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MEDICAID OVERSIGHT: EXISTING PROBLEMS AND WAYS TO STRENGTHEN THE PROGRAM

TUESDAY, JANUARY 31, 2017

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

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

Present: Representatives Murphy, Griffith, Burgess, Brooks, Collins, Barton, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, Peters, and Pallone (ex officio).

Staff Present: Jennifer Barblan, Counsel, O&I; Elena Brennan,

Legislative Clerk, O&I; Paige Decker, Executive Assistant & Committee Clerk; Scott Dziengelski, Policy Coordinator, Health; Blair Ellis, Digital Coordinator/Press Secretary; Emily Felder, Counsel, O&I; Jay Gulshen, Legislative Clerk, Health; Brittany Havens, Professional Staff, O&I; Peter Kielty, Deputy General Counsel; Katie McKeough, Press Assistant; Jennifer Sherman, Press Secretary; Luke Wallwork, Staff Assistant; Gregory Watson, Legislative Clerk, C&T; Everett Winnick, Director of Information Technology; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Una Lee, Minority Chief Oversight Counsel; Miles Lichtman, Minority Staff Assistant; Dan Miller, Minority Staff Assistant; Jon Monger, Minority Counsel; Dino Papanastasiou, Minority GAO Detailee; Rachel Pryor, Minority Health Policy Advisor; Matt Schumacher, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

Mr. Murphy. Good morning, everyone. Welcome to the newly refurbished -- well, I want to call it the Oversight and Investigation Committee room, which is sometimes used by Energy and Commerce. What a beautiful room and it should be more conducive to a good hearing.

This is the first one of the 115th Congress, so welcome here, and welcome to our witnesses today, and welcome back to my friend and colleague, Ranking Member Diana DeGette of Colorado.

This is our Medicaid oversight hearing on existing problems and ways to strengthen the program. The subcommittee convened this hearing today to examine a critical component of the Patient Protection and Affordable Care Act, Medicaid and Medicaid expansion.

As the world's largest health program, Medicaid provides healthcare coverage for over 70 million Americans and accounts for more than 15 percent of healthcare spending in the United States. In 2015 alone, Federal taxpayers spent over $350 billion on Medicaid, and the costs continue to rise each year. According to the Congressional Budget Office, the Federal share of Medicaid spending is expected to rise significantly over the coming decade, from $371 billion in 2016 to $624 billion in 2026, over 10 years.

At a time when Medicaid program costs are skyrocketing, it makes sense to ask the question, is Medicaid adequately serving our most vulnerable populations? Medicaid was originally designed as a safety net to care for health of some of our most vulnerable populations: Low-income children, pregnant women, parents of dependent children, the elderly, individuals with disabilities. And for many years

serving as a psychologist, I know I've treated many kids that without their disability coverage from Medicaid, it would be a struggle for them.

But far too often, Medicaid's own rules keep it from best serving the families that it was designed to help. These restrictions surrounding Medicaid do not allow doctors and nurses the flexibility they need to arrive at the best outcome for patients. For instance, most Medicaid programs do not use physician-focused alternative payment models that can improve care and reduce costs.

And studies show that Medicaid coverage does not necessarily result in better health outcomes. One often cited study in Oregon found that Medicaid coverage increases healthcare use and improves self-reported health and mental health, while having no effect on mortality or physical health. Similarly, the National Bureau of Economic Research found that Medicaid enrollees obtained only 20 to 40 cents of value for each dollar the government spends on their behalf.

Further, reports by nonpartisan watchdogs, two of which are here today, show that the Medicaid program remains a target for waste, fraud and abuse. Because of the size and scale of the program, improper payments, including payments made for people not eligible for Medicaid or for services that were not provided, are extremely high. The Government Accountability Office estimates Medicaid paid out over 17 billion in improper payments in fiscal year 2014 alone.

For these reasons, Medicaid has been designated as a high-risk program by the GAO for 14 years, since 2003. And despite the

longstanding problems in the Medicaid program, the Patient Protection and Affordable Care Act expanded Medicaid to a whole new population. In 32 States, Medicaid benefits have been opened up to adults under the age of 65 who make less than 133 percent of the poverty level.

Since open enrollment began in October 2013, roughly 11 million individuals have signed up for Medicaid coverage under the new eligibility parameters. This means that the majority of individuals covered under ObamaCare have enrolled through the Medicaid program instead of purchasing private health insurance plans.

The costs associated with insuring the 11 million new Medicaid enrollees have been far more expensive than the Obama administration predicted. A report released by the Department of Health and Human Services found that the average cost of expansion enrollees was nearly 50 percent higher than projected. Medicaid expansion enrollees cost an average of $6,366 in fiscal year 2015, which is 49 percent higher than the agency predicted the year prior.

This means that not only are expansion enrollees expensive to insure, but the costs are difficult to predict. Further, because of the high matching rate, the Federal taxpayer is on the hook for the vast majority of expenses associated with new enrollees. Unfortunately, reports show both States and the Federal Government cannot effectively oversee and implement Medicaid expansion. The GAO found errors in Medicaid eligibility determinations that could lead to misspending of funds. Likewise, the Inspector General found troubling evidence that the Federal Government failed to implement

requirements in the Patient Protection and Affordable Care Act that were supposed to improve program integrity and root out waste, fraud and abuse.

While we all acknowledge there are serious weaknesses and deficiencies in how this program operates, we also recognize the responsibility of the Federal Government to provide a safety net to the most vulnerable among us. That means ensuring that taxpayer dollars are spent in a way that actually improves health outcomes and serves the Medicaid population. We want this to work, not hinder services. And I hope we can, in a bipartisan way, support its strengths, acknowledge the problems, and together find some solutions.

Tomorrow, the Health Subcommittee will discuss legislative solutions to strengthen Medicaid, but as we move forward with legislation, we must also be careful not to repeat the worsening problems that already exist in the program. As we will hear from our witnesses today, we have a lot of work to do and I'd like to thank our witnesses for appearing today and look forward to an informative discussion.

I now turn to the ranking member Ms. DeGette for 5 minutes.

[The prepared statement of Mr. Murphy follows:]

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

Ms. DeGette. Thank you very much, Mr. Chairman. It's good to be back for another session of Congress.

We have two new members on our side of the aisle on this subcommittee this year, and I am so happy to welcome them. Dr. Ruiz is here with us at the end. He's an actual emergency room doctor, and he'll be able to bring us so much great perspective on issues like this hearing and other hearings.

And then Scott Peters, who's not here at this moment, I am pleased he's here. He and I comprise two-thirds of the NYU law graduate delegation to Congress. So I am happy we're loading up this committee with NYU law grads.

You know, I think I'd be deceiving myself if I thought that today's hearing was intended to actually strengthen the Medicaid program. Although I hope it's not so, I fear that this discussion about Medicaid is intended to lay the groundwork for drastic cuts to the program and eventually to repeal the Affordable Care Act's historic Medicaid expansion. So I'd like to talk a few minutes about the importance of this program and what Medicaid expansion has accomplished for the American people.

Today, more than 70 million low-income Americans, including seniors, children, adults, and people with disabilities, have access to quality health care, thanks to Medicaid. And contrary, frankly, to what my colleagues on the other side of the aisle think, the Medicaid program delivers this care efficiently and effectively. The costs per beneficiary are actually substantially lower than for private

insurance and have been growing more slowly per beneficiary.

Numerous studies have shown that Medicaid has helped make millions of Americans healthier by improving access to primary and preventative care and by helping Americans manage and treat serious disease. In fact, the Medicaid program literally saves lives. Research published in the New England Journal of Medicine reported that previous expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York actually reduced deaths by 6.1 percent. The ACA's historic Medicaid expansion has let States build on this record of success and provide insurance to millions of Americans who otherwise would not have had access to health care.

Last year -- and we need to think about this -- more than 12 million low-income adults had healthcare coverage because of the Medicaid expansion. This is astonishing. And combined with other important provisions of the ACA, this has helped drive the uninsured rate to the lowest level in our country's history.

It's important to note these are not people who shifted from private insurance to the Medicaid expansion; this is people who had no insurance and were using the emergency rooms as their primary care facilities. In Colorado, for example, the rate of the uninsured was cut in half since the enactment of the ACA and through the expansion of Medicaid.

Now, aside from the benefits that have accrued to the people, Medicaid has actually resulted in tremendous savings for the States. Hospitals nationwide have seen their uncompensated care burden drop

by $10.4 billion since the ACA became law. Denver Health Medical Center, which is in my district, this week reported to my office that their uncompensated care claims actually fell by 30 percent since passage of the ACA. This is real savings. And also, we know that Medicaid is helping people get access to vital health care services.

I had a listening session last week in Denver about the ACA. I had 200 people show up at this listening session. And most of the people who told their heartrending stories talked about how they were employed, but they couldn't afford private insurance. And due to the Medicaid expansion, they now had mental health services. They had drug treatment and opioid treatment services. They had services for catastrophic accidents that they have had, and on and on. It got to the point where I literally had to take a packet of Kleenex out of my purse and put it on the podium, because everybody, including my staff and myself, were in tears listening to these stories. This is what the majority wants to take away and this is what we're talking about.

We can all talk about eliminating waste, fraud, and abuse in the program. We're all for that, and I would support that 100 percent. But taking away vital health care for so many millions of Americans is wrong, and we must fight against taking that important benefit away.

I yield back.

[The prepared statement of Ms. DeGette follows:]

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

Mr. Murphy. The gentlelady yields back.

And we don't have anybody else on our side of the aisle who wants to give an opening statement. I believe Mr. Walden is detained in a meeting and he will come back later. Perhaps over there.

Mr. Pallone, do you want to be recognized for 5 minutes?

The ranking member of the committee, Mr. Pallone, is recognized for 5 minutes.

Mr. Pallone. Thank you. Thank you, Mr. Chairman. It's great to be back in our room here today. It looks really nice.

For 7 years now, Congressional Republicans have railed against the Affordable Care Act with a steady drumbeat of repeal and replace, and for 7 years they have sabotaged implementation of the law. And here we are today, Republicans are misleading the public, in my opinion, with falsehoods that the law is failing, and that could not be further from the truth.

The truth is, after 7 years of claiming they could do better, they have no plan to replace the Affordable Care Act. The subcommittee should be evaluating the impact that repeal would have on the American people and the national healthcare system, but instead, Republicans are holding yet another hearing to highlight their ongoing opposition to the law's Medicaid expansion, despite clear evidence that the expansion has made health care affordable and available for the first time to 12 million people nationwide.

Tomorrow and Thursday, the committee is holding hearings on what Republicans consider to be the first pieces of the GOP healthcare

replacement plan. But the fact is that none of these bills will prevent 30 million Americans from losing their healthcare coverage. None of them will reduce the chaos in the healthcare system that will inevitably result if Republicans successfully repeal the Affordable Care Act.

The fact is, Republicans are already creating uncertainty and instability in the individual market. This instability will ultimately result in reduced consumer choice, higher premiums, and will endanger the health and welfare of millions of Americans. In other words, the Republican-made chaos in the healthcare system has already begun.

And, of course, we're seeing the same thing with the President's immigration executive orders. I just hope that at some point our GOP colleagues join us against what I consider reckless and rash actions and oppose President Trump's actions.

Congressional Republicans continue to ask the American people to trust them and they have a plan and that somehow everything will be okay. They've repeatedly assured the American public that no one will lose coverage with a Republican replacement plan, a claim that President Trump and his advisers also continue to make.

But recently-released audio at a closed-door meeting from the Republican retreat last week confirms that they simply have no plan. At that meeting, Republicans admitted that repealing the Affordable Care Act could eviscerate coverage for the roughly 20 million Americans now covered through State and Federal marketplaces as well as those covered under the Medicaid expansion. In fact, one Republican member

at the retreat warned, and I quote: "We'd better be sure that we're prepared to live with the market we've created with repeal."

So my Republican colleagues are also trying to claim that the Affordable Care Act is already collapsing under its own weight and that the replacement plan will, quote, rescue the American people from ObamaCare. Republicans are so scared to own the chaos they are causing, they're trying to pretend that the law is imploding on its own, which could not be further from the truth.

Americans today have better health coverage and health care, thanks to the Affordable Care Act. The law's Medicaid expansion has helped improve the quality, accessibility, and affordability of health care for millions of Americans. And my colleagues would be wise to consider the impact that their actions will have on the millions of Americans who are currently benefitting from the Affordable Care Act.

If my Republican colleagues finally took their ideological blinders off, they would realize that the Affordable Care Act should not be repealed. And I say this because I don't really care about the ideology. The fact of the matter is that real people are going to be harmed if the Affordable Care Act is repealed, and I hope that at some point my Republican colleagues will admit that and that we can work together to improve the healthcare system.

I yield back.

[The prepared statement of Mr. Pallone follows:]

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

Mr. Murphy. The gentleman yields back.

And we'll move forward now with our witnesses. I want to ask unanimous consent, however, that the members' written opening statements be introduced into the record. And, without objection, the documents will be entered into the record.

I'd now like to introduce our five witnesses for today's hearing.

First up, we have Ms. Carolyn Yocom -- welcome here -- director of health care at the U.S. Government Accountability Office.

Next, we welcome Ms. Ann Maxwell, Assistant Inspector General in the Office of Evaluation and Inspections in the U.S. Department of Health and Human Services, Office of Inspector General.

Next, we want to welcome Mr. Paul Howard, who is a senior fellow and director of health policy at the Manhattan Institute.

As well as Mr. Josh Archambault -- got that right? -- senior fellow at The Foundation for Government Accountability.

Last, we welcome Mr. Timothy M. Westmoreland, professor from practice, and senior scholar in health law at Georgetown University Law Center.

Welcome all of you. Thank you to all our witnesses for being here today, providing testimony before the subcommittee. I look forward to hearing from you on this important issue.

Now, you are aware that the committee is holding an investigative hearing and when doing so has the practice of taking the testimony under oath.

Do any of you have any objection to testifying under oath?

Seeing no objections, we'll move forward.

The chair then advises you are, under the rules of the House Rules Committee, entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? Seeing nothing there too.

In that case, if you'll please rise, raise your right hand, I'll swear you in.

[Witnesses sworn.]

Mr. Murphy. Seeing all witnesses answered in the affirmative, you are now sworn in and under oath, subject to the penalties set forth in Title 18, Section 1001 of the United States Code.

We're going to call upon you each to give a 5-minute summary of your statement.

