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TESTIMONY BY ALAN R. WEIL

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National Academy for State Health Policy (NASHP)

Before the

Energy and Commerce Committee

Subcommittee on Health

United States House of Representatives

Hearing on

Making Medicaid Work for the Most Vulnerable

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The views presented are those of the author and do not necessarily represent those of NASHP trustees or sponsors.

EXECUTIVE SUMMARY

Medicaid is the “workhorse” of the American health care system. It is not glamorous, but it is effective in achieving its goals of providing access to health care services and relieving the financial burden associated with care for those least able to afford it. Medicaid is a dynamic program that is evolving to meet the changing needs of vulnerable populations, leading change in how care is structured and delivered, and participating in the nationwide transformation of care delivery and financing.

In this testimony I describe steps Medicaid is taking to address the particular needs of the population it serves. Examples of the kind of innovation that occurs continually within the Medicaid program can be found in the areas of developmental screening, oral health, long term services and supports, and eligibility streamlining.

I then discuss how Medicaid is working with other public and private systems to promote better health outcomes and a more efficient, better organized health care system. I review six examples of these interdisciplinary approaches: Medicaid managed care, patient-centered medical homes, health homes, integration with public health, accountable care models, and the State Innovation Models program.

I conclude by noting that Americans who are without health insurance seek access to care and to be treated with dignity, just like anyone else. While the nation debates the future of Medicaid and the future of the health care system, Medicaid is the only practical option millions of vulnerable Americans have for meeting their health care needs.

Chairman Pitts, Ranking Member Pallone, and members of the committee, I appreciate the opportunity to appear before you today to discuss how Medicaid is meeting the needs of the most vulnerable Americans. I am the Executive Director of the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization dedicated to excellence in state health policy and practice. NASHP works with state leaders to identify emerging issues, develop policy solutions, and support innovation in policy and practice. Prior to joining NASHP, I directed a major research project at the Urban Institute, and, before that, I was executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

Medicaid Overview

Ten years ago, I called Medicaid the ‘workhorse’ of the American health care system.¹ That characterization remains true today. Medicaid is not glamorous, but it is strong and effective in achieving its goals. Medicaid provides access to critical health and social supports for the most vulnerable Americans, whether they are poor children and their families; people with profound health care needs such as those with traumatic brain injuries, serious and persistent mental illnesses, cerebral palsy, multiple sclerosis, Down’s syndrome or autism; or in need of social supports due to frailty or dementia. Medicaid is an expression of our nation’s commitment to the most vulnerable.

Because the Medicaid program is so complex, it is worth reminding ourselves of a few important facts. In 2012, Medicaid covered more than sixty-two million Americans.²

¹ Weil, A. There’s Something About Medicaid. *Health Aff (Millwood)*. Jan 2003 22(1):13-30.

² Kaiser Family Foundation. Medicaid: A Primer-Key Information on the Nation’s Health Coverage Program for Low-Income People. Washington (DC): KFF. 1 Mar 2013. Accessible from: <http://kff.org/medicaid/issue-brief/medicaid-a-primer/>

Children and their parents account for about forty-seven million of these, but despite representing seventy-five percent of enrollment, they only account for thirty-four percent of spending. Fully forty-two percent of Medicaid program costs are associated with meeting the needs of people with disabilities, while the remaining twenty-three percent are spent on elders, where Medicaid fills in the significant gaps in Medicare coverage—most critically Medicare’s lack of a long-term care benefit.³ Medicaid is administered by the states within federal standards, and is financed jointly by the two levels of government. In FY 2011, federal Medicaid expenditures were \$275 billion, where they represented 7.6% of the federal budget, while state Medicaid expenditures were \$157 billion, representing on average 23.7% of state general fund spending.^{4,5}

Just like private health insurance, Medicaid is a financing mechanism. Its primary functions are to provide access to health care services and relieve the financial burden associated with care for those least able to afford it. Evidence demonstrating Medicaid’s success in achieving these goals is unambiguous. Myriad studies compiled in the Institute of Medicine’s 2009 report “America’s Uninsured Crisis” conclude that Medicaid and the Children’s Health Insurance Program improve access to services, increase the likelihood that an enrollee will have a usual source of care, increase the use of primary and preventive services, and reduce unmet medical needs.⁶ One recent study from

³ Kaiser Family Foundation. Medicaid Enrollees and Expenditures, FFY 2009. KCMU/Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64, 2012. Washington (DC): KFF. Accessible from: <http://kff.org/medicaid/slide/medicaid-enrollees-and-expenditures-ffy-2009/>

