

**Testimony to the Energy and Commerce Subcommittee on Health**  
**“Examining the Administration’s Approval of Medicaid Demonstration Projects.”**

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Thank you Chairman Pitts, Ranking Member Green and all the Members of the Subcommittee for inviting me here today. Four years ago I testified before this Committee as a concerned Governor on the state of the Medicaid program. Today, I am testifying as a former Governor who hopefully can lend a perspective of the challenges and opportunities faced by states. Four years ago, states were struggling with increasing Medicaid costs while trying to balance their budgets and the federal government was dealing with trillion dollar deficits and long term unsustainable debt.

Today, states are still trying to juggle the demands of increasing health care costs while balancing their budgets and funding other state priorities. On the federal side, deficits have come down in the short-term but are expected to rise exponentially in the not too distant future. The loads of accumulated debt and unfunded future liabilities are still issues that must be addressed. Under President Obama, the federal debt has increased by almost 73 percent to \$18.3 trillion.

Last week the Congressional Budget Office released its Long-Term Budget Outlook. The document stated that the federal debt held by the public “is now equivalent to about 74 percent of the economy’s annual output, or gross domestic product.” CBO estimates that under our current trajectory, twenty five years from now the federal debt held by the public would exceed 100

percent of GDP. These are scary numbers and that is not even counting the tens of trillions of dollars in unfunded liabilities our government has already promised to spend in the future.

Debt levels exceeding 100 percent of GDP are not sustainable and we will not have the benefit of other countries bailing us out. Ignoring these problems will not make them go away but will make them much more difficult to manage in the future. The next generation of Americans and their kids are being saddled by our inability or unwillingness to control our spending.

At the end of the day we have to pay for what we are promising. Before the Supreme Court ruled the Medicaid expansion was voluntary, the Administration had proposed to reduce the higher FMAP promised for expansion populations through a “blended rate” proposal. Now it has backtracked on that proposal. But, backing away from its funding promise less than two years after the law was enacted was certainly an admission of the financial difficulties facing the program. The Administration may have changed its tune now but the budget numbers will not allow the current growth in Medicaid spending to continue.

I understand this hearing is not about our deficits and debts but any discussion about the future of Medicaid and our health care programs must include some mention of our ability to pay for the bills we are accumulating today because it will affect the ability of future generations to pay for their priorities and experience the excellence of the American economy. This is not political philosophy, it’s just honest accounting and basic math.

In 2014 the federal government spent \$300 billion on Medicaid. In only ten years that number is estimated by CBO to be over \$575 billion, nearly double. When you add in the state’s share the Medicaid program will cost close to a trillion dollars a year. Mandatory spending programs are already drowning out our ability to pay for things like highways or adequately fund our military.

Currently, approximately two-thirds of all federal spending is mandated for entitlements or paying interest on the debt.

So the question becomes: how can we provide quality health care for the truly needy in the most cost-effective manner? I believe a critical solution is empowering each state to run its Medicaid program in the manner that best meets the needs of its population. Give states more statutory options that allow them to innovate on plan design and health care delivery – rather than forcing them to go through a long and drawn-out waiver process for common-sense improvements.

States should be able to tailor Medicaid benefits in ways that make sense for the populations they serve. Allowing states to better tailor benefit design for differing eligibility categories based on the unique characteristics of the group can save money while actually even improving the quality of care provided.

If Medicaid is really for the patients it serves, shouldn't we ask them what they want? Let's scrap the paternalism and put the patient at the middle of this. For example, would some non-disabled adults welcome the chance to pay a small co-pay if it ensured them better or more timely access to a doctor? States should ask them and be free to respond to their health care needs. After all, in the many states where doctors will not see new Medicaid patients, a Medicaid card just proves the adage that having an insurance card does not necessarily mean having access to care.

I'm reminded of the experience of my good friends in Indiana – Governor Pence and former Governor Mitch Daniels. In Indiana, the Medicaid program surveys its beneficiaries to gauge their satisfaction and inform its program management. And the results are truly outstanding.

