Responses of NAMD Executive Director Matt Salo to the House Energy and Commerce Committee Subcommittee on Health Questions for the Record

August 4, 2015

The Honorable Representative Pitts

In your testimony, you talk about a "path to permanency" for states that have been operating under an 1115 waiver for decades. I think this is a common-sense idea the Committee should explore. Have you given thought to what criteria would be needed for determining what states could be "grandfathered" in this manner?

The "pathway to permanency" concept is a means for the federal government to acknowledge the demonstrated successes of states in administering their Medicaid programs via alternative pathways under the 1115 waiver option. Depending on the state in question, these alternative pathways could be coverage expansions beyond the maximum federal poverty level (FPL) for certain eligibility groups, such as women and children, or they could be the fundamental model the state uses to deliver Medicaid services to the majority of its beneficiaries, such as statewide managed care. The overall goal of any pathway to permanency approach should be to recognize that the Medicaid statute as written 50 years ago does not reflect today's service needs nor the innovative approaches states are taking to meet those needs. This is the reason so many states utilize 1115 waivers, and is also why a permanent solution is needed to give states the certainty and stability they need to continue innovation and ensure existing innovations remain in place.

NAMD is pleased to see the Centers for Medicare and Medicaid Services (CMS) begin to acknowledge the viability of long-standing state innovations in the release of its informational bulletin on a "fast track" 1115 waiver renewal process, released on July 24, 2015. This bulletin outlines criteria under which existing 1115 waivers will be approved on an accelerated timeline comparable with the approval of state plan amendments or section 1915 waivers. These criteria include established demonstrations that have completed a full extension cycle without major changes and the waiver showing compliance with reporting of deliverables showing positive monitoring and evaluation results. However, this fast track approval process is not applicable to 1115 waivers that propose "major or complex changes," which include but are not limited to:

- Medicaid expansions tied to enhanced federal medical assistance percentage (FMAP);

- Delivery system reform, financing, and payment initiatives that cannot be authorized under state plan authority, including delivery system reform incentive payments (DSRIP);
- Demonstrations impacting dually eligible Medicare-Medicaid beneficiaries;
- Establishing home and community-based services (HCBS) programs;
- Demonstrations with caps on enrollment and eligibility limitations;
- Uncompensated care pools.

While we understand the rationale for CMS putting some of these restrictions in place to ensure sufficient federal oversight of the Medicaid program, we believe a true pathway to permanency will require more flexibility than what is allowed for under this fast track review policy. While this policy is a step in the right direction, the most innovative state approaches fall under the above-outlined "major or complex changes" which render them ineligible for expedited review. Unfortunately, this means these states' successful programs will not benefit from the policy and will continue to be subject to the full review process, which can be burdensome and inefficient for these states who should be held up as exemplars of innovation.

A true pathway to permanency must recognize that in many instances, states have met or exceeded the expectations embedded within the 1115 demonstration process. The fundamental criteria of an 1115 waiver is that the state's alternative model meets the objectives of the Medicaid program in a budget-neutral manner to the federal government. States that have operated a demonstration for multiple review cycles and have consistently demonstrated compliance and successful outcomes, regardless of the nature of that demonstration or the populations covered, should be eligible for expedited review of their waivers.

CMS could consider implementing a two-tiered expedited review process, applying its new "fast track" policy as formulated for demonstrations that do not address what the agency considers major or complex topics, and reserving a second expedited review policy for more innovative demonstrations which have been in place for two or more consecutive review cycles. This alternative review process should acknowledge that states which have operated demonstrations for this length of time and have been able to clear the full review and renewal process without difficulty have sufficiently demonstrated the viability of their demonstrations. Therefore, they should no longer be subject to the full review process and should not be expected to make the case for their innovations from scratch. This would free up badly needed administrative resources at both the state and federal level to focus on other aspects of the Medicaid program and give states the reassurance that their programs can continue operating into the future.

Furthermore, while much of the focus on permanency has revolved around the Section 1115 waiver authorities, there are a number of other waiver authorities that could be streamlined as well. Section 1915 of the Social Security Act allows for states to implement mandatory managed care (1915b) and home and community based alternatives to institutional care (1915c). Both of

these have been in place for more than 30 years and no longer represent deviations from the norm. We would therefore urge your consideration of statutory changes that would allow these types of approaches to become automatic components of the Medicaid state plan.

