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Statement of

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before the

Medicaid Commission

on

Short-Term Medicaid Reform

on behalf of

The National Governors Association

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Governor Sundquist, Governor King and Members of the Commission, I appreciate the opportunity to appear before you today on the National Governors Association's Medicaid Reform proposal. On June 15, 2005, NGA released a preliminary policy paper that outlined recommendations for Medicaid reform. The NGA Medicaid Working Group has continued to work since that time to develop further details on areas of the proposal that are particularly relevant to the ongoing effort in Congress to meet the reconciliation targets for both spending and revenues.

This statement represents the current thinking of the nation's Governors. However, it is critical that the Commission understand that this is work in progress and does not represent a final recommendation.

It is also important to stress the fact that we see today's discussion of policy recommendations as the beginning, not the end, of the process. We look forward to working with the Commission over the next 18 months as you develop policies to make Medicaid the nation's public health insurance programs more efficient, accountable, and responsive.

The Problem

It is difficult to overstate the impact of Medicaid on state budgets. It now represents about 22 percent of the average state budget and is a larger percentage than all elementary and secondary education. If you add health care spending for state employees and other programs, state health care spending totals about one-third of all spending, and is equal to spending on all education – elementary, secondary and higher. Looking into the future, the state fiscal situation is ominous as states will not be able to fund both health care and education. Over the next ten years, failure to reform Medicaid will likely play out in terms of cuts in education, particularly higher education.

High Cost Populations. The Medicaid program is increasingly serving populations with very serious and expensive health care needs. Low-income frail seniors, people with HIV/AIDS, ventilator-dependent children, and other individuals with serious mental and physical disabilities represent only about 25 percent of the Medicaid population, but account for more than 70 percent of Medicaid's budget. The average cost of providing health care to seniors and people with disabilities is more than six times the cost of providing care to pregnant women and children. Medicaid provides expensive chronic care and long-term care services that are largely unavailable anywhere else in the health care system. Meanwhile, those who are dually eligible for both the Medicare and the Medicaid Program account for 42 percent of total Medicaid spending. Demographic trends suggest that these cost pressures will continue to increase.

Caseload Growth. The Medicaid caseload has increased 40 percent over the last five years. The influx of 15 million beneficiaries in a five year period presents a fundamental challenge to states. The greatest growth has been of pregnant women, children, and families, due in part to the erosion of employer-sponsored health care. At first this was due to declines in U.S. economy, but it has continued as the economy recovered because fewer of the new jobs being created offer health insurance. Small businesses in particular are finding it increasingly more difficult to afford health insurance for their employees. Families that are losing coverage are concentrated among low-income individuals primarily below 200 percent of poverty.

More important, the population of seniors and people with disabilities, who already account for 70 percent of Medicaid's $330 billion annual budget, will grow considerably over the next 20 years. Specifically, the over age 65 population will grow 64 percent, by 2020 and the over age 85 population will grow 3.1 percent per year over the next two decades.

Without reform, the case load will continue to grow in the high single digit rate and perhaps even higher over the next two decades as increasing costs shift individuals from private coverage to Medicaid, or to the growing ranks of the uninsured.

The Consumer Price Index for Health. The consumer price index for health care has been increasing 2 to 3 times the average price index. Medicaid, like all insurers, has been faced with these rising costs.

Without reform, the Medicaid program is unsustainable. States will be forced to cut large numbers of beneficiaries off the program if they are not given tools to better manage their programs, particularly if the economy slows. Providing flexibility to states to tailor their Medicaid program to fit the needs of their unique populations is critical to modernizing the program.

The Vision

The policies that are outlined in the NGA paper released in June do not represent comprehensive health care reform. Medicaid, however, is inextricably linked to the rest of our health care system and its payers. Consequently, the scope of that paper is wider than the existing Medicaid program as it focuses both on populations that may become Medicaid eligible as well as some underlying cost drivers in the overall health care system.