I think there probably -- I don't know if they'll light up in this room yet. Is there some lights down there that will go on for them when they are -- we'll see. Is there something right in front of you? Green means keep talking; yellow means finish up; and then red means stop. So we want you to keep on time.

So Ms. Yocom, you may begin. You are recognized for 5 minutes.

TESTIMONY OF CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ANN MAXWELL, ASSISTANT INSPECTOR GENERAL, OFFICE OF EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; PAUL HOWARD, SENIOR FELLOW, DIRECTOR, HEALTH POLICY, THE MANHATTAN INSTITUTE; JOSH ARCHAMBAULT,

MPP, SENIOR FELLOW, THE FOUNDATION FOR GOVERNMENT ACCOUNTABILITY; AND TIMOTHY M. WESTMORELAND, J.D., PROFESSOR FROM PRACTICE, SENIOR SCHOLAR IN HEALTH LAW, GEORGETOWN UNIVERSITY LAW CENTER

TESTIMONY OF CAROLYN L. YOCOM

Ms. Yocom. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, it is a pleasure to be here today to discuss actions needed to prevent improper payments in Medicaid.

Medicaid finances health care for a diverse population, including children, adults, people who are elderly, or those with disabilities. It also offers a comprehensive set of acute and long-term healthcare services.

Medicaid is one of the largest programs in the Federal budget and one of the largest components of State budgets as well. In fiscal year 2016, Medicaid covered about 70 million people, and Federal expenditures were projected to total about $363 billion. Unfortunately, over 10 percent of these expenditures, over 36 billion, are estimated to be improper, that is, made for treatments or services that were not covered by the program, were not medically necessary, or were never provided.

The program's size and diversity make it particularly vulnerable to improper payments. By design, Medicaid is a Federal-State partnership, and States are the first line of defense against improper payments. They have responsibility for screening providers,

detecting and recovering overpayments, and referring suspected cases of fraud and abuse. At the Federal level, CMS supports and oversees State and program integrity efforts.

In 2010, the Patient Protection and Affordable Care Act gave CMS and States additional provider and program integrity oversight tools. The act also provided millions of low-income Americans new options for obtaining health insurance coverage through possible expansions of Medicaid or through an exchange, a marketplace where eligible individuals may compare and purchase health insurance.

My statement today focuses on four key Medicaid program integrity issues that we have identified, steps CMS has taken, and the related challenges that the agency and States continue to face.

First, with regard to ensuring that only eligible individuals are enrolled in Medicaid, CMS has taken a variety of steps to make the Medicaid process more data-driven, yet gaps exist in their efforts to ensure the accuracy of Federal and State enrollment efforts, including enrollment for those who are eligible as a result of the expansion.

As one example, we found that Federal and selected State-based marketplaces approved Federal health insurance coverage and subsidies for 9 of 12 fictitious applications made during the 2016 special enrollment period.

Second, efforts to improve oversight of Medicaid managed care. CMS has provided States with more guidance on methods of identifying improper payments made to providers and has acted in response to our recommendations on requirements for States to audit managed care

organizations and providing States with additional audit support, but further actions are needed. In particular, encounter data, which allow States and CMS to track services received by beneficiaries that are enrolled in managed care, are not always available, timely, or reliable.

Third, CMS has taken steps to strengthen the screening of providers. There are new risk-based initiatives for overseeing provider checks. And these are important steps, but there are additional challenges that remain to ensure that the databases check eligibility and that States can share information with each other on providers who are ineligible for coverage.

Lastly, CMS has implemented a number of policies and procedures aimed at minimizing duplicate coverage between Medicaid and the exchanges. Our work did identify some duplicate coverage; and since our report, CMS has started conducting checks on duplicate coverage and intends to perform these checks at least two times per coverage year. This could save Federal and beneficiary dollars, but CMS needs to develop this plan a little more broadly and make sure that they are assessing the sufficiency of these checks.

In closing, Medicaid is an important source of health care for tens of millions of Americans. Its long-term sustainability is critical and requires effective Federal and State oversight.

Chairman Murphy, Ranking Member DeGette, and members of the committee, this concludes my prepared statement. I'd be pleased to respond to questions.

[The prepared statement of Ms. Yocom follows:]

******** INSERT 1-1 ********

Mr. Murphy. Thank you, Ms. Yocom. Now, Ms. Maxwell, you are recognized for 5 minutes.

TESTIMONY OF ANN MAXWELL

Ms. Maxwell. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished members of the subcommittee. Thank you for the opportunity to appear before you today to discuss how to protect taxpayers and Medicaid patients from fraud, waste, and abuse.

I first wanted to give you a sense of what Medicaid fraud looks like. It can be very complex and include very different kinds of schemes. For example, in one instance, we indicted the owners of a network of over 30 nursing homes and assisted living facilities that billed for services that patients didn't need. In another example, we convicted a doctor for writing fake prescriptions for expensive drugs that were then sold on the black market or billed to Medicaid. It is exactly these type of schemes that highlight the need to protect Medicaid against unscrupulous providers who steal, at the expense of taxpayers, and put patients at risk.

Today, I want to highlight actions that we can take to better protect Medicaid from these types of fraud schemes and other vulnerabilities facing Medicaid. State Medicaid agencies and the Centers for Medicare and Medicaid, known as CMS, share responsibility for funding as well as protecting Medicaid. And we recommend they

focus on three straightforward program integrity principles: Prevent, detect, and enforce.

First and foremost, CMS and States must prevent fraud, waste, and abuse. Focusing on prevention is critical and commonsense, but Medicaid programs sometimes fall short and end up chasing after providers to remove them from the program or to recover overpayments.

State Medicaid agencies should know who they are doing business with before they give them the green light to start billing. To help with that, we recommend that States fully implement criminal background checks, conduct site visits, and collect accurate data about providers.

In addition, to prevent incorrectly paying providers, we recommend that States learn from past administrative errors and proactively update their systems to prevent improper payments. Medicaid should only be paying the right amount for the right service.

The next critical program integrity safeguard is the ability to detect fraud, waste, and abuse in a timely manner. Accurate data is an essential tool for doing this. However, as we've just heard and our work shows, national Medicaid data, including data from managed care companies, has deficiencies. Sophisticated data analytics exist to detect potential fraud, to detect patient harm, and even to target oversight, but they are ineffective without accurate and timely data.

Further, without national data, States cannot see the whole picture. For example, we found providers enrolled in one State Medicaid program that had been terminated by another State. But without shared data, States had no way of knowing this and had to find

out the hard way that they had enrolled fraudulent and abusive providers.

Finally, it's imperative to take swift and appropriate enforcement action to correct problems as well as to prevent future harm.

Federal and State enforcement efforts have very high return on investment, yielding annual recoveries in the billions of dollars and imposing criminal penalties on thousands of wrongdoers each year. However, States face challenges in taking full advantage of their administrative authorities, including suspending provider payments and terminating providers, where appropriate.

In addition, State Medicaid fraud control units lack a key authority. Currently, these units can investigate allegations of patient abuse that occur within institutions, but if that alleged abuse took place in a patient's home or a different community setting, they cannot. Medicaid patients receiving services in their home should have as many protections as those in institutions.

In closing, our work reveals a number of opportunities to improve Medicaid safeguards. In particular, a heightened focus on the program integrity principles of prevention, detection, and enforcement will help protect Medicaid now and as it evolves. Prioritizing program integrity will ensure that Medicaid funds are used as intended, to provide needed healthcare services and long-term nursing home care for those who are in most need.

We appreciate the committee's attention to Medicaid program

integrity. We've seen it strengthened in the last year, thanks to the efforts here in Congress, and we hope that our work will continue to be a catalyst for continued positive change. Thank you.

[The prepared statement of Ms. Maxwell follows:]

******** INSERT 1-2 ********

Mr. Murphy. Thank you, Ms. Maxwell.

Now, Mr. Howard, you are recognized for 5 minutes.

TESTIMONY OF PAUL HOWARD

Mr. Howard. Thank you. Thank you, Chairman Murphy, Ranking Member DeGette, members of the committee. I'd like to thank you for the opportunity to testify today about Medicaid program oversight and ways we might strengthen the program.

Medicaid is undoubtedly a vital component of the Nation's safety net for low-income and vulnerable populations. But an open-ended, automatic Federal matching formula has had vast unintended fiscal consequences, both for the States and the Federal Government, often crowding out funding for other safety net services and supports that might have a bigger impact on the measured health of these populations and their prospects for continued economic mobility.

As you know, Medicaid is a hybrid program that, on average, pays approximately 62 percent through its Federal match, although the upper limit is around 80 and the lowest match is 50 percent. This encourages States to maximize the drawdown of Federal dollars through a number of, sometimes legally questionable, funding designs that my colleagues at GAO and HHS OIG have just mentioned. This Byzantine funding structure makes it extraordinarily difficult for the Federal Government to oversee effectively program integrity. It also encourages wealthier States to spend more on their programs to draw

down more Federal dollars. In a 2010 book, Mark Pauly and John Grannemann highlighted that the highest quintile of States by income spent 90 percent more than the lowest quintile of States.

When it comes to waste, fraud, and abuse, we see New York State, which has historically spent much more than other States. Even though it has only 6 percent of the Nation's population, it has spent approximately 11 percent of total Medicaid expenditures and spends 44 percent more per enrollee. The OIG also found that over a period of 20 years, the State had an improper payment rate for its State developmental centers, which the State was overpaid by $15 billion, simply because a payment structure that the State and the Federal Government agreed to in 1990 was never updated to reflect the fact that the State had, in fact, moved the disabled out of the developmental centers and into community supports. To the State's credit, Governor Cuomo in 2011 created a Medicaid redesign team that began to address the program and began first by conceding that the program delivered poor value for beneficiaries and taxpayers.

Since then, through a number of far-reaching highly aggressive reforms, including capping most of the State's State spending outside of the disabled population, lowering that spending from 6.2 percent to 4 percent, the State has saved hundreds of millions of dollars, shifted an emphasis from institutional care to community care, and begun to address some of the behavioral components of poor health that leave these populations using disproportionately emergency rooms.

The right way to view our healthcare dollars is not to say that

Medicaid has per-unit costs that are very low and, thus, it's more efficient. The better question to ask is, are dollars that we're automatically spending on Medicaid, might they be better purposed to other programs, either an expanded State income earned tax credit, supportive housing for the seriously mental ill, or any other support or service that might have a bigger impact on improving measured health outcomes.

My colleague Oren Cass last year put out a very important study that noted from the period of 1975 to 2012, our spending on low-income supports had doubled, but that 90 percent of the increase had gone to health care. He estimated that if our median spending, either by enrollment or per enrollee, was nationalized, we could save as much as $100 billion annually, and that is money that could be placed elsewhere in other support programs.

In short, we have thickened one strand of our safety net for low-income Americans while neglecting others. If the safety net feels threadbare in places, it's because we have encouraged the States to overspend on health care. What I'm not saying is that Medicaid has no value. There is clear research that shows that Medicaid has an extraordinary rate of return on investments in maternal health and child health.

But large rigorous, randomized, controlled experiments like the Oregon experiment have, as the chairman said, showed no increase in measured health outcomes. Other studies continue to show that the social determinants of health have a much bigger impact on mortality,

obesity, asthma, and mortality from cancers like lung cancer, than simply spending more money on health insurance per se.

I'd like to suggest just a few ways we could address this disparity in conclusion. We should agree on broader safety net goals that hold the States responsible for meeting them in ways that are transparent both to the States and the Federal Government.

We should reform the financing incentives of the program to ensure that we're not incentivizing States to automatically funnel additional Federal dollars to health care. They might choose to do so, but we shouldn't effectively bribe them to do so.

And finally, CMS should continue to give more leeway to the States in programming, designing, and spending Medicaid dollars, including on nonhealth supports.

I believe that these reforms would serve both conservative and liberal ends and should be the focus of the 115th Congress. Thank you very much.

[The prepared statement of Mr. Howard follows:]

******** INSERT 1-3 ********

Mr. Murphy. Thank you, Mr. Howard.

Mr. Archambault, you are recognized for 5 minutes.

TESTIMONY OF JOSH ARCHAMBAULT

Mr. Archambault. Chairman Murphy, Ranking Member DeGette, and members of the committee, my name is Josh Archambault and I work at the Foundation For Government Accountability, a think tank that is active in 37 States, specializing in health and welfare reform.

This morning, I'd like to highlight how the ACA's Medicaid expansion has worsened problems for the truly needy, and I'd like to start with a video.

[Video played.]

Mr. Archambault. Sadly, Skyler's story represents just one of nearly 600,000 individuals currently sitting on waiting lists for Medicaid services. Individuals with developmental disabilities, traumatic brain injuries, and mental health disorders who are less likely to receive the needed care now that Medicaid has been expanded.

The ACA expanded Medicaid to a brand new population, which consists largely of childless, able-bodied adults who are working age, and have only dimmed the hopes further for families like Skyler.

But the problems go much farther beyond situations like hers. The Governor of Arkansas, due to expansion costs, has proposed nearly a billion dollars in cuts to traditional Medicaid, primarily from patients with expensive medical needs, the developmentally disabled,

and the mentally ill is what he said.

So why is this happening around the country? The new ObamaCare expansion population is awarded a higher match rate. This funding formula has pernicious unintended consequences. Let me explain it this way: If a State needs to balance its budget, which they all do need to every year, State officials have to turn to Medicaid, because it's the biggest line item, also growing faster than revenue. If you want to save one State dollar in State funds, on average, you need to cut just over $2 from the traditional Medicaid population, the aged, the blind, the disabled, pregnant women, and children. But if they want to save that same $1 in State funds for the expansion population, this year they need to cut $20. I know you all can guess who faces cuts first, and it's heartbreaking.

Over enrollment under ObamaCare's Medicaid expansion will encourage States into even deeper cuts. Data from 24 of the expansion States show that enrollment has been over by 110 percent on average, more than double initial estimates. The cost overruns have been significant. Just to name a few, California found themselves 222 percent over budget; Ohio, $4.7 billion or 87 percent over budget. These enrollment and budget trends mean fewer resources for the truly needy.

Now, history could have warned us of this. Arizona and Maine both expanded Medicaid to the same able-bodied childless adult population before the ACA, and both had to take measures to rein in costs. Arizona had to stop a number of organ transplants. Maine capped enrollment,

created wait lists. This happened even without the lopsided extra funds that follow expansion enrollees, which brings me to my last point, concerns over eligibility issues.