Today, Medicaid is the world's largest health insurance program and at the federal level the spending is on autopilot. Yet, you say in your testimony that simple accounting for Medicaid is extremely difficult, if not impossible. While I understand the shared federal-state nature of the program is challenging, surely you're not suggesting that benefits cannot be quantified, dollars cannot be tracked effectively, or that accountability is not needed. Can you please clarify and expound upon your point?

While it is the case that the Medicaid program has grown increasingly complex over its 50 year history and covers the sickest, frailest, and most medically complex patients in the country, NAMD does not mean to imply that this complexity belies the need for effective program oversight at either the federal or state level. We strongly believe in the need to ensure that Medicaid's taxpayer dollars are spent wisely and well. Medicaid Directors take their responsibilities for maintaining the Medicaid program's integrity and ensuring effective program outcomes extremely seriously, a responsibility that is shared by our federal partners at CMS. However, as states increasingly turn to new payment and delivery system approaches, such as bundled payments for episodes of care, value-based purchasing, and new capitation arrangements for managed care plans, the traditional oversight mechanisms called for by certain stakeholders like the Government Accountability Office (GAO) are not the most appropriate way to conduct oversight.

As Medicaid continues to innovate, the oversight mechanisms applicable to its innovations must themselves evolve. Medicaid's broad aims are to transition towards a healthcare system that rewards value, quality, and outcomes over volume of services delivered. Yet the type of oversight the GAO calls for does not reflect this objective or the reality of the Medicaid program today. GAO is constrained by a narrow interpretation of what constitutes federal budget neutrality. Its approach would stifle current and future innovation in the Medicaid program. Instead of focusing on this limited vision of oversight, Medicaid Directors and CMS understand that a more expansive and flexible standard is needed to verify effective program outcomes in areas as diverse as long-term care delivered in the community, complex behavioral health services delivered to person with serious mental illness, or services for the dually eligible coordinated with the Medicare program.

Indeed, the very purpose of the 1115 waiver program is to promote innovation, which inherently requires a different evaluative lens than the one applied to the traditional Medicaid program. The variation inherent in waivers across the nation's 56 Medicaid programs precludes a one-size-fits-all oversight approach of the type GAO believes appropriate. Instead, CMS correctly adopts waiver-specific evaluation plans which tailor oversight activities to the waiver's activities. While such an approach makes a high-level oversight review difficult to

conduct, it does not preclude effective and appropriate oversight of Medicaid waiver programs. It is precisely this type of approach that we encourage and support.

One frustration often voiced by State officials is the time it takes to negotiate and secure an 1115 waiver. For example, in Indiana, it took the governor 2 years to negotiate the waiver for HIP 2.0. What thoughts do you have about parameters Congress could put around the process to provide some certainty for states? What policy factors would we need to think through?

The length of time required to approve an 1115 waiver is often variable and at times extensive, an issue which arises in other aspects of the Medicaid program as well – most recently around the question of Medicaid managed care rate development approvals. We believe this is primarily due to the amount of information that is requested during these approvals and the relative scarcity of state administrative resources to furnish and analyze the requested data.

What would be most useful is for Congress to support enhanced administrative resources for the states. For example, many state administrative activities in Medicaid receive the minimum federal match of 50%. However, other high-priority activities, such as systems development, receive enhanced federal matches of 75% or even 90%. In times of budgetary constraints, Medicaid's administrative resources are often reduced, leaving fewer state staff on hand to oversee an increasingly complex program and conduct the analyses and negotiations necessary to see a waiver proposal approved. Providing states with the tools necessary to support their programmatic innovations with commensurate investments in administration would be a welcome step.

Though we appreciate the Committee's focus on the length of time waiver approvals can take, we do not believe a Congressionally-mandated deadline for waiver approvals is the correct direction to go in. Waivers are inherently complex and striking the right balance between innovation and oversight can be a delicate process. Finding the right balance among these priorities, and determining the length of time it takes to do so, is a function best left to CMS and the states.

We do agree, however, that the process can take far too long in many instances, and we should be doing more to encourage shorter turn-around timelines for approvals and renewals. Encouraging HHS to reduce unnecessary reporting, reviewing, and duplication could help achieve this goal without setting arbitrary time limits. States currently must deal with labor intensive applications and reviews, labor intensive reporting and report reviews, and labor intensive audits, much of which is not focused on our broad shared mission of improving beneficiary health outcomes. Reducing the complexity in the process can lead to greater accountability, which should be welcomed by all.

Congress can indicate its overall support for timely approvals of successful demonstrations in other states being translated to a different state, though even in these circumstances taking the

state's unique program and population into account would be better served by the enhanced administrative resources we call for above.