⁴ Congressional Budget Office. Federal Grants to State and Local Governments. Washington (DC): CBO. 5 Mar 2013. Accessible from: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43967_FederalGrants.pdf

⁵ National Association of State Budget Officers. State expenditure report: examining fiscal 2010–2012 state spending. Washington (DC): NASBO; 2012. Available from: http://www.nasbo.org/sites/default/files/StateExpenditureReport_1.pdf

⁶ Institute of Medicine of the National Academies: Committee on Health Insurance Status and Its Consequences, Board on Health Care Services. America’s Uninsured Crisis: Consequences for Health and

Wisconsin shows enrollment in Medicaid leading to reductions in hospitalizations and, in particular, preventable hospitalizations.⁷

People without health insurance live sicker and die younger than those with any form of health insurance, including Medicaid.⁸ When Medicaid coverage expands, deaths decline.⁹ For statistical and ethical reasons, it is hard to tie a specific form of health insurance to specific improvements in health, but recent research provides important evidence of some direct health benefits associated with Medicaid coverage even as it fails to show evidence of improvement in other areas. I am unaware of any private health insurance plan that has been subject to the same scrutiny as Medicaid regarding its health effects, yet the vast majority of Americans would never question if having health insurance is good for them.

At a time when Medicaid is poised for growth and the country is debating the program's efficacy, my testimony will focus on the changing nature of the program. In my work with states, I see a dynamic program that is evolving to meet the changing needs of vulnerable populations, leading change in how care is structured and delivered, and participating in the transformation of care delivery and financing that is occurring around the country.

Health Care. National Academies Press, Washington (DC). 2009. Accessible from: <http://www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx>

⁷ DeLeire, T., Dague, L., Leininger, L., Voskuil, K., Friedsam, D. Wisconsin Experience Indicates That Expanding Public Insurance to Low-Income Childless Adults Has Health Care Impacts. *Health Aff(Millwood)*. 2013 Jun. 32(6):1037-1045. Accessible from: <http://content.healthaffairs.org/content/32/6/1037.full>

⁸ Institute of Medicine, "America's Uninsured Crisis."

⁹ Sommers, B., Baicker, K., Epstein, A. Mortality and Access to Care among Adults after State Medicaid Expansions. *New England Journal of Medicine*, 13 Sept 2012: 367:1025-1034. Available from from <http://www.nejm.org/doi/full/10.1056/NEJMsa1202099#t=articleMethods>

Meeting the Needs of the Medicaid Population

In this first section of my testimony I discuss steps Medicaid is taking to address the particular needs of the population it serves. The areas I discuss represent just a few examples of the kind of innovation that occurs continually within the Medicaid program. The areas I will focus on are developmental screening, oral health, long term services and supports, and eligibility streamlining.

Developmental Screening

As the source of insurance coverage for one of every three children, Medicaid has a particular interest in assuring that children with developmental delays or at risk of delay are identified and receive needed services. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 required the development of a core set of quality measures for child health. Released in early 2011, one of the core measures is the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool at certain ages.

Research suggests that many health problems and disorders in children could be prevented or ameliorated with prevention, early detection, and intervention. Prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial and cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention. Evidence also indicates that pediatric primary care providers who use a standardized, validated,

developmental screening tool more effectively identify children at risk for developmental delay than those who rely solely on medical judgment.¹⁰

Medicaid has led the way in promoting the use of valid screening methods to identify children who would benefit from early intervention services. The percentage of children receiving such screening has grown from 19.5 percent in 2007 to 30.8 percent in 2011-12, with improvement in every state but one.¹¹ Medicaid policy has played a critical role, with fourteen states requiring Medicaid providers to perform a standardized developmental screening as part of certain well-child exams. In twenty-six states, the Medicaid program pays an additional fee for standardized screening. Some states reimburse for more than one type of screen during a well-child visit (e.g. mental health, parental depression, autism).

North Carolina leads the nation in developmental and behavioral health screenings for children ages birth to five. Seventy-five percent of Medicaid well-child exams for children in this age range include a developmental screen, and the state requires the use of standardized screening tools during specific well-child visits in order to receive Medicaid reimbursement.

North Carolina began by implementing screening through its Community Care of North Carolina (CCNC) networks. Oklahoma is pursuing changes that will make developmental screening and follow-up a requirement for all three tiers of medical home recognition in the state. Oregon has made developmental screening a “must pass element” in its revised Patient Centered Primary Care Homes (PCPCH) standards to be

¹⁰ D. Rydz, et al. "Developmental Screening," *J Child Neurol*. 2005; 20(1): 4-21.

