EXAMINING THE ADMINISTRATION'S FAILURE TO PREVENT AND END MEDICAID OVERPAYMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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EXAMINING THE ADMINISTRATION'S FAILURE TO PREVENT AND END MEDICAID OVERPAYMENT

Thursday, September 20, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 2:27 p.m. in room 2154 Rayburn House Office Building, Hon. Paul A. Gosar [vice chairman of the Subcommittee] presiding.

Present: Representatives Gowdy, Gosar, DesJarlais and Davis.

Staff Present: Brian Blase, Professional Staff Member; Will L. Boyington, Staff Assistant; Molly Boyl, Parliamentarian; Katelyn E. Christ, Professional Staff Member; Linda Good, Chief Clerk; Mark D. Marin, Director of Oversight; Scott Schmidt, Deputy Director of Digital Strategy and Press Secretary; Jaron Bourke, Minority Director of Administration; Yvette Cravins, Minority Counsel; Adam Koshkin, Minority Staff Assistant; Suzanne Owen, Minority Health Policy Advisor; and Safiya Simmons, Minority Press Secretary.

Mr. GOSAR. The Subcommittee will come to order.

Today we have a real chance to address Government failure head-on and reign in abuse and mismanagement of one of the Nation's largest programs.

Today marks the Subcommittee's fifth hearing this Congress examining waste, fraud, abuse, and mismanagement in the Medicaid program. Each hearing has focused on specific instances when taxpayer resources were misused within the Medicaid program.

At the last hearing in April, we learned that Texas Medicaid program was spending more on braces than the rest of the Country's Medicaid dental programs combined. We also learned that the Center for Medicare and Medicaid Services failed to detect hundreds of millions of dollars in fraudulent claims for years, and that CMS only learned of these improper payments after an enterprising Texas journalist broke the story.

Today's hearing highlights another brazen example of Government failure. For decades New York has received a windfall from the Federal taxpayers through Medicaid overpayments that are so large I needed to double and triple-check with my staff that the information was accurate.

In Arizona, skilled nursing facilities which provide services comparable to New York's developmental centers receive about $200 per patient per day to treat patients. Last year New York's developmental centers received over $5,000 per patient per day, a rate nearly 25 times greater than a comparable rate in Arizona. A report by the Health and Human Services Inspector General shows these rates were ten times higher than rates received from private facilities in New York that perform similar functions.

Last year taxpayers paid nearly $2.5 billion for about 1,300 patients residing in New York's developmental centers. To put this number in perspective, Medicaid spending on New York's developmental centers alone exceeded the entire Medicaid budgets of 14 States. Moreover, Kansas' Medicaid program spends about as much to cover nearly 400,000 enrollees as New York's developmental centers received for their 1,300 residents.

What do we know about these excessive payment rates? We know the rates began to increase dramatically around 1990 as a result of New York's proposals that were repeatedly approved by CMS. We know that the payment rate skyrocketed because the payment rate formula allowed the State-operated facilities to retain two-thirds of the total Medicaid reimbursement when an individual left the facility. According to the HHS Inspector General, this meant taxpayers would pay twice for individuals who left the developmental centers, since most of them were transitioning into settings such as group homes also financed by Medicaid.

We know that from 1990 to 2010 CMS never questioned the excessive rates, and the reimbursements continued flowing to New York's State-operated developmental centers. CMS did not even identify overpayments until 2007, when they had reached over $3,700 per patient per day.

To make matters worse, we know that CMS failed to take any specific actions for three years after it had identified the problem.

In July of 2010, CMS chose to send a letter to New York officials only after a story appeared in the Poughkeepsie Journal about these excessive payment rates. We know that these high payment rates caused New York to backtrack on its plan to close developmental centers, as the overpayments allowed the State to plug holes in its budget.

And we know that as of three months ago CMS was negotiating a plan with New York that would allow New York's developmental centers to continue to receive billions of dollars in overpayments over the next five years.

We also know that the excessive payment rates received by the New York developmental centers break the law. The high rates violate title 19 of the Social Security Act, which mandates that Medicaid payment rates must be effective and economical. The high rates also violate Medicaid upper payment limit requirements, which prohibits States from claiming Federal matching funds for Medicaid payments that are in excess of what Medicare would have paid for similar services.

According to the Committee's estimates, Federal payments to New York's developmental centers may have exceeded the upper limit payment limits by $15 billion over the past two decades.

Penny Thompson, a witness today and the Deputy Director of the Center for Medicaid and CHIP Services at CMS has admitted that CMS failed to adequately protect taxpayers dollars in this case. Ms. Thompson is here today to address three key questions:

First, how could daily payment rates grow to exceed $5,000 per patient?

