

**THE EXTENDERS POLICIES: WHAT ARE THEY  
AND HOW SHOULD THEY CONTINUE UNDER  
A PERMANENT SGR REPEAL LANDSCAPE?**

---

---

**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON ENERGY AND  
COMMERCE  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

JANUARY 9, 2014

**Serial No. 113-111**



Printed for the use of the Committee on Energy and Commerce  
*energycommerce.house.gov*

U.S. GOVERNMENT PRINTING OFFICE

88-470

WASHINGTON : 2014

---

For sale by the Superintendent of Documents, U.S. Government Printing Office  
Internet: [bookstore.gpo.gov](http://bookstore.gpo.gov) Phone: toll free (866) 512-1800; DC area (202) 512-1800  
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan

*Chairman*

RALPH M. HALL, Texas

JOE BARTON, Texas

*Chairman Emeritus*

ED WHITFIELD, Kentucky

JOHN SHIMKUS, Illinois

JOSEPH R. PITTS, Pennsylvania

GREG WALDEN, Oregon

LEE TERRY, Nebraska

MIKE ROGERS, Michigan

TIM MURPHY, Pennsylvania

MICHAEL C. BURGESS, Texas

MARSHA BLACKBURN, Tennessee

*Vice Chairman*

PHIL GINGREY, Georgia

STEVE SCALISE, Louisiana

ROBERT E. LATTA, Ohio

CATHY McMORRIS RODGERS, Washington

GREGG HARPER, Mississippi

LEONARD LANCE, New Jersey

BILL CASSIDY, Louisiana

BRETT GUTHRIE, Kentucky

PETE OLSON, Texas

DAVID B. MCKINLEY, West Virginia

CORY GARDNER, Colorado

MIKE POMPEO, Kansas

ADAM KINZINGER, Illinois

H. MORGAN GRIFFITH, Virginia

GUS M. BILIRAKIS, Florida

BILL JOHNSON, Missouri

BILLY LONG, Missouri

RENEE L. ELLMERS, North Carolina

HENRY A. WAXMAN, California

*Ranking Member*

JOHN D. DINGELL, Michigan

*Chairman Emeritus*

FRANK PALLONE, JR., New Jersey

BOBBY L. RUSH, Illinois

ANNA G. ESHOO, California

ELIOT L. ENGEL, New York

GENE GREEN, Texas

DIANA DeGETTE, Colorado

LOIS CAPP, California

MICHAEL F. DOYLE, Pennsylvania

JANICE D. SCHAKOWSKY, Illinois

JIM MATHESON, Utah

G.K. BUTTERFIELD, North Carolina

JOHN BARROW, Georgia

DORIS O. MATSUI, California

DONNA M. CHRISTENSEN, Virgin Islands

KATHY CASTOR, Florida

JOHN P. SARBANES, Maryland

JERRY McNERNEY, California

BRUCE L. BRALEY, Iowa

PETER WELCH, Vermont

BEN RAY LUJAN, New Mexico

PAUL TONKO, New York

JOHN A. YARMUTH, Kentucky

SUBCOMMITTEE ON HEALTH

JOSEPH R. PITTS, Pennsylvania  
*Chairman*

MICHAEL C. BURGESS, Texas  
*Vice Chairman*

ED WHITFIELD, Kentucky

JOHN SHIMKUS, Illinois

MIKE ROGERS, Michigan

TIM MURPHY, Pennsylvania

MARSHA BLACKBURN, Tennessee

PHIL GINGREY, Georgia

CATHY McMORRIS RODGERS, Washington

LEONARD LANCE, New Jersey

BILL CASSIDY, Louisiana

BRETT GUTHRIE, Kentucky

H. MORGAN GRIFFITH, Virginia

GUS M. BILIRAKIS, Florida

RENEE L. ELLMERS, North Carolina

JOE BARTON, Texas

FRED UPTON, Michigan (ex officio)

FRANK PALLONE, JR., New Jersey  
*Ranking Member*

JOHN D. DINGELL, Michigan

ELIOT L. ENGEL, New York

LOIS CAPP, California

JANICE D. SCHAKOWSKY, Illinois

JIM MATHESON, Utah

GENE GREEN, Texas

G.K. BUTTERFIELD, North Carolina

JOHN BARROW, Georgia

DONNA M. CHRISTENSEN, Virgin Islands

KATHY CASTOR, Florida

JOHN P. SARBANES, Maryland

HENRY A. WAXMAN, California (ex officio)



## CONTENTS

---

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement .....	1
Prepared statement .....	2
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement .....	4
Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement .....	5
WITNESSES	
Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission (MEDPAC) .....	7
Prepared statement .....	9
Diane Rowland, Sc.D., Chair, Medicaid and CHIP Payment and Access Commission (MACPAC) .....	30
Prepared statement .....	32
Michael Lu, M.D., M.S., M.P.H., Associate Administrator, Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services .....	57
Prepared statement .....	59
Naomi Goldstein, Ph.D., Director, Office of Planning, Research and Evaluation, Administration for Child and Families (ACF), U.S. Department of Health and Human Services .....	66
Prepared statement .....	68
Answers to submitted questions .....	223
SUBMITTED MATERIAL	
Statement of the American Hospital Association, submitted by Mr. Burgess ...	102
Pallone documents .....	110
Pitts documents .....	128
Statement of the Federation of American Hospitals, submitted by Mr. Griffith .....	219



**THE EXTENDERS POLICIES: WHAT ARE THEY  
AND HOW SHOULD THEY CONTINUE UNDER  
A PERMANENT SGR REPEAL LANDSCAPE?**

**THURSDAY, JANUARY 9, 2014**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Lance, Cassidy, Griffith, Bilirakis, Ellmers, Pallone, Dingell, Capps, Matheson, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Gary Andres, Staff Director; Noelle Clemente, Press Secretary; Brenda Destro, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Amy Hall, Democratic Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; and Anne Morris Reid, Democratic Professional Staff Member.

**OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for an opening statement.

This subcommittee has played an integral role in advancing a permanent repeal of the SGR and implementing a replacement policy for Medicare reimbursement to physicians. We reported out Dr. Burgess's Medicare Patient Access and Quality Improvement Act of 2013, H.R. 2810, by voice vote, and the full committee reported it out favorably by a vote of 51 to 0 last July.

As we move ahead with a permanent SGR fix, we also need to examine the expiring Medicare/Medicaid Children's Health Insur-

ance Program—CHIP—and Human Services’ provisions that have traditionally moved with the SGR.

The purpose of today’s hearing is to look at these extenders and evaluate whether some of these short-term provisions should be made permanent and, if so, how best to accomplish this.

The list of extenders includes the following: the floor on Geographic Adjustment, or GPCI, for physician fee schedule, Ambulance Transitional Increase and Annual Reimbursement Update; Therapy Cap Exceptions Process, Special Needs Plans, Medicare Reasonable Cost Contracts, National Quality Forum—NQF; Qualifying Individual—QI program; Transitional Medical Assistance—TMA; Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals; Medicare-Dependent Hospital—MDA program; Medicaid and CHIP Express Lane Eligibility; Children’s Performance Bonus Payments; Child Health Quality Measures, Outreach and Assistance for Low-Income Programs, Child Health Quality Measures, Family-to-Family Health Information Centers, Abstinence Education, Personal Responsibility Education Program; Health Workforce Demonstration Program; the Maternal, Infant, and Early Childhood Home Visiting Programs; and Special Diabetes Program.

In our current budget climate, and with the Medicaid trustees predicting insolvency as early as 2026, hard decisions will have to be made. A determination that a policy should be made permanent must be based on data-driven analysis that justifies the extenders’ continued existence.

I am looking forward to hearing from our witnesses today, particularly MedPAC, which has come up with its own criteria for evaluating these provisions, which includes the effect possible action would have on program spending relative to current law, whether such action would improve beneficiaries’ access to care and quality of care, and whether action would advance delivery system reform.

This is a time for us to be very prudent, even skeptical, given the enormous cost of these policies and do our job on behalf of the taxpayers to ensure every dollar spent is reviewed for efficacy.

Thank you, and I yield the remainder of my time to Dr. Burgess, vice chairman of the subcommittee.

[The prepared statement of Mr. Pitts follows:]

#### PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

This Subcommittee has played an integral role in advancing a permanent repeal of the Sustainable Growth Rate (SGR) and implementing a sound replacement policy for Medicare reimbursements to physicians.

We reported out Dr. Burgess’ Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810) by voice vote, and the Full Committee reported it out favorably by a vote of 51 to 0 last July.

As we move ahead with a permanent SGR fix, we also need to examine the expiring Medicare, Medicaid, Children’s Health Insurance Program (CHIP), and human services provisions that have traditionally moved with the SGR.

The purpose of today’s hearing is to look at these “extenders” and evaluate whether some of these short-term provisions should be made permanent, and, if so, how best to accomplish this.

The list of extenders includes the following:

- Floor on Geographic Adjustment (or GPCI) for Physician Fee Schedule,

- Ambulance Transitional Increase & Annual Reimbursement Update,
- Therapy Cap Exceptions Process,
- Special Needs Plans,
- Medicare Reasonable Cost Contracts,
- National Quality Forum (NQF),
- Qualifying Individual (QI) Program,
- Transitional Medical Assistance (TMA),
- Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals,
- Medicare-Dependent Hospital (MDH) program,
- Medicaid and CHIP Express Lane Eligibility,
- Children's Performance Bonus Payments,
- Child Health Quality Measures,
- Outreach and Assistance for Low Income Programs,
- Family-to-Family Health Information Centers,
- Abstinence Education,
- Personal Responsibility Education Program,
- Health Workforce Demonstration Program,
- The Maternal, Infant, and Early Childhood Home Visiting Programs, and
- Special Diabetes Program.

In our current budget climate, and with the Medicare Trustees predicting insolvency as early as 2026, hard decisions will have to be made.

Any determination that a policy should be made permanent must be based on data-driven analysis that justifies the extender's continued existence.

I am looking forward to hearing from our witnesses today, particularly MedPAC, which has come up with its own criteria for evaluating these provisions, which includes the effect possible action would have on program spending relative to current law; whether such action would improve beneficiaries' access to care and quality of care; and whether action would advance delivery system reform.

This is a time for us to be very prudent, even skeptical, given the enormous costs of these policies, and do our job on behalf of the taxpayers to ensure every dollar spent is reviewed for efficacy.

Thank you, and I yield the remainder of my time to

Mr. BURGESS. Thank you, Mr. Chairman, and I do appreciate that you started your opening statement with the acknowledgment that the reason we are here today is because of the real progress that has been made on the repeal of the Sustainable Growth Rate formula, which has been a problem for a lot of us for a long time, so the cake is literally in the oven baking and today we are going to talk about what else may go into that before the process is completed.

There are certainly a number of Medicare- and Medicaid-related policies that every year plague providers because of the uncertainty that it brings to the program participation by provider payment each year. Not all of these policies are under our jurisdiction. Many are some that have proven successful but many of these programs are under our jurisdiction and many of them have proven successful such as the Special Diabetes programs and the Special Needs Plans. Others are essential to guaranteed access to care in States like Texas with large rural areas such as the Medicare-Dependent and Low-Volume Hospital programs. Still other extenders are necessary to block misguided policies like the Medicare therapy cuts. Capping rehabilitative access made no sense when it was first passed several years ago, and guess what? With the passage of time, nothing has improved. It still makes no sense. Doctors should be able to provide their patients with the option of therapy and never fear that either prior to or after surgery a patient will not be able to access the therapy services that they require.

So certainly, Mr. Chairman, I am appreciative of the work that this subcommittee did in moving the SGR reform along as we were

the initial subcommittee that passed real, meaningful Sustainable Growth Rate reform out of subcommittee on to full committee. Other jurisdictions have taken up that matter but it all started here with you, Mr. Chairman, and I am appreciative of that.

I would also ask unanimous consent to submit the testimony of the American Hospital Association for the record as well, and yield back.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. The Chair now recognizes the ranking member of the subcommittee, Mr. Pallone, 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. Thank you, Chairman Pitts.

I am pleased we are having this hearing today to discuss the temporary payment policies and programs we typically extended every year alongside the SGR. I thank our witnesses also for being here today to contribute to the discussion.

This subcommittee has an important role in reviewing and evaluating health care policies and the extenders provisions that will contribute to the health care communities' abilities to better serve beneficiaries under Medicare and Medicaid.

In many ways, extenders support the health care framework envisioned in the Affordable Care Act. They work through various mechanisms to support increased access to health care and to encourage higher quality and more efficient patient care.

In spite of all that, we move beyond the unworkable process of legislating extenders policies year to year. We need to set these policies up for success by providing a better sense of stability, and that is not to say that I think we should every provision permanently but moving towards a 3- to 5-year end date in some cases will better enable the subcommittee to conduct proper oversight and consider making changes periodically based on data collected over a sufficient amount of time.

In addition, we look to make changes to some of these policies but, more importantly, as we look to offset the costs associated with both the SGR and extenders, we must not cost-shift onto vulnerable patients who rely on these programs.

I just wanted to take a moment to highlight some extenders and how they help our Medicare and Medicaid programs, and this is not an exhaustive list, but certainly they are ones that I would like to work to urge this committee to extend. One is the Qualifying Individual, or QI, program in Medicare, which assists certain low-income Medicare beneficiaries by covering the cost of their Medicare Part B premium. This program helps reduce financial burdens and thereby improve access to needed health care services for low-income Medicare beneficiaries who do not qualify for Medicaid. In New Jersey, 40,000 people were able to get this needed financial assistance in 2013.

Another is the Transitional Medical Assistance, or TMA, program, which allows low-income families on Medicaid to maintain their Medicaid coverage for up to one year when their income

changes as a result of transitioning into employment. The TMA program helps keep people continuously insured, allowing for consistent access to primary care and prevention services.

I also wanted to highlight two payment policies that we implemented in the ACA. The Medicaid Primary Care Physician Bonus Payment augments the low physician rates in Medicaid compared to Medicare. Research has shown that higher Medicaid payments increase the probability of beneficiaries having usual source of care and at least one visit to a doctor. This is an important policy that I believe should be extended because, unfortunately, we still need time to understand the impact of the program in a meaningful and empirical way. I also believe that there are physicians who are essential to the Medicaid program such as neurologists, psychiatrists and OB/GYNs that aren't included in the bonus payment but should be.

We also included in the ACA performance bonuses for States that increased enrollment of children in Medicaid and streamlined enrollment procedures for Medicaid and CHIP. New Jersey was one of 23 States that received a bonus payment in 2013 through this program. Minimizing barriers to enrolling in coverage makes a difference in how many children are enrolled each year and ultimately whether they receive their prevention services and medical care they need.

And finally, I want to mention the Family to Family Health Information Centers, or F2F grant program. F2Fs assist families of children and youth with special health needs in making informed choices about health care, which in turn promotes improved health outcomes and more effective treatments. So F2Fs provide a unique service in that they are staffed by family members who have first-hand experience in navigating special needs health care services and that is why I have sponsored a bill, H.R. 564, to extend F2F funding through 2016 and will continue to advocate for its inclusion in any SGR package.

These are just a few examples of the many extender provisions that we must discuss as we move forward with an SGR fix. I have been pleased by the recent progress made on SGR, Mr. Chairman, and I stand ready to work with my colleagues on both our committee and Ways and Means and with our Senate counterparts to permanently repeal and replace the SGR and continue these important extender provisions.

I don't know if Ms. Capps would like my last 30 seconds. All right. Then I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. Our Chair is not here, so the Chair recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

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

My colleagues, this Congress seems to be, I hope, poised to eliminate the SGR and make it a program that will no longer be in existence so every year we don't have to go through the torture of trying to make sure that the harmful consequences of not extending

it would be averted. All three committees, two in the House and one in the Senate, have voted—our Committee voted unanimously—on the SGR. I hope we can get it across the finish line and let us get this job done.

The SGR issue has often served as a vehicle to address Medicare, Medicaid, the Children's Health Insurance Program and additional public health-related programs, which contain similar time limits. These provisions have been collectively referred to as extenders or extender policies. When we permanently repeal and replace the Medicare SGR policy, we must also address these associated extender policies. These policies seek to protect vulnerable patient populations and the providers and health programs that serve them, so we can't afford to leave them out in the cold and in jeopardy of being terminated.

In Medicare, we have policies that need to be extended relating to therapy caps and Special Needs Plans. Those have been discussed; they are well known. There are six public health extenders, some which have a long history of bipartisan support, and I am generally supportive of these public health programs, but I do want to note my reservations about extending the Abstinence Only program.

But I want to focus on the Medicaid and CHIP issues, which are often overlooked. Those policies help secure affordable coverage, boost enrollment of eligible children, and streamline administrative processes for States. For example, there is an Express Lane program. It gives States the option of relying on income data already in use for other federal programs, helping reduce bureaucracy and lower State administrative costs. This should be a permanent option for the States. The Transitional Medical Assistance and Qualified Individual programs are indispensable for low-income families. We must end the annual extender roller coaster and ensure this coverage is secure going forward. The CHIP bonus payments have been successful at getting States to adopt simplifications and find and ways to get people enrolled, get kids enrolled. Twenty-three States, more than half of them with governors who are Republicans, have qualified under this program. We should continue it through the current CHIP reauthorization. And also, I have heard a great deal from family doctors and pediatricians about the Medicaid primary care bonus. It is something that would provide stability and adequate payment for physicians comparable to what we do in Medicare, and there is no better way to assure access and provide an alternative to the emergency room for care than making sure that doctors, especially family care and pediatricians, will have the extra payment to allow them to see these patients.

So I am glad we are holding this hearing, and I want to yield the balance of my time to my friend and colleague from California, Ms. Capps, who has a number of public health provisions that are in this bill that are very meritorious.

Mrs. CAPPS. Thank you very much. Thank you, Waxman.

And I want to just simply add my thanks to the chairman and Ranking Member Pallone for holding this very important hearing today.

You know, we have had many discussions of how to move past the flawed SGR system, and I have frequently shared my views

that we can't and must not ignore the important health care extenders, many of which have been mentioned already. These typically go along with SGR patch legislation, small technical but critical policies that make a world of difference for health care providers and their patients.

I just want to stand ready to work with my colleagues on each of these issues, especially those that have been already mentioned—the Medicare therapy cap, the Medicaid primary care bump, the many critical Medicaid and public health care extenders that we are considering today, and again, thank you for yielding your time and also for holding the hearing today. Yield back.

Mr. PITTS. The Chair thanks the gentlelady. That concludes the opening statements of the members.

I would like to thank all of the witnesses for coming today. We have one panel. On our panel today we have Mr. Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission, MedPAC. We have Dr. Diane Rowland, Chair, Medicaid and CHIP Payment Access Commission, MACPAC. We have Dr. Michael Lu, Associate Administrator, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. And finally, Dr. Naomi Goldstein, Director, Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Thank you for coming. Your prepared testimony will be made part of the record. You will have 5 minutes to summarize your testimony, and that will be placed in the record.

At this point I will recognize Mr. Hackbarth for 5 minutes for his summary.

**STATEMENTS OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC); DIANE ROWLAND, SC.D., CHAIR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC); MICHAEL LU, M.D., M.S., M.P.H., ASSOCIATE ADMINISTRATOR, MATERNAL AND CHILD HEALTH BUREAU, HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND NAOMI GOLDSTEIN, PH.D., DIRECTOR, OFFICE OF PLANNING, RESEARCH AND EVALUATION, ADMINISTRATION FOR CHILD AND FAMILIES (ACF), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

#### **STATEMENT OF GLENN HACKBARTH**

Mr. HACKBARTH. Thank you, Chairman Pitts, Ranking Member Pallone and Vice Chairman Burgess. I appreciate the opportunity to talk about MedPAC's recommendations on these issues.

As the chairman noted, there is a long list of Medicare provisions under discussion here and it is a diverse list. I won't try to summarize our substantive views on those provisions. Instead, what I will do is describe the criteria that we used to evaluate provisions.

We looked at them in two batches. First, there was a 2010 request from the Congress focusing on some temporary Medicare extenders, as they are known. By definition, all of these provisions increase spending above the current law baseline. In evaluating

those provisions, what we did was ask the question, whether there is evidence that provision in question improves access to care, quality of care or enhances movement towards new payment models.

We also had a 2011 request from the Congress to evaluate various special payment provisions that apply to rural providers. There we used a similar test. We asked whether the provision in question was targeted so that it provided support to isolated providers necessary to assure access to care for Medicare beneficiaries, whether the level of the adjustment provided was empirically justified and whether it was designed to preserve some incentive for the efficient delivery of care. These tests that we applied are admittedly stringent tests but we believe that they are consistent with our statutory charge to make recommendations to the Congress that are designed to assure access to high-quality care while also minimizing the burden on the taxpayers.

We think a stringent test is particularly appropriate in the current context of SGR repeal. As the committee well knows, we have been long-time advocates of SGR repeal, well over a decade now. We are heartened by the progress that has been made towards repeal and recognize an important part of the remaining challenge is the financing of repeal, so we think a stringent test on the extenders is an appropriate test in this context.

So I welcome questions from the committee. Those are my summary comments.

[The prepared statement of Mr. Hackbarth follows:]

**Temporary Payment Policies  
in Medicare**

January 9, 2014

Statement of

Glenn M. Hackbarth, J.D.

Chairman

Medicare Payment Advisory Commission

Before the

Subcommittee on Health

Committee on Energy and Commerce

U.S. House of Representatives

Chairman Pitts, Ranking Member Pallone, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's recommendations as they concern temporary payment policies in Medicare.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.

### **Introduction**

As part of the Commission's Congressional mandate, each year MedPAC makes recommendations to the Congress on how payments to health care providers in Medicare should be updated or improved. Occasionally the Congress requests that the Commission review specific payment policies in Medicare, including temporary policies that require annual reauthorization at a budgetary cost to the taxpayer. In these instances, the Commission reviews the available data, policy options, and implications, and includes this analysis in our standing reports to Congress. In making our assessment of temporary policies, the Commission often uses a common set of questions:

- What effect would the policy have on program spending relative to current law?
- What effect would the policy have on beneficiaries' access to care?
- What effect would the policy have on the quality of care?
- Does the policy advance payment reform? Does it move Medicare payment policy away from fragmented fee-for-service (FFS) payment and encourage a more integrated delivery system?

The Commission's work may also include recommendations, as appropriate. In certain cases, the Commission has not made recommendations, but instead has developed a set of principles the Congress could use to evaluate payment policies

In what follows, I will review the Commission's findings and recommendations (if available) on the following temporary Medicare payment policies:

- Rural hospital add-on payments
- Medicare floor for physician work (GPCI)
- Medicare therapy caps exceptions process
- Medicare ambulance add-ons
- Medicare Advantage special needs plans

### **Rural hospital add-on payments**

A key objective of Medicare's rural payment adjustments is to maintain access to care. Areas with low population density may have small, isolated, low-volume care providers. In these cases, costs may be above average because the low population density prevents economies of scale, and the low volume and high costs may be beyond a provider's control. Special payments by federal or local sources may be needed to maintain access to care in these communities. However, in some cases, the special payments are not adequately targeted toward the hospitals needed for access.

### **Principles for evaluating rural add-on payments**

One challenge for policymakers is that the current mix of rural payment adjusters is not guided by a coherent set of underlying principles. The adjusters evolved separately, and there is not a clear common framework for how they are intended to work together to preserve access without duplicative, overlapping adjustments. In addition, they are not always targeted to the areas with the greatest concerns about access to care. The lack of targeting stems in part from Medicare's definition of "rural." Medicare defines rural as all areas outside of metropolitan statistical areas, so many adjustments can apply to rural areas with a single local provider as well as rural areas with many competing local providers. The Commission has created a framework of principles for rationalizing rural add-on payments that includes targeting providers that are necessary for access, empirically justifying (and not duplicating) payments, and maintaining incentives for cost control.

*Principle 1: Target payment adjusters to preserve access*

Payment adjusters should be targeted to providers that are necessary to preserve beneficiaries' access to care. Currently, special adjustments often go to rural providers, whether they are critical to maintaining access or not. This practice ignores the wide variation in provider supply in different rural communities.

*Principle 2: Focus low-volume adjustments on isolated providers*

Many of the current adjustments focus on increasing payments to low-volume providers. However, there are two types of low-volume providers. One type is isolated providers who have low volumes because of low population density in their markets. These providers often have difficulty covering their fixed costs given their low volume of cases. For these providers, low volumes are inevitable and beyond their control. A second type of provider has low volumes because neighboring competitors attract patients away from the low-volume provider. These providers are not necessary for access, and it may be inappropriate to give a low-volume adjustment to two competing low-volume hospitals that are 5 or 10 miles from each other. By focusing low-volume adjustments on isolated providers, rather than making the adjustment available to all providers with low volumes, Medicare can best use its limited resources to serve Medicare beneficiaries.

*Principle 3: Empirically justify the magnitude of payment adjustments*

The magnitude of the adjustment should be determined empirically. For example, it is necessary to determine the degree to which a low patient volume makes it more difficult for a provider to cover its fixed costs. Patient volume should be measured as total patient volume rather than solely Medicare patient volume, because economies of scale depend on total volumes of patients.

*Principle 4: Maintain incentives for cost control*

It matters not only how much money is paid to rural providers, but also how it is paid. For example, Medicare's approach of paying prospective payment rates to providers puts stronger pressure on providers to control their costs. Cost-based payments reduce this incentive. Therefore, cost-based reimbursement could be limited to the most isolated providers with very low case volume and highly variable costs that are hard to predict.

**Inpatient low-volume adjustment**

In our 2001 Report to Congress on Medicare in rural areas, the Commission recommended that the Congress require the Secretary to create a low-volume adjustment for hospitals that are more than a specified distance from other facilities. The Congress enacted a low-volume adjustment in 2003 and the Secretary implemented it, determining that only hospitals receiving prospective payment (PPS hospitals) with fewer than 200 total discharges that are more than 25 miles from another hospital warrant such an adjustment. Because many of the smallest hospitals are already critical access hospitals (CAHs), which receive cost-based reimbursement, the low-volume adjustment applied to only 2 PPS hospitals in 2010. CMS has the regulatory authority to increase the number of hospitals that qualify for this adjustment by increasing the total discharge threshold from 200 up to 800, which would expand the number of hospitals that could qualify for the adjustment.

In 2010, the Congress enacted an additional temporary low-volume adjustment for hospitals that are 15 miles or more from another PPS hospital. Unlike the permanent low-volume adjustment which lets the Secretary determine the discharge threshold, the Congress mandated that inpatient payments increase for any hospital with fewer than 1,600 Medicare discharges. PPS payments are increased by 25 percent for hospitals with 200 or fewer Medicare discharges, with the adjustment declining linearly until it phases out for hospitals with 1,600 or more Medicare discharges. For example, a hospital with 200 Medicare discharges gets a 25 percent add on, a hospital with 900 Medicare discharges gets a 12.5 percent add on, and a hospital with 1,600 Medicare discharges receives no add on. The adjustment is not well targeted with over 50 percent of rural IPPS hospitals qualifying for the adjustment.

The Commission has raised several concerns about this adjustment:

- The program is not focused on isolated hospitals because low-volume hospitals are allowed to be any distance from critical access hospitals.
- The adjustment can be duplicative of sole community hospital (SCH) payments. A sole community hospital receives SCH payments based on its historical cost inflated forward, and then can receive a low-volume add-on payment in addition to the cost-based payments.

- The amount of the adjustment may be more than is empirically justified and may reduce incentives for cost control. Rural hospitals within the bottom quintile of Medicare volume (those that would receive the largest add-on payment) had 7.1 percent Medicare margins in 2012 compared to a -5.4 percent for all hospitals. The 12.5 percent higher profit margin at the lowest volume hospitals suggests that the adjustment is larger than is empirically justified.
- The adjustment is based on Medicare discharges rather than total discharges. Economies of scale depend on total discharges (not just Medicare discharges), so the adjustment has a weaker connection to a provider's problem with economies of scale than an adjustment based on total discharges. Basing the adjustment on Medicare discharges also discriminates in favor of hospitals with large numbers of private-payer patients and against hospitals with larger shares of Medicare discharges.

**Table 1. Low-volume policy favors hospitals with larger non-Medicare shares**

Type of hospital	Medicare discharges	Private-payer and other discharges	Total discharges	Low-volume adjustment
Hospital A: high Medicare share (70%)	1,500	600	2,100	2% increase
Hospital B: low Medicare share (30%)	600	1,500	2,100	18% increase

Note: We rounded data from two hospitals that would have qualified for the low-volume payment based on their 2009 Medicare volume.

Source: MedPAC analysis of CMS data.

Table 1 shows the 2009 volumes of Medicare and total discharges for two hospitals and simulates how the low-volume adjustment would affect those hospitals in 2011. Hospital A, with a 70 percent Medicare share, receives only a 2 percent low-volume add-on due to having 1,500 Medicare discharges (the maximum number of discharges still eligible for the add-on). It has 2,100 total discharges. Like Hospital A, Hospital B has low economies of scale with the same number of total discharges (2,100), but it receives an 18 percent add-on because a smaller share of its patients are Medicare beneficiaries (600). Hospital B is unfairly advantaged under the current system, especially if a large share of its non-Medicare patients is highly profitable privately insured patients.

While the Commission did not make a recommendation about the temporary inpatient low-volume adjustment, the set of principles we advanced could be used as a guide to modify the policy to better target Medicare's assistance to low-volume, isolated providers.

### **Medicare floor for physician work (GPCI)**

The fee schedule for physician and other health professionals includes geographic practice cost indexes (GPCIs) that adjust payment rates for costs such as rent and office staff wages that vary depending on the geographic area in which a service is furnished. The work GPCI is one of three geographic payment indexes. The other two adjust for practice expense and professional liability insurance. Together, they adjust payments for resource costs that are beyond providers' control and that vary geographically.

Arguments for and against one of the GPCIs—the GPCI for the work effort of the physician or other health professional—have persisted since the development of the fee schedule in the 1980s. The chief argument made in favor of a work GPCI is that cost of living varies across areas. If payment rates for fee schedule services are not adjusted with a work GPCI, the supply of physicians and other health professionals might not be sufficient in high-cost areas and beneficiary access to care in those areas could suffer.

One argument made against the work GPCI is that the data used to construct it are flawed. For example, differences across practices in return on investment (profitability of practices), geographic variation in the volume of services provided under fee-for-service payments, and the market concentration of insurers or providers limit the usefulness of data on physician earnings for creating an index. In addition, if data on the earnings of physicians and other health professionals were used to construct the work GPCI, there would be a circular relationship between the work GPCI and the data used to construct it.

Another argument against a work GPCI is geographic equality. That is, the work of physicians and other health professionals is the same in all areas, so there should be no difference in payment levels across different geographic areas. Still others cite the extra demands or costs of rural practice, such as greater on-call time and travel, and assert that physicians and other health professionals must be paid more to locate in rural areas. By contrast, the work GPCI tends to

lower payment rates in rural areas relative to urban areas because professional earnings in rural areas are lower.

Concerns about the work GPCI have led the Congress to put constraints on its application. First, the GPCI is limited to one quarter of the relative cost of professional work effort in a locality compared to the national average, which means that three quarters of the payment for work effort is not adjusted by the GPCI. Second, the GPCI is limited by a temporary floor that suspends it in localities with costs of living below the national average. Without further legislation, the floor will expire at the end of March 2014.

The Commission's findings are, first, that there is evidence of the need for some level of geographic adjustment of fee schedule payments for professional work. Cost of living varies geographically. Earnings vary geographically for the professionals in the work GPCI's reference occupations. To the extent that we can measure geographic variation in physician earnings, those earnings vary geographically.

However, the current GPCI is flawed in concept and implementation. Conceptually, it is based on the earnings of professionals in a set of reference occupations (e.g., lawyers, architects, teachers), but the labor market for those professionals may not resemble the labor market for physicians and other health professionals. Implementation of the work GPCI is flawed because there appear to be no sources of data on the earnings of physicians and other health professionals of sufficient quality to validate the GPCI.

While the work GPCI is flawed, the Commission believes it does not warrant an immediate change in law. Under current law, the floor expires but only one quarter of the GPCI is applied. While we are unable to determine whether the work GPCI has an effect on the quality of care, there is no evidence that the GPCI affects beneficiaries' access to services. Moreover, the Commission believes that any access concerns would be better addressed through other targeted policies, such as the primary care bonus.

Weighing the need for some geographic adjustment, but recognizing that there is insufficient data in the short run to revise the work GPCI, the Commission made the following recommendation:

- **The Commission recommends that Medicare payments for the work effort of physicians and other health professionals be geographically adjusted. The adjustment should reflect geographic differences in cost per unit of output across labor markets for physicians and other health professionals.**
- **Further, the Congress should allow the GPCI floor to expire as current law requires and adjust payments for the work of physicians and other health professionals only by the current one-fourth GPCI (because of uncertainty in the data) while the Secretary develops an adjuster to replace it.**

Because the recommendation follows current law, it will not directly affect program spending.

### **Outpatient therapy caps exception**

The Medicare outpatient therapy benefit covers services for physical therapy, occupational therapy, and speech-language pathology. Medicare spent about \$5.7 billion in 2011 on outpatient therapy services for about 4.9 million beneficiaries. Medicare pays for outpatient therapy services through the fee schedule for physician and other health professional services.

There are annual per beneficiary spending limits (known as caps) on outpatient therapy; one for physical therapy and speech-language pathology services combined, and another for occupational therapy services. Each cap is set at \$1,920 in allowed charges for 2014. However, there is an exceptions process that allows beneficiaries to continue to receive outpatient therapy above these caps. A broad exceptions process allows providers to deliver services above either spending cap relatively easily, limiting the effectiveness of the caps. The exceptions process is scheduled to expire on March 31, 2014 under current law. Once the exceptions process expires, therapy caps would be enforced (in effect establishing hard caps) with no process to obtain coverage for additional services beyond those limits. We estimate that about 20 percent of beneficiaries receiving outpatient therapy would have their therapy truncated at the cap.

The Commission is concerned that on the one hand, hard caps would impede access to necessary and useful care for Medicare beneficiaries. For the right clinical indications, outpatient therapy services provide significant benefits. On the other hand, the automatic exceptions process is not

an effective mechanism to control volume. There is wide geographic variation in the use of outpatient therapy services, raising concerns about program integrity and unnecessarily high levels of Medicare spending. In addition, Medicare lacks basic information to evaluate the medical necessity of therapy services, such as patients' functional status and the outcomes of therapy services.

To balance these concerns the Commission makes three recommendations. The first is to improve physician oversight and program integrity, the second is to ensure access to care while managing Medicare's costs, and the third is to strengthen management of the therapy benefit in the long-term.

**Ensure program integrity**

The Medicare program currently lacks clear clinical guidelines as to who needs outpatient therapy, how much therapy they should receive, and how long they need services. In addition, there is limited physician oversight to determine a patient's clinical progress and whether services continue to be necessary. Data with which to judge the clinical necessity of therapy services are not collected by the Medicare program. Under these circumstances, Medicare has few tools to constrain excessive use of and spending for outpatient therapy services.

In addition, holding health status equal, use of outpatient therapy varies across the country, suggesting inappropriate use in areas where spending far exceeds the national average. Payment edits based on established national guidelines for appropriate therapy are needed to target aberrant therapy billers and identify geographic areas where abuse of the benefit is suspected.

The Commission's first recommendation aims to improve physician oversight over therapy services and restrain inappropriate use of therapy.

**The Congress should direct the Secretary to:**

- **Reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and**

- **Develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use PPACA-granted authorities to target high-use geographic areas and aberrant providers.**

The current certification period for the outpatient therapy plan of care is 90 days, and during that period therapy users can use unlimited amounts of therapy without review by the ordering physician. However, a 90-day certification period is longer than the average therapy episode, which lasts for 33 days. Reducing the time frame to 45 days would increase physician engagement and potentially restrain the overuse of services that may otherwise occur during a 90-day period.

In some areas of the country where there has been excessive use of outpatient therapy, CMS's contractors have developed payment edits for high amounts of therapy, reviewed claims from therapy providers that exhibit unusual billing patterns, and conducted site visits to verify the presence and legitimacy of providers. CMS should extend those efforts. Focusing on outlier geographic areas and aberrant providers should reduce the burden on providers in areas where there is little evidence of inappropriate use.

Based on the experience of recent program integrity activities regarding outpatient therapy, we would expect that increased physician oversight of therapy and narrowing the gap between the highest spending areas and the nationwide average would reduce unnecessary program spending. Some of this reduction may be offset by an increase in the number of physician visits paid under Part B if beneficiaries who reach the initial 45-day limit want to continue with their treatment.

#### **Ensure access while managing Medicare's costs**

Under current law, the automatic exceptions process will expire at the end of March. At that time, the hard caps on therapy services will take effect—there will be no exceptions, even for necessary services over the cap. To strike a balance between maintaining beneficiaries' access to necessary services and managing spending on therapy services, the Commission recommends:

To avoid caps without exceptions, the Congress should:

- **Reduce the therapy cap for physical therapy and speech-language pathology services combined and the separate cap for occupational therapy to \$1,270 each in 2013. These caps should be updated each year by the Medicare Economic Index;**
- **Direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose;**
- **Permanently include services delivered in hospital outpatient departments under therapy caps; and**
- **Apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.**

Each cap is \$1,920 in allowed charges for 2014. Reducing each therapy cap to \$1,270 would accommodate the annual therapy needs of most beneficiaries, while restraining excessive utilization. The lower caps would allow for roughly 14 physical therapy and speech-language pathology visits and 14 occupational therapy visits before any requirement for medical review. Under a reduced cap, about two-thirds of therapy users could receive services before reaching the caps.

The manual medical review process for therapy claims that exceed cap limits should be streamlined. The contractors who manage the process should accept requests for review electronically, reviews should be completed and decisions should be issued within 10 business days, and beneficiaries should be allowed to have two visits during the review process for which the provider bears financial responsibility.

The recommendation also includes hospital outpatient departments (HOPDs) under therapy caps. The Commission believes Medicare should apply the policy of annual caps to all therapy settings—including HOPDs—to ensure that no setting has an unfair competitive advantage.

In the America Taxpayer Relief Act of 2012, the Congress adopted the portion of our recommendation to apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.

We expect that the parts of this recommendation that have not been adopted by the Congress will result in an increase in Medicare spending relative to the hard cap that will take effect after March 31, 2014, under current law. The Commission strongly believes that a manual review process is essential to ensuring beneficiaries' access to needed care; this process would permit additional utilization relative to current law. However, this recommendation should decrease Medicare spending relative to the automatic exceptions process that is currently being used.

In addition, we note that if spending on outpatient therapy services is projected to be above current law, and the Congress wishes to further constrain spending, it could lower therapy caps further and increase the number of services subject to medical review, reduce payment rates for longer episodes of care, or increase beneficiary cost sharing for longer episodes.

#### **Improve management of the benefit in the long term**

The Medicare program does not have adequate data with which to evaluate the medical necessity and outcomes of outpatient therapy. Medicare's primary source of information on therapy services is claims data, but the diagnosis information currently required for Medicare payment does not permit any meaningful assessment of how a given therapy regimen relates to a given diagnosis. Claims data also lack measures of functional status, which could help determine the impact of therapy services on the patient's functional ability. The Commission's third recommendation aims to improve the longer term management of the benefit, with specific focus on improving the quality of claims data and developing a tool to collect data on functional status.

#### **The Congress should direct the Secretary to:**

- **Prohibit the use of V-codes as the principal diagnosis on outpatient therapy claims, and**
- **Collect functional status information on therapy users using a streamlined standardized assessment tool that reflects factors such as patients' demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected**

**with this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.**

In the first part of the recommendation, the Commission raises concerns about the use of a certain type of billing code, the V-code. V-codes describe the services beneficiaries receive rather than provide a description of their clinical condition. The Commission recommends that CMS deny claims which have V-codes as a principal diagnosis for therapy, which would require therapists to use more clinically relevant diagnosis codes.

The second part of the recommendation is for CMS to develop a single patient assessment instrument that measures functional status and the outcomes of therapy services over time. This streamlined tool should allow Medicare to categorize therapy users by severity of condition, track their improvement over time, and ultimately pay therapy providers for their performance. Better data could also help lay the groundwork for CMS to develop larger payment bundles that would include outpatient therapy services.

#### **Medicare ambulance add-ons**

Medicare spending for ambulance services in 2011 was \$5.3 billion, or about 1 percent of total benefits spending. Medicare pays for ambulance services under a fee schedule that uses relative value units (RVUs) to calculate a base payment, and the distance a patient is transported to calculate a mileage payment. Medicare also makes several add-on payments to certain ambulance providers; two are permanent and three are temporary. The temporary ambulance add-on payments Congress asked MedPAC to study have the following effects:

- increase payments for ambulance transports provided to beneficiaries in urban areas by 2 percent and in rural areas by 3 percent;
- increase payments for ambulance transports in “super-rural” areas by 22.6 percent; and
- designate certain counties as rural for purposes of applying a 50 percent increase in payments for air ambulance services provided in rural areas.

These three temporary add-on payment policies accounted for about \$192 million in Medicare spending and the two permanent add-on payment policies accounted for approximately \$220

million more, for total add-on payments of about \$412 million, or about 8 percent of total Medicare payments for ambulance services.

In the Commission's analysis, we found no evidence of Medicare beneficiaries having difficulty accessing ambulance services. We observed consistent growth in ambulance service use per beneficiary and spending for these services. The number of ambulance suppliers participating in Medicare grew steadily from 2007 to 2011. Over the same period, Medicare ambulance volume grew by roughly 10 percent, and basic life support (BLS) nonemergency services grew more rapidly than more complex types of services.

Much of the growth in BLS nonemergency transports was concentrated among a small share of ambulance suppliers and providers. Many of the newest suppliers entering the marketplace focus on providing nonemergency BLS services. Further, even more pronounced growth has occurred in nonemergency ambulance transports to and from dialysis facilities, and there is tremendous variation across states and territories in per capita spending for those types of transports.

We were unable to independently evaluate the financial performance of ambulance providers in Medicare, since Medicare currently does not collect supplier or provider cost data to set or update ambulance payment rates. GAO surveyed a sample of ambulance suppliers in 2012 and found that the 2010 median Medicare margin for the survey sample was 2 percent with the temporary add-ons, and estimated that the margin would be -1 percent without the add-ons. GAO's estimate of the range of median margins in 2010 is -2.3 percent to 9.3 percent with the add-ons and -8.4 percent to 5.3 percent without the add-ons. GAO also found that higher costs were associated with lower volume, more emergency versus nonemergency transports, and higher levels of government subsidies. In addition, the Commission's analysis finding that for-profit suppliers and private equity firms have recently increased their entry into the ambulance industry suggests that profit opportunities in the industry have been available.

In examining the add-on payments, the Commission finds the current ground ambulance add-ons are not well targeted. For example, the permanent rural short-mileage add-on increases payments for all ground transports in any rural ZIP code. This is problematic because the criteria of

transports being rural and short mileage are not good indicators that a transport originates in an area that has the potential for generating a low volume of transports, is isolated, or whose transports have higher costs—a supplier could have a volume of transports well beyond any reasonable standard of low-volume and still receive the add-on. The costs of providing transports are higher in isolated, low-volume rural areas and add-ons should be directed to those areas, not others, as is now the case.

Extending any of the temporary add-ons would increase costs without improving access, quality, or advancing clinical integration, and as a result, the Commission would not recommend doing so. However, to ensure beneficiary access remains, the Commission suggests a two-step approach: (1) Rebalance the relative values for ambulance services by lowering the relative value of basic life support nonemergency services and increasing the relative values of other ground transports, and (2) Replace the permanent rural short-mileage add-on for ground ambulance transports with a new budget neutral adjustment directing increased payments to ground transports originating in geographically-isolated, low-volume areas.

Rebalancing should be budget neutral relative to current law and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on. Because payments for transports other than BLS nonemergency will be maintained at their current level (at which no access problems have occurred) access should be maintained for all those transports including all emergency transports.

The new, targeted adjustment would apply to transports originating in geographically-isolated, low-volume areas. An area, rather than a supplier or provider, would be considered low-volume based on the likelihood of that area generating less than a defined number of transports in the course of a year (discussed in detail in the June 2013 MedPAC Report to Congress). This would offset the expiration of the super-rural add-on and protect access in isolated, low-volume areas.

**Thus, the Commission recommends that the Congress should:**

- **allow the three temporary ambulance add-on policies to expire;**

- **direct the Secretary to rebalance the relative values for ambulance services by lowering the relative value of basic life support nonemergency services and increasing the relative values of other ground transports. Rebalancing should be budget neutral relative to current law and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on; and**
- **direct the Secretary to replace the permanent rural short-mileage add-on for ground ambulance transports with a new budget neutral adjustment directing increased payments to ground transports originating in geographically-isolated, low-volume areas to protect access in those areas.**

Our analysis also suggests that greater focus on program integrity in this area is warranted. For example, we find that the number of dialysis-related transports has increased rapidly in recent years, about twice as fast as all other ambulance transports, and there is tremendous variation across the states in the use of and Medicare spending on dialysis-related ambulance transports. The HHS-OIG has found that many ambulance transports are not medically necessary, raising questions about the rapid growth and unwarranted variation in spending on BLS non-emergency transports such as those to dialysis facilities and transports to community health centers for partial hospitalizations.

As a first step to ensuring appropriate use of the ambulance benefit, there should be no ambiguity over medical necessity. There should be clear definitions and guidelines as to which nonemergency ambulance transport should be covered, and of the terms “recurring” and “nonrecurring” transports. Clear guidelines would enable the Medicare administrative contractors (MACs) to use uniform and complete pre-payment edits to review claims, and the recovery audit contractors (RACs) could expand their audits to include the medical necessity of Medicare Part B BLS nonemergency ambulance transports.

There is also a need for regular and periodic reviews of all nonemergency ambulance claims to search for unusual patterns of use, and to rapidly implement administrative safeguards and apply existing legal authorities to eliminate any identified excessive and fraudulent use. If these steps

are not enough to curb clinically inappropriate and potentially fraudulent use of ambulance transports to dialysis facilities and other nonemergency treatment settings, additional authorities to implement techniques such as prior authorization may be needed. We recommend that:

**The Congress should direct the Secretary to:**

- **promulgate national guidelines to more precisely define medical necessity requirements for both emergency and nonemergency (recurring and nonrecurring) ground ambulance transport services;**
- **develop a set of national edits based on those guidelines to be used by all claims processors; and**
- **identify geographic areas and/or ambulance suppliers and providers that display aberrant patterns of use, and use statutory authority to address clinically inappropriate use of basic life support nonemergency ground ambulance transports.**

Reducing clinically inappropriate use of BLS nonemergency services should result in program savings.

#### **Medicare Advantage special needs plans**

In the Medicare Advantage (MA) program, special needs plans (SNPs) are a sub-category of coordinated care plans (CCPs). What primarily distinguishes SNPs from other MA plans is that SNPs limit their enrollment to one of the three categories of special needs individuals: dual-eligible beneficiaries, residents of a nursing home or community residents who are nursing-home certifiable, and beneficiaries with certain chronic or disabling conditions. In contrast, regular MA plans must allow all Medicare beneficiaries residing in their service area to enroll in the plan that meet MA eligibility criteria.

SNP authority expires at the end of 2015. In the absence of congressional action, on January 1, 2016, the SNP designation will sunset. SNPs that wish to continue in the MA program will have to operate as other MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs. The current law Medicare baseline assumes that SNP authority will expire. If this occurs, some beneficiaries enrolled in SNPs will likely return to traditional

FFS. If SNPs are reauthorized and beneficiaries remain enrolled in SNPs, program spending will increase relative to the baseline because spending on beneficiaries enrolled in MA is on average higher than Medicare FFS spending for similar beneficiaries.

However, there may be reason to consider a more targeted approach to reauthorizing SNPs based on their relative value to the Medicare program. We evaluate each type of SNP on how well it performs on quality of care measures, whether it encourages a more integrated delivery system than is currently available in traditional FFS Medicare, and how SNP reauthorization would affect Medicare program spending.

#### **I-SNPs**

Institutional SNPs, known as I-SNPs, are plans primarily for beneficiaries residing in nursing homes. They perform well on a number of quality measures. In particular, I-SNPs have much lower than expected hospital readmission rates. This suggests that I-SNPs are able to reduce hospital readmissions for beneficiaries that reside in nursing homes. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.

**Considering these factors, the Commissions recommends the Congress permanently reauthorize I-SNPs.**

#### **C-SNPs**

Chronic condition SNPs, known as C-SNPs, are plans for beneficiaries with certain chronic conditions. In general, C-SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures. The Commission recommended in 2008 that the list of conditions that qualify for a C-SNP be narrowed, and although the list of C-SNP conditions was reduced, we continue to believe that the list is too broad. It is our judgment that regular MA plans should be able to manage the majority of clinical conditions that currently serve as the basis for a plan to be established as a C-SNP and that the C-SNP model of care for these conditions should be imported into MA plans. This will move MA plans toward providing services that are more targeted to particular populations. This will also improve the integration of the delivery system in regular MA plans for chronically ill enrollees.

There has been recent movement in the MA plan industry in this direction of importing the C-SNP model of care into regular MA plans. There may be a rationale, however, for maintaining C-SNPs for a small number of conditions, including end-stage renal disease (ESRD), HIV/AIDS, and chronic and disabling mental health conditions. These conditions dominate an individual's health and may warrant maintaining separate plans for these conditions while innovations in care delivery for these populations are still being made. However, the ability of MA plans to adequately care for beneficiaries with these three conditions should be revisited in the future.

**Considering these factors, the Commission recommends the Congress should:**

- **Allow the authority for chronic care SNPs (C-SNPs) to expire, with the exception of C-SNPs for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions;**
- **Direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions;**
- **Permit current C-SNPs to continue operating during the transition period as the Secretary develops standards. Except for the conditions noted above, impose a moratorium for all other C-SNPs as of January 1, [2014.]**

#### **D-SNPs**

Special needs plans for beneficiaries dually eligible for Medicare and Medicaid, known as D-SNPs, generally have average to below average performance on quality measures compared to other SNPs and regular MA plans, with some exceptions. D-SNPs are required to have contracts with states. However, the contracts have generally not resulted in D-SNPs clinically or financially integrating Medicaid benefits.

We found exceptions under two D-SNP models in which an incentive exists to clinically and financially integrate with Medicaid benefits. Under one model, the D-SNP covers Medicare and some or all Medicaid long-term care services and supports (LTSS), behavioral health services, or both through a single plan and through its contract with the state. Under another model, a managed care organization administers the D-SNP and the Medicaid plan that furnishes some or

all of the LTSS or behavioral health services. Some of the same dual-eligible beneficiaries are enrolled in both plans. Under this model, integration occurs at the level of the managed care organization across the two plans.

A number of administrative misalignments act as barriers to integrating Medicare and Medicaid benefits and may hamper the D-SNPs' ability to integrate and coordinate benefits for dual eligible beneficiaries. Most of these barriers (the inability to jointly market the Medicare and Medicaid benefits that D-SNPs furnish, multiple enrollment cards, and lack of a model contract for states to use as a reference) can be alleviated by the Secretary of Health and Human Services. Aligning the Medicare and Medicaid appeals and grievances processes, however, would require a change in statute.

**The Commission recommends the Congress should permanently reauthorize dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.**

Mr. PITTS. The Chair now recognizes Dr. Rowland 5 minutes for her summary.

**STATEMENT OF DIANE ROWLAND**

Dr. ROWLAND. Thank you, Chairman Pitts, Ranking Member Pallone and members of the subcommittee. I am pleased to be here today to share MACPAC's expertise and insights as the committee considers extension of several legislative provisions affecting Medicaid and the Children's Health Insurance Program, CHIP.

MACPAC was authorized in 2009 and began its work in 2010 to provide the Congress with analytic support on a wide range of Medicaid policy issues and CHIP issues. The focus of our work is on how to improve the efficiency, effectiveness and administration of Medicaid and CHIP, to reduce complexity and improve care for the over 60 million beneficiaries with Medicaid and CHIP coverage. During the coming year, we will be looking at the implementation of the Patient Protection and Affordable Care Act and the coordination of Medicaid, CHIP, and exchange coverage. We will be looking at children's coverage and the status and future of the CHIP program, at cost containment and payment system improvements underway in the States for Medicaid, at issues for high-cost, high-need enrollees, and on Medicaid administrative capacity. But today I will focus on the issues that are up for reauthorization and extension.

Specifically, one of the areas the Commission has looked at carefully is Transitional Medical Assistance, or TMA. TMA provides additional months of Medicaid coverage to low-income parents and children who would otherwise lose coverage due to increased earnings and helps to promote increased participation in the workforce, a goal of all of us. It was originally limited to 4 months and has since 1990 been raised to a 6- to 12-month period through the extenders we are discussing today. This provision applies to the lowest-income Medicaid beneficiaries who qualify under the welfare level guidelines and indeed helps to reduce churning between Medicaid, employer-based coverage and uninsurance. This churn is disruptive for the plans that service these patients, providers and the government entities that process these changes as well as for the beneficiaries themselves. MACPAC recommends eliminating the sunset date for the Section 1925 TMA that allows the 6- to 12-month coverage and also provides States with additional flexibility to do premium assistance as people transition from Medicaid to the workforce.

We also have recommended that when States expand Medicaid to the new adult group under the Affordable Care Act, they be allowed to opt out of Transitional Medical Assistance because in that case there would be no gap in the coverage they would receive either through Medicaid under the new options or through subsidized exchange coverage.

With regard to Express Lane Eligibility, we looked at ways in which the program can be streamlined and eligibility can be improved and see that the Express Lane Eligibility provides children with enrollment under CHIP and Medicaid with an express vehicle so that it eliminates some of the duplication that goes on in program determinations. Thirteen States have implemented this meth-

od of establishing eligibility, and we will continue to monitor the use and effectiveness of this approach and are in the process of reviewing the December 13th report by the Secretary of Health and Human Services and will provide our comments on that report to the Congress.

In terms of the CHIP program and outreach and eligibility, we see that bonus payments have provided a strong incentive to the States to improve outreach and enrollment processes for children and now many of these strategies are required in the new eligibility and enrollment processes being implemented effective in 2014. So we will look at the potential restructuring of the bonus payments to try and see how those need to be restructured in light of the changes under the Affordable Care Act.

We also strongly support developing policies that will help us improve the way to measure the quality of care for children including the requirement in the extenders to develop a core set of child health quality measures. There is no other way to really be able to compare the quality of care being provided or to assess it without some standardization of the methods used, and we know that you will be looking for us to do such comparisons and really strongly support having the data and ability to do that.

