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"Examining Medicaid and CHIP's Federal Medical Assistance Percentage"

Testimony of:

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Good morning, Chairman Pitts, Ranking Member Green, and other distinguished members of the Committee. Thank you for the opportunity to testify about the Office of Inspector General's (OIG) oversight of the Medicaid program. OIG has identified protecting the integrity of the expanding Medicaid program as a top management challenge for the Department of Health and Human Services (HHS).

My testimony today will focus on the Federal Government's role with respect to financing the Medicaid program through the Federal matching rates. As a partner with the Federal Government, States have an obligation to ensure that Federal dollars are spent accurately and in accordance with program rules. As discussed with Committee staff, I will cover two areas of vulnerability identified by our work related to Federal matching. First, OIG audits have found that some States claim Federal reimbursement for expenditures that do not qualify for enhanced matching rates. Second, our work has also found some States that use financing mechanisms to shift Medicaid costs to the Federal Government, thus distorting the matching rates.

OIG's mission is to protect the integrity of the HHS programs and the health and welfare of the people they serve. We advance our mission through a nationwide network of audits, evaluations, investigations, enforcement actions, and compliance efforts. Activities directed at the Medicaid program are a critical component of our work. Between Federal fiscal years (FY) 2011 and 2015, annual Medicaid expenditures rose more than 25 percent, from $430 billion to more than $538 billion, and Medicaid now serves more than 72 million individuals. By Federal FY 2023, Medicaid is projected to have annual expenditures of $835 billion and serve 79 million individuals.

The Medicaid Federal-State Partnership

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. Since the inception of Medicaid, the responsibility for administering and funding the program has been shared between the Federal Government and the States. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although States have considerable flexibility in designing and operating their Medicaid program, each State must comply with applicable Federal rules, including a requirement that payment for care be consistent with efficiency, economy, and high quality of care.

The Federal Government pays for its share of a State's medical assistance expenditures according to a formula defined in the Social Security Act. That share is known as the Federal medical assistance percentage (FMAP). Each year, as required by the Social Security Act, the Secretary

of Health and Human Services calculates and publishes FMAP rates. The FMAP rates that apply for most medical service costs are determined based on a State's relative per capita income and by law cannot be lower than 50 percent and cannot exceed 83 percent. The average regular FMAP is 57 percent.

States can receive enhanced FMAP rates for certain situations, populations, providers, and services. For example, the Patient Protection and Affordable Care Act (ACA) provides an initial FMAP rate of 100 percent for expenditures related to "newly eligible" individuals in States that choose to cover that population. Other examples of enhanced FMAP rates for specific expenditures include those for family planning (90-percent FMAP) and services provided through an Indian Health Service (IHS) facility (100-percent FMAP).

Ensuring the Accuracy of Enhanced State Matching Rates

While enhanced FMAP rates provide States with additional Federal funding for specified populations and services, they also increase the risk that expenditures could end up in incorrect categories. This potentially shifts a greater financial burden to the Federal Government. I will discuss three specific types of expenditures that we have found incorrectly charged to enhanced FMAP categories. These include family planning services, services provided in IHS facilities, and State adjustments to prior Federal reimbursements.

Expenditures Charged to Incorrect FMAP Categories—Family Planning Services

States are required to furnish certain family planning services and supplies and can receive Federal reimbursement for these services and supplies at the enhanced FMAP of 90 percent. OIG has conducted a number of audits involving State Medicaid agencies' family planning claims reimbursed at the enhanced rate. The reviews covered claims for inpatient, clinic, laboratory, and pharmacy services, as well as supplies claimed as family planning at the enhanced rate.

Most State agencies we audited did not fully comply with Federal and State requirements for claiming the enhanced rate for family planning services and supplies. Most State agencies claimed the 90-percent enhanced family planning rate for services that were Medicaid eligible but did not qualify as family planning services. These services should have been billed at the regular FMAP. We also found that some State agencies submitted claims at the enhanced FMAP for duplicated claims, as well as claims for services that were not Medicaid eligible at all. As a result, OIG recommended that 19 States return a total of $82.7 million.

