STATEMENT OF

VIKKI WACHINO

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR MEDICAID AND CHIP SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICAID AT 50: STRENGTHENING AND SUSTAINING THE PROGRAM

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON HEALTH

JULY 8, 2015

U.S. House Committee on Energy & Commerce

Subcommittee on Health

Medicaid at 50: Strengthening and Sustaining the Program

July 8, 2015

Chairman Pitts, Ranking Member Green, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the importance of the Medicaid program, reflect on some of its achievements over the past 50 years, and discuss the Centers for Medicare & Medicaid Services' (CMS') work with states in key areas such as broadening access to coverage, strengthening the quality of care through payment and delivery system reforms, and enhancing the program so that it meets the needs of our beneficiaries most effectively.

The Medicaid program provides health insurance coverage for more than 70 million Americans, playing a particularly important role in providing coverage for low-income children, adults, pregnant women, people with disabilities, and seniors. The health insurance coverage Medicaid provides ranges from prenatal and pediatric care, to preventive care aimed at stemming chronic diseases, to long term care services and supports. Federal financial support and flexibilities in program rules, along with new tools and options made available through the Affordable Care Act, have helped provide a platform for CMS and states to adopt a range of improvements and innovations in their Medicaid programs. Under the Affordable Care Act, Medicaid eligibility has been simplified and aligned across coverage programs. Thanks to these simplifications and the availability of Medicaid coverage to more low-income adults, millions more uninsured Americans are gaining coverage.

Because Medicaid is jointly funded by states and the Federal Government and is administered by states within Federal guidelines, both the Federal Government and states have key roles as stewards of the program, and CMS and states work together closely to carry out these responsibilities. Under the Medicaid Federal-state partnership, the Federal Government sets forth a policy framework for the program and states have significant flexibility to choose options that enable them to deliver high quality, cost-efficient care for their residents. CMS is committed to working with states and other partners to advance efforts that promote health, improve the quality of care, and lower health care costs.

This month we mark the 50th anniversary of the Medicaid program. For five decades, Medicaid has helped facilitate access to needed health services and provided financial security through protection from high out-of-pocket costs for millions of low-income Americans. Medicaid has played a vital role in providing comprehensive care for children that helps support their growth, school readiness, and development into healthy adults. Medicaid has also supported working families whose employers do not offer affordable health insurance, and fostered better health for pregnant women and positive birth outcomes for their babies by facilitating access to critical prenatal services. It has helped address the frequently complex health needs of people with disabilities, and supported them in living independently. And it has covered long-term care services and supports for millions of America's seniors and works in concert with Medicare to meet critical health needs. Over time, Medicaid has also risen to new challenges, providing care for people with HIV and AIDS, meeting the screening and treatment needs of people with breast and cervical cancer, and contributing to financial stability for low-income families by helping them maintain coverage during economic downturns.

Medicaid plays a fundamental role in assuring that low-income people have access to a high level of care. According to survey research released by the Commonwealth Fund last month, 95 percent of adults who had continuous Medicaid coverage in 2014 had a regular source of care, and the percentage of people who rated the quality of the care they received in the past 12 months as excellent or very good was comparable to that of people enrolled in private coverage. Adults enrolled in Medicaid also reported getting key preventive services like blood pressure checks at higher rates than did individuals who were uninsured. And Medicaid beneficiaries were less likely to have had problems paying medical bills than did individuals who had private coverage or who were uninsured. They were also less likely than those who were uninsured to skip getting medical care or to let a prescription go unfilled due to cost.[1]

Recent research that examined the long-term impact of Medicaid on the population it serves demonstrates that it is a sound investment for the Nation. Earlier this year, researchers at the National Bureau of Economic Research reported the results of longitudinal research that

[1] http://www.commonwealthfund.org/publications/issue-briefs/2015/jun/does-medicaid-make-a-difference

examined children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) over time. They found that being enrolled in Medicaid and CHIP confers substantial benefits on individuals, and the country as a whole, when they reach adulthood. Specifically, the researchers found that individuals who were eligible for Medicaid and CHIP as children had higher cumulative wages as adults than their peers. The researchers estimated that the Federal Government recoups 56 cents of each dollar spent on childhood Medicaid by the time those children reach age 60.[2]