With regard to the Qualifying Individual program and the Special Needs Plans, we really have been looking very carefully at the importance of the role that Medicaid plays as a wraparound for Medicare beneficiaries, especially helping the very lowest income to not only afford their premiums but to get better and more integrated care, and we will continue to try and work to assess ways in which we can improve the coordination and delivery of care for individuals who are dually eligible and very low income.

So in conclusion, we will continue to keep Congress informed of our progress in examining these issues. We look to try and find ways to reduce administrative burden and streamline the programs as well as provide better care to the beneficiaries for better investment of the dollars that this government puts into this care.

Thank you very much for having us today, and we look forward to continuing to share our work with you in the future.

[The prepared statement of Dr. Rowland follows:]



Statement of  
Diane Rowland, ScD, Chair  
Medicaid and CHIP Payment and Access Commission

Before the  
House Committee on Energy and Commerce  
Subcommittee on Health

January 9, 2014

### Summary

The Medicaid and CHIP Payment and Access Commission (MACPAC) has identified five priorities for 2014: implementation of the Patient Protection and Affordable Care Act (ACA), children's coverage, cost containment, issues for high-cost high-need enrollees, and Medicaid administrative capacity. For testimony today, we focus our remarks on Medicaid provisions set to expire in 2014.

**Transitional Medical Assistance (TMA).** TMA provides additional months of Medicaid to low-income parents and children who would otherwise lose coverage due to income increases from additional hours of work. Originally TMA was limited to four months but has been set at six to twelve months since 1990.

- Reducing moves in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, and reduces the likelihood of inpatient hospital admissions and emergency room visits. Churning between insurance programs is also disruptive for the plans, providers, and government entities that must process those changes. Although some churning is inevitable, steps can be taken to reduce churning that is disruptive to care delivery. For states, eliminating the sunset date would end the uncertainty around TMA's future and the possibility they might have to revert to TMA rules from 1990.
- MACPAC recommends eliminating the sunset date for Section 1925 TMA. The Commission also recommends that states expanding Medicaid to the new adult group be allowed to opt out of TMA, since these states have no eligibility gap between Medicaid and subsidized exchange coverage.

**Express Lane Eligibility (ELE).** ELE is an optional program to streamline enrollment of low-income children into coverage. A key strategy to promote children's enrollment under CHIP, it is now a part of outreach and enrollment efforts in Medicaid. According to HHS, 13 states have implemented ELE, garnering \$3.6 million in net annual administrative savings. MACPAC will monitor the use and effectiveness of ELE and report to the Congress on improvements.

**CHIPRA Bonus Payments.** States can earn bonuses if they implement at least five of eight outreach and retention efforts and substantially increase enrollment of children eligible for, but not enrolled in, Medicaid. Starting in 2014, four of these strategies are now required. The Commission will examine the role of bonus payments as part of its work on the future of CHIP.

**Child Health Quality Measures.** CHIPRA included several provisions to improve quality of care for children, including requirements that the Department of Health and Human Services (HHS) identify and maintain a core set of child health quality measures for voluntary use in Medicaid and CHIP, and award grants to states for demonstration projects. MACPAC strongly supports efforts to measure and improve health care quality for all Medicaid and CHIP enrollees although it has not made a formal recommendation on future funding.

**Qualifying Individual (QI) Program and Special Needs Plans (SNPs).** MACPAC has been exploring how to improve care coordination for individuals with both Medicare and Medicaid coverage. The QI program requires states to pay the Part B premium for certain low-income Medicare beneficiaries with 100 percent federal funding. This is an important source of financial protection for approximately 500,000 QIs. An extension would enable many low-income Medicare beneficiaries to continue to receive help paying their Medicare premiums and remove uncertainty for states as well. MACPAC has not made recommendations specifically regarding the extension of statutory authority for Medicare special needs plans.

**Statement of Diane Rowland, ScD, Chair**  
**Medicaid and CHIP Payment and Access Commission**

Good morning Chairman Pitts, Ranking Member Pallone and Members of the Subcommittee on Health. I am Diane Rowland, Chair of the Medicaid and CHIP Payment and Access Commission (MACPAC) and I am pleased to be here today to share MACPAC's expertise and insights as this Committee considers the extension of several legislative provisions affecting Medicaid and the State Children's Health Insurance Program (CHIP).

**MACPAC's Charge and 2014 Priorities**

MACPAC was created in 2009 and began its work in 2010 to provide the Congress with analytic support on a wide range of Medicaid and CHIP policy issues including:

- eligibility and enrollment,
- access to care,
- payment policies,
- benefits and coverage policies,
- quality of care, and
- interaction of Medicaid and CHIP with Medicare and the health care system generally.

MACPAC is statutorily required to submit two reports to the Congress annually that review Medicaid and CHIP policies and make recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on a wide range of issues affecting these programs. The 17 commissioners, appointed by the U.S. Government Accountability Office (GAO) have diverse backgrounds in medicine, nursing, public health, and managed care, and include

parents and caregivers of Medicaid enrollees and experts in the administration of Medicaid and CHIP at the state and federal levels. They represent different regions across the United States and bring varying perspectives and experience to the Commission's deliberations.

As the Commission prepares its analytic agenda for 2014, it has identified the following five priority areas as the focus of its analyses:

- implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), focusing on areas of interaction among Medicaid, CHIP and exchange coverage,
- children's coverage and the current status and future of CHIP,
- cost containment and delivery and payment system improvements to promote efficiency and value,
- Medicaid's role in providing care for high-cost high-need enrollees including those dually eligible for Medicare and Medicaid, and
- state and federal administrative capacity to manage the programs.

For our testimony today, however, I will focus my remarks as requested on Medicaid legislative provisions set to expire during 2014. The Commission does not have formal recommendations on all of these provisions, but will offer insights from our ongoing work as appropriate. In crafting our analyses and recommendations to the Congress, the Commission seeks to improve program efficiency and reduce complexity in Medicaid and CHIP. Our comments on the provisions below reflect these goals.

## **Expiring Provisions and Related MACPAC Recommendations**

### **Transitional Medical Assistance**

Transitional Medical Assistance (TMA) provides additional months of Medicaid coverage on a temporary basis to low-income parents and their children who would otherwise lose coverage due to increases in earnings. The authorization and funding for TMA, under Section 1925 of federal Medicaid law, is currently set to expire after March 31, 2014. TMA has been available since 1974. This extension of temporary Medicaid coverage was intended to ensure that parents would not forgo work opportunities out of fear of losing Medicaid coverage (U.S. House of Representatives 1972, GAO 2002).

As originally enacted, TMA provided four months of extended Medicaid coverage, with no sunset date. However, since 1990, the Congress has extended TMA to provide at least 6 and up to 12 months of coverage for working families under the authority of Section 1925 of federal Medicaid law. Such extensions lengthened the bridge from Medicaid to the workforce for many families, encouraging additional work earnings. Most recently, the Bipartisan Budget Act of 2013 (H.J. Res. 59) extended TMA funding and authorization by three months, from December 31, 2013 to March 31, 2014.

National data on TMA enrollment and expenditures are not available. A 2011 survey of states by GAO found that, in the 43 responding states, over 3.7 million individuals were enrolled in TMA (Table 1). The 36 states that provided GAO with expenditure data reported a total of \$4.1 billion in TMA spending in 2011—less than 1.4 percent of these states' total Medicaid benefit spending (GAO 2013). There is also little information on the number of states implementing various options permitted under TMA.<sup>1</sup>

TMA is only available to the very lowest income parents and children who are enrolled in Medicaid under Section 1931 of the Social Security Act. Section 1931 was created in the welfare reform legislation of 1996. Prior to welfare reform, individuals eligible for the cash welfare program, Aid to Families with Dependent Children (AFDC), were automatically eligible for Medicaid—and only these individuals could qualify for TMA. When AFDC was eliminated by welfare reform, that eligibility pathway to Medicaid for low-income families was replaced by Section 1931 so that parents and children who would have been eligible for the state's AFDC program could still qualify for Medicaid. By linking this new pathway to TMA, the Congress maintained a way for the poorest families to convert from welfare assistance to work without losing health insurance coverage during the transition. Current Section 1931 eligibility levels vary by state from 13 percent of the federal poverty level (FPL) in Alabama (approximately \$2,500 in annual income for a family of three) to levels above 100 percent in a number of states (CMS 2013a).

Adults who will be newly eligible for Medicaid under the ACA expansion of up to 133 percent FPL do not qualify for TMA, as newly eligible adults are not eligible under Section 1931. Similarly, TMA is not available to children or other enrollees eligible through other Medicaid pathways (CMS 2013a).

Without further Congressional action, TMA will revert to its original four-month duration on April 1, 2014. In reverting to TMA's pre-1990 eligibility policies, states would need to make significant changes to their eligibility systems that would increase costs, both for states and the federal government. States would also lose some of the flexibility they currently have under Section 1925 TMA. For example, states may currently require TMA beneficiaries to enroll in employer-sponsored insurance if offered to them. States using this option must pay the enrollees' share of premiums and cost sharing. At least 23 states use this premium assistance option under TMA to purchase employer-sponsored insurance—an option that would disappear if Section 1925 TMA is not

renewed (GAO 2012). This option currently provides the opportunity for low-income individuals to transition to employer-sponsored insurance rather than abruptly facing the premiums and cost-sharing requirements that might discourage them from working or working more hours.

The Commission recognizes the importance of providing incentives to promote increased earnings and employment opportunities for the lowest income Americans and that TMA has helped many to move on to employment without compromising ongoing health care during the transition. We also recognize that expanded coverage through Medicaid under the ACA raises issues regarding the future of TMA in expansion states. However, in non-expansion states, there is a gap in coverage between states' Section 1931 income levels and eligibility for subsidized exchange coverage, which makes the role of TMA important for those with income below 100 percent FPL for whom subsidized coverage is not available. In expansion states, by contrast, those individuals who lose TMA after four months could be eligible for Medicaid's new adult group.

For enrollees, changes in income and family situations can cause a change in health coverage in terms of covered benefits, cost sharing, providers, and health plans. Reducing moves in and out of Medicaid, such as through TMA, has been shown to lower average monthly per capita spending in Medicaid, increase utilization of preventive care, and reduce the likelihood of inpatient hospital admissions and emergency room visits (Ku et al. 2009). Churning between insurance programs is also disruptive for the plans, providers, and government entities that must process those changes.

For states, eliminating the sunset date for TMA would end the uncertainty around TMA's future and the possibility they might have to revert to TMA rules from 1990. It also reduces the administrative burden of more frequent eligibility determinations that would be associated with four-month TMA.

For providers and health plans, the continuation of 6- to 12-month TMA would reduce the administrative burden associated with individuals moving on and off of Medicaid. Longer tenure by

enrollees with the same plan or provider can help ensure that efforts to improve care management and quality improvement are not compromised because of churning.

Some churning is inevitable, but the Commission's recommendation to eliminate the sunset date for TMA seeks to reduce churning that is disruptive to care delivery. The eligibility of parents and childless adults enrolled in Medicaid must be redetermined annually, with changes in income or family status potentially leading to a change in source of coverage. Steps can be taken, however, to smooth transitions and mitigate the consequences of churning—thus ensuring continued coverage and preserving access to care.

**MACPAC recommendation.** MACPAC recommended in its March 2013 report that the Congress end the sunset date for Section 1925 TMA. Ending the sunset date for TMA would ensure that low-income parents would continue to receive 6 to 12 months of Medicaid coverage after increasing their earnings. Such transitional Medicaid coverage removes one disincentive for parents to return to work or work more hours. Ensuring stable coverage also helps ensure that Medicaid enrollees continue to receive needed care for ongoing conditions, and helps prevent uninsurance. Ending the sunset date for Section 1925 TMA would also end the perennial uncertainty states face as to whether they will need to reinstitute TMA policies from 1990 and lose the flexibility to implement policies such as premium assistance for employer-sponsored insurance.

According to Congressional Budget Office (CBO) estimates provided to MACPAC in December 2013, ending the sunset date for TMA would actually save the federal government \$1 billion to \$5 billion over the five-year period from 2015 to 2019. The savings result in part from 6- to 12-month TMA replacing forms of coverage more costly to the federal government, such as Medicaid coverage of newly eligible individuals at 100 percent federal matching rate for 2014–2016 in expansion states.

The Commission also recommended in March 2013 permitting expansion states to opt out of TMA altogether, since these states have no eligibility gap between Medicaid and subsidized exchange coverage. Combined, the two parts of the Commission's March 2013 TMA recommendation were originally projected by CBO to have little effect on federal spending. However, the same policy is now projected by CBO to increase federal spending by \$5 billion to \$10 billion in the five-year period between 2015 and 2019, because of changes in how CBO projects the federal cost of expansion states opting out of TMA. The Commission will restate its support for these strategies for promoting insurance stability in its upcoming March 2014 report to the Congress.

### **Other Expiring Provisions**

#### **Express Lane Eligibility**

Express Lane Eligibility (ELE) is an optional state program designed to help streamline the enrollment of low-income children into Medicaid and CHIP. Under this option, states may rely on the income and eligibility information of other federal programs, including the National School Lunch Program and the Supplemental Nutrition Assistance Program, to determine whether a child is eligible for Medicaid or CHIP. This has been a key strategy to promote children's enrollment under CHIP and is now a part of outreach and enrollment efforts for Medicaid under the ACA. It is one of eight outreach, enrollment, and retention strategies states could implement to increase enrollment of eligible children in both Medicaid and CHIP and qualify for performance bonus payments between fiscal year (FY) 2009 and FY 2013. ELE has been implemented by 13 states and the U.S. Department of Health and Human Services (HHS) estimates that there are 180,000 annual new enrollments and 825,000 annual renewals attributable to ELE, with \$3.6 million in net annual administrative savings (Hoag 2013). ELE was most recently extended through September 30, 2014.

Current ELE authority applies only to children. States may receive permission from the Centers for Medicare & Medicaid Services (CMS) to use ELE for adults in Medicaid or CHIP through a Section 1115 waiver. As of 2013, 2 of the 13 states—Alabama and Massachusetts—that have implemented ELE have used waivers to extend ELE provisions to adults.

In its May 2013 public meeting, the Commission reviewed the results of an HHS interim evaluation report on the ELE option. The final evaluation report was submitted to the Secretary of Health and Human Services in December 2013. The Commission will review and assess the information provided in the Secretary's report in public session and, consistent with its statutory charge, will provide the Congress with our comments on the report within six months of the report's release and make recommendations to the Congress as appropriate.

MACPAC will continue to monitor the use and effectiveness of ELE for the current program as well as under the simplified and streamlined Medicaid and CHIP enrollment processes under the ACA. We will report to the Congress on the use of the ELE option beyond fiscal year 2014 and offer areas for improvement of income verification processes as well as issues related to data quality and availability.

#### **CHIPRA Bonus Payments**

To promote broader enrollment of children eligible for Medicaid or CHIP coverage, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) created a fund for performance bonuses to states that experienced substantial increases in enrollment of children in Medicaid (not CHIP) and implemented at least five of eight specified outreach and retention efforts in their Medicaid and CHIP programs. Rather than promoting an expansion of eligibility, these bonus payments were structured to incentivize activities that would reduce uninsurance and increase enrollment among the poorest uninsured children who were already eligible for Medicaid. In the

context of the Commission's deliberations on the future of CHIP, we plan to explore how bonus payments might be used to incentivize other activities to reduce uninsurance among low-income children.

CHIPRA bonus payments were authorized for FY 2009 through FY 2013. From FY 2009 to FY 2013, \$1.1 billion has been paid to 27 states that have met the specified requirements and increased child Medicaid enrollment (CMS 2013b). Most recently, \$307 million in bonus payments were made to 23 states on December 30, 2013 (Table 2).

While the ACA extended funding for the CHIP program by two years (from FY 2013 to FY 2015), CHIPRA bonus payments were not extended. In fact, the ACA explicitly called for the termination of CHIPRA bonus payments after FY 2013 (§2101(c) of the ACA). The context for CHIPRA bonus payments arguably has changed because of the ACA. Four of the eight criteria for states to qualify for bonus payments are now required for children's eligibility in Medicaid and CHIP, beginning in 2014, so all states must comply. These are: no asset test; no requirement for an in-person interview; use of the same application and renewal forms in both Medicaid and CHIP; and administrative renewal based on information available to the state.<sup>2</sup> (A list of qualifying outreach and enrollment strategies by states receiving bonus payments can be found in Table 3.) With the implementation of the ACA and intensive focus on outreach to those who are eligible but not enrolled in coverage, children's enrollment in Medicaid can be expected to increase in 2014 more due to the ACA than due to the bonus payment incentives.

The context for CHIP serving lower-income children with incomes too high to qualify for Medicaid has changed since the program's enactment in 1997. Effective in 2014, the ACA offers coverage opportunities under Medicaid and exchange plans for many low-income families. The Commission is examining the future of CHIP in this context and plans to provide information and analyses to

Congress in both its March and June 2014 reports. The Commission will examine the potential role of bonus payments as part of this work on the future of CHIP.

#### **Child Health Quality Measures**

CHIPRA included a number of provisions aimed at improving quality of care for children. These included requirements for the Secretary of Health and Human Services to identify, publish, and update a core set of child health quality measures for voluntary use in Medicaid and CHIP, provide technical assistance and a standardized reporting format for states, and award grants for demonstration projects aimed at improving the quality of children's health care under Medicaid and CHIP. An appropriation of \$45 million for each of FY 2009 through FY 2013 (\$225 million total) was made available for these activities until expended. A similar set of provisions aimed at adults was included in the ACA with an appropriation of \$60 million for each of FY 2010 through FY 2014.

MACPAC strongly supports efforts to measure and improve the quality of health care for all Medicaid and CHIP enrollees, although the Commission has not voted on a formal recommendation regarding the extension of funding. In a June 2011 comment letter to the Secretary of Health and Human Services, the Commission noted that broader use of child health measures that are nationally recognized, evidence-based, and standardized could improve the ability to make comparisons across states and payers, and to identify which program characteristics and policies have the greatest impact on quality.<sup>3</sup> The Commission has also focused its attention on high-need populations, recommending in its March 2012 report to Congress that the Secretary, in partnership with the states, should update and improve quality assessment for Medicaid enrollees with disabilities.

**Qualifying Individual Program**

The Qualifying Individual (QI) program is one of four Medicare Savings Programs (MSPs) that provide varying levels of assistance with Medicare cost sharing and premiums depending on an individual's income and assets. These are:

- Qualified Medicare beneficiaries (QMBs),
- Specified low-income Medicare beneficiaries (SLMBs),
- Qualifying individuals (QIs), and
- Qualified disabled and working individuals (QDWTs)

See Table 4 for further information on benefits, eligibility, and enrollment for each of the MSPs.

The QI program requires states to pay the Part B premium for Medicare beneficiaries with incomes between 120 and 135 percent FPL (around \$13,700 to \$15,300 for an individual in 2013), but with 100 percent federal funding. The amount of federal funding available for the program is limited by state-specific allotments that are reauthorized and appropriated by the Congress periodically.

The QI program was most recently extended via the Bipartisan Budget Act of 2013 (H.J. Res. 59) for three months, from December 31, 2013 to March 31, 2014. The legislation allocated \$200 million for that time period.

The Commission recognizes the important source of financial protection the MSPs provide for low-income Medicare beneficiaries. In its March 2013 report, the Commission examined Medicaid's role in covering Medicare cost sharing and premiums for low-income Medicare beneficiaries through these programs. In 2011, MSPs provided coverage for Medicare Part A and Part B cost-sharing expenses for 8.3 million persons dually eligible for Medicaid and Medicare, including approximately 500,000 persons enrolled in the QI program who only receive Medicaid coverage of their Part B

premiums and who do not receive full Medicaid benefits, such as benefits for long-term services and supports, in their state (MACPAC 2013).

MACPAC has noted that while QI enrollees, unlike other individuals dually eligible for Medicare and Medicaid, are not full Medicaid enrollees, the program requires administrative coordination between state Medicaid programs and the federal Medicare program. In working to improve efficiency and simplification within Medicaid and across programs, the Commission has identified the Medicare Savings Programs as an area of future work. The Commission plans to assess how Medicare and Medicaid may be better aligned to provide more seamless coverage for these enrollees.

The uncertainty of whether the QI program will be extended has been a source of concern for both states and enrollees alike. An extension would enable many low-income Medicare beneficiaries to continue to receive help paying their Medicare premiums. The Commission will continue to examine these issues and inform the Congress of its work.

#### **Special Needs Plans**

Special Needs Plans (SNPs) are Medicare Advantage plans authorized under Title XVIII of the Social Security Act. The American Taxpayer Relief Act of 2012 extended SNP authority through the end of 2014.

The Commission has been exploring the effectiveness of efforts to improve care coordination for individuals with both Medicare and Medicaid coverage as part of its work on high-cost high-need enrollees. It has examined models of care that provide integrated services to dually-eligible Medicaid and Medicare enrollees including the Program of All-Inclusive Care for the Elderly (PACE) and SNPs. PACE focuses its system of care around individuals age 55 and older with health needs requiring a nursing home level of care. The Commission also has examined systems of care offered

by fully integrated dual-eligible special needs plans (FIDE SNPs), which are dual-eligible special needs plans (D-SNPs) that enter into risk-based contracts with state Medicaid agencies and Medicare to provide certain acute care services, long-term services and supports, and coordination of Medicare and Medicaid services (42 CFR 422.2). Six states (California, Hawaii, Massachusetts, Minnesota, New York, and Wisconsin) have programs that are fully integrated, with the plan at risk for both Medicaid and Medicare services and dually-eligible individuals enrolled in the same managed care plan for both sets of benefits CMS 2013(c). Arizona and Texas require that Medicaid managed care plans offer D-SNP products, but dually-eligible individuals may be enrolled in separate plans for Medicaid and Medicare services (Saucier 2012).

Several states have looked to D-SNPs as a model upon which to build. Many of the requirements for plans participating in the Financial Alignment Initiative being conducted by the CMS, for example, are based on requirements for D-SNP plans. Other states including Arizona and Tennessee propose to align and better integrate services between the two programs by building on existing D-SNPs (AHCCS 2013; TennCare 2012). The Commission continues to monitor and examine the Financial Alignment demonstrations and other state initiatives as they are implemented and plans to provide the Congress with further information on these initiatives as their results become available.

The Commission has not made recommendations specifically regarding the extension of statutory authority for Medicare special needs plans. However, one area we have examined is the development of appropriate risk adjustment methodologies for integrated care models including D-SNPs. Determining payment amounts and the portion of the total plan payment attributable to Medicare versus Medicaid is a key issue in designing integrated care models. The Commission's work highlighted several issues to consider when developing capitation rates for integrated care plans such as D-SNPs, including accounting for voluntary enrollment, the need for better risk

adjustment models and appropriate measures of functional status, and the treatment of supplemental payments (MACPAC 2013). This work is also part of the Commission's broader look at providing services to low-income and special needs populations through managed care.

As the Commission pursues its analytic agenda on payment and access issues related integrated care models specifically and Medicaid managed care more generally, it will keep the Congress informed of its work and recommendations for program improvement.

### **Conclusion**

MACPAC has made specific recommendations to the Congress ending the sunset date for TMA, removing a disincentive for parents to seek employment opportunities without losing Medicaid coverage during the transition and giving states more certainty in program funding. TMA provides continuity of coverage and reduces uninsurance for low-income families on a temporary basis while parents transition to employment or more work hours, a policy the Commission supports funding without a sunset on a permanent basis.

The Commission is actively considering children's coverage in both Medicaid and CHIP. The Commission has highlighted the future of CHIP in the context of new coverage options under the ACA as a priority for 2014 and expects to report to the Congress on these issues in both its March and June 2014 reports. MACPAC will actively review CHIP bonus payments and child health quality measures issues in this context and will keep the Congress informed of our work.

Medicaid's role in providing care for high-cost high-need enrollees, including those dually eligible for Medicare and Medicaid is a MACPAC priority for 2014, building on the Commission's work in this area over the past two years. We will continue to keep the Congress informed of our progress in examining these issues, including the QI program, as analyses are completed.

Thank you, Members of the Subcommittee. I would be happy to answer any questions you may have.

## References

Arizona Health Care Cost Containment System (AHCCCS). 2013. Letter from Thomas J. Betlach to Melanie Bella, Director Medicare-Medicaid Coordination Office, regarding “Arizona capitated financial alignment demonstration withdrawal.” April 10, 2013.

<http://www.azahcccs.gov/reporting/Downloads/Integration/ArizonaCapitationFinancialAlignmentDemonstrationWithdrawal.pdf>.

Bureau of TennCare (TennCare). 2013. Letter from Darin J. Gordon to Melanie Bella, Director Medicare-Medicaid Coordination Office, regarding “Tennessee capitated financial alignment demonstration withdrawal.” December 21, 2012.

[http://aishealth.com/sites/all/files/tenncare\\_withdrawal\\_letter\\_to\\_melanie\\_bella\\_12\\_21\\_12.pdf](http://aishealth.com/sites/all/files/tenncare_withdrawal_letter_to_melanie_bella_12_21_12.pdf).

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. “State Medicaid and CHIP income eligibility standards effective January 1, 2014.”

<http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. “CHIPRA performance bonuses: A history.”

<http://www.insurekidsnow.gov/professionals/eligibility/pb-2013-chart.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013c. Centers for Medicare & Medicaid Services (CMS). 2013. "Special needs plan comprehensive report." As of December 2013. Washington, DC: CMS. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html>.

Congressional Budget Office (CBO). 2013. *Children's Health Insurance Program spending and enrollment Detail for CBO's May 2013 baseline*. Washington, DC: CBO. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44189-CHIP.pdf>.

Grady, A. 2008. *Transitional medical assistance (TMA) under Medicaid*. Report no. RL31698. Washington, DC: Congressional Research Service. [http://assets.opencrs.com/rpts/RL31698\\_20040630.pdf](http://assets.opencrs.com/rpts/RL31698_20040630.pdf).

Hoag, S., et al. 2013. *CHIPRA mandated evaluation of Express Lane Eligibility: final findings*. Washington, DC: Mathematica Policy Research.

Ku, L., P. MacTaggart, and F. Pervez, et al. 2009. *Improving Medicaid's continuity of coverage and quality of care*. Washington, DC: Association for Community Affiliated Plans.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. *Report to the Congress on Medicaid and CHIP*. March 2013. Washington, DC: MACPAC. [http://www.macpac.gov/reports/2013-03-15\\_MACPAC\\_Report.pdf?attredirects=0](http://www.macpac.gov/reports/2013-03-15_MACPAC_Report.pdf?attredirects=0).

Saucier, P., J. Kasten, B. Burwell, et al. 2012. *The growth of managed long-term services and supports (MLTSS) programs: A 2012 update*. Ann Arbor, MI: Truven Health Analytics.  
[http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP\\_White\\_paper\\_combined.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf).

U.S. Government Accountability Office (GAO). 2013. *Medicaid: Additional enrollment and expenditure data for the transitional medical assistance program*. Report no. GAO-13-454R. Washington, DC: GAO.  
<http://www.gao.gov/assets/660/653058.pdf>.

U.S. Government Accountability Office (GAO). 2012. *Medicaid: Enrollment and expenditures for qualified individual and transitional medical assistance programs*. Report no. GAO-13-177R. Washington, DC: GAO.  
<http://www.gao.gov/assets/660/650816.pdf>.

U.S. General Accounting Office (GAO). 2002. *Medicaid: Transitional coverage can help families move from welfare to work*. Report no. GAO-02-679T. Washington, DC: GAO.  
<http://www.gao.gov/assets/110/109281.pdf>.

U.S. House of Representatives. 1972. Summary of H.R. 1, the Social Security Amendments of 1972 as approved by the conferees. Washington, DC. *Congressional Record*, October 17, 1972, p. 36919.

---

<sup>1</sup> For example, to continue eligibility for the second six months of TMA, families are required to report on a quarterly basis (in the fourth, seventh and tenth months of their coverage) their gross earnings and child care costs. Five states have used a new state plan option to waive this requirement (MACPAC 2013). However, the number of states implementing this policy under a waiver has not been reported since 2002, when 19 out of 46 reporting states did not require quarterly reporting (Grady 2008).

<sup>2</sup> The other four policies to qualify for CHIPRA bonus payments are 12-month continuous eligibility, presumptive eligibility, Express Lane Eligibility, and premium assistance for employer-sponsored coverage (§2105(a)(4) of the Social Security Act).

<sup>3</sup> [http://www.macpac.gov/comment-letters/MACPAC\\_Comments-HHS\\_Reports\\_to\\_Congress\\_Dec2010.pdf](http://www.macpac.gov/comment-letters/MACPAC_Comments-HHS_Reports_to_Congress_Dec2010.pdf)

**TABLE 1. Enrollment and Expenditures (in Millions of Dollars) for Transitional Medical Assistance (TMA), 2011**

State	TMA enrollment (43 states reporting)	TMA expenditures (36 states reporting)	Total Medicaid benefit expenditures (36 states reporting)	Percentage of Medicaid benefit spending attributable to TMA (36 states reporting)
<b>Total for states reporting</b>	<b>3,710,535</b>	<b>\$4,098.2</b>	<b>\$301,831</b>	<b>1.4%</b>
Alabama	1,927	\$2.3	\$4,793	0.0%
Alaska	2,889	-	-	-
Arizona	45,562	-	-	-
Arkansas	3,235	\$6.7	\$3,952	0.2%
California	336,635	\$186.3	\$54,065	0.3%
Colorado	64,643	-	-	-
Connecticut	-	-	-	-
Delaware	17,585	-	-	-
District of Columbia	1,332	-	-	-
Florida	424,312	\$296.1	\$18,128	1.6%
Georgia	111,554	\$75.3	\$8,065	0.9%
Hawaii	6,271	\$11.2	\$1,524	0.7%
Idaho	7,089	\$15.7	\$1,515	1.0%
Illinois	445,481	\$563.0	\$12,836	4.4%
Indiana	109,114	\$91.4	\$6,566	1.4%
Iowa	41,180	\$45.0	\$3,317	1.4%
Kansas	15,632	\$21.8	\$2,669	0.8%
Kentucky	54,119	\$74.4	\$5,652	1.3%
Louisiana	24,893	\$21.2	\$6,298	0.3%
Maine	23,427	\$58.2	\$2,356	2.5%
Maryland	96,945	\$193.2	\$7,320	2.6%
Massachusetts	64,886	\$100.5	\$13,007	0.8%
Michigan	166,496	\$313.5	\$12,063	2.6%
Minnesota	35,359	\$66.8	\$8,271	0.8%
Mississippi	37,348	-	-	-
Missouri	109,357	-	-	-
Montana	-	-	-	-
Nebraska	40,903	\$50.9	\$1,637	3.1%
Nevada	10,297	-	-	-
New Hampshire	-	-	-	-
New Jersey	35,627	\$43.9	\$10,501	0.4%
New Mexico	50,532	\$82.4	\$3,318	2.5%
New York	-	-	-	-
North Carolina	-	-	-	-
North Dakota	-	\$20.6	\$702	2.9%
Ohio	371,193	\$525.1	\$15,533	3.4%

TABLE 1, Continued

State	TMA enrollment (43 states reporting)	TMA expenditures (36 states reporting)	Total Medicaid benefit expenditures (36 states reporting)	Percentage of Medicaid benefit spending attributable to TMA (36 states reporting)
Oklahoma	86	\$0.1	\$4,008	0.0%
Oregon	70,197	\$103.7	\$4,386	2.4%
Pennsylvania	240,330	\$319.1	\$20,395	1.6%
Rhode Island	8,128	\$11.0	\$2,099	0.5%
South Carolina	62,190	\$117.0	\$4,931	2.4%
South Dakota	-	-	-	-
Tennessee	55,669	\$139.6	\$7,970	1.8%
Texas	135,068	\$125.6	\$27,847	0.5%
Utah	22,846	\$18.4	\$1,733	1.1%
Vermont	-	-	-	-
Virginia	20,042	\$33.3	\$6,894	0.5%
Washington	145,992	\$180.4	\$7,335	2.5%
West Virginia	3,135	\$11.4	\$2,740	0.4%
Wisconsin	187,016	\$160.7	\$6,878	2.3%
Wyoming	4,013	\$12.4	\$527	2.4%

Notes: The “-” indicates that data were not available from the state. State officials were asked by GAO to provide an unduplicated enrollment number for each year. Alaska and Arizona could not provide unduplicated enrollment data. Officials in 22 states reported enrollment data by state fiscal year, 6 reported by federal fiscal year, 13 reported by calendar year, and 2 reported average monthly enrollments. Expenditures are federal fiscal year.

Sources: For TMA enrollment and expenditures, U.S. Government Accountability Office (GAO), *Medicaid: Additional enrollment and expenditure data for the transitional medical assistance program*, Report no. GAO-13-454R, March 15, 2013, <http://www.gao.gov/assets/660/653058.pdf>. For total Medicaid benefit spending, MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2012, MACStats Table 6.

TABLE 2. CHIPRA Bonus Payments for Fiscal Year (FY) 2009 to 2013

State	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Alabama	\$1,468,033	\$5,687,952	\$20,356,368	\$15,822,112	\$11,487,387
Alaska	707,253	4,913,942	5,748,452	4,121,160	2,637,399
Colorado	-	18,203,273	32,906,502	47,490,797	58,489,650
Connecticut	-	-	5,169,927	2,981,808	1,717,085
Georgia	-	-	4,891,788	2,217,833	-
Idaho	-	876,171	458,932	1,446,004	5,402,512
Illinois	9,460,312	15,325,041	15,297,689	13,305,164	6,298,211
Iowa	-	7,702,644	9,955,808	11,448,316	10,615,376
Kansas	1,220,479	5,461,248	5,958,759	12,760,085	10,854,406
Louisiana	1,548,387	3,661,104	1,915,111	-	-
Maryland	-	11,445,344	27,998,890	37,500,197	43,470,168
Michigan	4,721,855	8,436,607	6,893,004	4,377,476	1,602,468
Montana	-	-	5,034,670	7,185,360	7,025,902
New Jersey	3,131,195	8,765,386	17,554,512	24,357,753	22,429,198
New Mexico	5,365,601	8,967,885	5,246,129	2,724,565	1,663,071
North Carolina	-	-	11,567,319	18,594,703	11,589,603
North Dakota	-	-	3,175,469	2,743,944	1,078,574
New York	-	-	-	643,064	13,110,267
Ohio	-	13,127,633	20,819,999	18,966,255	10,829,869
Oklahoma	-	-	481,452	-	-
Oregon	1,602,692	10,567,238	22,323,821	25,923,850	24,393,154
South Carolina	-	-	2,712,649	2,939,771	17,536,595
Utah	-	-	-	9,861,838	5,325,544
Virginia	-	-	24,620,902	19,973,322	18,004,201
Washington	7,861,411	20,649,662	19,014,483	13,763,513	7,844,055
Wisconsin	-	23,432,822	33,261,014	17,128,227	13,917,864
West Virginia	-	-	136,270	-	-
<b>Total</b>	<b>\$37,087,218</b>	<b>\$167,223,952</b>	<b>\$303,499,919</b>	<b>\$318,277,117</b>	<b>\$307,322,559</b>
<b>payments</b>				<b>7</b>	
<b>Number of states</b>	<b>10</b>	<b>16</b>	<b>25</b>	<b>24</b>	<b>23</b>

Notes: The "-" indicates that no payments were received by the state in that year. The bonus payments for FY 2013 are considered preliminary and subject to reconciliation after states' Medicaid enrollment numbers are finalized in early 2014.

Source: Centers for Medicare & Medicaid Services (CMS), "CHIPRA Performance Bonuses: A History," December 2013, <http://www.insurekidsnow.gov/professionals/eligibility/pb-2013-chart.pdf>.

TABLE 3. Qualifying Outreach and Enrollment Strategies Among States Receiving CHIPRA Bonus Payments for FY 2013 Child Enrollment Growth in Medicaid

State	12-month Continuous Eligibility	No Asset Test for Eligibility*	No In-Person Interview*	Joint Medicaid/CHIP Renewal Form*	Automatic Administrative Renewal*	Presumptive Eligibility	Express Lane Eligibility	Premium Assistance
Alabama	✓	✓	✓	✓	✓	–	–	–
Arkansas	✓	✓	✓	✓	✓	–	–	–
Colorado	–	✓	✓	✓	✓	–	✓	✓
Connecticut	–	✓	✓	✓	✓	✓	–	–
Idaho	✓	✓	✓	✓	✓	–	–	✓
Illinois	✓	✓	✓	✓	✓	✓	–	–
Iowa	✓	✓	✓	✓	–	✓	✓	–
Kansas	✓	✓	✓	✓	✓	✓	–	–
Maryland	–	✓	✓	✓	✓	–	✓	–
Michigan	✓	✓	✓	✓	–	✓	–	–
Montana	–	✓	✓	✓	✓	✓	–	–
New Jersey	–	–	✓	✓	✓	✓	✓	–
New Mexico	✓	✓	✓	✓	✓	✓	–	–
North Carolina	✓	✓	✓	✓	✓	–	–	–
North Dakota	✓	✓	✓	✓	✓	–	–	–
New York	✓	✓	✓	✓	–	–	–	–
Ohio	✓	✓	✓	✓	–	✓	–	–
Oregon	✓	✓	✓	✓	✓	–	✓	–
South Carolina	✓	✓	✓	✓	–	✓	–	–
Utah	–	✓	✓	✓	✓	✓	–	–
Virginia	–	✓	✓	✓	✓	–	–	✓
Washington	✓	✓	✓	✓	–	–	–	✓
Wisconsin	–	✓	✓	✓	✓	–	–	✓
<b>Total</b>	<b>15</b>	<b>22</b>	<b>23</b>	<b>23</b>	<b>17</b>	<b>13</b>	<b>5</b>	<b>5</b>

Notes: Bonus payments for FY 2013 are considered preliminary and subject to reconciliation after states' Medicaid enrollment numbers are finalized in early 2014.  
 \* Beginning in 2014, these policies are now required in all states for individuals whose eligibility is determined based on modified adjusted gross income (MAGI), including children.  
 Source: Centers for Medicare & Medicaid Services (CMS), "FY 2013 CHIPRA Performance Bonus Awards," December 2013, <http://www.asurckidnow.gov/professionals/eligibility/fy2013-pb-table.pdf>.

TABLE 4. Medicaid Benefits by Dual-Eligible Category

Dual Eligible Category	Medicaid Benefit Status	Enrollees in 2011 (millions)	Description	Federal Income Limits	2013 Federal Resource Limits (Individual/ Couple)	Medicaid Benefits
<b>Medicare Savings Programs (MSPs)</b>						
Qualified Medicare beneficiaries (QMBs)	Partial benefit (QMB only)	1.3	Qualify for Medicaid payment of all Medicare premiums and cost sharing, but are otherwise ineligible for Medicaid in their state	Up to 100% FPL	\$7,080/ \$10,620	Medicare Part A premiums (if needed) Medicare Part B premiums Medicare deductibles and coinsurance
	Full benefit (QMB plus)	5.3	Qualify for Medicaid payment of all Medicare premiums and cost sharing, and also meet Medicaid eligibility criteria in their state and qualify for full Medicaid benefits	Up to 100% FPL	\$2,000/ \$3,000	Medicare Part A premiums (if needed) Medicare Part B premiums Medicare deductibles and coinsurance Full Medicaid benefits
Specified low-income Medicare beneficiaries (SLMBs)	Partial benefit (SLMB only)	0.9	Qualify for Medicaid payment of Medicare Part B premiums and are otherwise ineligible for Medicaid in their state	Between 100 and 120% FPL	\$7,080/ \$10,620	Medicare Part B premiums
	Full benefit (SLMB plus)	0.3	Qualify for Medicaid payment of Medicare Part B premiums, and also meet Medicaid eligibility criteria in their state and qualify for full Medicaid benefits, which include payment for Medicare cost sharing within the limits of the state plan. Depending on their state, they may also receive Medicaid payment of Medicare Part A premiums.	Between 100 and 120% FPL	\$2,000/ \$3,000	Medicare Part B premiums Medicare deductibles and coinsurance (within the limits of the state plan) Medicare Part A premiums at state option Full Medicaid benefits

TABLE 4, Continued

Dual Eligible Category	Medicaid Benefit Status	Employees in 2011 (millions)	Description	Federal Income Limits	2013 Federal Resource Limits (Individual/Couple)	Medicaid Benefits
Qualifying individuals (QIs)	Partial benefit	0.5	Qualify for Medicaid payment for Medicare Part B premiums and are otherwise ineligible for Medicaid in their state	Between 120 and 135% FPL	\$7,060/ \$10,620	Medicare Part B premiums
Qualified disabled and working individuals (QDWIs)	Partial benefit	Fewer than 100 individuals	Have lost their Medicare Part A benefits due to their return to work but are eligible to purchase Medicare Part A, qualify for Medicaid payment of Medicare Part A premiums, and are otherwise ineligible for Medicaid in their state	At or below 200% FPL	\$4,000/ \$6,000	Medicare Part A premiums
<b>Non-MSP</b>						
Other full-benefit dual eligibles	Full benefit	1.9	Do not meet income or resource requirements for QMB, SLMB, or QI but meet Medicaid eligibility criteria in their state and qualify for full Medicaid benefits, which includes payment for Medicare cost sharing covered within the limits of the state plan. Depending on their state, they may also receive Medicaid payment of Medicare Part A premiums.	Varies by state and Medicaid eligibility pathway	\$2,000/ \$3,000	Full Medicaid benefits Medicare coinsurance and deductibles (within the limits of the state plan) Medicare Part A premiums at state option

**Notes:** FPL is the federal poverty level. Section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are less restrictive, enabling states to expand eligibility above these standards. Not all resources (e.g., value of house, value of one vehicle, etc.) are counted toward resource limits. Section 209(b) states may use Medicaid eligibility criteria that are more restrictive than the Supplemental Security Income program, but may not use more restrictive criteria than those in effect in the state on January 1, 1972. For information on state Medicaid income eligibility levels for persons age 65 and over and individuals with disabilities, see MACStats Table 11 in MACPAC's March 2013 report. Resource limits for QMB, SLMB, and QI are adjusted annually for inflation. QI expenditures are fully federally funded and total expenditures are limited by statute. Medicaid coverage of additional premiums for Medicare Advantage plans is optional for states (§1905(p)(3)(d)).

**Sources:** MACPAC 2013.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Dr. Lu 5 minutes for a summary of his testimony.

#### STATEMENT OF MICHAEL LU

Dr. LU. Thank you, Chairman Pitts, Ranking Member Pallone and members of the committee. Thank you for the opportunity to testify today.

HRSA focuses on improving access to health care services for people who are uninsured, isolated, or medically vulnerable. The agency collaborates with government at the federal, state, and local levels to improve health and achieve health equity through access to quality services and a skilled health care workforce.

I am pleased to provide an overview and update on two of our programs: the Maternal, Infant, and Early Child Home Visiting program, which I will just refer to as the home visiting program, and the Family to Family program.

The home visiting program, administered by HRSA, includes collaboration with Administration for Children and Families, supports voluntary evidence-based home visiting services during pregnancy and to parents with young children up to age 5. Providers in the community work with parents who voluntarily sign up to participate in the program to help them build additional skills to care for their children and family. Priority populations include low-income families, teen parents, family with a history of drug use or of child abuse and neglect, families with children with developmental delays or disabilities, and military families.

The strength of the overall program lies in an evidence-based approach, decades of scientific research which shows that home visiting by a nurse, a social worker or early educator during pregnancy and in the first year of life improves specific child-family outcomes including prevention of child abuse and neglect, positive parenting, child development and school readiness. The benefit of home visiting for the child continues well into adolescence and early adulthood. For example, previous work in this area has shown that among 19-year-old girls born to high-risk mothers, nurse home visiting during their mother's pregnancy and in their first 2 years of life reduce the 19-year-old's lifetime risk of arrest and conviction by more than 80 percent, teen pregnancy by 65 percent, and led to reduce enrollment in Medicaid by 60 percent.

In addition, a number of studies indicate home visiting programs have a substantial return on investment. The most current one funded by the Pew Charitable Trust found that for every dollar invested in home visiting, \$9.50 is returned to society.

Early data collected by HRSA found that within the first 9 months of implementation in 2012, the program provided more than 175,000 home visits to 35,000 parents and children in 544 communities across the country. Preliminary data from 2013 indicates that more than 80,000 parents and children are receiving home visiting services, and the program is now available in 650 counties across the country, which is 20 percent of all the counties in the United States. States and communities are the driving force in terms of carrying out this program. With our support, States and communities are building capacity in this area and have demonstrated improved quality, efficiency and accountability of their

home visiting programs. States have the flexibility to tailor their programs to serve the needs of their different communities and populations. States are able to choose from 14 evidence-based models that thus fit their risk communities needs capacities and resources.

We have taken a number of steps to ensure proven effectiveness and accountability. HRSA and ACF provide ongoing technical assistance to grantees and promote dissemination of best practices by supporting collaborative learning across States. Additionally, we closely monitor States' progress. The data are collected on an annual basis, and by October 2014, States are expected to demonstrate improvement in at least four out of the six benchmark areas.

Additionally, HRSA administers the Family to Family Health Information Center program with centers in all 50 States and D.C., which provides support, information, resources and training to families of children with special health care needs. These centers are staffed by parents of children with special health care needs. These parents provide advice and support and connect other parents to a larger network of families and professionals for information and resources. The centers also provide training to professionals on how to better support families of children with special health care needs and assists States in developing and implementing family center medical home and community system of care for these children.

HRSA closely monitors program effectiveness. A 2012 Family Voices report supported by HRSA on the activities and accomplishments of these centers indicated that between June 2010 and May 2011, so a 1-year period, approximately 200,000 families and 100,000 professionals received direct assistance and training from these centers. Greater than 90 percent of the families reported being able to partner in decision-making, better able to navigate through services and more confident about getting needed services.

I appreciate the opportunity to testify today, and I will be pleased to answer any questions that you may have.

[The prepared statement of Dr. Lu follows:]



**Statement of**

**Michael Lu, M.D., M.S., M.P.H**

**Associate Administrator  
Maternal & Child Health Bureau**

**Health Resources and Services Administration  
U.S. Department of Health and Human Services**

**Before the  
Committee on Energy and Commerce  
Subcommittee on Health  
U.S. House of Representatives**

**Washington, D.C.**

**January 9, 2014**

Chairman Pitts, Ranking Member Pallone, and Members of the Committee, thank you for the opportunity to testify today. I am Dr. Michael Lu, Associate Administrator of the Maternal & Child Health Bureau (MCHB) at the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS).

HRSA focuses on improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA's mission is to improve health and achieve health equity through access to quality services and a skilled health care workforce. The Agency collaborates with government at the Federal, State, and local levels, and also with community-based organizations, to seek solutions to primary health care challenges.

We are pleased to have the opportunity to share with you today some of the activities underway in MCHB associated with the goal of enhancing access to care for women, children and families.

#### **HRSA's Maternal & Child Health Bureau**

As Associate Administrator of MCHB, I have the opportunity to direct programs with an overall mission of improving the health of America's mothers and children, including children with special healthcare needs, and their families. MCHB's vision for the Nation is one where all children and families are healthy and thriving.

We carry out our mission through targeted programs designed to improve maternal and child health in our nation. I am pleased to provide an overview and update on two of our programs: the Maternal, Infant, and Early Childhood Home Visiting and the Family-to-Family programs. Their activities are complementary but with different purposes and program design.

#### **Home Visiting**

The Maternal, Infant, and Early Childhood Home Visiting program, administered by HRSA in close collaboration with the Administration for Children and Families (ACF), aims to improve health and developmental outcomes for children and families who reside in at-risk communities through implementation of evidence-based voluntary home visiting programs. The Affordable Care Act provided initial funding of \$1.5 billion in mandatory dollars for 2010 through 2014. The President's Fiscal Year (FY) 2014 Budget proposes to extend and expand this program in future years.

The Maternal, Infant, and Early Childhood Home Visiting program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to age five. Providers in the community work with parents who chose to participate in the program voluntarily to build the skills to help take care of their children and family. Priority populations include: low-income families; teen parents; families with a history of drug use or of

child abuse and neglect; families with children with developmental delays or disabilities; and military families.

The legislation requires that all grantees demonstrate improvement in six benchmark areas:

1. Improved maternal and newborn health;
2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
3. Improvement in school readiness and achievement;
4. Reduction in crime or domestic violence;
5. Improvements in family economic self-sufficiency; and
6. Improvements in the coordination and referrals for other community services and supports.

The strength of the overall Maternal, Infant, and Early Childhood Home Visiting program lies in its evidence-based approach. The program is built on decades of scientific research. This research shows that home visiting by a nurse, a social worker, or early educator during pregnancy and in the first years of life improves specific child and family outcomes, including prevention of child abuse and neglect, positive parenting, child development and school readiness. And that positive impact continues well into adolescence and early adulthood. For example, previous work in this area has shown that among 19-year old girls born to high-risk mothers, nurse home visiting during their mother's pregnancy and their first two years of life reduced their lifetime risk of arrest or conviction by more than 80 percent, teen pregnancy by 65 percent, and led to reduced enrollment in Medicaid by 60 percent.<sup>1</sup> There have been a number of return-on-investment studies. The most current one, funded by The Pew Charitable Trusts on Nurse Family Partnership, found that for every dollar invested in home visiting, you get \$9.50 in return to society.<sup>2</sup>

In order to meet the legislative directive of prioritizing home visiting models that demonstrate evidence of effectiveness, HHS established rigorous criteria and conducted a systematic review of the research. This review determined that to date 14 models meet the evidence-based criteria. Since the models target different populations and support different interventions, 41 States have implemented more than one model. States are tailoring their programs to fit the needs of their different communities and population groups. The models most frequently selected by States are

---

<sup>1</sup> Eckenrode J, Campa M, Luckey DW, Henderson CR Jr, Cole R, Kitzman H, Anson E, Sidora-Arcoleo K, Powers J, Olds D. Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Arch Pediatr Adolesc Med.* 2010 Jan;164(1):9-15.

<sup>2</sup> Miller, T., "Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Return on Investment: Executive Summary." (personal communication), 2012.

Nurse-Family Partnership, Healthy Family America, Parents as Teachers, and the Early Head Start-Home Based Model.

The Maternal, Infant, and Early Childhood Home Visiting program is being implemented on a national scale. There are three components to the program. All 50 States, the District of Columbia, and five territories received formula grants based on child poverty rates to provide home visiting services to at-risk families that chose to participate in the program. HHS also awarded competitive funding to 19 States for development grants focused on building the capacity of the workforce, data infrastructure, and care coordination and referral systems. Thirty-one States received expansion grants to build upon efforts already underway and expand services to more families and more communities. The home visiting program also includes a 3% set aside for grants to Tribes, Tribal and Urban Indian Organizations, which is administered by the Administration for Children & Families.

Most States started serving families through the home visiting program at the end of 2011. Our early data found that, within the first nine months of implementation in 2012, the program provided more than 175,000 home visits to over 35,000 parents and children in 544 communities across the country. Preliminary data from 2013 indicate that more than 80,000 parents and children are receiving home visiting services, and the program is now available in 656 counties across the country, which is 20 percent of all the counties in the United States, and includes three-fourths of urban areas that have populations over 500,000. As a result, we are expanding the reach of home visiting programs that have been proven critical in improving maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills; children's cognitive, language, and social-emotional development; and school readiness. This effort will help ensure that our most vulnerable Americans are on track from birth.

States and communities are the driving force in terms of carrying out this program. And while home visiting services may have existed in some States and communities before this program, they were often not evidence-based, quality was variable and services were often uncoordinated. With the support of this program, States and communities are building capacity in this area and have demonstrated improved quality, efficiency and accountability of their home visiting programs.

Several States are building upon the national Maternal, Infant, and Early Childhood Home Visiting framework and demonstrating strong leadership. For example:

**California** is offering home visiting services to over 10,000 homes in the State where parents have chosen to participate. CA MIEHCV is a leader in providing home visiting workforce education and training to address the critical areas of domestic violence and mental health.

**Georgia** has tailored its focus to build on the capacity for the Georgia Home Visiting Information System, a centralized intake system that integrates state and local data systems to assure at-risk families are appropriately identified and receive home visiting services. At the state level, as Georgia utilizes multiple evidence-based home visiting models, families are matched to the appropriate models based on program expertise and availability. At the local level, central intake coordinators accept referrals, conduct standard screening, and connect families who chose to participate to local home visiting programs as appropriate.

**Michigan** is creating an evidence-based, data-driven, home visiting system utilizing three evidence-based models that will improve the well-being of families in eight high need communities with a special focus on improving birth outcomes and reducing health disparities. Michigan is also collaborating directly with Tribal communities and a MIECHV Tribal grantee to reduce infant mortality by the implementation of evidence-based home visiting with Tribal families.

**Texas** is implementing five evidence-based home visiting models and supports home visiting services through 24 sites distributed across seven communities in the State. With the support of the home visiting program, Texas continues to strengthen a data-driven, local early childhood system focused on improving school readiness. The Texas program is also working to enhance the abilities of home visiting program models to better engage fathers in home visiting services and their children's lives.

HRSA and ACF have taken a number of steps to ensure program effectiveness and accountability. HRSA and ACF provide ongoing technical assistance to grantees and encourage the dissemination of best practices, which accelerates collaborative learning across States. Additionally, HRSA and ACF closely monitor States' progress toward 37 outcome measures in six benchmark areas, such as improvements in breastfeeding and reductions in emergency room visits. These data are collected on an annual basis and, by October 2014, States are expected to demonstrate improvement in at least four of the six benchmark areas.

Furthermore, the law calls for a national evaluation to assess the impacts of Maternal, Infant, and Early Childhood Home Visiting using a random assignment study paired with a rich implementation and cost study. The goal of the national evaluation is to inform the field about specific program components that might lead to even greater positive outcomes for families. While each program model is based on research, this evaluation will not only identify which specific program features are associated with program outcomes across models but will also provide new learning to strengthen home visiting services in state and local communities.

### **Family-to-Family Health Information Centers**

Additionally, HRSA administers a unique program that focuses specifically on providing support to families of children and youth with special health care needs. The Family-to-Family program helps families connect to and share information and resources, acquire the skills to partner with their children's health care providers, and better navigate the health care system.