FGA's work around the country has found deep systemic problems. First, States need to be checking eligibility far more frequently; and second, States need to be checking more data when they check eligibility. Life changes such as moving out of State, getting a raise, or death are going unnoticed for far too long, and meanwhile, States continue to cut checks to managed care companies for cases that no longer qualify for the program.

My written testimony highlights a couple of those States that have had bipartisan success in tackling this waste and fraud, but much more is needed. Thank you.

[The prepared statement of Mr. Archambault follows:]

******** INSERT 1-4 ********

Mr. Murphy. Thank you.

I now recognize Mr. Westmoreland for 5 minutes.

TESTIMONY OF TIMOTHY M. WESTMORELAND

Mr. Westmoreland. Mr. Murphy, Ms. DeGette, and members of the committee -- subcommittee, thank you for the invitation to speak today.

I take a backseat to no one on program integrity issues in the Medicaid program. People who care about Federal programs have to work to ensure that Federal funds are well used. Program integrity problems are, however, not new. Military contractors cheated the Union Army during the Civil War. Where money is being spent, whether it be private, State, or Federal, and no matter how good the cause, there are bad actors trying to steal it.

Program integrity efforts are especially important in Medicaid. This is because billions of dollars are at stake, as are the health and well-being of most vulnerable people in America. This importance is well illustrated by the fact that at the same time the ACA expanded Medicaid coverage, it also made significant improvements in program integrity efforts.

But as important as combatting fraud and abuse in Medicaid is, policymakers should keep it in perspective. As big as they are, the numbers must be viewed as what they are and as a whole.

First, we should be careful about our terms. Not all of what is labeled improper payments, in the vernacular, is fraud or even

mistaken. Most are appropriate, but simply badly documented, and may even be underpayments. And the actual loss to the government is much smaller than it may appear. The OIG and the GAO footnotes in my testimony cite to this terminology.

But, as the prepared statements of GAO and OIG witnesses at today's hearing have outlined, HHS has already implemented many efforts to address the more serious problems of program integrity. Some of these efforts are longstanding and some of them are just underway, but there are many efforts focused on making sure that Medicaid is spending its money well, and they are having an effect.

But I am especially concerned today that policymakers often respond to waste, fraud, and abuse with blunt instruments aimed at the wrong targets. Any review of the actual Medicaid program dollars that were stolen or misspent will reveal that the major culprits are unscrupulous providers. Pharmaceutical companies that price gouge, equipment suppliers that don't deliver, and Medicaid mills of doctors, dentists, and clinics that don't provide -- that provide unnecessary services if they provide services at all. But all too frequently, the political and legislative response is to institute cuts or restrictions on beneficiaries and the providers who actually care for them.

There is simply nothing in the recent reviews of program integrity that justify the policy proposals that are now on the table and before this committee. Reduced/capped Federal funding does nothing to improve program integrity, but it does put coverage at risk for low-income Americans and shifts the cost for the most expensive

services to States, localities, providers, and charities. This is wrong.

Program integrity problems are meaningful only when they are considered in the context of the many successes of the Medicaid program. For example, the Medicaid expansion of the ACA means that 11 million people have Medicaid coverage who did not have it 3 years ago. The percentage of people without insurance in America is at an all-time low of 8.9 percent. The burden of uninsured care in hospitals in expansion States is down 39 percent, and costs to those States are commensurately lower.

Rural hospitals in expansion States are at half the risk of closure of those in nonexpansion States. Community health centers are seeing 40 percent more patients. People with serious mental illnesses are 30 percent more likely to receive services in the expansion States. Services for opioid addiction are available to working-age adults, often for the first time.

The Medicaid expansion of the ACA has fundamentally repaired a longstanding mistake in the program. People always had to fit into some sort of category, but this categorical eligibility has never made sense. Poor women need health insurance both before and after they have babies. Poor children keep needing health insurance even when they turn 19. Poor people with chronic illnesses need health insurance before they become disabled. Poor older adults need health insurance when they are 64, not suddenly when they are 65.

The real problems here are poverty and uninsurance. In the 32

States that have adopted the Medicaid expansion, where making this part of the insurance system finally make sense, and be fair for vulnerable people. Please do not turn back this response.

Lincoln did not give up on the Civil War because the government was sold bad mules. We do not stop buying drugs because drugmakers charge fraudulent prices. We punish the wrongdoers, correct the price, and get the treatment to the people in need. That is what should be done here. Don't reverse all this progress by rationalizing that program integrity problems demand wholesale legislative changes in Medicaid. There are real babies in that bath water.

Thank you.

[The prepared statement of Mr. Westmoreland follows:]

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Mr. Murphy. Thank you.

I now recognize myself for 5 minutes of questioning.

Ms. Yocom, your October 2015 report found gaps that limit CMS's ability to check for different eligibility groups. Newly eligible under expansion -- the newly eligible under expansion and previously eligible are appropriately matched with Federal funds.

Now, in the Federal facilitated exchange States, CMS will not be able to assess the accuracy of eligibility determinations until 2018. Does this create the potential for improper payments then?

Ms. Yocom. Well, it certainly creates a lot of uncertainty about what is going on with eligibility and whether progress is being made. The decision to suspend the estimate of eligibility was based on trying to give States time to understand the new rules and the new range of matching rates that could be applied.

From our perspective, though, transparency of the process and how it is proceeding is, it would not be a bad thing. It would be good to know what's going on.

Mr. Murphy. Okay, thank you. In States that determine eligibility, GAO found that eight out of the nine States audited identified eligibility determination errors and improper payments associated with those errors. Are those errors reflected in the CMS eligibility determination error rate, and does CMS correct these errors, and why or why not?

Ms. Yocom. Right now, they are not reflected in the eligibility rate estimates that CMS puts out. Instead, there is a rate that was

produced a couple of years ago of 3.1 percent, and that's being applied until 2018.

Mr. Murphy. Why is it applied until 2018?

Ms. Yocom. I'm not sure of the reasoning for that year. I think time, I guess.

Mr. Murphy. Was that an accurate number? You said that 1 percent. Is that an accurate number that's being applied?

Ms. Yocom. It's a number I believe that goes back to 2013 or 2014. That was an error rate --

Mr. Murphy. Just continuing that on. So this relates to my next question. I've heard that CMS has put a freeze on measuring eligibility determinations for Medicaid. What does this freeze mean, and how will we will measure eligibility errors and improper payments?

Ms. Yocom. It means that we're relying on an error rate that's about 3 or 4 years old, yeah, and that we don't right now know what's going on with the eligibility determinations.

Mr. Murphy. So we're using old data that's not accurate anymore. We're asking a question, what's the error rate? You're saying, we don't know, so we're going to use a number from a few years ago?

Ms. Yocom. That is correct.

Mr. Murphy. Okay. Now, so if a parent asks their child, how did you do on your report card, and they say, got all As, it could be accurate, except if you're maybe dealing with a high school senior that you didn't ask specifically and say, I'm just assuming the grades I got in third grade, I'm just continuing to carry those over year to

year, so I'm a valedictorian. Now, that doesn't make sense, of course, but you're saying the same thing applies here?

Ms. Yocom. Yes. Right now, they are not publishing or I believe even calculating an improper payment rate right now. They are working with the States on a State-by-State basis.

Mr. Murphy. So when people make a statement everything is fine, these are staying pretty stable, we just have inaccurate data we're working with. See, we want to fix this, but we don't have accurate data to help us know how big the problem is. Is that correct?

Ms. Yocom. At this point, we don't know.

Mr. Murphy. Okay. Mr. Archambault, since we can't measure the actual eligibility improper payments due to this freeze that's been imposed in the past administration, let's try and get an idea of the types of eligibility errors and how much they cost the Federal Government.

Do you have any examples from your work of improper eligibility determinations and how that translates to improper spending?

Mr. Archambault. Sure. There's a couple of States that I highlight in my written testimony.

In Illinois, in 2012, they passed a law to hire an outside third-party vendor to look at eligibility errors. And their track record has actually been quite impressive. In their first year, they found about 300,000 individuals who are ineligible for Medicaid; and in their second year, they actually found 400,000 individuals who were ineligible for their program.

And it runs the gamut from individuals who had passed away in the 1980s who were still on their program to individuals who were simply moving out of State, got a raise, didn't report that information. The State of Arkansas recently also did a review of their Medicaid program and found things like 43,000 individuals who didn't live in the State who remained on their Medicaid program, 7,000 of who had never lived in the State.

Mr. Murphy. Are those people who are making Medicaid claims, do we know?

Mr. Archambault. So in many cases, this is why it's so important. As States have moved towards the managed care environment, it almost doesn't matter. States continue to cut a check to managed care companies regardless of whether those individuals are showing up to the doctor or not. That's why this is even more important now that States have moved in that direction.

Mr. Murphy. So it's hundreds of thousands of people are in this category that they're still getting paid even though they're not alive, in the State, or getting care.

Mr. Archambault. Correct. In some cases, it's just waste. If somebody moves and is still Medicaid eligible, we just want to make sure two States aren't paying two different managed care companies for their care. In other cases, it's outright fraud.

Mr. Murphy. Do we have a total dollar value for that?

Mr. Archambault. When you're not measuring, it's very hard to see. But I will say that my written testimony goes through and

documents a number of State audits that show eligibility is a huge issue when it comes to applications.

Mr. Murphy. Thank you. My time is expired.

Ms. DeGette, 5 minutes.

Ms. DeGette. Thank you, Mr. Chairman.

Ms. Maxwell, you talked about the complex investigations that your agency is undertaking into some of these Medicaid fraud issues. These investigations involve large numbers of personnel and also technical support. Is that right? They're complex investigations, correct?

Ms. Maxwell. Absolutely. We partner with the State Medicaid fraud control units.

Ms. DeGette. And do you know approximately how many people at your agency are involved in these investigations?

Ms. Maxwell. Well, in some respects, we all are. So even though the Inspector General has a cadre of inspectors, we're also auditors, evaluators, lawyers, and all of us contribute to the fraud-fighting efforts of the Inspector General's Office.

Ms. DeGette. Okay. Are you familiar with the executive order that President Trump issued on January 22nd, in which he said that, quote, "No vacant positions existing at noon on January 22nd, 2017, may be filled and no new positions may be created except in limited circumstances," end quote?

Ms. Maxwell. I am familiar with that.

Ms. DeGette. Has your agency determined will that freeze the

hiring at your agency?

Ms. Maxwell. Given that it's quite new, there hasn't been an assessment yet of how that will affect the OIG, but I can tell you, as you have pointed out, that the work that we do does rely on personnel. We use sophisticated data analytics.

Ms. DeGette. Let me stop you then. If the personnel at your agency, the hiring was frozen, what would that do to your ongoing fraud investigations?

Ms. Maxwell. We would need to double down and do as much as we could with the resources that we have.

Ms. DeGette. Would it impact those investigations?

Ms. Maxwell. Absolutely. We need the personnel to analyze the data in order to fight fraud most effectively.

Ms. DeGette. Thank you.

Now, I wanted to ask you a quick question, Mr. Archambault, and the question I wanted to ask you, you showed that really heartrending tape about the young girl who was on a waiting list for quite some length of time for the care she needed. She was in Arkansas, is that correct?

Mr. Archambault. Correct.

Ms. DeGette. And the Governors of the States decide whether they are going to use that money for cases like that or others -- they decide how they're going to use the Medicaid money that comes to their States. Isn't that correct?

Mr. Archambault. Within limits.

Ms. DeGette. Yes.

Mr. Archambault. I mean, the Federal Government sets the guidelines by which they have to --

Ms. DeGette. But the Governor of Arkansas decided where that money would be spent and decided not to put it into that kind of a program. Is that right?

Mr. Archambault. Again, the question and point that I am trying to make --

Ms. DeGette. No. My question is yes or no.

Mr. Archambault. As far as the wait list is concerned?

Ms. DeGette. The Governor decided how to allocate that money. Is that correct?

Mr. Archambault. They have funds that come in, and they can decide to invest in buying down a wait list.

Ms. DeGette. And that's the Governor that decides that.

Mr. Archambault. In a nonexpansion State, we have seen States buy down their wait list.

Ms. DeGette. Okay, thank you very much. Yes or no would have worked.

I want to ask you, Mr. Westmoreland, a couple questions. Now, uncompensated care costs are what hospitals pay for patients that cannot pay their bills. Is that correct?

Mr. Westmoreland. Yes.

Ms. DeGette. Who bears the cost of uncompensated care?

Mr. Westmoreland. It's a complicated question, but the direct costs are usually borne by State and municipal governments, because

they pay for public general hospitals.

Ms. DeGette. And then where do they get their money from?

Mr. Westmoreland. By and large, they get their money from taxpayers.

Ms. DeGette. Okay. Now, I talked in my opening statement about how the ACA Medicaid expansion is driving uncompensated care costs lower. Can you briefly explain why that's correct?

Mr. Westmoreland. Yes. If a hospital is dealing with people who have no source of insurance, it, by and large, can provide the services and then chase them down. And people oftentimes have no money or declare bankruptcy.

In the instance in which they are insured, either through the exchanges or through the Medicaid program, then the hospital can turn to a third-party payer and they are no longer uncompensated care if they can get some payment from those insurances or from Medicaid.

Ms. DeGette. Okay. Now, some of the States that did not expand the Medicaid component of the ACA have not experienced as large a reduction in uncompensated care costs. Is that correct?

Mr. Westmoreland. Yes.

Ms. DeGette. And why is that?

Mr. Westmoreland. Those States are still dealing with the same number of people without health insurance who are low income. The States who have expanded have a source to turn to, their Medicaid program, which is in the Medicaid expansion situation, largely paid for by the Federal Government.

Ms. DeGette. Great.

Thank you. I yield back.

Mr. Murphy. The gentlelady yields back.

I now recognize Mr. Barton for 5 minutes.

Mr. Barton. Well thank you, Mr. Chairman. I am glad to be a part of the first oversight hearing. I'm glad we have some new blood on the subcommittee. We have a new doctor on the Democratic side. I'm glad to have him. We have Dr. Burgess on our side. So when the bloodletting begins, we'll have two doctors that can take care of us and keep us going.

I want to focus the panel's attention on a few numbers. The first number is 20 trillion. The second number is 325 million. Our national debt is about $20 trillion, give or take a trillion or two. We have around 325 million Americans. If you divide 325 million into 20 trillion, you get about 66, 67 thousand dollars that every American owes of the national debt.