¹¹ Child and Adolescent Health Measurement Initiative, Data Resource Center for Child & Adolescent Health, “Newsletter, April 9, 2013.” (Retrieved April 10, 2013).

released in October 2013 and an incentive metric for its Coordinated Care Organizations (CCOs).¹²

Medicaid is not only leading in policy; it is leading in outcomes. Children with public health insurance are now more likely to receive a developmental screen than children with private health insurance.¹³

Oral Health

In 2000, Surgeon General David Satcher called poor oral health America's silent epidemic.¹⁴ State Medicaid programs are actively pursuing efforts to ameliorate this crisis for the vulnerable populations they serve.

For example, North Carolina's *Into the Mouths of Babes* program pioneered the use of Medicaid funding to encourage doctors and nurses (who children are more likely to see than a dentist) to provide oral screenings and fluoride varnish to very young children, as soon as their first teeth erupt.¹⁵ Evaluations have shown the *Into the Mouths of Babes* program is cost-effective in preventing decay, reducing the number of children who must be treated in a hospital for extensive decay, and improving a child's likelihood

¹² Information about state approaches to improving developmental screening can be found at <http://www.nashp.org/abcd-welcome>.

¹³ The Data Resource Center for Child and Adolescent Health, a project of the Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health: Question 4.16: Developmental Screening During Health Care Visit, age 10 months – 5 Years by Type of Insurance. Accessed June 18, 2012. Available from: <http://www.childhealthdata.org/browse/survey/results?q=257&g=74>

¹⁴ U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville (MD): U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. Accessible from: <http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf>

¹⁵ Snyder, A. "Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations. National Academy for State Health Policy, March 2009. Accessible from: <http://nashp.org/publication/increasing-access-dental-care-medicare-targeted-programs-four-populations>.

of being seen by a dentist for routine care.¹⁶ This innovative practice has spread across the country, with forty-four state Medicaid programs following suit by 2013.¹⁷

Washington's *Access to Baby and Child Dentistry* program is a long-standing, successful partnership between Medicaid, counties, and local dental associations in which enhanced Medicaid payments are made to general dentists who receive specialized training and agree to treat children under the age of five. This very successful initiative helps provide timely preventive care to children at high risk of dental decay. Between 1997 and 2004, the number of Medicaid-enrolled children receiving dental care more than doubled, and the number of children under age two who received care more than quadrupled.¹⁸

Maryland responded to the tragic death in 2007 of a child from a brain infection resulting from untreated dental caries with a comprehensive set of dental policy changes, including Medicaid payment rate increases, administrative streamlining, and enhancements to public health programs.¹⁹ Since then, the state has experienced a marked improvement in children's access to dental care, with use of preventive dental

¹⁶ Stearns, S. et. al. Cost-Effectiveness of Preventive Oral Health Care in Medical Offices for Young Medicaid Enrollees. *Archives of Pediatric & Adolescent Medicine* 2012; 166(10): 945-951. Accessible from: <http://archpedi.jamanetwork.com/article.aspx?articleid=1355373>.

¹⁷ American Academy of Pediatrics. State Medicaid Payment for Caries Prevention Services by Non-Dental Professionals. (updated June 2013). Accessible from: <http://www2.aap.org/oralhealth/docs/OHReimbursementChart.pdf>.

¹⁸ Pew Center on the States. Washington's ABCD Program: Improving Dental Care for Medicaid-Insured Children. Washington (DC): The Center. 29 Jun 2010. Accessible from: <http://www.pewstates.org/research/reports/washingtons-abcd-program-85899373157>.

¹⁹ Maryland Dental Action Coalition. Maryland Oral Health Plan, 2011-2015. 2011. Accessible from: <http://www.mdac.us/maryland-oral-health-plan/>.

services among Medicaid-enrolled children rising by nineteen percentage points between 2007 and 2011.²⁰

While dental access for children in Medicaid lags behind children with private health insurance, CMS reports that between fiscal years 2007 and 2011, twenty-four states achieved a ten percentage point increase in the proportion of children with a preventive dental visit.²¹ These improvements reflect continued efforts by states to tackle the persistent challenge of low-income children's access to oral health care.²²

Long-Term Services and Supports (LTSS)

As the nation's primary payment source for long-term services and supports, Medicaid policy largely defines how low-income elders and people with disabilities receive skilled nursing services, residential services, and supports for activities of daily living. From 1999 to 2009, the share of Medicaid LTSS spending devoted to home and community based services for older people and adults with physical disabilities increased from 18.6 percent to 35.1 percent. States continue to shift their Medicaid long-term services and supports expenditures from nursing facility care to home and community-based services. This shift promotes human dignity and saves money.

