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OPPORTUNITIES TO IMPROVE HEALTH CARE

WEDNESDAY, SEPTEMBER 5, 2018

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:04 a.m., in Room 2123, Rayburn House Office Building, Hon. Michael Burgess, M.D. [chairman of the subcommittee] presiding.

Present: Representatives Burgess, Guthrie, Barton, Shimkus, Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Carter, Walden (ex officio), Green, Engel, Schakowsky, Matsui, Castor, Sarbanes, Schrader, Kennedy, Cardenas, and Degette.

Also Present: Representatives Walberg, Welch, and Dingell.

Staff Present: Mike Bloomquist, Staff Director; Samantha Bopp, Staff Assistant; Adam Buckalew, Professional Staff Member, Health; Daniel Butler, Legislative Clerk, Health; Karen Christian, General Counsel; Jordan Davis, Senior Advisor; Melissa Froelich,

Chief Counsel, DCCP; Adam Fromm, Director of Outreach and Coalitions; Ali Fulling, Legislative Clerk, O&I, DCCP; Theresa Gambo, Human Resources/Office Administrator; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Associate, Health; Ed Kim, Policy Coordinator, Health; Ryan Long, Deputy Staff Director; James Paluskiewicz, Professional Staff, Health; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Josh Trent, Chief Health Counsel, Health; Jacquelyn Bolen, Minority Professional Staff; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; Rachel Pryor, Minority Senior Health Policy Advisor; and Samantha Satchell, Minority Senior Policy Analyst.

Mr. Burgess. I call the Subcommittee on Health to order. I am going to ask our guests to please take their seats. And, again, welcome to everyone for the first September hearing of the Health Subcommittee of the Energy and Commerce Committee, the most productive subcommittee in the United States House of Representatives.

So today we are joined by a panel of witnesses. I will recognize myself for 5 minutes for an opening statement. We are joined by a panel of witnesses who are going to provide us testimony on a variety of topics and legislative ideas, ranging from initiatives to address drug pricing to reducing fraud at the Centers for Medicare and Medicaid Services to improving the care of children with complex medical conditions.

These bills cover different topics within healthcare, but there is a common thread that connects all. All of the bills in discussion drafts before us today have the aim to improve the access and the quality of care for America's patients and their families.

So, first, I would like to commend Representative Buddy Carter of Georgia for his hard work on legislation to prohibit gag clauses in Medicare and private health insurance plans. Gag clauses prohibit pharmacists from informing patients that paying in cash will result in lower out-of-pocket costs than the insurer's cost-sharing arrangement unless the patient directly requests such information.

The draft bill being discussed today is essential in both lowering drug costs for individuals and freeing the pharmacists to do what many consider would be the right thing, in fact, freeing the pharmacist to simply do their job. It would ban an employer and individual health insurance plans, in addition to Medicare Advantage and Medicare part D plans, from using gag clauses.

This bipartisan policy has been a shared priority for Mr. Carter and others on the committee for quite some time, and it was brought further to the forefront by the

administration's drug pricing blueprint that many of us attended a Rose Garden ceremony in May. While the gag clauses are already prohibited in Medicare, it is important that we protect consumers by putting this in statute and sending this bill to the President's desk as soon as possible.

Today, we are also considering several Medicaid bills and discussion drafts that will further prevent and investigate fraud and abuse in addition to increasing access for certain beneficiaries. H.R. 3891, introduced by Representatives Walberg and Welch, will improve the authority of the State Medicaid Fraud Units, which currently investigate provider fraud and patient abuse only in healthcare facilities and care facilities. According to the Health and Human Service Office of the Inspector General, Medicaid Fraud Control Units recovered almost $2 billion in fiscal year 2017. This legislation builds upon the success of these Fraud Control Units by broadening their authority to investigate and prosecute abuse and neglect of beneficiaries in noninstitutional or other settings.

Another discussion draft before us today will codify the Health Fraud Prevention Partnership, which will further enable our public and private institutions to combat fraud within the healthcare system.

Healthcare Subcommittee Vice Chairman Guthrie and Representative Dingell have introduced the EMPOWER Care Act, which will extend the Money Follows the Person Demonstration for an additional 5 years. This Medicaid demonstration, which was established in 2005, has enabled eligible individuals in States across our Nation, including Texas, to receive long-term care services in their homes or other community settings rather than in institutions such as nursing homes. Not only does this increase the comfort and quality of life for many Medicaid beneficiaries, but it has reduced hospital readmissions and saved money within the Medicaid program.

The final Medicaid discussion draft, the ACE Kids Act, is introduced by full committee Vice Chairman Barton and Representative Castor of Florida and has received substantial feedback from stakeholders and has been revised to reflect this increased input. The goal of this legislation is to improve comprehensive care for medically complex children through a State option to create a Medicaid health home specific for children. The bill will also increase data collection and add a requirement for the Department of Health and Human Services to issue guidance on best practices for providing care for this unique and complex pediatric population.

I do want to thank the members whose legislation we are considering today. They have put in a lot of time and effort and certainly as has their staff. They put this into the development and fine-tuning of the language. I look forward to hearing from our witnesses and having a productive discussion on these important public health initiatives.

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

[The prepared statement of Mr. Burgess follows:]

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

Mr. Green. Thank you, Mr. Chairman, for holding today's hearing on these bipartisan drafts and legislation to improve the delivery cost of healthcare in our country. In particular, I am happy to see that our committee will be considering H.R. 3325, the Advancing Care for Exceptional Kids, or ACE Kids Act. I am grateful to Representatives Barton and Castor for their commitment to the children with complex medical needs and their quest to improve the system of care provided to our Nation's most vulnerable population.

I am also proud to be a cosponsor of the ACE Kids Act. The ACE Kids Act aims to improve the delivery care for children with complex medical conditions served by Medicaid. It presents a great opportunity for us to implement better care delivery and payment models to support children and their families.

The current discussion draft will establish a Medicaid health home State option, specifically targeting children with medically complex conditions, and require the Department of Health and Human Services to issue guidance regarding the best practices for using out-of-State providers for children with medically complex conditions. States who accept this new home health option for children with medically complex conditions will receive an enhancement 90 percent Federal medical assistance percentage, FMAP, for the first eight fiscal year quarters after the option is adopted.

The discussion draft seeks to achieve three primary goals: improve the coordination of care for children; address the problems of fragmented access, especially when the necessary care is only available out of State; gather national data to help researchers improve services and treatments for children with complex medical conditions.

I also want to thank our stakeholders in my area in Houston, Texas, Children's Hospital -- I am glad to have Dr. Cook on the panel I think today, no, anyway -- and my

colleagues for moving this important legislation. Children with medically complex conditions require a lot of healthcare and generate significant cost. One study found that children with complex medical conditions who account for just over 5 percent of all children in Medicaid account for 34 percent of all Medicaid spending for children.

While the data is compelling, it is important not to reduce these children and their families to statistics. We must do a better job to ensure that all of these exceptional children get the care they need.

Children with medically complex conditions often have multiple illnesses and disabilities and commonly need to see a number of physicians and specialists. The necessary care often requires these special children to travel across State lines to see one of the small number of pediatric specialists for their conditions. Under our current system, parents of kids with complex conditions struggle to coordinate the intricate multistate care of their children. We need this legislation to make sure that this care is more coordinated and seamless for families. The discussion draft is an important step forward.

We must ensure that final legislation is robust and meaningful in accomplishing our shared goals of improving care and removing barriers for children with complex medical conditions. The ACE Kids Act now has 99 cosponsors, evidence that the health of our children is an issue above partisanship and brings us all together. I look forward to working with my colleagues to move the legislation forward and give our children the bright futures they deserve.

I support the other four bills in discussion draft being considered today. Many of these bills, including H.R. 3891, will expand the authority of State Medicaid Fraud Control Units to investigate and prosecute Medicaid fraud and abuse at noninstitutional settings, and the discussion draft to codify the Health Fraud Prevention Partnership are comments

and changes to current law and should receive wide bipartisan support.

I also support the discussion draft to prohibit the use of the so-called gag clauses in Medicare and private health plans that prohibit pharmacists from informing consumers that their prescription can be purchased at a lower price. While I support the gag clause discussion draft, I hope the committee will consider a deeper examination for rising costs of prescription drugs and consider what Congress can do to help seniors struggling to afford their medication.

And like you, Mr. Chairman, I want to thank our colleague from Georgia for bringing this up. This is a major issue with the seniors in my district in Houston and Harris County, Texas. I thank our witnesses for joining us today and look forward to hearing their testimony. Again, Mr. Chairman, thank you, and I yield back the remainder of my time.

[The prepared statement of Mr. Green follows:]

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

The chair recognizes the gentleman form Oregon, the chairman of the full committee, Mr. Walden, 5 minutes for an opening statement, please.

The Chairman. Well, thank you, Mr. Chairman, and thanks for all your great work in this subcommittee, that and the members. Again, today we are taking up bipartisan issues that really matter for people's health and the cost of healthcare. So I think it is a real another step forward.

So I traveled across Oregon over the last 5 weeks, covering 2,000 miles, 39 meetings, and 12 counties. You know, these issues come up, especially about healthcare, the cost, the quality. Accessing affordable healthcare is a real important issue, and it is one we consistently try to tackle in this committee.

Today, we hope to build on the bipartisan achievements of the committee under the leadership of Chairman Burgess and Ranking Member Green and review yet another slate of bills that can help improve our overall healthcare system. Now, among those we will examine is the one we have heard about already pertaining to gag clauses, which have been front and center in the national debate on drug prices.

Many patients who are struggling to afford costly prescription drug prices may not know that actually paying for their medications with cash is sometimes cheaper than using their health insurance. And with the high deductibles right now, you ought to be informed as a consumer. What is worse is some contracts prohibit pharmacists from telling their customers when this is the case.

So banning these so-called gag clauses has gained tremendous bipartisan support, rightly so, with these bills in both the Senate Finance and Senate Health Committees advancing without objection. We will review the draft legislation banning group health plans offered by employers and individual health plans as well as Medicare Advantage

and Medicare part D plans from limiting a pharmacist's ability to inform a consumer about the lower cost out-of-pocket price for their prescription.

Now, another practical bill will give the administration additional authority to better detect and stop fraud and abuse in the healthcare system. This has been an area of interest for both the Obama and Trump administrations, and it is supported by the committee's ranking member, Mr. Pallone, as well as myself. I look forward to our continued bipartisan work in this space.

We will also consider three bills in the Medicaid space that will help ensure the beneficiaries who are receiving the support and care they deserve in the setting that works best for them. Mr. Guthrie and Ms. Dingell's bill, H.R. 5306, for example, extend funding for the Money Follows the Person Demonstration Program, that is MFP Demonstration, in Medicaid.

The MFP Demonstration provides additional resources for State Medicaid programs to help ensure Medicaid patients needing long-term care are served in their communities or in their homes instead of at institutions. By many measures, the MFP Demonstration has been successful.

We will also consider a bill offered by Mr. Walberg and Mr. Welch, H.R. 3891, that will help improve the authority of State Medicaid Fraud Control Units, or MFCUs. Currently MFCUs are only allowed to investigate cases of provider fraud and patient abuse in healthcare facilities or board and care facilities. This legislation would broaden that authority so that these units could investigate and prosecute abuse and neglect of Medicaid beneficiaries in noninstitutional or other settings. Practically speaking, this bill will improve the ability of MFCUs to help protect vulnerable Medicaid patients from harm, while reducing the program's resources diverted by fraud.

And, finally, we will consider an amendment in the nature of a substitute to a

familiar bill authored by our full committee vice chair, Mr. Barton, and Representative Castor. That is H.R. 3325. Under current law, a health home State plan amendment cannot target by age or be limited to individuals in a specific age range. Centers for Medicare and Medicaid Services has reported that States have identified this inability to target health home services as an operational challenge. This bipartisan bill seeks to address that challenge by giving States a new option through the existing health home model to coordinate care for children with medically complex conditions.

So further discussion of this report and bill, I would yield the balance of my time to full committee vice chair, Mr. Barton, and thank our witnesses for joining us today.

[The prepared statement of The Chairman follows:]

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

Mr. Barton. Well, thank you, Mr. Chairman. You know, every now and then, we have a day when it reminds us why we ran for Congress. Today is one of those days. As Mr. Green in his opening statement just itemized, the ACE Kids Act, all the good things that it will do. So I don't need to go through that.

But we are going to have a hearing on that bill today among the other four bills, and hopefully, on Friday, we are going to mark it up. ACE Kids is a bill that has been in some shape or form before this subcommittee for about 6 years. The bill, the draft discussion today, is one of those rare things. It is totally bipartisan. Half of the cosponsors are Republican; half are Democrat. On this subcommittee, Mr. Latta, Mr. Lance, Mr. Guthrie, Mr. Bilirakis, Mr. Long, and Mr. Carter are Republican cosponsors. Mr. Green, Ms. Eshoo, Mrs. Dingell, Ms. DeGette, Ms. Castor, Mr. Kennedy, and Mr. Cardenas are Democratic cosponsors. We have half the subcommittee cosponsor this bill. It doesn't expand coverage; it doesn't increase spending. It makes it better, Mr. Chairman. It allows families to choose. It allows the care providers to coordinate, and you can go across State lines.

This is a really, really good bill. I hope we have a great hearing. I want to thank Rick Merrill from Fort Worth, Texas, for testifying in its favor, and I look forward to the discussion and the questions.

With that, I yield back, Mr. Chairman.

[The prepared statement of Mr. Barton follows:]

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

The ranking member of the full committee has not yet arrived, so we will delay his opening statement until his arrival.

But I do want to welcome and thank our witnesses for being here and taking time to testify before the subcommittee on these pending pieces of legislation. Each witness will have the opportunity to give an opening statement, and this will be followed by questions from members.

So, today, in order, we are going to hear from Mr. Hugh Chancy, owner, Chancy Drugs, and member of the board of directors of the National Community Pharmacists Association; and Mr. Curtis Cunningham, vice president, National Association of States United for Aging and Disabilities, and assistant administrator, Long-Term Care Benefits and Programs, Division of Medicaid Services, Department of Health Services from the State of Wisconsin; Mr. Matt Salo, the executive director of the National Association of Medicaid Directors; Mr. Rick Merrill -- always have to have a Texan on the panel, so welcome and thank you for joining us today -- Mr. Rick Merrill, who is the president and CEO of Cook Children's Health Care System in beautiful downtown Fort Worth, Texas; Mr. Derek Schmidt, the attorney general for the State of Kansas; and Dr. David Yoder, executive director of Member Care and Benefits, Blue Cross Blue Shield Association's Federal Employee Plan.

Again, thanks to all of you. We appreciate you giving of your time today to testify. Mr. Chancy, you are now recognized 5 minutes to summarize your opening statement, please.

STATEMENTS OF HUGH M. CHANCY, RPH, OWNER, CHANCY DRUGS, HAHIRA, GEORGIA, AND MEMBER, BOARD OF DIRECTORS, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; CURTIS CUNNINGHAM, VICE PRESIDENT, NATIONAL ASSOCIATION OF STATES UNITED FOR AGING AND DISABILITIES (NASUAD), AND ASSISTANT ADMINISTRATOR, LONG-TERM CARE BENEFITS AND PROGRAMS, DIVISION OF MEDICAID SERVICES, DEPARTMENT OF HEALTH SERVICES, STATE OF WISCONSIN; MATT SALO, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF MEDICAID DIRECTORS; RICK MERRILL, PRESIDENT AND CEO, COOK CHILDREN'S HEALTH CARE SYSTEM, FORT WORTH, TEXAS; DEREK SCHMIDT, J.D., ATTORNEY GENERAL, STATE OF KANSAS; AND DAVID YODER, PHARM.D., M.B.A., EXECUTIVE DIRECTOR OF MEMBER CARE AND BENEFITS, BLUE CROSS BLUE SHIELD ASSOCIATION'S FEDERAL EMPLOYEE PLAN.