Indiana recently noted that more than 71 percent of enrolled HIP 2.0 members are participating in the HIP Plus program, which provides vision and dental benefits. HIP Plus also enables

members to avoid co-payments because they make monthly payments into a type of health savings account.

States should have more freedom to require more personal responsibility for the Medicaid program. If Medicaid enrollees are benefitting from the program, is it so radical to ask them to contribute a small amount? Doing so would reduce costs but also benefit those beneficiaries who use services responsibly. Despite the contention that emergency room visits would go down under PPACA, a recent survey by the American College of Emergency Physicians reports that ER visits are increasing. A January 2014 study of Oregon residents enrolled in Medicaid found those on the program used the ER 40 percent more than those without insurance and often for primary care service and non-emergency services. The emergency room is the most expensive site of service in our entire health system. States should be able to institute enforceable, appropriate co-pays for non-disabled individuals on Medicaid when those individuals improperly use the ER – without going through the unpredictable hurdles of an 1115 waiver process and playing “mother-may-I” with CMS. This is a modest proposal built on the idea of personal responsibility.

If you or I – or anyone not on Medicaid – misses a doctor’s appointment without notice, the person is charged a small fee. People tend not to miss doctor appointments because they do not want to pay the penalty. Yet, if a Medicaid patient misses an appointment, doctors can try to charge a penalty but it is not enforceable. For some doctors, missed appointments are their number one frustration with the Medicaid program. If they allot six slots a day to Medicaid patients altogether, and only half show up then they miss out on three paying patients and three other Medicaid patients don’t get to see the doctor. When doctors’ frustrations boil over they stop taking Medicaid patients, which hurts the responsible patients on the program who have a

tougher time finding a physician. This would not be appropriate for all Medicaid patients, but why should states have to ask CMS for permission to allow providers to charge a non-disabled adult a modest co-pay? If the Administration believes low-income consumers are smart shoppers on the Exchanges, why do they have the gentle prejudice of small expectations? After all, Exchange enrollees face co-pays, deductibles and cost-sharing. Is there something so fundamentally different between an adult at 138 percent FPL and 139 percent FPL?

Medicaid is a government benefit funded by taxpayers to provide care to those in need. Some states have advocated instituting work requirements or job-training for able-bodied adults as a condition of receiving Medicaid benefits. Adults who can work should be incentivized to work if they want to continue receiving government benefits. This would decrease costs by making people self-sufficient, while also positively affecting individual health outcomes. Plus, letting states test work or job training requirements especially makes sense given that CBO estimates that expanded Medicaid eligibility under the ACA will, on balance, reduce incentives to work. Unfortunately, the Administration has steadfastly opposed this common-sense reform when Republican governors have requested it in their 1115 waivers. But if the purpose of 1115 waivers is to test different delivery system and benefit design ideas in Medicaid, what are the bureaucrats at CMS so afraid of?

Justice Louis Brandeis famously stated “a state may, if its citizens choose, serve as a laboratory.” Today, many states want to be the laboratories of democracy, but CMS is standing in the way by not approving common-sense waivers that could unleash a revolution of state experimentation and innovation. I am increasingly convinced that change only happens when Congress – like the good members of this Committee – passes legislation to break off the shackles of CMS’s rules. Even if these rules are well-intended, and even if they are well-executed – which we know they

often are not, based on GAO's testimony – state legislators, governors and providers are far better positioned to direct and implement innovative ideas in their states than is CMS.

PPACA created the Center for Medicare and Medicaid Innovation (CMMI). It was designed to test different models to see what would work in health care delivery. Yet we already had and still have 50 laboratories to test innovative programs to improve health outcomes and reduce costs. However, CMS and the rigidity of the federal Medicaid rules as well as the opaque and inconsistent standards for waiver applications are preventing states from truly developing plans that fit their individual populations and testing new programs that can be templates for others.

For states, CMS has the heavy hand where it is judge and jury on whether a state can start or continue an innovative program under a waiver. However, when CMMI wishes to conduct a demonstration project or expand an existing project those determinations are shielded from all outside review. Specifically the law states there should be no administrative or judicial review of those decisions. The irony is thick but shameful. CMS in Washington wants unfettered discretion to conduct its own demonstrations, but then forces states to come hat in hand when they want to test something new. This is an embarrassing double-standard. Are the virtues of CMMI bureaucrats so elevated, or different from the motivations of state leaders across our country?