As we approach Medicaid's 50th anniversary, CMS is building on Medicaid's past successes and enhancing the program. Today I would like to highlight some of the key areas in which CMS is working with states to strengthen the program's ability to serve its beneficiaries:

- modernizing the eligibility and enrollment process for Medicaid and CHIP to support a strong consumer experience;
- expanding Medicaid eligibility to decrease the number of uninsured Americans and lower the costs of uncompensated care;
- strengthening payment and delivery systems reform to encourage coordinated, high quality, patient-centered care;
- continuing to advance the ability of seniors and people with disabilities to receive home and community-based care;
- updating the Medicaid managed care rules to promote quality, transparency, and access to care and to align with the rules of other payers;
- enhancing data systems to more accurately measure health care quality and strengthen program integrity and Medicaid financial management; and
- strengthening program integrity efforts to better combat and prevent fraud, waste, and abuse.

Modernizing Medicaid and CHIP Eligibility and Enrollment Processes

In our implementation of the Affordable Care Act, CMS has substantially simplified and modernized Medicaid and CHIP rules and processes for most people who apply for Medicaid and CHIP, creating an enrollment process that helps eligible consumers enroll in Medicaid and

[2] http://www.nber.org/papers/w20835

CHIP and access their coverage more quickly and smoothly. These rules are designed to align and coordinate with policies and procedures established for people who enroll in qualified health plans through the Marketplace. Before these changes, consumers would often encounter a paper-dependent process that was unnecessarily complex and time intensive, sometimes involving long waits for a decision on a family's eligibility that posed logistical challenges for working families and could delay access to needed care.

Now, consumers can use a single, streamlined application to apply for Medicaid, CHIP, and qualified health plans through the Marketplace. Consumers can apply online, over the phone, or by mail, and can get help from application assistors in their communities, or via call centers that help people apply for coverage. CMS and states have established an electronic approach to verifying financial and non-financial information needed to determine Medicaid, CHIP, and Marketplace eligibility. States now rely on available electronic data sources to confirm data included on the application, facilitating faster eligibility decisions and promoting program integrity. In addition, simplified renewal processes help ensure that people retain Medicaid and CHIP coverage for as long as they are eligible, and that beneficiaries who remain eligible get needed services like prescription medications.

Modernized state eligibility and enrollment systems underpin many of these simplifications by enabling automated eligibility verification, offering online applications and streamlining the consumer experience. To help states invest in these systems, CMS made available 90-percent matching funds through December 31, 2015, for eligibility system design and development, and the enhanced 75-percent matching rate indefinitely for maintenance and operations of such systems provided that these systems met certain standards and conditions that were designed to support a simple, streamlined enrollment process. In April, in a Notice of Proposed Rulemaking, CMS proposed ongoing access to the 90-percent and 75-percent matching authority for eligibility and enrollment systems to provide states with additional time to complete their full systems modernization, retire outdated "legacy" systems, and promote a dynamic, integrated, enterprise approach to Medicaid information technology systems. Refinements were made to the standards and conditions to ensure optimal systems development and efficient use of state and Federal funding.

As a result of these simplifications and systems improvements, states are making substantial progress processing Medicaid and CHIP applications more efficiently, often in real or near real-time. For example, in Washington, 92 percent of applications are processed in under 24 hours; in New York, 80 percent of applications are processed in one session; and in Rhode Island, 66 percent of applications are processed without manual intervention or the requirement of additional information.

