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ON

CMS'S FINANCIAL MANAGEMENT OF THE MEDICAID PROGRAM

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE & ENTITLEMENTS

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Hearing on CMS's Financial Management of the Medicaid Program
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Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight of financial management in the Medicaid program. 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, but it depends on clear lines of responsibility and shared expectations. CMS takes seriously our role in overseeing the financing of states' Medicaid programs, and we continue to look for ways to refine and further improve our processes.

Medicaid Background

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In FY 2014, an estimated 65 million people on average will receive health care coverage through Medicaid.

Although the Federal Government establishes general guidelines for the program, states design, implement, and administer their own Medicaid programs. The Federal Government matches state expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent.

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. Under Medicaid, states must cover certain medical services and are provided the flexibility to offer additional benefits to beneficiaries. Unlike most other types of coverage,

Medicaid has a major responsibility for providing long-term care services. Medicare and private health insurance generally furnish only limited coverage of these benefits. 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 and states implement reforms to modernize and strengthen the program and its services. While focused on implementation of the Affordable Care Act, CMS has been working closely with states to implement delivery system and payment reforms. CMS has encouraged state efforts with new tools and strategies to improve the quality of care and health outcomes for beneficiaries and to promote efficiency and cost effectiveness in Medicaid. And, as always, CMS works to ensure appropriate financial management mechanisms are in place to ensure dollars are spent appropriately.

CMS has seen many of those efforts pay off in the form of slowed, and in some cases declining, spending. Total Medicaid expenditures increased by only 0.8 percent in FY 2012, which was the second-lowest rate of growth in the program's history. At the same time, while enrollment in Medicaid grew, per enrollee spending is estimated to have decreased by 1.9 percent.[1]

Financial Management in Medicaid

Medicaid's Federal-state matching arrangement reflects 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. The matching arrangement depends on states' own contributions, which ensure their commitment to managing costs and quality. 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. Oversight of states' financial management of their Medicaid programs is a critical component of our work.

[1] http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf

The Federal Government oversees state Medicaid program implementation in part through review of the state plan. The state plan is an agreement between a state and the Federal Government describing how that state administers its Medicaid program. The plan provides assurances that a state abides by Federal rules and may claim Federal matching funds for its Medicaid program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for provider payment rates, and the administrative requirements that states must meet to participate. States frequently send State Plan Amendments (SPAs) to CMS to review and approve. CMS also reviews managed care contracts and reported expenditures. Some states use program flexibility provided by the Secretary through section 1115 demonstrations to test new or existing approaches to financing and delivering Medicaid and CHIP. When a state is implementing all or part of its Medicaid responsibilities through a section 1115 demonstration, CMS reviews compliance with Federal requirements in approving the demonstration and expenditure authorities and Special Terms and Conditions applicable to the demonstration, and through state reporting requirements that may be implemented through the Special Terms and Conditions. The demonstration authorities, including the Special Terms and Conditions, effectively amend or expand the agreement set forth in the state plan. Together with the state plan, the demonstration authorities describe how the state administers its program for the period of the demonstration. CMS monitoring activities for demonstrations include review of quarterly program reports, evaluation/implementation progress reports, and monitoring the Federal budget limit established for the demonstration against the state's actual reported expenditures to ensure claims are permissible and within the scope of the demonstration's goals and objectives.

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 Federal financial participation (FFP) matches with states' actual expenditures. This process applies

whether or not some or all of a state's expenditures are authorized through the state plan or a section 1115 demonstration.

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 the 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 or is not supported by the state's documentation. States have the right to appeal a disallowance, in whole or in part. 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, as of FY 2013, CMS identified from state reported expenditures approximately $9.7 billion in questionable Medicaid costs. In FY 2013 CMS took action on an estimated $2.7 billion (with approximately $375 million recovered and $2.4 billion resolved). Furthermore, an estimated $188 million in questionable reimbursement to states was averted due to CMS funding specialists' preventive work with states to promote proper state Medicaid financing.

Finally, as part of our ongoing financial management oversight, CMS provides regular updates through the budget and expenditure reporting system related to proper claiming of expenditures. And in spring 2014, CMS provided in-depth training to states on the budget and expenditure claiming forms.

