



Testimony of
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Commerce; Subcommittee on Health

on
“Examining the Administration’s Approval of Medicaid
Demonstration Projects”

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Chairman Pitts, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify today on a crucial topic for our nation's health care delivery system.

Intro

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, which is the nation's health care safety net. 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

Medicaid is the nation's most vital health care safety net program, providing health coverage for more than 72 million Americans. The program, which spent more than \$450 billion last year, is jointly funded by federal and state governments, but administered by states under broad federal standards.

Medicaid provides health coverage to millions across America, 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.

Health Care Innovation – The Charge



To believe its critics, Medicaid must be either broken or overrun with fraud, waste and abuse. These charges are short sighted, lack context, and fail to understand that it is in fact the broader US health care system that needs significant improvement. The US health care system faces many challenges: health care cost inflation, sub-optimal health care outcomes, and -- due to decades of both proactive as well as passive policies -- a tectonic shift of responsibility for the sickest, frailest and most complex patients directly to Medicaid.

The good news is that Medicaid is taking this challenge head-on. There is a widespread desire amongst Medicaid Directors to reorient the health care system to achieve better care, better health and lower costs. To successfully achieve this vision, because they are responsible for the oldest, sickest, frailest and most complex and costly patients in the country, Medicaid programs must serve as a platform for innovation and system-wide care improvement.

The Challenge

The challenge, however, is that the underlying Medicaid statute is not structured to meet this need. The statute is now 50 years old, and often reflects a health care reality that no longer exists. States must seek federal approval to waive portions of the statute that would otherwise prevent such mainstream approaches as managed care or home and community-based alternatives to nursing home care. Every single state operates multiple waivers, representing a growing majority of the entire program under a variety of poorly aligned authorities.

While states, in partnership with the federal government, have used these waiver authorities to drive transformational improvement in the health care system, it remains a sub-optimal way to administer the program, and changes are necessary to ensure the continued success of state reform efforts.

State Medicaid Directors and NAMD have been vocal in the need for improvements, innovation and the transformative power of Medicaid. Our paper on creating [a climate for innovation](#) in Medicaid can serve as a guiding point in this conversation. And while not the focus of this hearing, it is important to note



that far greater challenges exist when trying to coordinate systemic improvement across state Medicaid programs and Medicare.

The Good News

States have for decades successfully leveraged the flexibility associated with the 1115 research and demonstration waiver process to achieve many different and critical goals for Medicaid. This authority allowed the state of Arizona to initially adopt Medicaid in 1982 with a revolutionary approach of managed care for the majority of its beneficiaries, a process made complete when it expanded managed care to elderly and disabled populations later that decade.

This authority allowed numerous states in the 1990s to both expand coverage while at the same time expanding the use of private managed care organizations to improve beneficiary health care. Tennessee, Oregon, Hawaii, Massachusetts and many others blazed new trails in these areas.

More recently, several states have utilized the 1115 waiver approach to craft alternative approaches to the Medicaid expansion envisioned in the Affordable Care Act. Arkansas began this innovation with the development of the private option, and was soon followed by states like Michigan, Iowa and Pennsylvania who all adopted a variety of other approaches in order to craft expansion alternatives that made sense in those states. Notably, Indiana demonstrated the ability for the 1115 waiver authority to fully embrace different approaches to consumer engagement with its Healthy Indiana 2.0 program.

Still other states have pursued the 1115 waiver model to craft Delivery System Reform Incentive Payment (DSRIP) models. States as varied politically and geographically as Texas, California and New York are all hard at work transforming the health care culture through these approaches right now.

There are many more examples of delivery system and payment reform innovation, and this testimony should not be taken as an exhaustive catalogue.

Accountability and Oversight

With great power comes great responsibility, and all of these approaches involve significant investment on behalf of both the state and our federal partners to ensure that not only are these efforts achieving



critical health care improvement targets, but that we are both being wise stewards of the taxpayer dollar.

This accountability takes many forms: a formal evaluation process at the end of every major waiver period; voluminous reporting requirements that hit upon both process and outcomes; a budget neutrality test to ensure that the federal government not spend more on the waiver than it might have in the absence of the waiver; and finally a public input process that is replicated both at the state level and then again at the federal level for both initial waivers and amendments.