For more than two decades, Washington has been leading the way providing long-term services and supports in the community, enabling older adults and individuals with disabilities to have choices about where they live, what services they receive, and who

²⁰ Centers for Medicare and Medicaid Services. CMS Oral Health Initiative and Other Dental-Related Items, CMCS Informational Bulletin 04-18-13. 18 Apr 2013. Accessible from: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-04-18-13.pdf>

²¹ Ibid.

²² See, for example, Government Accountability Office. Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns, GAO-11-96. Washington (DC): GAO. 30 Nov 2010. Accessible from: <http://gao.gov/products/GAO-11-96>.

provides their services. By offering a wide range of services, avoiding waiting lists for in-home care, and expediting services, the state has been successful at diverting individuals from institutions. Washington has one of the most balanced long-term services and supports systems in the nation, with three-quarters of individuals receiving services in the community, rather than in institutions, and sixty-two percent of its long-term services and supports budget spent on home and community-based services.

Washington has actually reduced the number of persons residing in nursing facilities. The state has been successful in transitioning individuals out of nursing homes and back into the community by assigning case managers to develop and implement transition plans. Washington works not only with those who have just arrived in a nursing home, but also those who have been resident for an extended period, who require a more comprehensive set of supports to return to the community. Between 2005 and 2010, Washington decreased the number of Medicaid supported nursing facility residents by six percent.²³

Eligibility Streamlining

Medicaid eligibility was built on a welfare application platform, which presents significant barriers for busy families unable to take unpaid time to wait in line to enroll and requires a large bureaucracy for administration. Taking advantage of opportunities created by the delinking of Medicaid from welfare in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (commonly known as welfare reform) and the creation of the State Children's Health Insurance Program in 1997, states have made

²³ AARP. Across the States: Profiles of Long-Term Services and Supports. 2012. Accessible from: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

major strides in simplifying their eligibility processes to improve customer service and so the program can better serve those who meet eligibility standards.

Before they were required to take these steps by the Affordable Care Act, states were moving away from administratively burdensome requirements like face-to-face interviews and asset tests and embracing innovations such as presumptive eligibility, allowing for continuous eligibility regardless of income fluctuations, and borrowing data from programs like SNAP to determine eligibility more efficiently. States are relying on new technologies to make Medicaid enrollment a more modern, 21st century experience. Some states already use electronic case records, allow electronic verification of eligibility and information sharing across programs, and allow individuals to update their information using a consumer-facing personal account. Nearly all states are using new, enhanced federal matching funds to upgrade their antiquated computer systems.

In 2010, Louisiana became the first state to implement Express Lane Eligibility. The Department of Health and Hospitals partners with the Department of Children and Family Services to use SNAP eligibility determinations to automatically enroll and renew children's Medicaid coverage.

Also in 2010, Oklahoma launched the nation's first online, real-time enrollment system for Medicaid, which can accept applications, generate documentation requests, make determinations, and enroll individuals into a plan 24 hours a day, 7 days a week. Oklahoma's automated system allows eighty-two percent of applicants to enroll when they apply, with about half of those applicants required to submit additional documentation that confirms their eligibility. The automated system offers a particular benefit to busy families: in 2011, one-quarter of online applications were submitted in the

evenings after 5 p.m. or on weekends.²⁴ The eligibility system has been able to maintain operations even when state offices are closed. For two days in February 2011, most of Oklahoma's agencies were closed due to a blizzard, but the automated system continued operations, enrolling 780 individuals.

Integration with Other Systems

Medicaid is increasingly working with other public and private systems to promote better health outcomes and a more efficient, better organized health care system. In this section I review six examples of these interdisciplinary approaches: managed care, patient-centered medical homes, health homes, integration with public health, accountable care models, and the State Innovation Models program.

Medicaid Managed Care

All but three states rely upon managed care for delivering care to at least some of their Medicaid enrollees. Two-thirds of Medicaid enrollees receive most or all of their benefits in managed care. Recent trends are toward greater reliance upon mandatory Medicaid managed care programs for more complex populations, such as children with special health care needs and people of all ages with disabilities. Half the states have voluntary or mandatory programs that enroll individuals who are dually eligible for Medicare and Medicaid into a managed care program.²⁵

States' use of managed care reflects a desire to achieve cost savings and budget predictability. These programs enable states to tap into care management strategies developed in the private sector. Managed care plans have data systems that gather

²⁴ Turner T., Online enrollment [PowerPoint Presentation]. Oklahoma Healthcare Authority; 2012.