Expenditures Charged to Incorrect FMAP Categories—Indian Health Service

Medicaid services that are provided through IHS facilities also receive an enhanced FMAP, with the Federal Government paying 100 percent. We have conducted reviews in Indiana, California, Oregon, Alaska, and South Carolina to determine whether these States correctly claimed

Medicaid expenditures for services provided through IHS facilities. Our work has found that States are not always correctly claiming FMAP for these services.

In two States, Indiana and Alaska, we found the State agencies incorrectly claimed $2.3 million in Medicaid expenditures for IHS facilities. Indiana overstated the Federal share of Medicaid expenditures by $993,000. Although these expenditures were Medicaid services and eligible for Federal reimbursement at the regular FMAP rate, they were not services provided in an IHS facility and did not qualify for the enhanced 100-percent rate. Alaska overstated the Federal share of IHS Medicaid expenditures by more than $1.3 million because of data entry errors.

In similar audits in Oregon and South Carolina, we found that although the State agencies correctly claimed IHS expenditures, they incorrectly claimed ACA enhanced primary care physician payment expenditures and ACA expenditures for "newly eligible" individuals under the category of IHS expenditures. The States should have claimed these costs under the appropriate FMAP category. In future years, as the enhanced FMAPs for ACA "newly eligible" individuals decrease from 100 percent to 90 percent by 2020, there will be an impact if States continue to incorrectly claim expenditures for this population at the 100-percent FMAP for IHS expenditures.

While these reviews have not generally found a significant financial impact on the Medicaid program resulting from these errors, they show that States need to improve how they report and claim Federal reimbursement for these services.

Incorrect FMAP for Federal Share Adjustments

The Form CMS 64 is used by State agencies each quarter to make adjustments for any identified overpayment or underpayment. State agencies regularly make adjustments to prior claims for Federal reimbursement for a variety of reasons, including correcting inaccurate provider billings and retroactive changes in provider payment rates. We have conducted a number of reviews of States to determine whether correct FMAPs were used when reporting claim adjustments. At the time of our audits, FMAP rates were temporarily increased due to the American Recovery and Reinvestment Act of 2009.

In Massachusetts and Maine, we found that the State agency did not always use the correct FMAPs when processing claim adjustments. Specifically, the State agency processed the whole amount of adjusted claims as new expenditures rather than treating only the increases as new expenditures. Overall, we identified over $110 million of overpayments to these two States involving more than 2.5 million claims.

Ongoing and Planned OIG Reviews—ACA Enhanced FMAP Areas

We are reviewing various enhanced FMAP payment provisions implemented under the ACA to determine whether States correctly applied enhanced FMAP payment provisions of the ACA. The following areas are part of OIG's planned and ongoing work:

- Enhanced Federal Medical Assistance Percentage for "newly eligible individuals." OIG is reviewing selected States' Medicaid claims to determine whether States correctly applied the enhanced FMAP payment provisions of the ACA. The ACA, section 2001, authorizes States to claim FMAP of 100 percent until 2017 for services provided to individuals who are newly eligible under Medicaid expansion.

- Enhanced Federal Medical Assistance Percentage—Primary Care Payment Bump. OIG is reviewing selected States' Medicaid claims to determine whether States correctly applied enhanced FMAP payment provisions of the ACA. The ACA, section 1202, required that for 2013 and 2014 Medicaid payments to primary care providers be at least equal to Medicare payments to primary care providers. During these years, the Federal Government should have paid 100-percent FMAP for the difference between the Medicare rate and the Medicaid rate that had been in effect.

- Community First Choice State plan option under the ACA. OIG will review Community First Choice (CFC) payments to determine whether the payments are proper and allowable. Section 2401 of ACA added section 1915(k) to the Social Security Act, a new Medicaid State plan option that allows States to provide statewide home and community-based attendant services and support to individuals who would otherwise require an institutional level of care. States that elect this option can receive a 6-percent increase in their FMAP for CFC services.