Expanding Medicaid Eligibility

As a result of the Affordable Care Act, states have the opportunity to expand Medicaid eligibility to individuals ages 19-64 years of age with incomes up to 133 percent of the Federal poverty level (FPL). For the first time, states can provide Medicaid coverage for low-income adults without dependent children without the need for a demonstration waiver. The Affordable Care Act provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent FPL through Calendar Year 2016, and covers no less than 90 percent of costs thereafter. This increased Federal support has enabled 28 states and the District of Columbia to expand Medicaid coverage to more low-income adults. Most recently, in January, Indiana expanded its efforts to bring much needed access to health care coverage to uninsured low-income residents. Primarily as a result of the expansion of coverage to low-income adults and the eligibility and enrollment simplifications CMS and states have made, 12.3 million people have gained Medicaid or CHIP coverage since the beginning of the Affordable Care Act's first open enrollment period.[3]

States that have expanded their Medicaid programs are documenting significant reductions in uncompensated care and the uninsured rate. Hospitals provided over $50 billion in uncompensated care in 2013; in 2014, there was a $7.4 billion reduction in uncompensated care costs, and with 68 percent of the reduction coming from states expanding Medicaid.[4] And of the 11 states with the greatest reductions in uninsured rates in 2015, 10 had expanded Medicaid

[3] http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf
[4] http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib_uncompensatedcare.pdf

eligibility.[5] This coverage is translating into tangible improvements in population health. Nearly one-third of the cases of diabetes in the United States have not been diagnosed; however, in states that expanded Medicaid, the number of beneficiaries with newly identified diabetes rose by 23 percent, compared to 0.4 percent in states that did not expand Medicaid, in the first six months of 2014.[6]

CMS is committed to working with states to expand Medicaid in ways that work for them, while protecting the integrity of the program and those it serves. For example, in Iowa and Arkansas, under section 1115(a) demonstrations, some new Medicaid enrollees receive their coverage from Qualified Health Plans offered in the individual market through the Marketplace. Michigan's Health and Wellness Plan promotes healthy behaviors through education and engagement of beneficiaries and providers. Iowa's demonstration includes a Healthy Behaviors program under which a beneficiary is eligible to reduce his/her premium payment amount by engaging in health improvement activities.

Accelerating States' Efforts on Medicaid Delivery System Reform

States and CMS share a strong interest in achieving better health and better care at lower cost. Medicaid plays a major role in the health care delivery system, and funds 16 percent of the Nation's health care services.[7] The expansion of Medicaid to new populations presents both states and CMS with additional opportunities to pursue delivery system reforms that improve the Medicaid patient experience while helping to drive innovation across the health care system. CMS is engaged in a variety of initiatives to work with states, providers, and other stakeholders to help spur innovation. CMS has collaborated with states in key areas to improve the quality of care and reform payment and delivery systems, has worked with innovator states to advance specific reforms, has provided states with tools and guidance developed to meet the needs of Medicaid beneficiaries, and is working to measure and improve quality across states, in coordination with similar efforts underway in Medicare and in the private market.

[5] http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx
[6] http://care.diabetesjournals.org/content/38/5/833.long
[7] http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

Earlier this year, Department of Health and Human Services (HHS) Secretary Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they provide. This initiative will ultimately create a payment environment that appropriately promotes and rewards better care management for persons with chronic illness. CMS is dedicated to working with states to advance delivery system reforms that support these goals throughout the Medicaid and CHIP programs.

Strong Start

The Strong Start for Mothers and Newborns initiative includes two strategies to reduce premature births: first, working with hospitals to reduce the number of early elective deliveries across all payers; and second, testing models of enhanced prenatal care to reduce preterm births among women covered by Medicaid or CHIP.

The first strategy is a public-private partnership and awareness campaign to reduce the rate of non-medically indicated early elective deliveries prior to 39 weeks. Working together with Partnership for Patients, HHS sponsored public-private efforts to improve the safety, reliability, and cost of hospital care. The Partnership for Patients is an initiative that works with providers to identify potential hospital safety solutions and test models for improving care transitions from the hospital to other settings, and for reducing readmissions for high-risk Medicare beneficiaries. CMS collaborated with Hospital Engagement Networks, a group of providers that work at the regional, state, national, or hospital system level to help identify solutions already working and disseminate them to other hospitals and providers, across the country to identify and spread best practices to reduce potentially unnecessary early elective deliveries, which contributed to a 70.4-percent reduction in early elective deliveries between 2010 and 2013 among participating hospitals. For example, the Ohio Perinatal Quality Collaborative used a range of interventions to shift almost 21,000 births from between 36-38 weeks' gestation to 39 weeks gestation between September 2008 and October 2011. This shift reduced NICU admissions by three percent (approximately 621 admissions), which alone resulted in an estimated $24.8 million in savings for the three year period. Almost half of these births were to mothers enrolled in Medicaid.