Second, how is the Federal Government going to correct this specific problem?

Third, how is the Federal Government going to prevent this type of wasteful spending in the future?

As I mentioned at the start, Arizona sent me to Washington to solve problems. Hard choices will have to be made on how to reduce Federal spending, but ending overpayments to New York's State-operated developmental centers should not be a hard choice at all. We must end it now.

I thank our witnesses for being here today and I look forward to hearing their testimony about how we can best act to stop these overpayments immediately and end similar abusive practices in any State in the near future.

Thank you.

I now recognize the distinguished Ranking Member, Mr. Davis, for his opening statement.

Mr. DAVIS. Thank you very much, Mr. Chairman.

I have always felt that waste, fraud, and abuse have no place in Government programming, so I thank you for holding today's hearing about how the flexibility provided to States in setting the maximum rates payable under the Medicaid program, referred to as upper payment limits, were misused to obtain Federal Medicaid matching payments, exceeding actual cost of services to the States.

But this was not a problem created by the current Administration. Unfortunately, the title of the hearing obscures the reality that the problem with excessive New York reimbursement rates spans several decades and Administrations, including those of President George W. Bush, George H.W. Bush, and Ronald Reagan. It does not appear that the Obama Administration may be the first to deal with the problem, but holding them responsible for this problem is a bit like blaming a detective for the case he has not solved.

In the past, New York, like many States facing budget deficits, sought an advantageous Medicaid State plan to help pay for its share of health care costs, while balancing the long list of needs of a financially strained State. However, a recent New York Times editorial on September 17th describes the New York Medicaid program as undergoing an extensive transformation over the last year. The current Administration is changing its Medicaid program and could become, according to the Times, a model on how to cut Medicaid without harming beneficiaries.

We have provided new tools and innovations through the Affordable Care Act to perform the necessary oversight to detect and punish fraud. That is necessary to retain the confidence of taxpayers and meet the required statutory standard of efficiency and economy.

Currently the State of New York and CMS are under intensive negotiations to determine a path forward. I applaud their efforts and look forward to a resolution.

Finally, I hope that today's hearing is not intended to undermine Medicaid or to provide a political plug for Paul Ryan's plan for block granting Medicaid and dismantling Federal oversight. We must remember that Medicaid ensures critical health services to our most vulnerable populations: low-income children and families, people with disabilities, pregnant women, and the elderly.

A recent poll released in July of this year by the nonpartisan Kaiser Family Foundation found that 67 percent of respondents favored expanding Medicaid to cover more low-income, uninsured adults under the Affordable Care Act. We must ensure Medicaid remains strong and under Federal oversight and distribution.

I look forward to the testimony of our two witnesses and again I thank you, Mr. Chairman, for calling this hearing. I think it is particularly relevant and important to making sure that our taxpayers get the most for their money.

I thank you and yield back the balance of my time.

Mr. GOSAR. I thank the gentleman.

A statement on Medicaid overpayments will be placed in the record. Without objection, so ordered.

Members may have seven days to submit opening statements and extraneous material for the record.

We would like to now welcome our panel.

First of all we have Mr. John Hagg, who is the President of the Medicaid audit team at the Office of the Inspector General for the Department of Health and Human Services. We also have Ms. Penny Thompson, who is the Deputy Director of the Center for Medicaid and CHIP Services at the Centers for Medicare and Medicaid Services.

Pursuant to Committee rules, all witnesses will be sworn in before they testify. Would you please rise and raise your right hands?

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Mr. HAGG. I do.

Ms. THOMPSON. I do.

Mr. GOSAR. Let the record reflect that the witnesses answered in the affirmative.

Thank you. Please be seated.

In order to allow for a timely discussion, please limit your testimony to five minutes. Your entire written statement will be made part of the record.

Mr. Hagg, you may go first.

WITNESS STATEMENTS

STATEMENT OF JOHN HAGG

Mr. HAGG. Good afternoon, Mr. Chairman, Ranking Member Davis, and other distinguished members of the Committee. Thank you for the opportunity to testify about the Office of the Inspector General's recent audit report regarding Medicaid payments in New York.

Medicaid payment rates for State-operated developmental centers in New York are extremely high. In state fiscal year 2009, New York claimed more than $2.2 billion in Medicaid reimbursement for these centers. The actual cost of operating the developmental centers was $578 million. The $2.2 billion equaled over $4,100 per day for each of the 1,700 beneficiaries and resulted in New York receiving Federal matching funds of over $1.1 billion.

