STATEMENT OF

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ON

MEDICAID FINANCIAL MANAGEMENT

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES
SUBCOMMITTEE ON REGULATORY AFFAIRS, STIMULUS OVERSIGHT AND GOVERNMENT SPENDING

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Chairmen Gowdy and Jordan, Ranking Members Davis and Kucinich, and Members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight over Medicaid's financial management.

Medicaid Background

Medicaid is the primary source of medical assistance for millions of low-income, disabled, and elderly Americans and is a central component of our nation's medical safety net, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In fiscal year (FY) 2012, an estimated 56.6 million people on average will receive health care coverage through Medicaid.

Although the Federal government establishes minimum requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. In general, States pay for the health benefits provided, and the Federal government, in turn, matches qualified State expenditures based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent. Administrative expenses are generally matched at a 50 percent rate for all States, although the rate is higher for certain administrative expenditures. On average, the Federal government expects to pay nearly 58 percent of State Medicaid expenditures in FY 2013 for Medicaid benefits, and in FY 2013, the Federal share of current law Medicaid outlays is expected to be nearly $283 billion.

States that choose to participate in the Medicaid program and receive Federal matching payments are required to cover individuals who meet certain minimum categorical and financial eligibility standards. Medicaid beneficiaries include children, pregnant women, adults in families with dependent children, the aged, and people with disabilities who meet certain minimum income eligibility criteria that vary by eligibility category. States have the flexibility to extend coverage

to other groups, such as women who have breast and cervical cancer, through State plans and under demonstration authority. States that participate must cover certain medical services, such as nursing home care, and are provided the flexibility to offer additional benefits to beneficiaries, such as home- and community-based long-term services and supports. States also have broad flexibility on how they will design their service delivery system; most Medicaid beneficiaries are served through managed care but for some States and for some populations, the program relies on a fee-for-service system. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the States in eligibility, services and service delivery, as well as reimbursement rates to providers and health plans.

Medicaid is currently undergoing significant change as CMS implements reforms to modernize and strengthen the program and its services. Beginning in 2014, the Affordable Care Act eliminates long-standing limitations on coverage that have prevented many of the lowest-income uninsured Americans from qualifying for Medicaid. In 2014, Medicaid will be available to most individuals (subject to citizenship and immigration status) under age 65 with family incomes below 133 percent of the Federal poverty level (FPL) with an additional 5 percent income disregard (for an effective eligibility level of 138 percent FPL, or approximately $15,415 for a single individual in 2012). The final rule (CMS-2349-F) released on March 23, 2012, significantly streamlines many of the complex eligibility categories currently in statute, implements simpler rules for determining income eligibility, and requires modernized and coordinated systems for processing applications for most Medicaid applicants. These proposed changes build on successful State efforts to streamline eligibility, enrollment, and renewal processes, and apply these administrative improvements nationally.

As we prepare for the Medicaid eligibility changes, CMS is also moving towards data-driven decision-making with newly expanded data sets, such as the Transform Medicaid Statistical Information Systems (MSIS) pilot project, which is currently being tested in 10 States and will be nationally implemented in 2014. CMS is also working to strengthen the program through active engagement with States through initiatives such as our Medicaid Integrity Institute and our Value-Based Purchasing Collaborative and the resources provided through the new

Medicaid.gov website. These, and many other changes, will modernize the program and strengthen program operation, while ensuring that beneficiaries receive better care and that Federal taxpayer dollars are used effectively and efficiently.

Financial Management in Medicaid

Since the enactment of Medicaid in 1965, the Federal government has given States the option of receiving Federal matching funds to help them pay the costs of health care and long-term care for their low-income residents. Medicaid's Federal-State matching arrangement reflect the fiscal commitment on the part of the Federal government towards paying for part of the cost of health and long-term care services for certain categories of low-income Americans, regardless of the number of eligible individuals or the extent of their medical needs. The matching arrangement depends on States' own contributions, which ensure their commitment to managing costs and quality. It also facilitates States' ability to extend coverage for health and long-term care services to their low-income residents beyond the minimum standards. CMS takes seriously our responsibility to ensure that States correctly report their Medicaid expenditures so that we can ensure Federal Medicaid funds are appropriately spent.