The second Strong Start strategy is a four-year initiative to test new approaches to prenatal care and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or CHIP who are at risk for having a preterm birth. The goal of the initiative is to determine if these approaches to care can reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery and over the first year of life. The initiative is currently supporting service delivery through 27 awardees and 213 provider sites, across 30 states, the District of Columbia, and Puerto Rico. While more thorough analysis must be completed, preliminary findings after year one of the program suggest that the enhanced prenatal care models may have a positive effect on some birth outcomes — specifically, increased rates of breastfeeding, decreased rates of cesarean section delivery, and decreased rates of preterm birth in comparison to national averages.

Health Homes

The Affordable Care Act created an optional Medicaid State Plan benefit that allows states to establish Health Homes in order to better coordinate care for people with Medicaid who have chronic conditions. Health Home providers operate under a "whole person" philosophy to integrate and coordinate all primary, acute, and behavioral health care, and long-term care services and supports, and to measure quality of care. Through this program, states receive a 90-percent enhanced Federal Medical Assistance Percentage (FMAP) for health home services for the first eight quarters and receive their regular match rate thereafter.

To date, CMS has approved Health Home State Plan Amendments in 19 states, the first of which was Missouri. Missouri's Medicaid program, in conjunction with its Department of Mental Health, successfully launched two Health Home initiatives: one designed to improve care for Medicaid beneficiaries with physical health conditions and one for beneficiaries with behavioral health conditions. Under these initiatives, participating Health Home providers delivered patient-centered culturally sensitive care, enhanced care management and care coordination across health care settings, and improved access to individual and family supports, including referral to community, social support, and recovery services. Missouri's Health Home programs

reported reductions in-hospital admissions per 1000 of 12.8 percent and 5.9 percent, respectively, while emergency-room usage per 1000 also declined by 8.2 percent and 9.7 percent in each program. The state is also reporting an improvement in several key clinical indicators, including hemoglobin A1C levels in participants with diabetes mellitus, as well as LDL cholesterol levels and systolic and diastolic blood pressures in participants with heart disease.

Innovative State Delivery System Models

Many State Medicaid agencies have started using a variety of approaches to improve and modernize their delivery and payment systems. For example, in 2012, Oregon launched a new managed care model, creating Coordinated Care Organizations (CCOs) that are risk-bearing, locally-governed provider networks that deliver community-driven coordinated care to Medicaid beneficiaries. These entities provide all Medicaid enrollees with physical, behavioral, and dental health services. The CCOs are paid via a global Medicaid budget that grows at a fixed rate, while allowing for some flexibility in the services that a plan provides. Oregon is held to quality and spending metrics to ensure that quality continues to improve as the state and CCOs control costs. The CCOs are held accountable for performance-based metrics and quality standards that align with industry standards, new systems of governance, and payment incentives that reward improved health outcomes. CMS has also worked with states to advance integrated care models like patient centered medical homes and accountable care organizations.

Delivery System Reform Incentive Program

CMS works with interested states to pursue state-initiated and developed delivery system reform initiatives. Through Delivery System Reform Incentive Payment (DSRIP) programs, authorized through section 1115(a) demonstrations, states support hospitals and other providers in enhancing how they provide Medicaid services. The first DSRIP initiatives were approved in 2010, and the most recent initiative will begin this year. The lessons learned over this period of time have helped CMS to refine the DSRIP initiatives and focus them on sustainable, beneficiary-focused changes to how providers are organized and how care is paid for under the Medicaid program. Currently, eight states have section 1115(a) demonstrations with DSRIP programs.

These initiatives are continuing to evolve, with the most recently approved DSRIP program providing funding for a broader set of providers, more specific evaluation metrics, and requirements to meet statewide goals. CMS will continue to work with these states to design and evaluate both short- and long-term outcomes of these initiatives and the impacts they are having on care delivery, the costs of services, and the overall health of Medicaid beneficiaries.