So why are these Medicaid payment rates so high? Chiefly, because there is no requirement that Medicaid payments be limited to the actual cost of providing services. When the current rate-setting methodology began in 1985, New York's daily payment rate for the developmental centers was $195 per beneficiary. By 2009, the rate had grown to over $4,100 per day. The $4,100 far exceeds the daily payment rate for all other similar public and private facilities in New York which provided similar services for a fraction of the cost of Medicaid.

Unlike the developmental centers, the payment rates for these other facilities were based on cost and ranged from $257 to $902 per day. If New York had used actual cost as part of its rate-setting methodology for the developmental centers, total Medicaid reimbursements could have been at least $1.4 billion less in 2009. This could have lowered Federal Medicaid payments by at least $700 million for that year alone.

For over a decade, OIG has recommended that payments to public providers be limited to the actual cost of providing services. This would help ensure that in New York and other States Medicaid payment methodologies for public providers are reasonable and economical. Until such time as payments to public providers are limited to actual cost, CMS should work with New York to ensure an appropriate Medicaid daily rate for State-operated developmental centers.

Thank you for your interest in this important issue. I would be happy to answer your questions.

[Prepared statement of Mr. Hagg follows:]

Testimony Before the United States House of Representatives

Committee on Oversight and Government Reform:
Subcommittee on Government Organization, Efficiency and Financial Management; and Subcommittee on Health Care, District of Columbia, Census and the National Archives

"Examining the Administration's Failure to Prevent and End Medicaid Overpayments"

Testimony of:
John Hagg
Director of Medicaid Audits

September 20, 2012

2 p.m.

Rayburn Building, Room 2154

Testimony of:
John Hagg
Director of Medicaid Audits
for the Centers for Medicare & Medicaid Audits
Office of Inspector General, U.S. Department of Health and Human Services

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Introduction

Good afternoon, Chairman Gowdy, Ranking Member Davis, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Office of Inspector General's (OIG) recent report involving Medicaid payment rates for State-operated developmental centers in New York. My testimony will provide an overview of the report findings, recommendations, and related work.

Overview

Medicaid payments to developmental centers in New York State far exceed New York's actual costs of providing services to Medicaid beneficiaries.[1]

New York claimed $2.27 billion ($1.13 billion Federal share) in Medicaid reimbursements to pay for services related to 15 developmental centers in State fiscal year[2] (SFY) 2009. New York's methodology was not based on actual costs. If New York had used actual costs in its rate-setting methodology, Medicaid reimbursements to the developmental centers could have been as much as $1.41 billion less in SFY 2009.[3] In turn, the Federal Government could have saved as much as $701 million in that year alone.

Based on the foregoing and previous audits of payments to public providers in other States, OIG recommends that payments to public providers be limited to the actual cost of providing services. This would help ensure that in New York and other States, Medicaid payment methodologies for public providers are reasonable and economical. Until the Centers for Medicare & Medicaid Services (CMS) implements a policy to limit payments to actual cost, it should work with New York to ensure an appropriate Medicaid daily rate for State-operated developmental centers.

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[1] *Medicaid Rates for New York State Operated Developmental Centers May Be Excessive*, available at http://oig.hhs.gov/oas/reports/region2/21101029.asp.
[2] New York's fiscal year starts April 1st and ends March 31st.
[3] To arrive at this figure, we substituted actual costs for the State-calculated total reimbursable costs.

Background

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, CMS administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements, including a provision of the Act that requires that payment for care and services be consistent with efficiency, economy, and quality of care.[4] The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. By law, the FMAP rates cannot be lower than 50 percent. During our audit period, New York had an FMAP ranging from 50 to 58 percent.[5]

New York's Medicaid Program

In New York, the Office for People With Developmental Disabilities (OPWDD) provides services to both Medicaid and non-Medicaid eligible individuals with intellectual and developmental disabilities under a cooperative agreement with the Department of Health (DOH), which administers New York's Medicaid program. In SFY 2009, New York had approximately $45 billion in Medicaid expenditures, from which the State received $25 billion in Federal reimbursements.

Intermediate Care Facilities in New York

OPWDD oversees all Intermediate Care Facilities (ICF) for individuals with intellectual and developmental disabilities. These facilities are residential treatment options designed for individuals whose disabilities severely limit their ability to live independently. ICFs provide 24-hour onsite assistance and training, intensive clinical and direct-care services, supervised activities, and a variety of therapies. Developmental and intellectual disabilities include a variety of conditions that cause mental or physical limitation (e.g., autism and cerebral palsy).