- Payments to States under the Balancing Incentive Program. OIG is reviewing Balancing Incentive Program (BIP) expenditures in selected States to ensure that the expenditures were for eligible Medicaid long-term services and support (LTSS) and to determine whether the States used the additional enhanced Federal match correctly. Under the BIP (established by section 10202 of the ACA), eligible States can receive either a 2-percent or 5-percent increase in their FMAP for eligible Medicaid LTSS expenditures.

State Policies That Result in Inflated Federal Costs

In addition to vulnerabilities that exist with enhanced FMAP categories, the shared nature of Medicaid financing provides opportunities for States to shift costs and distort the Federal-State cost sharing partnership. In a September 2014 OIG Spotlight article entitled "Medicaid: State Policies that Result in Inflated Federal Costs," we cited a number of examples of State policies that caused the Federal Government to pay more than its share of Medicaid expenditures. While mechanisms such as provider taxes, intergovernmental transfers and upper payment limits, and inflated payments rates increase Federal funding that States receive, they cause a greater burden for financing the Medicaid program to be placed on the Federal Government. Thus, they distort statutorily defined FMAP rates and undermine the Federal-State partnership in financing health care.

Health-Care Provider Taxes

Health-care provider taxes can distort the Federal-State funding partnership. When used inconsistent with the law, the effects can be significant. In Federal FY 2015, States reported to CMS $21.9 billion in health-care-related tax collections. If a tax is health care related, it must be permissible to be used to fund the State share of the Medicaid program. To be permissible, a health-care-related tax:

- must be broad based or apply to all services within a class,
- must be uniform in that all providers are taxed at the same rate, and
- must not allow arrangements that return the collected taxes directly or indirectly to the taxpayer (hold-harmless arrangements).

In a 2014 review, we found that a gross receipts tax on Medicaid managed care organizations in Pennsylvania appeared to be an impermissible health-care-related tax under Federal requirements. OIG found that Pennsylvania applied a portion of what it collected from the tax to its share of Medicaid costs and, as a result, obtained nearly $1 billion in Federal Medicaid funds from 2009 through 2012. We recommended that CMS clarify its policy concerning permissible health-care-related taxes. In July 2014, CMS issued guidance to State Medicaid Directors and State Health Officials to clarify the taxation of health-care-related services and items. We are currently performing work to determine whether States are in compliance with the July 2014 guidance.

Intergovernmental Transfers and Upper Payment Limits

State policies that inflate Federal costs for Medicaid are not new. In a series of reports from 2000 to 2005, we found examples in which States developed mechanisms to apply money from intergovernmental transfers (IGT) to the States' share of Medicaid costs. IGTs are transfers of non-Federal public funds between State and/or local public Medicaid providers and the State Medicaid agency. In essence, these transfers increased the amount of Medicaid expenditures the Federal Government would have to cover and reduced the amount of the States' share of those same expenditures. In some cases, States transferred the additional Federal Medicaid money to their general treasury funds to use for a range of purposes with no direct link to improving quality of care or increasing services to Medicaid beneficiaries.

The most conspicuous use of the IGT mechanism centered on supplemental payments available under upper payment limit (UPL) rules. The UPL is an estimate of the maximum amount that would be paid to a category of Medicaid providers (usually hospitals and nursing homes) under Medicare payment principles. The difference between the State's reimbursement rate and the UPL is called a supplemental payment. Generally, State payments that exceed UPLs do not qualify for Federal matching funds.

Our reviews looked at States' use of IGTs in which some or all of the Medicaid funds directed to local public nursing facilities as supplemental payments made under UPL rules were returned to

the States instead of being retained at the facilities for the care of the patients. In each review, we found that the total Medicaid payments (per diem rate plus supplemental payments) were sufficient to cover operating costs, but the net payments were not. This was because the nursing facilities were required to return substantial portions of their supplemental payments to the States to be used for other purposes. As a result, they were underfunded and we believe that this had a negative effect on the quality of care provided in the facilities.