The non-Medicaid recommendations had three goals:

1) To increase quality and health outcomes by applying modern technology and accountability to our health care system;
2) To develop alternative, more effective policy tools that would assist individuals and employers to obtain and maintain private health insurance as opposed to having these individuals become Medicaid eligible; and
3) To improve financing and delivery of long-term care by developing incentives for quality private long-term care insurance products, community-based care, innovative chronic care management, and alternative financing approaches.

In terms of Medicaid itself, the June 15th paper offered both short-term and long-term reforms that will help modernize, streamline, and strengthen this vital program. Short-term reforms are the subject of my testimony today; however, they should not be viewed outside of the long-term goals of Medicaid reform. These recommendations were not developed to generate any particular budget saving number. Instead, they were developed as effective policies that would maintain or even increase health outcomes while potentially saving money for both the states and the federal government.

Basic Principles for Medicaid Reform

As the Commission develops its recommendations for Congress, I urge you to follow the following three major principles.

1. Create savings for both states and the federal government. Do not solely shift costs from the federal government to the states;
2. Develop Short-term policies that are consistent with good long-term policies; and
3. Provide flexibilities to allow states to manage the program through the economic cycle.

Reforming Medicaid

There are several areas of reform that the NGA is proposing, which would give states additional flexibility to streamline their programs. As stated previously, these recommendations are preliminary and are still in the process of being refined.

I. Prescription Drugs

Increased transparency. Reforms are needed to bring greater transparency to pharmaceutical pricing methods for Medicaid. Currently, states negotiate prices on prescription drugs according to the published average wholesale price (AWP). There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. A different reference price should be established and made available to the states that more accurately reflects the actual price for drugs.

The Average Manufacturer Price (AMP) should be used for this purpose; however, reforms need to be made to ensure that manufacturers are appropriately reporting pricing data. Such improvements should include reforms to ensure: 1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates should be provided to states monthly rather than the current quarterly reporting; and 4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.[1]

[1] Recent reports by the General Accounting Office (GAO) and the Office of Inspector General (OIG) identified problems with AMP, particularly in manufacturer price determination methods and reporting, and oversight by CMS. Improvements in these areas are essential to ensure that AMP is a reliable and accurate reference price for states.

Option for Closed Formulary. States should have the option of adopting closed formularies, just like the federal government does in the VA system and with the new Medicare PDPs. Adoption of a closed formulary would mean that the state would not be guaranteed a rebate or the "best price"; however, some states, with enough negotiating power and leverage, could negotiate lower overall drug prices than in the current system, even with supplemental rebates. [2]

Dispensing Fees. With the introduction of a new price methodology (AMP), states should have flexibility to determine appropriate dispensing fees for drugs. Dispensing fees should not be linked to the price of drugs, as was proposed by the President, nor should they be capped. Flexibility to determine dispensing fees is important to ensure that pharmacies are appropriately compensated and that pharmacists are encouraged to dispense the most cost-effective drugs for beneficiaries.

Increased Minimum Rebates for Brand Name Drugs. The minimum rebates that states collect on brand name drugs should be increased to 20 percent (from 15.1 percent) to ensure lower total costs that would not solely impact pharmacists. Medicaid's "Best Price" provision should not be eliminated in exchange for this.

"Authorized Generics". For those states that continue to rely on the Medicaid drug rebate and "best price" provisions, reforms should be made to ensure that all drugs be included in these calculations. "Authorized generics" should be included in calculations of best price for the brand name drug. In addition, an "authorized generic" should qualify a particular drug for having a CMS set FUL. Currently, if at least three versions of the drug are rated as therapeutically equivalent by the FDA and the drug has at least three suppliers listed in current editions of national compendia, an FUL should be set by CMS.