CMS tracks State expenditures to compute the amount of Federal Financial Participation (FFP), or the match CMS will provide to the State to fund medical expenditures and program operations. CMS tracks State expenditures through the Medicaid Budget and Expenditure System (MBES) and State Children's Health Insurance Budget and Expenditure System (CBES). The MBES/CBES is a web-based application the Medicaid State agencies use to report budgeted and actual expenditures for Medicaid and the Children's Health Insurance Program (CHIP). The MBES/CBES also stores the State's historical budget and expenditure records for data analysis purposes.

To ensure financial stewardship over Federal taxpayer money, CMS verifies that actual State expenditures reconcile with the monetary advance CMS gives to States for their anticipated quarterly budgeted costs. States may submit a revised request for Federal funds if their original request proves insufficient, but they must provide justification for doing so. Thirty days after the end of the budget quarter, States must report actual expenditures and include supporting

documentation such as invoices, cost reports, and eligibility records to ensure that the FFP matches with States' actual expenditures.

CMS employs a team of accountants and financial management specialists in regional offices to review these submissions, look for anomalies, and request additional documentation or justifications as necessary. These individuals also perform focused financial management reviews of specific Medicaid service and administrative expenditures. Focused financial management reviews generally involve selecting a sample of paid claims for review related to certain types of Medicaid provided services. These reviews are useful in identifying unallowable costs and in highlighting where additional policy clarification or oversight may be needed. These accountants and financial management specialists also perform audit resolution tasks and coordinate with State auditors and the Department of Health and Human Services' Office of Inspector General (HHS OIG) to ensure State expenditures and corresponding claims for Federal matching funds are allowable.

CMS issues deferrals and disallowances to States that provide inadequate documentation or justification for Medicaid claims. A deferral withholds funds from the States until additional clarification or documentation is received from the States regarding Medicaid expenditures claimed. A disallowance is a determination by CMS that a claim or portion of a claim by a State for Federal funds is unallowable (States have the right to appeal, in whole or in part, a disallowance). CMS oversight over State expenditures is a careful balance of ensuring that States receive the guaranteed Federal share, while also ensuring the FFP is only spent on appropriate, documented activities in the Medicaid program. As part of achieving that goal, CMS removed, in FY 2011, an estimated $949 million (with approximately $915 million recovered and $34 million resolved) in deferrals, disallowances, and recoveries of approximately $6.3 billion identified in questionable Medicaid costs. Furthermore, an estimated $223 million in questionable reimbursement was averted due to CMS funding specialists' preventive work with States to promote proper State Medicaid financing.

Rate-Setting and Program Oversight

In conjunction with CMS' review of State expenditures, CMS also oversees and approves State coverage and payment policies through the State plan and amendments. States establish their own Medicaid provider payment rates within broad Federal requirements. States generally pay for services on a fee-for-service basis or through managed care contracts with private health insurers. Under fee-for-service arrangements, States pay providers (for example, physicians and hospitals) directly for services. States develop their payment rates based on many factors, including consideration of local health care markets, the underlying costs of providing the services, and payment rates by Medicare or commercial payers in the local community. Regardless, Medicaid payment rates set by the States must be consistent with efficiency, economy, and quality of care.

CMS sets an outer bound for how much States can pay providers in certain fee-for-service arrangements. The Medicaid Upper Payment Limit (UPL) requirements provide that payments for inpatient hospital, outpatient hospital, clinic, nursing facility, and other services in the aggregate are not allowed to exceed an estimate of what Medicare would have paid for the same services. The UPL is calculated in the aggregate for each Medicaid service and for each provider type (private, non-State government, and State government-owned). A State plan amendment that proposes to increase payment rates for these services will typically require the State to demonstrate that the increase in payment rates will not result in the total payments for any provider type exceeding the UPL.

Under managed care arrangements, States contract with organizations (typically, private managed care plans) to deliver care through networks of providers. States are required to have actuarially sound capitation rates, which means the rates have been developed in accordance with generally-accepted actuarial principles and practices, are appropriate for the population and services, and are certified by actuaries. States are also required to use utilization and cost data derived from the Medicaid population or a comparable population and set requirements on special risk-sharing arrangements. Managed care plans must have in place quality assessment, reviews, and measures to ensure that Medicaid beneficiaries are accessing and receiving quality care. CMS Regional Offices are required to review and approve States' managed care contracts

and capitation rates, using established standard operating protocols for review and approval of contracts as well as contract and rate review checklists.