#### **History**

From 2002 through 2007, 36 States received Real Choice Systems Change Grants for Community Living from the Centers for Medicare & Medicaid Services and MCHB to establish Family-to-Family Health Information and Education Centers for families of children with special health care needs to give information to and mentor other families. Funding for the Family-to-Family Health Information Centers was established by the Family Opportunity Act as a part of the Deficit Reduction Act of 2005 to provide information and support to parents of children with disabilities and special health care needs to partner with their health providers. The Affordable Care Act extended the program from 2010 through 2012. In FY 2013, the American Taxpayer Relief Act of 2012 (ATRA) extended the program for one year. The recently enacted Bipartisan Budget Act of 2013 extended funding for Family-to-Family Health Information Centers through April 1, 2014.

### **Family-to-Family Health Information Centers**

A Family-to-Family Health Information Center is a statewide, family-staffed center that provides information, education, technical assistance and peer support to families of children with special health care needs about how to access health and related resources in their States and communities. Children with special health care needs are those children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions, and who also require health and related services of a type or amount beyond that required by children generally. According to the 2010 National Survey of Children with Special Health Care Needs, approximately 11.2 million (or 15.1 percent) of children ages zero to 17 years in the United States have special health care needs. Nearly 60 percent of children with special health care needs experience more complex service needs beyond a need for prescription medications to manage their health conditions. Over one-third of parents of children with special health care needs reported difficulties in accessing needed community-based services and not feeling they, as parents, are treated as full partners in their children's care.

The Family-to-Family Health Information Centers are responsible for developing partnerships with those organizations serving children with special health care needs and their families, including State Maternal and Child Health Block Grants program, other parent/family-led organizations and patient navigator programs in their States. They are typically staffed by

parents of children with special health care needs. With their knowledge of and experience with state and community resources, they provide advice, offer resources, and access a network of other families and professionals for support and information.

In May 2012, \$5 million in Affordable Care Act funding was allocated to support 51 HICs, one in each State and the District of Columbia. Each center received \$95,700 to perform the activities outlined in statute. The ATRA in FY 2013 extended the \$5 million funding for Family-to-Family Health Information Center to continue their activities outlined in the statute.

The centers assist States in developing and implementing a plan to achieve appropriate community-based systems of services for children with special health care needs and their families, including increasing families' confidence in relating to the health care system and their problem-solving capacity; culturally-appropriate communication between families and providers to reduce health disparity; and family participation—to improve transition, strengthen community-based systems, and decrease bottlenecks within specialty referral process. MCHB monitors program effectiveness by measuring six core outcomes that include: family/professional partnerships, medical home, early and continuous screening, adequate financing, community services and transition to adulthood. Family-to-Family Health Information Centers have made notable contributions to meeting these outcomes. A 2012 Family Voices report supported by HRSA on the activities and accomplishments of F2F HICs indicated approximately 200,000 families and 100,000 professionals received direct assistance and/or training from a center between June 2010 and May 2011.<sup>3</sup>

### **Conclusion**

The work of these two programs are examples of full partnerships across Federal, State and local stakeholders focused on improving the health of America's mothers and children. They capitalize on a proven evidence based approach to services, the support and full engagement of families in addition to providers, and as a result, these programs are making a difference in growing human potential for some of the nation's most vulnerable children and families, including high-risk families and children with special health care needs.

I appreciate the opportunity to testify today, and I would be pleased to answer any questions you may have.

---

<sup>3</sup> National Center for Family/Professional Partnerships. 2012 Activities & Accomplishments of Family-to-Family Health Information Centers. Albuquerque, NM: Family 2012. [http://www.fvncfpp.org/files/5513/5066/2047/2012F2F-Booklet\\_10-19-2012-r.pdf](http://www.fvncfpp.org/files/5513/5066/2047/2012F2F-Booklet_10-19-2012-r.pdf).

Mr. PITTS. Thank you. The Chair now recognizes Dr. Goldstein 5 minutes for summary of her testimony.

#### STATEMENT OF NAOMI GOLDSTEIN

Ms. GOLDSTEIN. Thank you for the opportunity to be here today. I plan to speak about three programs my agency oversees as well as our collaboration with Dr. Lu and his colleagues on evaluating the home visiting program he described.

Each of these programs uses knowledge from past research, and in keeping with direction from Congress, we are carrying out evaluations to continue to learn about effective approaches for meeting the goals of these programs. We aim to make our evaluations rigorous so the results are sound and credible and also relevant and useful for policymakers and practitioners.

First, the Health Profession Opportunity Grants program funds training in high-demand health care professions for low-income people. It uses a career pathways framework based on past research. The program has funded 32 grantees including five tribal organizations. Of those people completing a training program, over 80 percent have become employed. The most common training is preparation for jobs such as nursing assistant or orderly, short courses that can be the first step in a career pathway. Last year we published three reports on the implementation of these grants and the outcomes for participants. Grantees are using a range of creative strategies. For example, one grantee in Pennsylvania is using Google Hangouts for real-time tutoring in a highly rural service area. We plan to release additional reports this year and next. We are also studying how the program affects participants' education, employment, and earnings.

Second, the Personal Responsibility Education program is designed to educate youth on both abstinence and contraception. The statute reserves the majority of funds for program models that are evidence-based or substantially so. All models must provide medically accurate information. HHS sponsors a systematic review to identify programs with evidence of impacts. So far, 31 program models have met the review criteria. We continue to learn about what works. We recently released a report describing State choices about program design and implementation such as how they define and how they reach target populations. Further findings from the national evaluation will be released over the next couple of years. We are also studying the impacts of four local program approaches to address gaps in the evidence base.

Third, in the Abstinence Education program, States are encouraged to use models that are evidence-based, and again, all models must provide medically accurate information. In 2007, HHS completed an evaluation of four local abstinence programs, which found no effects on abstaining from sex. The study also found no effects on the likelihood of unprotected sex. However, three abstinence models are among the 31 teen pregnancy prevention models that meet HHS evidence criteria. The Abstinence Education statute provides no funding for research and evaluation. However, HHS is supporting evaluation of abstinence education through some of its broad teen pregnancy prevention activities. For example, one Vir-

ginia grantee of the Personal Responsibility Education program is evaluating an abstinence curriculum.

Finally, Dr. Lu mentioned our collaboration on the home visiting program. The statute reserves the majority of funding for home visiting models that meet evidence criteria. The statute also requires continual learning through a national evaluation and other activities. HHS sponsored a systematic review of evidence similar to the review of teen pregnancy prevention evidence. So far, 14 home visiting models have met the review criteria.

The design of the national evaluation has been informed by an advisory committee of experts required by the statute. Most recently the committee reviewed and endorsed plans for a report to Congress due in March 2015. The evaluation is using a rigorous random assignment design to assess the effectiveness of the program overall and of the four home visiting models most commonly chosen by the grantees.

I hope these brief descriptions convey some sense of the accomplishments of these programs and of our ongoing efforts to learn and improve.

Thank you again for inviting me to testify. I would be happy to address any questions.

[The prepared statement of Ms. Goldstein follows:]



**Statement of**

**Naomi Goldstein, Ph.D.**

**Director**

**Office of Planning, Research and Evaluation**

**Administration for Children and Families**

**U.S. Department of Health and Human Services**

**Before the**

**Committee on Energy and Commerce**

**Subcommittee on Health**

**U.S. House of Representatives**

**January 9, 2014**

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to testify today. My name is Naomi Goldstein, and I have served since 2004 as Director of the Office of Planning, Research and Evaluation (OPRE) in the Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACF promotes the economic and social well-being of families, children, individuals and communities through a broad array of programs carried out in partnership with states, territories and tribes, with other federal agencies, and with community-based organizations and local governments. I am pleased to share with you today information about the activities of a few of these programs, and what we are learning from them.

ACF's Office of Planning, Research and Evaluation studies ACF programs and the populations they serve. OPRE conducts its work primarily through competitively awarded grants and contracts for research and evaluation projects. We aim to make our work both rigorous and relevant, and to disseminate it in ways that are useful for policy-makers and practitioners.

ACF appreciates your interest in our work, and welcomes the opportunity to discuss with you the Health Profession Opportunity Grants, Abstinence Education, and Personal Responsibility Education Programs. I will also speak about ACF's collaboration with the Health Resources and Services Administration (HRSA) on the evaluation of the Maternal, Infant and Early Childhood Home Visiting Program.

#### **Health Profession Opportunity Grant Program**

The Health Profession Opportunity Grants (HPOG) Program funds training in high-demand healthcare professions targeted to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals. The program is designed to meet the demand for healthcare workers in communities and improve the job prospects for adults from hard-working families, matching careers in a growing field with people who are eager to fill them.

The program was established by the Affordable Care Act (ACA). In 2010, ACF awarded five-year funding to 32 grantees in 23 states. Five of the grantees are tribal organizations. ACF provides approximately \$67 million annually to these grantees. HPOG grantees are post-secondary educational institutions; workforce investment boards (WIBs), state and local government agencies, and community-based organizations. Grantees coordinate services with state and local WIBs, state and local TANF agencies and federal and state offices of Apprenticeship, among other partners.

Career pathways (CP) programs have developed over the past decade as a comprehensive framework of adult developmental and vocational education and supportive services designed to address the challenge of providing post-secondary skills training to low-income and educationally disadvantaged populations. This framework builds on past research showing that similar programs can improve employment and earnings.<sup>1,2,3,4,5</sup>

<sup>1</sup> Bragg, D., Harmon, T., Kirby, C., & Kim, S. (2010, August). Bridge programs in Illinois: Summaries, outcomes, and cross-site findings. Champaign, IL: Office of Community College Research and Leadership, University of Illinois.

As of December 2013, approximately 25,800 participants have enrolled in HPOG programs. Of the more than 12,000 participants who have completed an occupational or vocational training program, more than 10,000 participants have become employed since the program began. Among those who became employed, their average wage is \$12.37 per hour.

The majority of HPOG participants were single females at program entry, with one or more dependent children. While most were not TANF recipients at enrollment, most had a household income of less than \$20,000 when starting the program, and almost two-thirds received some form of public assistance at program intake. The most common training among participants is preparation to become a nursing assistant, aide, orderly, or patient care attendant, generally short training courses that can be the first step in a longer career pathway. Other common trainings included instruction to be a licensed or vocational nurse, registered nurse, and medical assistant. HPOG participants also engaged in pre-training college study skills and basic skills education classes. Grantees provide a variety of support services including case management and counseling services; financial assistance for tuition, books, and fees; and social service supports, including assistance with transportation, child care and emergency assistance. Grantees also provide employment assistance in the form of job search workshops, career coaches, and placement and retention assistance.

ACF is using a multi-pronged research and evaluation strategy to examine outcomes and impacts for HPOG participants as well as program implementation and systems change resulting from HPOG programs. The HPOG impact evaluation uses a rigorous random assignment design that will show how variations in program services affect program impacts. The HPOG impact evaluation report, to be released in 2016, will report on education impacts such as credential attainment and impacts on employment and earnings as well as job quality for participants 15 months after program entry.

All HPOG grantees are participating in a companion study on program implementation, systems change, and outcomes. ACF will complete and release interim reports from this study in 2014 and a final report in 2017, as well as interim and final tribal program evaluation reports in 2014 and 2015.

While the formal evaluations are still in progress, we have already heard first-hand about grantees that are addressing barriers to employment through innovative strategies and partnerships. For example, Bergen Community College is the lead organization for a consortium that includes ten community colleges in Northern New Jersey and has designed a “boot camp”

---

<sup>2</sup> Helmer, M., & Blair, A. (2011, February). *Courses to employment: Initial education and employment outcomes findings for students enrolled in Carreras en Salud Healthcare Career Training 2005–2009*. Washington, DC: The Aspen Institute. Retrieved from <http://www.aspenwsi.org/WSIwork-HigherEdpubs.asp>

<sup>3</sup> Barnett, E., Bork, R., Mayer, A., Pretlow, J., Wathington, H., & Weiss, M. (2012). *Bridging the gap: An impact study of eight developmental summer bridge programs in Texas*. New York, NY: National Center for Postsecondary Research.

<sup>4</sup> Maguire, S., Freely, J., Clymer, C., Conway, M., & Schwartz, D. (2010). *Tuning in to local labor markets: Findings from the Sectoral Employment Impact Study*. Philadelphia: Public/Private Ventures.

<sup>5</sup> Roder, A., & Elliot, M. (2011, April). *A promising start: Year Up's initial impacts on low-income young adults' careers*. New York: Economic Mobility Corporation.

curriculum that provides participants with an orientation to healthcare occupations. As another example, Central Susquehanna Intermediate Unit in Pennsylvania is using “Google hangouts” to facilitate real-time tutoring and homework assistance in a highly rural ten-county service area to support students who are completing healthcare training programs. In California, the San Diego Workforce Partnership initiated the formation of a “common customer workgroup” that brings together workforce and human services agencies to streamline their efforts while also helping participants navigate the system more easily.

#### **Personal Responsibility Education Program**

Teen birth rates have fallen significantly in recent years. Nevertheless, births to teens remain relatively common in the U.S. Preliminary data for 2012 indicate that more than 300,000 children were born to mothers between the ages of 15 and 19. Teen births are associated with a range of negative outcomes for teen parents and their children. For example, teen parents use public assistance more often and finish high school less often. Furthermore, it is estimated that teen childbearing in the U.S. costs taxpayers billions a year in lost revenue and increased expenditures for foster care, public assistance, and criminal justice services.

Congress authorized a new evidence-based teen pregnancy prevention program called the Personal Responsibility Education Program (PREP) through the ACA. The program is designed to educate adolescents on “both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections” and to prepare youth for adulthood by addressing topics such as healthy relationships, adolescent development, and healthy life skills. It is funded at \$75 million a year through fiscal year 14 and is administered by the Family and Youth Services Bureau (FYSB), within ACF.

The program design was guided by research and evaluation that has demonstrated what works to reduce teen pregnancy. In 2010, HHS sponsored a transparent, systematic review of the teen pregnancy prevention evidence base, in order to independently identify teen pregnancy prevention programs with evidence of impacts on teen pregnancies or births, sexually transmitted infections, or associated sexual risk behaviors. The review identified, assessed, and rated the rigor of program impact studies and described the strength of evidence supporting different program models. The review is ongoing and partially supported by PREP funds. Based on the review, HHS identified evidence-based programs, defined as those with: (1) studies with designs that have the best chance of finding unbiased impact estimates; and (2) a positive, statistically significant impact on sexual activity, contraceptive use, sexually transmitted infections, pregnancies, or births. There are now 31 different program models that have met the review criteria for evidence of program effectiveness. Most youth served through PREP formula funding (93 percent) will participate in one of these evidence-based programs. We released a report last fall on how states are scaling up these evidence-based programs; the report also highlights how some states are reaching their target populations.

Let me highlight three key accomplishments of the PREP program to date. First, the reach of the program is quite broad. States plan to serve a total of 300,000 youth through formula grant funding over the course of the five-year grant period. These youth are being reached through

over 300 different program providers operating in over 1,300 different sites across the country. Second, most state grantees are focusing on high-risk youth. Three-fourths of state program providers operate in high-need geographic areas. And third, state PREP grantees are creating an infrastructure to support successful replications of evidence-based programs through training, technical assistance, and monitoring.

The PREP program includes two key components – formula grants for evidence-based programs and competitive grants for promising programs. The majority of the funding (\$55 million a year) is available via formula grants for states and territories. Programs funded through these grants are required either to be evidence-based or to substantially incorporate elements of evidence-based programs. Forty-nine states and territories draw down formula grant funding. In the states and territories that have not taken up formula grant funding, unallocated funds are awarded to organizations within the state or territory via competitive grants. Within these states and territories, a total of 37 grantees receive competitive funding. In addition, \$10 million was made available through PREP for competitive grants to implement and evaluate promising new teen pregnancy prevention strategies. Twelve grantees receive funding through these competitive grants for innovative strategies. Finally, about \$3 million a year is available for competitive grants to tribes and tribal organizations.

We now have the opportunity to add to our knowledge about what works to reduce teen pregnancy – and to learn more about what it means to scale up evidence-based programs – through an independent evaluation that ACF is sponsoring of the PREP program. Mathematica Policy Research, our evaluation contractor, is: (1) conducting a descriptive study to document how PREP programs are designed and are implemented by states; (2) collecting and analyzing performance measure data for all formula-grant funded PREP programs; and (3) assessing the effectiveness of four specific PREP-funded programs, with an eye to filling gaps in the teen pregnancy prevention evidence base. In 2013, we released a report from the descriptive study (which I discussed earlier). The report documents key decisions states made about the design of their PREP programs. Further findings from the evaluation will be released on a rolling basis, culminating in short-term and long-term impact findings from the four selected sites in 2016 and 2018, respectively.

### **Abstinence Education**

Through the Title V State Abstinence Education Program, \$50 million per year is available via formula grants to states “to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity.” The program was first authorized in 1996 by the Personal Responsibility and Work Opportunity Reconciliation Act, and was most recently authorized by ACA. In FY13, 39 states and territories drew down Title V funding. The program also is administered by FYSB’s Adolescent Pregnancy Prevention Program.

The program provides funds to states to teach young people the social, psychological and health gains to be realized by abstaining from sexual activity. States are encouraged to develop flexible, effective abstinence-based plans that are responsive to their specific needs. As part of

those plans, states are encouraged to use abstinence education models that are evidence-based and all models must provide medically accurate information.

Many states focus directly on youth in foster care, and one state, Kansas, has dedicated the entire program to abstinence education for youth in foster care and the parents, adoptive parents, agency staff, and community professionals impacting the lives of children in foster care. Most grantees also include mentoring, counseling or adult supervision in some capacity.

In the 1990s and 2000s, HHS funded an evaluation of four programs, which showed that youth in the program group were no more likely than control group youth to have abstained from sex; at the same time, program group youth were no more likely to have engaged in unprotected sex than control group youth.

More recently, HHS has reviewed the current evidence base for teen pregnancy prevention programming and found three abstinence program models to meet the criteria for evidence of effectiveness. These models are:

- Promoting Health Among Teens – Abstinence Only;
- Making a Difference; and
- Heritage Keepers Abstinence Education.

The Abstinence Education statute provides no authority for dedicated research and evaluation funding. However, HHS is supporting evaluation of abstinence education through some of its broad teen pregnancy prevention research and evaluation activities. For example, a PREP grantee, Lighthouse Outreach in Virginia, is conducting an evaluation including an abstinence curriculum and a character-development curriculum.

#### **Research and evaluation in the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)**

As Dr. Lu mentioned, HRSA and ACF collaborate on implementing the MIECHV program. Dr. Lu mentioned our collaboration on research and evaluation for this program, and I will provide some additional detail. The MIECHV program is based on a large body of research on the effectiveness of home visiting for pregnant women and families with young children. Impacts have been seen across a broad range of outcomes, including maternal health, school readiness, parenting, prevention of child maltreatment, and family economic self-sufficiency. The MIECHV statute calls for a rich set of research and evaluation activities to continue to generate new knowledge. First, it requires the Secretary of HHS, to establish criteria for evidence of effectiveness and to reserve the majority of program funding for home visiting models that meet those criteria. Second, the statute requires a national evaluation of MIECHV. Third, it calls for rigorous evaluation of promising approaches implemented by grantees, that is, home visiting models that don't meet the evidence criteria. Fourth, it calls for the collection of performance management data by grantees. Finally, it calls for an ongoing portfolio of research and evaluation activities.

Following an opportunity for public comment, in 2010 the Secretary established criteria for evidence of effectiveness of home visiting models. ACF awarded a contract to conduct a thorough, transparent, systematic review of the evidence on models of home visiting, applying these criteria. This project is known as the Home Visiting Evidence of Effectiveness, or HomVEE. It conducts an exhaustive literature search for impact studies, determines the quality of the studies based on their ability to produce unbiased impact estimates, and assesses whether the available evidence for particular home visiting models meets the HHS criteria. The project conducts annual reviews to update the evidence on models that have already been reviewed and to review emerging evidence on models not yet reviewed. To date, the project has reviewed 35 models and found 14 to have evidence of effectiveness.

The statute directs HHS to conduct a national evaluation of MIECHV and includes specific requirements related to the evaluation. First, it requires the establishment of an Advisory Committee which has reviewed the design of the study and outline of the Report to Congress, which is due in March, 2015. Second, the law requires that the evaluation examine the states' needs assessments, address all the outcome domains noted in the legislation, examine impacts across different models and populations, and include a cost study. The evaluation, known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE), uses a rigorous random assignment design to answer questions of overall impacts as well as impacts for individual home visiting models. It will examine features of models and their implementation that lead to stronger impacts, and will include information on the costs of implementing home visiting models and the cost effectiveness of MIECHV.

In order to support grantees in evaluating promising approaches and collecting benchmark performance management data, we have provided technical assistance to grantees on establishing benchmarks, creating data systems, reporting performance management data, building continuous quality improvement processes and conducting rigorous evaluations.

Finally, the legislation calls for an ongoing portfolio of research and evaluation. ACF and HRSA have undertaken activities including a tribal research center, investigator-initiated grants, and a home visiting research network to build on the prior work and expand the knowledge base.

Thank you again for inviting me to testify. I would be happy to address any questions.

Mr. PITTS. The chair thanks the gentlelady for her testimony and now we will begin questioning. I recognize myself for 5 minutes for that purpose.

Mr. Hackbarth, I believe that this committee needs to be diligent in its spending priorities and consider every one of these policies carefully before deciding whether they warrant extension. Many constituencies are advocating for making these extenders permanent. In your testimony, you lay out a set of criteria to use when considering these extenders. Using your criteria, do you believe that all or the majority of these extenders warrant extension?

Mr. HACKBARTH. Certainly not all. I haven't done a count so I would be reluctant to say whether a majority are not, but we think many should not be extended.

Mr. PITTS. In your opinion, based on your criteria, do you have a couple of programs that Congress needs to look at with a very critical eye as we begin this review?

Mr. HACKBARTH. Well, we just focus on the world of payment provisions, some of which are permanent and some of which are temporary and under consideration here. As I said in my opening comments, we did an extensive review of Medicare rural health issues, which was published in June 2012, I believe, and part of that was to examine the special payment provisions against the criteria I mentioned in my opening comments, namely are they targeted to isolated providers, are they empirically justified and do they retain some incentive for efficiency, and we found a number of those provisions to not.

So let me focus in on one in particular. There is a temporary Low-Volume Adjustment in the Medicare program. This is a hospital payment adjustment for providers that have low volume. There are a couple serious problems with that adjustment. First of all, it is based only on Medicare discharges. If the issue we are trying to address is small size and a lack of economy of scale, the appropriate index of that is total discharges, not Medicare discharges. In addition to that, it looks to us like the magnitude of the adjustment is too large. And then finally, it is not directed only at isolated providers so hospitals that are in close proximity to, say, a Critical Access Hospital can qualify for the Low-Volume Adjustment. In fact, there are some hospitals like Sole Community Hospitals that can in effect double-dip, get special payments as Sole Community Hospitals and also low-volume payments as well.

Mr. PITTS. Thank you. I want to commend you for putting forward the criteria you referenced in your testimony. I believe it will be helpful to me and others on this committee as we consider the extenders before us today.

Dr. Rowland, like MedPAC, does MACPAC have a similar set of established criteria by which to weigh the Medicaid extenders that consider issues like cost and taxpayer burden against current benefit that the policy delivers to beneficiaries? And if not, how do you take into account issues of cost and other important considerations that MedPAC is advocating?

Dr. ROWLAND. Well, we are obviously a much newer body than MedPAC so have begun to try to establish the criteria by which we would look at the various policies. One of the strongest criteria is, does this policy promote efficiency, effectiveness and reduce com-

plexity in the programs. So we looked at these various extenders in terms of their role. The only area in which we have made strong recommendations is around Transitional Medical Assistance, or TMA, and we are continuing to look at the others both in terms of their cost but also in terms of their impact on beneficiaries on State administration and on federal dollars and spending.

Mr. PITTS. Thank you.

Dr. Goldstein, we only have 30 seconds, but I understand that ACF provides technical assistance to grantees on a number of issues. However, very little of that assistance includes how to encourage more teens to choose abstinence or sexual risk avoidance. Please describe the technical assistance that you provide on abstinence compared to other topics such as contraceptives.

Ms. GOLDSTEIN. I am actually not prepared to address that but I will be glad to take that question back to my program colleagues and provide an answer for the record.

Mr. PITTS. All right. Now, the committee published a report that analyzes abstinence or sexual risk avoidance programs, and it describes over 22 peer-reviewed studies that show statistically significant evidence of the positive impact of these programs. Are you familiar with that report?

Ms. GOLDSTEIN. I am.

Mr. PITTS. And have you, or would you share it with grantees as part of the technical assistance?

Ms. GOLDSTEIN. Again, I will take that back to my program office colleagues and provide an answer for the record.

Mr. PITTS. Thank you. I have gone over time. I now recognize the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I have a number of documents on the extenders that I wanted to ask unanimous consent to enter into the record. I am not going to read them all because it would take up my whole 5 minutes but I can maybe hand you the sheet here.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you.

I had a question initially of Dr. Lu. I have been a strong supporter of the Family to Family Health Information Center program in the past and the program has helped so many families in my State and across the country manager their special health care needs, and that is why I introduced a bill that would extend the funding for these centers into 2016. I was also pleased to see the Senate went even furthering their SGR bill by extending the program until 2018 and included \$1 million increase.

So my question is, in addition to helping families with special health care needs, I was wondering if you could talk a bit more about some of the contributions that the F2F program has made to our overall health care system.

Dr. LU. As you mentioned, Congressman Pallone, these centers are unique in that they are staffed by parents of children with special health care needs, so as parents, they understand the challenges, the issues that other parents face. They know the system. They can provide advice and support and they can connect other parents to this larger network of families and professionals for sup-

port. They can help the families find the best health care providers. They also partner with providers, and in doing so they can really improve on the outcomes as well as cost-effectiveness of the care for a very vulnerable population of children.

Mr. PALLONE. I think you kind of answered my second question, but could you just talk a little bit more about how the Family to Family Health Information Center program is different from other HRSA programs and how the staffs are uniquely qualified to help families with special care needs? I know you kind of answered that but—

Dr. LU. Yes, that is right, and because it is unique in the sense that they are staffed by parents themselves, and in terms of the support, the information, the resources, the training that they can provide from their firsthand experience, I think that is irreplaceable.

Mr. PALLONE. All right.

Mr. Chairman, the work of these Family to Family Centers has long been supported by members on both sides of the aisle so I am hopeful that the program can be continued when the committee addresses the extenders.

I wanted to ask Ms. Rowland a question also about the CHIPRA bonus payments. CHIP enrollment performance bonuses established by CHIP have incentivized States to more effectively administer their CHIP programs as evidenced by the growing number of States receiving these bonuses each year. For the fiscal year 2009, 10 States received bonuses for a total of \$37 million. In fiscal year 2013, 23 States received bonuses for a total of \$307 million. So I think it is important to continue providing incentives to States to more effectively administer CHIP. In order to qualify for these bonus payments, States have to implement five of eight enrollment best practices or simplifications. While the ACA has now required some of these best practices, States have not uniformly adopted all of them, and there is a lot more work to do. Express Lane Eligibility, Presumptive Eligibility and 12 Months Continuous Enrollment are all very important for enrollment and retention of children in coverage, in my opinion.

So I just wanted to ask you, wouldn't you agree that working to encourage States to adopt these simplifications is critical and that the availability of the enrollment bonus is in part responsible for getting States interested in adopting these best practices?

Dr. ROWLAND. Well, I think we have learned a great deal about the quality of these best practices and that is why some of them are now required. And I think to continue to look at ways to encourage States to do outreach and effective enrollment of the eligible but not enrolled children is an important way to reduce the uninsurance of children. So certainly being able to maybe look at some other incentives to provide in the bonus payments that perhaps if the State chooses to eliminate its waiting period for CHIP, for example, that that would be another thing that you might want to add on to qualifying for the bonus payments. But I think that really gives you the ability to give States a true incentive to go out and find many of these eligible but not enrolled children, and we really just need to look at ways to structure those bonus payments

so that we are trying and testing all of the ways to smooth and streamline enrollment.

Mr. PALLONE. Thank you.

You know, I just wanted to mention, Mr. Chairman, currently the CHIP is authorized for 2015 but I believe we should extend the bonus payments for the life of the program, and I agree, as we get evidence from the ACA, we want to retool and qualify the threshold but for the time being to encourage States to keep making gains in coverage. It would make sense to keep the program going. And it is also true that of the States that have qualified, more than half are led by Republican governors, so this is a program that has good results in both red States and blue States. I hope we can continue it. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. I would also like to do what you did, and I will just give you the list. I have a number of letters that I would like to submit for the record. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. All right. The Chair recognizes the vice chair of the subcommittee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. I thank the chairman.

Dr. ROWLAND, let us stay on the issue of Transitional Medical Assistance for a moment. Now that the Affordable Care Act has been implemented and we are all lying in the elysian fields of Obamacare, is the TMA even necessary any longer?

Dr. ROWLAND. Well, sir, I think it depends on what the option that the State chose to pursue. So certainly in the States that have chosen to do the expansion of coverage, there is a way to eliminate the gap as earnings go up because the coverage can be continuous. But as you know, half of the States have not opted to pursue the extension of eligibility for adults that is coming through the Affordable Care Act, and in those States, Transitional Medical Assistance is particularly important because it would enable individuals to really get the ability to go into the workforce.

Mr. BURGESS. I thank you for the answer. So if I understand you correctly, the extension of Transitional Medical Assistance should only be for those States that are non-participating in the Medicaid expansion, as is their right under the Supreme Court decision.

Dr. ROWLAND. Well, Transitional Medical Assistance at the 4-month level exists for all States. This is about whether it should be extended to the 6 to 12 months, which also provides States with some additional flexibility to do premium assistance as people transition into the workforce. So it gives States the ability to really move people from Medicaid into private insurance, and I think that is a very important aspect of Transitional Medical Assistance.

Mr. BURGESS. Yes, I think that was actually—I have to interrupt you for a minute because my time is limited. I think that was actually a flaw in the Affordable Care Act. We can talk about that. But for continuation of Transitional Medical Assistance, really it seems to me that that is only necessary in those States that did not participate in the Medicaid expansion, again, which was their right under a Supreme Court ruling.

Dr. ROWLAND. Correct, except if you are concerned about the cost, there actually is a higher cost for the federal government to

individuals in the States that do the transition to the Affordable Care Act coverage because there it is 100 percent federal financing as opposed to the shared financing that goes on for Transitional Medical Assistance. So the—

Mr. BURGESS. Again, forgive me for interrupting, but that is a temporary state also and we all know that the FMAP for those States that are participating is going to have to change at some point in the future. There is a limit to how much money the Chinese will loan us for that program.

Now, you mentioned churning, and I think that is an important issue and one that I don't think was ever completely well thought through as the Affordable Care Act was discussed because you are going to have people that continuously earn at different levels during the course of a year, and 137 percent of federal poverty level may sound great when we talk about it here in a committee or in a federal agency, but in real life, there are people whose income may fluctuate wildly throughout the course of the year. When we had the hearings on the people affected by the blowup of the Deep-water Horizon, we had a hearing down on the Gulf Coast of Louisiana. We heard from a shrimper who earned a fantastic amount of money during the month of May but the rest of the year he is flat broke. So he is going to transition from Medicaid into an exchange and then back into Medicaid. That seems terribly inefficient as a way to structure that. So your program prevents that from happening?

Dr. ROWLAND. It would help maintain coverage throughout the period so that during these lapses where one month there is a lot of income and the next month there is less, you have continuous eligibility during that period so it eliminates having to transition and really helps managed-care plans to be able to more effectively provide continuous care as well as reduces State administrative burden.

Mr. BURGESS. Forgive me. I don't think it is our role to help managed-care plans.

Dr. Lu, let me just ask you a question because in both your spoken and your written testimony, you talk about a study among 19-year-olds. Their lifetime risk of arrest was significantly lowered. What period of time did this study comprise?

Dr. LU. The study, I believe, was a longitudinal follow-up of these children and families over a two-decade period.

Mr. BURGESS. Correct. It would have to be two decades if you are dealing with a population of 19-year-olds who received home visits during their gestations with their mothers, but you cite a lifetime arrest risk as being diminished. I mean, most of us expect to live longer than two decades when we are born, so how actually have you compiled those figures? Is there some way to project the lifetime risk of arrest or conviction at age 19?

Ms. GOLDSTEIN. I can speak to that. The lifetime arrest record that Dr. Lu referred to is as long as their life had been so far, so it was through the age of 19. It was not a projection beyond that point.

Mr. BURGESS. Very well. I thank you for clarifying that.

Mr. Chairman, I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for questions.

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

Dr. Rowland, I want to draw your attention to a provision that was enacted into law this past December that I fear will have serious consequences for access to care in Medicaid. We all agree that Medicaid should not pay for care that someone else is liable for, and the statute has protections to ensure that States can recoup when other parties are liable financially. But for pediatric and neonatal care, for more than 20 years the law had required States to pay promptly and chase other sources of payments later. This is to ensure children, infants and pregnant women could get access to care promptly with no delay. The law was changed in December to say that States must delay payments to those providers for up to 90 days while they chase other potential sources of payment. Congress would be outreached if anyone proposed delaying payments to Medicare physicians for 90 days for a service provided. I am concerned this change in law will have a negative impact on providers' willingness to participate in Medicaid and will harm access to care for children and infants. Could you comment on this?

Dr. ROWLAND. Well, as you know, this committee has long been concerned about access to care for Medicaid beneficiaries and the willingness of physicians to participate in the program. One of the areas that MACPAC has been looking at is, what are the barriers that prevent more primary care and specialists from participating in the program, and we learned from that that payment delays and inability to get payments processed is one of the identifiable issues that doctors raise about why they are unwilling to participate in this program. So I think one really needs to look at whether such a delay in payment would affect the access to care that is so important given Medicaid's substantial role today in paying for nearly 50 percent of all births in the country and a high share of the neonatal care. This is critical to look at.

Mr. WAXMAN. It seems just logical, and we should expect that that is going to happen if we are going to delay payments just to delay payments when we don't it anywhere else and there is no reason to delay it.

Mr. Hackbarth, last month this committee held a hearing where we heard from a number of stakeholders about how the changes to the Medicare Advantage program under the ACA were affecting patients, and if you listened to some of the testimony you would think that Medicare Advantage was withering on the vine and that beneficiaries are no longer able to choose among private plans as they had before. I would be interested to hear MedPAC's perspective on the current state of the Medicare Advantage plans. Are plans really in such dire straits?

Mr. HACKBARTH. Well, enrollment in Medicare Advantage continues to grow and last year increased about 9 percent. Medicare beneficiaries continue to have a large choice of different options. The average per county is now 10, which is down slightly from the year before. Just this week, the CMS actuaries reported that in 2012, for the population newly aging into the Medicare program, over 50 percent of the new Medicare enrollees chose a Medicare

Advantage plan, which I think is a potentially significant milestone.

Mr. WAXMAN. Let me ask you about the parity between an Advantage plan and Medicare fee for service. Can you tell us, did the Affordable Care Act set Medicare on a path to parity between FFS and Medicare Advantage or do you believe that Congress should stick to the ACA reforms and continue moving forward, or is there any justification for repealing these reforms?

Mr. HACKBARTH. We have long advocated, Mr. Waxman, going back more than a decade that there be financial neutrality between Medicare Advantage and traditional Medicare. We continue to believe that that is the wise course. The Affordable Care Act moves in that direction, and we would encourage Congress to stick with that course. We expected that with fiscal pressure resulting from the reduction in benchmarks that in fact plans would respond in part by lowering their costs if in fact the bids have fallen concurrent with tightening of the benchmarks. So it is evolving pretty much as we expected and we urge you to continue on this path.

Mr. WAXMAN. I know there was a recent recommendation for additional changes to Medicare Advantage payments from the Commission. This deals with how Medicare Advantage plans offered by employers to retirees are priced. Could you describe this recommendation and why you believe it is important?

Mr. HACKBARTH. We haven't quite yet made the recommendation. It is up for consideration at our meeting next week where we will be voting on recommendations for our March report to Congress. The issue here is that the bidding system used for employer-sponsored plans is different, and there is basically no incentive for plans to bid low in the employer-sponsored area, which results in higher payments for Medicare. So we are looking to options for using market bids that come from the rest of Medicare Advantage programs to set payments for the employer-sponsored plans that would reduce Medicare outlays somewhat by using those market-based bids.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman, and welcome. It is a great hearing and it is important to remember extenders and of course tied with the SGR.

So I have got a chart. It is the budget numbers for, I think if we do this right, 2012 just to keep this debate in perspective. And if you look at it, the budget is \$3.45 trillion. Of that, Medicare is \$251 billion—no, Medicaid is \$251 billion, Medicare is \$466 billion. Those are 2012 numbers.

So my first question is to Mr. Hackbarth and Dr. Rowland. We don't move any of these extenders, and they lapse. What happens to the solvency debate of Medicare and Medicaid? How much does that improve the extended life of these programs and how many days or months? Mr. Hackbarth?

Mr. HACKBARTH. Mr. Shimkus, I don't have in my head what the total spending impact of all of the various temporary provisions is. I don't know if my colleagues have it here. If not, we could get you that number.

Mr. SHIMKUS. OK. But you understand where I am headed to with this question, I am sure.

Dr. Rowland, do you—and I am going to go back to you in a minute but do you have a response to that?

Dr. ROWLAND. The only estimate that we have is that the Congressional Budget Office has estimated that making the Transitional Medical Assistance provision permanent would reduce federal Medicaid spending.

Mr. SHIMKUS. But in the billions, in the hundred billions or in—

Dr. ROWLAND. In the \$1 to \$5 billion over a 5-year period.

Mr. SHIMKUS. OK. So the point being is this. These programs, and we can debate the relevancy, in our federal budget, mandatory spending is driving our national debt. These will really hardly affect the solvency debate on both Medicare and Medicaid. Mr. Hackbarth, would you agree with that?

Mr. HACKBARTH. They are not large relative to these numbers. Another potential reference point is how do they compare to the cost of repealing SGR, in other words, how much do they add to the challenge of financing SGR repeal. That is a number where it looks a lot more significant relative to—

Mr. SHIMKUS. Obviously, because proportional.

Dr. Rowland?

Dr. ROWLAND. Yes, these are compared to total Medicaid spending. These are very small, but they still represent obviously spending that helps—

Mr. SHIMKUS. So the overall debate, which we try to raise all the time and I have been talking about since 1992, if we don't get a handle on our mandatory spending programs, they will end up consuming the small blue portion, which is our discretionary budget. We will continue to have these budget fights. We will continue to try to squeeze because the red areas are going to continue to grow unless substantial, significant reforms occur, which is—and we, since I have been here since 1996, I started talking about this in 1992, we are unwilling to make those tough choices to have a Medicare program for future generations and to have a Medicaid program. And I fear for the future. That is just the macro debate. I am glad we are having this debate, but it gives me the opportunity to put real numbers on the board because real numbers matter for our children and our children's children, and as Dr. Burgess said, who is subsidizing our debt, also foreign countries.

Let me go then to, I represent about a third of the State of Illinois, pretty big area, 33 counties. I would hope in these evaluations that we understand distances, the importance of rural health care providers in 30 to 45 miles and what is that cutoff. So in essence, the Medicare-Dependent Hospitals and the Low-Volume Hospitals, I understand these reforms, but the importance of this debate for rural America is, there is nowhere else to go. They are it. And if they don't have the volumes, as you mentioned, to justify their existence, we need to figure out how to make sure that those doors stay open.

Mr. HACKBARTH. We emphatically agree, Mr. Shimkus, that we need to preserve access for Medicare beneficiaries that live in areas that are not sparsely populated. Our point, though, is what need

to do is make sure we target our assistance to those isolated providers, and if we target it well, we can actually provide more assistance, more effective assistance than if we spread our available dollars loosely over a larger number of providers, many of whom are not necessary to assure quality care.

Mr. SHIMKUS. And Mr. Chairman, if I could just make this final statement. It is not a question. But Dr. Hackbarth, you are only one who raised the ground ambulance extenders, and I think you raised the point, and I think as we look at that, there has to be a time frame by which we get real data and reevaluate that data.

Mr. PITTS. Mr. Dingell for questions.

Mr. DINGELL. Good morning, Mr. Chairman. Thank you for your courtesy and for holding this hearing today. It is very important. And I want to thank our panel members for being here. I am not going to be asking questions today because I want to make a few observations about the urgent need to get SGR reform over the finish line.

I would like to observe that SGR reform is urgently necessary because without it, the whole problems of Medicare and our taking care of health care in this country in making the Affordable Care Act is going to suffer terribly as will the people.

Now, every year for the last decade, the Congress has stopped in to reverse severe cuts in reimbursements for physicians wisely mandated under Medicare as mandated by the SGR. Due to our failure to fix this fatally flawed payment system, doctors and other medical providers have experienced enormous uncertainty and have been able to plan for the future, and the country and medical system has suffered because of it. Last year the Congress made bipartisan, bicameral progress in repealing and replacing the SGR with a new system that provides stable payments for doctors in the short term and incentivizes them to move the alternative payment models forward in the long term.

It is really a shame that we weren't able to put this in because of budget matters without having to address the question of how we are going to pay for it because it solves a problem that was created by some very unwise actions by the Congress. The legislation is going to make a significant contribution to the change in our efforts to provide health care for our people and it will award doctors for their performance rather than for the quantity of the work and begins to take steps away from the fee-for-service system, parts of which are so badly broken.

I am confident that the three bills passed by this committee, the Ways and Means Committee, the Senate Finance Committee can be reconciled and sent to the President's desk before March 31 deadline but there are still hurdles to be overcome.

I want to commend the members of the committee, the leadership of the committee and the other committees in the House and Senate for the leadership which they gave in this matter and for the vision and for their hard work and for the decency with which they worked. This hearing is an important contribution to resolving the problem, and I want you to take my commendations, Mr. Chairman, for your part in all that has been done, and I want you to appreciate not only what you have done but what others have done to bring us to this point.

I want to observe that it would be a terrible calamity if we don't carry this thing across the finish line. I want to make it very clear that Medicare beneficiaries should not have their benefits reduced or cost increased to pay for the reform of SGR. Both sides must be willing to compromise and all persons must understand that the resolution of this problem will probably not be perfect from anybody's view but at least we will make progress in getting rid of something that is causing us vast difficulty in achieving our purposes. So our goals must be responsible compromise, and I have observed over the years, compromise is an honorable activity and it is something which will make this institution work.

Second, I am very pleased that the so-called extenders and the policies that are traditionally considered a part of the short-term Medicare physician payment formula patches are the focus of today's hearing. You have been very perceptive in doing that, Mr. Chairman, and I thank you.

I am also pleased that the Senate Finance Committee included many of these critical extenders in their permanent SGR bill. Many of the extenders provide critical benefits to Americans across the country, especially Medicare and Medicaid beneficiaries, people who have great need of these things. We must not forget about these critical programs as Congress moves forward with SGR reform. Specifically, the Qualifying Individual program, Transitional Medical Assistance, Express Lane Eligibility and CHIP bonus payment programs must not be allowed to expire and should be extended as part of the long-term SGR bill. Congress should consider extending many of these programs on a permanent basis, given their proven track records and the fact that the annual SGR patch will not be available as a vehicle in the future.

Furthermore, I hope that the Congress will consider reinstating Section 508 wage classification that expired in 2012. I also believe that the Medicare primary care payment increase should be extended as well.

In closing, I hope we can build off the momentum we generated last year to get a long-term SGR bill across the finish line while not leaving extenders beyond. I look forward to continue to working with you and all my colleagues, the leadership on this committee and the leadership in the House and Senate to get this bill to the President's desk before the March 31 deadline.

Mr. Chairman, there are great accomplishments that have been made in this matter. We have taken major steps to solve a terrible problem which has been inhibiting responsible consideration of health care for the American people, and I hope that we don't lose this opportunity because we let some kind of partisan or other misfortune create difficulties for us.

Again, I commend you. This is an example of how oversight should work, and I thank you for your leadership.

Mr. PITTS. The Chair thanks the gentleman and thanks him for his leadership and cooperation on this issue of repeal and reform of the SGR. Thank you for the sentiments you have expressed, and I share those with you.

Now the Chair recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman. I thank the panel here.

Mr. Hackbarth, you have talked about a number of things with quality, and quality and value are of great concern to all of us, but I want to talk about some of the issues of readmission rates and also deal with some of the measures. For example, reports have come out from Medicare about readmission rates for such things as heart attack, pneumonia, hip and knee replacements. I don't think we have those same things on a pediatric level, do we, Dr. Lu or Dr. Goldstein? Do we look at readmission rates for pediatrics? OK.

But on the Medicare level, what we have to be concerned about is that when people have a chronic illness, we know a small portion of folks on Medicare, for example, make up a large portion of the cost, particularly those with chronic illness. I think 90 percent of the cost is caused by chronic illness. And when you have a lot of chronic illness, you also have a 50 percent higher rate of depression. You have untreated depression and chronic illness, you double the cost.

So along those lines, MedPAC has recommended new criteria for payment to rural hospitals. Now, under MedPAC's criteria recommendations, should a facility with fewer than 100 beds and approximately 60 percent of discharges under Medicare qualify for the Medicare-Dependent Hospital Payments program?

Mr. HACKBARTH. Mr. Murphy, we think that the Medicare-Dependent Hospital program suffers from some of the issues that I have referred to earlier. For example, it is not targeted at isolated hospitals, and so a Medicare-Dependent Hospital can receive these higher payments, these subsidies, if you will, even when it is in close proximity to say, a Critical Access Hospital.

Mr. MURPHY. But I think some of those are in danger of being changed. One of my concerns with Medicare is how it does not pay for coordinated care. For example, Southwest Regional Medical Center in Greene County, Pennsylvania, used its Medicare-Dependent Hospital funding to provide case management services for patients upon discharge. So if you were to eliminate those payments, could it not lead to readmissions of patients who had trouble following their discharge orders?

Mr. HACKBARTH. Well, we absolutely share your concern about better care for complicated patients, many of whom have multiple—

Mr. MURPHY. I just want to make sure there is funding to help them.

Mr. HACKBARTH. Well, we don't think that this sort of program is the best way to attack that problem. We think that mechanisms like accountable care organizations where an organization assumes responsibility for a full range of conditions.

Mr. MURPHY. This hospital I am talking about is way outside of a 25-mile boundary from a Critical Access Hospital, and when I look at what is happening here—and let me go to something that was recently in the Baltimore Sun. They talked about 500 patients in the State of Maryland with psychiatric problems account for \$36.9 million a year with regard to psychiatric services because one of the problems that occurs is when someone has a psychiatric problem such as psychosis and they have a co-occurring symptom of that called anosognosia, which means they are not aware they have a problem. That also occurs, for example, in stroke victims

who may have a right-sided problem in a stroke, and if the left side of their body doesn't work, they do not even know that the left side of the body doesn't work. And with psychiatric symptoms, they may not realize their hallucinations or delusions are not real.

So what happens when they are discharged from a hospital, they stop taking their medication, and it is essential in these cases that there is someone who is working with them. Now, that is in Baltimore, but the example I am giving is hospitals in a very rural area. I just want to make sure we have mechanisms in place to look at coordinated care, and the reason for that is, as long as we are using measures such as readmission, readmission alone can't be the criteria because sometimes readmission is a symptom of the disorder where we are not maintaining that coordination. So what advice, where could we go with this in improving this?

Mr. HACKBARTH. Well, again, I think the clinical problem that you are raising is a really important one, not just for the individual patient but for the program. Our goal is to address the needs of the patient in the most effective way possible. We don't think that poorly targeted subsidies, some of the money from which might be used for good purposes, is the best way to deal with a systemic problem such as you have identified. So if we have a finite amount of money to spend, which we do, we need to be very careful. So one thing that has been done recently in post-discharge care is to create a code where clinicians will be paid for coordinating care post discharge. That is a much more targeted response to the clinical problem as opposed to paying more for Medicare-Dependent Hospitals.

Mr. MURPHY. Well, let us continue to work on that together.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman, and thank you, witnesses, for your testimony today.

Drs. Lu and Goldstein, the Affordable Care Act established several new programs that you described in your testimonies, the Personal Responsibility Education Program, or PREP, and also the Maternal, Infant, Early Childhood Home Visiting program, as well as the Health Workforce Demonstration Projection for Low-Income Individuals. I am interested in all of these.

You mentioned that comprehensive evaluations are ongoing. From your testimonies, even as we await results of these comprehensive evaluations, early indications seem to me that these programs are successful, and importantly, they are grounded in sound evidence. Could you each just say a word, if you will, a very brief description on the successes of these programs thus far and how these three programs are informed by available evidence? Let us start with you, Dr. Lu, but also Dr. Rowland just for a minute each.

Dr. LU. I can share about the home visiting program. As I mentioned, the home visiting program is built on decades of evidence on its effectiveness, and as of 2013, we are now reaching and serving more than 80,000 parents and families in 738 communities, and that is two-thirds of all the communities identified by the

States to be in the highest risk for adverse health outcomes in the country.

Mrs. CAPPS. Let me just turn to you, Dr. Rowland, for one of the other programs, if you would.

Dr. ROWLAND. We mostly looked at the way in which Medicaid care can be coordinated and clearly have looked at the fact that case management and integration of services is really critical, especially for coordinating the care for people with behavioral problems.

Mrs. CAPPS. OK. Dr. Lu, I was a long-time visiting nurse, and I know firsthand of the benefits home visiting can have on high-risk pregnant women, children and families, helping them be healthy, make healthy choices, accessing critical health care services and supports needed to have healthy babies. I am referring now to a program in my district. The San Luis Obispo Department of Health delivers a nurse family partnership model, which has shown long-term improvements in child health and educational achievements as well as family economic self-sufficiency. The home visiting program supports States in expanding these programs and services to reduce poor birth outcomes, preventable childhood injuries, all the good things that happen along with these home visits, issues that affect all of us as taxpayers. So I just want to get on the record what is at stake if this program is not continued, Dr. Lu.

Dr. LU. Well, if the program is not continued, families will be losing services that are proven to improve maternal-child health outcomes and have all the positive benefits on positive parenting, children's cognitive, social, emotional and language development as well as school readiness. Also, the investments that States and communities have made to build up the service systems and capacity will be lost if the program is not continued.

Mrs. CAPPS. Right. Dr. Goldstein, in your testimony you mentioned that States receiving Title V funding for Abstinence Only Until Marriage Education programs are encouraged but not required to use evidence models that are medically accurate. This differs from the statutory requirements in PREP that say these programs which teach both abstinence and contraception must be evidence-based and medically accurate. Could you elaborate on the difference in the evidentiary standards for these two programs?

Ms. GOLDSTEIN. Certainly. The statutes require that grantees in both programs provide medically accurate information. The PREP program also requires that services be evidence-based or substantially incorporate elements of evidence-based programs. The Abstinence Education program does not have such a requirement although we have encouraged grantees to use evidence-based approaches, and as I noted, there are evidence-based models for a range of approaches to teen pregnancy prevention including both comprehensive sex education and abstinence education.

Mrs. CAPPS. Thank you. I was very much involved with a school-based program for teen parents when I was in my community as a school nurse, and I have such vivid images of these young women and parents incredibly strong and hardworking but if they had had appropriate medically accurate information, education, empowerment, they could have delayed these pregnancies and they could have still been really good parents but they would have had time

to complete their preparation for the future, setting up a more viable economic future for their families and children, and that is why I believe our investments in PREP are so critically important.

I thank you again, all of you, for your testimony today, and I yield.

Mrs. ELLMERS [presiding]. The gentlelady yields back. I now call on Dr. Cassidy from Louisiana for 5 minutes.

Mr. CASSIDY. I was 15 minutes behind, so anyway. Oh, my gosh, Madam Chair, can I defer and come back because I was thinking I had two more people head of me?

Mrs. ELLMERS. OK. That would be fine. The gentleman yields back for a later time. Mr. Griffith from Virginia, 5 minutes.

Mr. GRIFFITH. Thank you, Madam Chair. I appreciate that.

As we prepare to permanently repeal and replace the SGR, I believe we must also address two vital extenders, and we have talked about these previously in testimony today, the Medicare-Dependent Hospital and the Low-Volume programs, which are critical for my constituents and my rural hospitals in southwest Virginia. If these programs are not extended, Virginia hospitals in total will lose about \$10 million and most of the hospitals that qualify are in my district, but \$10 million in Medicare reimbursements next year at a time when they are already being hit hard by new costs, deep cuts to Medicare, other programs, and an economic crisis which is exacerbated by the Administration's new regulations and what many of us refer to us as their casualties in the war on coal. This combination of factors have already resulted in one of my rural hospitals closing in Lee County and at least eight of the remaining hospitals in my district benefit from these two essential programs. They keep the hospital doors open in some economically distressed areas that are pivotal to vital access to care for my rural constituents. I have got Smith County, Russell County, the Lonesome Pine Hospital in Big Stone Gap, and I invite you all to go see the soon-to-be-a-major-motion-picture-based-on-the-book-of-the-same-name, Mountain View in Norton, Pulaski, Buchanan, Tazewell, and Wythe. These are not hospitals that are necessarily close to a lot of other hospitals.

Mr. Hackbarth, let me go ahead and ask you something. I was reading your testimony, and you talked about several programs that were based on how many miles one hospital was away from another. Do you know, is that done on a map or is that done on road miles? And the reason that is important of course is because when you come from a mountainous district, if you just look at the flap map sitting in your office, two hospitals might only be 15 miles away but it might be a 45- to 50-minute trip.

Mr. HACKBARTH. I will have to check this, Mr. Griffith, but I am pretty sure that it is road miles, and my recollection is that the regulations also take into account unique conditions like mountains and difficulties and certain times of the year, but I will verify that and get back to you.

Mr. GRIFFITH. And I appreciate that because oftentimes we see that in the areas. People say well, yes, there is another pharmacy just down the road if one closes. Well—

Mr. HACKBARTH. I come from a mountainous area also.

Mr. GRIFFITH [continuing]. It may be just down the road but it might not be easy to get to.

Knowing a little bit about my background, do you think that district and other districts like mine would be hurt if the provisions were not extended or made permanent, particularly talking about Medicare-Dependent Hospital and Low-Volume programs?