Rate-Setting and Program Oversight

Medicaid beneficiaries access services through both fee-for-service (FFS) and managed care arrangements. As described above, the state plan sets out the methodologies for establishing the fee-for-service payment rates for providers. To change the way a state pays Medicaid providers in this context, a state must submit a SPA to CMS to review and approve. Before the SPA's effective date, the state must also issue a public notice of the change. The notification is to inform providers and other stakeholders of changes to Medicaid payment rates.

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. Payment rate methodologies often include mechanisms to update the rates based on specified trending factors, including a state-determined inflation adjustment rate. CMS reviews SPA reimbursement methodologies for consistency with the Social Security Act and other Federal statutes and regulations. Section 1902 of the Social Security Act requires that states "assure that payments are consistent with efficiency, economy, and quality of care."

To promote efficiency, economy, and quality of care, CMS sets an outer bound, the Medicaid Upper Payment Limit (UPL), for how much states can pay providers under certain fee-for-service arrangements. The UPL for institutional providers such as hospitals and nursing facilities is not a limit on payments to individual providers, but is calculated in the aggregate for each affected category of Medicaid services and for each provider type (private, non-state-government, and state-government-owned). A SPA proposing to increase payment rates for these services will require the state to demonstrate that the increase in payment rates will not result in total payments for any provider type exceeding the UPL for that category of services.

There is a different standard applied to rates paid in capitated managed care arrangements. Federal law requires Medicaid capitated rate arrangements to be actuarially sound. Under CMS regulations, state contracted actuaries must certify that the rates paid are actuarially sound. As capitated managed care arrangements have become a commonly used approach to Medicaid service delivery and are expected to grow in the coming years as new beneficiaries enroll, CMS has increased our oversight of this rate setting process. For the 2014 contract year, CMS, in collaboration with CMS' Office of the Actuary (OACT), issued a rate-setting consultation guide; held in-depth consultation meetings with states and their consulting actuaries to discuss that guidance; and identified key elements that should be described in the filed rate methodologies. We are working closely with states during this review process in order to ensure rates are actuarially sound and meet all requirements. We are committed to improving our oversight across all capitated contracting arrangements through new initiatives that increase transparency.

Ongoing guidance to states

As part of our ongoing management of the program, CMS regularly provides guidance to states on matters relating to financial management, including two recent letters that detailed our work to improve data analysis and other financial management tools.

The first letter, issued in March 2013[2], announced our intention to work with the National Association of Medicaid Directors (NAMD) to establish an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. That workgroup has met regularly and has made substantial progress in expanding state access to Medicare and CMS data for program integrity purposes.

In this same letter, CMS also announced that we would require states to submit UPL demonstrations on an annual basis, allowing CMS and states to have a better understanding of the variables surrounding rate levels, supplemental payments and total providers participating in the programs and the funding supporting each of the payments described in the UPL demonstration. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan.

[2] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf

Specifically, beginning in 2013, CMS required that states submit UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. In 2014 and annually thereafter, states will be required to submit annual UPL demonstrations for the services listed above and clinics, physician services (for states that reimburse targeted physician supplemental payments), intermediate care facilities for the developmentally disabled (ICF/DD), psychiatric residential treatment facilities and institutions for mental disease (IMDs). This information must be submitted by the state prior to the start of the state fiscal year. For most states, this means that a state submits, for CMS review, these UPL demonstrations by June 30th of each year. CMS has received the first round of these submissions from states and is currently reviewing them.

More recently, CMS issued guidance related to the allowable and unallowable use of provider-related donations and the use of certain types of public-private arrangements.[3] These arrangements generally involve Medicaid supplemental payments or special add-ons to the base payment rate that are contingent upon or otherwise related to agreements between government and private entities under which the private entities assume obligations to provide donated services or other transfers of value as directed in the arrangements.

Our goal in providing this guidance is to clarify for states what is authorized under the law and ensure that states have the information and support they need from CMS to promote flexibility while ensuring compliance with Federal statute and regulations. The guidance is coupled with ongoing work with states as questions about these and related matters arise in the course of SPA review and financial management oversight.