STATEMENT OF HUGH M. CHANCY, RPH

Mr. Chancy. Chairman Burgess, Ranking Member Green, members of the subcommittee, thank you for conducting this hearing. My name is Hugh Chancy. I have been practicing community pharmacy since 1988. I am currently an owner of five community pharmacies in the southern part of Georgia, and I am here on behalf of the National Community Pharmacy Association. I currently serve as NCPA board of directors. NCPA represents America's community pharmacists, including owners of more than 22,000 independent community pharmacies. I am here today as a healthcare provider and a small business owner to present my experience with restrictive contractual language, often called gag clauses, that may result in patients being charged inflated prices for their medications.

My first experience with so-called gag clauses occurred in 2015, when one of my pharmacies served several patients on the city's employment-sponsored insurance, including the city mayor. The city had just changed insurance providers, and many of my patients experienced a rise in their prescription copays. Specifically, the mayor's copay of his medication went from roughly $7 to $26.

When I noticed this difference, I informed the mayor that it would be cheaper if he paid cash for his prescription or off of his insurance. The mayor was fortunate to have the political wherewithal to contact the right people in charge of the city's insurance plan and to complain about the changes and the oddities of paying more for the prescription on insurance than off. It goes without saying that many of the patients do not have similar avenues to voice their concerns about prescription drug coverage.

After the mayor contacted the plan, the plan consulted with their PBM, who issued us a verbal warning to my pharmacy for talking to the patient about the drug cost. The PBM stated that we are in violation of our contract for disparaging the plan when we discuss the cost of the drug off insurance. We were told that if our pharmacy were to do so again, there would be consequences and possibly exclusion from the PBM's network.

The common denominator in all community pharmacies' experiences with gag clauses is a strained relationship with PBMs. When a patient comes to the pharmacy and presents insurance, the pharmacy is bound by the terms of the patient's insurance and the PBM's rules. Put simply, pharmacists do not play a role in determining the patient's financial responsibility for prescription medications that they access through any prescription drug coverage.

If a patient does not present insurance or if a patient inquires directly, however, pharmacies can tell the patient alternative means to purchase a drug. When a PBM is

involved, however, communication with the patient becomes murky, because pharmacies are contractually required to charge the patient what the PBMs say when the prescription is processed.

I am often asked what gag clauses look like in contracts, but the answer to that question is not as simple as it may seem. The expression "gag clauses" is a misnomer, because what is most often being referred to are multiple contract provisions or requirements embedded in lengthy PBM provider manuals that include overly broad confidentiality requirements and nondisparagement clauses. Some PBMs have even included provisions that can be interpreted as prohibiting communication with news media, policymakers, and even elected officials.

Ultimately, these provisions have the effect of chilling a range of pharmacist communications with patients for fear of retaliation by the PBM. For this reason, the gag clause issue goes well beyond drug price disclosures. Further, community pharmacies like mine have very little negotiating power to strip these provisions out of their contracts.

As a solution to this problem, community pharmacies need a place to point into law that will allow for the free flow of information between them and the patients. NCPA supports the discussion draft that is the focus of this hearing. The draft is legislation to prohibit gag clauses in Medicare and private insurance by banning health plans from restricting a pharmacy's ability to inform customers about the lower cost, the out-of-pocket price for their prescription.

Additionally, NCPA appreciates the work that Congressmen Buddy Carter and Peter Welch have done in introducing legislation that would also meaningfully address contract provisions that prohibit or penalize a pharmacist from communicating different cost options to their patients.

Also, I was pleased to hear that CMS recently sent a letter to plan sponsors and Medicare explaining that any form of gag clauses in contracts is unacceptable. In addition, 25 States have passed legislation prohibiting gag clauses. These actions give pharmacists the ability to point to laws and rules that prevent PBMs from restricting free flow of information.

In conclusion, as Congress demands increased transparency in the prescription drug marketplace, this committee can provide a much needed stake in the ground to allow pharmacists to freely discuss drug costs with their patients. Providing the free flow of this kind of information is a step in the right direction to meaningfully addressing drug costs for Americans. Thank you.

[The prepared statement of Mr. Chancy follows:]

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

Mr. Burgess. Thank you, Mr. Chancy. Thanks for sharing your testimony with us.

Mr. Cunningham, you are recognized for 5 minutes to summarize your opening statement, please.

STATEMENT OF CURTIS CUNNINGHAM

Mr. Cunningham. Thank you. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to discuss Money Follows the Person Program.

In addition to serving as assistant administrator for Long-Term Care Benefits and Programs in Wisconsin, I am also the vice president of the National Association of States United for Aging and Disabilities, known as NASUAD, which is a nonpartisan association that represents administrators of aging, disability, and long-term supports and services in all 50 States, District of Columbia, and territories.

I am also designated as the Wisconsin disability director and serve on the National Policy Work Group for the National Association of State Directors of Developmental Disability Services.

I am honored to be here today to represent NASUAD and speak about Money Follows the Person and its impact on individuals that require long-term supports and services.

The MFP program, as it is frequently called, was first created by the Deficit Reduction Act of 2005 as a way to provide States with increased resources and flexibilities that assist in the transition of individuals from institutional long-term care settings to home and community-based services.

The creation of MFP gave States crucial tools to increase choices or options for individuals who receive long-term services and supports in accordance with the landmark Olmstead decision that mandates that States ensure that participants receive services in the most integrated setting based on their needs and their preferences. States began operating MFP in 2007, and between 2007 and 2017, 43 States transitioned over 75,000 individuals into the community.

MFP also results in significant cost savings. According to the national MFP evaluation, the average annual person's spending during the first year following the transition into the community declined by over $20,000 for older adults and people with disabilities and by over $48,000 for individuals with intellectual and developmental disabilities. All told, this has resulted in $1 billion in savings during the first year of transition alone for these individuals.

The evaluation also estimated that 17 States evaluated, roughly one-quarter of the older adults and one-half of the individuals with intellectual and developmental disabilities would not have transitioned without the support of MFP.

One of the reasons MFP provides an opportunity for deinstitutionalization for individuals who would not otherwise move into the community is due to the flexible services that this program provides.

MFP allows for supplemental services that are not covered through the standard Medicaid long-term services and supports, and provides opportunities for innovation to address some of the common barriers to community transitions. Some examples include, in Wisconsin, we funded community living specialists who review nursing home diagnostic data to identify people who indicate they would like to move into the community, and these community specialists assist them in that movement.

Nearly every State has identified lack of accessible affordable housing as a

significant challenge that can prevent community placements. In Tennessee, MFP funded a housing counseling and a pilot program to support bridge subsidies for individuals leaving institutions. Many States also use MFP funding to support programs that help beneficiaries gain and maintain employment, provide behavioral supports, provide outreach consultation with nursing facilities, and then also provide grants to Tribal entities to develop their own community relocation initiatives.

Critically, in Wisconsin, many other States use MFP funds to address waiting lists through diversion initiatives and expand available slots for their community-based waivers. States also use MFP to support Aging and Disability Resource Centers, which provide comprehensive information and referral services to keep people in the community. Finally, MFP also serves several States in their person-centered thinking and organizational thinking.

Finally, it is important to remember that, behind each of these statistics, there are real people. I would like to share one of those stories. In Delaware, MFP changed the life of a young mother of three who was a victim of a violent crime. She found herself in a nursing home due to her injuries, which left her paralyzed from the waist down. Prior to the crime, she was working, supporting her family; and while in the facility, she had no income. Being in the nursing facility was difficult for her and her children. While they could visit her in the facility, she was not at home to be part of their daily lives or put them to bed at night.

MFP was able to transition her home with her children and her mother as their caretaker after spending 8 months in the facility away from her children. After the transition, she continued to improve the quality of life. She is learning how to drive an adapted vehicle. Her intention is now to attend vocational rehab so that she can return to work to support herself and her children.

As you can see, these unique programs provide benefits to a wide range of people. Not only is it valuable to States. It is fiscally responsible and results in savings for the Federal Medicaid program. Lastly and most importantly, it improves the lives for the individuals we serve.

Although significant progress and success has been made in rebalancing HCBS, there is still a lot of work that can be done. Almost 60 percent of all Medicaid expenditures for long-term services and supports are delivered to older adults and people with physical disabilities or for institutional care.

On behalf of NASUAD, I therefore encourage Congress to continue this important program. Our members across the country have seen great value in the program, and the interventions have become more effective as the States experimented with and learned from innovative ways to provide these supports.

We encourage Congress to continue to work with NASUAD, our membership, and the broader aging and disability community to demonstrate the financial and human benefits of a program in order to secure the extension of MFP. Thank you for the opportunity to comment, and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Cunningham follows:]

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

Mr. Burgess. Thank you, Mr. Cunningham.

The chair now recognizes Mr. Matt Salo for 5 minutes to summarize your opening statement, please.

STATEMENT OF MATT SALO

Mr. Salo. Thank you so much, Chairman Burgess, Ranking Member Green, members of the subcommittee. My name is Matt Salo, and I represent the National Association of Medicaid Directors. These are the folks in each of the 56 States and U.S. territories who run the Medicaid program.

I want to briefly just frame Medicaid and what my members do before touching briefly on three of the bills that you are currently considering. I think it is important to recognize just how big, complex, and important Medicaid is. Medicaid covers more than 70 million Americans. We spent more than $550 billion last year, and it is roughly 30 percent of the average State budget and 3 percent of the Nation's GDP.

Medicaid is the backbone of the U.S. healthcare system, and in many ways and for many of the populations that we are talking about today, it is the backbone of America. And I think that it is important, despite the complexity of all the things we are talking about -- we are talking about some very, very different components of Medicaid today -- it is important to keep in mind the importance and the breadth of the things that we try to achieve. And arguably, I think Medicaid is clearly the largest and most important healthcare program, not only in this country but arguably in the world.

One way that I think it is important to also frame it is, you know, similar to the parable of the six blind men trying to describe an elephant and sort of only looking at what they can see and touch, if you look at any of the pieces today, you might think, oh,

well, Medicaid's a program for medically complex kids or Medicaid's a program for frail seniors or adults with disabilities. It is all of those things and many, many more.

My members, the State Medicaid directors, their job, no matter what State they are in, is to try to improve the healthcare system to deliver a better healthcare experience to the people that we serve while being responsible stewards of both State and Federal taxpayer dollars, and to do so in ways that are meaningful and relevant in the State and in the cultural community that they reside.

My members are driving significant complicated healthcare reforms to the delivery system of Medicaid and the broader U.S. healthcare system. We are driving sustainable payment reforms to try to bring Medicaid from a fee-for-service system into a value-based system. This is complicated. This is multisector. This is multiyear. This is difficult work, but it is critically important.

Three of the bills I want to touch on real briefly. We have talked a lot about the ACE Kids Act. This has been a very complex, a very fluid piece of legislation. As Chairman Barton has referenced, it has been around for at least 6 years now. I would just sort of -- I would hope that the message that we give is that if we want something like this to be successful, look to the example of CHIP.

CHIP was a program created in 1997 that sought to improve coverage and care for kids in this country. And the way that it evolved and the way that it was created and the way that it ultimately has become one of the most bipartisan and most successful programs that this committee has worked on is that it embraced two concepts, one of which is that if we want to make significant -- if we want States to make significant progress in areas like this, it has got to embody two principles: one, enhanced Federal support; and, two, increased State flexibility. Because no matter what we are looking at, the ways that States, from New York to Texas to California and everything in between,

their healthcare cultures, their healthcare systems are different, and it has to be cognizant and respectful of those differences as we are trying to provide the best possible healthcare, not to just to those kids but to everybody else that we serve. So, if we want this to be successful, we have to ensure that it is flexible, ensure that there is strong sustained Federal support, and I believe that we can get there.

Second, very, very briefly, Money Follows the Person. I can be very brief on this, because there is no question that this works. There is no question this is highly successful. There is no question this is incredibly important to continue not just for the short-term but for the long-term. I think we should be talking about how long can we reauthorize this for. Can we make this permanent? And that is one of the things that we always talk about is, if we find something that works, let's make it permanent. And I think clearly this works, and clearly this is an important part of our conversation.

The final piece on the Medicaid Fraud Control Units. Very important conversation, especially in light of increased movement from institutional to noninstitutional. But I would urge you also to think more broadly about how we are approaching program integrity. Program integrity is not just fraud or abuse or safety. It is those things, but it is more.

The Fraud Control Units exist within the Attorney General's Office, not within Medicaid. We have to make sure that if we are going to invest in targeted areas like this, which we should, we have to make sure that we are coordinating the efforts across the system. And I have got a couple of other ideas, in terms of things that we could do to improve this.

And then, just finally, I will say I would be happy to also talk about some of the other possible reforms in Medicaid that my members would love to see to help them in their efforts to improve the Medicaid program for taxpayers, for beneficiaries, for

providers, and for all of us. So I would be happy to answer questions at the end, and thank you for having me.

[The prepared statement of Mr. Salo follows:]

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

Mr. Burgess. Thank you, Mr. Salo. Thanks. Just a historical note since two of you now have brought up the Deficit Reduction Act of 2005. It was late in December of 2005 when this committee passed the Deficit Reduction Act. Mr. Barton was chairman at the time. And now all these many years later to hear about an enduring part of that that actually did perform as indicated, it is gratifying. It was a big bill with a lot of moving parts, but I am grateful that that one did deliver.

Mr. Merrill, we are grateful to have your presence on the subcommittee dais today. You are recognized for 5 minutes to summarize your opening statement.

STATEMENT OF RICK MERRILL

Mr. Merrill. Thank you very much. I thank Congressman Barton, Chairman Barton, Chairman Burgess, and Ranking Member Green. You guys did such a great job describing ACE Kids and the importance of it and the benefits of it. I am not sure I could top that, but I will do my best to equal this today.

Chairman Burgess, Ranking Member Green, and members of the subcommittee, I am Rick Merrill, the president and CEO of Cook Children's Health Care System in Fort Worth, Texas, and I am chair of the Children's Hospital Association Board of Trustees. On behalf of my hospital system, our CHA member institutions and the patients and families we serve, thank you for the opportunity to speak in strong support of H.R. 3325, the Advancing Care for Exceptional Kids Act of 2017, or ACE Kids, as we refer to it.

We are extremely grateful to Representatives Barton and Castor for their leadership on behalf of children, as the original cosponsors of this bipartisan legislation, and to the nearly 100 additional House Members who have joined them as cosponsors. We also wish to thank the leadership of the Energy and Commerce Committee and the Health Subcommittee for devoting considerable time and resources to working towards solutions in this important area.

In addition, we want to recognize Chairman Burgess and Ranking Member Green for their longstanding leadership and support of the Children's Health Insurance Program and the recent reauthorization of the Children's Hospital Graduate Medical Education Program, which was passed by the Senate last evening. Thank you for that.

Last year, Cook Children's treated children from more than 35 States, recorded nearly a half a million child visits in our 60 pediatric specialty clinics, 240 visits in our

Mercy Department and Urgent Care Center, and registered over 11,000 inpatient admissions. With over 1.5 million patient encounters a year, Cook Children's provides comprehensive and coordinated care across our fully integrated system, including home health services and a health plan which enrolls over 100,000 Medicaid children, many of whom have serious disabilities.

