House Committee on Energy and Commerce Subcommittee on Oversight and Investigations Hearing on "Examining How Improper Payments Cost Taxpayers Billions and Weaken Medicare and Medicaid" (April 16, 2024)

Additional Questions for the Record

The Honorable Cathy McMorris Rodgers

1. **The Commission voted to recommend that states report the sources of the financing for the states' non-federal share. There was recently an article in the Wall Street Journal entitled, "How California Uses Medicaid to Rip You Off," that called into question how California finances its Medicaid program. Could you speak more about how the Commission reached this recommendation?**

   The Commission's recommendations that will be included in Chapter 1 of the June 2024 Report to Congress are focused on improving the transparency of Medicaid and CHIP financing to account for providers' costs of financing the non-federal share when assessing Medicaid and CHIP payments. The amount providers pay in health-care related taxes, intergovernmental transfers, and certified public expenditures can be seen as additional costs that effectively reduce the gross payments. As such, the net payment that providers can use to cover the cost of providing services is lower than the gross amount initially received. As part of our work, we interviewed a wide variety of policy experts, state and federal officials, and provider representatives who stressed the importance of analyzing both gross and net payment amounts when developing payment policy and assessing how these payments relate to statutory goals of access, quality, and efficiency.

   The Commission has long held that analyses of Medicaid payment policy require complete data on all Medicaid payments that providers receive as well as data on the costs of financing the non-federal share necessary to calculate net Medicaid payments at the provider level. In the March 2016 Report to Congress, the Commission recommended that CMS improve the transparency of payment and financing data for hospitals, and in the March 2023 Report to Congress, the Commission made a similar recommendation for nursing facility payments. The Commission's June 2024 recommendations build upon those prior recommendations to include all types of Medicaid financing for all providers, not just hospitals and nursing facilities.

2. **Considering the varied data capabilities across states, what federal support do you believe is necessary to standardize data collection processes in Medicaid across all of 56 different Medicaid programs? How can the federal government assist in these improvements?**

   MACPAC has conducted varied analyses that have identified the need to improve data collection processes. As background, states can currently receive enhanced federal match on certain activities related to Medicaid information technology systems, also known as Medicaid Enterprise Systems (MES). States can receive 90 percent federal match for the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to

provide more efficient, economical, and effective administration of the state's Medicaid plan and 75 percent for the operations and maintenance of such systems (Section 1903(a)(3)(A)-(B)). However, not all of the costs associated with implementing new data systems may be eligible for the enhanced match, such as staffing costs.

MACPAC's work on Medicaid demographic data demonstrates the importance of collecting data using validated and standardized measures. Standardized measures facilitate the collection of comparable, high-quality data, which are important for measuring the health experiences of Medicaid beneficiaries across states. However, the Commission's work also indicates that it is necessary to provide states with flexibility to customize their demographic data collection based on their own programmatic needs and priorities, as long as these data can be aggregated to support federal reporting standards and cross-state analyses. For example, all state Medicaid programs are required to report the federal minimum race and ethnicity standards to the Transformed Medicaid Statistical Information System (T-MSIS). In addition to collecting these categories, some states have chosen to collect additional ones based on their state population demographics.

In the June 2022 Report to Congress, the Commission highlighted that greater data sharing of patient health information through interoperable information technology (IT) such as electronic health records could foster clinical integration and promote coordinated care. However, behavioral health providers face significant barriers to adoption of such technology. Barriers include cost, requirements to segment patient substance use disorder information, and the lack of clear guidelines for behavioral health IT. The Commission made the following recommendations:

- The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health Information Technology to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health information technology adoption and interoperability.
- The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health Information Technology to jointly develop a voluntary certification for behavioral health information technology.

Guidance on how to deploy existing authorities and federal funding opportunities would help states identify approaches for advancing the adoption and use of health IT for behavioral health providers, furthering integrated care efforts among state Medicaid agencies. In addition, the development of a voluntary certification for IT appropriate for behavioral health and integrated care practice settings could provide a path toward comprehensive adoption of high-quality behavioral health IT tools, ensuring real-time data sharing and collaboration between behavioral health providers and virtually all hospitals and physicians.

3. Given the evolving capabilities of modern technology, how can advanced tools such as artificial intelligence and machine learning be integrated into Medicaid's verification and eligibility processes to reduce errors and enhance the precision of eligibility determinations?

Existing rules require states to verify eligibility and process redeterminations using electronic data to the extent possible. As states have prepared for and conducted renewals at the end of the public health emergency, there has been an increased focus on the use of electronic data for verification as a means of easing the burden of the process for states and individuals, as well as to decrease potential inaccuracies that may result from human error. Most recently, CMS suggested strategies on ensuring timely and accurate processing of applications, including employing an eligibility system that interfaces with

electronic data sources and maximizes automated workflows. For example, CMS notes that an automated rules engine can enable states to process applications faster and with few errors.

MACPAC's prior work has also indicated that states may realize efficiencies through connections to electronic data sources and automating ex parte renewal processes.

4. **How do you evaluate the effectiveness of current cost-control measures within Medicaid? Given the complexities of state-federal dynamics, what further steps would you recommend to ensure the program's fiscal sustainability without compromising the quality of care provided to beneficiaries?**

   Examining any policy or research question, including those addressing cost control measures in Medicaid, would first require MACPAC to identify and assess the availability and quality of data. If data are available, MACPAC would design an analytic plan responsive to the study questions. Depending on the data and analysis, we may consult with other technical experts. Our research methods also include qualitative strategies including expert interviews such as with state and federal Medicaid officials; literature reviews; and environmental scans. MACPAC assesses the evidence to identify key findings and trends and present them to Commissioners for their deliberation. If the evidence supports policy recommendations, the Commission may consider and vote on them.

5. **Considering the varying structures of Medicaid Managed Care and Fee-for-Service, what are MACPAC's recommendations for aligning incentives in Managed Care to reduce improper payments while ensuring quality and access?**

   Improper payments are payments that do not meet Medicaid program requirements, and typically involve situations where a state or provider missed an administrative step. The Payment Error Rate Measurement (PERM) program samples both fee-for-service and managed care payments to determine if state payment decisions complied with applicable federal regulations and state policies. However, due to differences in the FFS and managed care payment structures, PERM methodologies differ. For FFS delivery systems, PERM examines a sample of FFS claims to assess potential errors in state payments to providers. For managed care, rather than look at service claims, PERM examines state capitation payments made to plans to assess potential errors in those payments.

   The federal government plays an important role in leading such efforts as part of its charge is to protect the program integrity of the Medicaid program. As such, in the June 2019 Report to Congress, MACPAC recommended that the Secretary of the Department of Health and Human Services conduct a rigorous examination of current state program integrity activities to identify effective design and implementation approaches, and disseminate findings to state Medicaid agencies. Should the Secretary implement this recommendation, efforts could include a focus on approaches to further understand managed care improper payments and strategies to prevent them.