Our hearing memo says there's 70 million people that are covered by Medicaid. You subtract the 70 million people covered by Medicaid from 325 million citizens, it means there are 250 million Americans that owe not only their share of the national debt but also the $66,000, $67,000 times 70 million that the Medicaid recipients owe, because, by definition, Medicaid recipients are below the poverty level and they can't pay it back.

Those are big numbers. We're spending at the Federal level about $350 billion a year, and the States are adding another $150 billion.

So we're spending about $500 billion a year to provide health care for low-income Americans. That may or may not be sustainable, but we know that we can't sustain adding half a trillion to a trillion dollars every year to the national debt.

We all want to keep Medicaid, but we want to improve it, and that's what this oversight subcommittee is looking at. How do we improve Medicaid so that we get more bang for the buck, real health care to real people that need it, and yet make it affordable so that taxpayers who are funding it can continue to fund it.

Mr. Howard, you talked about, in your opening statement, a little bit about New York, with 6 percent of the population, getting 11 percent of the Medicaid dollars. Do you want to explain to the subcommittee why that's so or would you like for me to explain it?

Mr. Howard. Thank you, Congressman.

There is clearly an incentive, given the open-ended Federal match, for wealthier States, both because of ideology and simply because they have a larger tax base, to draw down more Federal dollars. It also inhibits attempts to pursue program efficiency.

When you think of a State like New York, let's say New York wanted to design a more efficient primary care program that saved a million dollars. Because of the 50 percent Federal match, it would have to cut spending by $2 million. So there's a ratchet inherent in the open-ended Federal match that tends to bid up State spending for the States that have the funds to do it, but makes it very hard to turn the ratchet around and correct it and find more efficient ways to

deliver care. And I think that's a challenge facing the Nation, not just, of course, for Medicaid, but for private insurance and Medicare as well.

In an environment where there is no incentive for providers to look outside the box, new ways to deliver care more efficiently, more cost-effectively, they simply don't pursue those areas.

I think some of the changes that Governor Cuomo has instituted in New York, if they were done by a Republican administration, I think we would have heard, you know, howls of outrage; but because it is a Democratic administration, you capped spending, you ended automatic payment increases. You did a lot of things that are very, you know, quote/unquote, "progressive," but are really nonpartisan ways to improve program efficiency. And I think that other States and the Federal Government should look at ways to give States more program efficiency and better incentives.

RPTR BAKER

EDTR SECKMAN

[11:00 a.m.]

Mr. Barton. Do you think it would be appropriate to look at the way the formula allocates Medicaid dollars per se to try to harmonize it with current low-income populations across the Nation?

Mr. Howard. I think that's an important tool. I think States would also really appreciate the opportunity to be able to spend Medicaid dollars on non-health-related supports that might actually, you know -- in terms of accessing transportation, in terms of accessing other services -- that might make those populations both more compliant with care and in better health in the long term. I think they would be very open to that.

Mr. Barton. My time is about to expire. I'm going to have some questions for the record dealing with block-granting programs back to the States.

I do want to welcome Mr. Westmoreland back to the committee. Nobody yet has admitted it, but at one point in time, he was one of the brain trusts on the minority side and helped Mr. Waxman and Mr. Dingell actually create the Affordable Care Act. And we appreciate your expertise coming back before the committee.

Mr. Westmoreland. It's nice to be back in 2123.

Mr. Barton. I yield back, Mr. Chairman.

The Chairman. We now recognize Mr. Pallone for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman.

My questions are to Mr. Westmoreland. Mr. Westmoreland, Mr. Archambault made some claims illustrated with a video regarding one individual's experience specifically with the Arkansas Medicaid program's home and community-based services waiting list. And I'm concerned that Mr. Archambault in his testimony attributed a causal relationship between Medicaid expansion and HCBS waiting lists and that somehow the Medicaid expansion he claims exacerbates or causes these waiting lists. I don't believe that to be true. I don't think that the facts show that it's true. I think the wait lists are a result of State decisions, and cutting or capping or block-granting Medicaid will only make the situation worse.

And I like to use anecdotes. I remember one year I went to a conference -- a couple years ago -- in Houston with Mr. Green. I think Mr. Burgess was there too. And in between the health conference, I went over to the Texas Children's Hospital at the Medical Center, and, you know, I talked to the officials there. It was a beautiful place with this beautiful lobby, but literally people, particularly mothers with their children, were just literally camped out in the lobby of this place that looked like a hotel. And I asked, why are they all here? It was because they couldn't access the emergency room because there were so many people that they were literally waiting for hours to use the emergency room with their kids. So this notion that somehow the Medicaid expansion is causing the waiting list -- I think it's just the opposite. I think that it's the lack of Medicaid expansion in these

States that's causing the problems in most situations.

In any case, let me just ask you some questions, Mr. Westmoreland. Can you provide some background on the HCBS waivers in the Medicaid program? Isn't it true that the decision to have an HCBS waiting list is a State flexibility; that is, they are a direct result of State choices on the design of their Medicaid programs and the amount of resources States make available to provide HCBS?

Mr. Westmoreland. Yes. There's no restriction at the Federal level on how much a State may turn to HCBS instead of to traditional institutional services. It's a State decision.

Mr. Pallone. So, if I can just summarize, States decide whether to limit their HCBS waivers to a defined number of slots and to create waiting lists once those slots are filled, and CMS allows States to increase or decrease the number of slots as they wish. And isn't it actually true that, in the case of Arkansas, the Federal Government would be willing to pay 69 percent of the cost of care if the State chose to increase the number of its slots and that, until January 1 of this year, the State was spending none of its own funds on the expansion population?

Mr. Westmoreland. I have to admit I don't know the specifics of the last part of your question, but other than that, I would say yes. It's entirely a State decision, and Arkansas has made the decision of the size of the waiver.

Mr. Pallone. And isn't it also true that 12 States and the District of Columbia have no waiting lists at all and that the

overwhelming majority of those States that have no waiting lists have actually also expanded Medicaid?

Mr. Westmoreland. I believe so, yes, sir.

Mr. Pallone. Isn't it also true that the two States with the longest waiting lists are Texas and Florida, which have not expanded Medicaid -- of course, I use my example, my anecdotal evidence there at the Children's Hospital at the Texas Medical Center -- but these are the two States that have the longest waiting lists?

Mr. Westmoreland. I know that Texas and Florida have not expanded. I did not know that they were the longest waiting lists. I know that they have waiting lists.

Mr. Pallone. I mean, my problem is that I just think there's no evidence that States are choosing to expand Medicaid or keep their expansions at the expense of vulnerable people waiting for HCBS and that examining State choices on both expansion and HCBS waivers actually leads to a contrary conclusion. If anything, all the Federal expansion dollars only strengthen the Arkansas economy and revenues and improve the finances of providers by reducing uncompensated care, as has been shown in multiple States around the Nation. I don't think it's -- I think it just makes basic sense. If States expand Medicaid, they're getting 100 percent Federal dollars, and they have a lot more money to care for people; it's only going to be natural that they have more money to spend on people who are eligible. So this notion that somehow, you know, by cutting the expansion or eliminating the expansion, cutting Medicaid, getting rid of Medicaid, there's no way

in the world that that's going to help the situation with people, you know, who are trying to seek care. They're just going to end up in an emergency room. They're going to be waiting for the emergency room. They're not going to get preventative care. They're not going to see a doctor. None of it makes sense. If you wanted to comment.

Mr. Westmoreland. If I may, Mr. Pallone, I'd like to juxtapose your comment with that of Chairman Barton, who points out that possibly there will be proposals to block-grant and cap the Federal funding. I have to say that, if the Congress adopts capped funding for Medicaid, we're going to see more, not fewer, waiting lists. Less funding and the loss of the individual entitlement services is exactly what's underlying the story in that video. And if the program is capped and Federal participation is limited, it will only get worse, not better.

Mr. Pallone. Thank you.

The Chairman. Now I recognize the new vice chairman of the subcommittee, Mr. Griffith of Virginia.

Mr. Griffith. Thank you, Mr. Chairman.

Mr. Archambault, get out your money. Are you ready? All right. So my understanding of your testimony was that you were, in fact, saying that the States have to make choices with their limited resources, and that the Federal Government under the ACA is going to lower its Medicaid expansion money down to 90 percent. As States find themselves with larger burdens than was anticipated when they expanded Medicaid, they have to make decisions on where it's cut. And we have created through the ACA -- and I say "we" loosely because I wasn't here when they voted

on that -- but the Congress and the government created a situation where the States are rewarded for cutting traditional Medicaid, which deals mostly with children and people who are in greater need, and that, because of that disincentive or that incentive to spend it on the new folks, the newly found under Medicaid, under the new categories, we create the situation where States are having to make a decision as to whether they quicken the shortage on the waivers, get rid of those waivers as fast as they can, or whether they spend that money somewhere else. Was my understanding correct?

Mr. Archambault. Correct, Congressman. There's both direct and indirect outcomes as related to expansion. And my point is that we are not fulfilling the promises to the most vulnerable in our society, wait list or not, but we are making new promises to an able-bodied population that does not qualify for long-term welfare benefits in any other place. And States are being put in a situation where they're having to make very tough decisions and making cuts in reimbursement rates that directly impact those with developmental disabilities, those in nursing homes. The access and quality questions that have surrounded Medicaid for decades will only get worse for the truly needy.

Mr. Griffith. And so what you're saying is we need to pay attention to that, and we need to make sure that we have incentives that encourage people to take care of the truly needy and the young. And maybe the new group needs to -- we need to refigure that formula out. That is what you're saying?

Mr. Archambault. Absolutely. I think as part of the repeal-and-replace discussion, as we're talking about changing Medicaid going forward, it absolutely must be on the table. And we would strongly recommend looking at freezing new enrollment in expansion States and not allowing other States to expand so you can address this underlying issue of refocusing programs on the truly needy.

Mr. Griffith. We have a real habit of doing that.

Mr. Howard, I want to ask you, and the reason I say "get your money out" is because I thought the $20 bill versus the $2 was very instructive, Mr. Archambault.

Mr. Howard, you touched on this, but you didn't get into detail. We have a situation where, even in traditional Medicaid, we have rewarded States that play games. Virginia elected not to have a sick tax. That's what it was called when there was a proposal a number of years ago, a couple decades ago, to start taxing the beds of the sick so that they could create that money and then put it into Medicaid and then get matching money from the Federal Government. Even though we were at a fairly low match, that would have given us those $2 from money that we collected from sick people. But many States have come up with these various schemes to get money by claiming that they're charging more. And what they're really doing is creating some kind of a sick tax scheme. And shouldn't we put a stop to that -- over time? I'm not saying we have to get rid of it immediately. But shouldn't we over time be trying to get rid of that so that everybody knows what exactly

they're getting and not having to charge sick people money so we can get more money for Medicaid?

Mr. Howard. The Federal Government has capped the amount of provider taxes that States are able to use, but still we're talking a very significant amount of money. I think the last estimate from GAO was about $25 billion. Many, many States use these provider taxes. They use enhanced payment rates for State-owned facilities, intergovernmental transfers to draw down and raise their effective Federal match.

Mr. Griffith. And while they may be legal, there's some real ethical questions about that, isn't there?

Mr. Howard. Well, it's a real issue of program efficiency, absolutely.

Mr. Griffith. Okay. Because I want to move on to something else. I heard somebody earlier say that ObamaCare wasn't collapsing, and that was some myth. I got to tell you: We have got all kinds of numbers. Twenty-five percent average increase. Nearly a third of U.S. counties have only one insurer. A trillion in new taxes. 4.7 million Americans had to change their healthcare plan because they got kicked off of the plan that they liked. All kinds of problems out there.

But you know what I find instructive is anecdotal. It happened to me yesterday twice. After church, a group of us generally go to lunch. I try to stay out of politics at lunch, and a discussion broke out at the other end of the table I was not involved in where they were

talking about, what do we do as we go forward? And one fellow said: Look, as a Christian, I don't mind paying some more money, but when my insurance rates for my family have gone from to $450, $500, to $1,250 a year and I'm getting less insurance, it's hurting my family. And that's a problem.

Later that evening, at a small group gathering of different people, there was a big discussion about whether or not a family could afford to justify spending money for their daughter, who had the flu -- several families had been ravaged by flu over the last couple of weeks -- because they, in order to afford health insurance, they had gotten such a high deductible; it was going to cost them $75 to get Tamiflu. And they were debating whether or not they should do that if their other kids got it and what they should do as they go forward. These are real-life examples of how ObamaCare is, in fact, failing the American people.

I yield back.

The Chairman. The gentleman yields back.

I now recognize Ms. Castor for 5 minutes.

Ms. Castor. Thank you, Mr. Chairman.

Well, thank goodness for Medicaid in America, especially back home in Florida. 3.6 million Floridians rely on Medicaid for their health services. A lot of my neighbors in skilled nursing, Alzheimer's patients, Medicaid is the lifeline for these families. Not to mention, 50 percent of children in Florida rely on Medicaid to go see the pediatrician and get their checkups, along with the State Children's

Health Insurance Program. And Florida didn't expand Medicaid, so that 3.6 million number are really our neighbors in nursing home or community-based care or children or my neighbors with disabilities. And based upon what they tell me, Medicaid is working for them. It works.

Medicaid spending growth is lower than private health insurance. It's lower than Medicare. That's because sometimes States try to get by on the cheap in paying providers. That's one place for reform, that we could improve access if we would pay our providers a little bit more and do better there. Medicaid is flexible. I've watched in Florida as they've moved to a managed care system. I have questions about that, but that was a decision of the State. They had all that flexibility under Medicaid. They've also began a change toward more home and community-based services to help keep older folks out of skilled nursing, which can be very expensive.

Then -- but we have to remain mindful about the fiscal cost and fiscal responsibility. That's why, in the Affordable Care Act, we passed a lot of new program-integrity provisions to strengthen Medicaid. The most important provisions involved a shift from the traditional pay-and-chase model to a preventative approach by keeping fraudulent suppliers out of the program before they can commit fraud. All participating providers in Medicaid and CHIP programs must be screened upon enrollment and revalidated every 5 years. So think about that as you move toward repeal of the Affordable Care Act. Why would we want to repeal these important program-integrity provisions

relating to Medicaid? I don't think that's the path that we all want to go down.

What this is, though, I think the real fear is that this whole terminology of block grants and per-capita caps is simply a stalking horse for less care for my neighbors back in Florida and all Americans. For every Alzheimer's patient, for every child that needs to go see the pediatrician, I want folks to be aware of what block grants and per-capita caps means because it sounds good. But what that means is devastation and sabotage to the Medicaid program.