For many years now, we have taken care of some very sick kids, and I think we have done a good job in our part of Texas, but I am here today to tell you that we could and should to do better. Medicaid covers over 37 million children. A small percentage of these kids have complex medical conditions requiring ongoing and specialized care. These children have diagnoses that are multiple and varied, from cerebral palsy to cystic fibrosis to congenital heart disease and even childhood cancers. They typically are under the continuous care of multiple pediatric specialists and require access to specialized care and additional services, often from outside their home State. Additionally, their care accounts for a drastically disproportionate percentage of Medicaid spending on children.

Behind each of these data points is a real child and family, families like the Beckwiths. Alex and Maddy Beckwith of Keller, Texas, are some of the most remarkable, kindest 14- and 4-year-olds that you could hope to meet, but they both also suffer from mitochondrial disease, along with other health issues. Mitochondrial disease is a serious condition without a cure. It requires lifelong medication and therapy.

Due to their conditions, Alex and Maddy, their care is complex and ongoing. And so they actually have become like family members to the staff at Cook Children's. They see 15 specialists between them and require major interventions to remain medically stable. The ACE Kids Act is about improving care for children like Alex and Maddy by expanding access to patient-centered pediatric-focused coordinated care tailored to their

unique needs. The ACE Kids Act would modify Medicaid's existing health home option to give States the ability to implement health home specifically targeting children with complex medical conditions.

These new pediatric health homes would follow national guidelines in implementing a care plan for the medically complex child, coordinating care from providers, such as physicians, children's hospitals, specialized hospitals, nonphysician professionals, and home health and behavioral health providers. These homes will help families manage the challenges associated with their child's care while improving quality of care for the children enrolled.

Participation will be completely voluntary for these children. Families, healthcare providers, and the pediatric health homes will work within the existing State's Medicaid program, including those States with Medicaid managed care. The focus of ACE Kids is creating opportunities for providers, plans, and States to collaborate to provide the best quality of care for these children.

The ACE Kids Act is also about using existing Medicaid resources more efficiently. A large and growing body of research shows that coordinating care for people with chronic conditions can, indeed, reduce spending. The potential cost savings the ACE Kids model could produce have been demonstrated through projects supported by the Center for Medicare and Medicaid Innovation. The CMMI Coordinating All Resources Effectively Award, that is the CARE Award, implemented care coordination programs serving 8,000 children with medical complexity. Collectively, the 10 hospitals participating in the CARE Award, including Cook Children's, reduced emergency department visits by 26 percent, reduced inpatient stays by 32 percent, and in just the full year of operation coordinating care for these children, care ultimately reduced overall Medicaid costs for these children 2.6 percent. Additionally, prior independent analysis

of the ACE Kids Act conducted shows substantial potential long-term savings in the Medicaid program.

The ACE Kids Act will create a data and quality framework to drive improvement in care and further reduce cost. The bill outlines a definition of children with medically complex conditions who will be eligible to participate in the program and includes standardized data reporting requirements related to their care. This information and sharing does not exist in Medicaid today. There is currently no national data available to inform our policies for children with medical complexity.

Since its original introduction in the 113th Congress, the ACE Kids concept has continued to evolve, based on extensive stakeholder feedback. This bill reflects the results of this collaborative process and has received support from many organizations dedicated to children's health.

In closing, the ACE Kids Act will have an opportunity to help children and their families who face some of the most significant health challenges. On behalf of children's hospitals nationwide and the thousands of children and families that we care for at Cook Children's, we look forward to working with Congress to pass ACE Kids this year and advance solutions that improve care for all kids. Thank you.

[The prepared statement of Mr. Merrill follows:]

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

Mr. Burgess. Thank you, Mr. Merrill.

Mr. Schmidt, you are recognized for 5 minutes to summarize your opening statement, please.

STATEMENT OF DEREK SCHMIDT, J.D.

Mr. Schmidt. Thank you, Mr. Chairman, Ranking Member Green, thank you all very much for conducting this hearing today. I want to particularly thank Representative Walberg and Representative Welch for their leadership in bringing forward H.R. 3891.

It is a bipartisan bill not only on your side but on ours, and I testify today wearing two hats: first, as the immediate past president of the National Association of Attorneys General, the nationwide organization of all 56 State, territory, and District of Columbia attorneys general, a nonpartisan organization. To the extent my testimony conveys information that is in the two National Association letters submitted with my testimony, it is testimony on behalf of the organization. To the extent I may testify on other matters, for example, illustrate points with experiences from Kansas, it is my testimony as the State of Kansas attorney general.

A quick word about the -- I would slip into the jargon, Mr. Chairman, the MFCUs, the Fraud Control Units, but we tend to call them MFCUs. Title 19 of the Social Security Act, of course, requires every State to have one or obtain a waiver. Forty-nine States, North Dakota being the exception, have a MFCU, as does the District of Columbia. None of the territories does.

So there are 50 of them nationwide. Of those 50, 44 are housed within the Office of the Attorney General. The other six are housed at another location in State

government, but, of course, none can be housed, by law, within the Medicaid program itself. The whole point in Congress' enactment is to have an outside entity watching, the fraud fighters, the abuse fighters outside connected with, coordinated with, communicating with, but separate from the program itself.

Kansas is one of those States where the MFCU is housed in the Attorney General's Office. These are valuable programs from a State perspective because, like the Medicaid program itself, the cost is shared. The ratios are slightly different. It is a 75-percent Federal/25-percent State mix on the cost. That is a tremendous value-added proposition from the standpoint of being able to detect, investigate, and prosecute Medicaid fraud or the abuse of Medicaid beneficiaries. And so they are very attractive and, therefore, robustly used among the States, including in Kansas.

HHS OIG data shows that in fiscal 2017, the total recoveries nationwide from the MFCUs were about $1.8 billion, a little under $2 billion, and the total number of criminal convictions were about 1,500, give or take. Of that number, about 370 of those 1,500 criminal convictions were patient abuse convictions as opposed to fraud against the program convictions. And it is that distinction between fraud and abuse investigations, prosecutions, and efforts to detect that is the subject of H.R. 3891.

The distinction is important. I don't know the historical reasons for it. I suspect staff does. But for whatever reason, when Congress enacted the provisions in title 19, it drew a jurisdictional distinction between the ability of a Medicaid fraud control unit to address fraud, an effort to steal public money from the Medicaid program, and the authority of a MFCU to address the abuse of patients, whether it is physical or financial or sexual or whatever sort of abuse it might be.

And to boil it all down, the net is cast wider statutorily in terms of our ability to go after fraud than it is in terms of our ability to go after patient abuse. In a phrase, we can

essentially go after fraud wherever we find it, but with respect to patient abuse, we can only go after it when we find it in what the statute calls a healthcare facility or in some States, at a statutory option, a board and care facility, in other words, in an institutional setting.

We cannot use those MFCU assets to detect, investigate, prosecute patient abuse cases in a noninstitutional setting. And obviously, when you lay that alongside the tremendous growth in HCBS services, home healthcare delivery services outside of an institution, that disconnect, the problem with that becomes obvious.

So consider, for example, our folks, for example, in Kansas investigating a home healthcare fraud, a PCA fraud sort of circumstance, and we are at a nonresidential or noninstitutional, in a residential setting for the purpose of figuring out where the money went, and we discover evidence of abuse or neglect of the patient. We can no longer use those MFCU assets to pursue the investigation and prosecution of the patient abuse or neglect, even though we can continue to pursue the investigation and prosecution of the financial fraud. We don't think that makes any sense. And that is precisely what H.R. 3891 is designed to collapse, to allow us the broader scope with respect to both.

This is not just an academic point. In my written testimony, I highlight some cases from Kansas, where we have prosecuted serious physical or other abuse against patients in an institutional setting. We have cases where we have not been able to proceed because we are in a noninstitutional setting. We functionally, in Kansas at least, we go beg, borrow, and plead for a local police department to please take up the cause, or a local prosecutor. And we just don't think that makes any sense from a policy standpoint in today's healthcare delivery method.

So we would encourage the enactment of H.R. 3891, both as our association and as myself. I would be delighted to answer any questions. And I would just end where I

started. From our vantage point, like you, most of our members, not all of our members but most of our members are elected officials. We are Republicans, Democrats, and sometimes other, and there is no daylight on this issue among our members.

The first of the two letters that reflect NAAG policy had 38 signers. It was led by Attorney General Jepsen from Connecticut and myself, a Democrat and a Republican. The second had 49 of our 56 members. And remember, there are only 50 MFCUs. Forty-nine signed on, and it was led by Attorney General Jepsen and myself, Attorney General Donovan from Vermont, a Democrat from Vermont, and Attorney General Hunter, a Republican from Oklahoma. So we are all behind this, and we are grateful for your time.

[The prepared statement of Mr. Schmidt follows:]

******** INSERT 1-5 ********

Mr. Burgess. Great. Thank you, Mr. Schmidt.

Dr. Yoder, you are recognized for 5 minutes to summarize your opening statement, please.

STATEMENT OF DAVID YODER, Pharm.D.

Dr. Yoder. All right. Thank you, Mr. Chairman. First, I would like to thank both Chairman Burgess and the Ranking Member Green for their leadership in holding today's hearing and providing an opportunity to discuss key ways to improve healthcare.

My name is David Yoder. I am the executive director, Member Care and Benefits at the Blue Cross Blue Shield's Federal Employee Program. BCBSA is a national federation of 36 independent community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one in three Americans.

Blue Cross and Blue Shield companies offer quality healthcare coverage in all markets across America and participate in all Federal insurance programs. BCBSA, through the FEP, administers health insurance to approximately 5.4 million Federal employees, retirees, and their families. We are committed to high-quality affordable coverage for all, regardless of preexisting conditions.

Today I am going to address a couple areas. One is how BCBSA and its member companies are working to reduce fraud and abuse and the need to eliminate gag clauses related to prescription drugs. Fraud and abuse is an essential step to ensure the affordability of healthcare and addressing, reducing, and, to the extent possible, preventing the opportunity for fraud and abuse.

BCBS companies are diligent in working to stay ahead of fraud and abuse. The

BCBSA National Antifraud Department is dedicated to the support and promotion of BCBSA's antifraud efforts nationwide, including for the FEHBP program. This effort includes direct investigative support of local Blue Cross Blue Shield special investigative units, coordination of multiplan investigations, working with Federal and State law enforcement, and providing subject-matter experts to BCBSA's Office of Policy and Representation, the media, and the government entities.

Among various governmental efforts, the Federal Government established the Healthcare Fraud Prevention Partnership, HFPP, to improve the detection and prevention of healthcare fraud. BCBSA and several of our member companies are active participants in the HFPP. We support the HFPP and Congress' desire to establish explicit authority for HFPP and its activities. As Congress takes steps to codify the HFPP charter, we recommend improvements to help the partnership fulfill its objectives, which were in my submitted written testimony.

Turning to gag clauses, BCBSA does not support the use of gag clauses and is unaware of any Blue Cross and Blue Shield company or contracted pharmacy benefit managers to have gag clauses in place with pharmacies. We commend CMS for taking a tougher position on gag clauses and support legislation to ban gag clauses and any prohibitions on allowing pharmacists to make information and cost savings known to the member at the point of sale.

To the extent that some of the industry includes such clauses in their contracts, consumers may be deprived of information that will help them make prudent decisions when paying for prescription drugs. With this in mind, we would also encourage pharmacists to advise patients on generic substitution and alternative medications, so long as this is done in direct communication with the dispensing physician.

Full transparency is critical for consumers to have the necessary information to make choices that work best for them. It is also important that pharmacists advise consumers to consider the impact of not using insurance coverage to pay for their prescriptions. While certain beneficiaries might pay lower out-of-pocket costs on a given prescription, drugs purchased outside the insurance benefit in most cases will not count toward the beneficiary's deductible or maximum out-of-pocket limits, which may reduce the value of their insurance coverage.

RPTR MOLNAR

EDTR SECKMAN

[11:00 a.m.]

Dr. Yoder. That is why we support elimination of gag clauses. We believe that pharmacists should also inform consumers about the potential risks of not using their drug coverage so they can make more informed decisions.

In closing, BCBSA applauds the committee for taking on these important issues as it is critical that all stakeholders work together to ensure the affordability of healthcare for all Americans. We support these efforts to drive the healthcare system to higher quality, lower costs, and improve access to care for everyone.

In line with these goals, we urge Congress to continue its efforts to ensure that people have timely access to safe, effective, and affordable cutting-edge prescription medications when they need them. Achieving this important goal will require the public and private sectors to collaborate to develop solutions that benefit patients and the entire healthcare system. Thank you for the opportunity to testify today and your leadership in seeking opportunities to improve healthcare. And I look forward to taking any questions. Thank you.

[The prepared statement of Dr. Yoder follows:]

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

Mr. Burgess. Thank you.

Thank you, Dr. Yoder, and thanks to all of our witnesses for your testimony. So we will move into the question-and-answer portion of the hearing. And I would actually like to defer my questions until later in the hearing and recognize the vice chair of the full committee, Mr. Barton of Texas, 5 minutes for questions, please.

Mr. Barton. Thank you, Mr. Chairman, I am very honored and flattered to take your question time at this time. I sincerely mean that.

First, I want to ask unanimous consent, Mr. Chairman, to place into the record statements of support for the ACE Kids Act. We have almost two dozen national groups that are supporting the draft bill in its current form, and I would like to put that in the official record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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

Mr. Barton. Thank you, Mr. Chairman.

Mr. Merrill, I want to thank you for coming up from Fort Worth for your testimony. I want to thank you for all the years you and your national group that you are the president of this year have supported us and helped us to refine the bill. Can you tell the subcommittee -- and I don't think you said this in your opening statement -- what percent of Medicaid-eligible children meet the eligibility requirements of the ACE Kids Act?

Mr. Merrill. I would have to probably get that specific number for you or percentage for you. It is definitely a small percent.

Mr. Barton. I am told it is around 1 or 2 percent.

Mr. Merrill. That is close to the number. I just wanted to make sure I stated an accurate number.

Mr. Barton. All right. This is a friendly hearing. We don't require total specificity.

Mr. Merrill. Just want to answer it as best I can and correctly.

Mr. Barton. All right. Now, to the best of your knowledge, this small percentage of Medicaid-eligible children that would qualify for ACE Kids, what is a seat-of-the-pants estimate about the cost to Medicaid by that 1 or 2 percent?

Mr. Merrill. Yeah, again, I would have to get the number for you. I don't have the number off --

Mr. Barton. If I were to throw out 30 percent, would you strongly disagree with that?

Mr. Merrill. Percentagewise, I think it is up close to 40 percent.

Mr. Barton. Forty percent.

Mr. Merrill. In terms of an actual dollar amount, I would have to get that

number.

Mr. Barton. So here we have a situation where, thankfully, of the 37 million eligible Medicaid children, there are not very many that have these complex medical conditions. But for those that do, they take a hugely disproportionate share of the cost.

Mr. Merrill. That is correct.

Mr. Barton. So, if we can do something that provides better care, more comprehensive care, and actually saves money, that is a win-win. Would you agree with that?

Mr. Merrill. I would absolutely agree with that. I think everyone does win. I would say all in, all win, frankly, on ACE Kids. I think that will matter greatly for these families, these children. It will matter to the State programs in saving Medicaid dollars and improving care and outcomes for these kids, and, as I said, all in, all win.

Mr. Barton. Are you aware of any provider organization that actually provides services, whether it be doctors, therapists, hospitals, anybody in this country, that opposes the ACE Kids Act?

Mr. Merrill. Is -- I am sorry?

Mr. Barton. Are you aware of anyone that is actually providing services to these eligible children that opposes this bill?