Medicaid Innovation Accelerator Program

To spur innovation between CMS and the states, CMS created the Medicaid Innovation Accelerator Program (IAP) with the goal of improving health and health care for Medicaid beneficiaries by supporting states' ongoing payment and service delivery-reform efforts. The IAP is consistent with recommendations made by the National Governors Association Health Care Sustainability Task Force, which focused on system transformation and state innovations that rely on the redesign of health care delivery and payment systems. Through the IAP, states can receive targeted program support designed around their ongoing delivery and payment system-innovation efforts.

CMS selected four areas as IAP's program priorities in consultation with states and stakeholders: (1) substance use disorders; (2) Medicaid beneficiaries with high needs and high costs; (3) community integration to support long-term services and supports; and (4) physical and mental health integration. CMS has been working intensively with seven states over the past five months on the first priority area to develop and implement substance use disorder service delivery reform activities. Additionally, CMS announced the details of the second IAP program priority area, improving care for Medicaid beneficiaries with complex needs and high costs, at the end of June 2015 via a national webinar. The final two program priority areas, community integration to support long- term services and supports and physical and mental health integration, have target launch timeframes of fall and winter of 2015, respectively. CMS also is working with some states to support data integration across Medicare and Medicaid to provide integrated care for Medicare-Medicaid enrollees.

All states can be laboratories for health care reform. As noted above, 19 states have initiated comprehensive health homes for people with multiple chronic conditions. Several states have

developed shared savings payment models through State Innovation Models. Twelve states are testing new delivery and payment models for people who are dually eligible for Medicaid and Medicare through the Financial Alignment Initiative. While payment and service delivery innovation is well underway in states, there are common challenges to all Medicaid delivery reforms, particularly in technical areas such as data analytics, payment modeling and financial simulations, quality measurement, and rapid cycle learning. IAP will help strengthen all of our efforts on delivery reform and move Medicaid payment and delivery to the next level by addressing these shared issues.

State Innovation Models

The CMS Innovation Center created the State Innovation Models (SIM) initiative for states that are prepared for or committed to planning, designing, testing, and supporting evaluation of new payment and service delivery models in the context of larger health system transformation. The SIM is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and CHIP beneficiaries.

In Round One of the SIM Initiative, 25 states were awarded funds to design or test innovative health care payment and service delivery models in the form of Model Design, Model Pre-Test, and Model Test awards. In Round Two,[8] the SIM Initiative is providing funds to 28 states, three territories, and the District of Columbia. This includes both Model Design awardees, states that are designing plans and strategies for statewide innovation, and Model Test awardees, states that are testing and implementing comprehensive statewide health transformation plans. Including the Round Two awardees, over half of states, representing 61 percent of the U.S. population, will be working to support comprehensive state-based innovation in health system transformation. Many of the states participating in SIM are developing new approaches to delivering care to Medicaid and CHIP beneficiaries. For example, in Maine, the SIM grant from CMS has supported the state to design a vision for a robust multi-payer model, including components such as health homes and shared savings.

[8] For more information: http://innovation.cms.gov/initiatives/State-Innovations-Round-Two/index.html

Financial Alignment Initiative

Today there are over 10 million Americans enrolled in both the Medicare and Medicaid programs, commonly known as "dual eligible" beneficiaries. The Medicare-Medicaid Financial Alignment Initiative is designed to better align the financial incentives of the two programs to provide these dual eligible beneficiaries with improved health outcomes and a better care experience.

The Financial Alignment Initiative created two model types: capitated and managed fee-for-service. In the capitated model, a state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. In the managed fee-for-service model, a state and CMS enter into an agreement by which the state is eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. Implementation of each demonstration is a collaborative effort between CMS and the state, and CMS has made several resources available to assist states with implementation activities. To date, new demonstrations are underway in 12 states, with approximately 400,000 dually-eligible beneficiaries participating in the financial-alignment models.

Moving Towards Home and Community-Based Care

CMS continues to look for ways to enable Medicaid beneficiaries with disabilities to receive home and community-based care, instead of relying on institutional care. The commitment to deliver care in ways that improve both efficiency and beneficiary outcomes extends beyond the delivery of acute and outpatient care to the delivery of long term care services as well. The passage of the Affordable Care Act provides new and expanded opportunities to serve more individuals in home and community-based settings.