Disproportionate Share Hospitals

Disproportionate Share Hospital (DSH) payments are made by States to qualifying hospitals that treat low-income and Medicaid patients. The Medicaid statue limits a qualifying hospital's DSH payments to the amount of eligible uncompensated care costs and this limit is commonly referred to as the hospital-specific limit. CMS is in the process of implementing new audit requirements for DSH payments. For States to receive FFP for DSH payments, Federal law requires States to submit an independent certified audit and an annual report to the Secretary of the Department of Health and Human Services (HHS) describing DSH payments made to each DSH hospital. The report must identify each disproportionate share hospital that received a DSH payment adjustment, and provide information to CMS to ensure the appropriateness of the payment amount. The annual certified independent audit includes specific verifications to make sure hospital DSH payments are within the hospital-specific limit.

The final rule CMS (CMS-2198-F) published on this requirement in 2008 specifies the elements for the required DSH report and the verifications required for the audit. CMS also developed additional guidance, including the General DSH Audit and Reporting Protocol and the DSH Report Format, to help States meet statutory and regulatory requirements. Audits and reports were required beginning with Medicaid State plan rate year 2005. The initial audit years of 2005, 2006, and 2007 were due to CMS on December 31, 2010. Each subsequent audit and report is due on December 31, 3 years after the completion of the State plan rate year. For example, State plan rate year 2009 audits and reports are due to CMS on December 31, 2012.

In FY 2011, CMS conducted in-depth reviews of a State and hospital in eight different regions of the country in an attempt to obtain a nationwide representation of audit implementation. Continuing this effort, CMS is conducting similar in-depth reviews for FY 2012 of a State and hospital in two additional regions. The reviews are intended to produce a greater understanding of how States, hospitals, and auditors completed the initial DSH audits and reports. CMS also plans to use this information to issue additional guidance to States to ensure

proper implementation and compliance with the auditing and reporting requirements. On April 5, 2012, CMS issued the first FY 2011 draft financial management review report to the State of Texas relating to its Medicaid DSH independent certified audit and report.

Oversight of State Funding Sources for State Portion of the Medicaid Program

As noted, Federal Medicaid matching payments are made based on actual State expenditures and, as such, our oversight responsibility includes ensuring that States appropriately fund their share of Medicaid expenditures for the care and services available under their State plan. As the States share in the cost of their Medicaid program, the State-Federal partnership in the Medicaid program builds in a natural incentive for States to use Federal Medicaid money judiciously. However, CMS is committed to ensuring the State-Federal financial partnership is not manipulated and States are complying with all statutory and regulatory requirements. Therefore, CMS carefully oversees and evaluates State funding sources for the non-Federal share of the State Medicaid program in order to ensure the balance set by statute between the State and Federal share of Medicaid funding is enforced.

Before CMS approves a State plan, a State must verify its funding sources meet statutory and regulatory requirements. Recognized sources of funding for the State share of Medicaid payments include:

- State legislative appropriations to the single state agency;
- Inter-governmental transfers (IGTs);
- Certified public expenditures (CPEs); and
- Permissible taxes and provider donations.

As part of the State plan amendment review process, CMS requires States to provide detailed information and assurances regarding the source of the non-Federal share. In addition to this review process, funding specialists are engaged in the regular review of all sources of the State match. In FY 2011, $223 million in questionable reimbursement was averted due to the funding specialists' preventive work with States to promote proper State Medicaid financing methods.

Since August 2003, CMS has been requesting information from States regarding details on how States are financing their share of the Medicaid program costs under the Medicaid reimbursement State plan amendment review process. Through this review process, CMS noticed that the enhanced payments some States make to health care providers are not financed in a manner consistent with the Federal statute. Specifically, CMS discovered that several States made claims for Federal matching funds associated with certain Medicaid payments, which the health care providers were not ultimately allowed to retain. Instead, through the guise of the intergovernmental transfer process, State and/or local governments required the health care provider to forgo and/or return certain Medicaid payments to the State, which effectively shifted the cost of the Medicaid program onto the Federal taxpayer. CMS continues to work with States to identify permissible sources of non-Federal share funding and will not approve a Medicaid State plan amendment if there is not a permissible non-Federal share funding source.