Mr. Merrill. I think that any time a new bill or approach to care is introduced, folks will -- organizations will have concern: What does it mean for me?

And based upon the original draft of 3 years ago and all of the work that has gone to try and address some of those concerns, the current bill, as it is reflected, I do believe, addresses most, if not all, of those concerns from those who might not originally have been fully in support of.

Mr. Barton. You can tell that you have been president of a national organization.

I am throwing you softballs, and you are being very ecumenical. The answer is no, there is no national organization that provides care -- now, there are some opponents but not of the people that are providing the care. To my knowledge, there are none.

Mr. Merrill. Fair enough.

Mr. Barton. Now, I want to ask Mr. Salo, you have mentioned two principles that legislation that actually works should have. You mentioned flexibility. Does ACE Kids have flexibility?

Mr. Merrill. It absolutely does.

Mr. Barton. I am asking the Medicaid director.

Mr. Salo. I got this one. I want to be careful about not spending too much time speaking to the actual structure of the current version because, as we have said, this legislation has evolved significantly over time. But our reading of the current version does seem to allow for greater flexibility. I think previous versions seem to say that, you know, States that were heavily invested in managed care as a delivery mechanism would actually get carved out, wouldn't be able to take advantage of this.

Mr. Barton. It is voluntary on a State basis --

Mr. Salo. If it is driven by the State, if it allows a State either that is heavy managed care or managed fee-for-service, like in a Connecticut, or something in the middle like Massachusetts with ACOs, as long as it allows the State to be able to design that in a way that meets not only the delivery system in their State but also meets the needs of the patients in that State.

And I think one of the other key issues is trying to get a handle on exactly how you define the population that is affected. You know, as Mr. Merrill said, there is no Federal definition of this, and so the question is, are you talking about, you know, 2 million kids? Are you talking about 50,000 kids? You had a research that talked about 8,000 kids and

how that was effective. It is going to be important to allow this to be flexible enough for the State to figure out, how can we make this work? Because if it creates silos within what a State is trying to do, that is going to create conflict, and that is not sustainable.

Mr. Barton. Mr. Chairman, my time has expired. Next time I would ask unanimous consent if I could ask the question and then answer it myself so that I could make sure I get the right answer I want.

Mr. Burgess. You usually do.

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

Mr. Burgess. Thank you. Thanks to the vice chairman. The chair now recognizes the ranking member of the subcommittee, Mr. Green. I would ask just 5 minutes for your questions, please

Mr. Green. Thank you, Mr. Chairman.

And I am following my friend Joe Barton that we would all like to be able to answer our own questions.

So, thank you, thank the whole panel for being here today.

Mr. Chairman, I would like to ask unanimous consent request on behalf of Ranking Member Pallone entered into the record letters from the Medicare Payment Advisory Commission, MedPAC, and Medicaid and CHIP Payment Access Commission, MACPAC, concerning their request for legislation to ensure both commissions can access drug rebate data for their respective analysis. Ask unanimous consent.

Mr. Latta. [Presiding.] Without objection, so ordered.

[The information follows:]

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

Mr. Green. Thank you, Mr. Chairman.

Mr. Merrill, thank you for being here today and sharing your expertise as a leading children's hospital, and, of course, you know where I am from. I have been involved with Texas Children's Hospital since I was a young State legislator in the seventies, but Cook Children's Hospital, I am glad my family hadn't had to take advantage of the Cook Hospital to treat out-of-State patients. In fact, in your testimony, you know that Cook Children's treated children from more than 35 States last year.

As you know the State-by-State nature of Medicaid program has made it difficult to coordinate care across State lines. The same State innovation and flexibility that makes Medicare/Medicaid able to respond to unique needs of the State's population can be the characteristics. I am hopeful that ACE Kids Act will help provide Cook Children's overcome this issue and ease some of the burden families are facing today when they are trying to coordinate your child's care. Would you please discuss difficulties that may arise when you are providing care for a medically complex child from out of State?

Mr. Merrill. Yes, there are, as most of you know, some States that do not have children's hospitals or some of the high-level care that is offered in some of the other States. And so, as a result, we do get referrals, as I mentioned, from a number of States. That is true for Texas Children's; that is true for a number of children's hospitals.

I would give you probably two examples. We had one particular patient that was referred to us from a neighboring State that did not have the high-level children services for bone marrow transplant services, and it becomes a negotiation and a long drawn-out discussion with the Medicaid program in those States. They can last -- those discussions can last anywhere from 2 weeks to 3 months. And in this particular case, it took well over 2 months for us to get this patient approved for the bone marrow transplant that they needed.

There is another example of a patient from up in the Midwest area who was referred to Cook Children's for some services that we offer that only a couple of other children's hospitals offer. It is a medically complex child, and it took us 3 months to negotiate a single case agreement. And in the end, we were never able to reach an agreement, and we do not know what happened to that patient.

So it puts at risk the health of these patients. The frustration, the anger from these parents, who really want to care for their kid, and certainly us on the receiving end, who want to deliver that care, all of us become very frustrated. And it is very difficult; it is time-consuming. And I believe that ACE Kids will allow us to streamline a lot of that effort so that we can get these kids quicker, sooner, to the right kind of care that they need.

Mr. Green. Thank you.

Mr. Salo, how can we disseminate, encourage more widespread adoption of best practices and care for children with medical complexity more effectively across State lines?

Mr. Salo. So I think that is a key function that our organization can provide, working in close tandem with CMCS, with Center for Medicaid and CHIP Services. I think we have acknowledged that in the case of, when you are talking about patients who are crossing State lines and dealing with jurisdictional issues like that, there is clearly a need for additional best practices, additional guidance, additional tools to make that work well. And I think we have been open in conversations with my colleagues here, as well as our friends at HHS, about how can we do that, how can we figure out what works, both in terms of -- well, it is mostly, I think, finding that balance between, how do you make the process as easy as possible for the family while also making sure, you know, that the cross-jurisdictional issues are respected and that we are not obligating an individual State

to another State's decision or to individual providers who are, you know, setting up a silo that perhaps is not in the best interest of the population as a whole?

I think we can get there. I think there is a lot of potential for best practices in this, absolutely.

Mr. Green. Mr. Chairman, I know I am out of time, but I want to thank our witnesses. And this is a piece of legislation -- I think it is important that we move on this. Thank you.

Mr. Latta. Well, thank you very much. The gentleman's time has expired and yields back.

And the chair now recognizes himself for 5 minutes.

Mr. Cunningham, if I could start with you. While preparing for today's hearing, I heard from a local, independent-living organization in northwest Ohio asking for my support of the EMPOWER Care Act. The center connects people with disabilities to programs and services that are necessary to achieve and maintain independence in the community.

Without the Money Follows the Person, the MFP, Program, this center would not be able to hire staff to serve as transition coordinators and help individuals maintain independence outside of nursing facilities. Since 2008, this local program has achieved 524 total transitions, and 77 percent of those transitions have reached 365 days of independence.

Furthermore, in the State of Ohio in 2017, the average annual Medicaid savings for individuals utilizing MFP was over $39,000 per person. How have the cost savings associated with the program been utilized for the benefit of your State Medicare population?

Mr. Cunningham. Sure. So, Wisconsin is fortunate to have a very robust home

and community-based services program, and the way we have gotten there is through utilizing MFP and other resources to create some innovative practices. And we look at that and some of the practices, like housing counseling and other things that we developed through MFP, we have now included in our HCBS package of benefits because they have been shown to be proven effective in making sure people relocate.

And, you know, we see a reduction in cost. The average nursing home cost in fee-for-service is about $5,256 per month. Our family care and HCBS programs have a PMPM of $3,200. So it is in our interest.

MFP has also allowed us to, as we have expanded our HCBS services, to move people off the waitlist, and we are on the cusp of eliminating the waitlist for all of the people that need HCBS services.

Mr. Latta. Let me follow up. Are there any challenges the States face during the transitions that could be better addressed in reauthorization?

Mr. Cunningham. You know, I think the flexibility, again, is very important. I think housing continues to be a challenge. The housing counseling that is done, we developed a database of available 811 housing vouchers through MFP. So I think just continuing the funding, I think the certainty of having MFP is also important because some of these programs that we have going, take, you know, 2, 3 years to test out, to see if they are cost-effective in moving forward. So I think that is what I would ask for now is to make sure this there is certainty there so we can keep some of these innovative practices going.

Mr. Latta. Well, thank you.

Mr. Salo -- am I pronouncing that right, is it Salo?

Mr. Salo. Salo.

Mr. Latta. Salo?

Mr. Salo. Yeah, rhymes with "halo."

Mr. Latta. Let me follow up, because in addition to the letter of support I received for the MFP Program, I also heard from an Ohio mother who has great concerns with the program. She cited that MFP forces individuals with severe and profound intellectual and developmental disabilities into a one-size-fits-all care model rather than allowing the patients and families to choose a care setting that best fits their own medical needs.

Do you believe there are gaps in the program that should better account for individuals with complex medical and behavioral needs?

Mr. Salo. I know that there are differences in philosophy about the nature of the spectrum of institutional versus non-institutional care and some who come down along the lines of the least restrictive, as Olmstead is always better, but I think that, from the State perspective, it is really critical to be mindful and respectful of the individual or the family decision to figure out what is the setting that is best for them.

In most cases, that will be in their home or in their community. But we certainly know there have been lots of conversations over the years with -- so, for example, parents of adult children with severe developmental or intellectual disabilities, whose kids have been in settings for a long time and are very fearful about having that changed. I think we need to be very, very mindful about not abruptly changing settings for people who are not ready for that.

But I think for most populations that we serve in the long-term care arena, the clear and undeniable trend is to move away from institutional and towards home and community-based settings.

Mr. Latta. Thank you very much. My time is expired. And the gentle lady from California is recognized for 5 minutes.

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

And I want to thank all the witnesses today for being here. I am pleased that we are hosting this hearing to discuss important opportunities in Medicaid and potential ways to improve transparency in our healthcare system.

I want to follow up on the EMPOWER Act. It is really a strong example of the importance of supporting Medicaid. The Money Follows the Person, MFP, is particularly important to seniors in institutional settings, such as nursing homes, who may be seeking care or services while still being surrounded by familiar faces and places.

And I think we all understand how important it is to look at this somewhat individually too, that there is not a one size fits all here as we move forward. And I really believe that each of us understand the concept of how important it is. And I also believe there are challenges here too.

I am interested also to hear more about the changes being made to the institutional residency period requirement. I understand that it will be decreased from 90 days to 60 days. How do you think changing the requirement will impact beneficiaries of the MFP? Mr. Cunningham?

Mr. Cunningham. Changing from 90 days to 30 days for the --

Ms. Matsui. Ninety days to 60 days. That period requirement.

Mr. Cunningham. So -- I am sorry. Could you repeat that?

Ms. Matsui. Okay. There are changes being made to the institutional residency period requirement. It will be decreased from 90 days to 60 days. I understand that that will give a lot more flexibility and allow other patients to be able to be involved in this. Is that correct?

Mr. Cunningham. Yes. Yes, that is correct.

Ms. Matsui. Okay. Now, there have been multiple studies showing the MFP

program can result in significant cost savings to States. And I think it is really important that Mr. Salo noted that the program expired in 2016, which forced States to scale back the program. And I am really concerned that this may have had unfortunate consequences for States and patients. Can you give me some examples here, with the challenges that might have occurred here?

Mr. Cunningham. Yeah, so, as I mentioned, as many of the programs that are ongoing, like our nursing home community specialists, as many States are running out of grant funding, they are having to wind down those programs. And that is impacting their ability to have those innovative processes to relocate people.

So I think a number of States have actually already expended their full grant amount, and I think in 2020 is when the full expenditures have to be completed. So, without an extension, you know, even at the State level, you know, you start to look at these programs and how do you maintain the staff to support these programs in the future once your grant funding goes away.

Ms. Matsui. Certainly, thank you.

And I want to talk a little bit about gag clauses. It is encouraging that this committee is taking steps to begin tackling the issue of transparency in our healthcare system. My understanding is that gag clauses impact the pharmacies, as well as the patients.

Mr. Chancy, would you like to comment on the impact gag clauses have on both patients and pharmacies, especially in relation to pharmacy benefit managers.

Mr. Chancy. Yes, I would love to. The gag clauses, actually, they do have an impact on both. The patient, our relationship is based on trust, and they depend on us to bring and help them maneuver through the intricacies of their healthcare, specifically with their prescription benefits. When we are not able to give them options, then it

kind of puts us in a situation where we aren't able to give them information that we feel like they need.

If we do, then we are running the risk of being in violation of contracts that sometimes we didn't even know that we were in violation of.

Ms. Matsui. Right.

Well, Dr. Yoder and Mr. Chancy, how well informed do you think the public is about gag clauses? Do you think the patients know to ask about prices at the counter?

Mr. Chancy. They are not very informed, and I think that because of the way the contracts have been written, not many people have talked about them. I think they are seeing more in the news now, and there is a little bit more interest, but it is nowhere near where it needs to be.

Ms. Matsui. Okay. If this legislation, Mr. Chancy, in front of us is passed, will pharmacists start telling patients about their alternatives? Or do you think there will be a need to have some sort of awareness or education campaign?

Mr. Chancy. I think pharmacies will, and I think a lot of pharmacists currently are doing that, but I think an awareness campaign would be fantastic.

Ms. Matsui. Okay. Thank you, and I yield back.

Mr. Burgess. [Presiding.] The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Kentucky, Mr. Guthrie, the vice chairman of the Health Subcommittee, 5 minutes for questions.

Mr. Guthrie. Thank you, Mr. Chairman, and for the Ranking Member, for holding a hearing on the EMPOWER Act, H.R. 5306, which would reauthorize the Money Follows the Person Program. I was very pleased to introduce this bill with my colleague as bipartisan with Debbie Dingell.

First Mr. Salo and Mr. Cunningham, as you know, H.R. 5306, as currently drafted, would extend the Money Follows the Person for 5 years. While this is ideal, would a 1-year extension be helpful?

Mr. Salo. A 1-year extension, I would argue, is better than letting it die. If those are the options?

Mr. Guthrie. Those are the options. Well, I don't know if those are the options, but if that is the option, then you would rather have a 1-year --

Mr. Salo. A 1-year extension is better than letting it die. A 1-year extension is not ideal. That is not enough time. If you understand how State government works, you know that when programs are dependent on Federal funding, or any source of funding, if you don't have long-term certainty about where the money is coming from, how much is coming, and the direction and speed which it flows, you have uncertainty. When you have uncertainty, you clamp down, you tighten up, and you stop spending. You go really, really conservative.

And, you know, if you get a year and you don't know what is going to happen that following year, you are probably not going to spend that money because you are going to be very, very cautious, and that is extremely disruptive to the people who need this. So the longer the extension, the better. I would argue making it permanent if you can, but 5 years would be -- 5 years is better than 1. One year is better than just letting it die.

Mr. Guthrie. Point well taken.

Mr. Cunningham?

Mr. Cunningham. Yeah, I reiterate what he said. I think the other thing to consider is that, when States see only a 1-year extension, you start to look at one-time type of things that are not as effective as really driving the long-term change that we want to use this funding for, so, yeah.

Mr. Guthrie. Thank you. I said for both. The point is well taken.

Mr. Cunningham, through the Money Follows the Person Program, over 88,000 individuals have transitioned from nursing homes and other institutions back to their own homes? I know there seems like a lot of support in the room for this, and I am very supportive of that as well.

What have we learned through the MFP program and about how the quality of life improves for individuals when they transition back to their homes and communities?

