative session in 2019. Is that correct?

Ms. Snyder. That is correct.

Mr. Burgess. And there were some assumptions made by the finance committees that are there in the Texas House and Texas Senate, the budget committees in the House and Senate, there were some assumptions made that the funding for State Children's Health Insurance Program would, in fact, continue until 2019. Is that correct?

Ms. Snyder. Yes, with the 23 percent additional bump in --

Mr. Burgess. So changes that we make now come after the fact for what your State Senators and State representatives assume to be what was going to be available for them to include in their budget, and any changes we make now would have a significant effect on the State budget that has already been passed and I believe signed into law. Is that correct?

Ms. Snyder. Exactly, an $800 million impact over the biennium.

Mr. Burgess. So I understand the importance of getting this done. And let me just also say that under current law, under the Affordable Care Act, under current law, something happens to

disproportionate share funding in Texas. Doesn't it?

Ms. Snyder. Yes.

Mr. Burgess. What is that that happens to disproportionate share funding? They have funds that go to hospitals that see a disproportionate share of Medicaid, low income, and uninsured. What happens to those funds in Texas?

Ms. Snyder. Can I ask you to clarify the question.

Mr. Burgess. What happens under current law, under the Affordable Care Act, so-called DSH funds, the disproportionate share funds, those additional funds paid to hospitals, paid to institutions to see a disproportionate share of Medicaid low-income and uninsured, what happens to those funds at the end of this fiscal year?

Ms. Snyder. And I am sorry, I don't know the answer to the question.

Mr. Burgess. Well, I know the answer.

Ms. Snyder. And I apologize.

Mr. Shimkus. I know the answer too.

Mr. Burgess. And I will be glad to share it with the committee. Those funds, under current law, under the Affordable Care Act -- of course, everyone is going to be lying down the allegiant fields of ObamaCare. There is going to be no need to provide additional funding to those hospitals because everybody has got this wonderful health insurance that was provided under the ACA.

But under current law, under current law, Texas is going to lose those funds in October of this year, and that was an effort -- we did

try to correct that in the bill that passed through this committee in a 28-hour markup and passed on the floor of the House the first part of May. And I know my State counterparts were very interested that we take care of that discrepancy, and I think that we have.

Let me just ask you, because I have run a little bit long with that, we all want our dollars to be spent appropriately. And Medicaid has a history. Sometimes dollars aren't always spent appropriately. But over and above the dollars being spent appropriately, if a patient is eligible for Medicaid, but they also have a commercial insurance, another third party that is supposed to be liable for their medical care, sometimes the path of least resistance is just to bill the Medicaid system, and that seems to be a quicker way of collecting the money.

But one of the things that we have been working on is to enhance the ability to collect the third-party liability, if there is coverage that is actually owed by another payer, a commercial insurer. So what has your experience been in managing potential overpayments within the State related to third-party liability?

Ms. Snyder. So we are very committed in the State of Texas to ensuring, when there is another payer source, that we are capitalizing on that payer source and that Medicaid remains the payer of last resort.

We have efforts underway, both within the Medicaid program and in conjunction with our inspector general, to ensure that we are systemically drawing on the funding that is available from those other payer sources. It is one of our priority projects every year,

understanding that that Medicaid impact is the payer last resort.

Mr. Burgess. Very good. Well, we will have legislation coming on that, and I appreciate your input on that.

Mr. Holmes, let me just ask you. I certainly appreciate what you do and what other people involved in community health centers and federally qualified health centers provide. When a patient sees a physician or a nurse practitioner at a federally qualified health center who is covered by Medicaid, is the rate reimbursed by Medicaid the same as it would be by a physician practicing in private practice in the same town?

Mr. Holmes. It is not, in most cases. Health centers are paid under a PPS system, and it is a bundled set of services for the Medicaid patient. And it is based on payment methodology that was passed through Congress many years ago. And that is different than a discounted fee for service payment arrangement that currently exists with a number of other Medicaid providers.

Mr. Burgess. And that would be the provider out in private practice?

Mr. Holmes. That is correct, unless those providers are in a capitation system or in some type of ACO.

Mr. Burgess. Be careful. We have heard that "capitation" is a bad word this morning.

Mr. Holmes. It is a method of payment where you are paid on a per-member per-month basis. And for that per-member per-month basis, you are delivering the scope of care within that agreement.

Mr. Burgess. And another aspect of the difference between a doctor in private practice and a doctor working in a federally qualified health center is the liability question. Is that not correct?

Mr. Holmes. That is correct.

Mr. Burgess. So a doctor in private practice has to carry medical liability insurance, which, as you know, in some areas, can be quite expensive. But in a federally qualified health center that cost is ameliorated by participation in the Federal Tort Claims Act. Is that correct?

Mr. Holmes. That is correct. And it was under Congress' direction to include health center physicians and providers in FTCA, because they felt it was a method to save healthcare dollars.