Mr. Westmoreland, describe the impact on the delivery of healthcare services to Americans if this approach is taken, block grants and per-capita caps.

Mr. Westmoreland. As I understand some of the proposals that are Medicaid, the basic point is to limit Federal participation and the State costs of running the Medicaid program. As healthcare costs grow over time, the States will be left holding the bag for those increased State costs, for Medicaid costs. And as changes occur in the population, as the baby boomer demographic enters into the population, as more and more services are provided for people with disabilities, as prescription drug costs go up, the increased cost over time will not be matched by the Federal Government. States will be left holding the bag.

Ms. Castor. And isn't it interesting that some Republican Governors believe this approach will have disastrous consequences for their ability to care for their older neighbors, neighbors with

disabilities, and children. For example, a Republican Governor from Massachusetts, in a letter to Congressman Kevin McCarthy, stated: We are very concerned that a shift to block grants or per-capita caps for Medicaid would remove flexibility from States as the result of reduced Federal funding. States would most likely make decisions based mainly on fiscal reasons rather than the healthcare needs of vulnerable populations and the stability of the insurance market.

Could you elaborate a little more what this would mean? I mean, you would have -- I think, in my State, they may not raise taxes. That's the choice, though, isn't it? Raise taxes to support our neighbors or cut?

Mr. Westmoreland. If Federal participation is limited in these fashions, it's the only way that would respond to Mr. Barton's concerns about deficit reduction. If Federal participation is limited in that fashion, then the States will have a choice either of reducing the number of people that they serve, cutting back and rationing the services to those people, or raising State and local tax.

Ms. Castor. And, Mr. Chairman, thank you.

I'd like to ask unanimous consent to enter into the record, if anyone is interested in learning more about Medicaid, March of Dimes and a number of experts are having a lunch-provided forum tomorrow -- or, excuse me, Thursday, February 2, 12:30 to 1:30, right here in Rayburn in the Sam Johnson Room, Rayburn 2020, to learn why Medicaid matters to kids. I encourage you all to attend.

[The information follows:]

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

The Chairman. Could you send a copy over to me? Thank you.

I now recognize Dr. Burgess for 5 minutes.

Mr. Burgess. Thank you, Mr. Chairman.

I want to thank our panelists for being here today. Very, very interesting discussion. Certainly a very timely discussion.

Ms. Yocom, let me ask you, Chairman Murphy was, I think, directing some of his questions about improper eligibility determinations, and one of the things that has concerned me for some time is the issue of third-party liability, a Medicaid patient who has actually other insurance but also has Medicaid. And my understanding is what happens is sometimes it's hard to collect from the party of the first part, the commercial insurer. Medicaid is more straightforward, so you end up in a situation where the person who should be responsible for the bill, the insurance company who has been contracted to provide care for that patient, actually is inadvertently kind of let out of the equation because it just becomes easier to chase the dollars in the Medicaid system. Is that a real phenomenon?

Ms. Yocom. It is. We did some work, I believe in part for your office, that took a look at third-party liability on some of the issues that the Medicaid program encountered. Some of it is about information systems and just being aware of the coverage, but then, even within that, it's about the interaction between the State Medicaid programs and the insurance companies and being able to assert the fact that they should be paying first.

Mr. Burgess. So to what extent are the States able to address

the underpayments by commercial insurers and the overpayments by Medicaid?

Ms. Yocom. We did make some recommendations to CMS to provide additional support and data on these issues. I would need to check to see whether or not they had been implemented and a little more about the specific.

Mr. Burgess. I'm given to understand that this is not a trivial problem, that there are a significant number of dollars involved. Is that correct?

Ms. Yocom. Yes, yes.

Mr. Burgess. And I think it's safe to say that it does vary from State to State. Some States do better than others. So you, if I recall correctly, back in the mid-2000s, in 2005, 2006, 2007, you had created a list of States where the percentages of dollars left behind were attributed to each State. And there were some significant differences. I think Texas was kind of middle of the pack. Iowa did very well. Some other States did very poorly. Do I recall that correctly?

Ms. Yocom. I believe that's right. And I think some of it is the more health plans involved, I think the harder it becomes. Some of the States that had a smaller group of insurers to work with I think were able to establish better relationships.

Mr. Burgess. Well, it just gets to the point. I mean, that was a GAO report of over 10 years ago. Is this problem fixable? Is it worth fixing?

Ms. Yocom. I think there have been some fixes done, but I'm not sure I remember well enough to tell you much more than that right now.

Mr. Burgess. Okay. I'll just let the subcommittee know there is some very insightful legislation coming on this subject, and I hope people will join me on that.

Ms. Maxwell, let me to ask you: Just staying on the third-party liability issue, you've discussed Medicaid overpayments in regard to providers not reconciling credit balances with the State. Is that correct?

Ms. Maxwell. That's correct.

Mr. Burgess. So it stands to reason, since States are not active in tracking down third-party liability claims, they're aware of beneficiaries with overlapping coverage that might receive services that are unintentionally paid for both by third parties and the State Medicaid plan. Is that a reasonable assumption?

Ms. Maxwell. Correct.

Mr. Burgess. Is it possible for States to take advantage of in-house data like this to approach practices that might not have reconciled their credit balances?

Ms. Maxwell. Yeah. That's what our recommendation focuses on: the ability of States to identify those overpayments and then recover them. The report that we looked at was $25 million in which credit balances had not been reconciled and States had not been able --

Mr. Burgess. State that number again.

Ms. Maxwell. $25 million for I believe it was eight States, I

believe.

Mr. Burgess. But it is not an inconsequential number. It is a number worthy of our attention, even though we deal with big numbers up here. Mr. Barton talked about trillions of dollars and dazzled everybody with that. But even focusing on these amounts is important, is it not?

Ms. Maxwell. Absolutely. From the Office of the Inspector General's perspective, every dollar counts. Every dollar that is overpaid or goes to a fraudulent provider means there's a dollar less to provide services.

Mr. Burgess. Thank you.

And, Mr. Chairman, I just want to point out that, as of 10 days ago or so, the day before inauguration, we had roundtables with the Governors up here, both on the Senate side and the House side, and it was one of the most impactful days that I have seen up here. There was so much energy and enthusiasm on the part of the Governors who want reforms in their system. They want this to be right. They want to deliver the care to their citizens. There's not unanimity of opinion whether it's a block grant or beneficiary allotment, a lot of discussion around the moving parts, but I will just tell you I was very encouraged at the level of involvement of our Governors in this issue.

Thank you. I yield back.

The Chairman. Thank you.

I now recognize the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. Tonko. Thank you. Thank you, Mr. Chair, and welcome to our panelists.

Mr. Archambault, I know that, in your testimony, you addressed the waiting list and the corresponding decline of services or inability of services. I know that our ranker, Representative Pallone, asked you a bit about this or the panel about it, and I just want to dig a little deeper into a claim that you did make where you insinuate that expanding Medicaid will lead to the 600,000 individuals on Medicaid waiting lists being less likely to receive services. First of all, can you explain what you mean by Medicaid waiting lists? I assume you're referring to the waiting list that some States maintain to receive home and community-based waiver services. Is that correct?

Mr. Archambault. Correct.

Mr. Tonko. So I would ask, do you know which State has the longest waiting list for home and community-based services?

Mr. Archambault. It's usually related to population. You're going to have more people who are usually eligible for the program, but there's not a straight correlation that way.

Mr. Tonko. Well, my information tells me that Texas is that list that has the longest waiting list. It's at some 163,000-plus people in 2014. And do you know how Texas' waiting list, of that 163,000, has been affected by the expansion of Medicaid?

Mr. Archambault. The data usually is a year or two delayed, so it's hard to draw a direct correlation. I would just point out that, if we want to make sure that we're fulfilling the promises to the most

vulnerable, I think getting lost in this discussion is that Medicaid is crowding out spending --

Mr. Tonko. Well --

Mr. Archambault. -- of all kinds, whether it's education, whether it's public safety or infrastructure, or the waiting list. I don't want to --

Mr. Tonko. I would suggest it depends on what States are doing with their Medicaid program, but Texas has not expanded its Medicaid, so that was the answer that I would share with you.

It's very interesting now that we look at some of these data. Mr. Archambault, do you know which State has the second longest waiting list for home and community-based services?

Mr. Archambault. Again, it depends on the population by category, and there's no correlation between expansion or not. The concern is even States that have expanded also have waiting lists. So, for me, it's about priorities. And for State lawmakers, they are being put in a very tough position where they're not able to help families like Skylar's, and that's deeply concerning to me.

Mr. Tonko. Well, Florida is the second in that list of Medicaid numbers, and they have not expanded with their Medicaid issue. And, you know, I think we can sense a pattern here, so we need to cut to the chase. Fully 61 percent of those individuals on waiting lists for home and community-based services live in the 19 States that have not expanded Medicaid. My home State of New York, one of the most populace in the country and one which has enthusiastically expanded Medicaid,

maintains a waiting list of zero individuals for HCBS waiver services and a track record that has really begun to be very favorable about per-capita costs for Medicaid. So it's difficult for me to see the real-world correlation that is addressed in testimony like yours where expanding Medicaid and waiting lists for home -- where there's a contrast or a choice that has to be made between expanding Medicaid or waiting lists that grow for home and community-based services. Do you have any actual evidence at all that speaks to that expansion and any correlation with HCBS?

Mr. Archambault. So, again, the point is that, when you talk to Governors and State policymakers, they are being put in the position where, in Arkansas, they have been trying for years to address issues like families like Skylar. Now they are having to --

Mr. Tonko. Just yes or no. Is there any correlation that you can cite? And I'll remind you: you're under oath. So is there any correlation that you can cite?

Mr. Archambault. What I will say is there is no correlation. It's not a yes-or-no question.

Mr. Tonko. So the answer to my question is no.

Mr. Archambault. There is no correlation, expansion or not, on whether you have a wait list.

Mr. Tonko. So, unfortunately, what we're seeing here from our witnesses today is a parade of alternative facts designed to obscure the simple truth.

Medicaid expansion is working. It has provided health insurance

to over 12 million people, and my colleagues on the other side of the aisle are engaged in a cynical attempt, I believe, to pit good versus good in an attempt to gut this program and rip health care away from millions of Americans. I find it unacceptable. I find it shameful, and I don't think we should sit quietly while people's right to health care is being threatened. With that, I just yield back the balance of my time.

The Chairman. Thank you.

I now recognize Ms. Brooks for 5 minutes.

Mrs. Brooks. Thank you, Mr. Chairman.

I don't think that trying to explore waiting list questions and waiting list issues is an attempt to gut Medicaid. In my view, it's an attempt to strengthen the services and the ability to provide people with developmental disabilities, traumatic brain injuries, mental illnesses, and ensure that those people on these significant wait lists receive care. And I would like to go back to you, Mr. Archambault, with respect to -- because I do think it's more complex than a simple yes or no, is there a correlation, or is there not a correlation. So could you please go into greater detail with respect to what your foundation, what you all have found with respect to the waiting lists, with respect to the people who are on the waiting lists, with respect to what the States want to do with the waiting lists? I'm going to let you use most of my time.

Mr. Archambault. Sure. Thank you, Congresswoman.

I would just say that to focus on a waiting list is a vacuum.

Mrs. Brooks. I'm sorry. What do you mean by "it's a vacuum"?

Mr. Archambault. Some States have delivered care -- the phrase that I'm sure you're all very familiar with: You've seen one State Medicaid program, you've seen one. Some States have decided to take their people that would qualify for a waiting list and include it into an 1115 waiver request and deliver services in a different way. My point is that the principles by which we have as a country for our safety net is that we make sure that a safety net program accomplishes a few things. One, is it targeted and tailored to the truly needy? Are we living up to the promises that we are making to these families and individuals before we make new promises?

Mrs. Brooks. And is it fair to say that those currently on waiting lists in the States are the truly needy? Is there any dispute about that?

Mr. Archambault. I think there would not be, and I would be happy to explore it, but I'm not sure how intellectual disabilities or mental illness would be seen as ones that we wouldn't want to try to help.

Mrs. Brooks. People typically who cannot take care of themselves.

Mr. Archambault. Correct --

Mrs. Brooks. Is that correct? People who are often not working. Is that correct?

Mr. Archambault. Correct.

Mrs. Brooks. People who truly are incapable of taking care of them physically or mentally themselves.

Mr. Archambault. Correct. And this was the traditional Medicaid population pre-ACA -- was the aged, the disabled, pregnant women, and children -- that we were trying to fulfill that promise to. The ACA changed that discussion.

Mrs. Brooks. And how did the ACA change that discussion?

Mr. Archambault. Well, expanded to a population that is the vast majority 82 percent childless, able-bodied adults. So, again, these are individuals that don't qualify for TANF. They don't qualify for long-term food stamps. They have not traditionally been a population. And what's really, really important for us to remember here is our goal is not to get people to stay on Medicaid. Ultimately, we want to make sure that they have better health outcomes, and I think most of us would agree ideally it's if they're able to work, that they're out in the workforce supporting themselves and on private insurance. And that's ultimately I think where we want to be as a country, and that's the discussion that we need to be having.

Mrs. Brooks. And is it fair to say that most of the people who are on the waiting list who are the developmentally disabled, traumatic-brain-injured people, and those with serious mental illness are always going to be on Medicaid?

Mr. Archambault. Correct.

Mrs. Brooks. It's a different type of population.

Mr. Archambault. Correct.

Mrs. Brooks. And what has been your discussion and findings with the Governors with respect to how most of them would like to take care

of this population? If there's consensus among Governors, what is the Governors' and the legislature's view with respect to this population?

Mr. Archambault. Yeah. I think there's ongoing concern by Governors that they're not going to be able to support these. Now, I will say there are exceptions to that rule, and if you look at the State of Kansas or the State of Maine, those Governors have been able to buy down their wait lists. I think Maine was gone from 1,700 individuals down to 200 individuals.

Mrs. Brooks. How did they do it?

Mr. Archambault. Well, they got some budget sanity. They did not expand Medicaid, and so they have been able to focus on eligibility, as we have talked about today, to make sure that their programs are truly focused on those that are the most needy, the aged, the blind, the disabled. And they've made that a priority in their States, and they've had success in buying down their wait lists.

Mrs. Brooks. I think we need to continue to explore the States that have found ways to have little to no wait lists. I certainly hope today our Governor, Governor Holcomb, is formally submitting an application to CMS for a Medicaid waiver to continue our successful Healthy Indiana Plan for an additional 3 years. It's an outstanding program that I hope folks on both sides of the aisle -- it is a way to save and to help those who truly need it. It can be replicated. I believe it's an incredible model that can work.