Mr. Cunningham. Sure, the MFP program does require a quality-of-life survey, and, at least in Wisconsin, when we ask if they are satisfied where they live, that satisfaction went from 68 percent to 72 percent. And then when we asked people that have transitioned to MFP if they like where they currently live, it went from 62 percent in the institution to 91 percent in the community.

Mr. Guthrie. People like to be home. And it is even more convenient and more helpful for the family members, too, to spend time with them and see them, more than in an institutional setting.

Mr. Cunningham. It allows them to become a participating member of --

Mr. Guthrie. Well, there certainly is an appropriate role for institutions, but that is absolutely right.

Okay. Again, Mr. Cunningham, of the 44 States that have recently participated in the Money Follows the Person, at least 10 States have exhausted their funds and stopped transitioning new participants to the community. By the end of the year, all remaining States will stop transitioning new participants through the program. Without an extension of this program, will we lose progress?

Mr. Cunningham. Yeah.

Mr. Guthrie. It is a given, huh?

Will more seniors and people with disabilities be forced into costly institutional placements?

Mr. Cunningham. Yes.

Mr. Guthrie. And then has the recent uncertainty hurt transition efforts?

Mr. Cunningham. Yes.

Mr. Guthrie. You are going through that.

And then one extra one. You have spoken about the importance of supporting people with disabilities to transition from institutional settings to the community. What has Wisconsin done to promote these transitions, both using MFP dollars and making use of Medicaid as a whole, and how are individuals counseled in the transition?

Mr. Cunningham. So one of the big things we do is a community living specialist. And through the diagnostic service information on -- through the MDS at nursing homes, there is a section Q that clearly asks the recipient, do you want to relocate into the community? And so we review and have set up a system where this information flows to our community living specialists in the ADRCs. And then they reach out to these people to discuss community options. So this is a cycling process. And so people that want to move out in the community are contacted and then worked to develop those community resources to move them in the community.

Mr. Guthrie. Okay. Thank you so much.

Thank you for your effort, Mr. Chairman. I really appreciate your effort in bringing this today, and I will yield back my time. Thank you.

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

Ms. Castor. Well, good morning, and thank you, Mr. Chairman, for calling this hearing.

Today I am thinking a lot about the children with complex medical conditions and their families. On behalf of the families across America who are faced with a complex condition that their child has, I want to thank everyone on this committee for moving the ACE Kids Act forward. It hasn't been easy. This has been a multiyear proposition. I have been working on this bill since the 113th Congress with Congressman Joe Barton, who has been the stalwart cosponsor and sponsor here, along with our partners: Jamie Herrera Beutler, Gene Green, Anna Eshoo, and Dave Reichert.

But the ACE Kids Act in this Congress has over 100 cosponsors, bipartisan, including a number of my Energy and Commerce colleagues, and I want to thank them, specifically Representatives Cardenas, Clarke, DeGette, Engel, Kennedy, Peters, Rush, Bilirakis, Costello, Guthrie, Harper, Lance, Long, and Olson. And I encourage our other colleagues to sign on to the bill as well. And thank you for your steadfast commitment to care for these children.

We also have a number of patient and stakeholder groups supporting the ACE Kids Act that range from the Children's Hospital Association to the March of Dimes to the American Academy of Pediatrics, and many more. Thank you all for consistently standing up for children with complex medical conditions.

And I want to also take a moment to thank the committee professional staff for their dedication to families and the hours they have spent working on this bill in a bipartisan fashion, especially Rachel Pryor and Samantha Satchell on the Democratic side, and Josh Trent and Caleb Graff on the Republican side.

Additionally, this bill would not be where it is today without the stellar work of my legislative director, Elizabeth Brown, and Representative Barton's staffers: Krista Rosenthall, Gable Brady, and Jeannie Bender.

But it is really the families who are the heroes here. It is the families of these

kids that have explained to Members of Congress on both sides of the aisle how important it is to have coordinated care. I became an advocate for the children and families that this bill will help after spending significant time back home in Tampa at the St. Joseph's Hospital -- Children's Hospital Chronic Complex Clinic that was started 16 years ago by a wonderful pediatric critical care doctor named Dr. Daniel Plasencia.

The ACE Kids Act is somewhat modeled after the St. Joseph's Children's Hospital Chronic Complex Clinic and the 700 kids and families that they serve. But, Mr. Merrill, you know this is the idea of home health, a medical home for these kids, is not unique. It is being done, and we need to take it to the national level.

The families I met with over the years have shared with me what they have gone through to get the proper care for their kids. The care that they were receiving was often fragmented and uncoordinated. But, most importantly, we have got to focus on making sure the kids have a better quality of life. And we think through this bill, we will be able to do that.

Mr. Merrill, you might remember Tish West testified a couple of years ago, and she said -- I met her daughter Caroline, who has been treated at St. Joe's -- she said: In the beginning of Caroline's life, I used to carry around these gigantic notebooks full of medical records and everything else so that we went from doctor to doctor, she would have to explain what was going on and what her illnesses were. But at this clinic, at this medical home now, they have the medical records; they are all electronic; everyone knows Caroline; they know what is going on with her.

Tish said: It is just a real collaborative effort, and she is much healthier as a result of that.

Do you think we are going to be able to make progress for more families if we pass the ACE Kids Act?

Mr. Merrill. I absolutely do. And our own experience in Texas with our STAR Program, which is somewhat equivalent of ACE Kids, we actually have care coordination clinics and medically complex clinics that would mimic a lot of structure that we are contemplating in ACE Kids.

I would give you one example of, just recently -- as we have 9,000 children that are signed up in our STAR kids; these are medically complex kids -- and the Cook Children's Health Plan. And so we took the most complex children of those 9,000, and our care coordinators, for the first 2 weeks, spent numerous times on the phone with these families and made home visits to these families to look at not only what their healthcare needs were but their social needs.

There was one particular example where a child and family had been for months and months carrying their child up the steps because they had no wheelchair ramp for the child in the wheelchair. We put a wheelchair ramp in for these families.

And so this care coordination and this care plan is, it is tailored for these specific families. And when it is tailored, we are able to anticipate needs, not just their medical needs but other social needs, and make it so much more easier for these families to navigate what can be a complicated system and help these children remain healthy.

I will just give you one quick example. This was actually a couple of weeks ago. We had a mother of one of these medically complex children call her case manager -- and by the way, these case managers, as you well know, have these incredible close relationships with these families. There is respect; there is great communication going on.

And this parent was distraught that she was getting close to the weekend and she wasn't able, through a series of events, to get a prescription filled for her child that was much needed for that weekend, called up our case manager. Our case manager calmed

the mom down, because of that relationship, took care of the prescription order from the physician, went to the pharmacy, picked up the drug, and delivered it to the home for this family, avoiding, by the way, an ER visit, guaranteed, and probably an in-patient admission. So that is the kind of activity that we anticipate under ACE Kids, the kind of work that will make life easier but keep these kids healthier, keep them out of the hospital, keep them closer to home, and I think that is a very positive thing for these families and their children.

Ms. Castor. Thank you very much.

And, Mr. Chairman, I would like to ask unanimous consent to submit for the record a letter from St. Joseph's Children's Hospital's CEO in favor of the bill.

Mr. Burgess. Without objection, so ordered.

The gentle lady's time has expired.

The chair now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions, please.

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

Mr. Chancy, I am going to ask you a couple questions. You mentioned that community pharmacists have little negotiating power when it comes to contract provisions set by the pharmacy benefit manager, and we have seen that in PBMs; we have seen that before.

Can you explain how smaller and rural community pharmacies are disproportionately affected by this inability to effectively negotiate and how that can, in turn, negatively impact patients?

Mr. Chancy. Yes. And our pharmacies, most of our pharmacies are in rural Georgia, and like, for example, one of our pharmacies, 25 percent of our business is through one PBM. And if they change their reimbursement model or whatever, it

impacts us in a great way.

And so the lack of getting on that contract or not getting on that contract depends on whether we, as a business, survive. One of the concerns in Georgia is we have four counties now that have no community pharmacies because of some of this, that they are dealing with.

Mr. Griffith. And not just that, but can't it affect the patients as well? So I have -- I know the committee is tired of hearing about Clintwood and Haysi, but if you look at them on a map, they look like they are only about 5 or 10 miles, maybe 12 miles apart. But there is a big mountain in between them, and the mayor of Haysi told me one time it takes him an hour; he always plans on an hour to get to any of the meetings he has to have in the county seat of Clintwood.

So, if you are the community pharmacy in Haysi and the PBM takes you off, that patient is now going to have to drive to Clintwood to get their drugs and rely on somebody that -- because most of us rely on our pharmacist, our community pharmacist. Is that not also a problem?

Mr. Chancy. It is. And CVS Caremark, Caremark being the PBM, many times they require their patients to go to one of their pharmacies. And in rural Georgia, there is not a CVS in every community or county, and so it compromises them with access.

Mr. Griffith. Yes, sir, I understand that.

Beyond drug-pricing disclosures, what are some of the other impacts that gag clauses have on the pharmacist-patient relationship? Can you think of any? Because I can think of one. A constituent came to me, and we were just talking about this whole gag issue, and she had stumbled across, and at first, she had questions about her pharmacist, because originally it wasn't considered a part of the formulary. So she had to pay cash for it. It cost her $17.

And as Chairman Walden said in his opening statement, then they notified her it was in her formulary, and she called in her prescription, and they told her she would have to pay the copay of $50. So she called her pharmacist all upset, thinking that he was doing something goofy. Doesn't that damage that relationship? And he explained to her that he wasn't allowed to tell her that, but since she had found out about it, she could pay with cash if she wanted to.

Mr. Chancy. Oh, definitely. And there are some times where the patient is required to get the brand instead of the generic, which is a cheaper copay, and I think it is just the rebates or some sort of agreements that they have worked out. And so that impacts them as well.

Mr. Griffith. Attorney General Schmidt, I have some theories. I like listening to the testimony and listening to folks, and you did a great job, and you got some great people signed on to these letters. But one of the concerns that I might have if we have -- and there is an answer to it, but it is going to take money and effort.

If you have got somebody who is skilled at determining financial fraud, they might go into the home -- let's say the fictional characters from "Seinfeld," George Costanza's parents, who were always fighting with one another -- now, if one of them was the patient, somebody who is a financial investigator might automatically assume that there is some kind of abuse going on there, and they have been having that relationship that way, as the fictional characters, 50 years or so.

And so aren't you going to have to train folks to be able to distinguish between -- I mean, financial fraud is different than physical or mental abuse, and there is a concern, and it gets complicated. Because I actually had a case one time where they thought the parents were doing something to an infant. I know this is a little bit different, but the infant was failing to thrive whenever it was in the parents' home. We ultimately

discovered the infant was allergic to dogs, and they had a dog in the house. So, every time they would put it in the aunt's house, the child would do better. They put it back in the parents' house, and the child would fail to thrive.

So there are a lot of complications with it, and I think that your financial investigators are going to have to be trained, if we give them this authority, and somebody is going to have to pay for that training, or else we will have people bringing cases that maybe they ought not.

And one of my concerns there is that when you bring a case, particularly against a family member, you are yanking that family apart, and you are pulling that person out, and you really have to walk with care. What do you say about that?

Mr. Schmidt. Right. Representative, certainly speaking for myself, I would be very sensitive to that concern. We see those types of dynamics, not just in the context of our Medicaid fraud work, but in the context of our broader criminal work for the State.

So we are accustomed to dealing with those sorts of distinctions. And we are human, and sometimes we get it right, and sometimes we don't. But I believe we do in most cases.

I would say one thing: I can't speak for every State. Perhaps the larger States with larger Medicaid Fraud Control Units do have distinct, financial-crimes investigators versus patient-abuse investigators. For Kansas and I think for most of the small and midsize States, we do not. We do have dedicated fiscal analysts who are the number crunchers that don't go on and do field investigations. So they are purely financial.

But with respect to our investigators in our MFCU, we have six sworn law enforcement officers. They are all cross-trained. They handle physical abuse, sexual abuse, financial abuse, as well as fraud. And the reason for that, under current law, is that they are doing those abuse cases when they occur in a healthcare facility. So they

already have the skills; they just can't apply them in the non-institutional setting.

Mr. Griffith. All right, I appreciate that, and I yield back.

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

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

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

I note that we have a number of representatives of ADAPT here in the hearing room listening to this, and I want to welcome all of you. ADAPT was founded in Denver, my district, and I have worked with them and also the Atlantis community for many, many years. It is one of the -- the Atlantis community is one of the oldest, independent-living centers in the country for individuals with disabilities, and they have really done courageous work over the years in educating all of us about why it is so important that we pass legislation that supports their independence and their ability to live in their homes and their ability to really lead the kind of productive American lives that everybody in this country should be able to do. So thank you all for coming out today.

There are a number of pieces of legislation that they support, but one of them specifically is H.R. 5306, the Ensuring Medicaid Provides Opportunities for Widespread Equity Resources and CARE Act. And then I want to thank Congresswoman Dingell and Congressman Guthrie for sponsoring that.

In Colorado, funding for the Money Follows the Person Program is aimed at facilitating the transition of Medicaid beneficiaries from nursing and other long-term care facilities to community-based services. And since we implemented this in Colorado in 2013, we have already transitioned 214 folks with physical, intellectual, or developmental disabilities, mental illnesses, and other impediments to really being able to live in these

community-based situations.

Mr. Cunningham, I wanted to ask you: Not only is this the right thing to do, but what I have heard is this actually saves money. Can you talk about the cost savings of programs like this?

Mr. Cunningham. Sure. So, yeah, it does. I mean, community-based care is cheaper than institutional care. We see, mentioned in our nursing home fee-for-service, it is about $5,256 per member, per month there. And in our home and community-based services programs, or community-based programs, the PMPM on average is about $3,233. So that is a savings of about $2,022 per member that you are moving out.

Given that they are numbers, there is always acuity and all this other stuff, but that is just a broad stroke of the estimate.

Ms. DeGette. And what are some of the other benefits to moving folks out of nursing homes and into community-based?

Mr. Cunningham. Well, I mean, there is a lot. You know, we operate from the view of person-centered planning and informed choice. So, once out in the community through person-centered planning, an individual can really think about how they want to self-actualize their own life and look at, you know, employment, look at engagement with loved ones, with family and community, and, quite frankly, engage in a life and fulfill the hopes that we all have in our individual lives.

Ms. DeGette. Thank you.

I want to talk briefly about this other bill -- what is the number -- it is a draft, the PBM gag clause prohibition, what an important bill that is. And I just want to talk for a minute to you, Mr. Chancy, about this. I have been, for about the last year, Congressman Tom Reed from New York and I have been -- we are the co-chairs of the

diabetes caucus, and we have been leading sort of an independent insulin inquiry.

And we sent letters of inquiry to the three brand name insulin makers about patient assistance programs and drug discount cards. And for a lot of these patients, these programs are a lifeline. Now, in your testimony, you stated that pharmacists can counsel patients about alternative purchasing options in some cases, such as when patients don't present a form of insurance.

If a patient asks about ways to lower their insulin cost at your pharmacies, do you counsel them about patient-assistant programs and drug discount cards?

Mr. Chancy. Yes, we do.

Ms. DeGette. Okay. And as part of this consult, do you tell the patients and clients that these financial assistance programs may not count towards their out-of-pocket expenses such as deductibles and copayments?

Mr. Chancy. Yes, we do.

Ms. DeGette. Good, that is great.