²⁵ Kaiser Family Foundation, "Medicaid Managed Care: Key Data, Trends, and Issues," (February 2012).

quality and utilization information that helps states monitor and improve program performance. While these programs have been controversial in some instances, they reflect a desire by states to utilize care coordination and care management methods and move away from Medicaid's fee-for-service history.

Patient-Centered Medical Homes

Medicaid has been a leader in promoting development of patient-centered medical homes, recognizing that strong primary care systems are the backbone of high performing health systems. Over the past seven years, states have been redesigning Medicaid to deliver better primary care through the medical home model, an enhanced model of primary care that provides whole person, accessible, comprehensive, ongoing and coordinated patient-centered care. Since 2006, twenty-nine states have launched one or more programs in Medicaid or the Children's Health Insurance Program, which offer new medical home payments and supports to primary care providers to deliver higher quality, more accessible, patient-centered care. In eighteen of these states, public and private payers and purchasers are working together to support multi-payer medical home projects, aligning objectives and incentives to spur system-wide transformation. Fifteen of these initiatives also include Medicare.

For example, in Michigan, Medicaid and Blue Cross Blue Shield have teamed up with Medicare to launch one of the largest medical home programs in the country, reaching over 1,000,000 patients. Maine's patient-centered medical home pilot includes ten multi-disciplinary community care teams serving multiple primary care practices. Maine is building on this critical infrastructure as it pursues additional payment and delivery system reforms, including health homes and community-driven accountable care

organizations. Maryland's multi-payer patient-centered medical home program serves 250,000 patients across Medicaid and the state's five largest commercial payers. Participating practices achieved significant savings in the program's first year. The state announced in October 2012 that twenty-three of the fifty-two participating practices received shared savings payments for containing costs while meeting program quality standards.²⁶

Health Homes

The health home model is an extension of the medical home that focuses on chronically ill Medicaid enrollees. Twelve states have received approval to implement health home programs under Section 2703 of the Affordable Care Act.²⁷ Health homes integrate physical health, behavior health, and long-term services and supports to meet the needs of the most complex populations.

States are using health home programs to design comprehensive, person-centered programs that best fit the needs of their high-risk, high-cost populations. Many states have successfully leveraged the existing medical home and primary care case management infrastructure already built in their state. Others have used the program to serve as a platform for future delivery reforms.

For example, New York phased in a statewide health home program that required providers to apply as a larger team with other providers in their community, strengthening or formalizing partnerships across the health care continuum and ensuring

²⁶ Comprehensive information regarding state efforts to support patient-centered medical homes can be found at <http://nashp.org/med-home-map>.

²⁷ <http://www.integratedcareresourcecenter.com/hhstateresources.aspx>.

that the spectrum of health and psychosocial needs of a patient could be met.²⁸

Washington recently received approval of its health home state plan amendment, which serves as a foundation for the state's Financial Alignment for Medicare-Medicaid Enrollees Demonstration.

Integrating Health Care Services and Public Health

Efforts to improve population health can be more effective if they blend personal health care services with public health interventions. Campaigns to reduce smoking offer an excellent opportunity to integrate these approaches.

Massachusetts provides an instructive example. In 2006, Massachusetts' health reforms included the addition of a smoking cessation benefit to the state's Medicaid program. At the time, Massachusetts was one of only six states to include smoking cessation as a Medicaid benefit. In Massachusetts, Medicaid enrollees can obtain up to two 90-day regimens of smoking cessation medications per year, although higher levels are permitted with preauthorization. The medications are available by prescription (by a doctor, nurse practitioner or physician assistant), and copayments are nominal. Counseling is available, with up to sixteen sessions per year, including two intake/assessment sessions and fourteen counseling sessions (with more available with preauthorization), in the form of individual or group sessions. Since in-person counseling is not available statewide, participants can also use telephone counseling services, including Quitworks, a program offered by the Massachusetts Department of Public Health. These services are also available from all Medicaid managed care plans and some plans offer additional benefits.

²⁸ http://www.chcs.org/usr_doc/2012-12-11_spa_approval_plan_pgs_%28phase_III%29.pdf.