Medicaid Managed Care. As more and more states utilize managed care to help administer their program, managed care companies should be able to directly access rebates for prescription drugs purchased for their Medicaid population. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

Purchasing Pools. States should be given greater ability both within their state and between states in establishing purchasing pools. For those states that choose to forgo the "best price" and rebate in order to close their formulary for the Medicaid program, they should be automatically able to combine their Medicaid population in with other state populations (e.g. state employees) in order to negotiate greater savings. Amend OBRA '90 to require drug companies to give Medicaid level prices to state funded drug programs, including Medicaid managed care plans, SPAPs, state

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[2] No other entity in the health care system is required by law to maintain an open formulary. Medicaid law (OBRA 90) was written so that this open-ended requirement was to be balanced by guaranteed minimum rebates from manufacturers. Many states feel that this trade-off does not allow them the flexibility to manage their programs effectively or the ability to truly negotiate deep enough discounts. Currently, states do not have the option of withdrawing from the Drug Rebate Program without sacrificing federal financial participation for prescription drugs.

employees, prison programs, and other programs such as drug discount programs for low income residents of a state.

Federal Upper Limit. To ensure that states do not pay too much for prescription drugs, a new federal reimbursement ceiling for all drugs should be established based on the AMP. In addition, the current practice of applying a Federal Upper Limit (FUL) to classes of drugs with three therapeutically equivalent products should be maintained; however, the current FUL in this instance is based on 150 percent of the AWP of the least costly therapeutically equivalent product, and should be revised to reflect 150 percent of the AMP of the least costly therapeutically equivalent product. [3]

Tiered Copay for Prescription Drugs. *(See this section under cost-sharing.)*

II. Long Term Care

Asset Transfer. States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, 1) the look-back period should be increased from 3 to 5 years; 2) penalty periods should begin at the time of application; and 3) the amount and types of funds that can be sheltered in an annuity, trust, or promissory note should be limited.

Accordingly, if at any time during the applicable five year look-back period an applicant, the applicant's spouse, or a fiduciary or person acting for the applicant, the applicant's spouse, or both, transfers or sequesters resources or the right to receive resources, income, or both, from any source, and as a result of the transfer or sequestration the funds available to pay for medical assistance are diminished, the applicant shall be ineligible for medical assistance for the period of time that would cause the transferred or sequestered resources, income, or both, to be fully expended at the weighted average nursing facility rate in effect when the transfer or sequestration occurred (either the monthly rate or the daily per diem multiplied by 30.42 and rounded to the nearest dollar). The disqualification period will begin with the date of application for Medicaid long term care services or if the individual is a recipient of Medicaid long term care services at the time of the transfer, the disqualification period shall begin with the month following the month of the transfer.

If the transfer is between spouses this rule does not apply to the extent that the transfer does not cause the transferees' resources and rights to receive income, resources, or both, to exceed the

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[3] Currently CMS sets FUL for drugs with generic equivalents, when there are three therapeutically equivalent drug products. The FUL is set at 150 percent of the published AWP price for the least costly therapeutically equivalent product. A recent OIG report found that Medicaid could save hundreds of millions of dollars per year by basing FUL amounts on reported AMPs. According to the report, if Medicaid based FUL amounts on 150 percent of the lowest reported AMP rather than 150 percent of the lowest published price (AWP), the program may have saved up to $300 million in just one quarter of 2004; an estimated $650 million per year of savings. Previous reports by the OIG in 2004 found that CMS does not effectively add qualified drugs to the FUL list (e.g. OIG found that 90 drug products were not included on the FUL list in 2001 that met the criteria and had they been they could have saved $123 million in 2001). CMS should ensure that a FUL is set for qualifying drugs in a timely manner.

maximum community spouse resource allowance in effect at the time of the transfer. This same exemption also applies to dependent disabled children. Furthermore, if a dependent disabled child is living in their parent(s) home at a time such parent is applying for Medicaid, that child has the right to stay in the home. In the event of death of the child, the state then has the right to recover the asset of the home.

Reverse Mortgages. Current law precludes the state to include certain assets as "countable" in determining Medicaid eligibility, including homes. This leads to the current "pay and chase" in estate recovery where states are left to recover funds after beneficiaries die. Reforms should be made to avoid trying to recover funds after the fact and instead have individuals be responsible upfront for their health care costs.