Because we take these obligations very seriously, states and the federal government should consider accountability that is meaningful – meaning that both the states and the federal government should be able to use data and reports to evaluate the programs in terms of the health of populations and the progress towards the ultimate goals of reducing cost and improving health. An **efficient** system of evaluation and reporting should be built with that goal in mind - so that both the states and the federal government can benefit from understanding the impact of the proposed transformation.

GAO's Concerns

The GAO and others have raised concerns about some of the safeguards in place, including around budget neutrality, and the extent to which certain innovations are consistent with the purpose of the program.

GAO is clearly frustrated with the ever-increasing complexity of Medicaid's role in the delivery of health care services to vulnerable populations, as well as how Medicaid is actively trying to transform the misaligned incentives inherent in the system. Their recommendations clearly impart their desire for Medicaid to be so constrained as to fall prey to simple financial auditing, but Medicaid's purposes as authorized by Congress in numerous expansive acts, as expanded by the Supreme Court through cases like *Olmstead*, and as applied in states over the last five decades are clearly of a scale and complexity that makes such simple accounting extremely difficult, if not impossible.

The degree of variation evident in Medicaid, its programs, services and populations served is effectively limitless, so it is difficult to see how CMS could, as GAO suggests, impose "written, specific" guidelines



for approval and continuation of *waivers* of Medicaid without introducing arbitrary and unintended limits on state creativity in meeting their citizens' needs.

To stress a point, these waivers are synonymous with innovation. Innovation itself is inherently uncertain and does not lend itself to strict empirical constraints based purely on historic growth rates and statutory limits. Of course there will be a tension between the need for innovation on the one hand, and the desire for federal budget constraints and predictability on the other. But it is important to note that a fixation on a finite set of data points will strangle the innovation we so desperately need.

It is also vital to note that states are using federal investment through Section 1115 demonstrations to enable transformation of Medicaid systems that can/will lead to reducing costs, providing higher quality care and improving the health of beneficiaries. Such investment is necessary if there is to be true transformation that will serve both the state and federal governments' goals of reducing costs while improving care.

One critical take-away is that all of these changes and improvements in the delivery and payment systems are easy to talk about, but very difficult to implement. At their core, these reforms can be viewed as fundamentally transforming the business model of health care as well. The key responsibility for government payers is to ensure that providers are given the tools they need to help transform their practice to be able to succeed. Therefore, up-front investments and the ability to look across multi-year periods for achieving budget neutrality are critical to program success.

Decades of experience has shown us that these investments cannot be done "on the cheap", and the wide spectrum of providers affected (hospitals, primary care physicians, long term services and supports, behavioral health specialists) cannot on their own operationalize the changes necessary to thrive in the new business model.

It is, therefore, abundantly clear that the process requires greater flexibility and ability for states and our federal partners to negotiate system improvements, not less.

What must change?



As much as we have achieved over the past several decades of reform, much more can be done. The progress we have made has not been easy, and the statutory and regulatory frameworks can be significantly improved and modernized.

The federal-state partnership must be improved to ensure focus on coordination, health outcomes, program integrity and efficiency, not on process measures or antiquated notions of program design. The current policies and procedures often bog states down in endless, repetitive reporting and change requests and do not prepare states with the tools Medicaid needs to succeed. Further, the culture of Medicaid oversight does not foster innovation—as exemplified by the restrictive way states must pursue demonstrations—and it does not provide a pathway to rapidly diffuse and broadly adopt successful program reforms.

Ultimately we must develop a new business practice to enable states to test and quickly standardize successful models that focus on Healthy people, Outcomes, and Value -- an H.O.V. program, if you will. At its core, a Medicaid H.O.V. program could improve the current demonstration process to provide a more rational path to achieve better care, better health and lower costs.

Components of this should include:

Creating a pathway to permanency. If something has been proven to be effective, after a couple of waiver cycles states should be able to retain that flexibility permanently into their program and without requirements to continually adapt the model to “research” something new. Every few years, as it has for the past 30, Arizona has devoted significant staff resource time to rolling out what should be pro-forma renewals of what has been, by all accounts, a model program.