Simultaneous with the inclusion of this new Medicaid benefit, the public health department launched a campaign to publicize the availability of the smoking cessation benefit. The campaign included radio and transit advertising and community outreach. In the first two years, forty percent of Medicaid enrollees in Massachusetts took advantage of the smoking cessation benefit. As a result, smoking prevalence among Medicaid enrollees dropped twenty-six percent in two years.

Costly medical procedures among those who utilized the cessation benefit also fell dramatically. Among benefit users, there were thirty-eight percent fewer hospitalizations for heart attacks and seventeen percent fewer emergency-room visits for asthma symptoms in the first year after using the benefit. There were seventeen percent fewer claims for maternal birth complications since the benefit was implemented, state health officials reported. The state saved \$3 for every \$1 that was spent on the smoking cessation program.²⁹

Accountable Care

Medicaid programs around the country are pursuing new models of accountable care that encourage health care providers to organize and coordinate care as they accept financial risk and accountability for health outcomes. Some states are building their models directly on the Accountable Care Organizations authorized by the Medicare program. Other states are developing approaches tailored to meet the specific needs of the state and the state's Medicaid population.

²⁹ Comprehensive information regarding the Massachusetts program can be found at <http://www.mass.gov/dph/mtcp>.

For example, New Jersey is launching a Medicaid Accountable Care Organization Demonstration Project in which groups of providers will assume responsibility for Medicaid populations within a designated geographic area under a shared savings payment model. Minnesota's Health Care Delivery Systems Demonstration will reward groups of Medicaid-participating providers and integrated delivery systems that can achieve savings below a total cost of care target while meeting quality performance requirements. Illinois is recognizing new collaborations of health care providers and community agencies called Care Coordination Entities that will assume financial risk for delivering a package of Medicaid services to enrolled beneficiaries.

Other states are using accountable care principles to develop innovations in their Medicaid programs. Colorado rolled out seven Regional Care Collaborative Organizations (RCCOs) that are responsible for providing medical management, care coordination, and support to Medicaid providers that function as medical homes. RCCOs and primary care providers can receive incentive payments based on performance on select quality indicators. Oregon has built upon a robust patient-centered medical home infrastructure to launch a statewide network of Coordinated Care Organizations (CCOs)—new health plans that secure integrated and coordinated health care for Oregon Health Plan enrollees under global budgets. CCOs are expected to move beyond fee-for-service payment mechanisms for compensating health care service providers, implementing alternative payment methodologies that are based on health care quality and improved health outcomes.³⁰

³⁰ Additional information regarding state approaches to develop accountable care models can be found at <http://www.nashp.org/state-accountable-care-activity-map>.

State Innovation Models

Twenty-five states have received support to test or further develop comprehensive, multi-payer payment and delivery system reforms through Centers for Medicare and Medicaid Innovation's State Innovation Models cooperative agreements. These states are pursuing the shared aim of better care and improved population health at lower cost, using reforms of their Medicaid programs as a catalyst for broader system improvements.

For example, Vermont's SIM approach includes the use of Community Health Teams and Support Services at Home programs, and is seeking to integrate mental health with medical services. Arkansas is focusing on a population-based care delivery model. In Arkansas' medical homes, each patient will be supported by a constellation of providers who address their complete health needs. Health homes will provide additional support to individuals with special needs. Patients will be managed by a "quarterback" provider who assumes responsibility for management of acute and chronic conditions. Minnesota organizes providers who are not formally integrated into "virtual ACOs" by aligning financial arrangements and creating a shared clinical information system. Minnesota's model seeks to integrate medical care, mental/chemical health, community health, public health, social services, schools and LTSS, and encourages providers to partner with community organizations to manage population health.

Conclusion

Medicaid's federalist structure is a source of tension, but also strength. Medicaid is costly, which reflects the profound needs of people vulnerable due to poverty and poor

health. Medicaid is imperfect and suffers from many of the same shortcomings as the rest of the American health care system. But I am unaware of any proposal to replace or fundamentally change the program that holds promise for better meeting the needs of the most vulnerable Americans. Indeed, those who propose major changes to Medicaid should subject their proposals to the same scrutiny they apply to the current program.

As states choose whether or not to expand their Medicaid programs, Congress should be aware that the program they have authorized is dynamic and evolving to meet the needs of the most vulnerable Americans. Americans who are without health insurance seek access to care and to be treated with dignity, just like anyone else. While the nation debates the future of Medicaid and the future of the health care system, Medicaid is the only practical option millions of vulnerable Americans have for meeting their health care needs. Medicaid works for the most vulnerable.

I greatly appreciate the opportunity you have given me to offer this testimony.