[4] Section 1902(a)(30)(A) of the Social Security Act requires that payment for services be consistent with efficiency, economy, and quality of care.

[5] Our audit period was April 1, 2008, through March 31, 2009. The American Recovery and Reinvestment Act effectively raised the FMAP for States beginning the first quarter of Federal fiscal year 2009. For October 1, 2008, through March 31, 2009, New York had an FMAP of 58.78 percent because of the enhanced percentage.

ICFs include State-operated and privately operated facilities with 30 or fewer beds and State-operated facilities with more than 30 beds. During our audit period, New York operated 13 facilities with more than 30 beds; it also operated 2 Small Residential Units (SRU)[6] that provided services to individuals with developmental and intellectual disabilities on the campus of 1 of those 13 larger facilities. Each of these 15 facilities[7] received the same daily reimbursement rate of $4,116 per beneficiary in SFY 2009. DOH claimed Medicaid reimbursement on behalf of 1,688 beneficiaries at the developmental centers of $2.27 billion ($1.13 billion Federal share). New York's actual costs for the developmental centers totaled $578 million.

Key State Plan Amendments Affecting Developmental Center Payment Rates

Developmental center payment rates are set using a complex methodology detailed in Attachment 4.19-D, Part II, of New York's Medicaid State plan. The first major revisions to the rate-setting reimbursement methodology for the developmental centers were approved in January 1986, retroactive to April 1984 under state plan amendment (SPA) 84-10. This state plan amendment allowed New York to use a trend factor and volume variance adjustment.[8] At this point, the rates were on a 2-year cycle. In year 1 of the cycle, rates were based on actual cost reports with yearend volume variance adjustments, while year 2 rates were based on the same cost reports, but trended forward with a volume variance adjustment. The following year, the rates would be readjusted using new cost reports to start the process over.

In 1991, SPA 90-12 was approved,[9] effectively eliminating the link between actual costs and total reimbursable costs by allowing New York to use base rates set in 1986 to be trended forward. Figure 1 below clearly shows a rapid increase in the rate once this amendment took effect.

Audit Findings

The Growth of Developmental Centers' Rate Significantly Outpaced Those of Other ICFs

The daily rate for a Medicaid beneficiary to reside in a developmental center grew from $195 per day in SFY 1985 to $4,116 per day in SFY 2009.[10] The daily rates for all other ICFs in New

[6] The SRUs have a 12-bed capacity.
[7] We refer to the 13 State-operated ICFs with more than 30 beds and the 2 state-operated SRUs as "developmental centers."
[8] The volume variance adjustment ensures that annual decreases in headcount at a developmental center do not cause that center to lose operating funds needed to support its fixed costs. It allows New York to retain 64 percent of the costs associated with beneficiaries no longer in a developmental center.
[9] The SPA went into effect retroactive to 1990. However, the State considered 1990 a transition year, and the major changes to the reimbursement methodology went into effect in 1991.
[10] The daily rates per beneficiary in SFY 2010 and 2011 were $4,556 and $5,118, respectively.

York during SFY 2009 (both State-operated and privately operated), which are based on actual costs, were $257 to $902,[11] with an average rate of $444.

Figure 1 compares the growth of the statewide Medicaid daily rate for developmental centers to the rates of three nondevelopmental center ICFs.[12]

Medicaid Daily Rate for Selected Intermediate Care Facilities in New York (1985-2009)

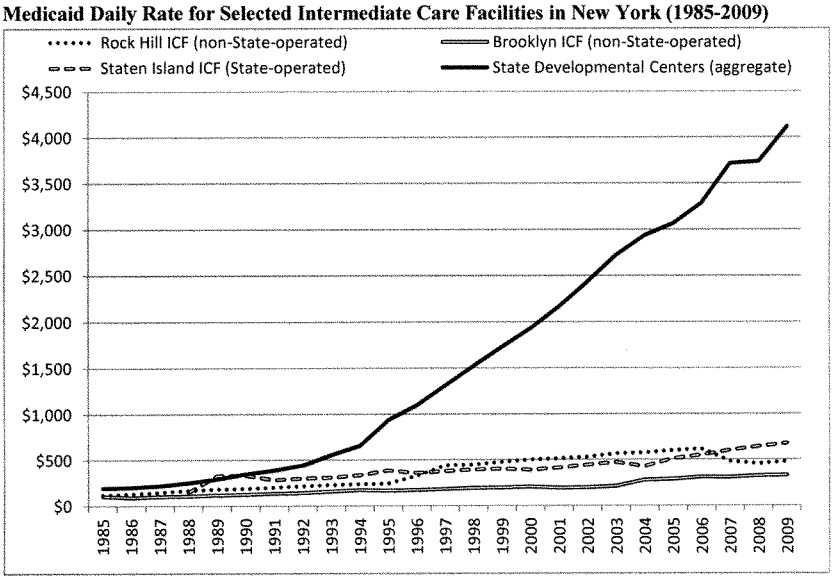

Figure 1

New York Claimed Significantly More for Developmental Center Services Than Its Actual Costs