Mr. HACKBARTH. Well, I can't obviously address the circumstances of your district. I don't know it. But again, our emphasis is on maintaining access for beneficiaries in remote areas. I think we are in complete agreement on that. And what we want to do or what we urge the Congress to do is with that goal in mind focus the subsidies on the institutions that are truly necessary to provide care in isolated areas, and right now we are concerned that some of these provisions including the Medicare-Dependent Hospitals and the Low-Volume Adjustment are not well targeted, and I would emphasize again in particular the Low-Volume Adjustment is problematic because even if you accept the premise, which we do, that there are economies of scale in the hospital business, in small institutions, many therefore have difficulty keeping their costs down. The right measure of that is not just Medicare discharges, it is the total discharges. This adjustment is based on Medicare discharges alone. So a hospital that has relatively few Medicare discharges can get a big adjustment whereas a smaller institution as more of an economic problem doesn't get the adjustment because it is a different mix of public and Medicare discharges. That is not fair, in addition to not being—

Mr. GRIFFITH. And that may very well negatively impact my hospitals because we have a disproportionate number—based on the rest of the country, we have a lot of older folks that live in our communities. We have had some counties that have depopulated of mostly the younger folks and so there is a disproportionate number of senior citizens in a number of the counties that are also rural and underserved. So I look forward to working with you on these formulas.

My concern is, as you might imagine, as we negotiate this, I don't want to lose anymore hospitals. We are hoping that we can replace the one that is gone but the parent company of two of the eight that I mentioned has announced today that they are looking for new ways to do things in the future and may even be seeking out a strategic partner because they are having some difficulties dealing with the new environment we are in, with the new laws passed in health care, with the economic situation in southwest Virginia and east Tennessee, and with lots of other things that are putting pressure on the hospitals and so anything that we can do as we find a better formula, that is great. I just don't want to see us taking away one of the items that is helping these hospitals survive in these small communities.

Mr. HACKBARTH. Well, if I could make a suggestion, the Low-Volume Adjustment that we are discussing here today is a temporary provision. There is a permanent Low-Volume Adjustment that already exists, and we believe it is structured in a way that is much better targeted, and so that is the foundation to build on for the committee.

Mr. GRIFFITH. I thank you, and I yield back.

Mrs. ELLMERS. The gentleman's time is expired. The Chair now recognizes Mr. Green from Texas.

Mr. GREEN. Thank you, Madam Chair, and I appreciate our panel being here. In fact, I know I met and worked with Dr. Hackbarth and Dr. Rowland at the Commonwealth retreat that you do every year, and I would encourage my colleagues to consider that. It is in February. Now, I have to admit, it is not the south of Florida this year but it is in Houston, Texas. But you will hear, it is bicameral, bipartisan, and bicommittee, because we typically in our committee don't deal with Ways and Means or Education and Workforce but you will have different members, and we can really come and problem-solve in an informal setting.

The Affordable Care Act takes a number of important steps to broaden access to health care, especially for people who are working and are unable to receive employer-sponsored insurance or afford individual market plans. While the number of uninsured is already decreased, some challenges remain, and I want to follow up on my colleague, Dr. Burgess, talking about the Transitional Medical Assistance churn. That churn is due to a small change in income and an individual will be switched from being eligible for Medicaid and be eligible for now subsidized coverage in exchanges. Switching back and forth between insurance coverage can mean a change in benefits, participating providers and pharmacies and out-of-pocket expenses, not to mention the administrative paperwork for the State or an insurance company or a doctor's office.

One of the programs to help reduce churning is the Transitional Medical Assistance, and Ms. Rowland, I understand that MACPAC has recommended Congress make TMA permanent in part because of this churn factor. Could you elaborate? And I know I am following up and I want to address some of Congressman Burgess's issues, but is that the reason because the recommendation from MACPAC?

Dr. ROWLAND. Well, we have tried to look at how to make transitions between coverage smoother and more streamlined, and one of the ways clearly is to help the lowest-income Medicaid beneficiaries who qualify through the 1931 provisions, which are the old welfare-related categories be able to maintain coverage, and we have looked at the time period, and the 12-month period really does provide for continuous coverage that allows them to go into the workplace and back and forth and the income volatility of individuals at that very low income and the income spectrum is very important to take into account to try to keep care continuous so that people don't have to end treatment and so that the States don't have to continually re-administer the benefits.

Mr. GREEN. Because it raises administration costs plus the cost to the patient.

And Dr. Burgess talked about in States, for example, Texas didn't expand their Medicaid and also does not have a State exchange. The TMA is really important in those States to make sure it happens, but even States that have their own state exchange or use the Medicaid expansion could use transition assistance.

Dr. ROWLAND. We believe that the Transitional Medical Assistance is critical in the States that have not expanded coverage to keep people from going to uninsurance from one dollar of increased

income. In the States that have elected to go forward with the expansion, the expansion will provide for a way to transition from Medicaid coverage on the income side to either the exchange or to the new Medicaid coverage options. So the Commission has recommended there that we consider giving States the ability to opt out of TMA if they are able to assure that transition, and that is an issue that we will be looking at in the future as well.

Mr. GREEN. And I know one of the concerns is a 12-month continuous eligibility to make sure there is not a gap in coverage, and I know in States like Texas, who has a 6-month for Medicaid and SCHIP also but Congressman Barton and I both have legislation to make sure that continuous coverage would be 12 months because if you have people that are low wealth, they are not going to come in every 6 months, and particularly if they are ill, they will have that lapse in coverage and they will show up at one of my emergency rooms and cost much more than having that continuous coverage.

The Medicaid primary care bump helps ensure that sufficient access to Medicaid providers as enrollment increases. The ACA requires States to raise their Medicaid fees to Medicare levels at least for family physicians, internists, pediatricians and primary care. Can you comment on the impact of that that lack of this parity between Medicare and Medicaid provider rates on physician participation. I know particularly because, for example, in Texas, TRICARE pays the lowest, Medicaid pays a little more and then Medicare pays more. Of course, private sector pays more. But to have that Medicaid and Medicare would help us actually have more physicians accept more Medicaid patients, I think.

Dr. ROWLAND. Well, one of the things that the Commission has looked at is in fact what are the incentives for physicians to participate within the Medicaid program and what are the barriers. And clearly, low payment rates and delayed payments are two of the issues that prevent many of the primary care doctors as well as specialists especially to participate in the program. So I think that looking at the fees that are paid or the payment levels for Medicaid are a very important piece. We have to look at the role managed care is now playing and so we really need to understand more about the payment levels within managed care plans, and we believe that improving access to primary care is of course a critical part of the Medicaid program and one that is very important to make sure we get full participation there. But the—

Mrs. ELLMERS. The gentleman's time is expired.

Mr. GREEN. Thank you, Madam Chair. I know we ran over time, but I appreciate the committee having this hearing today so hopefully we will come back and visit it again. Thank you.

Mrs. ELLMERS. Thank you. Now the Chair recognizes Dr. Gingrey for 5 minutes.

Mr. GINGREY. Madam Chair, thank you very much. I would like to also thank the witnesses. One very famous person once said there is nothing more permanent than a temporary federal government program. I think that was probably President Reagan, but of course, it could have been my good friend, Chairman Emeritus Dingell. I did like what he said this morning in regard to SGR and the bipartisanship and all the work that has gone into that, and we

continue to push to try to get that across the finish line in the next couple of months hopefully. I agree with him 99 percent of the time but I am not sure I agree completely with his remarks, don't leave the extenders behind.

As I said, there is nothing more permanent than a temporary federal government program. Our constituents need to realize that one of the most important things we do other than passing legislation is oversight of current legislation and temporary programs and indeed maybe even all programs that probably should be looked at every 10 years, every 5 years, and say hey, do we need to continue to do this, is it serving its purpose or is it time to end this program, even if it was permanent, but certainly on these temporary programs like these extenders, I think we need to look at a lot of them and question whether or not we need to go forward.

And let me then direct my question to Mr. Hackbarth. I will direct all my questioning to you. As an example, one such program, group of programs, are in the Medicare ambulance add-ons. In reviewing the data around ambulance service availability in the Medicare program, what have you found? For instance, have you found growth in the number of providers or has there has been a decrease, or to put it another way, has there been any evidence of service inadequacy in regard to the ambulance program?

Mr. HACKBARTH. Yes, we found no evidence of inadequate service. We found on the contrary evidence of growth in service, both in terms of the number of trips paid for but also significant new entrants, a lot of private capital, some big private equity firms buying into the ambulance business. This is one area where we do not have Medicare cost reports, and one of the things that we do when we don't have cost report information is look at the market for signals. When big money, smart money is buying into an area, it is usually a sign that—

Mr. GINGREY. So you are getting some ominous signals in regard to that. And I want to draw your attention to the ambulance extender title temporary increase for ground ambulance services under the Social Security Act. My office has been approached by a number of constituencies who want to make this extender permanent, and my staff confirms for me that this provision and its spending was never, never intended to be made permanent. Can you tell me, Mr. Hackbarth, if Congress intended this extender to be a temporary provision and do you believe the data supports making the policy permanent?

Mr. HACKBARTH. Dr. Gingrey, are you referring to the 2 and 3 percent add-on payments for urban and rural ambulance providers?

Mr. GINGREY. Yes.

Mr. HACKBARTH. That is a temporary provision and one that we don't think needs to be extended based on our analysis. We have suggested, however, that the rates paid for non-emergency transport be decreased and then use that money to fund higher payments for emergency transport, and the reason for that change is, we see a lot of this new entry that I referred to is really being targeted at non-emergency ambulance transport.

Mr. GINGREY. Yes, but with urban transports accounting for 76 percent, an increasing share of claims, and non-emergency ambu-

lance transport most common in the urban areas, do you still believe that urban adjustments are needed?

Mr. HACKBARTH. No, we do not but we do recommend that there be this recalibration of the rates for emergency and non-emergency rates.

Mr. GINGREY. Mr. Hackbarth and all of the panelists, thank you. I want to yield the remaining 22 seconds to my colleague from Tennessee, Ms. Blackburn.

Mrs. BLACKBURN. Well, I thank the gentleman for yielding, and since the time is so short, I will just say, reliable ambulance services are very important to our district. We have watched very closely the add-on payments. We think they are necessary for rural districts like mine, and the Low-Volume Hospital Adjustment is something for our rural hospitals we are very concerned about. Those are things that in my district we would like to see those made permanent, and with that, I yield back to the gentleman from Georgia.

Mr. GINGREY. I yield back.

Mrs. ELLMERS. The gentleman yields back. The Chair recognizes Dr. Christensen from the Virgin Islands for 5 minutes.

Mrs. CHRISTENSEN. Thank you, Madam Chair, and thank you all for being here with us this morning to discuss these important extenders.

I want to follow up on Congressman Green's questioning about the primary care bonus. The ACA boosted payment for primary care services for 2 years so that it would equal the Medicare payment rates, and I think that is an important step, and I believe it is something that is worth continuing into the future.

Dr. Rowland, the Commission doesn't have a recommendation yet on this policy, and I know there has been some concern that it is has been difficult to set up the payment changes, especially for policy, which at the moment, at least, is only short term, and to me, this further illustrates why important policies like the primary care bonus shouldn't really be temporary, it should be permanent. Could you comment on how the short-term nature of some policies can cause a disincentive for action?

Dr. ROWLAND. Well, clearly, the 2-year period for the bump-up in primary care payments is an important test of what the increase in payments will do to access to care, and that is something that it is too early to really evaluate but also what we know from programs is that it takes time to change incentives and so in that the short 2-year period, they really have not given enough incentive to many of the physicians who participate knowing that it may expire after 2 years. So I think it is very important to both look at what the effect of it has been, and then there has been some concern within the Commission about whether that payment bump limited to primary care physicians is really getting at some of the other gaps in participation, especially among specialty care, and especially among mental health and behavioral health providers.

Mrs. CHRISTENSEN. Yes, I would share that concern. You know, as you said, it is too early to really evaluate what impact those bonuses have had on access to care, and I am worried that some people would argue that we need more data before we decide to go forward with continuing this policy, which might set up a catch-22 because under current law, the policy will end before we might have

adequate data. Given what we know about underpayment in Medicaid, it would seem highly unlikely that payment parity would cause a decrease in access or cause beneficiary harm. Can you comment on that?

Dr. ROWLAND. Well, clearly, we do need time to look at what the effect of this has been but we also know that Medicaid payment levels have been extremely low in many areas and that this increase is likely to be one that will continue to be there for physicians and attract them, and we really need to look at the availability of primary care services and how to boost that as we try to decrease the use of emergency rooms.

Mrs. CHRISTENSEN. Dr. Goldstein, as we know, disparities exist in different teen population groups for sexually transmitted disease and teen pregnancies, so we are really pleased that under PREP, there is a focus on those vulnerable populations to reduce the incidence of both the pregnancy and the SDIs. Could you comment on the kinds of populations that PREP prioritizes and within that, what populations of States chosen to target?

Ms. GOLDSTEIN. Yes, the most common targeted population among States is in high-risk areas that have above-average rates of teen birth or sexually transmitted infections. Some States are also focusing on specific vulnerable populations such as Hispanic youth, African American youth, youth in foster care and in the juvenile justice system.

Mrs. CHRISTENSEN. OK. And PREP specifically sets aside a small portion of funding to implement and evaluate innovative strategies in order to expand the menu of effective programs among the vulnerable or marginalized young people. What is the process for evaluating these emerging strategies and the associated timeline for findings?

Ms. GOLDSTEIN. All of the grantees in the Personal Responsibility Education Innovation Strategies program are being evaluated. A few of them are included in a federal evaluation project, and reports on impacts are expected in 2016. The rest of the grantees are conducting their own evaluations. HHS is providing technical assistance to ensure that these evaluations are rigorous. The evaluations are designed to meet the HHS evidence standards, so when they are finished, the results can be reviewed for evidence of effectiveness, and we expect the grantees' evaluations will have impacts in 2016 as well.

Mrs. CHRISTENSEN. Thank you. I yield back.

Mrs. ELLMERS. The gentlelady yields back. The chair recognizes Dr. Cassidy from Louisiana for 5 minutes.

Mr. CASSIDY. Thank you, Madam Chair.

Mr. Hackbarth, just to follow up briefly on what Mr. Waxman said, in fairness, the cuts to the MA program, only 4 percent of them have actually been implemented so far. This is not a question; it is a statement. I gather the demonstration projects, which GAO criticized the kind of worth of, nonetheless have mitigated the cuts as of up to now and they actually don't begin to be implemented until frankly substantially this year and by 2019 there is estimates of decreased enrollment in MA plans because of this. That is not a question per se. It is just a kind of useful correction to Mr. Waxman's misleading.

Now, next, as regards the fully integrated Medicare Advantage programs, I see Senate Finance only wants to continue those D-SNPs which are fully integrated. You make the recommendation that we continue all of these programs. Is that a fair statement?

Mr. HACKBARTH. No, we recommend continuation of the fully integrated, those that assume both clinical and financial responsibility.

Mr. CASSIDY. Got you. So if they are two-sided risk, they would then be allowed to continue?

Mr. HACKBARTH. Well, all Medicare Advantage plans—

Mr. CASSIDY. Are two-sided risks, right? So tell me, when you say fully financially integrated, what do you mean by that? I am sorry.

Mr. HACKBARTH. Well, that they assume under a global payment responsibility for providing all of the covered services.

Mr. CASSIDY. But from what we just said, that would be all of those plans, correct?

Mr. HACKBARTH. In the Medicare Advantage program, yes, they are by definition all assuming financial risk. The issue on D-SNPs is, do they assume responsibility for both Medicare and Medicaid benefits.

Mr. CASSIDY. Correct.

Mr. HACKBARTH. And what we see is evidence that organizations that assume responsibility for both types of benefits actually can improve care and reduce costs. If those two are separate and there isn't that integrated responsibility—

Mr. CASSIDY. I see. So when you say integration, you mean between Medicaid and Medicare, the dual-eligible population?

Mr. HACKBARTH. Exactly.

Mr. CASSIDY. Got you. That makes sense to me. I agree with that, and I think that is a positive policy.

Let me move on to the ambulances. My colleagues have addressed this. But when I turn one ambulance service, they said the growth in the non-emergency services is because basically they are going out, finding somebody who has had a hypoglycemic episode, they do a finger stick, they find their glucose is low, they give them sugar, if you will, of some sort, they wake them back up. They don't transport them; they leave them there. And actually they are providing some basic services and saving money on the ER visit, if you will. Now, have you been able to look globally to see, one, if this is true, and two, if they are providing these services, does it decrease the Part A amount, for example?

Mr. HACKBARTH. I don't know about the specific example that you have described. My understanding of the Medicare payment rules for ambulance is that Medicare only pays if the patient is transported, so in the example you describe, if the ambulance goes out and doesn't transport the patient anywhere, then I don't think it is covered under the ambulance policy at all.

Mr. CASSIDY. Got you. And you also mentioned the difference between certain geographic locations as regards the frequency of transport for things like end-stage renal disease.

Mr. HACKBARTH. Absolutely.

Mr. CASSIDY. That seems like that would be variable upon poverty rates, upon degree of MA penetration that might provide services.

Mr. HACKBARTH. I am sure that there are a lot of factors that go into that variation but the variation is—

Mr. CASSIDY. But can we understand that unless we actually do some sort of statistical analysis correcting for rates and poverty, for example—

Mr. HACKBARTH. Well, we have not tried to do any sort of multi-variant analysis of the variation but I would be very surprised if poverty alone explained the sort of variation that we are talking about. We are talking about 20-, 30-fold variation across States.

Mr. CASSIDY. I get that. I will just say, coming from a State in which there is high levels of poverty, some of the poorest regions in the country are in Louisiana, I can understand how your rate of poverty may be 30-fold relatively to a suburb in New Jersey, a rural suburb.

Dr. Rowland, I am very intrigued by this integration of Medicaid and Medicare, the dual-eligible population, and I know that you referenced that, and you referenced that in your testimony. Can you give any preliminary results as to whether aggregating, or what are the preliminary results in terms of aggregating payment in terms of increasing coordination of care?

Dr. ROWLAND. Well, clearly there are efforts at the State level to try to integrate Medicaid services with Medicare services. We also have the financial alignment demonstrations that are now out in the field but there are no results back from them. In fact, most of them are just in the process of being launched.

What we have been looking at is how do you provide for better coordination of care, and as Mr. Hackbarth has noted, there is some evidence that when a plan integrates both sets of services, that they are more able to maintain them. We are particularly concerned about how to merge the behavioral health aspects together with the medical care in plans and have been looking not so much just at the dual-eligible population but at Medicaid's responsibility for people with disabilities, which includes many individuals who need that merger.

Mr. CASSIDY. If you have preliminary data on that, I would love it if you would share that with us.

Dr. ROWLAND. We will share it with you whenever we have it.

Mr. CASSIDY. I yield back. Thank you.

Mrs. ELLMERS. The gentleman yields back. The Chair recognizes Mr. Matheson from Utah for 5 minutes.

Mr. MATHESON. Thank you, Madam Chair, and thanks for holding this hearing.

I think we all want to have a permanent fix to the SGR issue, and our committee has passed out a bill last year, and we have had Ways and Means and Senate Finance look at this as well and move legislation, and I think we all desire that outcome of fixing this problem with SGR but it is really important we are having this hearing because we have to figure out how we are going to handle a lot of these extenders that have always been associated with these temporary one-time fixes, 12-month advances, 6-month advances, SGR. We had all of these extenders, and what are we going to do if we don't have that regular process on SGR anymore? How are we going to handle these? So I applaud this committee for holding the hearing today.

I have heard from so many providers and patient groups about their concerns about specific programs in a world where the SGR issue has been permanently fixed, and I want to say that I am actually going to keep my comments pretty brief, and I don't even have any questions for you. I just want to raise a couple of quick issues and I will yield back after that.

I do think that there are a number of these extenders that have been traditionally attached, as I said, to the SGR patch and we ought to talk about how important they are and what we do to fix them, critical programs like the Special Diabetes program, which has widespread, bipartisan support to providing funding for diabetes research, or the Maternal, Infant and Early Child Home Visiting program, which we have heard about earlier in this hearing. It helps provide coordinated resources to expectant new parents, improves newborn health and works to increase economic self-sufficiency. I think those are just a couple of examples of many of these programs in our discussion today which work to save money. They remove potential cuts to providers. They are going to maintain better access to beneficiaries and they provide really important services to certain at-risk populations.

So I am glad we are going through regular order, Mr. Chairman. Again, I applaud you for holding this hearing and I appreciate our panel coming here today and I look forward to continuing to work on these extenders, and I will yield back my time.

Mr. PITTS. The Chair thanks the gentleman, and with unanimous consent would like to enter into the record a statement by the Rural Hospital Coalition. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. The Chair now recognizes the gentlelady from North Carolina, Ms. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel today on this very important issue regarding SGR.

Dr. Hackbarth, I have a question in relation to some of the situations with the 2014 CMS changes that are coming with the physician fee schedule. In 2013, MedPAC reported to Congress that "if the same service can be safely provided in a different setting, a prudent purchaser should not pay more for that service in one setting than in another" and then it goes on to discuss some of the payment variations.

But in the 2014 CMS Medicare fee schedule, it seems to be doing the exact opposite. Can you expand on that and explain the thinking behind that?

Mr. HACKBARTH. Mrs. Ellmers, is there a particular example in the CMS proposed rule that you—

Mrs. ELLMERS. I am particularly concerned with oncology services, but certainly any of the outpatient services that can be provided in a hospital or outside in an outpatient setting or ambulatory care, the difference.

Mr. HACKBARTH. Yes. So you correctly stated what our principle is, which is that we shouldn't pay higher rates for hospitals if the same service can be safely provided in lower-cost settings, and we are in the process of making recommendations to the Congress to move Medicare policy in that direction. We made a recommendation about evaluation and management services a couple years ago.

At this upcoming meeting next week, we are looking at an additional batch of services, many cardiology services, for example. CMS doesn't always agree with our perspective on issues, and this is an example where I think there have been some differences of opinion.

Mrs. ELLMERS. OK. And too, I cited oncology services and some of the outpatient services but I am also concerned about reimbursement for some of the Medicare therapy services. Now, earlier—and I actually kind of crossed this off my list because I think you really referred to those changes coming more in the accountable care organizations. Is that true as far as the therapy cap issue?

Mr. HACKBARTH. So what we have recommended on outpatient therapy, we don't believe that there should be hard caps imposed on therapy services. That said, we do think that after some point, additional services should be subject to review before they occur, which is an approach very similar to what private insurers typically use in outpatient therapy.

Mrs. ELLMERS. OK. And just lastly, and this is really more of a comment and a question for you as well, I continue to be concerned about the physician reimbursement in relation to Part B payments through hospitals or Part A payments through hospitals with the upcoming CMS changes. I am afraid that with the trend that is moving forward that this is going to affect the viability of Medicare to our seniors, and I just want to get your reassurance if you can commit to continue to work with my office on making sure that MedPAC, that we work in conjunction to make sure that reimbursement is—

Mr. HACKBARTH. I would be happy to

Ms. ELLMERS. Thank you. Thank you, sir, and I yield back the remainder of my time.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman. I would like to thank you as well for organizing this hearing today and I would like to thank all of our witnesses for your service and attention to the health and well-being of American families and to our ability to provide health services in the most efficient manner.

I think most people understand that children have a better chance of success in life if they are healthy and they have consistent access to a pediatrician and the doctor's office and those important checkups, and health services provided under Medicaid have simply been fundamental to ensure that millions of American children do get those vision tests, the wellness checkups, immunizations in a consistent fashion, whether they are growing up healthy or they have certain special needs.

I want to make sure everyone is aware that in the Congress, we have a very active Children's Health Care Caucus. I co-chair the Children's Health Care Caucus with my Republican colleague, Representative Reichert of Washington, and with the help of the Children's Hospital Association, First Focus, the American Academy of Pediatricians and others, over the past 2 years we have had educational sessions on Medicaid for members and for professional staffers here on Capitol Hill, and I wanted to extend the invitation to all of my colleagues and to everyone in attendance today to at-

tend those sessions, and we get into a lot of the detail that we are discussing here today.

A number of members have brought up the issue of access to Medicaid. We know that over time there has been a real problem with enough providers to serve the population, and one good thing the Congress did a couple of years ago was to bump up the Medicaid reimbursement to doctors. Implementation didn't go as quickly as we wanted it to for primary care providers. Fortunately, HHS finally finished that, and we were able to include pediatricians and pediatric specialists, which I think is very important to children's health care.

But Dr. Rowland, can you tell us the status of implementation across the board now that HHS has that complete? Have States been able to implement it?

Dr. ROWLAND. Well, we think that most States have been moving forward with implementing it. The Commission is in the process of obviously looking at what can be learned from the State experiences and we will be going out to re-interview some of the States that we talked to earlier about how implementation has been proceeding. Unfortunately, data is always delayed beyond where we would like it to be. There aren't any specific data yet on what the impact has been on changes in terms of participation of physicians in the program.

The one issue that the Commission, however, has discussed and raised is whether that provision needs to also be broadened to other providers who help provide those primary care services and do not fall within the definition in the statute and especially to look at some of the specialists that are so important especially where there are intense pediatric needs and real shortages.

Ms. CASTOR. I think that is going to be a very important challenge for us moving forward and we should at least extend it now, and then based upon your data and recommendations go further to make sure that people are getting the care they need under Medicaid.

And we all have the goal of improving the overall efficiency of Medicaid and the Children's Health Insurance Program. One tool States have to assist them towards this goal is the Express Lane Eligibility. This efficiency simplifies and streamlines the application and renewal process by allowing States to use eligibility information obtained from other income checks like the School Lunch program or SNAP, and we all get annoyed when government or you go to the doctor's office and they are asking you to fill out paperwork again and again, the same information, and the Express Lane Eligibility helps reduce that duplicative paperwork. So I understand now that 13 States have proven to be real leaders in cutting paperwork and were able in doing that to reach thousands of more children and make sure they can get to the doctor's office.

This sounds very promising, but 13 is still pretty low. I know the Commission has not formally opined on Express Lane Eligibility but there is promising evidence. Could you tell us in terms of increasing enrollment as well as reducing State administrative costs how effective the Express Lane Eligibility has been?

Dr. ROWLAND. From what we can learn so far, it has been an effective way of shifting people from one program's eligibility deter-

mination process into the Medicaid program itself, so it has boosted enrollment in those States. It is now being looked at for adult eligibility in two States to try to see if under the waivers they have been granted through the ACA they can facilitate getting parents into coverage as well, and I think that the more we can simplify and streamline our eligibility processes and use electronic transfers to get more people covered without having to go through, as you say, reapplying, reapplying and reapplying, the better off both beneficiaries will be as well as the States that try to administer these programs.

Ms. CASTOR. Thank you very much.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Florida, Mr. Bilirakis, for 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this hearing, and I want to thank the panel for their testimony as well.

Mr. Hackbarth, the March 2013 MedPAC report included recommendations to permanently reauthorize integrated dual-eligible Special Needs Plans which include the Fully Integrated Dual-Eligible Special Needs Plans and a second successful model for integration. In the second model, one managed-care organization administers a Medicaid plan and a dual-eligible Special Needs Plan. The same Dual-Eligible beneficiaries are enrolled in both plans, and integration occurs at the level of the managed-care organization across the two plans.

Question. Why is it important that we retain this model in addition to the FIDE SNPs, and can you tell us about the benefits of this model and why MedPAC included a more broad definition of integration?

Mr. HACKBARTH. Well, the ultimate goal, as you say, is to get somebody to assume the responsibility for integrating Medicare and Medicaid both financially and clinically, and we allowed different paths to that because there are various types of issue that arise at the State level that may not make the fully integrated single plan model work in every State. Plans approached us and said that this dual plan model where the same beneficiary is both in the Medicare SNP and the Medicaid plan and they do the integration can work as well. In trying to be flexible, we wanted to accommodate that.

Mr. BILIRAKIS. Thank you. Second question for you, sir. Does the current star rating system penalize Special Needs Plans by rating them against all Medicare Advantage plans rather than against the SNPs?

Mr. HACKBARTH. We have not looked specifically at that question. I would think the answer is probably not but again, we haven't studied that.

Mr. BILIRAKIS. Would creating a more appropriate star rating system that is tailored to the specific population D-SNPs be more representative of their quality performance and provide more accurate information to beneficiaries?

Mr. HACKBARTH. We can look at that. As I say, we haven't studied that.

Mr. BILIRAKIS. When do you plan to?

Mr. HACKBARTH. We don't have any specific plans. I am saying we can take a look at that.

Mr. BILIRAKIS. Can you please follow up with me on that?

Mr. HACKBARTH. Sure, I would be happy to do that.

Mr. BILIRAKIS. I think that is very important. Thank you. I appreciate it very much.

Thanks, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, for a UC request.

Mr. GRIFFITH. Thank you, Mr. Chairman. I would ask for unanimous consent to submit a statement from the Federation of American Hospitals for their support of the rural extenders that I talked about.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. That concludes the questions of the members who are present. We will have some additional questions, the members will, and we will send those to you. We ask that you please respond promptly.

It was a very important hearing today. Thank you for the testimony that you have given to the members.

I remind members that they have 10 business days to submit questions for the record, and so they should submit their questions by the close of business on Friday, January 24th.

The Chair thanks everyone for their attention, and without objection, the subcommittee is adjourned.

[Whereupon, at 12:07 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



Liberty Place, Suite 700  
325 Seventh Street, NW  
Washington, DC 20004-2802  
(202) 638-1100 Phone  
www.aha.org

**Statement  
of the  
American Hospital Association  
before the  
Committee on Energy and Commerce,  
Subcommittee on Health  
of the  
United States House of Representatives**

**“The Extenders Policies: What Are They and How Should They Continue Under a  
Permanent SGR Repeal Landscape”**

**January 9, 2014**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the AHA appreciates the opportunity to submit a statement regarding certain Medicare provider payment provisions that are due to expire soon. We applaud the Committee for holding this hearing.

**LOW-VOLUME ADJUSTMENT**

*The Patient Protection and Affordable Care Act* improved the then low-volume adjustment for fiscal years (FY) 2011 and 2012. For these years, a low-volume hospital was defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges.



This enhanced low-volume adjustment was extended by Congress in several subsequent years. Over 500 hospitals received the low-volume adjustment in FY 2013.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect these costs. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient prospective payment system (PPS) prior to FY 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year. The improved low-volume adjustment better accounts for the relationship between cost and volume and helps level the playing field for low-volume providers and also sustains and improves access to care in rural areas. If it were to expire, these providers would once again be put at a disadvantage and have severe challenges serving their communities.

The low-volume adjustment expired on Oct. 31. However, the *Bipartisan Budget Act of 2013* extended the program through March 31, 2014.

#### **MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM**

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment.

To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are paid for inpatient services the sum of their PPS payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities.

The MDH program expired on Oct. 31. However, the *Bipartisan Budget of 2013* extended the program through March 31, 2014.

#### **AMBULANCE ADD-ON PAYMENTS**

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for

patients in rural areas, the *Medicare Prescription Drug, Improvement, and Modernization Act* increased payments by 2 percent for rural ground ambulance services and included a super rural payment for counties are in the lowest 25 percent in population density. Congress, in the *Medicare Improvements for Patients and Providers Act* (MIPPA), raised this adjustment to 3 percent for rural ambulance providers. Most recently, Congress extended these adjustments until March 31, 2014.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services.

#### **OUTPATIENT THERAPY CAPS**

Medicare currently sets annual per beneficiary payment limits for outpatient therapy services (physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP)) provided by therapists and other eligible professionals in certain settings. The law allows for an exceptions process to the cap if the therapy is deemed medically necessary. This exceptions process has been extended numerous times in legislation.

In 2012, the *Middle Class Tax Relief and Job Creation Act* temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012. The ATRA continued the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013, and further extended the therapy cap exceptions process through Dec. 31, 2013. *The Bipartisan Budget Act of 2013* extended both provisions through March 31, 2014.

In addition, the ATRA required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap through Dec. 31, 2013. As a result, in the Physician Fee Schedule final rule for calendar year 2014, CMS reassessed and reversed its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1.

While the AHA supports further extending the outpatient therapy exceptions process, we oppose expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.

**CONCLUSION**

Over the years, Congress has enacted several provisions to address the special challenges rural hospitals encounter in delivering health care services to the communities they are committed to serving. The AHA urges the Committee to recognize that the circumstances that necessitated these provisions continue to exist; therefore, it is appropriate that they be extended.



Liberty Place, Suite 700  
325 Seventh Street, NW  
Washington, DC 20004-2802  
(202) 638-1100 Phone  
www.aha.org

**Statement  
of the  
American Hospital Association  
before the  
Committee on Energy and Commerce,  
Subcommittee on Health  
of the  
United States House of Representatives**

**“The Extenders Policies: What Are They and How Should They Continue Under a  
Permanent SGR Repeal Landscape”**

**January 9, 2014**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the AHA appreciates the opportunity to submit a statement regarding certain Medicare provider payment provisions that are due to expire soon. We applaud the Committee for holding this hearing.

**LOW-VOLUME ADJUSTMENT**

*The Patient Protection and Affordable Care Act* improved the then low-volume adjustment for fiscal years (FY) 2011 and 2012. For these years, a low-volume hospital was defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges.



This enhanced low-volume adjustment was extended by Congress in several subsequent years. Over 500 hospitals received the low-volume adjustment in FY 2013.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect these costs. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient prospective payment system (PPS) prior to FY 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year. The improved low-volume adjustment better accounts for the relationship between cost and volume and helps level the playing field for low-volume providers and also sustains and improves access to care in rural areas. If it were to expire, these providers would once again be put at a disadvantage and have severe challenges serving their communities.

The low-volume adjustment expired on Oct. 31. However, the *Bipartisan Budget Act of 2013* extended the program through March 31, 2014.

#### **MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM**

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment.

To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are paid for inpatient services the sum of their PPS payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities.

The MDH program expired on Oct. 31. However, the *Bipartisan Budget of 2013* extended the program through March 31, 2014.

#### **AMBULANCE ADD-ON PAYMENTS**

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for

patients in rural areas, the *Medicare Prescription Drug, Improvement, and Modernization Act* increased payments by 2 percent for rural ground ambulance services and included a super rural payment for counties are in the lowest 25 percent in population density. Congress, in the *Medicare Improvements for Patients and Providers Act* (MIPPA), raised this adjustment to 3 percent for rural ambulance providers. Most recently, Congress extended these adjustments until March 31, 2014.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services.

#### **OUTPATIENT THERAPY CAPS**

Medicare currently sets annual per beneficiary payment limits for outpatient therapy services (physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP)) provided by therapists and other eligible professionals in certain settings. The law allows for an exceptions process to the cap if the therapy is deemed medically necessary. This exceptions process has been extended numerous times in legislation.

In 2012, the *Middle Class Tax Relief and Job Creation Act* temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012. The ATRA continued the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013, and further extended the therapy cap exceptions process through Dec. 31, 2013. *The Bipartisan Budget Act of 2013* extended both provisions through March 31, 2014.

In addition, the ATRA required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap through Dec. 31, 2013. As a result, in the Physician Fee Schedule final rule for calendar year 2014, CMS reassessed and reversed its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1.

While the AHA supports further extending the outpatient therapy exceptions process, we oppose expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.

**CONCLUSION**

Over the years, Congress has enacted several provisions to address the special challenges rural hospitals encounter in delivering health care services to the communities they are committed to serving. The AHA urges the Committee to recognize that the circumstances that necessitated these provisions continue to exist; therefore, it is appropriate that they be extended.



*Occupational Therapy:  
Living Life To Its Fullest®*

January 7, 2014

Chairman Joe Pitts  
Energy and Commerce Committee  
Subcommittee on Health  
2125 Rayburn House Office Building  
Washington, DC 20515

Ranking Member Frank Pallone  
Energy and Commerce Committee  
Subcommittee on Health  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone,

The American Occupational Therapy Association (AOTA) appreciates the opportunity to submit a statement, for the record, as the Committee examines Medicare extender policies. We are encouraged by the Committee's attention to this important topic and look forward to working with you as you seek more appropriate long term solutions to many of these continuing policies. In particular, AOTA urges the Committee to strongly consider the arbitrary dollar limit enacted against Medicare Part B therapy services in 1997 and its enduring impact on beneficiaries.

AOTA is the national professional association representing the interests of more than 140,000 occupational therapy practitioners and students. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners and their patients are greatly impacted by Medicare rules and payment policies, and AOTA appreciates the opportunity to weigh in as the Committee examines the future of Medicare extender policies, especially the Medicare Part B therapy cap.

As the Committee considers these policies in the context of ongoing Medicare provider payment reform, AOTA, respectfully, reminds the Committee that since the inception of the Sustainable Growth Rate formula (SGR) and the therapy cap in 1997, annual extensions to fix both have moved together. AOTA asks that the Committee recognize the interconnected nature of these two flawed policies by addressing the cap in any final legislation that reforms the Medicare physician fee schedule.

The therapy cap is uniquely problematic in that it exists as a statutory provision directly preventing Medicare beneficiaries from receiving covered services after an arbitrary dollar limit is reached. The policy puts government between the patient and the healthcare provider and restricts a physician's ability to prescribe treatment that is otherwise medically indicated. If the exceptions process were allowed to expire at its current level, a typical Medicare beneficiary would be limited to approximately a single evaluation and just 19 therapy sessions. For a stroke survivor, often needing 3-5 therapy session a week, the cap would allow for less than two months of care. Interrupting care in such an artificial manner serves only to reduce function in patients and diminish quality of life and the ability to live independently. Ultimately, these factors together contribute to poorer health outcomes and costlier care options for beneficiaries and the Medicare program, long term.



4720 Montgomery Lane  
Bethesda, MD 20814-1220

301-652-2682  
301-652-7711 fax

800-377-8555 TDD  
www.aota.org

Further, the creation of the therapy cap was not based on data, quality-of-care concerns, or clinical judgment, but rather as a means to generate savings. AOTA has argued from the outset that an arbitrary therapy cap on outpatient services, without regard to clinical appropriateness of care, discriminates against our nation's most vulnerable Medicare beneficiaries. Since its enactment, Congress has collectively agreed with that sentiment, demonstrating its distaste for the policy, consistently, by acting to delay its impact through moratoriums and the implementation of an exceptions process.

AOTA, along with the other therapy professions, has shared constructive proposals to address the therapy cap and maintained close dialogue with the Committees throughout the current discussions on SGR. As you may know, many of our suggested reforms were included in the Senate Finance Committee mark approved in Committee before the new year.

Now is the time to address the long flawed therapy cap policy. AOTA urges Congress to seize the momentum behind Medicare payment reform as an opportunity to develop a more thoughtful approach to how Medicare pays for therapy services. Including a long-term solution to the therapy cap in any legislative effort aimed at reforming SGR is critical to ensuring that our commitment to Medicare beneficiaries seeking medically necessary care is honored. We look forward to continuing to work closely with your Committee as you ready a comprehensive bill for House consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Christina Metzler". The signature is fluid and cursive, with a prominent initial "C".

Christina Metzler  
AOTA Chief Public Affairs Officer  
American Occupational Therapy Association, Inc.

December 9, 2013

The Honorable David Camp  
Chairman  
House Committee on Ways and Means  
1106 Longworth House Office Building  
Washington, DC 20515

The Honorable Sander Levin  
Ranking Member  
House Committee on Ways and Means  
1106 Longworth House Office Building  
Washington, DC 20515

Dear Chairman Camp, Congressman Levin and members of the House Ways and Means Committee:

The undersigned national organizations, representing a variety of stakeholders, including providers and consumers, are writing to express strong support for including the following programs in any year-end health extenders package: the **Qualified Individual (QI)** program, the **Transitional Medical Assistance (TMA)** program, and **Express Lane Eligibility (ELE)** as well as the **state incentive payment provisions and funding for quality improvement** in the **Children's Health Insurance Reauthorization Act (CHIPRA)**.

#### **Qualified Individual (QI) Program**

***Making the Qualified Individual (QI) program permanent is essential for low-income Medicare beneficiaries.*** QI pays Medicare Part B premiums for over 400,000 beneficiaries with incomes between 120 and 135 percent of the federal poverty level (about \$13,700 to \$15,500 per year for an individual) and limited assets (below about \$7,080 for an individual). For 2013, the value of this assistance is more than \$1,200 per person per year in premium savings alone. Moreover, because those with QI also automatically receive the Part D low-income subsidy, the value of the program is even more significant. The loss of QI would leave these beneficiaries with premiums approaching 10 percent of their incomes. As a result, many of them could be forced to drop their Part B coverage or face significant financial hardship. Moreover, making the program permanent will eliminate the uncertainty that beneficiaries and the states that administer QI have faced nearly every year as the program has approached expiration. A permanent QI program will be more stable and therefore better able to serve these vulnerable beneficiaries.

#### **Transitional Medical Assistance (TMA) Program**

***We also request that you make the Transitional Medical Assistance (TMA) program permanent and align it with other Medicaid provisions.*** TMA provides temporary health care coverage to families that have lost Medicaid eligibility because they have found a job or received a wage increase from their employer yet cannot afford to purchase insurance in the private market. The GAO estimates that TMA extended vital coverage to over 3.7 million Americans in 2011. The National Governor's Association deemed the program a "crucial work support" because it protects families who are attaining financial self-sufficiency from incurring burdensome health care expenses. Furthermore, TMA

will ease administrative burdens in states that have not expanded Medicaid by reducing “churn” within health insurance markets. The program has enjoyed wide-ranging support in the past and has been extended multiple times on a bipartisan basis.

**CHIPRA Express Lane Eligibility (ELE)**

*Express Lane Eligibility (ELE) in the Children’s Health Insurance Reauthorization Act (CHIPRA) of 2009 should be made permanent.* ELE allows states to rely on eligibility findings of other assistance programs to determine Medicaid and CHIP eligibility for children, which can create administrative efficiencies and prevents families from having to provide the same information to multiple agencies. Thirteen states use the ELE option to streamline enrollment or renewal procedures. If ELE expires, it would undermine the efforts of these states to simplify their enrollment processes and would also create more work, as they would need to change procedures and systems to reflect the loss of the ELE option. Rather than take this innovative option away, we support giving states additional flexibility to extend ELE to adults. This would allow states to adopt the same enrollment and renewal procedures for children and adults alike, an additional opportunity to make more efficient use of scarce state resources.

**CHIPRA State Incentive Payments and Funding for Quality Improvement**

*State incentive payments (or “performance bonuses”) and funding for quality improvement in CHIPRA should be extended through fiscal year 2015 to align with other CHIPRA provisions.* A growing number of states have received performance bonuses (CHIPRA section 104) by making significant progress reaching eligible-but-unenrolled children in Medicaid. The funds help states by offsetting the added costs of insuring the lowest-income children and encouraging them to adopt improvements in their children’s health coverage programs. Since the first year of awards in 2009, 23 states have received more than \$800 million. In 2012 alone, \$306 million was awarded to 23 states. To qualify for awards, states must adopt enrollment simplification measures that have been proven to help enroll children and keep them covered as long as they are eligible—typically improvements that cut unnecessary red tape in state enrollment systems. Far from a requirement, states have flexibility to decide which measures will best meet their unique state circumstances, such as adoption of ELE, using electronic data-matching to reduce paperwork, making it easier for families to renew, and other strategies that can minimize coverage disruptions for children. To receive funds, states must also demonstrate progress reaching eligible-but-unenrolled children by meeting aggressive enrollment targets in Medicaid. In 2011, 1.1 million children enrolled in Medicaid beyond expected levels due in part to this incentive. Extending the performances bonuses will help continue to bring down the uninsured rate among children. Additionally, Section 401 of CHIPRA created groundbreaking federal commitments to funding pediatric health care quality improvement and has helped further focus attention on quality improvement in maternal and child health care communities. Both the CHIPRA state incentive payments and funding for quality improvement should be extended.

We urge you to support low-income older adults, low-income working families and their children by making the QI program permanent, extending the TMA program, making CHIPRA Express Lane Eligibility permanent and extending both CHIPRA state incentive payments and CHIPRA funding for quality improvement. We appreciate your consideration and we look forward to working with you on protecting and preserving these critical programs.

Sincerely,

9to5  
ActionAIDS  
African American Health Alliance  
Alliance for a Just Society  
Alliance for Children and Families  
Alliance for Retired Americans  
American Art Therapy Association  
American Association on Health and Disability  
American Health Care Association  
American Heart Association/American Stroke Association  
American Nurses Association  
American Society on Aging  
Anxiety and Depression Association of America  
Association for Ambulatory Behavioral Healthcare  
Association for Community Affiliated Plans  
Association of Asian Pacific Community Health Organizations  
Center for Law and Social Policy (CLASP)  
Center for Medicare Advocacy, Inc  
Centering Healthcare Institute  
Children's Defense Fund  
Coalition on Human Needs  
Community Access National Network  
Community Catalyst  
Every Child Matters Education Fund  
Families USA  
First Focus Campaign for Children  
Gay Men's Health Crisis (GMHC)  
Gerontology and Human Development in Historical Black Colleges and Universities  
Health and Wholeness Ministries, Disciples Center for Public Witness  
HIV Medicine Association  
International Bipolar Foundation  
LEA net - A national coalition of local education agencies  
Legal Services for the Elderly  
March of Dimes

Medicare Rights Center  
Mental Health America  
Metropolitan Community Churches  
NAACP  
National Advocacy Center of the Sisters of the Good Shepherd  
National Alliance on Mental Illness  
National Alliance to Advance Adolescent Health  
National Association for Home Care & Hospice  
National Association of Community Health Centers  
National Association of Nurse Practitioners in Women's Health  
National Association of Pediatric Nurse Practitioners  
National Association of Professional Geriatric Care Managers  
National Association of States United for Aging and Disabilities  
National Center for Assisted Living  
National Center for Lesbian Rights  
National Coalition on Health Care  
National Consumer Voice for Quality Long-Term Care  
National Council of Jewish Women  
National Council of La Raza  
National Council on Medicaid Home Care  
National Health Care for the Homeless Council  
National Latina Institute for Reproductive Health  
National Network of Public Health Institutes  
National Physicians Alliance  
National Senior Citizens Law Center  
National Urban League  
National Women's Law Center  
National Women's Health Network  
Network for Environmental & Economic Responsibility Of United Church of Christ  
NETWORK, A National Catholic Social Justice  
PHI – Quality Care through Quality Jobs  
Presbyterian Church (U.S.A.)  
Racial and Ethnic Health Disparities Coalition  
RESULTS  
Service Employees International Union (SEIU)  
The Arc of the United States  
The Children's Partnership  
The Disability Rights Center  
The Global Justice Institute

November 22, 2013

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Fred Upton  
Chairman  
Committee on Energy and Commerce  
United States House of Representatives  
Washington, DC 20515

The Honorable Orrin G. Hatch  
Ranking Member  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Henry A. Waxman  
Ranking Member  
Committee on Energy and Commerce  
United States House of Representatives  
Washington, DC 20515

Dear Chairmen Baucus and Upton, and Ranking Members Hatch and Waxman:

As organizations representing the majority of the nation's physicians, we write to express our strong support for (1) extending for at least two more years the Medicaid primary care payment increase, which has only recently been implemented in a majority of states, and (2) including physicians practicing obstetrics and gynecology as qualified specialties, subject to the current eligibility requirement that at least 60 percent of their Medicaid billings are the primary care services as defined by the authorizing legislation, for the purposes of qualifying for the Medicaid primary care increases.

Federal financing for the states to increase Medicaid payment rates for designated "primary care" services by eligible specialties, to no less than the comparable Medicare rates, is set to expire at the end of 2014. Allowing this program to expire would further burden the already challenged Medicaid system. Patients will face obstacles to connecting with a patient-centered medical home and will be forced to rely on episodic, acute care services provided in other settings, foregoing the more cost-effective coordinated and preventive care services that primary care physicians provide. Policies aimed at improving access to physicians in the Medicaid program are strongly supported by our organizations because we understand that investments such as these lead to better quality of care for patients and decreased costs for state governments.

The policy of increasing Medicaid payment rates to no less than the comparable Medicare payments is based on well-established research that shows that low Medicaid payment levels in many states is associated with fewer physicians accepting large number of Medicaid patients into their practices, resulting in reduced access to persons covered under Medicaid:

Decker SL. In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Raising Fees May Help. *Health Aff.* 2012;31(8):1673-1679. Accessed at <http://content.healthaffairs.org/content/31/8/1673.abstract>

Shen and Zuckerman: The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries. <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2005.00382.x/abstract;jsessionid=ED0FE8AEA1FA49E1FFACEAB44EFC0F5C.f03t02>

We expect that extending the policy of ensuring Medicaid payments for eligible physician services at least through 2016 would demonstrate that it is effective in improving access to physician services, both for persons enrolled in the existing Medicaid program and persons who may become newly eligible for Medicaid in states that choose to accept the federal dollars to expand Medicaid. The extension is particularly important because its slow start up—with many states only now beginning to pay at the higher Medicare rates—combined with a lack of assurance that it will be extended beyond 2014 has not allowed an adequate enough time to demonstrate the program's effectiveness in improving access.

Over the past few years, our nation has taken significant steps towards improving access to health care for the uninsured and underinsured. A principal part of this effort has been the investment in primary care as the foundation of our nation's health care system. Expanding access to physicians, especially primary care physicians, is a priority for federal and state governments, as well as commercial insurance plans. In addition, we believe that inclusion of physicians practicing obstetrics and gynecology in the extension is integral to achieving the intended purpose of the Medicaid primary care payment increase. For many women, an ob-gyn is the only physician they see regularly during their reproductive years and the only point of entry into the health care system. As of 2010, Medicaid programs in 30 states and the District of Columbia recognized ob-gyns as primary care providers in their managed care organizations. With nearly half of births in the United States now financed by Medicaid, inclusion of ob-gyns will improve the continuity of care, particularly for those women who were previously on Medicaid for pregnancy-related services. We also note that private and public health care systems similarly are making this investment in primary care as a means of improving access to health care for patients and as a means of improving the overall quality and efficiency of care provided.

Our members are dedicated to working individually and collectively to ensure that all patients, including low-income working families who depend on Medicaid, have access to needed primary care services. However, many physicians do not participate in the Medicaid program due to poor payment rates that, historically, are well below the actual costs of providing care. This results in reduced access to care for the most vulnerable patients and higher costs to federal and state governments.

Although a principal goal of this Medicaid policy is to improve access to primary care, the policy also increases payments to many subspecialists in internal medicine and pediatrics, with the purpose of increasing participation and access to their services.

A key to achieving our joint goals of ensuring increased access and improved quality is ensuring that Medicaid and Medicare payment policies are aligned with the access and quality goals established by public and private health care systems. The Medicaid payment increase is an important policy that attempts to better align payment rates with cost of care for primary care physicians, thus increasing access to primary care physicians for millions of Medicaid patients.

We urge you to extend the Medicaid primary care payment increase as well as inclusion of physicians practicing obstetrics and gynecology.

Sincerely,

American Academy of Family Physicians  
American Academy of Pediatrics  
American College of Physicians  
American Congress of Obstetricians and Gynecologists  
American Osteopathic Association

### January 2014 DRAFT MIPPA Funding Letter

Dear Member of Congress,

The undersigned organizations are writing to urge you to make permanent funding for community-based organizations for outreach and enrollment activities for low-income Medicare beneficiaries. This request is not to expand eligibility, but merely to assist those already eligible under current law.

Previous outreach efforts have been successful at improving access to prescription drugs and other needed services. In 2008, Congress enacted the MIPPA, which provided \$25 million to fund outreach and enrollment efforts for low-income beneficiaries under Section 119. Recognizing the crucial importance of these activities, Congress authorized appropriations that were available for obligation through FY2012. Section 610 of the American Taxpayer Relief Act (ATRA) extended funding through FY2013. Most recently, Section 1110 of the Pathway for SGR Reform Act extended funding to March 31, 2014.

On December 12<sup>th</sup>, the Senate Finance Committee in Section 209 of the SGR Repeal and Medicare Beneficiary Access Improvement Act voted on a bipartisan basis to permanently appropriate current level funding (\$25 million each fiscal year) for these critical low-income outreach and enrollment activities.

Previous allocations have led to important, proven results. Return on investment is estimated to be \$23 for every dollar spent. MIPPA resources enabled grantees to:

- Assist about 700,000 individuals in need;
- Generate \$1.9 billion in local economic activity;
- Reduce by almost 12% the number of beneficiaries without access to needed benefits for which they are eligible;
- Target rural communities to improve access to Medicare Part D; and
- Help thousands of beneficiaries save money and make the competitive market work better through improved information for consumers making complex choices, thereby fostering objective yet personalized plan selection and decision-making.

According to a recent Government Accountability Office (GAO) report, new Medicare Savings Program (MSP) enrollees almost doubled from 2009 to 2010 – from 192,963 to 377,151 new enrollees – and increased further 388,733 in 2011 and 393,465 in 2012 (according to preliminary estimates which will likely increase). This is due in large part to successful outreach and enrollment efforts under MIPPA. This important work improves overall economic conditions by increasing consumption and spending in communities to meet basic needs; mitigating individual debt, credit damage, or bankruptcy caused by large out-of-pocket medical expenses; reducing the occurrence of hospital bad debt and its accompanying costs; and lessening financial burdens on family members.

Despite these successful efforts, vulnerable Medicare beneficiaries continue to struggle to access the health care benefits for which they are eligible. Specifically:

- Approximately 2.3 million individuals eligible for the Medicare Part D Low-Income Subsidy (LIS/Extra Help), which helps pay for prescription drug costs, are not enrolled in the program. This represents nearly two-thirds of eligible low-income beneficiaries who are not automatically enrolled.
- Many beneficiaries are not aware that free counseling is available to choose the best Part D plan to meet their needs, which could save them up to \$500 in out-of-pocket costs each year, reduce Medicare spending, and improve market competition.
- A significant number of beneficiaries living in rural communities are not enrolled in Part D.
- Less than one-third of beneficiaries eligible for assistance paying Medicare Part B premiums through a Medicare Savings Program (QMB, SLMB and QI programs) receive that needed help.
- The economic downturn and a growing Medicare-eligible population highlight the increased need for these assistance programs.
- Continued education and outreach targeting this population is particularly urgent given the significant changes dual eligible individuals will soon be facing in states implementing new integration initiatives.

Our request is intended to reflect a straight extension of the same level of funding using the same ratios for funded entities as those used in previous years. Funding for outreach and enrollment efforts has been shared among State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the National Center on Benefits Outreach and Enrollment (NCBOE), which included competitive grants to develop state and local Benefits Enrollment Centers (BECs).