Home equity should be considered a countable asset in order to require individuals to use home equity to off-set long-term and other medical expenses that would otherwise be paid by Medicaid. Reverse mortgage loans are available to allow seniors (age 62 or older) to convert home equity into cash. To facilitate the use of reverse mortgages, however, reforms should be made to relieve seniors of the upfront costs of applying for such loans. For those seniors that are applying for Medicaid, reforms should be made to allow such costs be assumed into the annual payout of the mortgage.

Protections for seniors and their families should be put in place to allow a person who obtained a reverse mortgage to afford long-term care and medical expenses to shelter a certain portion of their home equity. The amount that would be sheltered would be 10 percent of the market value of the home or $50,000 (whichever is lower). States that can demonstrate that their current estate recovery programs are operating effectively, they should be able to opt-out of this provision.

Long-Term Care Insurance Partnership. To help the aging population plan for future long-term care needs all states should be allowed to participate in the Long-Term Care Partnership program. Federal law should be reformed to no longer prohibit the expansion of these partnerships.[4]

Protections, such as suitability, rating standards, non-forfeiture clauses, and inflation protection are important for individuals and states and are important to the success and potential savings of the Partnership program. As more states are given the ability to operate Partnership programs, flexibility to be innovative in such policies is important. New Partnership policies should not be prescriptively mandated into a single model that may become obsolete over time. Reciprocity between states that operate Partnership programs is an important goal. A nationwide standard of assets should be considered as models to implement expansion of the program are developed in order to ensure that the value of asset protection purchased in one state is comparable in value in another state.

III. Cost Sharing

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[4] Currently four states have been operating such partnerships that provide an incentive to individuals to purchase long-term care insurance. Individuals who purchase insurance through such partnerships are able to shelter a portion of their assets. The Medicaid program saves money under such partnerships because Medicaid becomes the payer after the policy benefits are exhausted; making Medicaid the payer of last resort, not the first.

Cost-Sharing Responsibility. States should be given the ability to implement common-sense, enforceable cost-sharing throughout the Medicaid program both to increase responsibility of Medicaid beneficiaries for the cost of their health care, and encourage cost-effective care in the most appropriate setting.[5] This new flexibility would be completely at state option, and states could choose to further restrict the types of cost-sharing in the program by income level, beneficiary category, or service type.

- **At or Below 100 Percent FPL.** Existing cost-sharing limits would remain for beneficiaries at or below the federal poverty level (*with the exception of tiered copays for prescription drugs as described below*); however, states would be given the authority to make cost-sharing enforceable. No beneficiaries in this group could be charged a premium.

- **Above 100 Percent FPL.** States would be able to increase cost-sharing beyond nominal levels for all beneficiaries above the federal poverty level and be given the authority to make cost-sharing enforceable. For these beneficiaries, premiums may be appropriate as a cost-sharing option for states and states should be given flexibility to experiment with mechanisms to collect these premiums. Beneficiaries will be protected by a 5 percent cap on the total amount of cost-sharing they would be responsible for (5 percent of total family income). This would increase to 7.5 percent for those higher income households (defined as above 150 percent FPL).

Cost-sharing would not be implemented on the following categories of beneficiaries or services, as under current law:

- Infants and children under age 18 that are provided "mandatory" coverage (0-5 133 percent FPL and 6-18 100 percent FPL)
- Preventive services for all children (well baby, well child care and immunizations);
- Pregnant women with respect to any services related to pregnancy or any other medical condition which may complicate pregnancy;
- Terminally ill individuals receiving hospice care with respect to any service;
- Inpatients in hospitals, nursing facilities, or ICFs/MR who as a condition of eligibility are required to apply most of their income to the cost of care;
- Emergency services, as defined by CMS; and
- Family planning services and supplies

Tiered Co-pays for Rx. Additionally, states should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. Although states may currently operate tiered co-pays, Medicaid's current cost sharing rules, with an unenforceable maximum co-pay of $3 per drug is not conducive to encouraging cost-effective utilization. States should be able to increase co pays on non preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill

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[5] Currently states are prohibited from implementing cost-sharing above nominal levels [deductible is $2 per family per month; co-payment from $.50 to $3; co-insurance is 5 percent of the state's payment rate for the item or services) and are prohibited from requiring cost-sharing for certain categories of beneficiaries and certain services.

the least costly effective prescription for treatment. Such co pays must be enforceable to be meaningful.