In SFY 2009, New York claimed nearly $2.27 billion ($1.13 billion Federal share) in Medicaid reimbursement for the developmental centers that had an actual cost of $578 million. Most of the difference between the actual costs and total Medicaid reimbursements is due to New York's starting point in its rate-setting methodology. New York refers to the starting point as "total reimbursable operating costs." This figure includes the prior year's total reimbursable operating costs, a volume variance adjustment, and a trend factor increase. Once adjustments are made to

[11] In SFY 2009, there were 519 non-State-operated ICFs with rates that ranged from $257 to $776 and 37 State-operated ICFs with rates that ranged from $476 to $902.

[12] The three nondevelopmental center ICFs were: (1) a non-State-operated ICF in Brooklyn, New York; (2) a non-State-operated ICF in Rock Hill, New York; and (3) a State-operated ICF in Staten Island, New York.

the starting point, New York also makes several other adjustments[13] before it calculates a final rate.

We substituted the prior year's actual costs for the reimbursable operating costs (starting point) to recalculate the Medicaid daily rate in SFY 2009 (see Table 1 for New York's calculation and OIG's recalculation). We did not individually assess each adjustment to the reimbursable operating costs in the rate calculation. Therefore, we chose to keep them in our comparison to provide a conservative estimate of possible savings.

New York's Calculation of Medicaid Daily Rate and OIG's Recalculation

Rate Component	New York Calculation	OIG Recalculation
Total Reimbursable Operating Costs - 3/31/08	$1,905,498,278	
Actual Costs for Developmental Centers - 3/31/08		$580,689,833
Net Adjustments[14]	$399,097,317	$277,034,766
Total Reimbursable Costs	$2,304,595,595	$857,724,599
Number of Beneficiary Days	559,974	559,974
SFY 2009 Medicaid Daily Rate	$4,116	$1,532

Table 1

If New York had used prior year actual costs as the starting point to calculate the Medicaid daily rate, its claim for reimbursement would have totaled $858 million ($429 million Federal share), a difference of $1.41 billion ($701 million Federal share). In addition, the SFY 2009 Medicaid daily rate would have been $1,532, or 63 percent less than the calculated reimbursement rate of $4,116.

Privately Operated ICFs Provided Similar Services at a Much Lower Rate

The Medicaid daily rate for developmental centers was substantially higher than the rate for privately operated ICFs, even those that were in similar locations and that offered comparable services.[15] During our audit period, the Medicaid daily rate for each resident of the Brooklyn

[13] New York has several additions and subtractions to the costs used to calculate the rate. The main additions in SFY 2009 were a provider tax assessment of $120 million and a health care enhancement fee of $182 million.

[14] The difference between New York and OIG calculation adjustments is due to the application of percentages used in various stages of the calculation (e.g., provider tax assessment based on 5.5 percent of reimbursements).

[15] As part of our audit work, we randomly selected 10 residents of the Brooklyn Developmental Center (BDC) and 10 residents of a privately operated ICF to review the residents' Medicaid billing history during our audit period. On the basis of our assessment, we determined that the array of services provided to the residents at the privately operated facility was comparable to that provided to the residents of the BDC; however, the private facility had a rate about one-eighth of the developmental facility.

Developmental Center (BDC), the largest developmental center in New York, was $4,116. In comparison, the approved Medicaid daily rate for residents of a privately operated ICF that operated three facilities within 10 miles of the BDC ranged from $421 to $535 per day, approximately one-eighth of BDC's rate. See Table 2 below.

Comparison of Reimbursement Rates, Therapies, and Annual Billing Per Resident

	State-Operated Developmental Center	Privately Operated Intermediate Care Facility
Reimbursement Rate(s)[16]	$4,116 per day	$421 to $535 per day
Therapies Included in Reimbursement Rate(s)	Occupational therapy Physical therapy Psychologist services Speech and language pathology Social work Dietetics and nutrition Rehabilitation counseling Nursing services Day treatment	Occupational therapy Physical therapy Psychologist services Speech and language pathology Social work Dietetics and nutrition Rehabilitation counseling Nursing services Day treatment
Annual Billing per Resident	Low: $1,489,623 High: $1,502,172	Low: $99,120 High: $149,670

Table 2

CMS and New York Should Develop a Reasonable Daily Rate for Developmental Centers

Our report provides a conservative estimate that the Federal Government could have saved approximately $701 million in SFY 2009 if New York had used actual costs as a starting point in its rate calculation. Over time, the difference between the rate and actual cost has grown and resulted in a rate that would not seem to meet Federal rules of economy and efficiency. CMS and New York should work together to develop a rate that is more reflective of these rules.