CMS also reviews State plan amendments that involve Medicaid payments that would be funded by a health care-related tax, as well as State legislation enacting a health care-related tax to ensure that all other statutory and regulatory requirements are met. This involves also analyzing the taxing structure in conjunction with the associated reimbursement methodology to ensure there are no hold harmless arrangements. If a waiver of the broad-based and/or uniformity requirements of the health care-related tax is necessary, then the State must also submit a formal waiver to CMS for review and approval. This review includes a detailed analysis of the necessary statistical tests as well as analysis of entire taxing structure to ensure compliance with the other statutory and regulatory requirements. CMS also learns of health care-related taxes through other avenues, including States asking CMS to review draft legislation or asking for other technical advice. Historically, the provision of early input and early feedback is the most effective and efficient way to develop a health care-related tax that is consistent with Federal requirements. CMS has a careful process in place to review and approve State plans and amendments.

Medicaid Program Integrity

Although States are primarily responsible for policing fraud in the Medicaid program, CMS provides technical assistance, guidance, and oversight in these efforts. CMS is committed to

detecting, deterring, monitoring, and combating fraud and abuse, as well as taking action against those that commit or participate in fraudulent or other unlawful activities.

This commitment is centralized in CMS' Center for Program Integrity, where the Medicaid Integrity Program is housed.

Because of Medicaid's unique Federal-State partnership, CMS has developed initiatives that specifically work to assist States in strengthening their own efforts to combat fraud, waste, and abuse. For the continuing education of State program integrity employees, the Medicaid Integrity Institute (MII) stands out as one of CMS's most significant achievements. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to States in a structured learning environment. In its three years of existence, the MII has offered numerous courses and trained over 2,464 State employees at no cost to the States.

In addition, CMS has provided regulatory and sub-regulatory guidance to States in connection with the States' Medicaid audit activities. One example is the Medicaid Recovery Audit Contractor (RAC) Program. On September 16, 2011, CMS published the final rule for the Medicaid RAC program (CMS-6034-F). The Medicaid RAC program is administered by the States and involves the auditing of claims for services furnished by Medicaid providers. RACs review claims after payment, using both simple and detailed reviews that include medical records. Medicaid RACs must identify both overpayments and underpayments. States are required to pay the RACs a contingency fee for the identification of overpayments, and have discretion to determine the fee methodology for the identification of underpayments. All fees paid to Medicaid RACs must be out of the amounts recovered. States were required to have their RAC programs in place, absent an exception, by January 1, 2012, and all States have submitted State plan amendments to establish State-level Medicaid RAC programs or have requested and been granted an exception.

In addition to providing regulatory and sub-regulatory guidance, CMS has hosted a number of activities to assist States in the implementation of their Medicaid RAC programs. During FY 2011, CMS hosted a series of technical assistance webinars and teleconferences for States to aid

them in their RAC program implementation. Topics included an overview of the Medicaid RAC final rule, Medicare RAC best practices, RAC fraud referrals, and State reporting on performance metrics. CMS also launched the Medicaid RACs At-A-Glance webpage[1] in February 2011 that shows a U.S. map providing basic information on the status of implementation for each State's RAC program.

Another example of CMS working with States to prevent and recover inappropriate payments is the Audit Medicaid Integrity Contractors (MICs). Audit MICs are CMS contractors that conduct audits to identify Medicaid overpayments. Between 2009 and November 1, 2011, Audit MICs initiated 1,663 audits in 44 States. Through both direct provider audits and automated reviews of State claims, those efforts have identified an estimated $15.2 million in overpayments. During FY 2011, CMS made a dramatic shift in the way it develops MIC audits, working more collaboratively with the States in ways designed to achieve stronger results. All the audits assigned in the second half of FY 2011 were collaborative audits that benefit from both State and Federal resources and insight. In addition to Federal and collaborative audits, States reported they conducted an additional 122,631 audits in FY 2009. Those State efforts have identified an estimated $964 million in overpayments. CMS also provides States assistance with "boots on the ground" for special investigative audits. Since October 2007, CMS has participated in 10 projects in three States, with the majority of activity occurring in Florida. States reported these reviews have resulted in $40 million in savings through cost avoidance. CMS helped States review 654 providers, 43 home health agencies and DME suppliers, 52 group homes, and 192 assisted living facilities. During those reviews, CMS and States interviewed 1,150 beneficiaries and took more than 540 administrative actions against non-compliant providers. Besides identifying inappropriate provider activities, these reviews also result in an ongoing sentinel effect in these vulnerable areas of the Medicaid program.