Unfortunately, we still have a waiting list in Indiana. We don't want a waiting list. But I certainly hope that, with the new nominee

to lead CMS, Seema Verma, a Hoosier, we can make all of Medicaid a far stronger and better program. With the controls in place, as a former U.S. attorney, I've worked with the MFCU units. We need to do more to support them. We need to do more to support all of these efforts to make sure that our truly vulnerable are protected.

With that, I yield back.

The Chairman. Okay.

I now recognize Ms. Clarke for 5 minutes.

Ms. Clarke. I thank you, Mr. Chairman, and I thank our ranking member.

Before I get into my actual questioning, I actually want to respond to Mr. Howard because, as a proud New Yorker, I must correct the impression left by your characterization of the Empire State. Are you aware that the New York State's Medicaid Redesign Team has been a national leader in controlling costs and improving quality for Medicaid members? The Empire Center for Public Policy, self-described as a physically conservative think tank and government watchdog, released an analysis in September of 2016 that New York Medicaid spending per recipient has dropped from $10,684 to $8,731, or 18 percent, between 2010 and 2014, at nearly twice the national average.

According to the independent New York State Comptroller's Office, the MRT restrained total Medicaid spending growth to only 1.7 percent annually during the period of fiscal year 2010 to 2013. This marks a significant reduction over the trend for the previous 10 years of 5.3 percent. During the same 3-year period, Medicaid re-enrollment

grew by more than half a million people. Billions of dollars have been saved, and per-recipient spending has been slashed. In fiscal year 2014 and 2015 alone, a total of $16.4 billion was saved thanks to the MRT initiative. This track record of success led the Comptroller's Office to declare that MRT represents the most comprehensive restructuring of New York's Medicaid system since the program began in 1966. And we have no waiting list.

I would like to now turn to Mr. Westmoreland. In Mr. Archambault's written testimony, he cited numerous concerns about Medicaid expansion. However, he ignores the fact that this program has also had a positive impact on the quality of life and health for millions of Americans. He also ignored the fact that many of the positive impacts, such as cost savings, from preventative medical exams and early detection and treatment of disease will result in future cost savings to the States and the Federal Government. I am a strong supporter of Medicaid expansion because I see the significant value of the program. I'm interested in improving the program and not destroying it.

So, Mr. Westmoreland, Mr. Archambault claims that the Medicaid expansion funding threatens the truly vulnerable. Can you clarify why this is not the case?

Mr. Westmoreland. I'd begin with first challenging the discussion, as I did in my testimony, of who's truly vulnerable. I want to be clear that not all people with disabilities, cognitive, traumatic brain injury, any of those discussions that have been

ongoing, were traditionally eligible for Medicaid. It was tied to a 75-percent poverty and receipt of SSI, and many people whom we would all consider to be disabled have never been eligible for the Federal Medicaid program until the enactment of the ACA. So let's start with those people.

Secondly, I would point out that there have been significant studies, economic and macroeconomic studies, some by business schools, some by economists, showing that States actually have significant budget savings and revenue gains by having the Medicaid expansion in their State. So I think that it's clear that States benefit on a financial basis and that their citizens benefit on their financial basis in the ways that I outlined in my testimony.

Ms. Clarke. Mr. Westmoreland, both Mr. Archambault and Mr. Howard claimed that Medicaid expansion poses an unsustainable burden on State budgets. Can you clarify why this is not the case? Why have most States that have expanded Medicaid actually experienced net budgetary savings associated with the expansion?

Mr. Westmoreland. Yes. Let's start with the healthcare expenses that, as we discussed earlier, there are fewer uncompensated care costs within the State. In addition to that, there is an influx of Federal funds into the State to pay for healthcare services, and those Federal funds have a reverberating multiplier effect in the State economy. And, finally, States are able to provide, as you suggested, preventive and early-intervention services that might not have been available to uninsured adults before and actually lower the ongoing

healthcare costs for those people.

Ms. Clarke. It is my understanding that numerous studies have disproven the myth that Medicaid expansion diminishes work incentives. Is that correct?

Mr. Westmoreland. Yes, ma'am.

Ms. Clarke. I yield back the balance of my time, Mr. Chairman.

The Chairman. Thank you.

Now I recognize a new member to our subcommittee, the gentleman from Michigan, and Reverend, Mr. Tim Walberg.

Welcome aboard here to our committee.

Mr. Walberg. Thank you, Mr. Chairman.

Mr. Archambault, I appreciate the safety net illustration, that we want to have safety nets. We don't want to have safety nets forever for people. I remember, I never worked over a safety net, but I remember working at U.S. Steel South Works and third helper of going out and being responsible to swing a sledge and take the plug out of a heat of molten steel and had a fall-protection strap on me. I appreciated that, but when the shift ended, I didn't want that strap. I wanted to move on. That's a laudable goal, that we find ways to make sure that people who truly need that safety net have it, that we make sure that we don't waste it on others who don't and encourage them to move on in a very positive way.

I'd like to ask you for a further response from your testimony, and also, Ms. Maxwell, I'd like for you to comment after Mr. Archambault. Your testimony references some of the waste and fraud

issues that face our Medicaid programs, individuals that have passed away decades ago, individuals using high-risk or stolen Social Security numbers, and tens of thousands who had moved out of State yet remained on Medicaid. What can we do to combat some of these problems more effectively?

Mr. Archambault. So there's a number of things that we would recommend, and thank you, Congressman, for the question. The first one is allow States to check eligibility more frequently. Under the ACA, there was a change that States could only redetermine eligibility once a year unless they were given a reason to recheck eligibility. We have found that States that are able behind the scenes to access data internally within State government but also through third-party vendors, if they're able to run those on a quarterly or monthly basis, they're finding that these people, individuals have life changes, just like all of us. So, whether they move or they die or whether they get a significant raise, we need to make sure that we find that sooner rather than later. Otherwise, we're just wasting money, and I believe that there's bipartisan agreement on that, that we need to make sure. The other thing is that we need to make sure that the Federal databases, which we haven't talked a lot about, the quality of the data in those is quite poor. If you talk to State leaders, they will complain constantly about how late the data is, out of date, and it's not flexible enough. So making sure that States are able to look for dual enrollment, for example -- and the Food Stamp program is moving in this direction. We should be doing it for Medicaid, just to make sure that

we're not wasting money as a result of individuals moving across State lines.

Mr. Walberg. Thank you.

Ms. Maxwell, could you add to that?

Ms. Maxwell. Thank you. I would love to. I would definitely echo what we just heard about the crucial need for better Medicaid data. It hampers the ability to understand these programmatic issues for policy decisions but also is significantly deterred for us trying to find fraud, waste, and abuse. In addition to that impacting detection, we also need to think about protecting the Medicaid program from fraud ever happening in the first place. So it, again, in addition to the data, would encourage us to continue to work with States to improve enhanced provider screening to make sure that providers that get in are the providers we want to get in and we want to pay.

Mr. Walberg. Thank you.

Mr. Archambault, an audit in Arkansas revealed more than 43,000 individuals on Medicaid who did not live in the State, with nearly 7,000 having no record of ever living there. More than 20,000 Medicaid enrollees were also linked to high-risk identities, including individuals using stolen identities, fake Social Security numbers, et cetera. Something of interest to me in Michigan, has recently identified more than 7,000 lottery winners receiving some kind of public assistance, including individuals winning up to $4 million. Those jackpots are something that ought to encourage them not to be on Medicaid assistance.

Mr. Archambault, do these individuals get approved for and stay enrolled in the Medicaid program, and is it the Federal Government or the States dropping the ball?

Mr. Archambault. Well, Congressman, maybe a little bit of both, to answer that question. And I think what's really important here is that there are some policy changes that have happened. The Affordable Care Act removes an asset test for the Medicaid program, by and large. There's some that it still applies to. But as a result, these sorts of outlier cases admittedly, but when an individual wins $4 million, takes a lump-sum payment, they may not qualify that month, but the very next month, they would qualify for this program and can remain on. Let alone we're not checking for 12 months in most cases, so we wouldn't know. The point I'm making here is we need to make sure that these gaping holes that exist, we have data in many cases within a State government. We have data across State lines. And the Federal Government needs to incent States to say: Look, if you are doing this on a more regular basis and identifying fraud, you can take a little bit of that savings to pay for those efforts. This points to Mr. Howard's point that that is not the incentive that's inherent in the current financing structure that we have set up.

Mr. Walberg. Thank you.

My time has expired.

The Chairman. I now recognize Dr. Ruiz for 5 minutes.

Mr. Ruiz. Thank you, Mr. Chairman.

As many of you know, I grew up the son of farm workers in the

medically underserved community of Coachella. I have seen firsthand what it means when a community is medically underserved and when they cannot access care. I can tell you this: If it was not for Medicaid, the Coachella Valley and regions like mine all across the country would not have access to health care that every one of us up on this dais and our families enjoy. If we repeal Medicaid expansion, people will lose healthcare coverage. They will stop seeing their doctors because the costs will be too high, and they will stop taking their lifesaving prescriptions because they are too expensive. In California alone, the nearly 3.5 million individuals who enrolled in Medicaid under the ACA expansion provision could lose their coverage. That's millions of families losing access to health care. And if we repeal Medicaid expansion, uncompensated costs will increase, straining our Nation's healthcare system, which will drive up costs for everyone because, you see, when people don't have health insurance, they don't stop getting sick. And our emergency departments do not turn someone away because they don't have insurance. Emergency physicians treat the patients, like they should. So the hospitals have to make up the costs. And in 2014 alone, Sutter Health Systems in California saw a decrease in uncompensated care by 45 percent in 2014. All hospitals in my district, in particular San Gorgonio Hospitals, have seen a drop in uninsured patients in the emergency department by half. So we need to expand Medicare even more, make it more efficient and more desirable for providers to see more Medicaid-insured patients.

Listen, fraud is bad, and political amplification of the problem

to wrongfully justify cutting health insurance for sick patients is bad. So here's the possible common ground. Here's what I think we can both agree on. If we start with the premise that we want to cover more uninsured, economically struggling families like the middle class and more vulnerable families, then we're on the same page. But if you start with the ideological goal to cut or end Medicaid, then you'll breed mistrust, and millions of people will be harmed, including the middle class. So the real question -- and the real question, Mr. Howard, is, are sick and injured people getting the care they need? Because anything short of this is negligence. So let's tackle fraud so that we can expand coverage to more struggling, uninsured middle class families.

So the question that I have, Ms. Yocom, if you were to choose one thing that you can do to combat fraud, if there's one action that you can take that we can make the biggest difference in the system, what would that be?

Ms. Yocom. I think it's around the providers, making sure that we have eligible providers who are in good standing and that those who are not in good standing and should not be providing services aren't going across States to provide services.

Mr. Ruiz. Thank you.

Ms. Maxwell, the one thing, the one thing that would make the biggest difference?

Ms. Maxwell. I would absolutely have to go back to the data. Without that sort of transparency, we cannot see what's happening in

the program, and we have a lack of data across the Nation and also data coming in from the managed care companies.

Mr. Ruiz. Thank you.

Mr. Howard, the one thing, if you had one thing that you can change to make the biggest difference in fraud, what would it be?

Mr. Howard. In fraud in particular?

Mr. Ruiz. Medicaid.

Mr. Howard. Yes. Engage data transparency, as my colleague here on the dais was just saying. Medicaid data should be enclaved for all the States to look at so they can benchmark provider performance and engagement.

Mr. Ruiz. Thank you.

Mr. Westmoreland, what does the evidence suggest about how Medicaid expansion is making health care more affordable? Is there evidence, for instance, that Medicaid expansion is reducing patients' need to forego medical care due to costs?

Mr. Westmoreland. Medicaid expansion is highly associated with a decline in personal bankruptcies. It is also associated with greater financial security for families who are newly eligible.

Mr. Ruiz. So these are middle class families who are having some economic security because of the Medicaid expansion. What does the body of evidence say about how Medicaid expansion has affected patient access to primary care and preventative care?

Mr. Westmoreland. Those beneficiaries who are newly insured under the Medicaid expansion have much higher rates of traditional

sources of care, seeing primary care, and using preventive health services.

Mr. Ruiz. Thank you very much.

My closing statement is, if this is leading to increase in expansion for economically struggling middle class families, then, you know, I'm in.

But if the ultimate goal is to create a facade and amplify a problem politically to then justify policies that will hurt the middle class and that would decrease health insurance, then I'm not in.

So let's tackle fraud so that we can expand more health coverage to middle class families.

Thank you very much.

The Chairman. Thank you.

Now we're recognizing another new member of our committee from, I think, UCLA, former State assemblywoman, State senator, mayor, Congresswoman Mimi Walters of California. You're recognized for 5 minutes.

Mrs. Walters. Thank you, Mr. Chairman.

My questions will be directed to Mr. Archambault. The supporters argued that Medicaid expansion would increase jobs. Has this happened?

Mr. Archambault. There's been a number of studies where the consultant predictions have been very off, whether it be enrollment or jobs. In particular, they are Iowa, Tennessee, where there were predictions of gains in hospital jobs and healthcare jobs as it related

to expansion, and the opposite has actually taken place, where there has been a loss in healthcare jobs.

Mrs. Walters. Okay. And during the conception of the ACA, supporters argued that Medicaid expansion would stop hospital closures. Has this been the case?

Mr. Archambault. So it certainly has not stopped hospital closures. In a number of States, hospitals have still closed. And I think it's important to realize that the supporters' claim that it is a silver bullet to stop closures has not been true. So you could list off Arizona, Massachusetts, a number of these States where they have expanded, and hospitals have still closed.

Mrs. Walters. Okay.

And, finally, Medicaid expansion was projected to lower emergency room use. However, you pointed out that the evidence suggests that emergency room use has increased after expansion and that many emergency room visits by Medicaid beneficiaries were deemed to be avoidable. Can you explain what might have led to this outcome?

Mr. Archambault. Sure. And my experience is not just influenced by the ACA. I live in Massachusetts and worked on RomneyCare and have studied RomneyCare very closely. And one of the things that becomes apparent is, both in the expansion population and the traditional Medicaid population, is folks are not getting coordinated care because they are showing up to the ERs at a much higher rate than those that are privately insured or even uninsured. And so, as a result, these are the questions that we need to ask about the

effectiveness of the program, the quality of the care that individuals are getting. There's been a number of surveys looking at, how many of these visits are avoidable? And, unfortunately, at least in Massachusetts, those surveys found that 55 percent of Medicaid visits to the ER were unavoidable.