Medicaid Payments to Public Providers Should Be Limited to the Actual Cost of Providing Services

The concern about payments to public providers extends beyond payments to New York developmental centers. From 2001 to 2005, OIG audited Medicaid payments to public providers in various States and identified payments far exceeding the cost of care.[17] In some cases, a large portion of the Medicaid payments was not retained by the facilities to provide Medicaid services to Medicaid beneficiaries. Rather, that portion of the Medicaid funds was returned to the State and put to other uses.[18]

[16] Rates in the table include ICF or developmental center services and day treatment services.
[17] See *Compendium of Unimplemented Recommendations* at Part III, pp.1-5, available at http://oig.hhs.gov/publications/docs/compendium/2011/CMP-03_Medicaid.pdf.
[18] In 2007, CMS published a proposed rule to, among other things, "limit reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost." The rule was finalized in May 2008, but was ultimately vacated by Federal District Court. See *Compendium* at Part III, p.3.

Based on the foregoing, OIG recommends that reimbursement be limited to an amount that does not exceed the provider's costs.

Conclusion

The Medicaid payment rates for the State-operated developmental centers in New York are extremely high. In SFY 2009, New York claimed more than $2.27 billion in Medicaid reimbursement for services provided to 1,688 Medicaid beneficiaries in 15 developmental centers. This equaled approximately $4,116 per day for each beneficiary. The actual cost of the developmental centers was $578 million.

Based on our recent work in New York involving the State-operated developmental centers and our prior audit work involving Medicaid payments to public providers in other States, OIG recommends that Medicaid payments to public providers be limited to the cost of providing services. This would help to ensure that in New York and other States, Medicaid payment methodologies for public providers are reasonable and economical.

Thank you for your interest in this important issue and the opportunity to be a part of this discussion.

Mr. GOSAR. Thank you very much, Mr. Hagg.
Now Ms. Thompson.

STATEMENT OF PENNY THOMPSON

Ms. THOMPSON. Mr. Chairman, Ranking Member Davis, and members of the Subcommittee, thank you for the invitation to come here today to discuss Medicaid payments to New York's State-run developmental centers.

As a former senior manager at the HHS Inspectors General, a former CMS director of program integrity, and deputy director now of Medicaid and CHIP Services, I am committed to safeguarding taxpayer dollars in the Medicaid program through rigorous financial management, as well as through comprehensive anti-fraud activities.

The payments for New York's developmental centers are excessive and unacceptable. As you have both said in your statements, this problem is longstanding. CMS' current priority is to correct New York's payment rate so that it is an economic and efficient rate, as appropriate and required by law. While, as you mentioned in your statement, we had considered for a time a transition period, we have ultimately decided to require an adjustment to proper payment levels without a transition. Once we have agreed upon a finalized payment methodology with New York, CMS will review past overpayments and determine if there are additional sums that need to be returned to the Federal Treasury.

Beyond our priority of fixing the problematic rate and recovering past over payments, CMS has developed a plan of action and management controls to drive future policy and guidance and correct the vulnerabilities that led to the overpayments in New York.

First, the current methods of enforcing the upper payment limit, which you mentioned in your statement, are not sufficient to protect Federal dollars. The defined payment methodologies in the plan in the case of New York do not necessarily ensure appropriate rates when elements of those methodologies trigger an overall escalation in the rates over time.

In the case of New York, the original payment methodology CMS reviewed, approved, was acceptable at that point in time, but over a period of time those automatic escalators resulted in a rise in cost, and through essentially the magic of compounding, as we can see in your chart, those rates took off at a very vertical pace.

To address these issues, CMS has been investing in its own data infrastructure to ensure that we have complete and timely Medicaid data so that we can look for these kinds of escalations and outliers and address them more quickly, and we have been investing in that infrastructure through a series of efforts, including some recent activities with a group of ten States to test a more complete and timely Medicaid data feed to CMS.

But our State partners bear responsibility and accountability, and they are in the best position to monitor their own data to ensure that they are adjusting rates as appropriate, responding to problems that indicate excessive payment rates or excessive utilization. We will be writing a letter to the State Medicaid directors and reminding them of their obligations and requiring them to report to us on a regular basis on the results of their efforts of looking

at data trends and identifying aberrancies and anomalies, and any corrective actions they are taking as a result of those results.