Managed care is no longer the boogeyman of health care, for example, and should no longer require a waiver to implement. But neither is managed care an automatic success everywhere it is implemented. Managed care is a tool, a means to an end, and like all tools, must be utilized properly for it to be



effective. The irony here is that by devoting significant staff resources to waiver approvals and renewals, states must divert attention away from where organizational expertise is needed – specifically focusing on how contract design, oversight and enforcement are fundamental to ensuring that managed care is successful.

More timely reviews and approvals. The current process simply takes too long. CMS is constrained by numerous obligations to review and approve state activity, and the lack of timely approval can greatly impede state reform efforts. We have noted significant delays in many areas, ranging from managed care capitation rate setting to HCBS transition plan approval, to say nothing of the obligations that CMS will shoulder once the proposed managed care regulations are finalized. These processes already can take too long and must be streamlined. A possible solution could include developing a functional clock similar to the state plan amendment process.

A better balance between transparency and flexibility. While a definitive checklist of what can be approved and how might provide some clearer guidance, it may also itself become obsolete, and would not necessarily allow CMS discretion to allow states to innovate beyond what is currently considered. CMS has recently begun publication of waiver applications and approvals online, which enables not only stakeholders and Congressmen, but also states themselves to easily assess what CMS has approved and why. The present hearing illustrates the welcome attention that such transparency brings to Medicaid's broad purposes, complexity, and need for investments in innovation.

State Medicaid Directors understand the federal government's desire for consistency across time and among states in the level of flexibility and in the general level of support CMS provides for state innovation. While we agree that this support should be generally strong, the nature of innovation is such that there must be evolution in what is undertaken. This means that states should not be limited by yesterday's standards, and every development in program improvement should be able to be brought forward to employ by others as they become ready.



They also understand the balance that must be struck as innovations spread across the states. The simple fact that one state has been successful does not necessarily mean that all other states will be immediately able to replicate that success. But it does mean that we have an obligation to facilitate the learning and advancements that will allow those other states to adopt and succeed with new approaches.

They also understand that not all experiments work, and that CMS will need to evaluate the success or failure of the innovations states are engaged in. In the most recent 1115 approvals HHS has worked with states to enhance evaluation plans, and to supplement state efforts with federal data and analytic support. Indeed, the federal government is likely to learn more in exploiting between-state variation than states are in observing changes only within their own borders, especially when 1115-supported experiments comprise the whole state and lack a true "control group."

Conclusion

State Medicaid Directors have been driving some of the most significant reforms to not only the Medicaid program, but the underlying health care system in history. These changes range from integrating care for the Medicare-Medicaid dual eligibles, constructing consumer-focused managed long term services and supports for a variety of populations, integrating behavioral health care services into the traditional acute care model, and adopting innovative approaches to improve health for high-cost, high need populations. 1115 waivers have been the tool Medicaid has used to drive many of these changes, and Medicaid Directors are proud of the progress we have made. But it is equally clear that the process can be improved in order to sustain these improvements and broadly disseminate them – to help ensure that these common sense reforms become the baseline, not the exception.

Working together states and the Federal government (both Congress and the Administration) could better position Medicaid for these challenges. The nation's Medicaid Directors have identified numerous shared goals with our federal partners. We believe that we have shared principles that should be



adopted in transforming the business practices and culture of the federal –state partnership that is the foundation of the Medicaid program.

Ultimately, state Medicaid Directors face more than programmatic hurdles in their race to bend, shape and re-tool their programs. The recommendations we have laid out will make it easier to develop and adopt system reforms, but improving the federal oversight and renewal process is not the only challenge that states face in their pursuit of excellence. For many states, staffing and expertise are in short supply. State and federal governments must be challenged to view investments in Medicaid administration, infrastructure and organization as some of the most important investments that can be made. Medicaid is more than 50 different Fortune 500 companies, and deserves the kinds of investments that successful Fortune 500 CEOs can afford to make – in hiring the right personnel, arming them with the right training, and empowering them to succeed.

Thank you for the opportunity to testify on behalf of the nation’s Medicaid Directors, and I look forward to answering whatever questions you may have.