The Center has been able to fund 29 BECs in 22 states, enabling nonprofits and state agencies to provide cost-effective, person-centered strategies to provide outreach and enrollment into benefits for low-income seniors and younger adults with disabilities. Grants have primarily ranged from \$45,000 - \$100,000 a year. During the recent competitive proposal cycle, there were numerous quality proposals from states which do not currently have a BEC that were not funded but could be awarded grants should additional funds be available. Since their inception in 2009, BECs have helped over 500,000 seniors and younger adults with disabilities, helping them to apply for over \$550 million in benefits, while also making systems for accessing those programs more efficient for government and more seamless for consumers.

The infrastructure, including processes and trained workforce, already exists to continue this work. Without extended funding, this infrastructure will erode, leaving millions unable to afford and access essential health care. We urge you to continue this critical support for vulnerable Medicare beneficiaries before the end of this year.

Groups signing earlier 12/12 letter

AARP  
 Alliance for Retired Americans  
 American Association on Health and Disability  
 American Society on Aging  
 Association for Gerontology and Human Development in Historically Black Colleges and Universities  
 B'nai B'rith International  
 Brain Injury Association of America  
 Center for Medicare Advocacy  
 Community Access National Network  
 Easter Seals  
 Families USA  
 GIST Cancer Awareness Foundation  
 HealthHIV  
 Leading Age  
 Lupus Foundation of America  
 Lutheran Services in America  
 Medicare Rights Center  
 Mental Health America  
 National Alliance on Mental Illness  
 National Asian Pacific Center on Aging  
 National Association for Home Care and Hospice  
 National Association of Area Agencies on Aging  
 National Association of Professional Geriatric Care Managers  
 National Association of Social Workers (NASW)  
 National Association of States United for Aging and Disability  
 National Caucus and Center on Black Aged  
 National Committee to Preserve Social Security and Medicare  
 National Consumer Voice for Quality Long-Term Care  
 National Council on Aging  
 National Hispanic Council on Aging  
 National Senior Citizens Law Center  
 OWL-The Voice of Midlife and Older Women  
 RetireSafe



United States House of Representatives  
 Committee on Energy and Commerce, Subcommittee on Health  
 Hearing on "The Extenders Policies: What Are They and How Should They Continue Under a  
 Permanent SGR Repeal Landscape?"  
 Thursday, January 9, 2014

Mr. Chairman and Members of the Subcommittee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare (NCPSSM), and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving, strengthening and promoting Social Security, Medicare and Medicaid.

Today, I am writing to urge you to extend the Qualified Individual (QI) program and therapy caps exceptions for Medicare beneficiaries as part of any legislation that would repeal and replace the Sustainable Growth Rate (SGR) formula. Extension of QI and therapy caps exceptions were included in previous annual SGR extenders packages, and they should be a part of any future SGR legislation because these programs are vital to the well-being of low-income and medically-frail Medicare beneficiaries.

The National Committee supports making the QI program permanent for qualifying Medicare beneficiaries. Since 1998, the QI program has paid for Medicare Part B premiums for qualified low-income beneficiaries with incomes between 120% and 135% of the Federal Poverty Level (about \$13,700 to \$15,300) and assets less than \$7,080. In addition, QI program recipients qualify for the Medicare Part D Low-Income Subsidy (LIS), or Extra Help, to help pay for their prescription drugs. LIS can save beneficiaries up to \$4,000 per year on prescription drug costs. Without the QI benefit, many people would be unable to pay their monthly Medicare Part B premium (\$104.90), and Part D prescription drug premiums and costs, which may result in forgoing needed health care and disrupting access to their doctors.

We also request that Congress include a permanent fix to the Medicare therapy cap exceptions process, preferably by repealing the caps, as required by S. 1871, the "SGR Repeal and Medicare Beneficiary Access Improvement Act," which was approved by the Senate Finance Committee on December 17, 2013. The changes in this legislation are intended to improve access for beneficiaries and to ensure appropriate payments to providers. The current caps, which limit the annual Medicare coverage available for outpatient therapy services impose an undue burden on millions of seniors who require care to improve and recover from serious medical conditions. If a full repeal of the Medicare therapy caps is not possible, we urge you to make the exceptions process permanent.

In brief, we are encouraged by the bipartisan, bicameral effort to repeal and replace the SGR provider payment system with one that bases payments on the quality and efficiency of care and allows for innovation in areas such as coordinating care for people with multiple chronic conditions. However, we are concerned about how Congress will pay for the SGR repeal and

replacement policy. We strongly oppose shifting more costs to seniors, which would be particularly damaging because half of Medicare beneficiaries are living on incomes of less than \$22,500 per year and already have high out-of-pocket costs for health care.

Instead, we support paying for the SGR repeal and replacement by restoring Medicare Part D rebates to individuals who are dually eligible for Medicare and Medicaid or the low-income subsidy, which would save over \$140 billion over 10 years.

As Congress moves forward with SGR repeal and replace legislation, we urge you to make the QI program permanent and repeal the Medicare therapy caps. Millions of Medicare beneficiaries rely on these programs in order to live independently.

Thank you for your efforts to repeal and replace the SGR formula and commitment to our nation's seniors.

Sincerely,

A handwritten signature in black ink that reads "Max Richtman". The signature is written in a cursive, flowing style.

Max Richtman  
President and CEO



NATIONAL  
QUALITY FORUM

1030 15TH STREET, NW, SUITE 800  
WASHINGTON, DC 20005  
202 783-1300 MAIN 783-3434 FAX

### Energy and Commerce Hearing

#### **“The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?”**

*January 9, 2014*

*While traditional “extender” provisions -- consisting primarily of short-term payment policies -- are the main focus of the January 9, 2014 Energy and Commerce hearing, funding renewals and other policy changes related to NQF and its quality work have recently been considered along with these items, beginning with the American Taxpayer Relief Act (ATRA, P.L. 112–240, H.R. 8, 126 Stat. 2313). For this reason, NQF would like to submit the following comments.*

We commend the Energy and Commerce Committee for its leadership in reforming physician payment by linking payment to quality measures. Your efforts are critical to driving toward a more transparent, patient-centered and higher performing healthcare system.

It may appear simple, but it is true: focusing payment on quality will only be effective if the tools we use to measure are themselves “high quality.”

More specifically, for quality measures to have an impact on physicians, other clinicians and the broader healthcare system the measures must be: understandable to patients and payers; actionable by physicians, hospitals and other providers; and meet high medical and scientific standards. Also, it is critical that a range of stakeholders agree on what is important to measure and that there is evidence that the measures selected can actually drive improvements in care.

To ensure high quality measures, we need criteria or standards. And to make sure that these measures are regularly used across the country, we need consensus or buy-in by all the sectors that have a stake in healthcare. That’s where NQF comes in.

NQF has two distinct but complementary roles focused on enhancing healthcare quality and value:

- Endorsing measures based on transparent and rigorous criteria;
- Convening diverse stakeholders to gain agreement on where improvement is needed and what measures can be used to reach our goals. Currently, a NQF-convened group makes recommendations to HHS on measure use for 20 plus Federal programs.

PAGE 2

A major result of this consensus building is creation of a standard portfolio of measures that is accepted as the "gold standard," with the measures increasingly used by public and private purchasers as well as accrediting/certifying organizations. This uniformity of quality priorities and specific measures helps lessen reporting burden on providers and sends strong signals about quality improvement goals to the marketplace.

To this point: a recent analysis shows that about 28 percent of NQF's library of measures are being used by two or more sectors, including the Federal government, private payers, states, communities, physician specialty societies, and others. Also, we know that the Federal government is actively using about half of NQF's portfolio of measures in its various programs. Given its size and reach, the Federal government is an important lever in encouraging all sectors to focus on the same quality improvement goals, and NQF measures are a critical tool in this effort.

In terms of funding, NQF is supported by membership dues, foundation grants, and Federal funding.

We urge Energy and Commerce to support stable, level and long term funding for quality measure development, endorsement, selection and evaluation. NQF does not develop measures so those funds would not come to the organization; however Federal support for development is critical to enhancing measurement innovation and impact.

Without these interdependent processes that constitute the measurement enterprise, the nation's health care system will lack the appropriate building blocks for evaluating and improving health care quality and reducing costs.

Thank you for the opportunity to provide these comments for consideration by the Energy and Commerce Committee.

January 8, 2013

The Honorable Joe Pitts  
Chairman  
Health Subcommittee  
House Energy and Commerce Committee  
Washington, D.C. 20515

The Honorable Frank Pallone  
Ranking Member  
Health Subcommittee  
House Energy and Commerce Committee  
Washington, D.C. 20515

Dear Representatives Camp and Levin:

**We are writing to urge that the Qualified Individual (QI) low-income Medicare beneficiary assistance program be made permanent, and be included in any permanent Medicare physician payment reform package.** Failure to do this would seriously threaten vulnerable Medicare beneficiaries' economic security and access to physicians.

The QI program pays Part B premiums for beneficiaries with incomes between 120% and 135% of the Federal Poverty Line (FPL) - about \$13,700 to \$15,300 - and less than \$7,160 in assets for an individual. Most Medicare beneficiaries pay a monthly Part B premium of \$104.90, an out-of-pocket cost that low-income QI recipients cannot afford. Receipt of the QI benefit also qualifies individuals for the Medicare Part D Low-Income Subsidy (LIS), or Extra Help, to help them pay for prescriptions. The LIS can save beneficiaries up to \$4,000 per year on prescription drug costs. An estimated 455,000 beneficiaries received QI assistance in 2010, the most recent year for which comprehensive enrollment data is available.<sup>1</sup>

According to analysis from the AARP Public Policy Institute<sup>2</sup>, median out-of-pocket spending on health care for Medicare beneficiaries with incomes between 101-150% of poverty is 27.3% - more than any other income category. Without the QI benefit, vulnerable seniors with incomes between 120-135% of poverty would **lose their Part B benefits and access to their doctor or be forced to pay almost 40% of their meager income on health care.**

Since December 2002, QI funding has been extended on a year-to-year basis within a larger "extenders package," driven primarily by the annual threat that Medicare physician payments will be cut unless Congress acts. Unlike other Medicare low-income protection programs, the federal funding is not assured, and funds available for the QI program do not automatically increase based on inflation and growing need. The program is 100% federally funded in the form of fixed grants. Therefore, once a state's federal funding has been spent, newly eligible individuals cannot enroll in the program. Current funding will end March 31, 2014 unless Congress acts.

**Without QI assistance, low-income Medicare beneficiaries would be forced to spend \$104.90 per month on Part B premiums or lose their Part B benefit.** This \$104.90 alone represents roughly 10% of a QI recipient's monthly income. Without QI, these beneficiaries

<sup>1</sup> <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html>

<sup>2</sup> Table 1 at [http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf)

could not afford their premiums and risk losing Part B coverage for doctor visits - leaving them with significant, unaffordable out-of-pocket costs every time they need to see a doctor. If they later attempt to re-enroll, they would face the full premium plus a harsh add-on penalty. They would also be in greater jeopardy of losing their Part D Low-Income Subsidy and access to affordable prescription drugs because QI enrollees automatically qualify for the extra help. In addition, a permanent physician payment fix is likely to increase Part B premiums relative to current law, making the QI benefit all the more critical to this vulnerable population.

**A permanent SGR fix, absent a permanent QI program fix, would place the future of the QI program in serious jeopardy.** Bipartisan support for a permanent SGR fix appears to be emerging. This presents opportunities and serious risks for the QI program and the vulnerable beneficiaries who depend on it. Many believe that the only reason the extenders bills have passed with bipartisan support is because of significant political pressure not to cut physician payments. A permanent SGR fix provides a vehicle for a permanent QI fix, ending the annual struggle to include it in the extenders package. However, failure to make the QI program permanent as part of an SGR repeal and replacement package would seriously threaten the prospects for future continued bipartisan support on Medicare extenders packages for expiring programs.

**Low-income beneficiaries need stability.** Since its inception, the QI program has faced expiration numerous times, with extensions typically made for only one-year periods just before the program was scheduled to expire. This instability causes havoc and uncertainty in the lives of those who rely on the QI benefit and runs counter to Medicare's goal of providing health security to those in greatest need.

We strongly urge that members of Congress demonstrate their support for low-income people with Medicare by making the QI low-income beneficiary program permanent.

AARP  
 AFL-CIO  
 AFT Retirees  
 Alliance for Children and Families  
 Alliance for Retired Americans  
 Alzheimer's Association  
 Alzheimer's Foundation of America  
 American Association on Health and Disability  
 American Association of People with Disabilities  
 American Federation of State, County and Municipal Employees (AFSCME)  
 American Society on Aging  
 The Arc of the United States  
 Association of Jewish Aging Services  
 Association of University Centers on Disabilities  
 B'nai B'rith International  
 Brain Injury Association of America  
 Center for Medicare Advocacy  
 Coalition on Human Needs

Community Catalyst  
Compassion and Choices  
Easter Seals  
Families USA  
Gray Panthers  
International Association for Indigenous Aging (IA2)  
Lupus Foundation of America  
Lutheran Services in America (LSA)  
Medicare Rights Center  
Mental Health America  
National Academy of Elder Law Attorneys (NAELA)  
National Adult Day Services Association (NADSA)  
National Alliance on Mental Illness (NAMI)  
National Asian Pacific Center on Aging (NAPCA)  
National Association for Hispanic Elderly  
National Association for Home Care and Hospice  
National Association of Area Agencies on Aging  
National Association of Nutrition and Aging Services Programs (NANASP)  
National Association of Professional Geriatric Care Managers  
National Association of State Long-Term Care Ombudsman Programs (NASOP)  
National Association of States United for Aging and Disabilities  
National Caucus and Center on Black Aged  
National Committee to Preserve Social Security and Medicare  
National Consumer Voice for Quality Long-Term Care  
National Council on Aging  
National Council on Medicaid Home Care  
National Disability Rights Network  
National Health Law Program  
National Multiple Sclerosis Society  
National Senior Citizens Law Center  
NETWORK, A National Catholic Social Justice Lobby  
OWL, The Voice of Midlife and Older Women  
PHI – Quality Care through Quality Jobs  
Service Employees International Union (SEIU)  
Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE)  
Southeast Asia Resource Action Center (SEARAC)  
United Cerebral Palsy (UCP)  
United Methodist Church – General Board of Church and Society  
United Neighborhood Centers of America  
United Spinal Association  
Wider Opportunities for Women (WOW)  
Women’s Institute for a Secure Retirement (WISER)



**Statement of the Rural Hospital Coalition**

House Committee on Energy and Commerce  
Subcommittee on Health

**"The Extenders Policies: What Are They and How Should They Continue Under a Permanent  
SGR Repeal Landscape?"**

January 9, 2014

Submitted by Nancy Taylor  
On Behalf of the Rural Hospital Coalition  
202.331.3133

**Statement of the Rural Hospital Coalition**House Committee on Energy and Commerce  
Subcommittee on Health

“The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?”

January 9, 2014

The Rural Hospital Coalition would like to thank Chairman Joe Pitts (R-PA), Ranking Member Frank Pallone (D-NJ), and other Members of the Health Subcommittee for holding a hearing on the Medicare extenders policies and for the opportunity to submit testimony on this important topic. The impact of these Medicare provider payment policies on rural beneficiaries, health care and communities cannot be understated. We strongly support the permanent extension of the Low Volume Hospital Adjustment and the Medicare Dependent Hospital Program at their current levels, as contained in the Senate Finance Committee bill passed out of Committee on December 12, 2013 (S. 1871). These two provisions go a long way to provide stability to health care services in rural communities around the country.

The Rural Hospital Coalition represents nearly one-fifth of all rural hospitals, with almost 200 facilities located across more than thirty states. Our hospitals are major drivers of many rural communities, providing jobs, revenue and the health care needed to keep rural Americans thriving. In many rural communities, rural hospitals serve as one of, if not *the*, largest employers. Rural hospitals can account for a full 20% of the revenue a rural community sees in a year. In addition, the existence of a high-quality hospital in a rural community is key to the economic development of that local community. A rural hospital is often a vital element in attracting investment and new employers to a rural community. Furthermore, a single hospital often serves as the sole provider of care for a community. Finally, rural Americans already earn significantly less than their urban counterparts, are more likely to live at or below the Federal poverty level, and are more likely to experience worse health overall<sup>1</sup>. Rural hospitals are therefore vital to the communities they serve.

Because rural hospitals serve residents who are less likely to have private health insurance or prescription drug coverage, these hospitals provide higher rates of uncompensated care than metropolitan facilities<sup>2</sup>. At the same time, rural hospitals generally see a greater share of patients on Medicaid than urban facilities<sup>3</sup> – a program that has historically paid less for hospital services than the actual costs associated with providing care<sup>4</sup>. And while Medicare payments to rural

<sup>1</sup> National Rural Health Association, What's Different about Rural Health Care?, <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>, Accessed December 26, 2013.

<sup>2</sup> Id.

<sup>3</sup> Rural Assistance Center, What are some challenges that rural hospitals face?, <http://www.raconline.org/topics/hospitals/faqs>, Accessed January 3, 2014.

<sup>4</sup> American Hospital Association, *Underpayment by Medicare and Medicaid: Fact Sheet*, December 2010, <http://www.aha.org/content/00-10/10medunderpayment.pdf>.

hospitals are also proportionally less than those paid to urban hospitals for the same services, the payment policies under consideration today help offset these and other challenges faced by rural hospitals – such as recruitment and retention of physicians and other providers<sup>5</sup>. In short, rural hospitals must manage the same overhead and operating costs as larger urban facilities, but have less opportunity to spread and recover these costs, often forcing rural hospitals to scale back services. Allowing the current rural Medicare payment policies to expire would not only threaten to deprive rural Americans of their only point of access to local health care services, it would also potentially weaken the economic backbone of these and surrounding communities.

Of the Medicare payment policies expiring on March 31, 2014, the two policies that are of greatest importance to rural hospitals and their communities were recently estimated by the Congressional Budget Office ("CBO") to **cost just over \$4.2 billion over ten years for a permanent, but modified, extension** (see enclosed for the full list of Medicare extenders vital to rural hospitals). This ten-year cost estimate amounts to **less than 1% of the projected total Medicare spending next year alone**. Furthermore, while these provisions have only a miniscule impact on overall Medicare expenditures, they provide a much-needed lifeline to rural communities, the beneficiaries who live there, and to hospitals and communities across the country. Below we provide some background and additional detail on the two most critical Medicare extenders, which are scheduled to expire on March 31, 2014.

#### **Improved Payment for Low-Volume Hospitals**

The improved payment for low-volume hospitals applies a percentage add-on for each Medicare discharge from a hospital that is located 15 road miles or more from another hospital<sup>6</sup>, and has less than 1,600 Medicare discharges during a fiscal year. This provision affords qualifying hospitals an enhanced payment to account for the higher incremental costs associated with a low volume of discharges, as compared to the lower incremental costs incurred per patient at higher volume hospitals. The enhanced payment is not provided after a one-time qualification, but requires that a hospital provide sufficient evidence to demonstrate that it continually meets the discharges and distance requirements, ensuring that hospitals which do not consistently qualify for the payment are not unjustly enriched by a one-time qualifying discharge rate or distance measurement. The CBO estimates that a permanent extension of the low-volume adjustment – though modified – would cost roughly \$2.8 billion over ten years.

#### **Medicare Dependent Hospital Program**

The Medicare Dependent Hospital ("MDH") program dates back to 1987, and was "intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges."<sup>7</sup> Congress applied this designation to rural hospitals with 100 beds or fewer, not classified as an SCH, and having at least 60% of inpatient days or discharges covered by Medicare. As noted by the Medicare Payment Advisory Commission ("MedPAC"), a greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payments under PPS. Additionally, the

<sup>5</sup> Id.

<sup>6</sup> This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

<sup>7</sup> MedPAC, *Summary of Medicare's special payment provisions for rural providers and criteria for qualification*, June 2001, at 142.

MDH designation provides small rural hospitals assurance that if its caseload falls by more than 5 percent due to circumstances beyond its control, the MDH will receive such payments as necessary to cover fixed operating costs. This designation allows many rural hospitals to keep their doors open. This provision was extended under the Patient Protection and Affordable Care Act, and was then scored by CBO as a 0. In a more recent estimate of a modified permanent extension of the MDH program, CBO projected that the overall cost would be roughly \$1.4 billion over ten years.

In addition to these two payment policies, there are at least three additional payment policies that will expire on March 31, 2014. Another seven Medicare extenders have already expired, but had previously provided similar support to rural hospitals – a loss that these providers continue to feel. We hope that this testimony provides insight into the impact that these Medicare payment policies have on sustaining health care delivery in rural America. Thank you and we look forward to working with all Members on these important issues.



## Medicare Extenders

As providers of health care in America's rural communities, we have a special understanding of the adverse impact failure to pass these extenders would have on beneficiaries and the providers on which they depend. Below is a list of provisions that have been addressed by Congress in the past.

- **Extension of improved payments for low-volume hospitals** - Applies a percentage add-on for each Medicare discharge from a hospital more than 15 road miles from another like-kind hospital<sup>8</sup> that has fewer than 1,600 Medicare discharges during the fiscal year. The estimated cost is approximately \$200 million over ten years for a one year extension.
  - *Expires: March 31, 2014.*
- **Extension of Medicare Dependent Hospital Program** - Extends the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. A one year extension was previously scored by CBO as a 0.
  - *Expires: March 31, 2014.*
- **Extension of outpatient hold harmless provision** - Extends the outpatient hold harmless provision for those rural hospitals and Sole Community Hospitals ("SCHs") with 100 or fewer beds. The estimated cost is approximately \$200 million over ten years for a one year extension.
  - *Expired: December 31, 2012 for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2013 for SCHs with more than 100 beds.*
- **Hospital wage index improvement** - Extends reclassifications under Section 508 of the Medicare Modernization Act (P.L. 108-173). The estimated cost is approximately \$300 million over ten years for a one year extension.
  - *Expired: March 31, 2012.*
- **Extension of payment for the technical component of certain physician pathology services** -- Allows independent laboratories to bill Medicare directly for certain clinical laboratory services. The estimated cost is approximately \$100 million over ten years for a one year extension.
  - o *Expired: June 30, 2012.*

<sup>8</sup> This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

- **Extension of exceptions process for Medicare therapy caps** - Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately \$900 million over ten years for a one year extension.
  - *Expires: March 31, 2014.*
- **Extension of the work geographic index floor under the Medicare physician fee schedule** - Applies a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately \$600 million over ten years for a one year extension.
  - o *Expires: March 31, 2014.*
- **Extension of ambulance add-ons** - Implements a bonus payment for ground and air ambulance services in rural and other areas. The estimated cost is approximately \$100 million over ten years for a one year extension.
  - *Expires: March 31, 2014.*
- **Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities** - Extended Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007. The estimated cost is approximately \$200 million over ten years for a one-year extension.
  - *Expired: June 30, 2012.*
- **Extension of physician fee schedule mental health add-on** - Increased the payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent. The estimated cost is approximately \$100 million over ten years for a one year extension.
  - *Expired: February 29, 2012.*
- **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** - Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals. This provision was previously scored by CBO as a 0 for a one year extension.
  - *Expired: June 30, 2012.*
- **Extension of Community Health Integration Models** - Removed the cap on the number of eligible counties in a State. This provision was previously scored by CBO as a 0.
  - *Expired: September 30, 2012.*



**Statement of the Rural Hospital Coalition**

House Committee on Energy and Commerce  
Subcommittee on Health

"The Extenders Policies: What Are They and How Should They Continue Under a Permanent  
SGR Repeal Landscape?"

January 9, 2014

Submitted by Nancy Taylor  
On Behalf of the Rural Hospital Coalition  
202.331.3133

**Statement of the Rural Hospital Coalition**

House Committee on Energy and Commerce  
Subcommittee on Health

“The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?”

January 9, 2014

The Rural Hospital Coalition would like to thank Chairman Joe Pitts (R-PA), Ranking Member Frank Pallone (D-NJ), and other Members of the Health Subcommittee for holding a hearing on the Medicare extenders policies and for the opportunity to submit testimony on this important topic. The impact of these Medicare provider payment policies on rural beneficiaries, health care and communities cannot be understated. We strongly support the permanent extension of the Low Volume Hospital Adjustment and the Medicare Dependent Hospital Program at their current levels, as contained in the Senate Finance Committee bill passed out of Committee on December 12, 2013 (S. 1871). These two provisions go a long way to provide stability to health care services in rural communities around the country.

The Rural Hospital Coalition represents nearly one-fifth of all rural hospitals, with almost 200 facilities located across more than thirty states. Our hospitals are major drivers of many rural communities, providing jobs, revenue and the health care needed to keep rural Americans thriving. In many rural communities, rural hospitals serve as one of, if not *the*, largest employers. Rural hospitals can account for a full 20% of the revenue a rural community sees in a year. In addition, the existence of a high-quality hospital in a rural community is key to the economic development of that local community. A rural hospital is often a vital element in attracting investment and new employers to a rural community. Furthermore, a single hospital often serves as the sole provider of care for a community. Finally, rural Americans already earn significantly less than their urban counterparts, are more likely to live at or below the Federal poverty level, and are more likely to experience worse health overall<sup>1</sup>. Rural hospitals are therefore vital to the communities they serve.

Because rural hospitals serve residents who are less likely to have private health insurance or prescription drug coverage, these hospitals provide higher rates of uncompensated care than metropolitan facilities<sup>2</sup>. At the same time, rural hospitals generally see a greater share of patients on Medicaid than urban facilities<sup>3</sup> – a program that has historically paid less for hospital services than the actual costs associated with providing care<sup>4</sup>. And while Medicare payments to rural

---

<sup>1</sup> National Rural Health Association, What's Different about Rural Health Care?, <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>. Accessed December 26, 2013.

<sup>2</sup> Id.

<sup>3</sup> Rural Assistance Center, What are some challenges that rural hospitals face?, <http://www.raconline.org/topics/hospitals/faqs>. Accessed January 3, 2014.

<sup>4</sup> American Hospital Association, *Underpayment by Medicare and Medicaid: Fact Sheet*, December 2010, <http://www.aha.org/content/00-10/10medunderpayment.pdf>.

hospitals are also proportionally less than those paid to urban hospitals for the same services, the payment policies under consideration today help offset these and other challenges<sup>5</sup> faced by rural hospitals – such as recruitment and retention of physicians and other providers<sup>5</sup>. In short, rural hospitals must manage the same overhead and operating costs as larger urban facilities, but have less opportunity to spread and recover these costs, often forcing rural hospitals to scale back services. Allowing the current rural Medicare payment policies to expire would not only threaten to deprive rural Americans of their only point of access to local health care services, it would also potentially weaken the economic backbone of these and surrounding communities.

Of the Medicare payment policies expiring on March 31, 2014, the two policies that are of greatest importance to rural hospitals and their communities were recently estimated by the Congressional Budget Office ("CBO") to **cost just over \$4.2 billion over ten years for a permanent, but modified, extension** (see enclosed for the full list of Medicare extenders vital to rural hospitals). This ten-year cost estimate amounts to **less than 1% of the projected total Medicare spending next year alone**. Furthermore, while these provisions have only a miniscule impact on overall Medicare expenditures, they provide a much-needed lifeline to rural communities, the beneficiaries who live there, and to hospitals and communities across the country. Below we provide some background and additional detail on the two most critical Medicare extenders, which are scheduled to expire on March 31, 2014.

#### **Improved Payment for Low-Volume Hospitals**

The improved payment for low-volume hospitals applies a percentage add-on for each Medicare discharge from a hospital that is located 15 road miles or more from another hospital<sup>6</sup>, and has less than 1,600 Medicare discharges during a fiscal year. This provision affords qualifying hospitals an enhanced payment to account for the higher incremental costs associated with a low volume of discharges, as compared to the lower incremental costs incurred per patient at higher volume hospitals. The enhanced payment is not provided after a one-time qualification, but requires that a hospital provide sufficient evidence to demonstrate that it continually meets the discharges and distance requirements, ensuring that hospitals which do not consistently qualify for the payment are not unjustly enriched by a one-time qualifying discharge rate or distance measurement. The CBO estimates that a permanent extension of the low-volume adjustment – though modified – would cost roughly \$2.8 billion over ten years.

#### **Medicare Dependent Hospital Program**

The Medicare Dependent Hospital ("MDH") program dates back to 1987, and was "intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges."<sup>7</sup> Congress applied this designation to rural hospitals with 100 beds or fewer, not classified as an SCH, and having at least 60% of inpatient days or discharges covered by Medicare. As noted by the Medicare Payment Advisory Commission ("MedPAC"), a greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payments under PPS. Additionally, the

<sup>5</sup> Id.

<sup>6</sup> This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

<sup>7</sup> MedPAC, *Summary of Medicare's special payment provisions for rural providers and criteria for qualification*, June 2001, at 142.

MDH designation provides small rural hospitals assurance that if its caseload falls by more than 5 percent due to circumstances beyond its control, the MDH will receive such payments as necessary to cover fixed operating costs. This designation allows many rural hospitals to keep their doors open. This provision was extended under the Patient Protection and Affordable Care Act, and was then scored by CBO as a 0. In a more recent estimate of a modified permanent extension of the MDH program, CBO projected that the overall cost would be roughly \$1.4 billion over ten years.

In addition to these two payment policies, there are at least three additional payment policies that will expire on March 31, 2014. Another seven Medicare extenders have already expired, but had previously provided similar support to rural hospitals – a loss that these providers continue to feel. We hope that this testimony provides insight into the impact that these Medicare payment policies have on sustaining health care delivery in rural America. Thank you and we look forward to working with all Members on these important issues.



## Medicare Extenders

As providers of health care in America's rural communities, we have a special understanding of the adverse impact failure to pass these extenders would have on beneficiaries and the providers on which they depend. Below is a list of provisions that that have been addressed by Congress in the past.

- **Extension of improved payments for low-volume hospitals** - Applies a percentage add-on for each Medicare discharge from a hospital more than 15 road miles from another like-kind hospital<sup>8</sup> that has fewer than 1,600 Medicare discharges during the fiscal year. The estimated cost is approximately \$200 million over ten years for a one year extension.
  - *Expires: March 31, 2014.*
- **Extension of Medicare Dependent Hospital Program** - Extends the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. A one year extension was previously scored by CBO as a 0.
  - *Expires: March 31, 2014.*
- **Extension of outpatient hold harmless provision** - Extends the outpatient hold harmless provision for those rural hospitals and Sole Community Hospitals ("SCHs") with 100 or fewer beds. The estimated cost is approximately \$200 million over ten years for a one year extension.
  - *Expired: December 31, 2012 for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2013 for SCHs with more than 100 beds.*
- **Hospital wage index improvement** - Extends reclassifications under Section 508 of the Medicare Modernization Act (P.L. 108-173). The estimated cost is approximately \$300 million over ten years for a one year extension.
  - *Expired: March 31, 2012.*
- **Extension of payment for the technical component of certain physician pathology services** -- Allows independent laboratories to bill Medicare directly for certain clinical laboratory services. The estimated cost is approximately \$100 million over ten years for a one year extension.
  - o *Expired: June 30, 2012.*

<sup>8</sup> This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

- **Extension of exceptions process for Medicare therapy caps** - Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately \$900 million over ten years for a one year extension.
  - *Expires: March 31, 2014.*
- **Extension of the work geographic index floor under the Medicare physician fee schedule** - Applies a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately \$600 million over ten years for a one year extension.
  - o *Expires: March 31, 2014.*
- **Extension of ambulance add-ons** - Implements a bonus payment for ground and air ambulance services in rural and other areas. The estimated cost is approximately \$100 million over ten years for a one year extension.
  - *Expires: March 31, 2014.*
- **Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities** - Extended Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007. The estimated cost is approximately \$200 million over ten years for a one-year extension.
  - *Expired: June 30, 2012.*
- **Extension of physician fee schedule mental health add-on** - Increased the payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent. The estimated cost is approximately \$100 million over ten years for a one year extension.
  - *Expired: February 29, 2012.*
- **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** - Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals. This provision was previously scored by CBO as a 0 for a one year extension.
  - *Expired: June 30, 2012.*
- **Extension of Community Health Integration Models** - Removed the cap on the number of eligible counties in a State. This provision was previously scored by CBO as a 0.
  - *Expired: September 30, 2012.*



**Statement for the Record  
Federation of American Hospitals**

**U.S. House of Representatives  
Committee on Energy & Commerce  
Subcommittee on Health**

***Hearing On "The Extenders Policies: What Are They and How  
Should They Continue Under a Permanent SGR Repeal Landscape?"***

**Thursday, January 9, 2014**

**2123 Rayburn House Office Building**



January 9, 2014

The Honorable Joe Pitts  
 Chairman  
 Committee on Energy & Commerce  
 Subcommittee on Health  
 U.S. House of Representatives  
 Washington, DC 20515

The Honorable Frank Pallone  
 Ranking Member  
 Committee on Energy & Commerce  
 Subcommittee on Health  
 U.S. House of Representatives  
 Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone:

On behalf of AARP's 37 million members and the millions of Medicare beneficiaries, thank you for holding a hearing to examine and address the health care policies which are typically extended or reauthorized along with the regular sustainable growth rate (SGR) "doc fix". Over the past year, the Energy and Commerce Committee has done considerable work to permanently repeal the SGR formula and reform the Medicare provider reimbursement process. We greatly appreciate the work of the Committee, as well as the efforts of the Ways and Means and Senate Finance Committees. However, it is crucial that important health care policy extenders are included in a final SGR bill. Two policies, in particular, are necessary to ensure that Medicare beneficiaries can maintain access to needed services.

Qualifying Individual (QI) Program

We support the extension of the QI program to help low-income Medicare beneficiaries afford Medicare Part B premiums. The QI program pays Part B premiums for beneficiaries with incomes between 120% and 135% of the Federal Poverty Line (FPL) - about \$13,700 to \$15,300 - and less than \$7,080 in assets for an individual. Most Medicare beneficiaries pay a monthly Part B premium of \$104.90, an out-of-pocket cost that low-income QI recipients cannot afford. This program has consistently been extended for periods in concert with SGR extensions. We urge the Committee to make the QI program permanent as part of SGR reform legislation.

Medicare Payment for Therapy Services

Medicare therapy caps serve as a significant barrier to accessing needed care for people with long-term, chronic conditions, most notably for those who require long-term therapy services. Today, Medicare coverage for outpatient therapy services -- including physical, speech-language pathology, and occupational care -- is limited through arbitrary per-beneficiary payment caps imposed by the Budget Control Act of 1997. In 2005, Congress developed an exceptions process that allows people with Medicare to receive Medicare-covered therapy services above the cap when medically necessary. We urge Congress to repeal the Medicare therapy caps as part of an SGR reform package to ensure access to

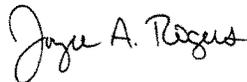
needed care for older adults and people with disabilities. In the absence of full repeal, we ask that Congress make the therapy cap exceptions process permanent.

The Senate Finance Committee-approved SGR legislation included a provision repealing therapy caps and replacing it with a focused medical review and prior authorization process. The review as to medical necessity and prior authorization could be focused on any of a number of factors, such as outlier patterns of use, questionable billing, and the presence of medical conditions. We support repealing the therapy cap, as it will allow beneficiaries to continue accessing needed therapy services. This approach represents a significant advancement that we hope will serve as the basis for a permanent reform of the therapy caps and exceptions process as part of a broader SGR repeal and replacement legislation.

However, we believe that any prior authorization policy should include an appeals mechanism for instances where prior authorization is not granted. In addition, we are concerned that basing medical review or prior authorization merely on the presence of "medical conditions", as opposed to post-surgical conditions, might result in effectively overturning the recent court settlement (*Jimmo vs. Sebelius*) which prohibits the application of an "improvement standard" to Medicare coverage of rehabilitation therapy and other skilled services. While this may not be the intent of this factor, in order to prevent it from having this effect, we suggest that any language specifically preclude the application of focused medical review or prior authorization in such a way as to impose an improvement standard on the use of rehabilitation therapy.

As the Committee finalizes SGR reform legislation, it is imperative to remember that the typical Medicare beneficiary lives on less than \$22,500 per year, and already spends nearly 17 percent of their income on health care expenses. These health extenders ensure that beneficiaries have access to needed services. Therefore, our endorsement of any final SGR reform legislation will depend on how Congress addresses offsets and extenders. We are confident that Medicare reimbursement can be reformed in a way which does not increase the financial burden on those who depend on the program. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at [agonzalez@aarp.org](mailto:agonzalez@aarp.org) or 202-434-3770.

Sincerely,



Joyce A. Rogers  
Senior Vice President  
Government Affairs

October 22, 2013

The Honorable John Boehner  
Speaker of the House  
U.S. House of Representatives  
Washington, D.C. 20515

The Honorable Nancy Pelosi  
Democratic Leader  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Speaker Boehner and Democratic Leader Pelosi,

We write to ask for your continued support for the Special Diabetes Program (SDP), which is improving the lives of 26 million Americans who have diabetes and yielding a real return on the federal investment. Diabetes costs our nation over \$245 billion annually, a staggering 41 percent increase from 2007. It is also the leading cause of kidney failure, non-traumatic amputations, and blindness and a major cause of heart disease and stroke. Americans with diabetes incur medical expenses that are 2.3 times higher than those incurred by those without diabetes.

The National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) announced recently that type 1 diabetes among American youth (people under age 20) rose by 23 percent between 2001 and 2009. At this rate, type 1 diabetes will double every generation.

While the growth in these statistics is alarming, the Special Diabetes Program is making meaningful progress in research studies and human clinical trials that are accelerating progress towards curing, treating, and preventing type 1 diabetes. A few of the SDP research achievements that are improving lives and will ultimately yield significant savings to our nation's health care system include:

- Artificial pancreas (AP) technologies, which would help people to better manage their blood sugar levels and avoid long-term and costly complications, are being tested in outpatient human clinical trials approved by the Food and Drug Administration (FDA), and are closer to being on the market. A recent study estimates the use of AP technology in working age adults who have T1D will result in nearly \$1 billion in savings to Medicare over 25 years.
- The discovery that 6.5 years of intensive blood glucose control can cut in half the onset of impaired kidney function in T1D patients. This finding will enable steps to be taken well in advance to avoid end-stage renal disease (ESRD), and save Medicare over \$126 billion over 25 years. Diabetes is the leading cause of ESRD.
- A treatment that reached the market last year preserves and even improves vision in people who have diabetic eye disease. This advance makes the difference between being able to see well enough to drive or hold a job – or not – and carry out other daily activities.
- Immune therapy drugs have slowed the immune attack for approximately one year in patients newly diagnosed with type 1 diabetes. Patients required less insulin and had improved glucose control for a period of time.

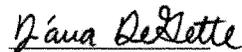
A continued investment in SDP will allow key clinical trials to continue without interruption, such as building on our understanding of the genetic underpinnings and environmental triggers of type 1 diabetes so the disease can be prevented altogether.

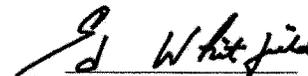
The Special Diabetes Program is also making a tremendous difference in the health of American Indians and Alaska Natives (AI/AN), who are burdened disproportionately with type 2 diabetes at a rate of 2.8 times the national average. In these communities, the program has increased significantly the availability of diabetes prevention and treatment services for those with diabetes. These increased services have translated into remarkable improvements in diabetes care including:

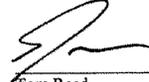
- The Special Diabetes Program for Indians (SDPI) supported the first large-scale national evaluation of the effectiveness of lifestyle interventions on diabetes incidence in diverse AI/AN communities. This demonstration project successfully translated the landmark Diabetes Prevention Program clinical trial conducted by the NIH into the real world of tribal communities.
- The average blood sugar level, as measured by the hemoglobin A1C test, decreased from 9.0 percent in 1996 to 8.1 percent in 2010. Every percentage point drop in A1C results can reduce risk of eye, kidney, and nerve complications by 40 percent.
- Average low-density lipoprotein (LDL) cholesterol, which is associated with multiple health problems, declined from 118 mg/dL in 1998 to 94 mg/dL in 2011. Improved control of LDL cholesterol can reduce cardiovascular complications by 20-50 percent.
- Between 1995 and 2006, the incident rate of End-Stage Renal Disease in AI/AN people with diabetes fell by nearly 28 percent – a greater decline than any other racial or ethnic group. Given that Medicare costs per year for one patient on hemodialysis were approximately \$82,000 in 2009, this reduction in new cases of ESRD means a decrease in the number of patients requiring dialysis, translating into millions of dollars in cost savings for Medicare, the Indian Health Service, and other third party payers.

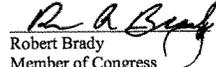
These are only a few of the many developments that are the result of the SDP. The groundbreaking discoveries made possible by the SDP are already improving diabetes care for the 26 million Americans combating the disease in ways that will reduce long-term health expenditures for costly diabetes complications. We are pleased that this program has received such overwhelming bipartisan support in the past and we look forward to working with you in the future to ensure the Special Diabetes Program can capitalize on the significant achievements to date and explore the opportunities that remain ahead.

Sincerely,

  
Diana DeGette  
Member of Congress

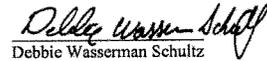
  
Ed Whitfield  
Member of Congress

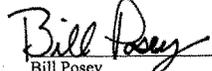
  
Tom Reed  
Member of Congress

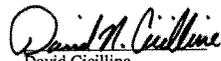
  
Robert Brady  
Member of Congress

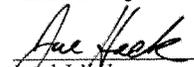
  
Rick Larsen  
Member of Congress

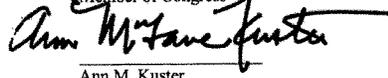
  
Lou Barletta  
Member of Congress

  
Debbie Wasserman Schultz  
Member of Congress

  
Bill Posey  
Member of Congress

  
David Cicilline  
Member of Congress

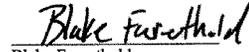
  
Joseph J. Heck  
Member of Congress

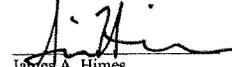
  
Ann M. Kuster  
Member of Congress

  
Xavier Becerra  
Member of Congress

  
Donald M. Payne, Jr.  
Member of Congress

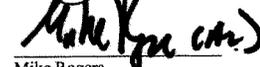
  
James R. Langevin  
Member of Congress

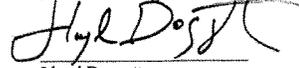
  
Blake Farenthold  
Member of Congress

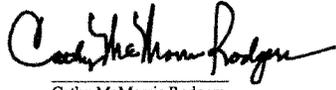
  
James A. Himes  
Member of Congress

  
Glenn Thompson  
Member of Congress

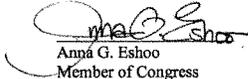
  
James B. Renacci  
Member of Congress

  
Mike Rogers  
Member of Congress

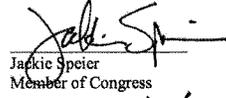
  
Lloyd Doggett  
Member of Congress



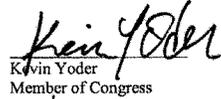
Cathy McMorris Rodgers  
Member of Congress



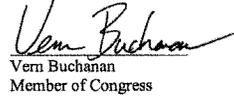
Anna G. Eshoo  
Member of Congress



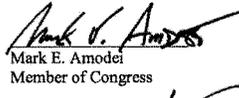
Jackie Speier  
Member of Congress



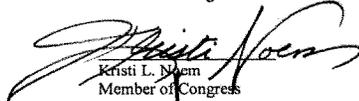
Kevin Yoder  
Member of Congress



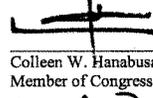
Vern Buchanan  
Member of Congress



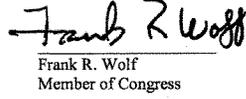
Mark E. Amodei  
Member of Congress



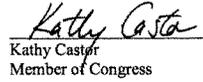
Kristi L. Noem  
Member of Congress



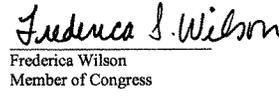
Colleen W. Hanabusa  
Member of Congress



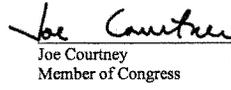
Frank R. Wolf  
Member of Congress



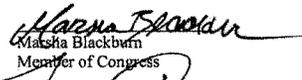
Kathy Castor  
Member of Congress



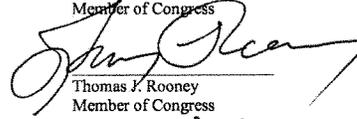
Frederica Wilson  
Member of Congress



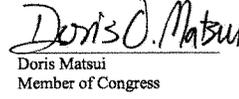
Joe Courtney  
Member of Congress



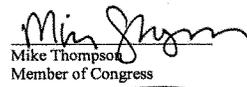
Marsha Blackburn  
Member of Congress



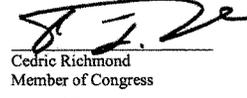
Thomas J. Rooney  
Member of Congress



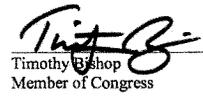
Doris Matsui  
Member of Congress



Mike Thompson  
Member of Congress



Cedric Richmond  
Member of Congress



Timothy Bishop  
Member of Congress

*Gregg Harper*

Gregg Harper  
Member of Congress

*Pete Olson*

Pete Olson  
Member of Congress

*Mark Pocan*

Mark Pocan  
Member of Congress

*William R. Keating*

William R. Keating  
Member of Congress

*Suzan K. DelBene*

Suzan K. DelBene  
Member of Congress

*Richard Hanna*

Richard Hanna  
Member of Congress

*Steve Stockman*

Steve Stockman  
Member of Congress

*Ann Kirkpatrick*

Ann Kirkpatrick  
Member of Congress

*Steven Palazzo*

Steven Palazzo  
Member of Congress

*Brett Guthrie*

Brett Guthrie  
Member of Congress

*David McKinley*

David McKinley  
Member of Congress

*Kurt Schrader*

Kurt Schrader  
Member of Congress

*Bradley S. Schneider*

Bradley S. Schneider  
Member of Congress

*Donna Edwards*

Donna Edwards  
Member of Congress

*Tim Murphy*

Tim Murphy  
Member of Congress

*Daniel T. Kildee*

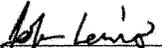
Daniel T. Kildee  
Member of Congress

*Ben Ray Lujan*

Ben Ray Lujan  
Member of Congress

*Peter T. King*

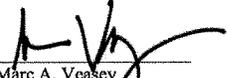
Peter T. King  
Member of Congress

  
John Lewis  
Member of Congress

  
John Yarmuth  
Member of Congress

  
Gus Bilirakis  
Member of Congress

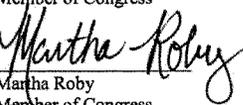
  
John Carter  
Member of Congress

  
Marc A. Veasey  
Member of Congress

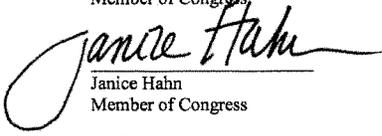
  
Paul Tonko  
Member of Congress

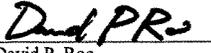
  
Gerry E. Connolly  
Member of Congress

  
Rence L. Eilers  
Member of Congress

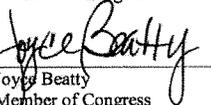
  
Martha Roby  
Member of Congress

  
Michael F. Doyle  
Member of Congress

  
Janice Hahn  
Member of Congress

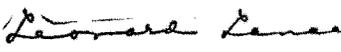
  
David P. Roe  
Member of Congress

  
Scott DesJarlais  
Member of Congress

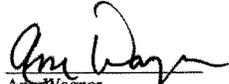
  
Joyce Beatty  
Member of Congress

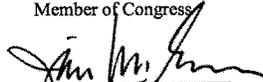
  
Gregorio Kilili Camacho Sablan  
Member of Congress

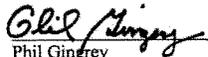
  
Denny Heck  
Member of Congress

  
Leonard Lance  
Member of Congress

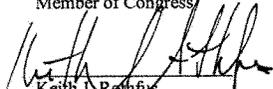
  
Alan Grayson  
Member of Congress

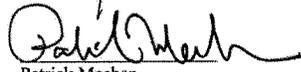
  
Ann Wagner  
Member of Congress

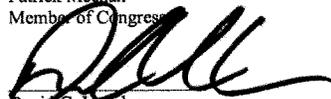
  
James P. McGovern  
Member of Congress

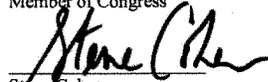
  
Phil Gingrey  
Member of Congress

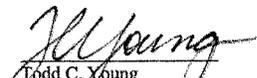
  
Eric Swalwell  
Member of Congress

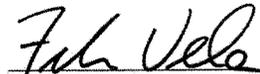
  
Keith J. Rothfus  
Member of Congress

  
Patrick Meahan  
Member of Congress

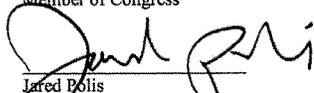
  
David G. Valadao  
Member of Congress

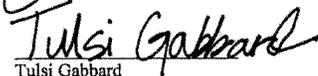
  
Steve Cohen  
Member of Congress

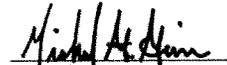
  
Todd C. Young  
Member of Congress

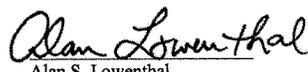
  
Filmon Vela  
Member of Congress

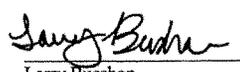
  
Suzanne Bonamici  
Member of Congress

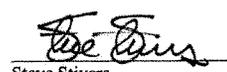
  
Jared Polis  
Member of Congress

  
Tulsi Gabbard  
Member of Congress

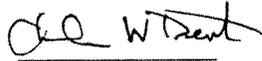
  
Michael Grimm  
Member of Congress

  
Alan S. Lowenthal  
Member of Congress

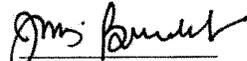
  
Larry Bucshon  
Member of Congress

  
Steve Stivers  
Member of Congress

  
Cheri Bustos  
Member of Congress



Charles W. Dent  
Member of Congress



Julia Brownley  
Member of Congress



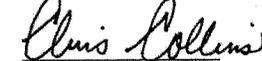
Theodore Deutch  
Member of Congress



Ron Barber  
Member of Congress



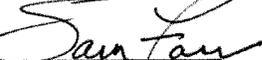
Jim McDermott  
Member of Congress



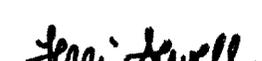
Chris Collins  
Member of Congress



Roger Williams  
Member of Congress



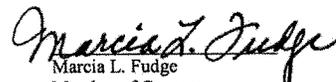
Sam Farr  
Member of Congress



Terri Sewell  
Member of Congress



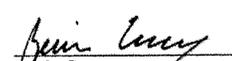
Devin Nunes  
Member of Congress



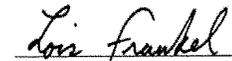
Marcia L. Fudge  
Member of Congress



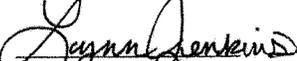
Keith Ellison  
Member of Congress



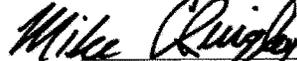
Kevin Cramer  
Member of Congress



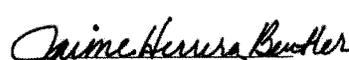
Lois Frankel  
Member of Congress



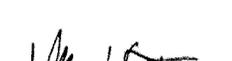
Lynn Jenkins  
Member of Congress



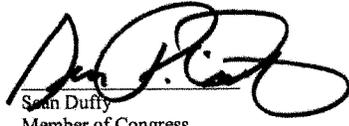
Mike Quigley  
Member of Congress



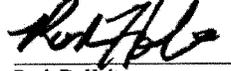
Jaime Herrera Beutler  
Member of Congress



Doc Hastings  
Member of Congress



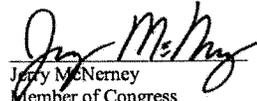
Sean Duffy  
Member of Congress



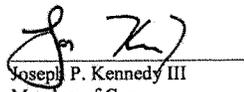
Rush D. Holt  
Member of Congress



Adam Kinzinger  
Member of Congress



Jerry McNerney  
Member of Congress



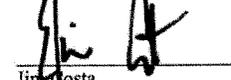
Joseph P. Kennedy III  
Member of Congress



Ed Perlmutter  
Member of Congress



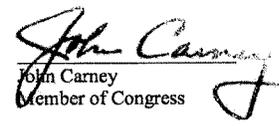
Sander M. Levin  
Member of Congress



Jim Costa  
Member of Congress



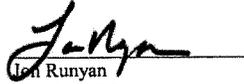
Chellie Pingree  
Member of Congress



John Carney  
Member of Congress



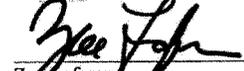
Matthew Cartwright  
Member of Congress



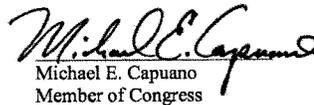
Jon Runyan  
Member of Congress



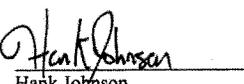
Robert J. Wiaman  
Member of Congress



Zoe Lofgren  
Member of Congress



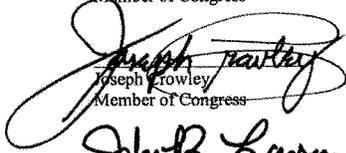
Michael E. Capuano  
Member of Congress



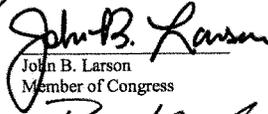
Hank Johnson  
Member of Congress



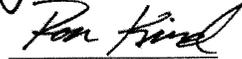
Derek Kilmer  
Member of Congress



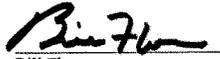
Joseph Crowley  
Member of Congress



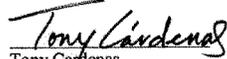
John B. Larson  
Member of Congress



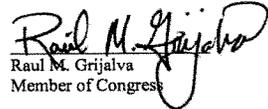
Ron Kind  
Member of Congress



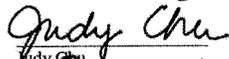
Bill Flores  
Member of Congress



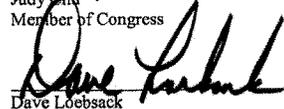
Tony Cardenas  
Member of Congress



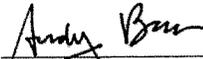
Raul M. Grijalva  
Member of Congress



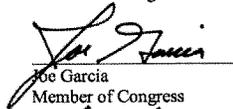
Judy Chu  
Member of Congress



Dave Loebsack  
Member of Congress



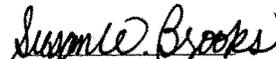
Garland "Andy" Barr  
Member of Congress