Mrs. Walters. Thank you.

I believe my time is expired.

The Chairman. I then recognize Ms. Schakowsky for 5 minutes.

Ms. Schakowsky. Thank you, Mr. Chairman.

The Affordable Care Act has just been a blessing for so many people in our country. Twelve million more Americans have access to health care.

Mr. Westmoreland, Governors across the country submitted letters in response to Representative McCarthy's request to describe the impact of the ACA and the expansion of Medicaid within their States. I'm assuming that you've seen some of these letters. For the record --

Mr. Archambault. Yes, ma'am.

Ms. Schakowsky. Even some Republican Governors appeared to have positive things to say about the expansion of Medicaid in their State. For example, the letter from my home State of Illinois stated that our -- the Governor stated that our Medicaid population, quote, "now stands at 3.2 million, almost one quarter of the State's population," and it went on to urge Republican leaders in Congress to, quote, "carefully consider the ramifications of proposed changes." Similarly, Governor Sandoval of Nevada stated in his letter to Mr.

McCarthy that, quote: I chose to expand the Medicaid program to require managed care for most enrollees and to implement a State-based health insurance exchange. These decisions made health care accessible to many Nevadans who never had coverage before -- coverage options before.

So, Mr. Westmoreland, can you briefly touch upon how the residents of States that expanded Medicaid under the ACA have benefited, such as Illinois and Nevada?

Mr. Archambault. I'm sorry. I didn't understand the last part of the question.

Ms. Schakowsky. I cited Illinois and Nevada, but can you briefly touch on how the residents of States that did expand Medicaid under the ACA have been benefited?

Mr. Westmoreland. Let's begin with 11 million people have Medicaid coverage who didn't have it before, and many of those people are in serious need. I would point out and agree with you that, of the Governors who wrote to Mr. McCarthy, none of them requested repeal, I believe. And 16 of the States were governed by Republican Governors. And Ohio, Mr. Kasich, one of your former colleagues, I think was most passionate in describing not only how it has benefited the residents of Ohio to have services but that, indeed, he believed that it was a moral duty to continue to cover these people under Medicaid.

Ms. Schakowsky. Thank you for that.

And can you briefly touch on how -- let's see, I also wanted to mention there are other examples, Republican-led States as you have

said, that have had positive outcomes for their residents. And beyond providing healthcare benefits to an additional 12 million people, how has Medicaid expansion helped States manage their budgets? Has it had a positive impact?

Mr. Westmoreland. As I suggested earlier, there have been business school studies and economic studies suggesting that States who have expanded Medicaid have had not only a net increase in Federal funds coming into the State, but they've also enjoyed some revenue increases because of the reverberating effects and providing those funds in hospitals. I would also point out to you that there is a long, long-term study to be done of how productivity might actually be improved by people having healthcare services who previously were denied those services.

Ms. Schakowsky. Thank you. Some of the letters I was referring to seem to raise concern by Republican Governors that changes to the Medicaid program would produce destabilizing cost shifts to the States. For example, Governor Baker of Massachusetts in his letter to Mr. McCarthy said, quote: Medicaid is a shared Federal-State partnership. Proposals that suggest that States may be provided with more flexibility and control must not result in substantial and destabilizing cost shifts to States.

So is there a valid concern of a major cost shift under the Republican proposals you are seeing, such as proposals to block-grant Medicaid or impose per-capita caps on spending? Should States be concerned about major cost shifts?

Mr. Archambault. States should be very concerned. The first question is, what level will the initial block grant and its formula be set at? But the major question for States to focus on is how the evolution, the increase of funding in the future, will evolve as compared with the actual cost of providing healthcare services to the number of people who need them. As I suggested earlier, States will be left holding the bag for both medical inflation and the number of people who have no health insurance.

Ms. Schakowsky. And what about, for those that are receiving health care through ACA's Medicaid expansion, are they at risk, particularly if they block-grant the Medicaid program?

Mr. Archambault. Well, first, I would suggest that my colleagues on this panel would point out that -- suggest that those people should be the first to go off of the healthcare rolls and that they would return to traditional Medicaid populations as they've existed over the last 20 or 30 years, so I would suggest that the people who are on Medicaid expansion are the people who are most likely to be on the chopping block to begin with.

But, secondly, I would say that, as every State, expansion or no expansion, experiences the growth in healthcare costs that is almost inevitable, looking at CBO or any other projections, if the States are left holding the bag and they do not have a guarantee of Federal funds, they're going to be cutting back on everyone.

Ms. Schakowsky. Thank you.

I yield back.

The Chairman. Thank you.

Another new member of our committee, Mr. Costello of Pennsylvania. I appreciate you being here. You're recognized for 5 minutes.

Mr. Costello. Thank you.

Ms. Maxwell, if I could ask a couple of questions on HHS OIG, has the number of criminal investigators increased or decreased over the years?

Ms. Maxwell. The number of criminal investigators specifically?

Mr. Costello. Yes.

Ms. Maxwell. I think, right now, we are below our FTE ceiling. We are still trying to hire more.

Mr. Costello. How many more do you think you need to hire?

Ms. Maxwell. Well, we would hire as many as you let us, but we need -- we're like 1,700 is where we're pegged for, the entire OIG.

Mr. Costello. True or false, for every $1 expended in the OIG, $7.70 is returned to the Health Care Fraud and Abuse Control Program?

Ms. Maxwell. That is true.

Mr. Costello. Has that been a consistent return?

Ms. Maxwell. As far as I know, it's been around 7, and it's the same thing for the Medicaid Fraud Control Units. They also had that similar ROI.

Mr. Costello. You conducted a review of State Medicaid agencies presented with allegations of provider fraud. Did you find that State agencies properly suspended Medicaid payments to those providers?

Ms. Maxwell. They did not make full use of those tools.

Mr. Costello. Which is to say they did suspend all --

Ms. Maxwell. They did not. Although, in a number of the cases where they did not suspend, the MFCU ultimately cleared the provider of wrongdoing.

Mr. Costello. Very good. Since your work -- on the issue of program integrity, since your work has repeatedly found CMS' oversight of States claiming of matching dollars is inadequate to safeguard Federal dollars, what more could CMS be doing to ensure the integrity of Medicaid matching?

Ms. Maxwell. There are a number of things along the program integrity principles that we believe CMS could do in conjunction with the States. Given that CMS and States share fiscal risk, we believe they should share accountability. So, as I mentioned, prevention, helping States implement the enhanced provider screening, helping them drive down improper payment rates, and then, of course, the data to be able to understand the program and detect fraud. And more importantly, the data helps us hone in on fraud, waste, and abuse and really target our oversight so that we can get this tricky balance right between trying to have really strong program integrity but also not put an undue burden on its providers.

RPTR BRYANT

EDTR HOFSTAD

[12:00 p.m.]

Mr. Costello. I'm going to shift this question to Mr. Archambault, but after he answers, anyone else feel free to respond, including what you just mentioned about the issue of, specifically, enhanced data-matching technology.

Because it seems to me that if you have technology and you have data, when we're talking about the ACA change which only requires States to perform one check per year, knowing that we have the data, knowing that we're a pretty technologically advanced society, it would be, I think, a little bit easier to go about detecting ineligibility or fraud or anything of the sort to cut down on those who are ineligible from being accepted into the Medicaid program.

Mr. Archambault, I see in your written testimony, in the first 10 months of operation, Pennsylvania's award-winning Enterprise Program Integrity Initiative identified more than 160,000 ineligible individuals who were receiving benefits, including individuals who were in prison and even millionaire lottery winners, resulting in nearly 300 million in taxpayer savings.

What can we do in order to pivot to real-time identification of something that doesn't seem quite right, rather than just relying on that one moment in time annually, to beef up program integrity here?

Mr. Archambault. So I think there's a number of things that the

Federal Government can do to enable States to do this.

The first one is that if they are investing State dollars in some of these efforts, if they are able to find cases that are ineligible, for them to be able to keep a piece of that savings up front and more than they get to save now, given the funding formula that we have.

The other one is let them check more frequently.

And then the third one is to make sure that the actual data that the Federal Government is allowing access to is timely or allows States to go somewhere else to get it from a private vendor if the Federal Government's data is not timely enough.

Ms. Maxwell. Yeah, I would agree that the coordination and sharing of data is critical between the Federal and State governments. One area where we found a real problem is, when providers are enrolled, they're asked who their owners are so we know who we're doing business with. And, in one case, we found that the State Medicaid agency thought there were 63 owners, Medicare thought there were 14 owners, and they told us there were 12. And so, trying to coordinate this data so all the programs know who we're doing business with.

In addition, we recommend that the Medicare data be improved so that Medicaid can actually share that and reduce the provider burden, in terms of letting them enroll in both different programs.

Mr. Costello. That gets, Ms. Yocom, to your point about the duplicate eligibility issue, correct?

Ms. Yocom. Yes, it does. And while we are a technologically advanced society, the Medicaid program truly is not. States' data

systems are pretty antiquated, and there is a lot of work to do to get good data systems that are more flexible and more agile.

Mr. Westmoreland. If I could, sir, I would also say that the recently published managed care organization rule provides for a substantial improvement in data systems. And I would ask this -- and this committee actually accelerated the effective date of that with your 21st Century Cures Act.

I would ask you to keep the MCO rule in mind as you move forward with the question of whether regulations will be withdrawn in the early part of this -- in the early part of this administration. I think it's a valuable addition to try to be able to find who -- I agree with all my colleagues that the data systems need to be improved, and I think the MCO rule does that.

Mr. Costello. Thank you all for your comments.

Mr. Murphy. Thank you.

And now, recognizing another new member of our committee, the owner of Carter's Pharmacy. Is that a place where we might see someone like, you know, Ellie Walker and Opie serving drinks at the Walker's store?

Mr. Carter. Very much so.

Mr. Murphy. But understanding of small-town medical care, good to have you on board here. Buddy Carter of Georgia's First District.

Mr. Carter. Thank you. Thank you, Mr. Chairman.

And thank all of you for being here. We appreciate your participation.

I want to preface my questions by apologizing if I ask you something you weren't prepared for. And if you don't know the answer, if you'll just simply tell me, you know, that you can get me the answer, that will be fine.

Ms. Maxwell, I understand, looking at your bio last night, that you have some expertise on the 340B program.

Ms. Maxwell. I do.

Mr. Carter. I don't want to get into that program; however, I want to explain to you a situation that exists in my district.

I have a hospital in my district that was participating and receiving moneys from the 340B program, and because they didn't meet the threshold, they were put out of that program. Now, they got back in it.

As I understand, there are two different levels that you can be at, as a sole community provider and also as a disproportionate share.

Ms. Maxwell. Uh-huh. Those are both covered entities, uh-huh.

Mr. Carter. Okay. Well, they got back in it as a sole community, okay? But what the CEO is telling me is that, because they can't get back as a disproportionate share, that they're losing over $300,000 a month. Now, that is significant for them. I'm sure it's significant for anyone, but for this hospital system it's very significant.

Now, he also is telling me that the formula that is used for that, that Medicaid participation, the Medicaid rate is also in that formula to determine whether they are a sole community or whether they're in the disproportionate share.

And what I'm hearing is that those States that did not expand Medicaid, like the State of Georgia, that they are put at a disadvantage, in that we aren't eligible for that. Is that true? Is that the case?

Ms. Maxwell. I'm going to have to take your offer to get back to you on that.

Mr. Carter. Okay.

Ms. Maxwell. My expertise really is in the 340B pricing of the drugs themselves and not as much in this disproportionate. But I know there have been issues, and I certainly know there are people in our office that can answer that question, and we'll get back to you as soon as we can.

Mr. Carter. Okay. Well, that's fair enough.

But my question is twofold: first of all, if that is the case; secondly, if that was the intention. Was that the intention, to penalize States that didn't expand Medicaid so that they couldn't receive these dollars, or was it an incentive to get those States to expand Medicaid?

Ms. Maxwell. I couldn't speak to the legislative intent.

Mr. Carter. Okay. Well, please include that in your answer. That's one of the things --

Ms. Maxwell. Absolutely. Will do.

Mr. Carter. I'm going to move now to Mr. Archambault and ask you, the video that you showed there -- now, understand, I spent 10 years in the Georgia State legislature, all on Health and Human Services,

so I understand about Medicaid. And, you know, we did the hospital bed tax in order to draw more dollars down, as was brought up by one of my fellow members earlier. In fact, they are looking at reauthorizing that again this year. And you bring up a valid point about how States balance budgets, because, quite honestly, we did it that way, and that was one of the reasons why.

But my question is about the video you showed. Now, I am a strong believer that Medicaid should include the aged, blind, and disabled. In fact, I think that if -- and if you'll help me -- that most of the costs in the Medicaid program can be attributed to the ABD. Would that be -- and what percentage would that be? Seventy, 80 percent?

Ms. Yocom, do you --

Ms. Yocom. I think it's at least two-thirds.

Mr. Carter. At least two-thirds?

Ms. Yocom. Yeah.

Mr. Carter. Okay. And we're all in agreement that that's most of it.

But my question, Mr. Archambault, was why didn't this patient -- why wasn't this patient eligible as disabled? It would seem to me like they wouldn't have had to have waited on the waiver.

Mr. Archambault. So, Congressman, thank you for the question. And I think it is important to know that we are talking about a couple different things here. What we were talking about in particular for her, for Skylar and her mother, is that there are some services that she could have access to under these waiver programs.

So, for Skylar, you can't just call a neighbor to babysit. You need to have certain skill sets to be able to be able to watch her, given her condition. And so this would allow access to those services.

It's not that individuals are completely off of Medicaid; it's that we are talking about, are we providing the services that we have promised to individuals in a holistic manner to be able to take care of these most needy?

Mr. Carter. Okay. Well, understand, again, I am one who believes that Medicaid should be taking care of that group. And once you get past that, now, we can have a discussion and we can debate, you know, who's to be covered and who's not to be covered. But I honestly believe, as a healthcare professional, that they should be covered.

Mr. Archambault. And, Congressman, that's my exact point, is that we are extending new promises to able-bodied, largely childless adults before fulfilling that promise.

Mr. Carter. Okay. Good. Thank you for that.

Very quickly, I'm sorry I don't have much time, Mr. Howard, I just wanted to ask you, HHS now projects that newly eligible Medicaid patients are going to cost $6,366 per enrollee in 2015 and that this is a 49-percent increase in what they had projected before. Why is that? Why are they costing more?