For beneficiaries at or below the federal poverty level, co-pays for preferred drugs would remain nominal, although they would be enforceable. For this population, states would be able to increase these enforceable copays beyond nominal amounts for a non preferred drug. States should be given broad authority to waive these co-pays in cases of true hardship or where failure to take a preferred drug might create serious adverse health effects.

IV. Benefits

Increased Flexibility to Tailor Benefits to Beneficiary Health Care Needs. The Medicaid population is very diverse and includes medically frail individuals as well as relatively healthy individuals that Medicaid serves as a traditional health insurance program. Currently "comparability" requirements limit states' ability to tailor benefit packages to meet different health care needs of beneficiaries. Reforms are necessary to allow states to design programs to support the health care needs of the diverse Medicaid population in their state. For medically frail populations, chronic care management provided in a managed care model holds promise for improving the health care of these individuals. (*see discussion of comparability and state wideness in waiver reform section).*

For relatively healthy individuals, flexibility as is afforded states in the SCHIP program would allow states to design an appropriate benefit package for these beneficiaries. This flexibility includes the ability to choose *to provide the set Medicaid benefit package* or to provide a tailored benefit package with four options for coverage:

1. *Benchmark coverage*: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.

2. *Benchmark equivalent coverage*: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.
3. *Existing state-based comprehensive coverage*: In the states where existing state-based comprehensive coverage exists (e.g. state-only funded programs; or waiver populations), the existing health benefits package is deemed to be meeting the coverage requirements.

4. *Secretary approved coverage*: This may include coverage that is the same as the state's Medicaid program; coverage provided in a Medicaid demonstration project approved by the Secretary; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

SCHIP benefits flexibility is not being proposed for the following categories of beneficiaries and services:

- Pregnant women, infants and children under age 18 that are provided "mandatory" coverage (0-5 133 percent FPL and 6-18 100 percent FPL);
- SSI recipients;
- Dual eligibles;
- Terminally ill individuals receiving hospice care;
- Inpatients in hospitals, nursing facilities, or ICFs/MR who as a condition of eligibility are required to apply most of their income to the cost of care;
- Medically frail and special needs populations; and
- Individuals eligible for long term care services.

V. Waiver Reform

Increased Ease of Waiver Approvals. Waiver applications are time consuming and costly for states that seek waivers to better manage their Medicaid program and meet the needs of beneficiaries. Increased ease for states to bypass some federal Medicaid requirements without having to go through a lengthy waiver approval process would facilitate innovation in the program.

States believe they and their federal partners would benefit from states' increased flexibility to create programs that target special populations or limited geographic areas before expansion to entire states. In many situations, smaller pilots or experiments could iron out problems and keep research investment to a minimum before decisions on whether or not a program works are made. With freedom to create smaller experiments states could test new care delivery and other concepts as well as assess demand and beneficiary/provider satisfaction before committing to an expensive and potentially risky new program.

For commonly waived portions of the Medicaid statute, states should be allowed to use the state plan amendment process. The state plan amendment process would include check boxes for typical waived items, such as those requiring that beneficiaries have "freedom of choice" of provider, and that services be comparable, statewide, and consistent with respect to amount, duration, and scope. States would realize cost savings because services would be implemented sooner and States would reduce administrative costs associated with waiver development and the waiver amendment/renewal process. The revised state plan amendment would also include a checkbox indicating limited geographic service area or other limitations. Similarly, 1915(b), 1915(c) and PACE waivers should also be administered through the state plan process. Certain protections in the waiver process should be maintained through this reform effort, such as the ability to control costs and utilization common to the 1915(c) waivers. To ease the administrative burden for those states that have an existing waiver; it should automatically become a part of the state plan after it has been renewed once.[6]

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[6] Through this mechanism, states would be able to expeditiously replicate waivers that have been implemented and sustained in other states. Some waivers are so commonplace and have been in existence for so long that they have become the standard of practice. Yet currently any new state that wanted to implement a similar program would be