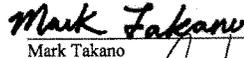
Joe Garcia  
Member of Congress



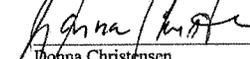
Earl Blumenauer  
Member of Congress



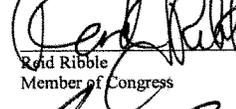
Susan Brooks  
Member of Congress



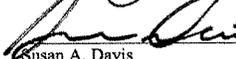
Mark Takano  
Member of Congress



Donna Christensen  
Member of Congress



Reid Ribble  
Member of Congress

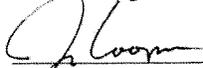


Susan A. Davis  
Member of Congress

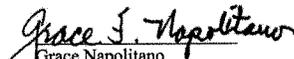


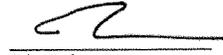
Carol Shea-Porter  
Member of Congress

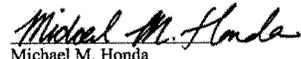
  
William Cassidy  
Member of Congress

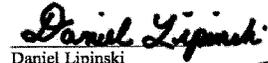
  
Jim Cooper  
Member of Congress

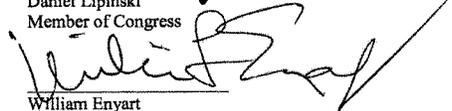
  
Juan Vargas  
Member of Congress

  
Grace Napolitano  
Member of Congress

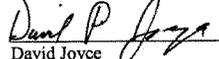
  
John Delaney  
Member of Congress

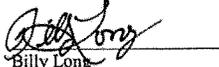
  
Michael M. Honda  
Member of Congress

  
Daniel Lipinski  
Member of Congress

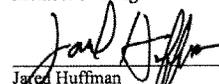
  
William Enyart  
Member of Congress

  
Michael H. Michaud  
Member of Congress

  
David Joyce  
Member of Congress

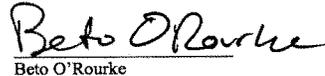
  
Billy Long  
Member of Congress

  
Niki Tsongas  
Member of Congress

  
Jared Huffman  
Member of Congress

  
Rick Crawford  
Member of Congress

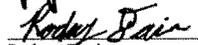
  
Betty McCollum  
Member of Congress

  
Beto O'Rourke  
Member of Congress

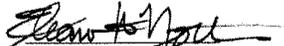
  
Timothy Walz  
Member of Congress

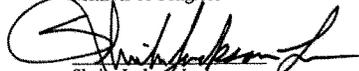
  
Bruce Braley  
Member of Congress

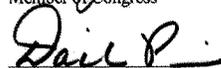
  
John Dingell  
Member of Congress

  
Rodney Davis  
Member of Congress

  
Mike McIntyre  
Member of Congress

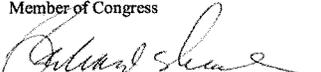
  
Eleanor Holmes Norton  
Member of Congress

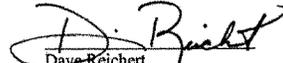
  
Sheila Jackson Lee  
Member of Congress

  
David E. Price  
Member of Congress

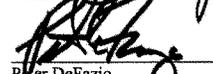
  
Al Green  
Member of Congress

  
George Miller  
Member of Congress

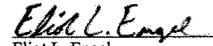
  
Richard E. Neal  
Member of Congress

  
Dave Reichert  
Member of Congress

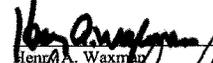
  
Blaine Luetkemeyer  
Member of Congress

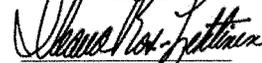
  
Peter DeFazio  
Member of Congress

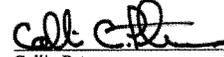
  
Danny K. Davis  
Member of Congress

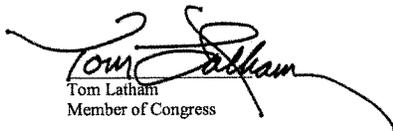
  
Eliot L. Engel  
Member of Congress

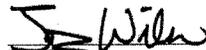
  
Howard Coble  
Member of Congress

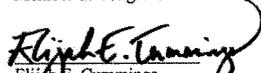
  
Henry A. Waxman  
Member of Congress

  
Ileana Ros-Lehtinen  
Member of Congress

  
Collin Peterson  
Member of Congress

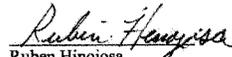
  
Tom Latham  
Member of Congress

  
Joe Wilson  
Member of Congress

  
Elijah E. Cummings  
Member of Congress

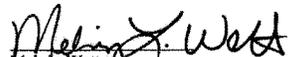
  
James P. Moran  
Member of Congress

  
Brad Sherman  
Member of Congress

  
Ruben Hinojosa  
Member of Congress

  
Barbara Lee  
Member of Congress

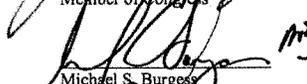
  
Ken Calvert  
Member of Congress

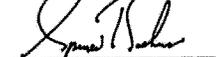
  
Melvin Watt  
Member of Congress

  
Jose E. Serrano  
Member of Congress

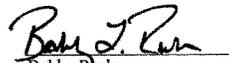
  
Lois Capps  
Member of Congress

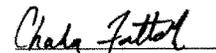
  
John F. Tierney  
Member of Congress

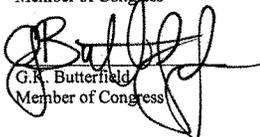
  
Michael S. Burgess  
Member of Congress

  
Spencer Bachus  
Member of Congress

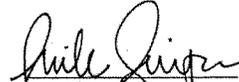
  
Robert E. Andrews  
Member of Congress

  
Bobby Rush  
Member of Congress

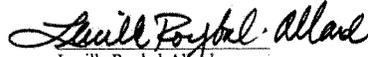
  
Chaka Fattah  
Member of Congress

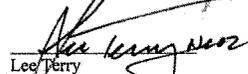
  
G.K. Butterfield  
Member of Congress

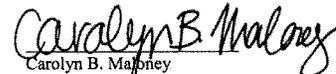
  
Nick J. Rahall II  
Member of Congress

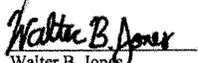
  
Mike Simpson  
Member of Congress

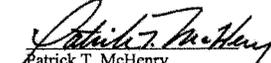
  
Don Young  
Member of Congress

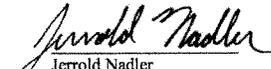
  
Lucille Roybal-Allard  
Member of Congress

  
Lee Terry  
Member of Congress

  
Carolyn B. Maloney  
Member of Congress

  
Walter B. Jones  
Member of Congress

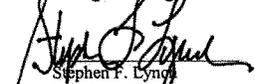
  
Patrick T. McHenry  
Member of Congress

  
Jerrold Nadler  
Member of Congress

  
Corrine Brown  
Member of Congress

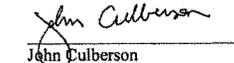
  
Carolyn McCarthy  
Member of Congress

  
Steve Israel  
Member of Congress

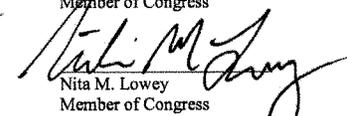
  
Stephen F. Lynch  
Member of Congress

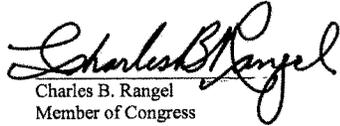
  
Gary W. Miller  
Member of Congress

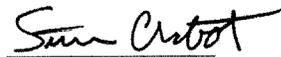
  
Yvette Clarke  
Member of Congress

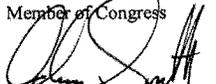
  
John Culberson  
Member of Congress

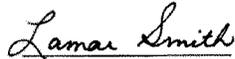
  
Alcee Hastings  
Member of Congress

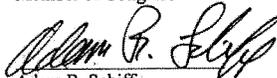
  
Nita M. Lowey  
Member of Congress

  
Charles B. Rangel  
Member of Congress

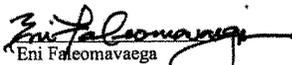
  
Steve Chabot  
Member of Congress

  
Adam Smith  
Member of Congress

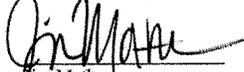
  
Lamar Smith  
Member of Congress

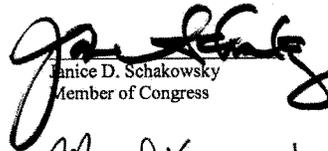
  
Adam B. Schiff  
Member of Congress

  
C.A. Dutch Ruppersberger  
Member of Congress

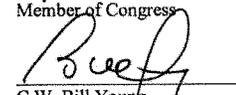
  
Eni Faleomavaega  
Member of Congress

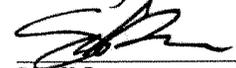
  
Frank A. LoBiondo  
Member of Congress

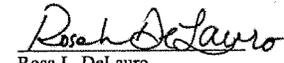
  
Jim Matheson  
Member of Congress

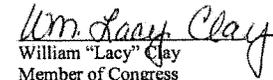
  
Janice D. Schakowsky  
Member of Congress

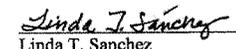
  
Michael G. Fitzpatrick  
Member of Congress

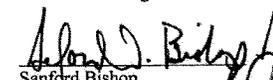
  
C.W. Bill Young  
Member of Congress

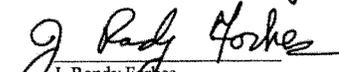
  
Scott H. Peters  
Member of Congress

  
Rosa L. DeLauro  
Member of Congress

  
William "Lacy" Clay  
Member of Congress

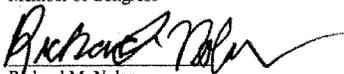
  
Linda T. Sanchez  
Member of Congress

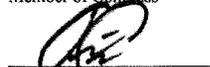
  
Sanford Bishop  
Member of Congress

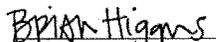
  
J. Randy Forbes  
Member of Congress

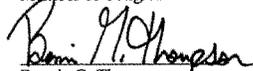
  
John Garamendi  
Member of Congress

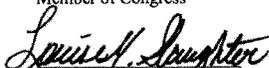
  
Jim Gerlach  
Member of Congress

  
Richard M. Nolan  
Member of Congress

  
Andre Carson  
Member of Congress

  
Brian Higgins  
Member of Congress

  
Bennie G. Thompson  
Member of Congress

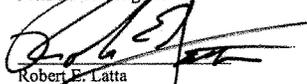
  
Louise McIntosh Slaughter  
Member of Congress

  
Robert Aderholt  
Member of Congress

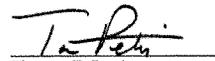
  
Rob Bishop  
Member of Congress

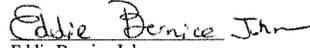
  
Madeleine Z. Bordallo  
Member of Congress

  
Shelley Moore Capito  
Member of Congress

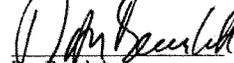
  
Robert E. Latta  
Member of Congress

  
Tom Cole  
Member of Congress

  
Thomas E. Petri  
Member of Congress

  
Eddie Bernice Johnson  
Member of Congress

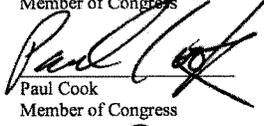
  
Gene Green  
Member of Congress

  
Dan Boren  
Member of Congress

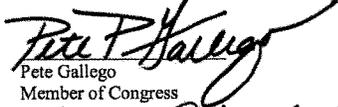
  
Mo Brooks  
Member of Congress

  
Joaquin Castro  
Member of Congress

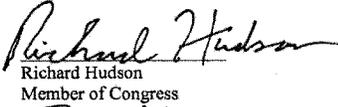
  
Michael Conaway  
Member of Congress

  
Paul Cook  
Member of Congress

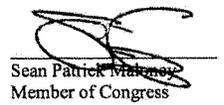
  
Mario Diaz-Balart  
Member of Congress

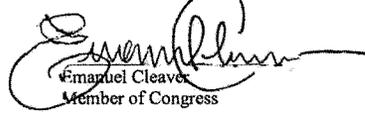
  
Pete Gallego  
Member of Congress

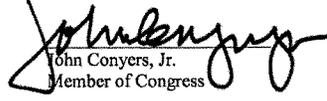
  
Vicky Hartzler  
Member of Congress

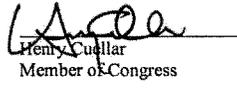
  
Richard Hudson  
Member of Congress

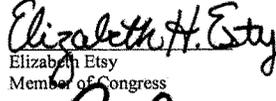
  
Doug LaMalfa  
Member of Congress

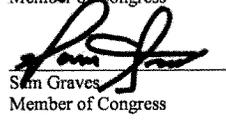
  
Sean Patrick Maloney  
Member of Congress

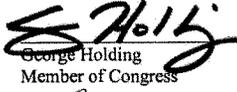
  
Emanuel Cleaver  
Member of Congress

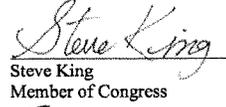
  
John Conyers, Jr.  
Member of Congress

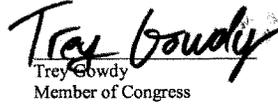
  
Henry Cuellar  
Member of Congress

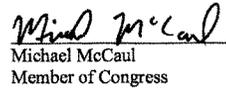
  
Elizabeth H. Esty  
Member of Congress

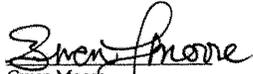
  
Sam Graves  
Member of Congress

  
George Holding  
Member of Congress

  
Steve King  
Member of Congress

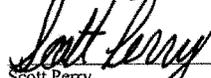
  
Trey Gowdy  
Member of Congress

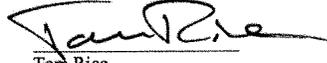
  
Michael McCaul  
Member of Congress

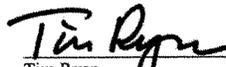
  
Gwen Moore  
Member of Congress

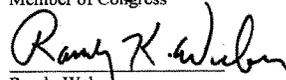
  
Mark Meadows  
Member of Congress

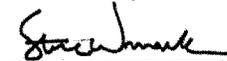
  
Bill Owens  
Member of Congress

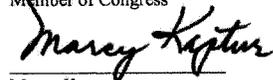
  
Scott Perry  
Member of Congress

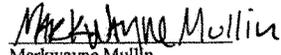
  
Tom Rice  
Member of Congress

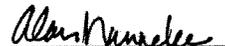
  
Tim Ryan  
Member of Congress

  
Randy Weber  
Member of Congress

  
Steve Womack  
Member of Congress

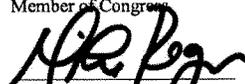
  
Marcy Kaptur  
Member of Congress

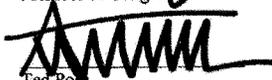
  
Markwayne Mullin  
Member of Congress

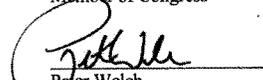
  
Alan Nunnelee  
Member of Congress

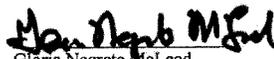
  
Steve Pearce  
Member of Congress

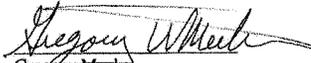
  
Gary Peters  
Member of Congress

  
Mike Rogers  
Member of Congress

  
Ted Poe  
Member of Congress

  
Peter Welch  
Member of Congress

  
Gloria Negrete McLeod  
Member of Congress

  
Gregory Meeks  
Member of Congress

Pat Tiberi  
Patrick J. Tiberi  
Member of Congress

Duncan Hunter  
Duncan Hunter  
Member of Congress

Kenny Marchant  
Kenny Marchant  
Member of Congress

Dina Titus  
Dina Titus  
Member of Congress

Tim Walberg  
Tim Walberg  
Member of Congress

Raúl R. Labrador  
Raúl Labrador  
Member of Congress

Garner Schoon  
Garner Schoon  
Member of Congress

Robert C. "Bobby" Scott  
Robert C. "Bobby" Scott  
Member of Congress

Nydia Velaquez  
Nydia Velaquez  
Member of Congress

Bill Pascrell, Jr.  
Bill Pascrell, Jr.  
Member of Congress

Jack Kingston  
Jack Kingston  
Member of Congress

Steven Horsford  
Steven Horsford  
Member of Congress

Allyson Waters  
Allyson Waters  
Member of Congress

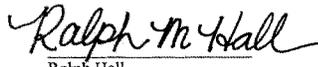
John Sarbanes  
John Sarbanes  
Member of Congress

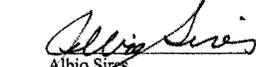
Chuck Fleischmann  
Chuck Fleischmann  
Member of Congress

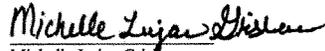
David Scott  
David Scott  
Member of Congress

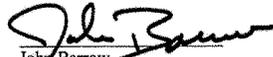
Patrick E. Murphy  
Patrick Murphy  
Member of Congress

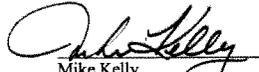
Robert Pittenger  
Robert Pittenger  
Member of Congress

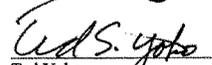
  
Ralph Hall  
Member of Congress

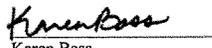
  
Albio Sires  
Member of Congress

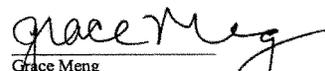
  
Michelle Lujan Grisham  
Member of Congress

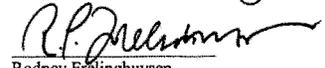
  
John Barrow  
Member of Congress

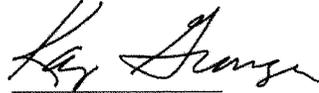
  
Mike Kelly  
Member of Congress

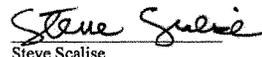
  
Ted Yoho  
Member of Congress

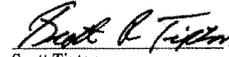
  
Karen Bass  
Member of Congress

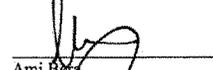
  
Grace Meng  
Member of Congress

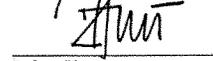
  
Rodney Frelinghuysen  
Member of Congress

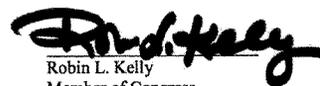
  
Kay Granger  
Member of Congress

  
Steve Scalise  
Member of Congress

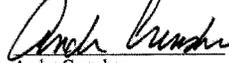
  
Scott Tipton  
Member of Congress

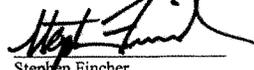
  
Ami Bera  
Member of Congress

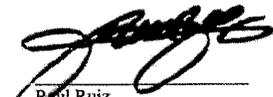
  
Robert Hurt  
Member of Congress

  
Robin L. Kelly  
Member of Congress

  
Bill Foster  
Member of Congress

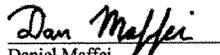
  
Ander Crenshaw  
Member of Congress

  
Stephen Fincher  
Member of Congress



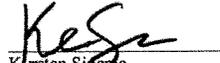
---

Paul Ruiz  
Member of Congress



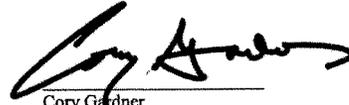
---

Dan Maffei  
Daniel Maffei  
Member of Congress



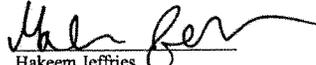
---

Kirsten Sinema  
Member of Congress



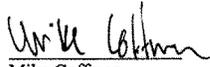
---

Cory Gardner  
Member of Congress

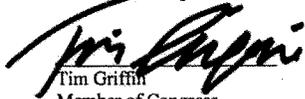


---

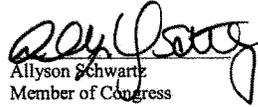
Hakeem Jeffries  
Member of Congress



Mike Coffman  
Member of Congress



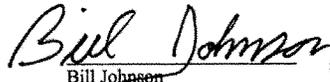
Tim Griffin  
Member of Congress



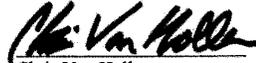
Allyson Schwartz  
Member of Congress



Chris Gibson  
Member of Congress



Bill Johnson  
Member of Congress



Chris Van Hollen  
Member of Congress

November 19, 2013

The Honorable Fred Upton  
Chairman  
Committee on Energy & Commerce  
United States House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Henry Waxman  
Ranking Member  
Committee on Energy & Commerce  
United States House of Representatives  
2322A Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

We are writing to urge swift congressional action this year to extend Medicare Chronic Care Special Needs Plans (C-SNPs) for the hundreds of thousands of chronically-ill beneficiaries who depend upon them. Our organizations represent patients suffering from heart disease, diabetes, kidney disease, depression, and dementia. We support programs targeted to the special needs of our patient populations, and believe that extending current C-SNP authority is the best way to ensure stable and predictable coverage for the most vulnerable beneficiaries.

C-SNPs focus on one chronic disease or condition that CMS has identified as being particularly prevalent and high-cost for the Medicare population. This targeted approach to disease has served as the incubator for innovation and advanced specialty care across the spectrum of targeted chronic conditions, including diabetes, congestive heart failure (CHF), end-stage renal disease (ESRD), chronic obstructive pulmonary disease (COPD), severe and persistent mental illness (SPMI), and HIV/AIDS. Recent data suggest that C-SNPs serve vulnerable populations that have historically been underserved – and can help reduce health disparities.<sup>1</sup> These beneficiaries are more likely to belong to minority populations and to be single or widowed than individuals enrolled in standard Medicare Advantage plans.

In addition to the conditions targeted by C-SNPs today, the C-SNP model can be expanded to concentrate on other high-cost, high-prevalence conditions for the Medicare population. For example, C-SNPs offer the possibility of care coordination interventions that take into account the needs of patients with dementia and their caregivers. Individuals with Alzheimer's Disease and related dementias confront unique challenges, both in executing activities of daily living and in treating other co-morbidities. C-SNPs can make comprehensive, patient-centered care available to such populations, ideally reducing the high costs of institutionalization that otherwise so often occurs.

More than 276,000 seniors and disabled beneficiaries have voluntarily enrolled in a Medicare C-SNP, where they receive specialized, highly-personalized care with customized benefits not available

---

<sup>1</sup> Cohen, R., Lemieux, J., Schoenborn, J., Mulligan, T. "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients." *Health Affairs*. January 2012 31:1110-119.

anywhere else in Medicare. These benefits include expanded access to specialty providers, free transportation to doctors' appointments, zero co-payments for specific treatments and medications, more generous coverage of high-cost specialty drugs, and intensive case-management services. If authority for C-SNPs is allowed to expire, hundreds of thousands of vulnerable beneficiaries will have their care disrupted, and opportunities for new classes of beneficiaries to benefit from this model will be lost – with no guarantee that standard Medicare Advantage plans will offer the same level of benefits, unique interventions, or specialized care. Unfortunately, it would be financially impossible to provide such specialized benefit packages in a regular Medicare Advantage plan, since under current law, these plans would be required to extend these benefits to each and every beneficiary – regardless of their health status.

Compared to traditional Medicare, many disease management programs offered by specialized C-SNPs have demonstrated superior results for patients. According to the 2012 SNP Alliance Profile Summary, C-SNPs that focus on diabetes have reduced inpatient hospitalizations by nine percent, while C-SNPs targeting CHF reduced these incidents by more than 30 percent.<sup>2</sup> Other examples include:

- One C-SNP achieved a 50 percent reduction in inpatient admissions in five months, the result of designating a case manager and nurse practitioner to receive referrals from persons with diabetes in lieu of emergency room visits.<sup>3</sup>
- Another plan achieved a 56 percent reduction in hospital admissions in three months for CHF patients by equipping each with a wireless scale that alerted clinicians of excessive weight gain and triggered same-day visits.<sup>4</sup>
- A C-SNP targeting mental illness achieved a 60 percent reduction in inpatient admissions for beneficiaries with SPMI through unlimited access to psychiatrists with an SPMI subspecialty, and assignment of other providers with no cost-sharing.<sup>5</sup>

Our organizations recognize that some improvements to C-SNPs may be helpful to improve Medicare beneficiaries' access to high-quality C-SNPs. However, we don't believe that ending the program is the answer. It is imperative that this model be allowed to continue to fuel the innovations in care and disease management that ultimately benefit the entire system until authority is available to managed care plans to provide enhanced benefit designs to cater to specific populations. We urge Congress to extend the authorization of C-SNPs so that our most vulnerable Medicare beneficiaries retain access to high-quality plans that are so effectively managing their care.

Sincerely,

Alzheimer's Association  
American Heart Association  
National Kidney Foundation

<sup>2</sup> "SNP Alliance Survey Continues to Show High Performance: Highlights of the 2012 Survey," SNP Alliance, April 2013.

<sup>3</sup> "SNP Alliance Position on MedPAC Reauthorization Recommendations," SNP Alliance, December 2012.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*

## Statement

On behalf of Genesis HealthCare LLC  
Subcommittee on Health, Energy and Commerce Committee  
U.S. House of Representatives  
Hearing on Medicare Extenders  
January 9, 2014

On behalf of Genesis HealthCare, LLC and its subsidiaries, Genesis Rehabilitation Services and Genesis Physician Services, we appreciate this opportunity to provide input to the Subcommittee regarding legislation to extend certain expiring provisions of the Medicare law. Genesis HealthCare LLC (Genesis) is a leading provider of post-acute and long term care services headquartered in Kennett Square, Pennsylvania. Through our rehabilitation and recuperative support programs we facilitate the transitions from acute care and from the skilled nursing setting back to the community.<sup>1</sup>

Our primary focus is with regard to the expiring provisions impacting the delivery of skilled rehabilitation services under Medicare Part B and their impact on our abilities to meet the restorative and recuperative care of post-acute Medicare beneficiary. We urge the committee to expeditiously:

- ***Extend the Medicare Part B therapy exceptions process until Medicare Part B Therapy caps are repealed.*** Section 1103 of the Bipartisan Budget Act of 2013 extends the Medicare Part B therapy cap exceptions process through March 31, 2014. Clinical experiences underscore that the Medicare Part B therapy caps deter medically necessary therapy interventions, shift costs to beneficiaries, increase lengths of stay, and exacerbate re-hospitalization. While we are hopeful that the 113<sup>th</sup> Congress will address the underlying failures of therapy caps, it is essential that Congress continue the therapy cap exceptions process while efforts move forward to repeal these arbitrary caps. Failure to act expeditiously shifts the costs of medically necessary therapy services

---

<sup>1</sup> On a daily basis, we meet the health services and shelter needs of nearly 50,000 residents. Assisting us in our care focus is our subsidiaries, Genesis Rehabilitation Services (GRS) and Genesis Physician Services (GPS). The over 15,000 professionals employed by GRS not only meet the needs of the GHC centers, but also provides physical therapy, speech-language pathology and occupational therapy services under contract to 1,600 locations spread across 44 states and the District of Columbia. Annualized, GRS provides rehabilitation services to nearly 400,000 Medicare beneficiaries. Through Genesis Physician Services, we employ over 125 physicians and 175 nurse practitioners and geriatric nurse specialists providing medical direction in our skilled nursing centers and coordinating the involvement of hundreds of attending physicians who have been credentialed to practice in our centers.

to the beneficiary in essence imposing a 100% co-payment on beneficiaries. As we have expressed in previous testimonies, the Medicare Part B therapy cap continues to be one of the most frustrating examples of policy failure. It was bad policy when enacted; it remains bad policy. We applaud Congressmen Gerlach and Becerra and the 150+ co-sponsors of H.R. 713 in their efforts to repeal the arbitrary therapy caps. The essence of geriatric medicine is restoring and/or coping with functional loss. Beneficiaries, care givers and loved ones should not have to choose between walking and talking; the Hobson's choice of current law.

- ***Refocus the medical manual review (MMR) process to secure useful information on utilization patterns; simplify the process and impose realistic requirements for processing of claims so that beneficiary services are not disrupted.*** There are real differences between the populations served under the Medicare Part B outpatient therapy services between institutional and independent practice settings. When Medicare Part B data is arrayed by setting, it becomes very obvious that the MMR process impacts disproportionately on services provided in the institutional setting, especially in the SNF setting. Data developed by a decade of CMS studies affirm an older and more medically complex patient in the institutional setting. Their needs often require a combination of therapies. Their services are delivered under physician order as part of a broader plan of care. While most Medicare Part B patients in the SNF setting have initially received services under Part A, we are experiencing a growth of beneficiaries who either have not broken their spell-of-illness, don't qualify for Part A coverage [3-day prior requirement] and/or have exhausted their Part A coverage.
- ***Mandate the General Accountability Office (GAO) to conduct a congressionally directed study in a reasonable timeframe as a follow-through to the study they previously conducted on how effectively CMS has implemented the MMR process and to secure guidance on whether there is need to differentiate the thresholds between institutional and private practice settings.*** The MMR process is not working. As implemented by CMS it is unfair, dysfunctional and punitive. Requests for additional information have become a horrendous administrative burden, reviews are not being done in a timely manner, overwhelmed CMS contractors are manipulating the process requiring duplicative submissions of information, and CMS is not managing the process.
- ***Review the consequences of the increase of the multiple procedure payment reduction for rehabilitation services (SLP, OT & PT).*** There has been nearly no consideration of the clinical consequences of the multiple procedure payment reduction (MPPR) for rehabilitation services.

Section 633 of the American Taxpayers Relief Act of 2012 increases the MPPR practice expense reduction to 50% effective April 1, 2013. The reality is that the real impact of the MPPR policy falls on the most frail and vulnerable of Medicare beneficiaries. Over half of nursing home residents receiving Medicare Part B therapy services receive multiple therapies. Indeed, the incidence of this ill designed policy has multiple times the impact on nursing home therapy provision than for the provision of similar services in the independent practice setting. In the institutional setting, rehabilitation interventions are part of the clinical response to help speed a successful transition from the acute to the community setting.

Rehabilitation interventions are cost effective geriatric care with the goal of restoring an individual to his/her former functional status or alternatively to maintain or maximize remaining function in order to help them continue to live as full a life as possible. Decisions made by both Congress and CMS are making it very difficult to deliver medically appropriate therapy services. When you combine the changes made under Part B with the payment revisions being implemented under Medicare Part A for post-acute providers (skilled nursing facilities, rehabilitation hospitals, home health agencies) coupled with the underfunding of rehabilitation services under Medicaid, what emerges is both an undervaluing of the importance of rehabilitation services and a disconnect between commitment and resources.

Skilled nursing centers have become the predominant site for helping restore function and to prevent further deterioration in activities of daily living. Our abilities to successfully transition these beneficiaries from institutional care to home and community based services are highly dependent on physician and non-physician professional services. In our centers, we are offering Medicare beneficiaries comprehensive care at a much lower cost venue than accruing hospital days. Our professional interventions are delivered in an effective and efficient manner that optimize quality, and help reduce the aggregate health system burden of care costs.

We applaud the committee leaders for reaching out for input. We are particularly appreciative of the approach the committees of the House of Representatives are taking with the iterative outreach for input and comments. This approach affords us an opportunity to interact with our medical professionals, those most engaged in direct hands on patient care, soliciting their reactions and providing them with the opportunity to comment on developing changes. These are complex issues, and we look forward to staying engaged in the process, working with individual members and committee staffs to help work through solutions.



*Setting The Standards in Rehabilitation*

January 7, 2014

The Honorable Joe Pitts, Chairman  
 The Honorable Frank Pallone, Ranking Member  
 Health Subcommittee, House Energy and Commerce Committee  
 U. S. House of Representatives  
 Washington, DC

Chairman Pitts and Ranking Member Pallone:

Please accept this statement for the record with respect to the hearing convened January 9, 2014, entitled "The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?"

PTPN is the nation's first and largest specialty network of rehabilitation therapists (PTs, OTs, SLPs) in independent practice. PTPN has led the rehabilitation industry in national contracting, quality assurance and provider credentialing since 1985, elevating the standard of therapy practice. PTPN continued its role as a rehab pioneer by becoming the first organization of its kind to launch a mandatory third-party outcomes measurement program in 2006. PTPN has approximately 900 provider offices (including over 3,000 physical therapists, occupational therapists and speech/language pathologists) in 23 states.

**Sustainable Growth Rate (SGR)**

On March 31 of this year a congressionally passed waiver of the statutory sustainable growth rate (SGR) formula will expire. Without an extension, or preferably a full repeal and replacement, the physician fee schedule update for the remainder of 2014 will be negative 20.1%. Moreover, because of the cumulative nature of the formula, updates for the foreseeable future will be negative as well.

PTPN commends the House Energy and Commerce Committee which led the formal repeal effort last year by unanimously passing H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, a bipartisan effort to transform the Medicare physician payment system. This bill repeals the flawed SGR formula and replaces it with a stable and more predictable system of payments. Instead of potential annual cuts, therapists and physicians will be rewarded for the quality of care they provide to Medicare beneficiaries. The legislation also includes new transparency and collaboration requirements, as well as directives to solicit input from expert medical organizations and other groups on the development and selection of quality measures.

[www.ptpn.com](http://www.ptpn.com)

26635 West Agoura Road, Suite 250 • Calabasas, California 91302 • (818) 883-PTPN

The House Ways and Means Committee and the Senate Finance Committee followed suit later in the year with Ways and Means passing a bill similar to Energy and Commerce while the Senate Finance took a broader approach that included repeal of the therapy caps and modification of the geographic practice cost index (GPCI) and other issues.

PTPN is generally pleased with the direction of and progress on SGR reform and applauds Energy and Commerce for leading the way. Of the three SGR measures considered and passed by the committees of jurisdiction, PTPN prefers the Senate Finance version for several reasons, but primarily because of the inclusion of these two above mentioned "extenders."

#### **Therapy Caps**

In April of this year, the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process or repeal the caps permanently. For the past eleven years, legislation addressing the SGR has consistently included provisions to avoid application of the arbitrary therapy caps to Medicare beneficiaries. These caps apply to Medicare patients in all outpatient health care settings with the exception of outpatient hospital departments. Beneficiaries who receive Part B rehabilitation services within a skilled nursing facility, a therapist's or physician's office, a home health agency, or a rehabilitation agency are subject to the arbitrary cap.

Some 14.5 percent<sup>1</sup> or 640,000 Medicare beneficiaries who receive outpatient rehabilitation services per year are estimated to exceed the existing statutory therapy cap if Congress does not repeal the cap or extend the exceptions process. Once the limit has been reached, beneficiaries who require additional services are responsible for the total cost. Seniors and individuals with disabilities with the most significant rehabilitation needs will have to decide between foregoing necessary care, changing providers of care, or paying 100 percent of the cost out-of-pocket. Beneficiaries who experience stroke, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be negatively affected by the therapy caps. Thus, beneficiaries with impairments and disabilities are adversely and unfairly impacted by this arbitrary payment policy.

The Senate Finance Committee's proposal (S.1871) would repeal the Medicare therapy caps effective upon passage of the legislation, eliminating the requirement for a KX modifier at \$1,900 and the need for yearly extensions. It would keep manual medical review at \$3,700 through 2014, then transition to a new medical review program in 2015. The new program would use prior authorization to allow therapists to request blocks of visits. The HHS Secretary would determine the level at which prior authorization applies and what services are subject to review. The bill also calls for a new data collection system to replace current functional limitation reporting procedures to be operational in or around 2017.

---

(1) Ciolek, DE, Wenke H. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002*. Final Report to the Centers for Medicare and Medicaid Services. November 22, 2004

The data collection system to be implemented will foster the development of “an alternative payment method” which was envisioned by the Balanced Budget Act of 1997. Ideally, these data will include quality information (e.g., functional outcomes data) which can be used to describe the type and amount of care that is needed by specified patients or groups of patients.

PTPN urges your committee to embrace the approach taken by the Senate Finance Committee. This path leads to a cost-effective replacement for the caps and a payment policy that is patient-centric and provides the best return-on-investment for therapy services under Medicare.

#### **Locum Tenens**

PTPN supports HR 3426 the *Prevent Interruptions in Physical Therapy Act*, which adds physical therapists to the statute allowing locum tenens arrangements under Medicare. This bill would modernize the Medicare statute which currently does not include PTs in the list of providers authorized to use this mechanism to ensure continuity of care. PTPN urges the inclusion of this no-cost provision in the Medicare reform legislation.

#### **Electronic Health Records**

PTPN urges Congress to extend to nonphysician providers the incentives for providers to establish electronic health records. Nonphysician providers such as independent physical therapists were not included in the federal programs that encourage and reward the adoption of health information technology. Yet, our members provide an important and valuable service that should be coordinated and communicated electronically. It makes little sense to develop an information superhighway but limit access to a few types of health care providers. The sooner Congress and the administration can set the standards for an interoperable electronic health records the sooner waste and redundancy can be wrung out of the system.

#### **Offsets**

Presently, none of the SGR reform proposals includes budgetary offsets. But it is recognized that funding sources sufficient to pay for these changes to Medicare payment policy are needed. PTPN suggests a change in the physician self-referral statute known as the in-office ancillary services exception (IOASE) which would render upwards of \$2 billion. Private, academic and governmental studies alike have shown a considerable propensity for overutilization of services when physicians are allowed to refer to therapy, imaging and laboratory entities in which they have ownership. By removing physical therapy (along with laboratory and imaging) services from the IOASE, inappropriate utilization can be curbed and billions of dollars can be saved.

Physician self-referral has been linked to increased utilization in numerous ways and by several reputable reports. Last fall, the Government Accountability Office (GAO) issued a report showing increased utilization in imaging when physicians own sophisticated imaging equipment. Moreover, the study found that physician utilization behaviors increased dramatically when a physician became an owner or investor in such a service. A GAO study with similar results in the anatomic pathology labs was published in June 2013.

The HHS Inspector General has continued to identify a high rate (78 to 91 percent) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Moreover, both the President's FY2014 budget and the Bowles-Simpson Commission have recommended that the in-office ancillary services exception be eliminated. Elimination of these practices must be addressed in an

Energy and Commerce Health Subcommittee  
Statement on Medicare Extenders  
January 7, 2014 Page 4

effort to provide a sustainable payment system for Medicare Part B and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

At a time when fiscal austerity for the nation coincides with the search for ways to curb inappropriate utilization of Medicare services, it is imperative we end this abusive practice of physician self-referral by eliminating the in-office ancillary services exception. PTPN urges Congress to include the above described policy change in legislation to reform Medicare payment.

**Conclusion**

The above-discussed issues have beneficial effects on the PT providers, the patient, and the Medicare system in the following ways. Repealing the SGR and adding PTs to the locum tenens statute have major impacts on the provider and secondary benefits for the patient. The therapy cap repeal (or the extension of the exceptions process) is primarily a Medicare beneficiary issue. Enabling nonphysician providers to access health information technology is beneficial to both PTs and their patients, and to the degree to which it creates efficiencies, the Medicare program. The benefits of curbing overutilization inure specifically to the Medicare program.

Thank you for the opportunity to provide these comments on the Medicare extenders and other issues of importance as you proceed to enact Medicare payment reform.

Sincerely,



Michael Weinper, PT, DPT, MPH  
President/CEO

Contact: Maggie Elehwany  
Vice President  
Government Affairs and Policy  
National Rural Health Association

[Elehwany@nrharural.org](mailto:Elehwany@nrharural.org)  
(202) 639-0550  
1025 Vermont St. NW, Suite 1100  
Washington, DC 20005

Testimony of the National Rural Health Association (NRHA)  
Concerning HRSA's Programs Impacting Rural Health  
*Submitted for the Record to the U.S. House of Representatives*  
*Subcommittee on Health Committee on Energy and Commerce*  
**– January 9, 2014**

The National Rural Health Association (NRHA) is pleased to provide the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health with a statement for the record on rural provisions that have a significant impact on the health of rural Americans and should be extended.

NRHA is a national nonprofit membership organization with a diverse collection of 21,000 individuals and organizations that share a common interest in rural health. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through research, communications, and education.

NRHA unequivocally supports a group of rural health provisions that assist rural communities in maintaining and building a strong health care delivery system into the future. Most importantly, these programs help increase the capacity of the rural health care delivery system and true safety net providers. Without these provisions, many rural health facilities will be forced to reduce services and staff, or close. The expiration of other extenders, such as outpatient transitional outpatient payments, or OPPS "hold harmless" payments, has already caused some Sole Community Hospitals to reduce staff and services.

Rural doctors, hospitals, and EMS providers across the nation will experience dramatic Medicare reductions if these programs are allowed to expire, putting Medicare beneficiaries' access to critical primary, emergency and hospital care in severe jeopardy. NRHA asks that the Medicare Dependent Hospital (MDH) designation, Low-Volume Hospital (LVH) adjustment, the current rural and "super-rural" ambulance payments, and the rural work floor in the Geographic Practice Cost Index (GPCI) be extended.

The MDH designation is designed to help rural hospitals that struggle to maintain financial stability under Medicare's fee schedule because of their small size and the large share of Medicare beneficiaries who make up their patient base. MDH's financial margins would degrade considerably without the designation's accompanying payment methodology.

Similarly, the LVH adjustment is designed to help isolated facilities that treat a very low number of beneficiaries. Congress created this program to help rural hospitals offset the higher incremental costs of providing care for seniors. The adjuster assists hospitals with certain fixed costs and other operating costs that low-volume hospitals struggle to meet because of a lack of economies of scale.

Equitable Medicare payments to rural hospitals keep hospital doors open and protect rural patients, the tax payer and rural communities. Rural care is quality primary care and is reimbursed at lower rates than specialty care which is most likely the care received in a non-rural setting. Eliminating rural hospital services or closing rural hospital doors only shifts Medicare costs to more expensive care. The loss of the MDH and LVH programs means rural hospitals will lose millions of dollars.

Cuts to rural hospitals hurt rural economies. A closed rural hospital can mean as much as a 20 percent loss of revenue in the local economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate. Even if a hospital doesn't close, reduced services compromise local access to care and job loss in the community.

Another critical program is the current rural ambulance payments which help sustain isolated rural EMS providers who have long transport distances that are not adequately paid for under the current reimbursement structure. These payments sustain incredibly important rural first responders and must be extended.

Lastly, the program designed to deliver payment equity to rural physicians and other providers paid under the physician fee schedule, commonly known as the "GPCI Work Floor," should also be extended. This limits the geographic payment reductions that Medicare is allowed to make to providers based on their practice location. The continuation of this policy is necessary to combat the provider shortage crisis in rural America.

The above provisions are congressionally established rural payment programs that are cost-effective and targeted that help maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country. While these programs are critical to the stability of the rural health care delivery system, they also provide exceptional value to the taxpayer. Recent data shows that the federal government spends 3.7% less per rural Medicare beneficiary than they do on urban beneficiaries.

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Subcommittee. These programs are critical to the rural health delivery system and help maintain access to high quality care in rural communities. We greatly appreciate the support of the Subcommittee and look forward to working with Members of the Subcommittee to continue making these important investments in rural health.



PRIVATE PRACTICE SECTION, APTA



American Physical Therapy Association

1055 N. Fairfax Street, Suite 204, Alexandria, VA 22314. TEL (703) 299-2410, (800) 517-1167 FAX (703) 299-2411 WEBSITE www.ppsapta.org

January 8, 2014

The Honorable Joe Pitts, Chairman  
 The Honorable Frank Pallone, Ranking Member  
 Health Subcommittee, House Energy and Commerce Committee  
 U. S. House of Representatives  
 Washington, DC

Chairman Pitts and Ranking Member Pallone:

Please accept this statement for the record with respect to the hearing convened January 9, 2014, entitled "The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?"

The Private Practice Section (PPS) of the American Physical Therapy Association (APTA) represents over 4200 members nationwide who operate their practices as small businesses.

#### **Sustainable Growth Rate (SGR)**

On March 31 of this year, a congressionally passed waiver of the statutory sustainable growth rate (SGR) formula, will expire. Without an extension, or preferably a full repeal and replacement, CMS has announced that the physician fee schedule update for the remainder of 2014 will be negative 20.1%. Moreover, because of the cumulative nature of the formula, updates for the foreseeable future will be negative as well. Not only is the SGR an example of a government policy (legislation) that does not work, but it also illustrates that efforts of Congress to undo this mistake – in the absence of complete repeal – are only making a bad situation worse.

PPS commends the House Energy and Commerce Committee which led the formal repeal effort last year by unanimously passing H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, a bipartisan effort to transform the Medicare physician payment system in a number of important ways. First and foremost, this bill repeals the flawed SGR formula and replaces it with a stable and more predictable system of payments. Instead of looming annual cuts, therapists and physicians will be rewarded for the quality of care they provide to Medicare beneficiaries. The legislation also includes new transparency and collaboration requirements as well as directives to solicit input from expert medical organizations and other groups on the development and selection of quality measures. The bill also provides additional revenues for development of new payment and care delivery models. H.R. 2810 passed the full committee by a 51-0 bipartisan vote on July 31, 2013.

The House Ways and Means Committee and the Senate Finance Committee followed suit later in the year with Ways and Means passing a bill similar to Energy and Commerce while the Senate Finance took a broader approach that included repeal of the therapy caps and modification of the geographic practice cost index (GPCI) and other issues.

PPS is generally pleased with this direction of SGR reform and applauds Energy and Commerce for leading the way. Of the three SGR measures considered and passed by the

Private Practice Section / APTA  
 Statement to Energy and Commerce  
 Medicare Extenders

January 8, 2014  
 Page - 1

committees of jurisdiction, PPS prefers the Senate Finance version for several reasons, but primarily because of the inclusion of these two above mentioned "extenders."

The Senate Finance Committee's proposal (S.1871):

- repeals the SGR formula and freezes baseline outpatient Medicare payments (i.e., a flat update) for 10 years (providers could receive payments above the base rate by participating in value-based incentive programs and transitioning to alternative payment models);
- repeals the Medicare therapy caps effective upon passage of the legislation, eliminating the requirement for a KX modifier at \$1,900 and the need for yearly extensions;
- keeps manual medical review at \$3,700 through 2014, then transitions to a new medical review program in 2015. The new program would use prior authorization to allow therapists to request blocks of visits. The HHS Secretary would determine the level at which prior authorization applies and what services are subject to review;
- calls for a new data collection system to replace current functional limitation reporting procedures to be operational in or around 2017;
- extends the 1.00 floor for the "work" GPCI through 2014. In 2015, the floor would become 0.995; in 2016 and beyond, the floor would be set at 0.99.

#### Therapy Caps

In April of this year, the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process or repeal the caps permanently. For the past eleven years, legislation addressing the SGR has consistently included policy to avoid application of the arbitrary therapy caps to those Medicare beneficiaries who are most in need of rehabilitation services. The caps apply to Medicare beneficiaries in all outpatient health care settings. Beneficiaries who receive Part B rehabilitation services within a skilled nursing facility, a therapist's or physician's office, a home health agency, or a rehabilitation agency are subject to the arbitrary cap.

Some 14.5 percent<sup>1</sup> or 640,000 Medicare beneficiaries who receive outpatient rehabilitation services per year are estimated to exceed the existing statutory therapy cap if Congress does not repeal the cap or extend the exceptions process. Once the limit has been reached, beneficiaries who require additional services are responsible for the total cost. Seniors and individuals with disabilities with the most significant rehabilitation needs will have to decide between foregoing necessary care, changing providers of care, or paying 100 percent of the cost out-of-pocket. Beneficiaries who experience stroke, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be negatively affected by the therapy caps. Thus, beneficiaries with impairments and disabilities are adversely and unfairly impacted by this arbitrary payment policy.

The data collection system to be implemented per S. 1871 will foster the development of "an alternative payment method" which was envisioned by the Balanced Budget Act of 1997. Ideally, these data will include quality information (e.g., **functional outcomes data**) which can be used to describe the type and amount of care that is needed by specified patients or groups of patients.

<sup>1</sup> Ciolek, DE, Wenke H. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002*. Final Report to the Centers for Medicare and Medicaid Services. November 22, 2004  
Private Practice Section / APTA January 8, 2014  
Statement to Energy and Commerce Page - 2  
Medicare Extenders

PPS urges your committee to embrace the approach taken by the Senate Finance Committee with one caveat: we would encourage the inclusion of some type of appeals process when prior authorization is not granted.

This path leads to a cost-effective replacement for the caps and a payment policy that is patient-centric and provides the best return-on-investment for therapy services under Medicare.

#### **Private Contracting**

Section 4507 of the BBA of 1997 included a provision allowing physicians and other selected providers of Part B services to opt-out of the Medicare program, meaning they can collect out-of-pocket payments from Medicare beneficiaries if certain requirements for opting-out are met. But this provision was only authorized originally for physicians, osteopaths, and selected non-physician providers (clinical psychologists, clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse mid-wives) in the BBA of 1997. Subsequently, the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) extended private contracting to podiatrists, dentists, and optometrists, effective December 2003. Physical therapists do not currently have the ability to opt-out because they are not included in the statutory language permitting same.

PPS prefers an expansion of the private contracting provisions as represented in HR 1310. But at minimum we urge Congress to extend to physical therapist the policy allowing these professionals to collect out of pocket from a Medicare beneficiary. Such an amendment would be beneficial to PPS members, afford beneficiaries the freedom of choice they deserve, without resulting in any greater expenditure, in fact quite likely some modest savings, for the Medicare program.

PPS recommends that the final Medicare payment reform legislation include an addition to existing law [Section 1802(b)(5)(B) of the Social Security Act] as follows:

*Inclusion of physical therapists under private contracting authority.  
Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(C)) is amended by striking "the term practitioner has the meaning given such term by section 1842(b)(18)(C)" and inserting "In this subparagraph, the term "practitioner" means an individual defines at section 1842(b)(18)(C) or an individual who is qualified as a physical therapist."*

#### **Locum Tenens**

PPS supports HR 3426 the *Prevent Interruptions in Physical Therapy Act*, which adds physical therapists to the statute allowing locum tenens arrangements under Medicare. This bill would modernize the Medicare statute which currently does not include PTs in the list of providers authorized to use this mechanism to ensure continuity of care. PPS urges the inclusion of this no-cost provision in the Medicare reform legislation.

#### **Offsets -- Curbing Overutilization of Therapy**

Since none of the SGR reform measures presently include budgetary offsets, it will be important to identify funding sources sufficient to pay for these changes to Medicare payment policy. PPS suggests a change in the physician self-referral statute known as the in-office ancillary services exception (IOASE) which would render upwards of \$2 billion. Private, academic and governmental studies alike have shown a considerable propensity for overutilization of services when physicians are allowed to refer to therapy, imaging and laboratory entities in which they have ownership. By

removing physical therapy (along with laboratory and imaging) services from the IOASE, inappropriate utilization can be curbed and billions of dollars can be saved.

Physician self-referral has been linked to increased utilization in numerous ways and by several reputable reports. Last fall, the Government Accountability Office (GAO) issued a report showing increased utilization in imaging when physicians own sophisticated imaging equipment. Moreover, the study found that physician utilization behaviors increased dramatically when a physician became an owner or investor in such a service. A GAO study with similar results in the anatomic pathology labs was published in June 2013.

The Office of the Inspector General of the Department of Health and Human Services has continued to identify a high rate (78 to 91 percent) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Moreover, both the President's FY2014 budget and the Bowles-Simpson Commission have recommended that the in-office ancillary services exception be eliminated. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for Medicare Part B and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

At a time when fiscal austerity for the nation coincides with the search for ways to curb inappropriate utilization of Medicare services, it is imperative we end this abusive practice of physician self-referral by eliminating the in-office ancillary services exception. PPS urges Congress to include the above described policy change in legislation to reform Medicare payment.

**Conclusion**

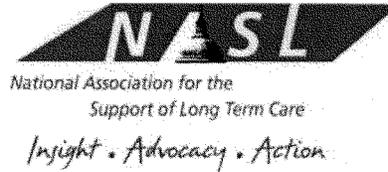
The above-discussed issues have beneficial effects on the PT providers, the patient, and the Medicare system in the following ways. Repealing the SGR, allowing private contracting, and adding PTs to the locum tenens statute, all have major impacts on the provider and secondary benefits for the patient. The therapy cap repeal (or extending the exceptions process) is primarily a Medicare beneficiary issue. The benefits of curbing overutilization inure specifically to the Medicare program.

On behalf of the Private Practice Section of APTA, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system.

Sincerely,



Tom DiAngelis, PT, DPT  
President



**STATEMENT OF THE  
NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE (NASL)**

**HEARING ON "THE EXTENDERS POLICIES: WHAT ARE THEY AND HOW SHOULD  
THEY CONTINUE UNDER A PERMANENT SGR REPEAL LANDSCAPE?"**

**UNITED STATES HOUSE OF REPRESENTATIVES  
COMMITTEE ON ENERGY AND COMMERCE  
SUBCOMMITTEE ON HEALTH**

**JANUARY 9, 2014**

---

National Association for the Support of Long Term Care  
1050 17<sup>th</sup> Street NW, Suite 500  
Washington, DC 20036-5558  
202-803-2385 [Cynthia@nasl.org](mailto:Cynthia@nasl.org)

The National Association for the Support of Long Term Care (NASL) submits this statement to the House Energy and Commerce Subcommittee on Health for its January 9, 2014 hearing on “The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?”

NASL is a national trade association representing providers and suppliers of services to long term and post-acute care settings. NASL-member rehabilitation therapy companies contract with nursing facilities and other long term care providers to provide in-house therapy services. NASL member companies employ thousands of speech-language pathologists, physical therapists and occupational therapists—all focused on providing multi-disciplinary therapy to medically complex patients who require therapy provided within the long term and post-acute care spectrum. NASL also represents health information technology developers, suppliers of durable medical equipment, nursing and therapy product equipment, labs, portable x-ray and diagnostic testing services specializing in the long term and post-acute care settings.

NASL also represents providers and other ancillary service providers including health information technology developers, suppliers of durable medical equipment, nursing and therapy product equipment, labs, portable x-ray and diagnostic testing services specializing in the long term and post-acute care settings.