Mr. Chairman, I am hoping, not just the PBMs, but the entire system of drug pricing is something we should be having hearings on, and we should be doing it before the end of this year. Because the PBMs, I mean, it is ridiculous that they tell pharmacies that they have these nondisclosure agreements. But really it is throughout the system. And I think we could still do it. I don't know about all the rest of my colleagues here, but I was home in Denver for most of the August recess; that is all people wanted to talk to me about, was the cost of healthcare and the ridiculous cost of prescription drugs. Thanks and I yield back.

Mr. Burgess. Thank you. The chair thanks the gentlelady.

The chair would remind members, we do have another hearing following this that is scheduled to begin at 1 p.m., and, generally, I am fairly generous with the time, but I

am going to ask members to really confine themselves to the 5 minutes for questions.

With that, Mr. Bilirakis, you are recognized 5 minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman, and I really --

Mr. Burgess. Oh, wait, would the gentleman suspend?

Mr. Bilirakis. Yes.

Mr. Burgess. I did not see Mr. Lance had ascended to the dais.

Mr. Lance, you are recognized for 5 minutes.

Mr. Lance. Thank you, Mr. Chairman.

I am not sure I have ascended to the dais, but I am certainly pleased to be here.

Mr. Merrill, in your testimony, you talk at length about your involvement in the Center for Medicare and Medicaid's innovations demonstration: Coordinating All Resources Effectively Award Demo. You wrote, collectively, these programs reduced emergency department visits by 26 percent and reduced in-patient days by 32 percent.

The first full year of operations coordinating care for these children, CARE ultimately reduced overall Medicaid costs by 2.6 percent while improving patient experience for 8,000 children.

Mr. Merrill, can you walk us through how CARE coordination works in practice? I certainly think it would be helpful for the committee to hear how this process works on a day-to-day basis in this demonstration and how the savings and patient satisfaction are being achieved.

Mr. Merrill. Thank you for that question. I think CARE Coordination and Health Homes, as I mentioned earlier, tailor the care needs around that child, and by doing so, we are able to create efficiencies, improve care, and alleviate the burden that these families oftentimes experience in navigating what can be a very complex healthcare environment. I think that is where the patient experience improvement comes from.

If you look at the CARES grant, one of the things that we did through this, with the 10 hospitals, Cook being one of those that participated, is we did use a common definition. And I believe, again, a common definition is really important if we are going to make improvements in not just the care, but the outcomes and the patient experience. Peter Drucker said: If you can't measure it, you can't improve it.

And while we were able to take 10 hospitals across 8 States and use a common definition, that was just really the first year of savings. I think there is a whole lot more on the table, but if we can scale that to more than just 8 States, take it to 50 States, then I think we have a real opportunity to drive best practices and ultimately improve the kind of care we are looking for, for these children.

But the CARE coordination from the health home is really where the rubber meets the road with these families, where you are working to tailor that very specific care model for that child.

Mr. Lance. Thank you very much.

Attorney General Schmidt, thank you for your work on the important issue of expanding the authority of the Medicaid Fraud Control Units, to detect, investigate, and prosecute Medicaid patient abuse in noninstitutional settings. In your testimony, you detail some certainly very unfortunate stories that have been uncovered and stopped. I encourage all of my colleagues to read the testimony carefully.

What has me all the more concerned is that, even as noninstitutionalized care and Medicaid has expanded -- and I support the expansion of Medicaid, and New Jersey has expanded it -- the ability to protect these patients from the types of abuse has not. My question to you, Attorney General, without this important change to law, what tools do States have to protect these patients?

Mr. Schmidt. Representative, the answer would vary State by State, but as a

general matter, and certainly in Kansas, it would be the general tools we have for any criminal investigation on any criminal subject. And the reason that matters and is less optimal, in my view at least, than having the specified authority under the Fraud Control Units, is that these are specialized individuals in units focused on patient abuse, as well as financial matters, within the confines of the Medicaid program. They are focused.

We have 400-plus law enforcement agencies in Kansas. They are terrific people. They do a great job, and they are stretched far, far too thin and often are unable to be focused in a way that a specialized entity can. So I think you just go from the small pool to the big ocean if you don't have this sort of specialized capacity to deal with abuse in the noninstitutionalized setting.

Mr. Lance. Thank you very much, Attorney General, and my thanks to the panel.

And I also want to thank those in the audience who are here advocating on behalf of this wonderful cause. And I have been honored to meet with some of those who are in the audience today, and we certainly welcome them for their advocacy here in Washington.

Mr. Chairman, I yield back 16 seconds.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentlelady from Illinois, Miss Schakowsky, 5 minutes for questions, please.

Ms. Schakowsky. Thank you, Mr. Chairman.

Recently I met with a 9-year-old named Naomi Bytnar who has a complex medical condition and is being treated at Advocacy Children's Hospital in my district. And I am just so proud to cosponsor H.R. 3325, the bipartisan ACE Kids Act, which will help many children just like Naomi get the care they need. I thank all of you who are supporting that.

I would also like to thank Representatives Dingell and Guthrie for introducing the bipartisan H.R. 5306, the EMPOWER Care Act, to reauthorize the Money Follows the Person, MFP, Program, which I am proud to cosponsor. The MFP Program has given over 88,000 individuals the opportunity to transition from institutional care, something I have been working on for decades now from my time in the legislature in Illinois.

Mr. Salo, without an extension of MFP, what will it mean for seniors and people with disabilities?

Mr. Salo. Without extension of Money Follows the Person, what you are going to have is a definite subset of people who are in an institution, in a nursing home, who don't want to be there, who don't need to be there, and are going to have enormous difficulty making the transition out, so, yes.

Ms. Schakowsky. Mr. Cunningham, what challenges do States face in supporting transition from institutions to the community, and how does MFP address those challenges?

Mr. Cunningham. So I think, you know, obviously housing is a big issue of finding a resident, especially if your housing has -- you no longer have the housing since you have been in the institution. I think -- so, through housing counseling funded through MFP, through projects like developing databases of available section 811 housing vouchers, that also provides assistance.

I also think another area that has been funded is the Aging and Disability Resource Centers. And I would say that this entity is critical in a comprehensive, long-term care system, because they can not only advise about the resources that Medicaid has but also about Medicare, about other resources within the community, to create natural supports and lower the cost of care and the Medicaid program bears but also other systems bear. So we have used that MFP to fund those ADRCs also.

Ms. Schakowsky. Thank you for that.

I want to go to the gag clause and -- turning to the gag clause, I want to emphasize that this committee can be doing much more to lower prescription drug prices, for example, basic transparency and price spikes requiring that the price in direct-to-consumer prescription drug ads and Medicare prescription drug negotiations. So there are things that we could do, but we must get rid of gag clauses because providing patients with information about pricing is critical.

Dr. Yoder, though, I want to ask you -- where are you? I am sorry. There you are. Okay. You raise a really interesting point in your testimony that paying out of pocket impacts deductibles, maximum out-of-pocket costs and for seniors, the doughnut hole. Senior groups have told me that this information would be useful at the pharmacy.

So what is the effect on the beneficiary's deductible, maximum out-of-pocket limits when paying out of pocket? How does this affect seniors in the doughnut hole?

Dr. Yoder. So, generally, when the medication is paid for out of pocket, those prescriptions don't get adjudicated to the PBM system. So there is no way for those accumulators to be added to that would reflect what the member's out-of-pocket is. So essentially that prescription is opaque to the health plan as well as the PBM. No one knows it was actually dispensed, other than the pharmacist who dispensed that. So it doesn't go toward any of those accumulators at all.

Ms. Schakowsky. So, when we talk about eliminating the gag rule, would it be useful, do you think, to share that information as well, so people really understand the consequences of paying out of pocket? In other words, someone might be told that if you pay the $50, you now will climb out of the doughnut hole, rather than the $10 if you pay out of pocket?

RPTR BRYANT

EDTR SECKMAN

[12:00 p.m.]

Dr. Yoder. Absolutely. We support making sure that the members and the enrollees do know what the consequences would be for doing that. In addition to not just the accumulators, in most cases those prescriptions don't go against any of the checks for medication duplication, drug interactions, things like that, because they are not going into the PBM system to see what all the other medications that member may be taking. So we absolutely do support that transparency so members do understand what the consequences would be for paying out of pocket versus using their copay cards.

Ms. Schakowsky. What you just said is a safety issue that it seems to me, you know, why couldn't this be recorded?

Dr. Yoder. Because the way the prescription adjudication system works, the PBMs don't see those prescriptions. They never go into the systems at all because they are just at the local pharmacy. The local pharmacy can do checking on the prescriptions they have for that member, but if the member goes to different pharmacies, if the member uses mail order, things like that, those prescriptions never even enter into the system.

Ms. Schakowsky. That is a concern we ought to deal with. Let me just say, as somebody who has -- I am over time. I am going to respect what you said, Mr. Chairman, and yield back.

Mr. Burgess. Thank you. The chair recognizes Chairman Walden, 5 minutes for questions, please.

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

Really good hearing, appreciate all your testimony.

Mr. Yoder, your testimony contemplates the possible downsides of cash purchases for medications which you were just talking about, such as mechanisms to catch potentially harmful drug interactions or medication nonadherence.

So I am kind of interested to hear how Mr. Chancy would respond to those concerns.

Mr. Chancy, in your experience, when discussing cash prices, do pharmacists have the necessary information before them to identify harmful drug interactions?

Mr. Chancy. Yes. Whether it is cash or whether it is insurance, our computer system will run the analysis on any drug interactions.

The Chairman. All right. And are there ways that we can improve this legislation to avoid any unintended consequences concerning potentially harmful drug interactions or medication nonadherence, things we could do to improve this legislation to prevent the kind of problems that are being discussed right now?

Mr. Chancy. Yes.

The Chairman. What would those look like?

Mr. Chancy. Pertaining to adherence?

The Chairman. Yes, to medication nonadherence and to harmful drug interactions.

Mr. Chancy. Well, I think if we are actually running it through the insurance, and I was not familiar with the insurance doing the drug-drug interactions on the back side, but I think if we were to know about those interactions, that would be helpful for us to help with the patients upfront, to make sure if there are any issues they are having, we can actually work with their physician to change medications or change drug regimens.

The Chairman. All right. Thank you.

Dr. Yoder, I am going to change gears here to the other bill. So I appreciate your providing ways we can improve the Healthcare Fraud and Prevention Partnership, and so I would like to focus on two of those. First, you mentioned that Blue Cross Blue Shield recommends creating improved mechanisms for the exchange of findings so that all participants are best informed of lessons gained from the experience.

What are some of the existing limitations on information sharing that we should be aware of?

Dr. Yoder. A couple things come to mind. So one would be some of the HIPAA requirements that are out there. So right now the way the data sharing goes through a third party which deidentifies the data, which is great for analysis. But if there are actual particular instances of fraud, that information doesn't necessarily flow through because of HIPAA and because people are not real comfortable about having those conversations.

The Chairman. All right. Are there things Congress could do to improve that information sharing?

Dr. Yoder. I think we would support any way that we could strengthen the committee charter or the charter for the organization to make it clear that you can share information within the confines that would not be HIPAA violations.

The Chairman. A violation of HIPAA, okay.

And, second, you note the partnership appears to be prohibited in its charter from advising Medicare and Medicaid of the schemes it identifies. I know that our staffs have asked HHS for a better explanation of why the charter is not allowed to provide advice to the Federal Government, a Federal official, or a Federal agency.

Are you familiar with the background of why the charter includes this firewall?

Dr. Yoder. No, unfortunately, we are not familiar with why that would be in

there.

The Chairman. Okay. And the draft bill includes report language that Congress recommended by Ranking Member Pallone. Do you believe that having the partnership report to Congress would amplify opportunities to prevent fraud and abuse across all payers?

Dr. Yoder. We actually don't have a position on that. It is hard to tell whether that would be impactful or not.

The Chairman. All right. Frank and I think it probably would be, so you might want to have an opinion on that later that is good, positive. Just kidding.

I think that is all I have for now. I appreciate your testimony on all these bills. We have got a lot of work to do, and we do it well on this subcommittee, and I appreciate the leadership of Dr. Burgess and yield back.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman.

I want to thank the panel for your testimony. Very important pieces of legislation that we are discussing today. All have earned bipartisan support for obvious reasons, given what you have been telling us and, I think, given the statements of our colleagues here on both sides of the aisle.

I wanted to focus on the EMPOWER Care Act again because a lot of people have spoken to it, but I think it is really critical. Obviously, we are at this stage where the authorization has expired. States have been sort of living on the reserves associated with it for some time, but that is going to be running out quickly. And the State of Maryland faces that challenge as well. So it is important for us to get this done, and that

is what the purpose of the legislation is.

I want to again -- I mean, the reason this is called the EMPOWER Act is because it is about empowerment. It is about giving the opportunity for independence, to make sure that seniors, people with disabilities, others have the opportunity to live and thrive in a more independent setting and redesigning the Medicaid program so it can help to support that.

So, Mr. Salo, I am going to direct this to you. And you have addressed it to some degree already. But I am interested again in just the perspective on what this does to promote independence and the benefits of it. I was thinking earlier that we often or increasingly we have been talking about how social determinants are having an impact on the way we deliver healthcare. But in a sense, what is offered by the EMPOWER Act and the Money Follows the Person approach is kind of a reverse of that.

If you think of it, it is using our healthcare system and the way we reimburse and organize the delivery of care to, in a sense, create social dividends. And so maybe you could speak again to that idea of how this program is creating social dividends, independence, employment opportunities that might not have been possible under the old construct, empowering individuals to be contributing members of their own community in ways that previously they might not have been able to be and, therefore, strengthening the broader community that benefits our country.

So talk about the social dividends. I have sort of just grabbed that phrasing for the purposes of this question, but I would be interested in, again, your perspective on what that independence opportunity offers to people.

Mr. Salo. Sure. I think I would be somewhat remiss -- and acknowledging it is outside of the purview of this conversation today, but I would be somewhat remiss in not reminding everyone that this country doesn't have a long-term care system. We have

Medicaid. Medicaid is it. Medicaid is by far the dominant player in long-term care, whether it is institutional or noninstitutional, for everyone in this country.

And because Medicaid is a means-tested program, that means that when Americans need long-term care services and supports, they have to go on Medicaid, and they have to impoverish themselves. Those are the rules. We didn't design it that way, but that is how we have fallen into it. That is how the system works. And I would argue, as a macro construct, that is not terribly empowering to begin with.

So I would just encourage as we look to the future to say, are there other ways we can think about providing the necessary long-term services and supports to Americans through other means? But having said that, within the construct of Medicaid, clearly what we are seeing is if we can embrace -- and we have, but as we embrace the trend for self-determination -- whether that is where do I want to live, do I want to work, how can I work, you know, who do I want to associate with -- MFP and many other efforts that have been underway in Medicaid for the past three decades have all been about empowering people and about providing freedom.

That I think is an incredibly important dividend. And I think what you see as a result of MFP, specifically getting people out of an institution who don't want to be there or who shouldn't be there, or whether it is any of the other efforts to try to provide upfront alternatives to prevent people from going into that institution in the first place, it is all about, how can we empower the individual and give them the self-determination that they need to make those meaningful choices for themselves? And I would argue that that makes their lives better, their family lives better, and their community lives better.

Mr. Sarbanes. I appreciate that. Just to close, I would say that, within that larger construct, it can be frustrating sometimes. I think what you are saying is the MFP

approach is an innovation, and we should pursue more innovations like that that can be empowering to people because it is better for our entire community when we do that.

Thank you, and I yield back.

Mr. Burgess. The chair thanks the gentleman.

The gentleman from Florida is recognized for 5 minutes for questions, please.

Mr. Bilirakis. Thank, Mr. Chairman.