Mr. Howard. Congressman, it may be because, in these new expansion programs, States have raised their reimbursement rates to providers to get these newly eligible populations in the system.

That's my understanding.

Mr. Carter. Huh. It would appear to me, if the -- again, I get back to the aged, blind, and disabled. If they were already included, they are the most expensive. And why are they -- I'm sorry. I know I'm running past my time. It just baffles me why it's gone up that much.

Mr. Murphy. Okay.

Mr. Carter. Thank you, Mr. Chairman. I yield back.

Mr. Murphy. Okay. Thank you.

I'm now going to recognize Mr. Collins for 5 minutes.

Mr. Collins. Thank you, Mr. Chairman.

I'm going to be directing this to you, Mr. Howard, but some background: I'm western New York, and New York, as we all know, is one of the highest States in Medicaid per capita spending and total spending. And while New York only has 6-1/2 percent of the Nation's population, it accounts for over 11 percent of the national Medicaid spending. And according to a 2014 report from Medicare and CHIP Payment and Access Commission, using data from 2011, New York spent 44 percent more per Medicaid enrollee than the national average.

There's all kind of complex and fragmented funding streams that make it very difficult to provide adequate accounting controls for the program.

So the question is this: In 2012, a report from the HHS Office of the Inspector General revealed that New York had systematically overbilled Federal taxpayers for Medicaid services for the mentally

disabled for 20 years. New York State developmental centers, which offer treatment and housing for individuals with severe developmental disabilities, had received 1.5 million annually per resident in 2009, for a total of 2.3 billion. State centers were compensated at Medicaid payment rates 10 times higher than the Medicaid rates paid to comparable privately run developmental centers.

So the simple question is, how could these overpayments go unnoticed for 20 years?

Mr. Howard. Congressman, it's because there is simply no financial incentive for the States to go back and police their systems in a way that would result in a significant decrease in Federal funding.

The State of New York actually settled with HHS, I believe, for $1.63 billion for overpayments. I think it was 2009 through 2011. So, to some extent, the problem was remedied, but the reality is, as I said before, the ratchet only goes one way.

Congresswoman Clarke pointed out earlier that Governor Cuomo has had quite a bit of success, which I noted in my testimony, in bringing down the payment rate -- pardon me, for the growth rate for Medicaid. I think if someone who had an R by their name had suggested what is effectively for New York State a cap on growth of the most nondisabled part of the program, that it would be held to 30 percent effectively below the historical payment rate for the program, I think there would have been cries of poverty and that we'd be throwing people out of the program. Miraculously, New York State providers found ways to significantly decrease their spending by hundreds of millions of

dollars.

I think that the belief that significant flexibilities or block grants or per capita caps would automatically mean less delivery of care ignores that economists on the right and left center of the aisle believe there's significant opportunities for efficiency in health care. And until we give States better programmatic and financial goals to seek out that efficiency, we are not going to be getting the best outcome for every dollar we're spending on health.

Mr. Collins. Well, you know, being a New Yorker and bringing this up, I would have to say, you know, while they apparently negotiated a significant settlement, it in fact did not reimburse the Federal Government for 20 years of egregious behavior which I would say was deliberate. You can't be charging 10 times the national average for 20 straight years and try to, you know, prove that this was not intentional.

So, you know, we talk about R's and D's. I have to wonder, if there wasn't a D behind the President's name and a D behind our Governor's name, if that settlement would have come closer to reimbursing the U.S. taxpayers for what I think was, you know, grand theft auto.

So another question about New York. Well, by the way, the reason I come at this the way I do, as a county executive of Erie County, largest upstate county, we're one of only a handful of States where the counties have to pay a share. And, by the way, on DSH and IGT for UPL, the counties pay 100 percent of the Federal match. The State pays nothing.

In the case of Erie County, my county, second, third, fourth city in the United States, city of Buffalo, 110 percent of our property taxes went to Medicaid. We couldn't raise enough property tax to even pay our county's share of Medicaid because of the way New York State runs this program. We had to supplement it with sales tax revenue. That's why I get a little emotional when I find out the State's been cheating for 20 years, especially the way they handle the counties.

But, also, as I understand it, in a 2009 report, New York State ranked last in affordable hospital admissions -- last. So our outcomes are so poor. What is going on in New York? And we've only got 20 seconds, but --

Mr. Howard. Just very quickly, I think there's also consensus that the amount of spending we put on health care does not automatically correlate to better outcomes. You know, so if you look at a scatter plot of State spending per enrollee, it's all over the map, and outcomes are all over the map, because there's an increasing body of research that says health behaviors, not access to care, not insurance, dictate long-term health outcomes. We just need to think about health differently.

Mr. Collins. And I couldn't agree more that there's no correlation between spending and outcome.

Thank you very much for your testimony.

Mr. Murphy. We now recognize the chairman of the full committee. Welcome back. Mr. Walden, you are recognized for 5 minutes.

Mr. Walden. Thank you, Mr. Chairman, and thank you for

conducting this oversight hearing.

I want to thank our witnesses today for your extraordinary testimony. It's very valuable in the work we're engaged in.

I want to focus on data and high risk, and especially to both the GAO and to the HHS OIG. Because my understanding is for 14 years running Medicaid has been on your high-risk list for a problem. What's behind that? Is that because CMS does not collect the right data to begin with?

Ms. Yocom. I think there's a couple of things behind it. One is the nature of the partnership itself, that by the time the Federal Government is reviewing expenditures, the expenditures have occurred, so that prevention-ability is --

Mr. Walden. That's always lacking?

Ms. Yocom. -- always challenging.

The second piece really is about data. You simply cannot run a program this large when you can't tell where the money is going and where it has been. And we need better data.

Mr. Walden. And so have you made recommendations to CMS to collect better data, and have they ignored those recommendations? Or what's the issue there?

Ms. Yocom. We have a report coming out in just a few days that might answer that question a little more fully, but I think Ms. Maxwell can now.

Mr. Walden. Well, feel free to go ahead and share it today if --

Ms. Maxwell. The IG has been focused on this area for quite some

time. We have followed the evolution of the national data and continue to push CMS to create a deadline for when they think that data will be available, specifically for program integrity reasons.

Mr. Walden. So one of the issues that's come up in the press is this issue of woodworking. Everybody's trying to count numbers here. And I like what you said about let's get to quality outcomes, but off that for a minute. So there's this issue of woodworking, how many people are eligible before that are being counted now as if they're new eligibles.

And my question is, do we know that answer? And, second, are there States that are getting reimbursed at a higher rate, as if we were paying for newly eligibles at what would be, what, a 95 percent rate now, when in fact those individuals were actually always eligible and the State should be compensated at a lower rate?

Do we know any data surrounding that, how many people are actually, quote/unquote, woodworking? Have States been reimbursed at a higher rate when they should have been reimbursed at a lower rate?

Ms. Maxwell. I can't speak to the working number specifically. I can tell you the IG has the same question that you have, and we have work underway to answer that exact question. So are States pulling down reimbursement for eligible beneficiaries as if they were in the newly eligible category --

Mr. Walden. Correct.

Ms. Maxwell. -- when, instead, they should have been enrolled in traditional Medicaid? And that work will be forthcoming.

Mr. Walden. Do you have a timeline on when you think you may have answers for us on that?

Ms. Maxwell. We have four States that we're looking at. The next two States probably in the next couple of months will be out, and then the other two probably later in the year.

Mr. Walden. Can you reveal what those four States are?

Ms. Maxwell. I can if you give me a minute.

Mr. Walden. Okay.

Ms. Yocom. And while she --

Mr. Walden. Ms. Yocom?

Ms. Yocom. -- is looking, we did issue some work that looked at this question, and we did identify some issues where it appeared that people were not accurately categorized by whether they received the 100-percent match or a State expansion match or their regular FMAP. We did identify problems there.

And one of the recommendations that is still outstanding in this area has to do with the fact that CMS adjusted the eligibility differences but then did not circle back and correct the financing that occurred. So we think those two things need to be related. If you identify an eligibility issue -- either way, if the matching rate is off, it should be corrected.

Mr. Walden. Yeah.

Ms. Yocom. CMS is starting to look at that, but --

Mr. Walden. It could be a big number. We don't know. But it's an important thing to get right.

I remember I spent about 4-1/2, 5 years on a community hospital board at a time when the Federal Government decided to go after virtually every hospital and allege billing misbehavior, shall we say, going back, I don't know, 8, 9, 10 years. And the threat to the hospitals was, we will use the RICO statute because you have engaged in criminal practice because of multiple cases.

And it just strikes me that they were willing to do that there. Everybody had to settle, because nobody wanted to go down that path. We know the government sometimes gets it wrong, but, oh, we'd never go after the government with RICO.

What is happening here with these States I guess is a legitimate question when we've got people that are aged, blind, disabled waiting to get on? Are we -- and a limited resource. And we don't have the data. That's what you're telling me, isn't it?

Ms. Maxwell. Yes. And I have the States. So we will have data on the four States, and they are Kentucky, California, New York, and Colorado.

Mr. Walden. Kentucky, California, New York, Colorado. And your timeline, again, to probably conclude your analysis?

Ms. Maxwell. The first couple will be probably the next month or two, and then the final two will be later this year.

Mr. Walden. All right.

Ms. Maxwell. We'll be sure to let you know.

Mr. Walden. And if we could do one thing with CMS to help you be able to do your job the way you want to do it, what would that be,

Ms. Yocom?

Ms. Maxwell. Oh, I hate to keep saying it, but it's got to be the data. We just absolutely need the data.

Mr. Walden. Ms. Yocom, same?

Ms. Yocom. Yeah, I would agree.

Mr. Walden. Okay. If there are specific items related to data, please get those to us. I'll be happy to work with the incoming CMS Administrator, and we will do our best to get you the data. Because it's important to all of us for our decisionmaking. And we know we have people waiting on the list, can't get access to care. And we've got to get the waste and the fraud out. We've got to get them off this risk list.

Thank you very much for your testimony.

Mr. Chairman, thanks for your leadership on this.

Mr. Murphy. The chairman yields back.

I have one more question I want to ask Mr. Howard. And this relates to trying to find some other ways of saving money and providing more effective care within Medicaid. And it has to do with more alternative payment models as a way to reduce costs. That being physicians, providers, hospitals are paid to take care of the patient, as opposed to a fee for service, which is every time someone shows up, you know, you bill them. It's sort of like paying a carpenter based upon how many nails he puts in a house. He'll put a lot of nails in that house.

Whereas, an alternative payment model, whether it is making calls

to the patient to check up on their medication, to remind them of their appointment, to counsel them, to keep them out of the emergency room, to get effective care, those sort of approaches.

So I'm thinking, in linking with the Medicaid amount, HHS estimated the improper payments from Medicaid amounted to 30 billion in 2015, with an error rate hovering around 10 percent. At the same time, studies like the Oregon Medicaid Experiment showed that Medicaid coverage does not necessarily result in better health outcomes, as we talked about before.

So what do you think about these alternative payment models as a way of saying that the skin in the game is also the physicians and hospitals, to make sure that they are doing all they can to keep the patients healthy?

Mr. Howard. Absolutely, I think that experimenting with these models is critical. You need the data to be able to understand who is the best provider. We talk a lot about waste, fraud, and abuse. That's certainly a big problem. But estimates from even people like Donald Berwick are that 20, potentially 30 percent of care is either ineffective or wasted.

And there are providers that we know are doing terrific jobs at a fraction of the cost; hospitals across the street from another hospital providing care more efficiently. If we had data transparency, we could encourage more competition among those across these payment models.

Mr. Murphy. Can you get us information on how you would see those

things worked out?

Mr. Howard. Absolutely.

Mr. Murphy. The committee would appreciate that.

Ms. DeGette, do you have a followup comment?

Ms. DeGette. I just had a couple comments, Mr. Chairman.

The first thing is that here's something we can agree on in a bipartisan way, is getting you folks the data that you need. So I'll just echo what Mr. Walden said. Whatever specific suggestions you have, let us know. And, also, I'm assuming that you need that staffing, that if we freeze your hiring, that's going to be a problem.

I just want to make a couple of comments about the Medicaid expansion, which is, first of all, a lot of people -- I keep hearing people today say that we really want to make sure that people who have chronic and severe diseases, like the videotape we saw, get services, and that's absolutely true. And then people on the other side keep talking about able-bodied adults.

And I would just point out that 80 percent of the people who are getting the Medicaid expansion are working. So, you know, they might be able-bodied adults, but they have jobs, and they were uninsured before because either their employers didn't offer insurance or because the insurance that they could get was too expensive. And so these people were going without health care, which, as Mr. Westmoreland and others said, that just increases the costs for everybody because of the costs of uncompensated care.

And if there's ways -- you know, I was just talking to Mrs. Brooks

about this. If there's ways that we can find efficiencies in the program -- all of us are for more efficiencies, and we're for delivering health care in a more cost-effective way, not just within Medicaid but within private insurance too. And this is something, again, I think that we could work in a bipartisan way to make this happen. But just to say, well, we shouldn't give the Medicaid expansion because these people are, quote, "able-bodied" adults is not understanding who's getting it.

I just want to close with an email that I got from my best friend from South High School in Denver, Colorado. We are not spring chickens anymore. And here's what my friend Lori Dunkley -- she sent this to me a couple weeks ago, without solicitation. She just sent it to me.

"I just want to add my story to others you are hearing about the Affordable Care Act. I was laid off during the recession and lost a lot of my retirement stability. Then, at age 54, I looked for a job for 3 years without success. I had no health insurance. Finally, I fell back on my journalism skills and landed work writing for several neighborhood papers. This has worked out fine, but only because of getting insurance through the ACA. I make very modest money, and so I qualify for the expanded Medicaid program. What a godsend. Since I am not yet Medicare age but too old for the job market, I don't know what I'd do without this help."

This is the people that we're talking about. So we have to figure out how we're going to give health care to the 11 to 12 million people who have gotten health care because of this Medicaid expansion. That's

what we're talking about.

Thank you, Mr. Chairman.

Mr. Murphy. The gentlewoman yields back.

And this will bring to a conclusion this hearing of the Subcommittee on Oversight and Investigations. I'd like to thank the witnesses and all members that participated in today's hearing.

I remind members they have 10 business days to submit questions for the record, and I ask the witnesses all agree to respond promptly to the questions.

Thank you so much for being here.

And, with that, this subcommittee is adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]