**Summary of Statement**

**NASL strongly believes now is the time to fix the Medicare Part B outpatient therapy cap and the underlying therapy payment system. NASL supports repeal of the arbitrary therapy cap, thereby ending the need for an annual Congressional extension of the therapy cap exceptions process. To achieve this, NASL supports maintaining the current Medicare Part B outpatient therapy cap exceptions process for a period of such time until CMS brings forward the long needed new payment system. Also, the current manual medical review process for claims above \$3,700 must be streamlined to make it more uniform and efficient for providers and patients alike.**

*History of the Medicare Part B Outpatient Therapy Cap*

In 1997, the Balanced Budget Act (BBA) created an annual financial cap or limit on physical therapy and speech-language pathology services and a separate cap on occupational therapy for most outpatient settings, beginning in 1999. This cap has put at risk Medicare beneficiaries' access to rehabilitative care that is integral to improving their functional abilities and independence, shortening lengths of acute hospital stay, reducing re-hospitalizations and driving down costs. In response to wide-spread concerns about the impact of the therapy caps on patients, Congress suspended the caps from 2000-2005. In 2006, Congress mandated that the Centers for Medicare & Medicaid Services (CMS) develop an exceptions process for Medicare beneficiaries with certain conditions who require therapy services that would exceed the cap. Congress has continually authorized the exceptions process since that time, and it is currently in effect due to the enactment of the *Pathway for SGR Reform Act of 2013*, which extends the exceptions process through March 31, 2014. Additionally, it prevents a scheduled payment reduction for physicians and other practitioners who are reimbursed under the physician fee schedule (PFS) from taking effect on January 1, 2014 and provides for a 0.5 percent update for such services through March 31, 2014. In total, Congress has overridden the therapy cap policy 11 times since the caps were enacted – to enable the most vulnerable Medicare beneficiaries to receive appropriate and medically necessary therapy as covered under the therapy benefit.

Several years ago, Congress directed CMS to develop an alternative payment system for Part B outpatient therapy. In 2007, CMS established a research project entitled Developing Outpatient Therapy Payment Alternatives (DOTPA). In addition, CMS commissioned the Short Term Alternatives for Therapy Services (STATS) project, and received a final report of short term alternatives in 2010 that included recommendations for pilot testing. The purposes of these projects were to identify, collect and analyze therapy-related data with respect to beneficiary need and the effectiveness of outpatient therapy services. The ultimate goal was to develop

alternate payment methodologies to the current cap on therapy. Despite the extensive time and resources put toward these projects by CMS and many stakeholders, including members of NASL, CMS has still not brought forward potential new reimbursement models.

With the lack of action by CMS, the therapy sector has been working to bring forward models for payment reform. NASL's work with The Moran Company in 2008 tested the feasibility of payment in nursing facility settings based on patient condition. This analysis demonstrated that a prospective payment system based on episodes of care for Medicare Part B therapies is in fact possible. NASL continues to work with The Moran Company to develop alternative approaches based on an episodic payment model, which is both easier for clinicians to manage and more amendable to introduction of quality measures and value-based purchasing mechanisms. Other organizations, including the American Physical Therapy Association and the American Occupational Therapy Association, are pursuing payment changes through coding reform. NASL has provided comments on these reforms. The time has come to bring forward payment models and to test them appropriately.

#### Status of the Current Extension

The current fee-for-service (FFS) payment system, which dictates annual payment updates based on the Sustainable Growth Rate (SGR), would give physicians and other Medicare practitioners a 3-month 0.5 percent rate increase and extend several Medicare provisions, including the Medicare Part B exceptions process for outpatient therapy services. Unless Congress acts by March 31, 2014, a 24.4 % reduction in physician reimbursements will occur. In addition to physicians, many other practitioners – including Medicare's Part B outpatient rehabilitation therapy providers – who are reimbursed under the Physician Fee Schedule (PFS), will also be impacted.

Part B Outpatient Therapy Benefit

Medicare's Part B outpatient therapy benefit is complicated. Therapy services are delivered in several different settings to a cross-section of beneficiaries who have varying acuity levels and who may require treatment involving any or all three distinct disciplines – physical therapy, occupational therapy, and speech language pathology.

The caps on therapy services discriminate against the oldest, sickest Medicare beneficiaries. The current cap on therapy services stands at \$1,920 a year for occupational therapy (OT), and \$1,920 for a combination of physical therapy (PT) and speech language pathology (SLP). An estimated 5.6 million beneficiaries received therapy under Medicare Part B in 2010. NASL data analysis by The Moran Company shows that 31% of the Medicare patients who received rehabilitative care in nursing facilities exceeded the PT/SLP cap and 71 percent exceeded the OT cap. In addition, for those nursing facility patients who exceed the caps, an even greater percentage of them exceed the \$3,700 threshold triggering manual medical review. We elaborate on this information below.

Profile of the Therapy Patient in a Nursing Facility: Patients in Nursing Facilities Are Older and More Medically Complex

A Medicare beneficiary receiving Part B outpatient therapy in a nursing facility is more likely to be medically complex and has more co-morbidities than patients in non-institutional settings. Nursing facility patients generally are older, and have particular characteristics that come with being older—they often are more frail with greater physical dependencies. The mean age for those receiving therapy in nursing facilities is age 81, with a significant percentage, 45%, who are above age 85.<sup>1</sup> This is in contrast to the patients receiving therapy in private office settings, where the mean age is 71. CMS' data shows that two-thirds of Medicare beneficiaries have multiple chronic conditions and that multiple chronic conditions increase with age.<sup>2</sup> Multiple

<sup>1</sup>See Table 1 "The Characteristics of Part B Therapy Patients in Nursing Facility and Office Settings are Distinctly Different" developed by The Moran Company based on an Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates.

<sup>2</sup> See page 10-11. Chronic Conditions Among Medicare Beneficiaries, CMS Chart book: 2012 Edition.

chronic conditions typically affect a patient's response to therapy. These patients have an increased likelihood of dementia or psychiatric illness, and lesser cognitive engagement can result in needing extended time to reach goals. Because patients in nursing facilities need 24 hour, 7-day a week care, they are less independent in general. These patients are more likely to be dually eligible and more likely to be female.

*Why Therapy Cap Policies are Detrimental to Nursing Facility Patients: Care Patterns Are Different for Nursing Facility Patients*

The co-morbidities, multiple diagnosis and complex medical needs of the beneficiaries in nursing facilities often result in higher levels of care as ordered by their physician. In fact, research undertaken by The Moran Company for NASL vividly shows that a larger proportion of patients receiving therapy in nursing facilities from multiple disciplines reach the therapy caps and thresholds compared to patients receiving therapy from only one discipline. The Moran Company research reached the following key conclusions:<sup>3</sup>

- Beneficiaries receiving therapy from multiple disciplines are significantly older than those receiving only physical therapy.
- Beneficiaries receiving therapy from multiple disciplines are significantly more likely to be poor (dually eligible) than those receiving only physical therapy.
- Beneficiaries receiving therapy from multiple disciplines are significantly more likely to be black.
- Beneficiaries receiving therapy from multiple disciplines are most likely to exceed the cap and manual medical review threshold.

*Patients receiving Part B therapy in nursing facilities exceed the caps and thresholds at a higher proportion than those receiving therapy in other settings.*

---

<sup>3</sup>See Table 2 "Multi-disciplinary Part B Patients Have Different Demographic Characteristics" developed by The Moran Company based on an Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates.

Did the Patient Receive Therapy in a NF?	Number of patients	% of Total Patients	Number of Patients Hitting the PT/SLP Cap	% of Total Patients who Hit the PT/SLP Cap	Number of Patients Hitting the PT/SLP Medical Review Threshold	% of Total Patients who Hit the PT/SLP Medical Review Threshold	Number of Patients Hitting the OT Cap	% of Total Patients who Hit the OT Cap	Number of Patients Hitting the OT Medical Review Threshold	% of Total Patients who Hit the OT Medical Review Threshold
YES	865,090	16%	285,760	31%	123,360	39%	153,480	71%	56,630	73%
NO	4,623,800	84%	635,193	69%	187,346	61%	62,380	29%	20,640	27%
All Therapy Patients (with known site of services)	5,518,890	100%	917,850	100%	310,340	100%	215,860	100%	77,270	100%

National Estimates based on 2% Standard Analytic Files for 2010

The table above illustrates further the impact of therapy cap payment policies on Medicare beneficiaries receiving therapy in nursing facilities. The chart shows the following:

- More than 5 million Medicare beneficiaries receive Part B outpatient therapy and 16% of those patients receive their therapy in a nursing facility.
- 31% of total patients exceeding the physical therapy/speech language pathology (PT/SLP) cap are in nursing facilities, or roughly double the number of patients overall that exceed the PT/SLP cap.
- 39% of total patients reaching the PT/SLP manual medical review threshold are in nursing facilities.
- 71% of total patients exceeding the occupational therapy (OT) cap are in nursing facilities, which is more than double the percentage of those reaching the OT cap in other settings.
- 73% of total patients reaching the OT manual medical review threshold are in a nursing facility, which is more than double the percentage of those reaching the threshold in other settings.

Clearly, this data shows that nursing facility residents are disproportionately at risk to reach the therapy cap limits and the MMR. Current Part B outpatient therapy policies do not distinguish between beneficiaries who are treated in institutions such as nursing facilities, and thus who are often higher cost cases with co-morbidities and complex medical needs, from other beneficiaries whose needs are very different and much less acute.

*NASL Supports Repeal of the Therapy Cap*

**NASL supports repeal of the arbitrary therapy cap thereby ending the need for an annual Congressional extension of the therapy cap exceptions process. Furthermore, the lack of an adequate payment system has led to Congress imposing the current increasingly confusing hodgepodge one-size-fits-all cost controls including the therapy cap, exceptions process, manual medical review, etc. that are not focused on the needs of the patient.** For this reason, NASL supports the development of a new payment system for Part B outpatient therapy that is primarily focused on the patient and reflects such key factors as clinical diagnoses, complexity of rehabilitative treatments and episodes of care. Because the PFS determines payment for Part B outpatient rehabilitation services, it is essential that any modifications to the PFS preserve the ability of outpatient therapy providers to provide the required level of treatment for Medicare beneficiaries. Any modifications to the codes or payment system reform must take into consideration all settings where outpatient therapy is provided.

*NASL Supports Streamlining the Current Manual Medical Review Process*

The *American Taxpayer Relief Act of 2012* required CMS to conduct a manual medical review (MMR) for beneficiaries whose therapy treatments exceeds a threshold of \$3,700 for either OT or for both PT and SLP services. CMS implemented a *prior-authorization process* that approved or denied care prior to its provision. The result was incredible delays of medically necessary treatment for Medicare beneficiaries. Following this rocky start, CMS then implemented a new process where Medicare Administrative Contractors (MACs) conducted *prepayment review* on claims processed between January 1, 2013 to March 31, 2013. CMS then again revised the MMR policy to require the Recovery Auditors (RAs) conduct review for all claims that reach the \$3,700 threshold on or after April 1, 2013. Since that time, the Recovery Auditors are conducting two types of review. The first is a *Prepayment Review* which reviews a claim above \$3,700 prior to paying the claim. This covers claims submitted by providers located in the Recovery Audit Prepayment Review Demonstration states, which are: Florida, California,

Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri. In these states, the MAC will send an additional documentation request (ADR) to the provider requesting the additional documentation be sent to the Recovery Auditor.

In the remaining states, RAs utilize the other process which is a *Post-payment review*. CMS will grant an exception for all claims with a KX modifier and pay the claim upon receipt. The RAC will then conduct post-payment manual medical review on the claim. According to CMS policy, application of the KX modifier is an attestation by the service provider of the medical necessity of the services being provided to the beneficiary.

While Congress intended for the MMR process to be completed within a ten business day window to avoid disruption of care for the patient, the process implemented by CMS and its contractors has been an administrative nightmare, as reflected in the June 2013 Medicare Payment Commission (MedPAC) report to Congress, and the Government Accountability Office (GAO) study, "Implementation of the 2012 Manual Medical Review Process [GAO-13-613]." GAO found that CMS did not issue sufficient guidance on how to process preapproval requests before the implementation of the MMR process in October 2012, and the MACs that conducted the MMRs were unable to fully automate systems for tracking preapproval requests in the time allotted.

It has been almost a year and a half since the MMR process was implemented in October 2012, and NASL's principal concerns with the MMR process continue to be that providers receive inconsistent and inefficient instructions; they often wait weeks to months beyond the required ten day review window to receive a payment decision; and they often wait even longer to receive payments for services provided. Today, there are unpaid claims that were approved for payment in the Spring of 2013.

NASL Surveys Members on MMR Experience

On December 14, 2013, NASL released survey results regarding the experience of its members with the MMR process. The survey shows that the MMR process ordered by Congress is seldom conducted in the required 10 business days. In fact, the survey shows at least 33 percent of the submitted MMR claims since January 1, 2013 are still waiting processing by Medicare contractors. Furthermore, Congress mandated that the MMR process be conducted over a 10-day time period so as not to disrupt patient therapy. The survey bore out what NASL has been hearing from its members since the inception of the MMR process. For that reason, NASL has joined with a coalition of 20 patient, consumer and provider organizations to urge Congress to retool the MMR system to achieve these goals:

1. Protect beneficiary access from care disruptions by strengthening the ten day MMR requirement.
2. Improve the MMR process by simplification, standardization, and automation of contractor and provider communications.
3. Require a GAO analysis of the MMR process as a follow up to the first report that revealed the problems.

We believe strongly that Congress must insist that CMS enforce a process where the required MMR review be conducted within 10 business days of contractor receipt of the necessary medical documentation, or otherwise be deemed approved. NASL calls on Congress to revisit this issue and insist the MMR process be focused on genuine claims outliers and not cause such disruption to the entire Part B outpatient therapy processing and payment system.

Conclusion

Simply stated, NASL remains convinced that the Part B Outpatient Therapy Cap Exceptions Process should be continued while we work to have the Medicare Part B Therapy Cap repealed. Additionally, CMS has not met the recommended 10-day time frame for the MMR process, or adequately processed claims that have not been submitted since October 2012.

NASL remains committed to working with the House Energy and Commerce Committee to develop a long term solution to modernize Medicare's post-acute care benefit and reimbursement system so that it treats beneficiaries, providers, and taxpayers fairly.

Table 1

**The Characteristics of Part B Therapy Patients in Nursing Facility and Office Settings are Distinctly Different**

Type of setting	% of beneficiaries						
	Not any	Not any Other Setting	Office only	1 or more noninstitutional	2 or more or more institutional	Office - 1 other	Office - 2 or more other noninstitutional
Mean age (SD)	81.1 (11.5)	75.5 (11.3)	71.1 (10.8)	70.8 (12.2)	72.8 (15.4)	70.9 (11.3)	72.1 (12.8)
Age group							
< 65	2%	2%	3%	1%	1%	2%	1%
65-69	2%	2%	3%	2%	3%	2%	2%
70-74	1%	1%	4%	2%	2%	4%	2%
75-79	2%	2%	3%	3%	2%	2%	2%
80-84	3%	2%	3%	1%	2%	3%	2%
85+	1%	1%	1%	1%	1%	1%	1%
Sex							
Male	1%	1%	2%	1%	2%	1%	2%
Female	1%	1%	1%	1%	1%	1%	1%
Race							
White	1%	1%	1%	1%	1%	1%	1%
Black	1%	1%	1%	1%	1%	1%	1%
Other/Unknown	1%	1%	1%	1%	1%	1%	1%
Current or ever by slightly							
Old age and maximum insurance	1%	1%	1%	1%	1%	1%	1%
Disability Insurance Benefits (DIB)	1%	1%	1%	1%	1%	1%	1%
RRD	1%	1%	1%	1%	1%	1%	1%
Both RRD & DIB	1%	1%	1%	1%	1%	1%	1%
Death eligibility							
Yes	1%	1%	1%	1%	1%	1%	1%
No	1%	1%	1%	1%	1%	1%	1%
Setting							
Urban	1%	1%	1%	1%	1%	1%	1%
Rural	1%	1%	1%	1%	1%	1%	1%
TOTAL*	22,028	5,232	124,354	82,767	11,573	12,190	1,896

\* 1,232 beneficiaries with unknown setting

Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates

Table 2

### Multi-disciplinary Part B Patients Have Different Demographic Characteristics

Characteristic	% of beneficiaries						
	PT only	SP only	OT only	PT + SP	PT + OT	OT + SP	PT + OT + SP
Mean age (SD)	71.3 (11.6)	76.7 (13.3)	72.8 (13.5)	77.6 (12.5)	76.4 (12.7)	79.4 (12.0)	79.0 (11.9)
Age group							
≤ 55	9%	8%	11%	6%	7%	6%	5%
56-64	9%	7%	9%	6%	7%	6%	6%
65-74	42%	23%	33%	23%	25%	16%	19%
75-84	30%	31%	27%	31%	32%	31%	33%
≥ 85	11%	32%	20%	34%	29%	41%	37%
Sex							
Male	36%	42%	33.61	40%	32%	31%	37%
Female	64%	58%	66.39	60%	68%	69%	63%
Race							
White	87%	86%	86%	86%	84%	85%	83%
Black	7%	9%	9%	9%	9%	12%	11%
Other/Unknown	6%	5%	4%	5%	7%	4%	6%
Current reason for eligibility							
Old age and survivors insurance	84%	85%	81%	88%	86%	88%	90%
Disability Insurance Benefit (DIB)	16%	14%	19%	12%	13%	12%	10%
ESRD	0%	0%	0%	*	0%	*	0%
Both ESRD & DIB	0%	0%	0%	*	*	*	0%
Dual-eligibility							
Yes	19%	38%	30%	37%	36%	54%	46%
No	81%	62%	71%	63%	64%	46%	54%
Setting							
Urban	79%	76%	78%	80%	80%	76%	80%
Rural	21%	24%	22%	20%	20%	24%	20%
<b>TOTAL*</b>	<b>188,443</b>	<b>11,473</b>	<b>15,446</b>	<b>5,133</b>	<b>27,358</b>	<b>2,261</b>	<b>16,288</b>

Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates



520 Eighth Avenue, North Wing, 3rd Floor  
 New York, NY 10018  
 212.869.3850/Fax: 212.869.3532

United States House of Representatives  
 Committee on Energy and Commerce, Subcommittee on Health  
 Hearing on "The Extenders Policies: What Are They and How Should They Continue Under a Permanent  
 SGR Repeal Landscape?"  
 January 9, 2014

Chairman Pitts, Ranking Member Pallone and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Medicare Rights answers 15,000 questions on our national helpline each year, serving older adults, people with disabilities, and those that help them—family caregivers, social workers, attorneys and other service providers. Through our educational initiatives we touch the lives of another 140,000 beneficiaries and their families. In addition, our online learning tool, Medicare Interactive, receives approximately 1.1 million visits annually.

We appreciate the opportunity to submit a written statement on the extenders policies. These policies traditionally accompany Congressional efforts to avert steep cuts to Medicare physician reimbursement tied to the Sustainable Growth Rate (SGR) formula. We are grateful for the bipartisan, bicameral process underway to repeal and replace the flawed SGR formula. At the same time, we strongly believe that Congress must simultaneously seek a *permanent* solution for extenders benefits critical to the health and well being of people with Medicare. We urge the following:

**Make the Qualified Individual (QI) program permanent.** In 2011, 520,000 people with Medicare received assistance to cover the full cost of their Part B premium through the QI program.<sup>1</sup> This critical benefit is afforded to older adults and people with disabilities with very low incomes and limited assets. Failure to make the QI program permanent as part of an SGR reform package threatens the health and well being of the most vulnerable people with Medicare.

Beneficiaries with incomes from 120% to 135% of the federal poverty level (about \$13,700 to \$15,300 per year) and less than \$7,080 in assets are eligible for the QI benefit, which saves them \$104.90 per month. This benefit alone amounts to nearly 10% of an eligible beneficiary's income. In addition, enrollment in the QI program automatically qualifies beneficiaries for the Low-Income Subsidy of

<sup>1</sup> Park, E. and Solomon, J., "Expiring Medicaid and CHIP Provisions Should Be Extended in End-of-Year Legislation," (Center on Budget and Policy Priorities: December 2013), available at: <http://www.cbpp.org/cms/?fa=view&id=4056>

Washington, DC Office:  
 1825 K Street NW, Suite 400  
 Washington, DC 20006  
 202.637.0961

[www.medicarerights.org](http://www.medicarerights.org) [www.medicareinteractive.org](http://www.medicareinteractive.org)

Medicare Part D, also known as Extra Help. According to the Social Security Administration, access to Extra Help saves low-income beneficiaries up to \$4,000 per year in prescription drug costs.<sup>2</sup>

Medicare Rights regularly assists callers to our national helpline with applications for Medicare Savings Programs (MSPs), including the QI benefit. In 2012, our counselors helped beneficiaries secure \$4.8 million dollars from MSPs and Extra Help. We know firsthand the difference that every dollar makes to older adults and people with disabilities living on low, fixed incomes—people like Mr. C.

Mr. C is a 72 year-old widower from New York City. He lives with multiple chronic conditions, including diabetes, high blood pressure and anxiety. Mr. C's monthly income amounts to only \$1,300 and he has no assets. He spends \$800 per month on rent and utilities, leaving just \$500 to cover other expenses. Mr. C is a Medicare beneficiary without any supplemental insurance. He receives Extra Help, without which he could not afford multiple medications, and the Supplemental Nutrition Assistance Program (SNAP), which helps him afford groceries. In recent years, Mr. C underwent multiple surgeries for his diabetes resulting in several amputations.

One of Mr. C's recent hospital bills remains unpaid because he simply cannot afford the cost. Alarmed by this, Mr. C called the Medicare Rights helpline for assistance. A counselor determined that he was eligible for the QI program and helped him apply for the benefit. Receipt of this \$104.90 monthly subsidy will make an immeasurable difference in Mr. C's life, allowing him to afford unpaid bills and cover basic needs that would otherwise go unmet.

Unlike other Medicare Savings Programs, the amount of federal funding available for the QI program does not automatically increase based on inflation and growing need, and Congress must act annually to ensure that federal funding for QI continues. States receive block grants based on need to provide QI benefits, meaning that once a state's funding is spent, no new eligible beneficiaries can enroll.

Historically, the QI program has been extended alongside an annual vote to undo Medicare physician payment cuts mandated by the SGR, known as the "doc-fix." The QI program should be made permanent to provide stability to both state governments and to low-income people with Medicare, like Mr. C. Congress must secure the future of the QI program alongside a permanent SGR fix, or risk threatening the basic health and economic security of vulnerable retirees and people with disabilities.

**Find a permanent solution for the Medicare therapy exceptions process.** Another critical extension that traditionally occurs alongside the annual doc-fix concerns the Medicare therapy exceptions process. Medicare therapy caps serve as a significant barrier to accessing needed care for people with long-term, chronic conditions, most notably for those who require long-term therapy services. Ideally, Congress should repeal the Medicare therapy caps as part of an SGR reform package to ensure access to needed

---

<sup>2</sup> Social Security Administration (SSA), "Extra Help with Medicare Prescription Drug Plan Costs," (2013), available at: <http://www.ssa.gov/prescriptionhelp/>

care for older adults and people with disabilities. In the absence of full repeal, we ask that Congress make the therapy cap exceptions process permanent.

Today, Medicare coverage for outpatient therapy services, including physical, speech language and occupational care, is limited through arbitrary per beneficiary payment caps imposed by the Budget Control Act of 1997. Since 1999, the year the caps were to be implemented, Congress has acted 10 times to avert execution of the caps. In 2005, Congress developed an exceptions process that allows beneficiaries to receive Medicare-covered therapy services above the cap when medically necessary. Like the QI program, this exceptions process is traditionally extended alongside the doc-fix.<sup>3</sup>

The Senate Finance Committee recently voted to approve the full repeal and replacement of the therapy caps as part of the *SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013*.<sup>4</sup> The approved framework provides a starting point for alleviating barriers to care imposed by therapy caps. This policy requires the Secretary of Health and Human Services to implement a prior authorization medical review process for therapy providers who meet specific criteria, such as high billing patterns compared to peers or other questionable billing practices.

While the proposal must be implemented carefully to promote beneficiary access to care, this approach is a marked improvement to the current therapy caps and exceptions process. The proposal appropriately establishes standards for therapy providers, the very individuals who order and control the delivery of services, as opposed to arbitrarily limiting care on a per beneficiary basis.

We suggest that these provider standards focus solely on provider behaviors and billing practices so as not to inadvertently limit access to therapy services for beneficiaries, most notably for those with particular medical conditions. In addition, we believe that the policy would be strengthened through the addition of an appeals mechanism for instances where prior authorization is not granted.

While many of the practical details regarding implementation of the proposed policy will be developed at the agency level, we are encouraged to see anti-fraud and overutilization efforts appropriately and narrowly targeted to avoid disruptions in needed care for vulnerable beneficiaries. In sum, we hope the concept approved by the Senate Finance Committee will serve as the basis for a permanent solution to the Medicare therapy caps and exception process as part of a broader SGR repeal and replacement strategy.

In closing, as negotiations on a permanent SGR solution move forward, we urge Congress to **protect people with Medicare from higher health care costs**. A legislative proposal to repeal and replace the SGR must not be paid for by shifting added health care costs to older adults and people with disabilities.

---

<sup>3</sup> Leadership Council of Aging Organizations, "Medicare Therapy Cap Exceptions Process Should be Made Permanent," (August 2013), available at: <http://www.lcao.org/files/2013/09/FINAL-LCAO-Therapy-Caps-Exceptions-IB.pdf>

<sup>4</sup> Senate Finance Committee, "Description of the Chairman's Mark: The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013," (December 2013), available at: <http://www.finance.senate.gov/legislation/details/?id=a275e061-5056-a032-5209-f4613a18da1b>

Half of all Medicare beneficiaries—nearly 25 million—live on annual incomes of \$22,500 or less. People with Medicare already contribute a significant and growing share of income on health care costs. Older adults averaged out-of-pocket health care costs of nearly \$4,800 in 2011, an increase of 46% since 2000.<sup>5</sup>

We do not support proposals to further income relate (means test) Medicare Part B and D premiums; prohibit or discourage “first dollar” Medigap coverage; raise the age of Medicare eligibility; or increase Medicare deductibles, coinsurances or copayments as offsets to pay for a permanent SGR solution. Instead, we believe that Congress should look to smart cost savers that eliminate wasteful spending, such as through the restoration of Medicare drug rebates for low-income beneficiaries.

Again, we are grateful to the Committee for embracing bipartisan negotiations to devise a permanent SGR solution. We ask you to ensure that an SGR reform package includes a permanent fix for the QI program and therapy caps, and we urge you to protect people with Medicare from higher health care costs.

Thank you for the opportunity to provide comment.

Sincerely,



Joe Baker  
President  
Medicare Rights Center

---

<sup>5</sup> Cubanski, J. “An Overview of the Medicare Program and Medicare Beneficiaries’ Costs and Service Use,” (Kaiser Family Foundation: February 2013), available at: <http://kff.org/health-costs/event/testimony-an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use/>; Administration on Aging (AoA), “A Profile of Older Americans: 2012,” (DHHS: 2012), available at: [http://www.aoa.gov/AoARoot/Aging\\_Statistics/Profile/2012/docs/2012profile.pdf](http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2012/docs/2012profile.pdf)



---

**NAMD WORKING PAPER SERIES**

***Advancing Medicare and Medicaid Integration: Improving  
the D-SNP Model for Dually Eligible Beneficiaries***

*September 2013*

---



## *Improving the D-SNP Model for Dually Eligible Beneficiaries*

### INTRODUCTION

State Medicaid directors and federal policymakers share the desire to improve the quality of care for dual eligible enrollees (those eligible for both Medicare and Medicaid), reduce unnecessary costs, and minimize disconnects between the two programs. This paper is part of the National Association of Medicaid Directors' ongoing body of work which focuses on approaches and tools for achieving these goals.<sup>[1]</sup>

Previous NAMD documents have discussed many of the current challenges as well as the opportunities for states to improve the system as part of their financial alignment demonstrations initiatives with CMS. NAMD continues to support the work of the Medicare-Medicaid Coordination Office (MMCO) and states to test new alignment models for the dually eligible population, but more is needed to fully fix the system.

In this paper, we address another possible pathway for integration that states are increasingly pursuing: Dual Eligible Special Needs Plans (D-SNPs). In addition to the well-documented fragmentation challenges that exist across states, there are challenges unique to integration initiatives involving the D-SNP program. Here we discuss these challenges and make recommendations so that states might more effectively employ the D-SNP platform to facilitate seamless coordination across the continuum of care.

We are grateful for the time and essential direction provided by the members of NAMD's D-SNP Workgroup. Their expertise and experiences combined with those of NAMD's full membership has led to a set of pragmatic policy recommendations that are critical for fixing the barriers to integration within the D-SNP program.

---

<sup>[1]</sup> National Association of Medicaid Directors policy priorities: <http://www.namd.org/priorities/04/08>



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

#### RECOMMENDATIONS

Further progress towards D-SNP integration will require a combination of federal legislative and administrative actions focused on reducing barriers and further supporting state initiatives to drive alignment between the D-SNP program and state Medicaid agencies. NAMD calls on federal policymakers to enact the following changes:

1. Permanently reauthorize D-SNPs that meet the state Medicaid agency's contracting requirements for integrating care.
2. Provide a uniform definition for "integrated D-SNP" that includes cross-cutting care coordination requirements and integrated systems.
3. Define the critical role of the state Medicaid agency in the contracting with and oversight of integrated D-SNPs.
4. Eliminate statutory misalignment in policies and procedures pertaining to enrollment, marketing and outreach, and grievance and appeals.
5. Allow the MMCO to grant the state Medicaid agency exceptions to Medicare's processes, timelines and requirements as well as waive Medicaid provisions which impede progress of the seamless delivery of patient-centered services across the care continuum.
6. Create a framework for MMCO to work with states to design integrated D-SNP agreements.
7. Create a permanent federal team to work with states on ongoing D-SNP administration issues.



## *Improving the D-SNP Model for Dually Eligible Beneficiaries*

### BACKGROUND

State Medicaid directors and federal policymakers share the desire to improve the quality of care for dual eligible enrollees (those eligible for both Medicare and Medicaid), reduce unnecessary costs, and minimize disconnects between the two programs. The Dual Eligible Special Needs Plan (D-SNP)—state contracting requirement as well as the financial alignment demonstration projects enabled by the Affordable Care Act (ACA), and creation of the Medicare-Medicaid Coordination Office (MMCO) are good first steps, but more is needed.

Previous NAMD documents have discussed specific areas of fragmentation between the programs as well as the opportunity for states to address some misalignments as part of their financial alignment demonstrations initiatives with CMS. NAMD continues to support the work of the MMCO and states to test new alignment models for the dually eligible population. In this paper, we address another possible pathway for integration that states may pursue: D-SNPs.

#### ***Current Situation***

According to the Congressional Budget Office, duals account for 13 percent of the combined population of enrollees but 34 percent of total spending.<sup>1</sup> Costs to provide care are high, health outcomes are poor, and the opportunity for innovation, cost savings, and better health care experiences for the dual eligible population are great.

Combined annual Medicare and Medicaid costs for the dually eligible population are about \$300 billion of the roughly \$900 billion spent annually on Medicare and Medicaid.<sup>2</sup> Much of the high cost is associated with high rates of chronic conditions like diabetes, cardiovascular disease, Alzheimer's and depression among people who receive both Medicaid and Medicare. Three in five have multiple ailments and more than two in five are mentally impaired. Nursing homes are an especially expensive form of health care and drive up cost. Among the dual eligible population, 70 percent of Medicaid costs are for long-term care including nursing homes.<sup>3,4</sup>

<sup>1</sup> See "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies" issued by the CBO, based on 2009 data - [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44309\\_DualEligibles.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44309_DualEligibles.pdf)

<sup>2</sup> See "Medicare-Medicaid Enrollee Profile: National Summary" issued by the CMS, based on 2007 data -

<http://www.information.gov/medicaid/medicaid-enrollee-profile-national-summary-final.pdf>

<sup>3</sup> Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Aligning Incentives in Medicare," June 2010:

<http://www.gao.gov/assets/2010/10/104871.pdf>

<sup>4</sup> Congressional Budget Office, "Rising Demand for Long-Term Services and Supports for Elderly People," June 28, 2013:

<http://www.cbo.gov/sites/default/files/cbofiles/attachments/44303-LTC.pdf>



## Improving the D-SNP Model for Dually Eligible Beneficiaries

### Problems with the Current Situation

While chronic diseases and heavy use of nursing homes account for much of the cost, how the bills are split between the two payers (Medicare and Medicaid) contributes to high costs, mismanaged care and inefficient treatment. A report last year by the Medicare Payment Advisory Commission (MedPAC), an independent congressional agency, concluded that conflicting incentives between Medicare and Medicaid leads health-care providers to avoid costs they are responsible for rather than coordinate care. In addition Medicare and Medicaid have several conflicting policies that result in administrative inefficiencies in the programs and confusion for enrollees.<sup>5</sup> We can and must do better.

### Medicare-Medicaid Integration Options

Today, there are two primary federal efforts to focus on improving care for the dually eligible population. First, the D-SNPs were created within the Medicare Advantage program to focus on enhancing benefits for dual eligibles. In later years, the Medicare Improvements for Patients and Providers Act (MIPPA) required that new or expanding D-SNPs have contracts with the state Medicaid agency in order to drive integration between the D-SNPs and Medicaid.<sup>6</sup> The ACA extended this requirement to all SNPs effective in 2013. The contracting requirement has led to incremental integration between some D-SNPs and state Medicaid programs.<sup>7</sup> However, in many states, there remains no meaningful integration or even coordination of care across the service continuum, including in some instances where D-SNPs have contracts with the state Medicaid agency. Further, states that have chosen to focus on the D-SNP platform for integration continue to identify legislative and administrative barriers to alignment.

More recently, the ACA established the MMCO to focus on the delivery of high-quality, coordinated care for dually eligible individuals. The MMCO has the authority to test innovative payment and delivery system models.<sup>8</sup> To date, the MMCO's work with states has focused primarily on access to data and on developing and implementing two demonstration models to better align services and supports for the state's dually eligible population. These include a capitated model and a managed fee-for-service model. The

<sup>5</sup> MedPAC, "Report to the Congress, Medicare and the Health Care Delivery System," June 2012.

[http://www.medpac.gov/investing/Am12\\_S03.pdf](http://www.medpac.gov/investing/Am12_S03.pdf)

<sup>6</sup> Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P.L. 110-275) [http://www.gpo.gov/fdsys/pkg/PLAW-110pub275.pdf](http://www.gpo.gov/fdsys/pkg/PLAW-110pub275/pdf/PLAW-110pub275.pdf)

<sup>7</sup> Medicare Payment Advisory Commission, "Report to the Congress, Medicare and the Health Care Delivery System," June 2012.

[http://www.medpac.gov/investing/Am12\\_S03.pdf](http://www.medpac.gov/investing/Am12_S03.pdf)

<sup>8</sup> The MMCO is established within CMS Centers for Medicare and Medicaid Innovation (CMMI). Congress set in statute specific functions for the MMCO. However its waiver authorities are limited to those granted to the Secretary's authority for CMMI. Specifically the ACA gives the Secretary authority to waive such requirements of Title XVIII (Medicare) and Title XI (general provisions, administrative simplification, civil money penalties/fraud and abuse) of the Social Security Act as may be necessary solely for the purpose of carrying out this section with respect to testing models described in subsection (b). The authority granted to waive provisions of Title XIX (Medicaid) applies to only three sections of this law: the requirement that Medicaid programs must be operated statewide; the requirement that states must have a public process to determine provider payment rates; and the requirement, within a section pertaining to Medicaid managed care, that no federal funds are available to pay for managed care except under a contract with the State under which prepaid payments are made on an actuarially sound basis.



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

MMCO has not yet issued comprehensive guidance addressing how it could work with interested states to improve upon the D-SNP platform to achieve these goals and to test other innovative options.<sup>9</sup>

#### ***D-SNP and Medicaid Misalignments***

The fragmented system of care for dual eligibles makes it challenging for CMS, states, and providers to offer an integrated continuum of care with aligned clinical and financial structures. This fragmentation makes it difficult, if not impossible, for people that need services the most to navigate the complex system that has evolved over time.

The efforts to redesign the system of care must consider that Medicaid and Medicare are distinct programs, and that each state has a unique program designed to meet the needs of their beneficiaries. Medicaid programs are differentiated on a number of critical factors, including the following:

- Procurement/contract timelines which can be driven by the start of a state fiscal year, state budgets, or other programmatic characteristics
- Member materials describing Medicaid services (including prescription drugs), rights and policies/processes
- Quality assurance processes
- Nuances in provider networks driven by geography or enrollee needs
- Systems capacity
- Healthcare delivery system structure
- Marketplace maturity of managed long-term care programs
- Beneficiary, provider and advocacy priorities that have led to unique state policies and approaches
- Political dynamics that have shaped Medicaid program policies and operations over many decades

In contrast, the D-SNP program must adhere to the nationally uniform Medicare Advantage program rules. This singular approach may not recognize the unique and varied needs of the dual eligible population. It also creates misalignments with the state-specific structure for the Medicaid program, which can and does target initiatives to certain subpopulations or conditions. Many of these areas of misalignment result in confusion for beneficiaries and impede access to the highest quality care. They also produce administrative inefficiencies and perpetuate clinical and financial misalignments.

Specifically, areas of non-integration between the D-SNP and Medicaid programs include:

<sup>9</sup> For example, see April 10, 2013 letter from Tom Bettlach, Director, Arizona Health Care Cost Containment System (AHCCCS)



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

- Temporary authority for the D-SNP program under Medicare Advantage versus the state administered Medicaid entitlement program
- Business system standards for the behind-the-scenes, day-to-day integration functions, including enrollments, payments, care management, and utilization management
- Separate assessments and models for care
- Separate policies for performance and quality improvement initiatives
- Different policies with respect to enrollment in managed systems of care
- Misaligned enrollment time periods based on a single federal Medicare Advantage policy and distinct state enrollment time periods
- Separate reviews of member materials by the state and respective CMS Regional Office that lead to conflicting or erroneous information
- Two separate processes required for individuals to enroll in Medicare and Medicaid
- Two benefit packages with duplication across certain services
- Different standards and processes with respect to medical necessity determinations
- Two cards, two sets of member materials and two provider directories
- Two sets of notices
- Inefficiencies for beneficiaries needing Medicaid coverage for services denied by Medicare
- Duplicative provider billing requirements
- Two different member service responses
- Potential conflicts between Medicare and Medicaid provider networks and network adequacy standards
- Lack of a consistent vehicle for CMS and states to communicate about entry and exit of plans to the D-SNP market
- Different approaches and requirements with respect to monitoring and oversight of health plan operations

The D-SNP-state contracting requirement and the establishment of the MMCO represent important steps towards integration. However, CMS has not yet presented a clear pathway for how the opportunities in the MMCO's financial alignment demonstration initiative can carry over into D-SNPs either under the demonstration authority or under regular D-SNP arrangements. Federal policymakers must address this gap in guidance for states.

#### *Improvements to the D-SNP Integration Pathway*

Further progress towards D-SNP integration will require a combination of federal legislative and administrative actions focused on reducing barriers and further supporting state initiatives



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

to drive alignment between the D-SNP program and state Medicaid agencies. This includes action to:

- Establish the D-SNP program as a permanent pathway for states to integrate care for the duals
- Provide a uniform definition for "integrated D-SNP" that includes cross-cutting care coordination requirements and integrated systems
- Clearly define the critical role of the state Medicaid agency in the contracting and oversight of integrated D-SNPs
- Eliminate statutory misalignment in policies and procedures pertaining to enrollment and grievance and appeals
- Allow the MMCO to grant exceptions to Medicare's processes, requirements and timelines and waive Medicaid provisions which impede alignment initiatives
- Focus MMCO initiatives on integrated D-SNP agreements with states
- Create a permanent federal team to work with states on ongoing D-SNP administration issues.

Policymakers should view these as interdependent recommendations necessary to create a successful, sustainable path forward, rather than standalone proposals. Taken together, we believe the recommendations will lead to improvements in beneficiary health and functional needs and system-wide improvements with higher quality and reduced costs for Medicare and Medicaid.



## Improving the D-SNP Model for Dually Eligible Beneficiaries

### Recommendations to Congress

---

**RECOMMENDATION 1: ESTABLISH THE D-SNP PROGRAM AS A PERMANENT PATHWAY FOR STATES TO INTEGRATE CARE FOR THE DUALLY ELIGIBLE POPULATION.**

---

The President and Congress should permanently authorize the Dual Eligible Special Needs Plan program to solidify this as a pathway that states may use to improve coordination between Medicare and Medicaid.<sup>10</sup> Reauthorization must be done in conjunction with certain statutory and regulatory changes to streamline the delivery of care for duals, as discussed in the remainder of this paper.

Long-term authority with an enhanced state role to address areas of non-integration will improve the health care outcomes for duals and reduce cost by offering:

- **Stable dual coverage.** Alleviating the uncertainty of authorization provides states, consumers, and D-SNPs the opportunity to structure long term solutions for dual eligible members. Frequent, short authorization periods limit state and private sector investment in the D-SNP delivery system. This dynamic needlessly limits alignment options and may threaten the stability of coverage for beneficiaries currently enrolled. While periodic review of policy is important, abbreviated authorization periods have made it difficult for states to plan for and finalize the scope of services, cost-sharing arrangements and contract terms with health plans that serve duals.
- **Improved continuity of care, coordination and outcomes for enrollees.** The MIPPA contracting requirements, as amended by the ACA, were a good first step to foster alignments between Medicare and Medicaid to improve the health of duals.<sup>11,12</sup> However, the statutory requirement does *not* provide states a meaningful role in resolving the clinical, financial or administrative conflicts between D-SNPs and Medicaid that are necessary to improve the health of duals. States need statutory authority for a defined, ongoing role to resolve remaining areas of non-integration, particularly in programmatic areas where there is overlap between the D-SNPs and Medicaid as previously discussed. Enhancing state

<sup>10</sup> Currently the SNP program is authorized through 2013. In its March 2013 report to Congress, the Medicare Payment and Advisory Commission (MedPAC), issued a similar recommendation: [http://www.medicare.gov/documents/Mar13\\_entirereport.pdf](http://www.medicare.gov/documents/Mar13_entirereport.pdf)

<sup>11</sup> Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P.L. 110-275); <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>, with final regulations issued by the Centers for Medicare and Medicaid Services, available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-04-15/pdf/2011-04-15.pdf>, Section 3205 of the ACA Affordable Care Act amends 164(c)(2) of MIPPA.

<sup>12</sup> For additional information on the eight contract requirements, see: MIPPA State Contracting Options, available at: [http://www.cms.gov/SpecalNeedsPlansDownloads/MIPPA\\_State\\_Contracting\\_Options\\_010410.pdf](http://www.cms.gov/SpecalNeedsPlansDownloads/MIPPA_State_Contracting_Options_010410.pdf)



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

involvement will allow Medicaid agencies to align the specific model of care, services, provider network and accountability mechanisms expected of D-SNP plans, while still maintaining beneficiaries' access to the full range of Medicare services and protections.

- **Consistency across integration initiatives.** Extending and improving the D-SNP program is an important option for states pursuing a financial alignment or alternative D-SNP-based demonstration proposal with the MMCO as well as for states seeking to streamline D-SNPs and the state Medicaid program through the state plan. Ensuring that beneficiaries are provided consistent information, services and access is essential regardless of the approach. Further, states require enhanced authority so they may define whether and how the D-SNP program will operate in areas where there is an MMCO-approved alternative demonstration program. Currently, D-SNPs may operate in the same geographic area as health plans participating in a state's financial alignment demonstration. However, this situation may create unnecessary confusion for beneficiaries if the competing programs disseminate different materials to beneficiaries and operate under different rules. It can also create confusion and misaligned incentives for providers since they may be subject to different requirements under the demonstration as compared to those under the D-SNP program.
- **Opportunity to conduct a comprehensive assessment of different integration models.** A permanent authorization allows for robust assessment of the integrated D-SNP model. The states could compare the experience of an integrated D-SNP to other alignment models currently available through the MMCO. They would determine which, if any, would most effectively promote care coordination of high-quality services in the state as compared to the bifurcated system that exists today.

---

**RECOMMENDATION 2: ESTABLISH A UNIFORM DEFINITION FOR "INTEGRATED D-SNP" THAT INCLUDES COORDINATION AND INTEGRATION EXPECTATIONS ACROSS THE CONTINUUM OF CARE.**

---

A critical component for improving the delivery of care for the dually eligible population is to establish a single definition for a clinically and financially integrated D-SNP which also mitigates operational barriers that otherwise would continue to impede integration. Specifically, federal policymakers should define an integrated D-SNP as one that:

- Assumes clinical and financial responsibility for Medicare and some or all Medicaid medical, behavioral, and long-term care services and supports; OR



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

- Assumes clinical and financial responsibility for Medicare and some or all Medicaid behavioral and medical services; OR
- Assumes clinical and financial responsibility for Medicare and some or all Medicaid long-term care services and supports and medical services.

While the federal government would set the overarching clinical and financial requirements for integrated D-SNPs, the state Medicaid agency would determine the type of integration approach applicable in its state, including any additional requirements integrated D-SNPs would be obligated to meet in order to operate in the state. Notably, these requirements are also consistent with the recommendations MedPAC outlined in its March 2013 report to Congress.<sup>13</sup>

#### *Medicare-Medicaid with D-SNPs will continue to evolve over time*

A maximum three year transition period to the integrated D-SNP definition would allow states and D-SNPs to develop the state-specific integrated model. The three year window is necessary to accommodate the different levels of readiness across the states as well as other state-specific programs or operational features. For example, several states already have fairly mature managed care programs, including managed long-term services and supports, with high levels of integration with D-SNPs. These states may have the expertise and capacity to transition to integrated D-SNPs in fewer than three years. Many other states recently implemented or have plans to implement managed care programs in one or more of the clinical service areas. This latter group of states may need the full three years to develop the integrated model with D-SNPs and align implementation of the model with the state's procurement processes.

The maximum three-year transition period for D-SNPs would allow for the following improvements:

- *Phased clinical integration.* A three-year transition enables states to develop the appropriate systems, infrastructure, and business relationships with D-SNPs to establish integrated programs. The level of integration will evolve over time as states build the necessary infrastructure and expertise across the continuum of medical, behavioral, long-term services and functional services and supports. As their capacity and experience mature, states would include additional populations in their coordination initiatives with the integrated D-SNPs.
- *Opportunity for CMS and state officials to address state-specific integration challenges.* Federal regulatory policy can provide the overarching parameters for the

<sup>13</sup> MedPAC, "Report to Congress, Medicare Payment Policy," March 2013. [http://www.medpac.gov/documents/mar13\\_EntireReport.pdf](http://www.medpac.gov/documents/mar13_EntireReport.pdf)



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

state role in managing the D-SNP program. Still, there will be state-specific Medicaid nuances that federal and state policymakers must address during this transition period. They will need time to develop solutions appropriate to the state Medicaid program in order to meet the needs of dually eligible enrollees, including resolving disconnects between Medicare Advantage and Medicaid provider network requirements, coordinating member materials, and formalizing the care coordination activities between Medicare and Medicaid providers.

- **Improved alignment of deadlines for Medicare D-SNP and Medicaid contracting and materials.** CMS requires D-SNPs to meet the uniform Medicare schedule for application, marketing and other materials. However, Medicare's rigid schedule conflicts with the state-specific procurement timelines and related policy decisions which are often structured around the state fiscal year. For example, the Medicare process currently begins almost two years before the start of the actual plan year (e.g. fall of 2012 for plan year 2014). During this time, states seeking to improve alignment must procure for and negotiate with D-SNPs that will also participate in the Medicaid program. In many instances, it is difficult for states to know both which D-SNPs are interested in participating in Medicaid and, of these, which CMS will ultimately approve to participate in the Medicare Advantage D-SNP program.

After the three year timeframe, authority would expire for those D-SNPs that do not meet the specified integrated definition, although a state may complete its integration process sooner. The state would develop a comprehensive transition plan for enrollees that would take effect in such circumstances. In order to minimize potential disruptions in service delivery, states would include the following in their enrollee transition plans:

- Enrollee education and outreach regarding the transition to an approved integrated D-SNP plan and alternative service delivery options
- Requirement that ineligible plans share information about services previously provided
- Qualifications for integrated D-SNPs eligible to receive passive enrollment<sup>14</sup>
- Policies for ensuring continuity of providers and services.

The maximum three-year transition period allows policymakers to balance the shared goal of full integration with the reality of state systems transformations and planning needs and timelines. However, the integrated definition is not intended to preclude any state selecting the

<sup>14</sup> Many states already have a passive enrollment policy for certain populations in their Medicaid program. Passive enrollment allows a state to automatically enroll a beneficiary in a plan chosen by the state Medicaid agency unless – before the effective enrollment date – the beneficiary chooses to enroll in a specific Medicaid plan. Many states require plans to authorize payment for a non-network provider during the beneficiary's transition period. In the case of Medicare services for the dually eligible population, beneficiaries also currently can elect to remain in original Medicare. CMS has explicitly permitted states to use passive enrollment in the financial alignment demonstrations approved to date. To date, most states plan a voluntary enrollment period followed by a passive enrollment period.



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

D-SNP program as its pathway to improve coordination for the dually eligible population. The proposed changes are prospective for states that may explore integration pathways at any point in the future. Ultimately, the policies governing the transition to integrated D-SNPs must meet state systems as they are today.

---

#### *RECOMMENDATION 3: CLEARLY DEFINE THE ROLE OF THE STATE MEDICAID AGENCY IN CONTRACTING AND OVERSIGHT OF INTEGRATED D-SNPs*

---

Long-term authority for the integrated D-SNP program must be paired with a statutorily authorized role for the state Medicaid agency. A defined role for Medicaid agencies will allow states to drive greater administrative alignment and systematic coordination of care. Doing so will create a better experience for enrollees and facilitate the flow of information gathered in one area of care—acute care, long-term services and supports, or behavioral services—to other providers involved in the development and implementation of treatment plans.

Specifically, Congress should clarify the following parameters for the state-D-SNP contracting arrangements:

- The state Medicaid agency retains authority to define the procurement process for selection of Medicaid plans, including those plans that will have opportunity to serve as integrated D-SNPs.
- The state Medicaid agency retains authority to determine the scope of clinical and financial responsibility that D-SNPs must assume, consistent with the revised definition for D-SNPs described above.
- Integrated D-SNPs must comply with the state Medicaid agency's initiatives to target subsets of the state's dually eligible population
- The state has authority to hold plans accountable for the targeted initiatives and features of the state Medicaid program, as well as requirements set forth in the state's MIPPA agreements pertaining to integration and coordination of care for dual eligible members.

Congress must address gaps in the state's authority for contracting with D-SNPs to ensure beneficiaries retain access to the full scope of benefits and services they are entitled to under both programs *in a coordinated fashion*. Clarity in these areas will give states the contracting tools they need to hold D-SNPs accountable for state-specific goals, program characteristics, and operational and administrative responsibilities. For example, states may want to include language in their D-SNP contract that aligns with the state's Medicaid home and community-based programs, health homes, and other waivers and state plan programs. Several states



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

also currently have statutory exclusions – known as “carve-out” arrangements – for certain benefits or diagnoses from Medicaid managed care programs.

---

**RECOMMENDATION 4: ESTABLISH A UNIFIED SET OF RULES FOR INTEGRATED D-SNPs**

---

It is well known that Medicare and Medicaid have complex administrative and procedural rules. In addition to their complexity, several key aspects of the two programs are simply incompatible. While states have worked with CMS to make progress in some areas, statutory requirements continue to hamper further movement towards alignment between the programs, including in states that choose to utilize D-SNPs as their integration platform. Notably, these policy conflicts translate into real world problems for individuals who are forced to navigate the idiosyncrasies of dual eligibility for Medicare and Medicaid.

A unified set of rules would help to mitigate several of these barriers.<sup>15</sup> Congress should grant the Secretary for the Department of Health and Human Services authority to develop unified rules for D-SNPs that would accomplish the following objectives:

- **Consolidate marketing and outreach materials for the dually eligible population.** Beneficiaries currently receive separate marketing and educational materials for Medicare and Medicaid benefit packages, even though they may be offered through a single health plan or provider. Streamlining the flow of information to beneficiaries would provide beneficiaries with a more holistic picture of the benefits available. Beneficiaries would be better able to assess the continuum of care and services that a health plan or provider is offering.
- **Establish a single administrative process and an eligibility verification system for enrollment.** Today, in many states dually eligible individuals must complete separate enrollment processes for Medicare and Medicaid even if their plan is responsible for the individual's Medicare and Medicaid services. Consistent with the concept of an integrated D-SNP, streamlined rules should be developed to allow the beneficiary to complete one process to enroll in a health plan to provide all of the services they are entitled to under the Medicare and Medicaid programs.

<sup>15</sup> MedPAC, “Report to Congress: Medicare Payment Policy,” March 2013 [http://www.medpac.gov/documents/Mar13\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar13_EntireReport.pdf)



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

Of note, however, is that the single administrative enrollment process may not be sufficient for resolving the full scope of challenges with enrollment coordination. Today, some states coordinate the enrollment for Medicaid and Medicare into a D-SNP "behind the scenes," but they have identified information and update gaps between the Medicare and Medicaid eligibility verification systems. This has led to operational issues in some programs. Therefore CMS should examine the feasibility of partnering with states on a system that allows for real-time Medicare and Medicaid eligibility and enrollment verification for all integrated Medicare-Medicaid coordination plan enrollments.

- **Strengthen the state option to conduct passive enrollment, implement mandatory enrollment and lock-in policies.**<sup>16</sup> State Medicaid agencies currently have authority – and extensive experience with – administering passive enrollment, mandatory enrollment and lock-in policies for the Medicaid portion of the beneficiary's services. Parallel authority is needed for the Medicare component of the benefit package. Today beneficiaries may enroll in different health plans for their Medicare and Medicaid benefits or they may be required to enroll in a Medicaid health plan but remain in the unmanaged Medicare fee-for-service program. These situations make it difficult for states to facilitate better-coordinated and beneficiary-centered care that could be available by combining the full continuum of services dual eligibles need into a single benefit package, delivered by a single organization responsible for coordinating all services.<sup>17</sup>
- **Coordinate grievances and appeals for the dually eligible population.** CMS has taken steps to implement an integrated denial notice for Medicare and Medicaid.<sup>18</sup> However, dually eligible beneficiaries must still navigate different appeals and grievances procedures depending on which program is financially responsible for the benefit at issue. Instead, there should be a single pathway for individuals to pursue their appeals and grievance regardless of whether the service at issue is guaranteed under the Medicare or Medicaid program, taking into account unique circumstances (e.g., court orders) that may exist in states.

<sup>16</sup> Passive enrollment is a process through which beneficiaries receive multiple notices about their enrollment options. Typically if the beneficiary does not opt out of the program, he or she is passively enrolled into a health plan in his or her geographical location. States also may utilize tools to ensure the health plan is best suited for the beneficiary's full range of needs. In conjunction with the financial alignment demonstrations that states are working with the MMCO to implement, CMS has said that states may not lock beneficiaries who are dually eligible for Medicare and Medicaid into managed care programs for fixed periods of time. Though no official guidance has been issued from CMS, a letter was sent last summer by CMS to state Medicaid directors that took a position against locking in beneficiaries for any set length of time.