The core mechanism that states have used to promote access to community-based services and supports for Medicaid beneficiaries is through Home and Community-Based Services (HCBS) waivers. Today, 47 states and Washington, D.C. operate at least one 1915(c) HCBS waiver. The Affordable Care Act also created new options under state plan authority for states to provide

home and community-based care. For example, the Affordable Care Act authorized Community First Choice under section 1915(k), a state plan benefit that offers community-based attendant supports and services to individuals who meet institutional levels of care. Five states have approved Community First Choice state plan amendments and CMS is also working intensively with several additional states on proposals that are under review.

As states continue to reduce their reliance on institutional care, develop community-based long-term care opportunities, and transition individuals living in institutions to community living, almost all of them have worked with CMS as part of our Money Follows the Person Rebalancing Demonstration Grant Program. Today, 43 states and Washington, D.C. participate in Money Follows the Person and receive enhanced Federal matching funds to serve individuals who move from institutional care to community integrated long-term care settings. In addition to Money Follows the Person, 18 states currently participate in the Balancing Incentive Program, also created by the Affordable Care Act, which provides enhanced Federal match to states that make structural reforms to increase institutional diversion and access to non-institutional long-term care services. According to the forthcoming Long-Term Services and Supports (LTSS) Expenditure Report to be released by CMS, 2013 data show that Medicaid spending on such services has tipped in favor of the community, with51 percent spent on community-based services versus 49 percent being spent on institutional services. Ten years ago, community-based spending made up just 33 percent of total long-term care spending.

Medicaid has also helped ensure that individuals are the focal point of the HCBS care planning process and that they have choice of and control over HCBS services. HCBS programs have a person-centered planning requirement – a process directed by the individual with long-term care service and support needs which may include a representative chosen by the individual, and/or who is authorized to make personal or health decisions for the person, family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include. HCBS programs also include the ability for an individual to "self-direct" their services. Participant or self-directed service options in long-term care financing programs provide individuals and their representatives the opportunity to hire, manage, and fire their direct-service workers. Funds may also be used to purchase other goods and services, such as assistive

technology, home modifications, personal care supplies, and transportation, within Federal and state guidelines. At least 38 states have self-direction programs in place for HCBS and about one quarter of all Medicaid beneficiaries receiving HCBS are self-directing some of their services, according to state-reported data in 2014.

As we move to more home and community-based services, acknowledging that the majority of Medicaid spending is in the area of long-term care services and supports, CMS is engaged in making sure that the delivery of these services is supported by robust data. As such, we are engaged in testing an experience of care survey and a set of functional assessment elements, demonstrating the use of personal health records and creating a standard electronic long-term services and support plan. This work will provide national metrics and valuable feedback on how health information technology can be implemented in this component of the Medicaid program.

Updating Managed Care

As the health care delivery system moves towards more integrated care and away from fee-for-service, states are increasingly moving to the use of managed care in serving Medicaid beneficiaries. Approximately 58 percent of Medicaid beneficiaries are enrolled in capitated, risk-based managed care for part or all of their services. Managed care is serving new populations, including seniors and people with disabilities who need long-term services and supports, and individuals newly eligible for Medicaid. Recognizing these changes, in May CMS issued a proposed rule to modernize Medicaid and CHIP managed care regulations to update the programs' rules and strengthen the delivery of quality care for beneficiaries. This proposed rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade and a major part of CMS' efforts to strengthen delivery systems that serve Medicaid and CHIP beneficiaries.