We also plan to convene a group of Medicaid directors and State program integrity subject matter experts to improve program integrity and financial management at both the Federal and State levels. We will be using case studies such as those that we discussed earlier this year, and in the case of New York, to identify ways in which we can improve our management controls and our financial controls.

Members of this work group will also provide input for a framework for measuring program integrity return on investment, and for increasing collaboration and alignment between Medicare, Medicaid, and commercial program integrity efforts. This work group will allow CMS and its State partners to address problems in a collaborative comprehensive manner.

To summarize, the Medicaid payments made to New York for the developmental centers were excessive and inappropriate. We are working to correct the payments to New York, as well as reviewing past overpayments to recover Federal dollars. We are also improving our monitoring and approval processes to detect excessive payments more quickly and to prevent excessive payments from being made in the first place.

I appreciate the Subcommittee's work and interest in this matter, and I continue to look forward to working with you as we make our improvements.

[Prepared statement of Ms. Thompson follows:]

STATEMENT OF

PENNY THOMPSON
DEPUTY DIRECTOR OF THE CENTER FOR MEDICAID AND CHIP SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICAID FINANCIAL MANAGEMENT IN NEW YORK STATE DEVELOPMENTAL CENTERS

BEFORE THE

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

SEPTEMBER 20, 2012

U.S. House Committee on Oversight & Government Reform
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
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Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the invitation to discuss Medicaid payments to New York's State-run developmental centers. The payments for these developmental centers are excessive and unacceptable. The Centers for Medicare & Medicaid Services (CMS) is currently working with New York to correct the payment rate so that it is an economic and efficient rate as required under section 1902 of the Social Security Act and is considering what further action may be needed specific to this situation. In addition, on a larger scale, CMS is reviewing and enhancing our data analytic capabilities and processes to increase accountability and to prevent similar excessive payments from remaining undetected in the future. As a former senior manager at the Department of Health and Human Services Office of the Inspector General (HHS OIG), as well as the former Director for Program Integrity at CMS, I can assure you the Administration is committed to safeguarding taxpayer dollars in the Medicaid program through rigorous financial management, as well as through comprehensive anti-fraud activities.

Background

Medicaid Program

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. Medicaid is a partnership between the States and the Federal Government. The Federal government establishes minimum requirements and provides oversight for the program, and States design, implement, administer, and oversee their own Medicaid programs within the Federal parameters. 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. For example, CMS matches the cost of Medicaid management information system design and operation, as well as some review activities, at a rate between 75 and 90 percent. On average, the Federal government expects to match State expenditures at a rate of nearly 58 percent in FY 2013 for Medicaid benefits.

State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to their unique health care, 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. The Federal government, in partnership with States, is responsible for oversight of program implementation.

The Federal government mainly oversees the State Medicaid program implementation through the State plan. The State plan is a contract 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 fund 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 to CMS to review and approve. CMS also reviews managed care contracts and reported expenditures.

Rate-Setting and Program Oversight

As described above, the State plan sets out the methodologies for establishing the payment rate for providers. To change the way a State pays Medicaid providers, a State must submits a State plan amendment to CMS to review and approve. Before the amendment'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 State plan amendment 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 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 State plan amendment 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. If CMS finds while reviewing a State plan amendment the State's payment rate will result in payments that will exceed the UPL, then CMS requires the State to revise the amendment, so that the payment rate falls under the UPL. Consistent with that framework, aggregate payments for services provided by inpatient hospitals, outpatient hospitals, clinics, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, for each provider type cannot exceed a reasonable estimate of what Medicare would have paid for the same services.

The Director of the Center for Medicaid and CHIP Services (CMCS) and the Medicaid regional administrators share the authority to ensure State plans and amendments meet the requirements provided under relevant Federal statutes and regulations. Specifically, the Director of CMCS reviews all State plan amendments that amend institutional payment rates. Approval is based on applicable law, as interpreted in policy statements and precedents previously approved by the CMS Administrator. The CMS Administrator, in consultation with the HHS Secretary, can deny a State plan or amendment.