<sup>17</sup> See, for example, the discussion by CBO about the challenges to integration which include the lack of authority for mandatory enrollment for Medicare services. See page 25 of the June 2013 white paper: [http://www.cbo.gov/sites/default/files/attachments/44268\\_DualEligibles.pdf](http://www.cbo.gov/sites/default/files/attachments/44268_DualEligibles.pdf)

<sup>18</sup> See, MA Denial Notices: <http://www.cms.gov/Medicare/Medicare-General-Information/BN/MADenialNotices.html> (accessed August 29, 2013).



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

Notably, these recommendations are largely consistent with those issued in MedPAC's March 2013 report to Congress.<sup>19</sup> Further, the MMCO also has undertaken a comprehensive review of these and other barriers which, when combined with the office's ongoing work with states on financial alignment demonstrations, should help to inform a regulatory framework.

Unified rules in these areas would afford a more rational way to administer these policies and procedures for CMS and states as well as the dual eligible population. Doing so also presents an opportunity to smooth the experience of the dual eligible individual as he or she evaluates options for receiving coordinated services.

---

**RECOMMENDATION 5: GRANT THE MMCO AUTHORITY TO HARMONIZE D-SNPs WITH STATE-SPECIFIC MEDICAID REQUIREMENTS**

---

In addition to resolving specific clinical and procedural areas of misalignment, Congress should establish a mechanism to address other barriers which stand in the way of D-SNP and Medicaid alignment.

Often these barriers are state-specific in nature and can originate in court decrees or state laws and regulations that are beyond the purview of the Medicaid agency. In addition, existing regulations, including MIPPA's contract requirements, do not consider how D-SNPs should operate in states that are implementing financial alignment demonstrations as the platform to improve coordination across the continuum of care for the dually eligible population.

Specifically, Congress should grant the MMCO authority to address these situations by doing the following:

- **Expand the MMCO's authority to waive provisions of the Medicaid statute.** While the MMCO's existing waiver authority has allowed states and CMS to make progress towards their alignment goals, states have found that this authority is limited in that it does not fully account for all the ways in which Medicaid's rules may conflict with those for Medicare.<sup>20</sup> To truly drive alignment between the programs, the MMCO requires broader Medicaid waiver authority equal to that already provided for Medicare. It also would allow the MMCO

<sup>19</sup> MedPAC's March 2013 report did not make a recommendation to Congress concerning passive enrollment or lock-in policies.

<sup>20</sup> Title XIX (Medicaid) applies to only three sections of the law: the requirement that Medicaid programs must be operated statewide; the requirement that states must have a public process to determine provider payment rates; and the requirement, within a section pertaining to Medicaid managed care, that no federal funds are available to pay for managed care except under a contract with the State under which prepaid payments are made on an actuarially sound basis.



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

to modify Medicare processes or policies if the state Medicaid agency identified this as the most feasible pathway for integration. Waiver authority would be employed with the clear intent of improving the care for dually eligible enrollees. Consistent with the MMCOs existing authority, the Medicaid waiver authority would not be used to undermine the entitlement to Medicaid services and protections.

- ***Establish a Medicare exceptions process for alignment initiatives.*** States pursuing the integrated D-SNP platform for integration may need exceptions to Medicare's singular approach to the D-SNP program. Today, the D-SNP rules are linked to those governing the Medicare Advantage program. This presents challenges for states as they try to harmonize Medicare's timelines, oversight, reporting and other requirements with Medicaid requirements and court decrees to which the state may be subject.

The modified authority to align Medicaid with Medicare and to grant states exceptions to Medicare rules would serve to ensure states and CMS can adopt the most appropriate policy for the beneficiary. These authorities are essential for facilitating ongoing D-SNP alignment agreements between states and CMS, as described in the following section.



## *Improving the D-SNP Model for Dually Eligible Beneficiaries*

### **Recommendations to the Administration**

---

**RECOMMENDATION 6: THE MMCO SHOULD FACILITATE INTEGRATED D-SNP AGREEMENTS WITH STATES.**

---

Over the last several years, the MMCO facilitated D-SNP efforts to meet the requirement to contract with state Medicaid agencies by the 2013 contract year.<sup>21</sup> The MMCO's efforts should not stop there. As previously noted these contracts are limited in their ability to resolve other major areas of non-integration. The MMCO should focus resources on resolving areas of non-integration between Medicaid and D-SNPs.

Specifically, the MMCO must convene staff from CMS' Medicare D-SNP and Medicaid divisions as well as state Medicaid agencies to facilitate agreements between interested states and CMS. The agreement would serve to memorialize the respective federal and state roles for oversight.

*CMS-State D-SNP agreements can improve efficiency and effectiveness of Medicare-Medicaid integration.*

The integrated D-SNP agreement would focus on the individual and joint agency roles and responsibilities. It would identify specific activities where Medicare and the state Medicaid agency would conduct coordinated – not duplicative – activities, particularly with regard to which level of government will conduct oversight to ensure compliance with the coordinated set of rules for the D-SNPs in the state. This approach also ensures that the dually eligible population will benefit from the state Medicaid agency's proximity to beneficiaries and their sites of care.

States wishing to leverage the D-SNP model to improve the beneficiary experience would work with CMS to determine which components would be addressed in the state-specific integrated D-SNP agreement. Issues that are not addressed in the agreement would be handled as they are today. Table 1 below identifies the major components of the integrated D-SNP agreement and examples of the specific activity within each component. The goal of the agreement is to streamline administration through one level of government, but it is equally essential that the agreement encourages ongoing collaboration between CMS and the state agency.

<sup>21</sup> MMCO Alignment Initiative update, March 12, 2013. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/AlignmentInitiativeUpdate.pdf>



*Improving the D-SNP Model for Dually Eligible Beneficiaries*

**Table 1. Components of CMS and state agreements for integrated D-SNP programs**

<b>Agreement Category</b>	<b>Components</b>
<b>Submission timeframes and deadlines</b>	<ul style="list-style-type: none"> <li>Alignment of Medicare and Medicaid timelines for submission of materials for contracts and readiness documents.</li> </ul>
<b>Oversight of marketing materials and activities</b>	<ul style="list-style-type: none"> <li>Review, approval and oversight of integrated D-SNP informational materials.</li> <li>Specify the role of brokers.</li> </ul>
<b>Oversight of member outreach and education</b>	<ul style="list-style-type: none"> <li>Review and oversight of consolidated information for beneficiary plan options and benefit packages.</li> </ul>
<b>Enrollment policies</b>	<ul style="list-style-type: none"> <li>State option to conduct passive enrollment, implement mandatory enrollment and lock-in policies.</li> <li>State specifies the frequency and tools for ensuring beneficiaries receive timely and accessible information on the changes and their options.</li> </ul>
<b>Services</b>	<ul style="list-style-type: none"> <li>Alignment of policies for any services that may be outside the scope of the definition of the integrated D-SNP, pharmacy, durable medical equipment, and nursing services.</li> </ul>
<b>Network adequacy reviews</b>	<ul style="list-style-type: none"> <li>Alignment of requirements concerning network adequacy reviews, including the standards and exceptions process that will be applied, and the role of CMS and the state Medicaid Agency, consistent with the clinical definition for the integrated D-SNP.</li> </ul>
<b>Quality assurance</b>	<ul style="list-style-type: none"> <li>Alignment of quality measures, including the elimination of duplicate or substantially similar measures currently required by Medicare and Medicaid.</li> <li>Alignment of priorities to focus on quality measures appropriate to the population or subpopulations of the dual eligibles enrolled in the integrated D-SNP.</li> <li>Alignment of reporting requirements for quality measures. The agreement also could specify which level of government would manage the quality review and reporting processes.</li> </ul>
<b>Plan performance measurement</b>	<ul style="list-style-type: none"> <li>Alignment of management of review and requirements for public reporting of performance.</li> </ul>



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

<b>Grievance and appeals</b>	<ul style="list-style-type: none"> <li>Alignment of other policies and process for beneficiaries and providers that may not be captured in other statutory or regulatory efforts to align these procedures.</li> </ul>
<b>Program integrity</b>	<ul style="list-style-type: none"> <li>Alignment of requirements and oversight activities to clearly delineate federal and state responsibility for oversight and remove duplicative policies.</li> </ul>

The agreement would take into account the CMS and state resources and capabilities, and the federal requirements where CMS has a statutorily mandated role in the oversight process. It also would delegate how CMS and the state would coordinate monitoring and evaluation of the quality of integrated D-SNP programs. For example, one but not both programs would bear responsibility for conducting ongoing quality assurance reviews and overseeing enrollee outreach and education.

Policymakers should ensure that such agreements could be modified when needed to incorporate future federal or state legislation, additional processes, or other changes to improve program and service delivery in each state. CMS and the state would work collaboratively to manage the agreement, and review, monitor, and approve activities as necessary in the designated areas of responsibility. The agreement would serve as a continuing blueprint of policies and operational responsibilities for the federal and state agencies.

---

**RECOMMENDATION 7: ESTABLISH A PERMANENT FEDERAL TEAM THAT WILL WORK WITH STATES ON ONGOING D-SNP ADMINISTRATION ISSUES.**

---

In the absence of a true partnership, breakdowns in communication and misalignments throughout the Medicare Advantage D-SNP and Medicaid contracting and operational processes can lead to suboptimal care for dually eligible beneficiaries, hamper effective plan contracting and management activities, and inefficiently use federal and state taxpayer resources. The CMS-state integrated D-SNP agreement would be an important step in addressing the fragmentation between the D-SNP and Medicaid programs. However, the agreement does not immediately rectify the silos that exist between federal Medicare staff and state Medicaid agencies as it relates to the D-SNP program.

In addition to the agreements, the MMCO should establish a dedicated D-SNP team that would work with states to address misalignments that arise in daily administration and affect all those involved – beneficiaries, CMS, states, and plans. The federal D-SNP team would serve as a



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

consistent point of contact for states as issues arise with D-SNPs. It also would facilitate a uniform process for disseminating Medicare information impacting the D-SNP program to state contacts.

The following are examples of critical daily administration issues on which the federal team and states need to regularly communicate to improve the beneficiary experience and avoid duplication of effort by the Medicare and Medicaid programs:

- Entry and exit of D-SNPs, including evaluations to determine whether a plan meets the revised qualifications for an integrated D-SNP as defined earlier in this paper;
- Identification of risks to health, safety or welfare of enrollees. The teams also would develop and implement solutions to any such risks;
- D-SNPs that have corrective action plans with either CMS or the state;
- Transition planning for enrollees, if necessary;
- Verification of dual status prior to enrollment in Medicare; and
- Other issues that would disrupt care for beneficiaries.

CMS also should continue to meet the demand for information from states newly interested in exploring the D-SNPs as a platform for integration. While helpful, CMS' existing D-SNP Resource Center is underutilized – by CMS and states – and limited in its scope.<sup>22</sup> New content could be added to highlight how states have used D-SNPs to drive integration. The following are examples of the types of resources that would assist states:

- Basic coordination agreement for states to adapt with their D-SNPs
- Examples of agreements that cover cost sharing and cost sharing/extended Medicaid benefits
- Immediate identification of Medicare changes applicable to the SNP program.

The Resource Center has potential to improve collaboration with states, particularly those who are newly exploring the option of improving integration using the D-SNP model.

<sup>22</sup> CMS State Resource Center <http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/StateResourceCenter.html>



### *Improving the D-SNP Model for Dually Eligible Beneficiaries*

#### CONCLUSION

We must act now. NAMD's proposals represent necessary first steps for addressing the full scope of obstacles to alignment between D-SNPs and Medicaid. We recognize that the details of these recommendations may involve difficult decisions and that other issues may not find resolution in the short-term. NAMD and its members are prepared to collaborate with Congress, the Administration, beneficiaries, and other stakeholder groups to ensure ongoing improvement for this population and increasing efficiencies for the federal government and states.

*The National Association for Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD provides a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of its member states now and in the future.*



**Statement for the Record**  
**Federation of American Hospitals**  
**Energy & Commerce Subcommittee on Health Hearing**  
*Hearing On "The Extenders Policies: What Are They and*  
*How Should They Continue Under a Permanent SGR Repeal Landscape?"*  
**Thursday, January 9, 2014**

The Federation of American Hospitals (FAH) is pleased to submit the following statement for the record as the U.S. House of Representatives Energy and Commerce Health Subcommittee considers expiring Medicare provider payment provisions especially critical to our rural hospitals. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America, as well as inpatient rehabilitation, long term acute care, psychiatric and cancer hospitals.

First and foremost, the FAH remains deeply concerned with the problems plaguing the current sustainable growth rate (SGR) formula and appreciates the Committee's efforts in providing a long-term resolution to the fundamental SGR flaw. In order to serve our patients' needs, America's hospitals rely on the quality and professionalism of their medical staffs. One of the greatest threats to our partnership with physicians is the lack of fair and predictable Medicare payment.

Furthermore, the FAH appreciates the Committee's interest in the impact of extenders policies on patients and providers alike. With twenty percent of America's population residing in rural America, rural hospitals are the health and economic backbone for many communities across America, delivering vital health care to millions of Americans. These facilities are often the sole source of comprehensive health care where they are located, and are typically the largest employer, and economic engine, in the communities they serve.

As Members of the Committee know all too well, hospitals have borne the brunt of mounting payment cuts in recent years – \$113 billion having been imposed in the last three years alone, with the sequester accounting for nearly half of that amount. In total, hospitals must now absorb well over \$400 billion in cuts in Medicare and Medicaid through 2023. In fact, rather than providing relief to the arbitrary Medicare sequester cuts, Congress in the budget agreement chose not only to maintain the level of the current sequester cuts to hospitals, but to extend these cuts an additional two years beyond the original timeframe. Such actions are never without consequences and will threaten jobs, patient access to care and hospital closures in rural regions.

Especially in this current economic environment, rural hospitals face a wide array of financial difficulties and operational challenges which imperil their ability to continue to serve these areas in the manner that rural citizens expect and deserve. In many ways, they are the frontline for the many cuts imposed on hospitals in recent years, chief among them the steady erosion of public funding under Medicare and Medicaid. Extending targeted payment policies that are set to expire at the end of March is critically important to bolster their fragile finances and help preserve these hospitals so they can continue to meet their mission.

The rural population served by community hospitals is typically older and poorer, which means that rural hospitals are forced to rely to a greater extent on Medicare and Medicaid funding, and are, therefore, especially vulnerable to cuts to these crucial sources of payment. These payment pressures, combined with the challenges of chronic workforce shortages, relentless regulatory burdens that increase in size and scope, limited access to capital, and the difficulty of a small rural hospital to generate economies of scale, further threaten an already vulnerable, yet vital community asset.

While we welcome the Subcommittee's examination of certain expiring policies, **we strongly urge the extension of the Low-Volume Hospital Payment Adjustment (LVH) and the Medicare Dependent Hospital program (MDH)** which provide vital support for rural hospitals that treat a relatively low volume of patients and a disproportionately high percentage of Medicare beneficiaries.

- **Low-Volume Hospital Payment Adjustment**

This provision recognizes the fact that rural facilities, which are typically small and more isolated, are handicapped in their ability to drive lower unit costs through greater economies of scale. This sliding-scale payment adjustment helps compensate for this competitive disadvantage. It is particularly important because Medicare payments fall so far below the cost of care, and because these small rural hospitals have virtually no other revenue recourse to defray this substantial payment shortfall.

- **Medicare Dependent Hospital Program**

As noted earlier, rural hospitals provide health care to communities that are typically older. This provision is designed to provide an additional measure of protection for smaller rural hospitals serving a disproportionate Medicare caseload – greater than 60 percent. Congress since 1987 has provided a modest supplemental payment to help ensure the survival of these hospitals and access to hospital care for seniors in rural communities. We urge Congress to continue this program and reassure seniors that the hospitals they depend on for care will be there when they need them.

The FAH is pleased to support legislation to extend the vital LVH and MDH programs. The Rural Hospital Access Act of 2013, H.R. 1787, was introduced by Representatives Tom Reed (R-NY) and Peter Welch (D-VT) and has the support of several Members of the Energy and Commerce Committee. In addition, S. 842 was introduced in the Senate by Senators Charles Schumer (D-NY) and Chuck Grassley (R-IA). Senators Schumer and Grassley were

also successful with an amendment in the Senate Finance Committee to their respective SGR legislation to permanently extend these two programs. The amendment passed by voice vote. The FAH remains hopeful that this Senate provision will be included in any final SGR package.

#### **National Quality Forum (NQF)**

The FAH strongly supports effective quality measurement based on standardized metrics that are scientifically sound and useable for public reporting and accountability. Essential to this goal is adequate, predictable and sustainable funding for measure development, multi-stakeholder review of quality measures for scientific soundness and multi-stakeholder assessment of quality measures for use in specific payment programs prior to rule-making. The FAH believes it to be critical that the development of any new streamlined value-based payment program, whether a Value-Based Performance (VBP) payment program or other quality program, recognize the critical role of the National Quality Forum (NQF) and the Measure Applications Partnership (MAP) convened by the NQF. These infrastructures have been instrumental in aligning public and private quality programs, streamlining measures, and providing perspective on whether measures are appropriate for specific federal quality programs and meaningful for patients, payers, providers and the private sector.

The work of the NQF and the MAP is a proven process for engaging strong multi-stakeholder efforts and consensus building, permitting a wide vetting of measures by multiple stakeholders based on criteria that establish validity, reliability, solid evidentiary base, and usability. Without these proven processes, we risk returning to fragmented past practices that had less consensus and alignment among quality programs in both the public and private sectors. The FAH strongly supports sustained, predictable funding for support of these programs and encourages the committee to include funding for these programs in the extender package.

#### **Conclusion**

Just this week, CMS reported that 2012 annual health care spending, including Medicare, is experiencing a significant slowdown. It is especially noteworthy that the Medicare slowdown occurred despite a 4.1 percent jump in enrollment in 2012. This news from CMS was the latest in a growing set of evidence from the federal government as well as academic researchers documenting a historic national spending slowdown with signs that this fortuitous cycle is likely to continue.

Experts attribute the spending slowdown to economic conditions and increasingly recognize structural factors as a root cause of the trend. These structural changes include cultural changes in the delivery of health care, innovative models of integrated care, and the adoption of technological advances such as interoperable electronic health records.

Slowing Medicare spending translates into *savings* – for the Medicare program and, in turn, federal deficit reduction. The June 2013 Dobson/Devanzo study commissioned by the FAH projected an additional \$1 trillion in deficit reduction over the next 10 years if trends continue.

The goal of bending the cost curve is clearly under way, but the fiscal pressures on America's hospitals continue. At the FAH, our members are committed to providing essential health care services, as well as implementing structural changes that will sustain and strengthen the spending slowdown. Such improvements to the delivery of care must not be disrupted by the imposition of additional cuts to hospitals. As rural hospitals struggle simply to keep the doors open, to maintain services and prevent layoffs, the LVH and MDH programs have succeeded in providing the critical rural safety net hospitals need to continue to meet their community mission.

The FAH encourages the Members of the Subcommittee to continue their support for these payment policy lifelines to rural hospitals, as well as to recognize the importance of the NQF as we all work toward quality health care. We always stand ready to work with Congress to ensure continued access to quality health care for seniors.

FRED LUPTON, MICHIGAN  
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA  
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
2125 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-6115  
Majority: (202) 225-2627  
Minority: (202) 225-3941

January 28, 2014

Dr. Naomi Goldstein  
Director, Office of Planning, Research and Evaluation  
Administration for Children and Families  
U.S. Department of Health and Human Services  
370 L'Enfant Promenade, S.W.  
Washington, D.C. 20447

Dear Dr. Goldstein:

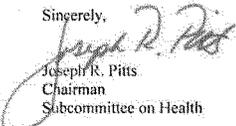
Thank you for appearing before the Subcommittee on Health on Thursday, January 9, 2014, to testify at the hearing entitled "The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?"

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Tuesday, February 11, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515 and emailed in Word format to [Sydne.Harwick@mail.house.gov](mailto:Sydne.Harwick@mail.house.gov).

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

  
Joseph R. Pitts  
Chairman  
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

**House Energy and Commerce Subcommittee on Health**  
**Questions for the Record from the Hearing on:**  
**The Extenders Policies: What Are They and How Should They Continue Under a Permanent**  
**SGR Repeal Landscape?**

**Chairman Pitts Question: ACF provides technical assistance to grantees on a number of issues, but very little of that assistance includes how to encourage teens to choose abstinence or sexual risk avoidance. Please describe the technical assistance you provide on abstinence compared to other types of assistance, such as contraception.**

**Dr. Goldstein Answer:**

ACF administers two Federal teen pregnancy prevention programs that provide formula grants to states – the Title V Abstinence Education Program, and the Personal Responsibility Education Program (PREP).

The legislation which established the Title V Abstinence Education Program did not provide funding for technical assistance activities. However, as part of routine grant administration, ACF does offer technical assistance to grantees and their sub-awardees. This assistance is frequently provided at the request of our grantees and often entails one-to-one guidance provided by ACF project officers to help grantees effectively administer their abstinence education programs.

Through these technical assistance conversations, ACF encourages Title V grantees to use evidence-based curricula that are medically accurate. Many of our grantees selected programs that HHS has identified as evidence-based, through the HHS Teen Pregnancy Prevention Evidence Review. The following three abstinence education programs have been identified by HHS as evidence-based, based on this evidence review:

1. *Heritage Keepers Abstinence Education*  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs/heritage-keepers-v2.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/heritage-keepers-v2.pdf)
2. *Promoting Health Among Teens - Abstinence Only*  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs/promoting\\_health.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/promoting_health.pdf)
3. *Making a Difference*  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs/making\\_a\\_difference.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/making_a_difference.pdf)

In addition, ACF provides information to Title V grantees through a variety of other methods, including conference trainings, webinars, and tip sheets. The following are examples of resources that are offered to Title V grantees:

- *AEGP Program Grant Administration Resource Guide*  
[http://www.acf.hhs.gov/sites/default/files/fysb/sap\\_guidance.pdf](http://www.acf.hhs.gov/sites/default/files/fysb/sap_guidance.pdf)
- *Title V State Abstinence Grantee Orientation Webinar, November 9, 2010*  
<http://www.acf.hhs.gov/programs/fysb/resource/aegp-20101109>
- *Abstinence Education Grant Program Medical Accuracy Guide*  
[http://www.acf.hhs.gov/sites/default/files/fysb/medical\\_accuracy\\_aegp.pdf](http://www.acf.hhs.gov/sites/default/files/fysb/medical_accuracy_aegp.pdf)

Personal Responsibility Education Program (PREP) grantees are required by statute to emphasize both abstinence and contraception, so the technical assistance for these grantees emphasizes both. Unlike the Title V Abstinence Education Program, the PREP Program does provide funding for technical assistance activities. The following are examples of resources that are offered to PREP grantees:

- State PREP Adulthood Preparation Topics Webinar, May 4, 2011  
<http://www.acf.hhs.gov/programs/fysb/resource/state-prep-adult-prep-110504>
- Making the Connections: Reducing Teen Pregnancy Risk by Promoting Healthy Relationships (offered to all grantees)  
<http://www.acf.hhs.gov/programs/fysb/resource/healthy-relationships-webinar-20130801>

**Chairman Pitts Question:** The Committee published a report that analyzed abstinence or sexual risk avoidance programs; it describes over 22 peer reviewed studies that show statistically significant evidence of the positive impacts of these programs. Are you familiar with that report? Have you shared this with grantees as a part of the technical assistance?

**Dr. Goldstein Answer:**

HHS is familiar with the report. We encourage grantees to use evidence-based curricula that are medically accurate. Many of our grantees selected programs that HHS has identified as evidence-based, through the HHS Teen Pregnancy Prevention Evidence Review.

The evidence review was conducted in four steps, using standards that are consistent with review standards in other fields. First, multiple literature search strategies and a public call for studies were used to identify relevant studies released from 1989 through roughly January 2011. Second, all studies identified through the literature search were screened against pre-specified inclusion criteria. To be eligible for review, a study had to examine the impacts of an

intervention using quantitative data and statistical analysis and hypothesis testing. Both randomized controlled trials and quasi-experiments were eligible. A study had to measure program impacts on a least one measure of pregnancy, STIs, or associated sexual risk behaviors (sexual initiation, frequency of sexual activity, recent sexual activity, number of sexual partners, or contraceptive use). Third, studies that met the inclusion criteria were assessed by teams of two trained reviewers for the quality and execution of their research designs. Fourth, for studies that passed this quality assessment, the review team extracted and analyzed information on the research design, study sample, evaluation setting, and program impacts. Evidence-based interventions are defined as those with: (1) a high- or moderate- quality rating of the study design; and (2) a positive, statistically significant impact on one of the sexual behavior or reproductive health outcomes of interest (e.g., sexual activity, contraceptive use, sexually transmitted infections (STIs), pregnancy, or birth).

HHS shares materials with grantees about program models identified as evidence-based, based on this evidence review. The following three abstinence education programs have been identified by HHS as evidence-based:

1. *Heritage Keepers Abstinence Education*  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs/heritage-keepers-v2.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/heritage-keepers-v2.pdf)
2. *Promoting Health Among Teens - Abstinence Only*  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs/promoting\\_health.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/promoting_health.pdf)
3. *Making a Difference*  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs/making\\_a\\_difference.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/making_a_difference.pdf)

#### **Additional Questions for the Record**

##### **The Honorable Joseph R. Pitts**

1. Since the Subcommittee and ACF rely on the results of the evaluations conducted on the PREP program to make decisions about legislation and funding, it is important to understand how long these programs impact adolescent decision-making and behavior related to sexual activity over the long term. Would you provide a chart that includes the number and timing for the post tests for each of the evidence based PREP programs? For example, are the participants tested upon completion of the program or are there follow-up tests as well? If you do not do follow-up testing beyond six months, how do you measure the sustainability of the results?

**Dr. Goldstein Answer:**

Below we provide a chart that summarizes the evaluation findings for the 22 teen pregnancy prevention program models that: (1) met the Teen Pregnancy Prevention (TPP) Evidence Review criteria as showing evidence of effectiveness; and (2) are being implemented by PREP grantees<sup>1</sup>. The chart provides the findings for the longest follow-up period reported in the study. The length of follow-up in the evaluation study is conducted at the discretion of the program evaluator. At each study follow-up point, the evaluation had to demonstrate attrition rates within the acceptable range in order to meet the review criteria.

The current HHS criteria for evidence of program effectiveness have no requirement for evidence of sustained impact (for example, impacts on short-term contraceptive use versus longer-term impacts on pregnancy deterrence). It can be difficult to compare studies by follow-up period due to the length of the program. For example, findings from a three-year program with a follow-up survey at the end of the program (i.e. 36 months post-baseline) would be difficult to compare with those from a six-month program with a follow-up survey at the end of the program (i.e. 6 months post-baseline).

---

<sup>1</sup> The program models being implemented by PREP grantees – along with the number of youth expected to be served by each program model - are listed in a recent report by Mathematica Policy Research. See p. C.3 of the report, available here: <http://www.acf.hhs.gov/programs/opre/resource/the-personal-responsibility-education-program-prep-launching-a>

Program name	Length of Last Follow Up <sup>2</sup>	Behavioral Outcome Measures <sup>3</sup>						
		Sexual initiation or abstinence	Recent sexual activity	Number of sexual partners	Frequency of sexual activity	Contraceptive use and consistency	Sexually transmitted infections or HIV	Pregnancy or birth
Adult Identity Mentoring (Project AIM)	12 months post-intervention	Not measured	Yes	Not measured	Not measured	Not measured	Not measured	Not measured
All4You!	6 months post-baseline (4 to 5 months post-intervention)	No	Not measured	No	Yes	Yes	Not measured	Not measured
Be Proud! Be Responsible! <sup>4</sup>	12 months post-intervention	Not measured	Not measured	Not measured	No	Yes	Not measured	Not measured
	3 months post-intervention	Not measured	Yes	Yes	Yes	Yes	Not measured	Not measured
	6 months post-intervention	Not measured	Yes	Yes	Not measured	Yes	Not measured	Not measured
Be Proud! Be Responsible! Be Protective!	12 months post-intervention	Not measured	Not measured	Yes	Not measured	No	Not measured	Not measured
Becoming a Responsible Teen (BART)	12 months post-intervention	Not measured	Yes (12 months post-intervention)	No	Not measured	Yes (6 months post-intervention)	Not measured	Not measured
iCuidate!	12 months post-intervention	Not measured	Yes	Yes	Not measured	Yes	Not measured	Not measured

<sup>2</sup> Length of last follow-up is the last follow-up period for which there are statistically significant positive findings that meet the TPP Evidence Review Criteria

<sup>3</sup> Yes = there was a positive, statistically significant finding on this measure; No = the outcome was measured and there was no positive, statistically significant finding; Not measured = the outcome was not measured or reported

<sup>4</sup> Three different studies of Be Proud! Be Responsible!, each with a separate sample and study design, meet the review criteria for demonstrating evidence of effectiveness. The results for each of the three studies are presented separately in the chart. None of the other program models have more than one study that meets the review criteria.

Program name	Length of Last Follow Up <sup>2</sup>	Behavioral Outcome Measures <sup>3</sup>						
		Sexual initiation or abstinence	Recent sexual activity	Number of sexual partners	Frequency of sexual activity	Contraceptive use and consistency	Sexually transmitted infections or HIV	Pregnancy or birth
Draw the Line/Respect the Line	At the program end (2.5 years after the baseline)	Yes	Yes	Yes	Yes	Not measured	Not measured	Not measured
FOCUS	11 months post-intervention	Not measured	Not measured	Yes	Not measured	No	Did not meet standards	Did not meet standards
HORIZONS	12 months post-intervention	Not measured	Not measured	Not measured	Not measured	Yes	Yes	Not measured
It's Your Game: Keep It Real (YG)	12 months post-intervention	Yes	Not measured	Did not meet standards	Did not meet standards	Did not meet standards	Not measured	Not measured
Making a Difference!	3 months post-intervention	Not measured	Yes	Not measured	No	No	Not measured	Not measured
Making Proud Choices!	12 months post-intervention	Not measured	No	Not measured	No	Yes	Not measured	Not measured
Promoting Health Among Teens! Abstinence-Only Intervention	24 months post-intervention	Yes	Yes	No	Not measured	No	Not measured	Not measured
Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention	24 months post-intervention	No	No	Yes	Not measured	No	Not measured	Not measured
Reducing the Risk	18 months post-intervention	No	No	Not measured	Did not meet standards	Yes	Not measured	No
Rikers Health Advocacy Program (RHAP)	10 months post-intervention	Not measured	Not measured	No	No	Yes	Not measured	Not measured

Program name	Length of Last Follow Up <sup>2</sup>	Behavioral Outcome Measures <sup>3</sup>						
		Sexual initiation or abstinence	Recent sexual activity	Number of sexual partners	Frequency of sexual activity	Contraceptive use and consistency	Sexually transmitted infections or HIV	Pregnancy or birth
Safer Choices	At the program end (1.5 years after the baseline)	No	No	No	Did not meet standards	Yes	Not measured	Not measured
Sexual Health and Adolescent Risk Prevention (SHARP)	12 months post-intervention	Not measured	Not measured	Not measured	Not measured	Yes	Not measured	Not measured
SIHLE	12 months post-intervention	Not measured	Not measured	Yes	Not measured	Yes	Yes	Yes (6 months post-intervention)
Teen Health Project	12 months post-intervention	Yes	Not measured	Not measured	Not measured	Did not meet standards	Not measured	Not measured
Teen Outreach Program (TOP)	At the program end (9 months after the baseline)	No	Not measured	Not measured	Not measured	Not measured	Not measured	Yes
What Could You Do?	6 months post-intervention	Not measured	Yes (3 months post-intervention)	Not measured	Not measured	No	Yes	Not measured

**The Honorable Henry A. Waxman**

- Chairman Pitts raised the topic of technical assistance (TA) provided to Administration for Children and Families (ACF) grantees during the hearing. How does ACF define TA and what types of TA activities does the agency engage in with PREP grantees?

**Dr. Goldstein Answer:**

ACF's PREP program defines Training and Technical Assistance as follows: "Significant planned and response-to-request training and other relevant subject matter expertise using a planning/implementation/evaluation framework; site visits and virtual meetings (e.g., phone or video-

conference); efforts to reduce barriers to using evidence-based programs; the regular provision of technical or scientific information in user-friendly formats; and other proactive efforts to support State and Community-Based youth-serving organizations to use evidence-based approaches in their work. T&TA is provided over time and should include proactive follow-up support. T&TA will be provided to grantees through several methods, to include phone, email, written materials, and face-to-face consultation. Training will primarily be provided through webinars, annual meetings, and regional training.”

ACF provides TA to PREP grantees through a variety of methods including: webinars, annual meetings, and regional trainings, phone calls, “cluster” phone calls, email, written materials, and face-to-face consultation. Online learning tools also available to assist grantees include: archived presentations, a web-based online community (“Community of Practice”), toolkits, tip sheets, and self-paced e-learning modules.

2. Chairman Pitts mentioned a July 2012 Energy and Commerce Majority Report that discusses “abstinence or sexual risk avoidance programs” and their impact. How does ACF define and make determinations regarding evidence-based programs? Do the programs cited in the July 2012 report meet ACF’s evidence-based criteria?

**Dr. Goldstein Answer:**

The Teen Pregnancy Prevention (TPP) Evidence Review is a systematic process conducted by HHS through contract with Mathematica Policy Research and its partner, Child Trends. The purpose of the Evidence Review, and its periodic updates, is to identify program models that have demonstrated positive impacts on teen pregnancies or births, sexually transmitted infections (STIs), or associated sexual risk behaviors.

*Overview of the TPP Evidence Review Methodology*

The findings from the initial TPP Evidence Review were released in March 2010 and covered studies released from 1989 through roughly December 2009. A second round of review was released in April 2012 and added studies released from roughly December 2009 through January 2011. The review was conducted in four steps as outlined below. Evidence-based interventions are defined as those with: (1) a high- or moderate- quality rating of the study design; and (2) a positive, statistically significant impact on one of the sexual behavior or reproductive health outcomes of interest (e.g., sexual activity, contraceptive use, sexually transmitted infections (STIs), pregnancy, or birth).

Below we provide more information about the review process. More detailed information on the protocol used to conduct the review can be found at: [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/eb-programs-review-v2.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/eb-programs-review-v2.pdf). In addition, frequently asked questions (FAQs) about the review can be found at: [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/db-faq.html](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/db-faq.html).

*Step 1: Study Identification*

Studies were identified in four ways: (1) scanning the reference lists of prior systematic reviews and research syntheses (Advocates for Youth 2008; Ball and Moore 2008; Chin et al. 2012; Kim and Rector 2008; Kirby 2007; Oringanje et al. 2009; Scher et al. 2006); (2) searching the websites of relevant Federal agencies and research or policy organizations; (3) issuing a public call for studies to identify new or unpublished research; and (4) having a research librarian conduct a keyword search of electronic citation databases. For the first update to the review findings, the review team also conducted a hand search of 10 relevant research journals and scanned the conference proceedings of five professional associations. The search covered both published and unpublished studies.

*Step 2: Study Screening*

All studies identified through the literature search were screened against pre-specified inclusion criteria. To be eligible for review, a study had to examine the impacts of an intervention using quantitative data and statistical analysis and hypothesis testing. Both randomized controlled trials and quasi-experiments were eligible. A study had to measure program impacts on a least one measure of pregnancy, STIs, or associated sexual risk behaviors (sexual initiation, frequency of sexual activity, recent sexual activity, number of sexual partners, or contraceptive use).

*Step 3: Study Quality Assessment*

All studies that met the review inclusion criteria were assessed by teams of two trained reviewers for the quality and execution of their research designs. The reviewers made their assessments following a pre-specified set of standards documented in the review protocol. At the end of the assessment, each study was assigned a quality rating of *high*, *moderate*, or *low* according to the risk of bias in the study's impact estimates. In developing the scheme, Mathematica drew upon the evidence standards used by nine other evidence assessment projects or research and policy groups. The high study quality rating was reserved for randomized controlled trials with low rates of sample attrition, no reassignment of sample members, no systematic differences in data collection between the research groups, and at least one subject or group (school, classrooms, etc.) in both the treatment and control conditions. The moderate study quality rating was considered for studies using quasi-experimental designs and for randomized controlled trials that did not meet all the review criteria for a high quality rating. To meet the criteria for a moderate study quality rating, a study had to demonstrate equivalence of the intervention and comparison groups on race, age, and gender; report no systematic differences in data collection between the research groups; and have at least one subject or group (school, classroom, etc.) in both the intervention and comparison conditions. Studies based on samples of youth ages 14 or older also had to demonstrate equivalence of the intervention and comparison groups on at least one behavioral outcome measure.

*Step 4: Assessment of Effectiveness of Interventions*

All impact studies meeting the criteria for a high or moderate study quality rating are considered eligible for providing credible evidence of program impacts. Studies receiving a low rating are not subject to data collection and extraction, as the information provided in these studies is considered not to provide credible estimates of program impacts. To meet the HHS criteria, the program's supporting research study must show evidence of a positive, statistically significant impact on at least one priority outcome measure for either the full analytic sample or a subgroup defined by (1) gender, or (2) sexual experience at baseline. The priority outcome measures are sexual activity (initiation; frequency; rates of vaginal, oral and/or anal sex; number of sexual partners), contraceptive use (consistency of use or one-time use, for either condoms or another contraceptive method), STIs, and pregnancy or birth.

*Review Findings*

For the first two rounds of review, more than 1,900 citations were found through the literature search and call for studies. From this initial citation list, 1,438 (73 percent) did not meet the inclusion criteria listed in Step 2, above, based on a review of the study's title and abstract. Full text articles were obtained for 541 citations, and from these citations, the review team identified 452 unique studies. An additional 252 studies were found not to meet the inclusion criteria after a review of the full text, and 112 studies were dropped for failing to meet the review criteria for a high or moderate study quality rating. A total of 88 studies met the review criteria for a high or moderate rating and a total of 31 programs met the criteria for demonstrating evidence of program effectiveness in this round of review.

The table below indicates whether the programs cited in the July 2012 House Committee on Energy and Commerce report issued by Chairman Pitts met ACF's evidence-based criteria. For a list of all studies reviewed in the HHS TPP Evidence review and whether they were assessed as low, moderate, or high quality, please go to: [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/all-studies-reviewed-v2.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/all-studies-reviewed-v2.pdf).

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Jemmott Study of Inner City Youth	Jemmott, J. B., Jemmott L. S., Fong G. T. (2010). Efficacy of a theory-based abstinence-only intervention over 24 months. Arch Pediatr Adolesc Med. 2010;164(2):152-159.	Yes	High Quality	Yes
Reasons of the Heart	Weed S., Ericksen I.H., Lewis A., Grant G.E., & Wibberly K.H. (2008). An abstinence program's impact on cognitive mediators and sexual initiation. American Journal Health Behavior, 32(1):60-73.	Yes	Low Quality	No
Game Plan/Aspire	Educational Evaluators, Inc. (2011) Evaluation Report of the Tesorosde Esperanza CBAE Evaluation report during 2008-09 project year. Program. -Impact Evaluation submitted to Department of Health and Human Services.	No	--	--
Choosing the Best	Weed, S.E., & Ericksen I.H., (2008) What kind of abstinence education works? Comparing outcomes of two approaches. Submitted for publication.	Yes	Low Quality	No
Heritage Keepers®: A Replication	Birch P. and Weed S. (2008). Effects of Heritage Keepers® Abstinence Education Program: A Replication. Salt Lake City: The Institute for Research & Evaluation.	No	--	--

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Choosing the Best/ STARS Georgia	Lieberman,LD,(December2010). Evaluation Report of the Choosing the Best, Inc./ STARS Georgia High School Abstinence Education Program, Submitted to HHS, ACYF under CBAE grant funding. Montclair, NJ: Montclair State University.	Under review <sup>5</sup>	--	--
L.I. Teen Freedom Program	Rue,L.A, Chandran,R., Pannu,A., Bruce,D., Singh,R.(2010). Estimate of Program Effects, L.I. Teen Freedom Program. Program Impact Evaluation submitted to Department of Health and Human Services.	Under review	--	--
The RIDGE Project, Inc.	Seufert, R.L. & Campbell,D.G. (2010).The RIDGE Project Evaluation 2008-2010. Program Impact Evaluation submitted to Department of Health and Human Services.	No	--	--
Earle School District	Rue, L. A., Rogers, J., Kinder, E., Bruce, D. (2009). Summative Evaluation: Abstinence Education Program Impact Evaluation submitted to Department of Health and Human Services, Grant # 90AE0219.	Yes	Low Quality	No
Arkansas Title V Funded Programs	Birch P. and Weed S. (2008). Phase V Final Report: Delivered to the Arkansas Department of Health. July 16, 2008. Salt Lake City: The Institute for Research & Evaluation.	Yes	Low Quality	No

<sup>5</sup> HHS is currently conducting a third round of the TPP Evidence Review and the findings are expected to be released later in 2014.

<b>Program Name</b>	<b>Evaluation Study Citation listed in the House Committee on Energy and Commerce Report</b>	<b>Reviewed in HHS TPP Evidence Review?</b>	<b>Study Quality</b>	<b>Evidence of Effectiveness</b>
Sex Can Wait	Denny, G., & Young, M. (2006). An evaluation of an abstinence-only sex education curriculum: An 18-month follow-up. <i>Journal of School Health</i> , 76 (8): 414-422.	Yes	Low Quality	No
Heritage Keepers	Weed, S.E., Ericksen I.H., & Birch P.J. (2005). An evaluation of the Heritage Keepers Abstinence Education Program. Evaluating abstinence education programs: Improving implementation and assessing impact. Washington DC: DHHS, Office of Population Affairs and the Administration for Children & Families.	Yes	Low Quality	No
Best Friends	Lerner, R., (2004). Can abstinence work? An analysis of the Best Friends Program. <i>Adolescent and Family Health</i> , 3(4), 185-192.	Yes	Low Quality	No
Pure & Simple Lifestyle (PLS)	Wetta-Hall, R. (2010). Pure & Simple Lifestyle (PSL): Evaluation of Teen Participants of the Pure & Simple Choice Curriculum, Year Five Program Impact Evaluation submitted to HHS.	No	--	--
Not Me Not Now	Doniger, A., Adams, E., Utter, C. & Riley, J. (2001). Impact evaluation of the "Not Me, Not Now: Abstinence-oriented, adolescent pregnancy prevention communications program, Monroe County, New York. <i>Journal of Health Communications</i> . 6, 45-60.	Yes	Low Quality	No

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
For Keeps	Borawski, E.A., Trapl E.S., Lovegreen, L.D., Colabianchi, N., & Block T. (2005). Effectiveness of abstinence-only intervention in middle school teens. American Journal Health Behavior, 29 (5), 423-434.	Yes	Moderate Quality	No
Worth the Wait	Tanner Jr., J.F., & Ladd, R.N. (2005). Saturation Abstinence Education: An application of social marketing In Golden A (Ed.) Evaluating Abstinence Education Programs: Improving Implementation and Assessing Impact. Washington DC: Office of Population Affairs and the Administration for Children and Families. Dept of Health and Human Services.	Similar Paper was reviewed	Low Quality	No
Abstinence By Choice	Weed, S.E. (2001, October 15). Title V abstinence education programs: Phase I interim evaluation report to Arkansas Department of Health. Salt Lake City: Institute for Research and Evaluation.	No	--	--
Stay SMART	St. Pierre, T.L., Mark, M.M., Kaltreider, D.L., & Aikin, K.J. (1995) A 27-month evaluation of sexual activity prevention program in Boys and Girls Clubs across the Nation. Family Relations. 44(1): 69-77.	Yes	Low Quality	No

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Facts	Weed, S.E. (1994). FACTS Project: Year-end evaluation report, 1993-1994. Prepared for the Office of the Adolescent Pregnancy Prevention Programs, U.S. Department of Health and Human Services.	No	--	--
Teen Aid/Sex Respect	Weed, S.E. (1992). Predicting and changing sexual activity rates: A comparison of three Title XX programs. Report submitted to OAPP, U.S. DHHS.	Yes	Low Quality	No
Teen Aid Family Life Education Project	Weed, S.E., Prigmore, J., Tenas, R. (1992). The Teen Aid FLE Project: 5th year evaluation report. Report submitted to HHS.	No	--	--

**The Honorable Lois Capps**

1. The Affordable Care Act established several new programs that you described in your testimonies: the Personal Responsibility Education Program; the Maternal, Infant, and Early Childhood Home Visiting Program; and the Health Workforce Demonstration Project for Low-Income Individuals. You mentioned that comprehensive evaluations of these programs are ongoing. From your testimony, even as we await results of the comprehensive evaluations, early indications are these programs have been successful. And, importantly, these programs are grounded in sound evidence. Would you please elaborate on the successes of these programs thus far and how these three programs are informed by available evidence?

**Dr. Goldstein Answer:**

**Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)**

The MIECHV program is based on a large body of research on the effectiveness of home visiting for pregnant women and families with young children. Impacts have been seen across a broad range of outcomes, including maternal health, school readiness, parenting, prevention of child maltreatment, and family economic self-sufficiency. The statute requires the Secretary of

Health and Human Services (HHS) to establish criteria for evidence of effectiveness and to reserve the majority of program funding for home visiting models that meet those criteria.

Following an opportunity for public comment, in 2010 the Secretary established criteria for evidence of effectiveness of home visiting models. HHS has sponsored a thorough, transparent, systematic review of the evidence on models of home visiting, applying these criteria<sup>6</sup>. The review conducts an exhaustive literature search for impact studies, determines the quality of the studies based on their ability to produce unbiased impact estimates, and assesses whether the available evidence for particular home visiting models meets the HHS criteria. The project annually updates the evidence on models that have already been reviewed and considers emerging evidence on models not yet reviewed. To date, the review has examined 35 models and found 14 to have evidence of effectiveness.

The MIECHV program is being implemented on a national scale. There are three components to the program. First, funds are allocated by formula, based on child poverty rates, so that evidence-based home visiting services for high-risk families are supported in every state. Second, 19 states have received development grants through a competitive process. The development grants have helped these states build capacity in terms of workforce development, data infrastructure, and care coordination and referral systems in communities across the states. Third, 31 states have also received expansion grants which helped states build upon efforts they already had underway to expand services to more families and more communities.

States spent the first full year of the program conducting the statutorily required needs assessment to determine the eligible communities and priority populations to establish MIECHV home visiting programs and to select the visiting program models that would best meet the community needs. Families began to receive services at the end of 2011 and data from 2012 found that the program had provided more than 175,000 home visits to over 35,000 mothers and children in 544 communities across the country. These numbers account for mothers and children, but do not include other family members, including fathers, in the household who may also benefit from the home visit. Preliminary data for year 2013 indicate that the program is now serving more than 80,000 mothers and children, and the program has now expanded to 656 counties across the country, which is an increase from approximately 8 percent to 20 percent of all the counties in the United States, including 75 percent of the U.S. urban areas with a population of over a half million.

The Department has taken a number of steps to ensure MIECHV supported home visiting programs are implemented appropriately and states are making progress toward

---

<sup>6</sup> Information about the procedures and results of the review is available at <http://homvee.acf.hhs.gov/>

improvements in outcomes. HRSA and ACF provide ongoing technical assistance to grantees and encourage the dissemination of best practices, which accelerates collaborative learning across states. Additionally, HRSA and ACF closely monitor the states progress on the 37 outcome measures in the six MIECHV benchmark areas, such as improvements in developmental screening, parents' support of early learning and development, and reductions in emergency room visits. These data are collected on an annual basis, and by October 2014, states are expected to demonstrate improvement in at least four of the six benchmark areas.

#### Health Profession Opportunity Grant (HPOG) Program

The HPOG program builds on past research showing that a sectoral approach to vocational education and employment services can be effective.<sup>7,8,9,10,11</sup> The program uses a career pathways framework that links education, employment, and human services to help adults gain marketable skills and credentials in high-demand occupations in health care. This approach emphasizes a pathway so participants can pursue what are called stackable credentials – starting with shorter training programs that provide entry-level qualifications, and continuing along a path to gain more qualifications and advance to better jobs.

ACF has awarded five-year funding to 32 grantees in 23 states to carry out this program. Five of the grantees are tribal organizations. Grantees are post-secondary educational institutions; workforce investment boards (WIBs), state and local government agencies, and Community-Based organizations. Grantees have established partnerships with state and local WIBs, state and local TANF agencies and Federal and state offices of apprenticeship, among other partners.

As of December 2013, approximately 25,800 participants have enrolled in HPOG programs. Of the more than 12,000 participants who have completed an occupational or vocational training program, more than 10,000 participants have become employed since the program began. Among those who became employed, their average wage is \$12.37 per hour.

The most common training among participants is preparation to become a nursing assistant, aide, orderly, or patient care attendant, generally short training courses that can be the first step in a longer career pathway. Other common trainings included instruction to be a licensed

<sup>7</sup> Bragg, D., Harmon, T., Kirby, C., & Kim, S. (2010, August). Bridge programs in Illinois: Summaries, outcomes, and cross-site findings. Champaign, IL: Office of Community College Research and Leadership, University of Illinois.

<sup>8</sup> Helmer, M., & Blair, A. (2011, February). Courses to employment: Initial education and employment outcomes findings for students enrolled in Carreras en Salud Healthcare Career Training 2005–2009. Washington, DC: The Aspen Institute. Retrieved from <http://www.aspenwsi.org/WSIwork-HigherEdpubs.asp>

<sup>9</sup> Barnett, E., Bork, R., Mayer, A., Pretlow, J., Wathington, H., & Weiss, M. (2012). Bridging the gap: An impact study of eight developmental summer bridge programs in Texas. New York, NY: National Center for Postsecondary Research.

<sup>10</sup> Maguire, S., Freely, J., Clymer, C., Conway, M., & Schwartz, D. (2010). Tuning in to local labor markets: Findings from the Sectoral Employment Impact Study. Philadelphia: Public/Private Ventures.

<sup>11</sup> Roder, A., & Elliot, M. (2011, April). A promising start: Year Up's initial impacts on low-income young adults' careers. New York: Economic Mobility Corporation.

or vocational nurse, registered nurse, and medical assistant. HPOG participants also engaged in pre-training college study skills and basic skills education classes. Grantees provide a variety of support services including case management and counseling services; financial assistance for tuition, books, and fees; and social service supports, including assistance with transportation, child care and emergency assistance. Grantees also provide employment assistance in the form of job search workshops, career coaches, and placement and retention assistance.

More detailed information can be found on ACF's webpage. ACF is using a multi-pronged research and evaluation strategy to assess the success of the HPOG program. These research and evaluation activities examine outcomes and impacts for participants as well as program implementation and systems change resulting from HPOG programs. Reports published to date include:

- A report on HPOG implementation and outcomes after the first year ([http://www.acf.hhs.gov/sites/default/files/opre/opre\\_report.pdf](http://www.acf.hhs.gov/sites/default/files/opre/opre_report.pdf))
- The HPOG Year Two Annual Report ([http://www.acf.hhs.gov/sites/default/files/opre/hpog\\_second\\_annual\\_report.pdf](http://www.acf.hhs.gov/sites/default/files/opre/hpog_second_annual_report.pdf))
- Two briefs focusing on the Tribal HPOG Grantee programs and evaluation ([http://www.acf.hhs.gov/sites/default/files/opre/tribal\\_health.pdf](http://www.acf.hhs.gov/sites/default/files/opre/tribal_health.pdf) and [http://www.acf.hhs.gov/sites/default/files/opre/hpog\\_practice\\_brief\\_supportive\\_services\\_june\\_2013\\_0.pdf](http://www.acf.hhs.gov/sites/default/files/opre/hpog_practice_brief_supportive_services_june_2013_0.pdf)).
- Two documents that the program office has produced: a compendium of success stories and of promising practices current HPOG grantees are using. ([http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG\\_SuccessStories\\_2013.pdf](http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG_SuccessStories_2013.pdf) and [http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG\\_PromisingPractices2013.pdf](http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG_PromisingPractices2013.pdf))

The year three annual report and two interim outcomes reports (one focused on the tribal grantees and one on the non-tribal TANF and low Income grantees) will be issued in the spring of 2014.

#### Personal Responsibility Education Program (PREP)

The majority of funds in the PREP program are reserved by statute for services that replicate evidence-based models, or substantially incorporate elements of models found to be effective on the basis of rigorous scientific research. In addition, programs must be medically accurate and complete.

Beginning in 2010, HHS has sponsored a transparent, systematic review<sup>12</sup> of the teen pregnancy prevention evidence base, in order to independently identify teen pregnancy prevention programs with evidence of impacts on teen pregnancies or births, sexually transmitted infections, or associated sexual risk behaviors. The review identified, assessed, and rated the rigor of program impact studies and described the strength of evidence supporting different program models. Based on this review, HHS identified evidence-based programs, defined as those with: (1) studies with designs that have the best chance of finding unbiased impact estimates; and (2) a positive, statistically significant impact on sexual activity, contraceptive use, sexually transmitted infections, pregnancies, or births. So far 31 different program models have met the review criteria for evidence of program effectiveness. Most youth served through PREP formula funding (93 percent) will participate in one of these evidence-based programs. ACF released a report last fall on how states are scaling up these evidence-based programs. The report also highlights how some states are reaching their target populations.<sup>13</sup>

The report shows that the reach of the program is quite broad. States plan to serve a total of 300,000 youth through formula grant funding over the course of the five-year grant period. These youth are being reached through over 300 different program providers operating in over 1,300 different sites across the country. In addition, most state grantees are focusing on high-risk youth. Three-fourths of state program providers operate in high-need geographic areas. Finally, the report finds that state PREP grantees are creating an infrastructure to support successful replications of evidence-based programs through training, technical assistance, and monitoring.

On a Federal level, ACF/HHS is supporting grantees to successfully replicate the evidence-based programs through training, technical assistance, and monitoring. The agency has developed a range of resources, including webinars and online toolkits, to encourage grantees to draw on the best available research findings to inform the administration of their programs.

---

<sup>12</sup> Information about the review procedures and results is available at [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/)

<sup>13</sup> The report is available at <http://www.acf.hhs.gov/programs/opre/resource/the-personal-responsibility-education-program-prep-launching-a>

