



**The Security and Reliability of the Health Exchange Data Hub:  
The State Medicaid Perspective**

Testimony of

Matt Salo

Executive Director

National Association of Medicaid Directors

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Good afternoon Chairman Meehan, Ranking Member Clarke, and distinguished members of the Subcommittee. My name is Matt Salo, and I am the Executive Director of the National Association of Medicaid Directors (NAMD). I appreciate the opportunity to testify before you today.

### Medicaid

Medicaid is the nation's health care safety net. Jointly financed by the states and the federal government, Medicaid spent more than \$420 billion last year to provide health care to more than 72 million Americans. The program is administered by the states within a broad federal framework which leads to enormous variation across states in terms of who is covered, what services are provided, and how those services are paid for and delivered. Furthermore, within any given state, Medicaid's role is broad, varied, and complex. Medicaid funds close to 50 percent of all births, and the majority of all publicly financed long-term care in this country. It also provides most of the nation's funding for HIV/AIDS related treatments, mental health services, and others. It is therefore very difficult to talk simplistically about Medicaid (either nationally, or within a state), despite its incredible importance in the U.S. health care system.

NAMD was created with the sole purpose of providing a home for the nation's Medicaid Directors and we represent all 56 of the state, territorial and DC agency heads. Our two broad objectives are to give the Medicaid Directors a strong, unified voice on national and federal matters as well as helping develop a robust body of technical assistance and best practices for them to improve their own programs. While no two programs look exactly alike, the Directors are unified in their heartfelt desire to improve the health and health care of the growing number of Americans who rely on the program.

### Implementing the Affordable Care Act -- Overview

No issue has been more polarizing in recent memory than the Affordable Care Act (ACA), often known as "Obamacare." While the ACA may not be wildly politically popular, or even well understood, it is the law of the land, and it will have far-reaching and fundamental impacts on the citizens of every state in the nation.

Politics aside, the key to the success or failure of this new law lies in how well it serves our citizens; and how well they are able to understand, access and afford their new health insurance options. In many ways much of the foundation hinges on reforms to the Medicaid program. The states have been working as quickly and effectively as possible for months, even years, to put together the pieces of this complex health insurance overhaul.

To fully understand the herculean task the ACA presented to state Medicaid programs, we must acknowledge that states began this journey from very different starting points. Likewise, even several years after the official ACA launch we can still expect to see differences in the structure of Medicaid programs -- and health care systems generally -- as states determine how to best meet the diverse needs of their citizens.

Regardless of their starting or ending points, there is a long list of changes that all states have to make to comply with the law. These include overhauling complex eligibility systems to conform to new standardized federal rules. State Medicaid agencies also have been working to integrate with new health insurance marketplaces to ensure that individuals and families receive consistent, accurate information about their eligibility for public insurance programs. And they have endeavored to minimize the burden and confusion for individuals and families trying to navigate the rules for these new programs.

Investments in this system overhaul are being made by states, and by the federal government—with everyone involved fully committed to ensuring that they work as well as possible. As envisioned, the new system would be able to process a few consumer data points (name, social security number) and determine the insurance program – Medicaid or the marketplace -- for which each individual in a family would be eligible. It also would begin the actual process of enrolling and paying for that coverage.

Achieving this vision requires real-time communication between states and the federal government and among multiple federal Departments that historically have never talked to one another. In many states, it requires a complete overhaul of decades-old Medicaid eligibility systems in order to interface with a new federal “hub.”

In addition to these technical hurdles, there is another reality to contend with: No two state Medicaid programs are alike. These differences have developed over the nearly 50 years of the program’s existence, and reflect the political and cultural dynamics of each state. These differences range from who is covered, which benefits are available and how care is both delivered and paid for, as well as the sophistication (or too often, lack thereof) of the state eligibility and information systems, many of which were built in the 1980s.

In a sense, states are building 50+ bridges all at the same time, from different starting points and hoping that these efforts meet exactly in the middle. These bridges CAN be built and they are in fact being built now. But it is vitally important that we take heed of the lessons of complex policy implementations in the past as well as the expertise states have with program and system implementations.

#### Privacy, Security, Confidentiality of Information

Security, privacy and confidentiality are among the highest priorities for state Medicaid Directors. They also hold their vendors to the same high expectations and work with them to ensure they too appropriately safeguard personal information.

While there have been security breaches in Medicaid, there have also been security breaches in the banking and credit card industries, with Internet service providers, and practically every other component of our increasingly interdependent economy. It is unrealistic to expect that these things can be prevented entirely, it is more important that we focus on how to minimize and mitigate the risks that are inherent in an interconnected society.

States currently handle many of these types of information in a highly secure way as they make eligibility determinations for the more than 70 million Americans currently on the program. States

routinely work with Chief Information Officers, consumer protection agencies, the inspector general's offices in a variety of state and federal agencies, and more in their efforts to protect consumer information.

While the specifications of the systems being built to interface with the federal data hub and the Insurance Marketplaces are new, states have decades of experience working across program platforms to ensure privacy, confidentiality, and security of patient information (medical and otherwise). Whether its communicating with private insurance companies to do third-party liability determinations, working with other programs such as TANF or SNAP to eliminate redundancies, working with a range of federal agencies to implement citizenship documentation requirements, or working with Medicare to improve care coordination for individuals dually eligible for both programs, state Medicaid directors have significant experience and perspective.

In each of these examples, it is important to note that the sharing of information across programs or payors is a vitally important function. In fact, the entire field of public health and program integrity would barely exist if data could not flow securely, quickly and effectively.

While I am not here to testify to the readiness schedule of the federal data hub, we do know from experience of the high level commitment to privacy and security. In fact, this commitment is one of the main drivers of our concern that the full range of operational capacity is not likely to be met by October 1. In fact, some of the earliest conversations with our federal partners revealed a significant stance on behalf of IRS that it was more important to ensure that the exchange of data was done securely than it was to do it quickly.

### The Road Ahead

As we approach the open enrollment date of October 1, 2013, there is one lesson that clearly stands out: we must be prepared for a turbulent take-off.

The magnitude of the changes and the many different pieces that have to be linked together mean everyone – consumers, policymakers, and other interested stakeholders – must have reasonable expectations of the systems and programs early on. In many instances, the consumer experience will not be immediately smooth. Real people are going to be frustrated when accessing the system. Whether it's a failure of computer algorithms to properly account for the startling complexity of real people's lives, or the difficulty in ensuring that these multiple state and federal agencies are communicating in real time, it will be bumpy.

However, it's also reasonable to expect that the experience can and will improve over time. As they do in advance of any major implementation, Medicaid agencies are trying to predict, plan for and set up procedures to resolve the problems that will inevitably arise. At the same time they will continue working towards the ultimate goal of compliance with the law's requirements and seizing other opportunities they've identified.

The health and safety of Medicaid clients is the main concern of Medicaid Directors, and they will continue their ongoing commitment to provide the best possible service to beneficiaries, while protecting the integrity of the program, and being responsible stewards of taxpayer dollars.