The proposed rule incorporates several core principles to update the regulations, specifically aligning with Medicare Advantage and private coverage plans, supporting state delivery system reform, promoting the quality of care, strengthening program and fiscal integrity, incorporating best practices for managed long-term services and supports programs, and enhancing the

beneficiary experience. Under the proposed rule, Medicaid managed care policies would be aligned to a much greater extent with those of Medicare Advantage and the private market, which would improve operational efficiencies for states and health plans, as well as improve the experience of care for individuals who transition between health care coverage options.
The proposed rule promotes state delivery system reform through encouraging initiatives within managed care programs that strive to improve health care outcomes and beneficiary experience while controlling costs. The proposed rule acknowledges the greater demand of mental health and substance abuse disorder services by clarifying that states are permitted to make a monthly capitation payment to a managed care plan for an enrollee that has a short term stay (no more than 15 days) in an institution for mental disease. The proposed rule would require a quality strategy for a state's entire Medicaid program and also establish a Medicaid managed care quality rating system that would include performance information on all health plans and align with the existing rating systems in Medicare Advantage and the Marketplace. By clarifying actuarial soundness requirements, CMS intends to strengthen fiscal and programmatic integrity of Medicaid managed care programs and rate setting. CMS also intends to implement best practices identified in existing managed long-term services and supports programs. The proposed rule would improve the beneficiary experience by making additional information and support systems available to individuals as they enroll in managed care. The proposed rule also supports beneficiaries by strengthening requirements on managed care plans to ensure that covered services are available and that individuals get high-quality, coordinated care through efforts such as strengthening network adequacy. In order to ensure CHIP beneficiaries the same quality and access in managed care programs, where appropriate, CHIP managed care regulations would be largely aligned with the proposed revisions to the Medicaid managed care rules.

Building Enhanced Data Systems

Improving and enhancing Medicaid data systems is an important part of CMS efforts to modernize the program. Better data systems can help both CMS and states measure health care quality and improve program integrity and Medicaid financial management. CMS has encouraged and supported states in their efforts to modernize and improve state Medicaid Management Information Systems, which will produce greater efficiencies and strengthen

program integrity. CMS also developed the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow CMS to review the completeness and quality of State MSIS submittals. CMS will explore using this data for the Medicaid improper payment measurement, evaluating section 1115 waivers and models being tested by the CMS Innovation Center, and to satisfy other HHS requirements. Through the use of T-MSIS, CMS will not only acquire higher quality data, but will also reduce state data requests. States will move from MSIS to T-MSIS on a rolling basis with the goal of having all states submitting data in the T-MSIS file format by the end of 2015.

Strengthening Program Integrity

CMS is committed to sound financial management of the Medicaid program and works to ensure that we are good stewards of taxpayer dollars. States and the Federal Government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and State dollars. This Federal-State partnership is central to the success of the Medicaid program, and it depends on clear lines of responsibility and shared expectations. Through provisions included in the Affordable Care Act and through CMS regulations, we are enhancing program integrity by strengthening provider and beneficiary eligibility safeguards, as well as by maintaining strong oversight partnerships and data exchanges with states. For example, the Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare, Medicaid, and CHIP.

HHS has implemented a Comprehensive Medicaid Integrity Plan (CMIP), which provides a strategy for CMS to improve Medicaid program integrity for the FY 2014-2018 period.[9] The execution of the strategies in CMIP will improve the ability of state Medicaid agencies and CMS to leverage program data to detect and prevent improper payments, which will strengthen the ability of state Medicaid agencies to safeguard state and Federal Medicaid dollars from diversion into fraud, waste, and abuse. In addition, CMS is working to streamline its assessments of state Medicaid program integrity activities. CMS began conducting comprehensive state program

[9] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

integrity reviews in 2007 on a triennial basis. These reviews play a critical role in how CMS provides assistance to states in their efforts to combat provider fraud and abuse.

Confronting Challenges and Moving Forward

Throughout its 50-year history, Medicaid has served as an adaptable program, adjusting to national and state-specific needs and meeting the health care needs of children, adults, pregnant women, seniors, and people with disabilities. For these low-income Americans, Medicaid has provided health insurance coverage that is affordable, accessible, and has served as the Nation's major source of long-term care coverage. CMS will continue to work closely with states and other stakeholders to continue to strengthen the Medicaid program in key areas such as modernizing the enrollment process; strengthening delivery systems and managed care; increasing our collection and use of data to make policy and program-management decisions; and enabling individuals with disabilities to live in their homes and communities.

I appreciate the Subcommittee's ongoing interest in the Medicaid program, and look forward to working with you to strengthen and improve Medicaid for the people the program serves.