Testimony of

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Chairman Burgess, Ranking Member Green, and members of the Subcommittee, thank you for the opportunity to testify today on legislative proposals to enhance the oversight of the Medicaid program and tools for states to improve health outcomes for key covered populations.

About NAMD

My name is Matt Salo, and I am the Executive Director of the National Association of Medicaid Directors (NAMD). NAMD is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. Our members drive major innovations in health care while overseeing Medicaid, the nation's largest health insurer which provides unique benefits and supports to its beneficiaries. NAMD serves as the voice for state Medicaid Directors in national policy discussions, supports state-driven policies and practices that strengthen the efficiency and effectiveness of Medicaid and actively monitors emerging issues in Medicaid and health care policy. NAMD also supports the leadership development of Medicaid Directors and their senior staff as they manage both the strategic orientation and day-to-day operations of the nation's largest health insurer.

Medicaid, together with the Children's Health Insurance Program (CHIP), provides health coverage for more than 71 million Americans; approximately one in five Americans are covered by these programs. Medicaid is jointly funded by the federal government and the states, which together spent $553 billion in FY 2016, and is administered by states under broad federal standards.

The Medicaid population is diverse, including eligible children, pregnant women, low-income families, elderly adults, people with chronic conditions and people with physical, developmental or behavioral needs. Medicaid funds close to 50 percent of all births and is the primary payer of long-term care in this country. Medicaid also provides most of the nation's funding for HIV/AIDS-related treatments and mental health services, among other forms of health care. More than 40 percent of Medicaid spending is aimed at addressing the shortfalls of the Medicare program for individuals dually eligible for both. Medicaid is also one of the nation's largest payers of behavioral health and substance use disorder services, making it a key tool in the toolbox for tackling the ongoing opioid crisis.

The unique characteristics of Medicaid, with its joint federal and state funding structure and significant latitude for states to customize their programs to best serve the needs of their local populations, are vital to its success. As the Subcommittee considers statutory modifications to Medicaid, the core characteristics of flexibility for states to most appropriately administer their programs and federal investment in Medicaid's tools will ensure the program continues to provide high quality care to Medicaid beneficiaries and be a responsible steward of state and federal taxpayer dollars.

ACE Kids and the Role of Medicaid in Covering Medically Complex Children

As previously noted, Medicaid and the Children's Health Insurance Program (CHIP) are core sources of coverage for the nation's children. This includes children with complex medical conditions who require specialized benefit designs and services, such as children with serious behavioral health needs, rare pediatric diseases, or those in the foster care system.

Many states have prioritized developing initiatives that take advantage of delivery system characteristics and existing provider infrastructure to improve care for this complex and vulnerable population. These initiatives can be innovative and cross-cutting, tackling both medical services and the broader context of a child's life to improve outcomes. For example, Florida's Medicaid managed care program uses a specialized plan focused on providing services to children in foster care, and New York is piloting a unique approach under which pediatricians in a specific area are held accountable for a child's readiness to enter the school system. Efforts like these are underway across the country, demonstrating Medicaid Directors' commitment to continuing to enhance care for children.

It is important to note that when we speak about the medically complex child population, we are discussing a population that is not monolithic. Their needs are diverse, as any number of conditions can be categorized as medically complex. For this reason, states will continue to need flexibility from our federal partners to design and implement solutions that reflect the unique needs of the children covered in the state. A program design that succeeds in urban areas in Minnesota may not be transferable to frontier counties in New Mexico. That said, Medicaid Directors are always eager to learn from one another to address common challenges. Identifying

effective models, the factors driving the model's success, and sharing that information widely across the states can raise the bar nationwide. NAMD works to foster this dialogue among our members, and our federal partners at the Centers for Medicare and Medicaid Services (CMS) do so as well.

What Medicaid Directors would prefer to avoid is being required to adopt a specific model or benefit design for the entirety of the medically complex child population. For the reasons noted above, a one-size-fits-all approach to this population is less likely to achieve the shared aims of improved health outcomes than an approach which emphasizes the need for flexibility and creativity and accounts for the facts on the ground.

Basing new federal options for states in this area on existing models with which states are already familiar, such as health homes, is a promising approach. Many states are already using the health home model to target specific and complex subpopulations, such as individuals living with multiple chronic conditions, individuals with HIV/AIDS, and individuals with serious mental illness. Expanding the health home option to incorporate medically complex children, providing strong federal investment in the model, and maintaining the flexibilities the model offers for states to customize a health home for a specific population of complex children would likely garner state interest and promote improved health outcomes.

As a final point, consider the creation of CHIP and the success of that program as illustrative of the most effective approach to enhance children's coverage. Prior to CHIP's creation in 1997, states had the option to expand their Medicaid programs to cover what would become the CHIP-eligible population. Some states chose to do so, though not all did. CHIP positively changed this environment by adopting two key policies: first, giving states new tools to create benefit designs and coverage not available under Medicaid; and second, providing strong federal investment via a higher matching rate for CHIP. This combination of flexibility for states and meaningful federal financial support produced a successful program which helped significantly reduce the uninsured rate among children and enjoys strong bipartisan support to this day. Applying these principles of flexibility and investment to a new option for medically complex children will produce similar success.

Money Follows the Person: A Valuable Tool Supporting Rebalancing Long-Term Care Towards the Community

Medicaid is the nation's primary insurer of long-term services and supports (LTSS). The populations receiving these services may have physical, intellectual, or developmental disabilities that require specialized supports or even around-the-clock care. Others may simply be individuals who, as they grow older, need help with their daily activities. Many of those receiving Medicaid LTSS are dually eligible for Medicare, receiving services from both programs. Although people who receive Medicaid-funded LTSS represent a small proportion of the total membership, they typically have complex needs and represent almost half of Medicaid spending.