I appreciate it. And I appreciate you agenda-ing the ACE Kids Act today. It is great legislation. I have been a strong supporter, a longtime supporter of that legislation. Bipartisan bill.

In the Tampa area, St. Joseph Children's Hospital has been running a Chronic-Complex Clinic for children, and I have toured that particular hospital and that clinic, and I tell you it is a wonderful thing. It is a great concept.

I have had the opportunity again to tour it over the past few years and see how integrated care model can benefit the children with complex medical issues. Again, the children, you know, we have seen examples time and time again where the children come up here and show us how well they are doing and how it benefits them and their families.

Mr. Merrill, you mentioned that children with medically complex conditions account for a large share of the Medicaid costs for children. Can you talk about how a medical home, such as the one at St. Joseph's, can bring savings to Medicaid? Do you have research showing these savings?

Mr. Merrill. Yes, thank you. Great question. There have been some studies, independent studies, done that have shown that the potential savings for ACE Kids for the Medicaid children could be anywhere from up to $5 billion to $13 billion over a 10-year period. And, as I said, under the CAREs grant, even though 2.6 percent sounds fairly small, I think that is just the beginning of some opportunity for us to really, if we can scale

this across all 50 States instead of just one-offs at different organizations -- and I know the hospital you mentioned, they do incredible work there, but they are by themselves. They are siloed. And if we can create a national database in which we are sharing data, working together, driving best practices, then, in the end, I think we truly can create the savings that everyone is looking for but also improve the patient experience through these coordinated care health homes.

Mr. Bilirakis. And that is obviously the most -- that is the priority, to improve the patient's experience and the quality of care for the child. And, again, it is convenient for the parents. So I would like to see a hospital in every region of the country that has the ACE Kids model.

Again, is quality measure data currently collected in Medicaid or Medicare?

Mr. Merrill. Yes, I think it is by State, and you will see different States starting to implement quality measures with a pay-for-play component to it. We are unaware of any quality measures that are specific to this medically complex population. I think that this bill contemplates that, as it should.

One of the very most important first things that I believe we should look at as a quality indicator is patient and family satisfaction. That is really what this bill is all about, making life much more convenient for these families, allowing them to navigate the healthcare system easier and have the better outcomes.

We could implement outcome measures, reduced readmissions, for example, for this population, because this population tends to bounce back into the hospital. But if we are successful at creating the medical home, then we believe that we can keep these children out of the hospital more often, closer to home, and deliver better care and better outcomes as a result of that.

Mr. Bilirakis. It is so very efficient too, because the doctors, they have multiple

appointments during the day, they can see --

Mr. Merrill. That is correct.

Mr. Bilirakis. -- the doctors. And, again, it is great for the child and the family. So I appreciate it. It is a no-brainer, as far as I am concerned, but sometimes no-brainers don't get passed up here. And I really appreciate the chairman agenda-ing this bill. It has got to get done.

Mr. Salo, you mentioned that it is important to avoid one size fits all and to allow for a flexible benefit design. And I agree. We have one Medicare program, but we have 50 Medicaid programs, each designed to serve the unique needs of their States.

Mr. Salo and Mr. Merrill, do you think that the latest discussion draft for ACE Kids promotes a flexible benefit design for States? Maybe, Mr. Salo, you want to go first. I know we don't have a lot of time.

Mr. Salo. Sure. I think we made a lot of progress, and I think as long as it continues to allow, you know, Florida to acknowledge its current delivery system, you know, Florida has a separate managed care organization completely focused on kids in the foster care system.

You know, New York has a system in place that holds pediatricians accountable for making sure that kids arrive at school at kindergarten ready to learn. There are efforts like this underway in lots of places. We want to make sure that this is a complement and improvement to those efforts as opposed to just running into them in a conflicting way.

Mr. Bilirakis. Mr. Merrill.

Mr. Merrill. This bill actually allows each State to implement the program that works for them. In Texas, with our STAR Kids, we have Medicaid managed care, and it works pretty well. I think it can work equally well in a fee-for-service environment.

And so I think that is the flexibility that is built into this, so that the States can, number one, opt in or out; and if they opt in, they can use their delivery system that they have in place today.

Mr. Bilirakis. It makes sense to me. And I want to thank the lead sponsors of this bill, of course, former Chairman Barton and also Representative Castor, and all the cosponsors. I am one of them as well.

Thank you very much. And I yield back, Mr. Chairman.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Oklahoma, Mr. Mullin, 5 minutes for questions.

Mr. Mullin. Thank you, Mr. Chairman. And thank you to our witnesses for being here. I am going to jump right into it.

Mr. Salo, first of all, can you talk about how, in addition to the obvious benefit to States of enhanced funding, the ability to incorporate medically complex children into a health home is a critical improvement compared to the current law?

Mr. Salo. Sure. I think if you look at any State in the country, what Medicaid directors are trying to accomplish is a move away from a historical healthcare system in this country, not just Medicaid but Medicare and commercial, that has been fee-for-service. And we are moving towards a world where care is coordinated. It is managed. It is holistic, and it is patient-centered.

That will look different in different States. It might be managed care. It might be ACOs. It might be patient-centered medical homes. It might be health homes. Each of those is going to work in the political and geographic and cultural realms in which those States reside.

So I think as long as you are -- if we acknowledge those, then I will channel my good friend Dennis Smith, who once talked about the historical healthcare system for

people with disabilities, for kids with medically complex needs, for frail seniors. The fee-for-service system, FFS, he said, it should stand for fend for self because that is what we require; that is what we are requiring of them.

And what Medicaid is trying to do is to create a system that is going to make it so that people don't have to spend their lives navigating multiple different silos and that the care itself is coordinated and managed in a better way. That is what Medicaid is trying to do.

Mr. Mullin. Thank you.

Mr. Schmidt, what protections do patients currently have when Medicaid Fraud Control Units detect abuse in a noninstitutional setting?

Mr. Schmidt. With respect to protections from the Medicaid Fraud Control Unit, I think the answer historic is none, or realistically, I mean, if we detect it, we are going to call some other law enforcement agency and say: Please take a look, we can't.

Mr. Mullin. How often do they actually pick it up?

Mr. Schmidt. It depends on the jurisdiction. We have had cases in Kansas that, for example, in some of our more robustly staffed jurisdictions, that they will take it. We have had others where we haven't felt good about having to hand the case off.

Mr. Mullin. They simply don't have the manpower or the knowledge to do it?

Mr. Schmidt. That is correct.

Mr. Mullin. Are there any other settings that Medicaid Fraud Control Units are prohibited from addressing patient abuse?

Mr. Schmidt. I believe the answer to that is no, but I would sure want to double-check that with the folks that -- there is nothing else on my radar screen. Nothing else on my radar screen.

Mr. Mullin. Can Medicaid Fraud Control Units detect, investigate, and prosecute

fraud inside the Indian Health Service facilities?

Mr. Schmidt. I don't know the answer to that. Sir, we don't have that issue having arisen in Kansas and I just don't know. I can certainly check with folks that would, if that would be helpful, and have them follow up.

Mr. Mullin. Can Medicaid Fraud Control Units pursue cases of patient abuse in his facilities?

Mr. Schmidt. I would have to do the same.

Mr. Mullin. Do the same?

Mr. Schmidt. Do the same.

Mr. Mullin. My point that I am trying to get at, obviously, Medicaid is a tool which can be utilized for the benefit of those in need and those in most critical need. It can also be utilized to help strengthen systems like his. But if we are going to be in the business of trying to investigate fraud, then we also need to have the ability to go into where it is being used, not limited access.

And I am sure you can appreciate that. You know, we want to make sure that, one, the dollars that was invested in Medicaid is being used properly by those that are receiving the funds.

And what I am trying to get at is, if there is a way for us to be able to help, we do want to help because, as you mentioned, our attorney general, Mike Hunter, is associated in helping on an important bill. We are also in desperate need of wanting to find out how we can help strengthen our his system. We don't know if there is abuse going on, because it hasn't been investigated. We don't believe there is, because we believe our Tribes are extremely good stewards of what they are using their assets for. You can go and you can look at the his facilities and the health clinics and the Indian hospitals throughout my district, and it is amazing what is happening, but can it be utilized further?

So my whole point on asking those questions -- and I didn't expect you to know, because currently I don't think there is -- I am here wanting to say I want to help. If we believe there is a reason for us to do it, I want to help. I want to make sure that those dollars are being used properly so we are not going after everybody, but we are only going to focus on the bad actors.

With that, Mr. Chairman, I yield back.

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

I think all members of the Health Subcommittee have been recognized, and we will now turn to members off the subcommittee.

And, Mr. Welch, you are recognized for 5 minutes for questions, please.

Well, let me clarify that statement. All members of the subcommittee with the exception of your subcommittee chairman, who deferred his questions. So you may go ahead of me. Mr. Welch, you are recognized for 5 minutes.

Mr. Welch. Mr. Burgess, you are always doing a generous thing. Thank you very much.

I want to speak to Mr. Chancy about the gag rule. That is astonishing. Mr. Carter and I have a bill in to get rid of it. But can you just give some description of what it feels like to be a pharmacist. And in my experience, the pharmacists have very close customer-pharmacist connections, and they are guiding their customer in the use of that medication, and it is a place the customer can go to because they trust the pharmacist.

So what is it like for a pharmacist to have this gag order when if he or she didn't have it and was free to speak, they could save that customer, who they value, an awful lot of money?

Mr. Chancy. It puts us in a very compromising situation because, like we had

mentioned earlier, our relationship with our patients are based on trust. And they depend on us to maneuver -- this stuff is complicated. We have to stay on our toes to keep up with it, and our patients really depend on us. And when we can't be fully forthright with them, then that just puts us in a compromising situation.

Mr. Welch. It kind of makes you feel dirty, right? I mean, it is awful, because they trust you. They are putting their medical situation in your hands. They are asking you intimate questions about, you know, this was my reaction, what do you think I should do? And they are assuming, since they trust you, that among other things, if you could save them a hundred bucks, you would, because it is not money going in your pocket.

Mr. Chancy. Oh, no, definitely not.

Mr. Welch. Do you have any idea why it is legal to put handcuffs on your ability to act?

Mr. Chancy. It has always been a bad rope for us.

Mr. Welch. Mr. Chairman, just bipartisan, I hope we can get rid of this. I mean, the idea that a pharmacist can't give relevant information on how to save money for their customer really is inexcusable. So I appreciate the hearing that you are having.

Thank you. And I want to talk to the attorney general a bit about your work. I mean, our Medicaid Fraud Unit in Vermont does a tremendous job, and it is both recovering money and, I think, also a deterrent against would-be malefactors. And, of course, when this legislation was initially passed, most of the Medicaid services were provided. They were provided in institutional settings.

So I would just ask you to elaborate about your reasons for supporting this legislation, and I have a bill in in order to accomplish your goals. But thank you.

Mr. Schmidt. Thank you, Representative. And, again, thanks to you and Representative Walden for your leadership in making this real. And as I mentioned

earlier, I worked very close with my friend, your attorney general, General Donovan, on this. And he and I have talked many times -- I certainly don't purport to speak for him -- but both coming from lightly populated States with substantial rural areas, how important this expansion is to allow us to have the capacity of skilled investigators and prosecutors who are expert in patient abuse matters to be available and deployable in areas that simply don't have them with respect to local resources.

So I think it is vitally important, and it doesn't make any sense to have this arbitrary restriction that I can see.

Mr. Welch. Right. And my understanding, you know, in the Vermont Medicaid Fraud Unit, we return a lot more money than it costs to run it. I think it is like six to one. I don't know what it is in your State.

But is there any reason to be apprehensive that if we expanded your authority to recover and deter bad conduct outside of the current law, that it would be a financial drain?

Mr. Schmidt. No, I don't think so. And I guess I would offer just a couple of thoughts on that point. Number one, obviously, the financial recoveries of a MFCU come principally from the fraud side, not the abuse side. And so I do understand at least those who articulate, well, it is different. But, having said that, most of the Medicaid Fraud Control Units, including ours in Kansas, are self-funding, and they are returning money to the taxpayers. And so I have no concern along those lines.

Mr. Welch. In Kansas, sort of like Vermont, you are kind of tight with a dollar, right?

Mr. Schmidt. I think that is true, and we wear that as a badge of honor.

Mr. Welch. Well, I think Mr. Walberg is too, so it has been great working with him. And I thank you for your work and your testimony on that.

Mr. Schmidt. Thank you, Representative.

Mr. Welch. Thank you. And I yield back.

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

The chair recognizes the gentleman from Michigan, Mr. Walberg, 5 minutes for your questions, please.

Mr. Walberg. Well, my good friend and colleague from Vermont, I am not tight; I am efficient.

Mr. Chairman, thank you for holding this hearing, and thank you for including our legislation as part of the bill packages here. I would like to ask, Mr. Chairman, unanimous consent to submit for the record letters from the National Association of Attorneys Generals, Families USA, and partnership for Medicaid Home Based Care, and express support for H.R. 3891.

Mr. Burgess. The ranking member is concerned about the letter from Families USA, but I think I will go ahead and accept them. We will.

[The information follows:]

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Mr. Walberg. Thank you.

Attorney General Schmidt, thank you for being here today and for your efforts in highlighting the need for legislative reforms offered by myself and my colleague, Representative Welch.

Medicaid Fraud Control Units play a vital role in bringing those who commit Medicaid provider fraud, patient abuse and neglect to justice. In my home State of Michigan, Medicaid Fraud Control Units, or MFCUs, recovered over $7 million in taxpayer dollars in 2017 and contributed to 24 convictions. Nationally, MFCUs are responsible for about $1.8 billion in recovered funds and 2,500 convictions.

I commend the work of these State Fraud Control Units and the attorneys general for protecting the most vulnerable of our population from harm as well as ensuring taxpayer resources are being used appropriately. So thank you.

Attorney General Schmidt, as you know, currently MFCUs may only investigate cases of patient abuse that occur in institutional facilities, et cetera. Let me move to what this bill could possibly do. If our legislation were to become law and MFCUs were permitted to widen the scope of their investigations, do you have any sense of how many Medicaid beneficiaries could be protected from abuse or the amount of taxpayer funds that could be recovered?

Mr. Schmidt. Representative, I don't have hard data, and I am not aware that it exists. If it does, I don't have it. I can give you anecdotal information from Kansas with numbers.

Mr. Walden. That would be helpful.

Mr. Schmidt. And you can draw from that what you will. In State fiscal year 2018 -- we are on a July through June fiscal year in Kansas. In State fiscal year 2018, our MFCU received 16 referrals of suspected patient abuse. Of that number, we found a

way to investigate or cause to be investigated 11. That leaves a difference of five. Out of those five, I didn't go back and personally review the files before this hearing, but if normal patterns hold, I suspect probably half of those there simply wasn't evidence of a crime, and so there was no further action to be taken, which leaves one or two that, had we had the ability to proceed in the noninstitutional setting, we could have investigated and, assuming there was evidence, prosecuted.

To put that in context for Kansas, we also prosecuted to conviction 16 criminal cases last year in our MFCU. It is coincidental that is the same number as the referrals. They aren't connected. So had we added one from a noninstitutional setting because of your bill, that would be a 6-percent increase in the number of convictions. If it were both, it would be a 12-percent increase.

Mr. Walberg. Could you give us an example of one of those where you had to turn a blind eye because of the inability?

Mr. Schmidt. Absolutely. The one that comes to mind that troubles me the most, it was a case in a very small county, very rural county, lightly resourced, both on the police law enforcement side and on the prosecutor side.