Both Congress and CMS took action to close this loophole by creating three aggregate UPLs—for State-owned providers, non-State-owned government providers (i.e., county-owned) and private providers. The creation of a separate aggregate payment limit for non-State government-owned facilities effectively reduced the amount of funds that States could gain by requiring public providers to return Medicaid payments through IGTs. While these changes dramatically improved the situation, they did not entirely eliminate the problem because regulations do not require that the supplemental funds be retained by the targeted facilities. Since funds are not required to be spent by the facility, States can continue to divert supplemental payments to other purposes.

Inflated Payment Rates

Some States have also inflated payment rates to providers in an effort to enhance Federal reimbursement. Medicaid regulations allow States to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed what Medicare would pay for the service. Developmental centers, a type of facility providing care for beneficiaries with intellectual and developmental disabilities, do not have an equivalent Medicare benefit to use as a guideline for Medicaid reimbursement. In a review of the New York Medicaid program, we found that payment rates for developmental centers were based on "total reimbursable operating costs," which reflected several factors, but did not reflect the actual cost of the service. This was particularly concerning because the daily payment rate for a Medicaid beneficiary in a developmental center jumped from $195 per day in 1985 to $4,116 a day in 2009, more than nine times the rate of increase in that timeframe at similar care centers. Put in context, if New York used actual costs in calculating its payment rates for FY 2009, payments would have been $1.41 billion less, saving the Federal Government $701 million.

Since we issued our report, CMS has taken action to recover a portion of the payments from State FY 2010−2011 as well as to retroactively adjust reimbursement rates for State FY 2013−2014, which were based on data from State FY 2010−2011. Since Medicare does not pay for these services, CMS found that these payments violated previously issued guidance on UPLs requiring States to pay on the basis of reasonable cost. On March 20, 2015, CMS and New York State agreed to a settlement that would result in a repayment of $1.95 billion.

We found similar evidence of inflated payments in a review of New York's Medicaid rates for residential rehabilitation services. These services are covered under a waiver program, and payment rates are calculated according to three factors set forth in 1992, which do not include actual costs. Examining payments in FY 2010, we found that the payment rate for residential rehabilitation services at State-operated residences was more than double the average rate at

privately operated residences. If New York had used actual costs to calculate payment rates for FY 2011, total reimbursement would have been $692 million less than what the State claimed, a reduction of $346 million in the Federal Government's share.

Corrective Action is Still Needed to Correct State Policies That Inflate Federal Costs

Collectively, our work suggests a need for a definitive regulation linking Medicaid payments to public providers to the actual cost of service. In January 2007, CMS proposed a rule that would have limited Medicaid reimbursement rates for public providers to provider's costs. CMS published the final rule in May 2007. However, this occurred during a congressional moratorium prohibiting the implementation of such a rule for 1 year, and a 2008 U.S. District Court decision forced CMS to eventually withdraw the regulation.

We continue to recommend that CMS provide States with definitive guidance for calculating the Federal UPL, which should include using facility-specific UPLs that are based on actual cost report data.

Conclusion

The Federal and State Governments share responsibility for operating the Medicaid program consistent with the Social Security Act. Within Federal and State guidelines, States fund their share of the program. States have considerable discretion in setting rates, paying claims, enrolling providers and beneficiaries, and claiming expenditures. States share accountability with the Federal Government for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers. This Federal-State partnership is central to the success of the Medicaid program.

Given the recent and projected growth in Medicaid, it is critical that CMS and the State Medicaid agencies continue to focus on strengthening the integrity of the Medicaid program and compliance with Medicaid rules. OIG is committed to providing effective oversight of the growing Medicaid program to ensure that funds are spent appropriately and in accordance with program rules, that fraud and abuse is detected and prevented, and that eligible beneficiaries receive needed and appropriate health care services.

This concludes my testimony. I would be happy to answer your questions.