As the Subcommittee knows, by statute Medicaid provides mandatory coverage of LTSS in institutional settings, such as nursing homes. Medicaid can also provide coverage for in home- and community-based services (HCBS), though this is at states' option and states must seek a waiver from CMS to do so. This is often referred to as the "institutional bias" in the Medicaid statute. All states have elected to use one or more waivers, which allow individuals to receive their supports at home and/or in a community setting of their choice.

A key objective of both states and CMS for the past several years has been to rebalance the provision of Medicaid LTSS from institutional settings towards the community. Rebalancing refers to reducing reliance on institutional care and expanding access to community-based LTSS. A rebalanced LTSS system gives Medicaid members greater choice in where they live and from whom they receive services. It also delivers LTSS that are integrated, effective, efficient, and person-centered. Finally, increasing the proportion of LTSS spend in the community has enabled states and the federal government to achieve significant cost savings.

This work is challenging, resource-intensive, and requires sustained effort. Fortunately, states have received valuable support for their rebalancing efforts in the form of the Money Follows the Person (MFP) Demonstration grant program. First passed in 2005, MFP has provided states with significant financial resources to develop the infrastructure necessary to support individuals' transitions from institutions back into the community. States have leveraged MFP dollars creatively, drawing on these funds to educate consumers about LTSS, support development of

the HCBS workforce, expand the reach of existing HCBS programs, test new service options such as substance use disorder interventions, and provided a valuable source of longitudinal data spanning over a decade on the barriers to rebalancing and the solutions needed to address them. In rural states where institutions may be particularly isolating, MFP dollars have helped return individuals to their local communities. Thanks in part to MFP, for the first time in FY 2013, more than 50 percent of Medicaid LTSS spending took place in HCBS settings, and the trend appears to be continuing.

Unfortunately, the success of MFP is currently in jeopardy. The program sunset in 2016, though grant dollars are available to states through FY 2018 and may be spent into FY 2019. That means states are currently tasked with winding down MFP-supported programs, in case a reauthorization does not occur. States are actively working with CMS to identify which elements of MFP programs can continue to be supported via other authorities, but it is clear that without reauthorization and associated funding many MFP-funded programs will need to be ended. This would negatively impact the ongoing rebalancing work states are undertaking and has the potential to greatly increase Medicaid LTSS spending. The process of planning for program wind-down, even if such measures prove to be unnecessary, strains limited state resources and creates uncertainty for providers and beneficiaries.

In order to avoid these problems, Medicaid Directors strongly support a prompt reauthorization of MFP. This reauthorization should occur quickly enough to provide states with continuity for existing programs. We are pleased to see the Subcommittee considering reauthorization, and we support the policy modifications in the current legislative package – especially the alteration of the institutional stay requirement for MFP dollars from 90 days to 60 days. Shortening the required stay in an institutional setting would better support individuals who enter facilities for rehabilitation, and unfortunately tend to become long-term residents, absent supports to enable them to move back to the community.

Enhancing Investment in State Program Integrity Efforts

Medicaid Directors understand the critical importance of safeguarding the integrity of the Medicaid program, and take seriously their obligation to ensure scarce state and federal resources

are being well utilized and beneficiaries are safely and appropriately cared for. States are strongly committed to identifying and eliminating waste, fraud, abuse, inefficiencies, and neglect in their programs. Federal tools and resources for states to conduct program integrity activities are greatly appreciated.

Medicaid agencies are not alone in the effort to improve Medicaid program integrity. There are many entities with responsibilities and authority in this area, including federal auditors within CMS, the Health and Human Services Office of the Inspector General, and the Government Accountability Office. There are also separate entities at the state level, such as Medicaid Fraud Control Units (MFCUs).

The Subcommittee is considering legislation to provide federal funding for MFCU investigations in non-residential settings. As we noted in the discussion on MFP, states are looking to increase the amount of LTSS provided in these settings, and agree that ensuring these settings are safe is a critical aspect in continuing this work. However, as MFCUs are separate from the Medicaid agency and primarily oriented towards law enforcement, it is important to recognize the need for coordination among the Medicaid agency, law enforcement, and other entities playing roles in this area. Careful consideration must be given to minimizing duplication across program integrity authorities and activities.

We wish to call the Subcommittee's attention to other statutory changes, beyond the MFCU funding change considered here, which can make Medicaid program integrity activities more robust and effective.

First, the federal investment in state Medicaid program integrity work can be enhanced. Currently, state program integrity activities are counted as administrative spending for purposes of federal match. The administrative match is 50 percent, the lowest level of federal match available. We encourage the Subcommittee to consider a higher match – such as 75 percent, which is what MFCUs receive – to maximize state resources invested in program integrity. Significant federal match for other key priorities, such as the 90 percent match for upgrading Medicaid data systems, has been highly successful. Similar consideration should be given for Medicaid program integrity.

The second potential change concerns how Medicaid overpayments identified by states are handled. Under current law, any time the state identifies an overpayment, it is obligated to return the federal share of that payment. The federal repayment must take place even if, for circumstances beyond the state's control, the state is unable to recoup the overpayment amount. While Congress has made changes to extend the window under which this repayment occurs, it must still occur regardless. This policy imposes a financial burden for states in circumstances where overpayments cannot be recouped, thereby creating a barrier to effective program integrity efforts. In essence, the policy punishes the state for conducting good program integrity practice in identifying overpayments. We encourage the Subcommittee to consider altering how identified overpayments are treated in instances where the states are unable to recoup the overpayments.

Conclusion

Thank you again for the opportunity to testify before the Subcommittee on these important topics. We look forward to continuing to work with you and providing the perspectives of Medicaid Directors on further improvements to the program and the individuals we serve.