CMS is actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid Integrity Program. CMS' goal is to utilize predictive modeling to enhance its analytic capabilities and increase information sharing and collaboration among State

[1] http://www.cms.gov/medicaidracs/

Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

CMS is committed to working with our law enforcement partners at the HHS OIG, the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ), who take a lead role in investigating and prosecuting alleged fraud. By sharing information and requiring all States to terminate any provider or supplier Medicare or a State terminated for cause, CMS and its partners are ensuring that fraudulent providers and suppliers cannot easily move from State to State or between Medicare and Medicaid. We are also providing training in the use of data analytic systems to the HHS OIG and DOJ, enabling investigators and law enforcement agents to more quickly analyze data, detect fraudulent trends, and prosecute fraud schemes. Our partnership with the HHS OIG and the DOJ continues to lead to the successful resolution of fraud cases, such as the recent settlement with WellCare, a health maintenance organization, which has agreed to pay $137.5 million to the Federal government and the States with which it contracted to resolve four lawsuits alleging that WellCare participated in a number of schemes to submit false claims to Medicare and various Medicaid programs and engaged in marketing abuses, such as cherrypicking of healthy patients in order to avoid future costs.

Looking Forward

CMS is committed to ensuring State compliance and financial integrity within the Medicaid program through many different types of activities. CMS is also committed to moving forward to a modern Medicaid program that rewards good outcomes and high-quality care instead of simply paying for the volume of health care provided. Many States are actively engaged with us and are leading the change to make Medicaid a leader in this industry-wide transformation.

For example, CMS is working to improve the quality and lowering the cost of care for the 9 million Americans enrolled in both Medicare and Medicaid (known as Medicare-Medicaid enrollees or "dual eligibles"). The Affordable Care Act created the new Federal Coordinated Health Care Office, referred to as the Medicare-Medicaid Coordination Office, to more effectively integrate benefits and services between the two programs and to improve the coordination between the Federal Government and States for Medicare-Medicaid enrollees.

Through our work and with our State partners, our efforts are advancing access to seamless, coordinated care programs for Medicare-Medicaid enrollees.

Another priority is helping State Medicaid agencies buy better value by linking quality, payment reform, and integrated care models through the Value-Based Purchasing Medicaid and CHIP (MAC) Collaborative. As the largest insurer in the country in terms of covered lives, Medicaid can better leverage its value-based purchasing power to achieve high quality at lower cost. Phase 1 of the Value-Based Purchasing MAC Collaborative, which focuses on ways to improve care and lower costs in non-risk based arrangements, began in February 2012, and will run through August 2012 or later.

Finally, CMS is modernizing its data systems, which will provide better and faster accountability and enforcement for the compliance issues and fraud detection systems described earlier. The activities delineated here reflect the strong Federal-State partnership upon which the Medicaid program is based as well as CMS' long-standing commitment to ensuring the accountability of the Medicaid program while protecting and improving the services provided to beneficiaries who rely on Medicaid for their health care needs.

BIOGRAPHICAL SKETCH

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Cindy Mann, J.D. has served as the Director of the Center for Medicaid, CHIP and Survey & Certification (CMCS) within the Centers for Medicare & Medicaid Services (CMS) since June 2009. As CMS Deputy Administrator and Director of CMCS, Ms. Mann is responsible for the development and implementation of national policies governing Medicaid, the Children's Health Insurance Program (CHIP), the agency's provider survey and certification activities, and the Clinical Laboratories Improvement Amendments (CLIA). CMSO also serves as the focal point for all CMS interactions with State and local governments and the Territories.

Prior to her return to CMS in 2009, Cindy served as a research professor at the Georgetown University Health Policy Institute and was the Executive Director of the Center for Children and Families at the Institute. Her work at Georgetown focused on health coverage, financing, and access issues affecting low-income populations and States. Cindy served as Director of the Family and Children's Health Programs Group at CMSO from 1999-2001, where she played a key role in implementing the CHIP program and led the Center's broader work on Medicaid policies affecting children and families. Before joining CMS (then HCFA) in 1999, Cindy directed the Center on Budget and Policy Priorities' federal and State health policy work. She also has extensive State-level experience, having worked on health care, welfare, and public finance issues in Massachusetts, Rhode Island, and New York.

Cindy holds a law degree from the New York University School of Law.