Over the past few months the issue of state flexibility has been in the news because of Florida's Low Income Pool program. The state of Florida devised a program they believe works best for their state. The Low Income Pool provides reimbursement to hospitals and other providers for uncompensated care. The current budget for that program is \$2.1 billion a year divided by the state and federal government based off of Florida's Medicaid match rate. Originally, CMS told

the state it would cut off all funds for the Low Income Pool program. CMS has since taken a few steps back saying they will only cut the program in half this year. They have stated their intention to eliminate payments in subsequent years because the state of Florida decided not to expand its Medicaid program for able-bodied working adults.

Putting aside for a moment the fact that this position meets the definition of coercion, states should not have to rely on the benevolence of CMS bureaucrats in order to run their programs in the manner they determine is most appropriate for their state. What works for the state of Florida may or may not work for other states, but Florida should have the authority and flexibility to make those choices for itself. Moreover, CMS has a basic responsibility to be more accountable to states and all taxpayers. In the fall of 2014, the Medicaid program in Florida asked CMS if it would approve any form of uncompensated care pool. Yet, despite repeated emails, calls, meetings, and other engagements, CMS did not answer this basic threshold question until April of this year. Why should unelected staff at CMS have the ability to hold hostage a state's budget – not based on a negative policy decision – but based on the lack of any decision whatsoever?

An April 2015 Government Accountability Office report found that more than twelve employment and workforce training programs were being funded by federal Medicaid dollars via waivers. When a workforce development program gets federal funding, but a program that reimburses hospitals for uncompensated care for low-income individuals is held up due to the Administration's political preference, any objective person must start to question whether the approval process is being subjectively administered. It is little wonder that the GAO report concluded that "in the absence of clear criteria, the bases for HHS's decisions are not transparent to Congress, states, or the public." For states, that simply means we are not sure of the rules of the road and CMS can change them at will. The waiver process should be reformed by having

broad, public criteria so that if a state's waiver meets one of the criteria, it is approved. Different rules should not be made for different states, and states certainly should not have their Medicaid waivers denied because it, within its rights, chose not to expand their Medicaid programs.

Additionally, the back and forth negotiation with CMS is both time consuming and resource intensive. An August 2014 American Action Forum study found the approval time for a new waiver lasted on average 337 days. And this finding only accounts for the time between when a state submitted a full, final application and when it was approved. It likely underreports all the discussions and informal negotiations that preceded the formal waiver application. Waiting almost a year to get approval for a waiver is difficult when states are crafting their budgets. In 2013 Chairman Upton and Chairman Hatch released a paper aptly named "Making Medicaid Work." Within the paper were several recommendations to improve the waiver approval process, which I applaud. Instituting an improved waiver consideration clock would help states plan for when a decision may be reached on their application. Now, I would encourage this Committee to pass legislation adopting a waiver clock which would force CMS to reply to states in a more timely and transparent manner throughout the 1115 process. Why shouldn't CMS be held to account to at least return calls, take meetings, and make decisions – up or down – in a transparent and timely manner?

The proposal also speaks to waiver reciprocity. If a state submits a waiver request similar to a waiver already approved by another state then there should be an expedited and streamlined process for approval of that waiver. There is no need for a state to wait for an answer and be subjected to rounds of information requests when a similar waiver has already been approved. The idea of states as laboratories of democracy is they can learn from each other and copy successful policies and programs.

Again, I recommend you pass legislation to give states the authority to get Medicaid programs without waivers, but at the very least, improve the waiver process. There are a lot of good ideas this Committee could start to act on. The framework, the ideas, and the energy from the states are real and actionable. I would encourage members to flesh out these ideas into legislation as there is time and interest.

In summary, the federal government should allow states to once again be the incubators of innovation. States, if given the opportunity and greater ability to manage their own programs, can provide the federal government more certainty over the long-term spending path of the Medicaid program while providing the truly needy with critical health care.