Mr. Burgess. And I don't disagree with that. In fact, probably when Gene Green was in the State House in the early 1990s, our State legislature provided doctors who did a certain percentage of Medicaid in their practice the first $100,000 in liability coverage. That didn't last, and I don't know why. It was probably too expensive as a State program.

But if we want to encourage the number of providers to see patients who are covered by Medicaid, that seemed to me to be a very forward-leaning aspect of what they did back in the early 1990s. So I want to thank my colleague from Texas. I am sure he was the -- I am sure he was the main driver of that liability assistance when it occurred.

Well, I want to thank all of our witnesses. Seeing no other

members wishing to ask questions, I do want to thank the witnesses for being here.

We received outside feedback from a number of organizations on these bills, so I would like to submit statements from the following for the record: the American Academy of Dermatology Association; America's Essential Hospitals; American Academy of Family Physicians; AHIP; the Healthcare Leadership Council; our House colleagues from Minnesota; a CHIP letter from 1,200 local State and national organizations. So without objection, so ordered.

[The information follows:]

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

Mr. Green. Mr. Chairman, I won't ask for the 4 minutes extra you have on your 5 minutes, but --

Mr. Burgess. No, sir, that was a cumulative -- I accrued all of the extra minutes I gave on your side and utilized them for our side, because I knew my questions would be most important.

Mr. Green. Well, I appreciate your activity, but that was taken at the end. All I want to do is -- give me 1 minute.

Mr. Burgess. The gentleman is recognized.

Mr. Green. First of all, I was in the legislature in 1991, and I am not sure but -- after that I ran for Congress. But the State of Texas is going to be in special session. Is that not correct?

Ms. Snyder. That is correct.

Mr. Green. In the next few weeks. Having been there and done that, nobody likes special sessions in summer.

But the other issue is, Texas did not expand Medicaid. Is that correct?

Ms. Snyder. That is correct.

Mr. Green. Okay. And the other issue is third-party coverage. That is not unusual, because if you have an auto accident, the hospital has -- in Texas, I assume everywhere else -- has a right to put a hospital lien on that, whatever you win from your lawsuits. So I don't have any problem with Texas doing that under Medicaid, so that is pretty common.

But, you know, that is not going to solve our problem with Medicaid in our terrible program we have in Texas. And even there, when

Democrats were in the majority, Texas has always have been very conservative. Our Medicaid program is nothing compared to some others.

And, in fact, I will give one example. After Katrina, the Houston area received a quarter of a million people. We brought them in under our Medicaid system, although the State legislature was out of session. We were able to get Federal money to do the State match for those folks, and over a period of time, they either went back to Louisiana or they became Texan. And that is when I found out that Louisiana actually gets 75 percent Federal reimbursement, and Texas receives 67 percent. And I would hope maybe our subcommittee could look at that and see why is it more expensive than Louisiana.

Mr. Burgess. Will the gentleman yield?

Mr. Green. I would be glad to.

Mr. Burgess. I do not know all of the intricacies of the formula that CMS uses to calculate, but it is based on the average State income as well and probably reflects that average State income in Texas is somewhat greater than the average State income in the State of Louisiana. And that is probably a fiscal fact for which we should both be extremely grateful and thank our lucky stars that we live in Texas.

Mr. Shimkus. Would the gentleman yield?

Illinois is a 50/50 State, so I just want you to put that on the record.

Mr. Green. Thank you, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman

yields back.

Let me just continue on the unanimous consent requests that I was doing. I also want to ask unanimous consent to submit for the record copies of the Congressional Record volume 141, issue 207, Friday, December 22, 1965, where Senator Patty Murray introduced to the record over in the Senate a letter to President Clinton asking for the participation in a per-capita cap arrangement.

Mr. Green. 1995.

Mr. Burgess. Did I say 1995?

Mr. Green. You said 1965.

Mr. Burgess. 1965. 1995. Time flies.

I also want to submit for the record a New York Times editorial from 1997, February of 1997, called "Making the Budget Bearable," where they point out that the President offers an important reform of Medicaid proposing to control future spending by placing a cap on the amount of Federal spending per enrollee and allowing States to place enrollees in managed care without going through the frustrating process of begging for Washington's approval.

Without objection, so ordered. Those things will be entered into the record.

[The information follows:]

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

Mr. Burgess. Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask that witnesses submit their responses within 10 business days upon a receipt of those questions.

Without objection, the subcommittee is adjourned.

Mr. Green. Mr. Chairman, we could be here all day, but I also wanted to remind you, in 1995, I think the Senate Republicans wanted an individual mandate.

Mr. Burgess. That was actually in response to a request for a block grant.

The subcommittee stands adjourned.

[Whereupon, at 1:14 p.m., the subcommittee was adjourned.]