Further Initiatives to Strengthen Medicaid and Ensure Financial Integrity

As the Federal-state partnership evolves, CMS continually updates and improves our financial management functions incorporating them into our day to day work. Over the last several years, we have undertaken several initiatives that build upon our existing programs and tools.

Improving Data and Data Analytic Capacity

[3] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-004.pdf

Programs with the size and scope of Medicaid and the Children's Health Insurance Program (CHIP) require robust, timely, and accurate data in order to ensure the highest financial and program performance, support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driven decision making. Section 4735 of the Balanced Budget Act of 1997 included a statutory requirement for states to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration.

CMS has worked with states to improve Medicaid and CHIP data and data analytic capacity through the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. This initiative includes changes to the Medicaid Statistical Information System (MSIS), which will be known as Transformed-MSIS or T-MSIS. We will be implementing T-MSIS with states on a rolling basis, beginning this summer.

The enhanced data available from T-MSIS will support improved program and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency.

Enhancing the Payment Error Rate Measurement (PERM) Program

The Affordable Care Act created significant changes to Medicaid and CHIP eligibility applicable to all states regardless of their decision to expand Medicaid. These changes require redesign of many Medicaid and CHIP business operations and systems, and interaction with other state and Federal partners.

In light of the importance of these changes in policy, operations, and systems, CMS and the states have a strong interest in ensuring timely feedback about the accuracy of determinations based on these changes and ways to quickly create improvements or corrections based on those results. The interaction of the Marketplaces, Medicaid, and CHIP, and the cross-program interdependencies and coordination built to create an efficient system of coverage, will need special consideration in the planning of future program measurements and accountability. Accordingly, the current methodologies applied to measurement of eligibility accuracy under

PERM need to be updated to reflect the changes states are making in their eligibility processes and systems and incorporate new regulations concerning the above changes.

For this reason, starting in 2014, CMS has implemented an annual 50-state pilot program strategy with rapid feedback for improvement, in state eligibility systems and eligibility determination processes in place of the Payment Error Rate Measurement (PERM) and the Medicaid Eligibility Quality Control eligibility reviews through 2016. The Medicaid and CHIP Eligibility Review Pilots will use targeted measurements to: (1) provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) identify strengths and weaknesses in operations and systems leading to errors; and (3) test the effectiveness of corrections and improvements in reducing or eliminating those errors.

Oversight of Non-Federal Share Funding

The Medicaid statute provides states with the discretion to finance the non-Federal share of program costs from a variety of sources including state general funds, special assessments, funds derived from health care related taxes or contributions from units of government through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Each type of non-Federal share funding is subject to Federal guidelines and oversight, and the statute provides that no more than 60 percent of a state's non-Federal share can be from local sources. At least 40 percent must be from state funds. This analysis is made at an aggregate state expenditure level including both medical assistance expenditures as well as state administrative expenditures.

States are specifically permitted in statute to source the non-Federal share through these mechanisms. Moreover, during the economic downturn, some states relied less on state general funds and more on other sources of funds, consistent with Federal law. This allowed funding for Medicaid services to be available even when state tax revenues were constrained. In instances where states are found to rely on Federal funds through funding or payment arrangements that do not adhere to Federal requirements, CMS has proactively addressed those issues through SPA disapprovals or other oversight and regulatory measures.

CMS thoroughly reviews the financing associated with each SPA that states submit to propose changes to service payments. With each request, CMS gathers information on the source of the

non-Federal share, the units of government that IGT funds or use CPEs, as well as supporting documentation related to health care-related taxes and provider-related donations. The information is analyzed and must be determined as an acceptable basis to serve as a source of the non-Federal share before CMS approves a SPA proposal.

Our Work Continues

CMS takes very seriously our responsibility to oversee taxpayer dollars, while ensuring Medicaid beneficiaries receive the services to which they are entitled. Financial management is a critical component of our day to day work on the Medicaid program, and we continue to look for ways to improve and enhance our approach to oversight of this important program. We are working closely with states to ensure they are upholding their end of the bargain and meeting the financial management practices expected of them.

I look forward to working with the Committee as we continue to improve the Medicaid program.