The matter came to our attention technically on a fraud claim, but it was obviously more than that. It was a case where an individual was being paid by the Medicaid program to provide personal care services in home for a beneficiary. The beneficiary was either nonambulatory or had substantial mobility restrictions, and so the PCA was supposed to be there all night long sitting with this person, providing the appropriate care. They didn't, and they billed for it, which is how it came to our attention as a fraud matter.

The reason it was particularly distressing is that, on one of those evenings before this was all uncovered, the beneficiary, who was a smoker, was home alone when the

PCA was supposed to have been there. The person was smoking, it appears, in bed. The cigarette dropped. It caught the house on fire, and the individual died. Now, there was Medicaid fraud in a small amount of dollars, but obviously the much greater harm there was the question of whether there was a criminal homicide, whether there was a negligent manslaughter or reckless manslaughter or some other form of prosecutable homicide, and we did not have the ability to use our MFCU assets to investigate that.

So we had to go back to the local police and the county attorney who called us in the first place and say: We are sure glad to help out of other assets, but we can't take this. We can prosecute him for two or three thousand bucks' worth of fraud, but that is not what this is really about.

Mr. Walberg. Thank you. Thank you, and I yield back.

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

The chair recognizes the gentlelady from Michigan, 5 minutes for questions, please.

Mrs. Dingell. Thank you, Mr. Chairman and Ranking Member Green, for allowing me to participate today in holding this hearing.

There are several bills being considered today. I am going to mostly confine myself to the EMPOWER Care Act before my colleague Mr. Carter speaks. And when his bill gets introduced, I am going to tell you of a story last week of picking up a prescription that was $1,300, and after you peeled me off the ceiling and I called the doctor and screamed and talked to the pharmacist, got an equivalent for $40. I am much more aggressive than many in asking questions, but, Mr. Carter, I am on your bill when you get it in.

But now I will confine my remarks to -- and that is a very true story -- H.R. 5306,

the EMPOWER Care Act, which I am proud to author with my friend and colleague, Congressman Brett Guthrie.

Improving long-term care has been one of my top priorities since coming to Congress. And as I have listened to all of you talk today, our long-term care system is broken. It doesn't work. Most people think Medicare covers it, as Mr. Salo previously noted, and are shocked to learn that, you know, if you are going to get sick, better do it only 90 days, 90 first, you are out, and that Medicaid is actually the single largest payer of long-term care in this country. And the private market is totally broken as well.

As we have heard in the testimony this morning, one program that is working well in terms of enhancing opportunities for independent living and supporting aging with dignity and has bipartisan support is the Money Follows the Person Program. We have discussed what it is this morning. It provides grants to States to cover transitional services for individuals who want to leave a nursing home or another institution and transition to the community care setting.

I have been working with my colleague Brett Guthrie from Kentucky to reauthorize this successful program that is proven to save taxpayers money and has successfully transitioned thousands of people from institutions to a community setting where they can be with their loved ones. We need to expand the program before it expires. I agree with you that 1 year isn't enough, but I will take 1 year if that is all we can get, because time is running short.

So I am going to quickly -- I am going to ask Mr. Cunningham these questions. Mr. Salo, if you want to chime in.

Money Follows the Person was created through bipartisan efforts. The program has been operating for more than a decade, and the legislation we are considering would have reauthorized the program for another 5 years. We will take the 1. Why is this

such a priority? How does this kind of long-term reauthorization support institutional transition efforts?

Mr. Cunningham. So I think one of the big things for MFP is that every State kind of has their own home and community-based waiver programs. And so depending on each State, MFP can be that flexible tool that can be used to move people out of institutions into the community. And so that flexibility is critical.

Mrs. Dingell. What challenges do States face in supporting transition from institutions to the community? How does MFP help address these challenges?

Mr. Cunningham. So, for many States, a lot of the services, such as housing counseling and other referrals, counseling, detection of people that want to relocate, these may or may not be covered as part of the Medicaid program.

So MFP can step in to provide those services. And then they can relocate into the community where some States may have available, you know, personal care assistants and other home and community-based services that can support them. So it bridges that gap.

Mrs. Dingell. Thank you. We know that hundreds of thousands of people with disabilities continue to wait on waiting lists for home and community-based services. How does MFP help address the problem for the population of people in institutional settings, and what would happen if we don't renew this?

Mr. Cunningham. So, in Wisconsin, what we have done with the enhanced Federal match is that we have reinvested that into our long-term care program to reduce and eliminate waiting lists. And within 36 months, we are going to be an entitlement for all individuals that need Medicaid home and community-based services.

And so MFP has been a vital part, and that reinvestment of those dollars into the long-term care system continue to support providing community-based services.

Mrs. Dingell. I want to thank all of you for everything that you are doing. Five minutes isn't enough time. But before I yield back, I would ask the chairman for unanimous consent to include for the record letters of support for H.R. 5306 from the Area Agencies of Aging Association of Michigan, the National Association of State Directors of Developmental Disability Services, the National Association of States United for Aging and Disabilities, and a group letter signed by dozens of health and aging organizations.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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Mrs. Dingell. Thank you. And I am over my time.

Mr. Burgess. The chair thanks the gentlelady.

The chair now recognizes the gentleman from Georgia, 5 minutes for your questions, please.

Mr. Carter. Thank you, Mr. Chairman. And thank all of you for being here.

Mr. Chairman, I want to thank you for holding this hearing today and for including the discussion on the gag clause legislation. It is something that is very important and something that I have stressed since I have been in Congress and something that is important to patients. I think that is the point that I would like to get across most is that this is something that is really hurting patients more than it is hurting anyone.

Mr. Chancy, I want to thank you for being here. I appreciate it very much. I know you have traveled a long way, as a lot of you have, but I wanted to ask you, Mr. Chancy, examples of gag clauses. Now, I think everybody by this point understands what we are talking about when we are talking about gag clauses, but have you actually seen a contract that had the language in there that -- and perhaps it wasn't written the way that you would understand it, but have you ever seen a contract like that?

Mr. Chancy. First of all, it is very difficult for us to even get our hands on these contracts, and they change frequently. So I have not seen anything that even stated that it was a gag clause.

Mr. Carter. Right. But just because it is not stated, there are other ways that the pharmacy benefit managers can get at this. You mentioned earlier about CVS/Caremark. CVS, of course, is a competitor, a national chain, I believe the largest drug chain in America. And yet Caremark, one of the top three PBMs in America, is the same company. You can make the argument that the Caremark owns CVS or CVS owns Caremark. It doesn't matter; they are the same thing. But there are other ways. Do

you ever get audited by any of these groups?

Mr. Chancy. Yes, we do. Actually, one of our stores is next door to a CVS, and they do audit us.

Mr. Carter. So, actually, you have got a contract with a PBM that has a drugstore right next to you, and you are getting audited by that PBM that owns that drugstore right next to you. Do you find that somewhat intimidating, if you will?

Mr. Chancy. Yes, and it is challenging at times.

Mr. Carter. I can imagine. I wanted to ask you, in your written testimony, you gave some examples of where you had actually told some patients about this. And I believe there was one example with a mayor of one of the municipalities around. Can you share that very quickly?

Mr. Chancy. Yes, that is correct. He came in, and his prescription came to be $26. And they had just changed insurance plans. And, you know, we told him that if you paid cash for this, it would be cheaper. And he said: I don't understand; I want to use my insurance.

And I said: Well, our cash price is $8, but if we use your insurance we have to charge you $26 -- because the PBM was actually taking $24 back from us.

Anyway, the point was out of pocket was $8 for him. Using his insurance, he had to pay $26.

Mr. Carter. So this point was brought up. I believe, Dr. Yoder, you may have brought it up. And it is a valid point, that, you know, if you don't use your insurance, it is not going to go toward your deductible.

Mr. Chancy, do you have an opportunity to know how close a patient is to their deductible? Is that any kind of information that you are privy to as a pharmacist?

Mr. Chancy. No, we don't. The only way we find that out is if we bill it through

their insurance and we find out that they have met their deductible or they haven't. So we fill prescriptions or process prescriptions until we get to that point.

Mr. Carter. But if we were realistic about this, the example that Representative Dingell just gave, now, that would have been $1,300 going toward a deductible. She made the choice to pay the $40, which obviously I think most of us would have. But the other example that you gave where it was $7 as compared to $26, that is not really going to impact the deductible that much, is it?

Mr. Chancy. Oh, no, not at all.

Mr. Carter. I don't think it is going to help them get there. So, with all due respect, Dr. Yoder, you know, that is the point we are trying to make here. Generally, you know, that is an extreme case. And that is exactly what we are talking about. I mean, that is nothing short of ridiculous, and we all understand that.

One other point that was made by Dr. Yoder was the fact that if you don't get it filled through the insurance company, that you may not see a drug interaction. But is it true, Mr. Chancy, that most pharmacies now have programs where they -- drug interactions are -- before you fill a prescription, you are going through the patient's profile and looking at all the drugs that are on there anyway?

Mr. Chancy. That is correct.

Mr. Carter. Okay. So it really should not be that much of a problem, unless they are getting it somewhere else, which could happen. But, for the most part, you find your patients to be getting their medications at one drugstore.

Mr. Chancy. That is correct.

Mr. Carter. Okay. Boy, 5 minutes flies when you have been waiting around all day to ask questions. I do want to thank all of you for being here, and this is something that is very important. Again, Mr. Chairman, I want to thank you for this discussion and

this hearing today. Very important. I could not agree with you more that this is the most important subcommittee in Congress. So thank you, and I yield back.

Mr. Burgess. And the most productive.

I recognize myself for 5 minutes.

Mr. Chancy, I just have to ask you, when you sign a contract, it is voluntary, so no one is forcing you to sign the contract. Do you have the option of not signing the contract and saying, "Hey, come back to me with a contract that doesn't have these nondisparagement riders in it"?

Mr. Chancy. We do have the option of opting out, but we don't always know what is in the contract.

Mr. Burgess. I guess that bothers me a little bit. But I can remember early in the days of managed care, as a physician, I had complained about a contract, and the lawyer advising the practice said: Well, you signed a stupid contract.

I said: Well, how do you tell it is a stupid contract?

He said: That is the first one they give you, and you signed it.

The only reason I am bringing this up is because, as a profession, you know, it may be incumbent on us as part of our profession to be ever-vigilant on behalf of our patients, especially as we get into more and more situations where ownership is not in the hands of the community pharmacist, not in the hands of the practicing physician, but in the hands of an insurance company, the government, or someone else. And, again, that is the only reason I bring that up is the charge for all of us has got to be not -- transparency will only go so far. You have got to be vigilant on top of that.

Mr. Cunningham, let me just ask you, because you mentioned some of the supplemental services that are covered, and you mentioned housing specifically. Is transportation ever covered?

Mr. Cunningham. I know the ability to develop plans to assist with transportation, in Wisconsin that is a covered benefit in our community. So what the ADRC would do is assist in developing a plan to ensure the individual has proper transportation in the community to both medical and also for social events.

Mr. Burgess. Because Wisconsin is one thing, but Texas, I mean, the distances are large. But it seems with ride-sharing abilities now, that actually could be quite cost-effective. You are not sending a taxicab company out to pick someone up, but with the ride-sharing apps that people are so accustomed to using now, again, it seems like that could be an option for increasing participation or increasing compliance on the part of the patient. That is why I was wondering if that had been one of the things that you had studied in your efforts.

Mr. Cunningham. Yes, it is a covered benefit in our waiver program. But to the extent they don't have transportation, I think that would be either MFP would be able to -- used to identify an affordable transportation. I am not totally sure of the exact reimbursement to the transportation provider.

Mr. Burgess. I may follow up. I will do some followup on that myself. But you intrigued me with your comments, General Schmidt. We have spent a lot of time in this subcommittee and the full committee dealing with the problems from opiate abuse and the recovery therefrom. And so some of your comments about the prosecutorial side, it is one thing to find that there has been diversion, but if a patient is actually harmed in the process.

We study sober homes to some extent here, and we had a panel of family members that came and talked to us. And three of those five panel members, family members, all talked about the danger and the damages from sober homes in not providing the type of care that they were supposed to provide, and people actually

suffered as a consequence. Has that been any part of your experience as well?

Mr. Schmidt. I don't know about the sober homes in particular, Mr. Chairman. But yes, I think I mentioned in my written testimony, we have criminal charges currently pending against an individual, of course, not yet adjudicated, so she is innocent unless and until proven guilty, but who was delivering -- she was a nurse in a variety of facilities, sort of rode a circuit and was supposed to be delivering medications to beneficiaries and instead was diverting those medications to illicit uses and obviously causing some fairly substantial harm to the beneficiaries, either in terms of pain management didn't happen or some of the medications' other purposes. So, yes, we have seen that.

And then the flip side of that, with respect to perhaps the intersection between H.R. 3891 and opioid enforcement, you know, we are looking at cases currently. We haven't filed any of these yet, so they may or may not pan out, either under current law or under expanded authority. But, you know, potential diversion cases, I will call them pill mill-type cases in a colloquial, where the diversion occurs outside of a healthcare facility or outside of a board and care facility. So they are outside the scope of the MFCU now.

And, you know, one of the things that we just sit around and sort of scratch our heads on is, well, what is our legal theory if we were able to prove this? And right now our legal theory if I want to use the MFCU assets is the fraud to the program for diverting those pills. I can prosecute for a few bucks a pill the financial loss.

But if that diversion results in serious bodily injury or death to somebody who is misusing those pills, which would be a separate crime under Kansas and Federal law, I can't use the MFCU assets to prosecute that much greater ill, and that just doesn't make sense to me.

Mr. Burgess. You are right. And this subcommittee, we are all about making

sense.

Mr. Merrill and Mr. Salo, I apologize.

Mr. Merrill, I just have to ask you, because we talked about this a little bit offline when we visited about this. You mentioned the STAR programs in Texas, and, of course, some of the headlines recently from one of the big managed care companies was not providing quite the services or their ability to reduce cost was essentially reducing benefits. And you had some thoughts about it is important to pay attention to the payer in some of these instances.

So could you kind of reprise those comments for this subcommittee?

Mr. Merrill. Well, I guess in its basic level, care is really never and should never be coordinated at the payer side of the equation. It should be coordinated at the provider side of the equation.

All of these caregivers play a role in this, but I can speak specifically about our own experience at Cook Children's. Since we are a provider-based HMO, we don't have premium expense or dollars or profits that have to go to Wall Street. It is a model that has been out there for quite some time. But the dollars that would normally go to Wall Street we actually reinvest in our community, and that allows us to do more care for these kids.

So I think you have a difference in philosophy on these two different approaches. I do believe personally that provider-based health plans do better work, because their premium expense is all focused on taking better care of these kids. And I know there has been some controversy over that in the STAR Kids program. If you read those articles, you will see that the complaints or concerns that were expressed were on that side of the equation and not on the provider side of the equation. I am telling you as straightforward as I know how, but that is I think the reality of the situation.

Mr. Burgess. I thank you for sharing that, because when you told me that the other day, I thought that was an important concept that needs to be out there.

Mr. Green, do you have any concluding thoughts?

Mr. Green. Nothing further, Mr. Chairman. Can I ask for 3 minutes at some future hearing?

Mr. Burgess. I was just aggregating all of the extra time I gave members on your side and capitalizing upon it. It is like access to capital, right?

So seeing that there are no further members wishing to ask questions, I once again want to thank our witnesses for being here today.

Additionally, in addition to all the other documents that we have accepted for the record, I want to submit documents from PillPack, Incorporated; LeadingAge; Medicaid Health Plans of America; and the American Association of Medical Colleges.

[The information follows:]

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

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

Without objection, the panel is again thanked and the subcommittee is adjourned.

[Whereupon, at 12:54 p.m., the subcommittee was adjourned.]