States should be given more flexibility within waivers in provider contracting. Although states now may contract selectively for some services without waivers, there are many more services where the ability to contract with, say preferred providers, might enable states to cut costs while improving quality. Contracting flexibility will be important in pay-for-performance (P4P) approaches. Additional at-risk contracts that share savings with provider groups are valuable to stretch increasingly scarce resources as they can lower care costs while improving quality. State purchasing pools have been successfully utilized for pharmaceutical products, but the same concepts might be applied to other services and products if requirements can be adequately addressed under current regulations or waivers.

Requirements for waivers to be cost-neutral can be an unrealistic burden on new or experimental programs. States should be given a greater period of time for waiver programs to be budget neutral (e.g. ten years vs. the current five year requirement). These reforms would allow states to implement programs such as disease management and quality improvement that are expected to result in savings in later years, but have significant upfront costs. The statute should also allow for states to consider savings to Medicare and other federal programs when considering the impact of Medicaid changes. There are many promising innovations in Medicare/Medicaid integration or care coordination that are never implemented because of outdated notions of siloed budget neutrality requirements.

To the extent that new flexibilities do not make them obsolete, current waivers should be grandfathered into the program in order to not undermine existing agreements between a state and CMS.

VI. Judicial Reform

The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. Also, U.S. Department of Health and Human Services officials should have to stand by states when one of their waivers is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.

VII. Medicare Rx "Clawback"

Congress and the Administration should partner with the states to make regulatory changes and enact legislative fixes to the law to ensure that the congressional intent of the program is realized and all states gain some form of relief from passage of the MMA.

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forced to submit and defend a lengthy waiver application and wait for a time consuming review. This process is lengthy and tends to discourage innovation by forcing states to make a substantial investment in any new programs without much benefit to anyone.

VIII. Reinvestment Options

As Congress considers reforms to the Medicaid program, certain reinvestments of federal dollars should also be considered. The following are some potential areas for reinvestment that need further discussion by the Governors.

Territories. The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

Quality and Technology Improvements. Grants to the states and/or an increased matching rate should be provided for quality improvement efforts in Medicaid, such as those being considered for Medicare. Such efforts include adoption of health information technology; improved patient safety; reduction of medical errors; chronic care management; and pay-for-performance.

Tax Credits and Deductions for Long Term Care Insurance. Some combination of a significant tax credits, e.g., $2,000, and deductions, e.g., $200, to provide an incentive for individuals to purchase long term care insurance.

Tax Credits and Purchasing Pools to Increase Access to Health Insurance. A combination of individual health care tax credits and tax credits for small employers combined with funding to create purchasing pools should provide assistance to low-income working individuals to enable them to obtain health insurance and avoid reliance on Medicaid.

Fraud and Abuse. Medicaid Directors have long asked for three items to help fraud and abuse efforts

1) Permit states the same opportunities as are currently afforded the federal government to limit, restrict, or suspend the eligibility of beneficiaries, subject to due process, who have been determined in state proceedings to have engaged in fraud or abuse involving the Medicaid program, even if they have not been convicted in federal court of the listed federal crimes.

2) Amend Section 1903(a)(6) of the Social Security Act to provide the same federal match for all costs associated with fraud and abuse activities conducted by the state Medicaid agency as currently received by the Medicaid fraud control units (75 percent). This enhanced funding would apply to direct fraud and abuse functions that include, but are not limited to, identification, investigation, and administrative actions (e.g. recoveries and provider exclusions).

3) Provide that when a state discovers an overpayment and determines it to be attributable to fraud or abuse, the state should refund the federal overpayment in the quarter in which the recovery is made, regardless of when the overpayment is discovered.

In closing, let me again thank you for the opportunity to appear before you. The nation's Governors look forward to working with you as you work to develop proposals to reform the Medicaid program. Without reform it is unsustainable.

Again, I appreciated the opportunity to provide you with the most current thinking of the Governors regarding short-term Medicaid reform.

I would be happy to answer any questions.