New York's Medicaid Program and Developmental Centers

In New York State, the Office for People with Developmental Disabilities (OPWDD) provides services to both Medicaid and non-Medicaid eligible individuals with intellectual and developmental disabilities under a cooperative agreement with the New York Department of Health, which administers New York's Medicaid program. OPWDD is responsible for coordinating services for over 126,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other disabilities. It provides services directly and through a network of nearly 700 nonprofit service-providing agencies; about 80 percent of services are provided by private nonprofits and 20 percent are provided by State-run services. The people served by OPWDD often present with multiple physical or cognitive conditions that require specialized or intensive treatment. Some individuals have dual diagnosis, autism spectrum disorder, and medical frailty. Individuals who are medically frail have multiple medical conditions, which result in high self-care needs, profound motor challenges, and more intensive staff support. This population is 5.5 percent of all of the individuals served by OPWDD in 2011.[1]

OPWDD oversees the State-run developmental centers for individuals with intellectual and developmental disabilities. These developmental centers are residential treatment options designed for individuals whose disabilities severely limit their ability to live independently. The developmental centers provide 24-hour onsite assistance and training, intensive clinical and direct-care services, supervised activities, and a variety of therapies.

New York State Developmental-Center Payment-Rate Calculation

In January 1986, CMS approved a New York State plan amendment which established a methodology for determining the provider payment rate for the State-run developmental centers described above. This methodology was retroactive to April 1984 based on the date the State plan amendment was submitted. In 1990, the State submitted a State plan amendment, which changed the original payment rate methodology. The payment methodology that CMS approved in 1986 updated the payment rate based on the trended actual base year costs. The revised

[1] OPWDD Statewide Comprehensive Plan: 2011-2015. October 1, 2011. http://www.opwdd.ny.gov/node/1384

payment methodology CMS approved in 1990 updated the payment rate based on the trended operating costs included in the prior year payment rates, instead of the trended actual base year costs. In 1994, New York submitted another State plan amendment, which modified the rates paid to the open developmental centers to include those net operating costs from closed developmental centers. This adjustment was intended to ensure that annual decreases in head count at a developmental center did not cause a center to lose operating funds needed to support its fixed costs. The State provided written assurances through the amendment review process the rates were still cost based and would not exceed the Medicare cost principles described above.

Since that time, the State made Medicaid payments and received Medicaid matching funds from the Federal government based on its 1994 reimbursement methodology. The payment rate calculation adopted in 1994 allowed New York State to continue to include in the calculation of the rate a majority of costs associated with beneficiaries no longer in a developmental center. It also allowed New York State to include in the calculation of the rate costs associated with centers when they were operating more beds. Both of these methodologies effectively inflated the starting point for the rate calculation each year based on the, apparently incorrect, assumption that actual costs would not decrease as the developmental centers shrank in size. When approving the reimbursement methodology, it is not clear if CMS completely understood how the State would implement the new methodology or the methodology's future impact if actual operating costs were to shrink dramatically year over year. Over subsequent years, this methodology generated rates that appear to have deviated substantially from actual, incurred costs. New York submitted the last State plan amendment related to these facilities in 2006.

According to the HHS OIG, the growth of the daily Medicaid reimbursement rate for State developmental centers has significantly outpaced those of privately operated developmental centers and New York claimed significantly more for the State-run developmental center services than its actual costs.[2] The daily rate for a Medicaid beneficiary to reside in a developmental center grew from $195 per day in 1985 to $4,116 in 2009, vastly outgrowing the Medicaid daily rate for private developmental centers.

[2] HHS OIG. "Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive." A-02-11-01029. May, 2012. http://oig.hhs.gov/oas/reports/region2/21101029.asp

In 2007, the CMS New York Regional Office began working with the State to gain access to their Medicaid Management Information Systems (MMIS) data warehouse to assist CMS with its ongoing monitoring of State claims information; it was not specifically related to monitoring of payment rates. However, as the Regional Office began running data-mining reports, they noticed the payment rates for two cost-based developmental centers appeared to be very high. As discovered below, although CMS identified the possibility of excessive payments through the data review, CMS did not begin working with New York to address the situation fully until 2010. Since then, CMS has been working with the State to understand the circumstances around the inflated rate and more fully address this problem.

At the same time as the high payment rates were being identified, CMS was developing regulations to limit reimbursement to individual governmental health care providers to the cost of treating Medicaid patients. That regulation would have limited the maximum government-provider payment rate, thereby addressing the high payment rate to New York's State-run developmental centers. In May 2007, as CMS was issuing the final rule, Congress imposed a moratorium prohibiting CMS from taking any action to finalize or otherwise implement the cost rule. Congress extended this moratorium through April 1, 2009, and a Federal district court struck down the final rule and ruled it had been issued in violation of the moratorium.

Currently, CMS is aggressively working to resolve this issue. We are working with the State to develop a rate that meets the statutory requirements of efficiency and economy and is within a reasonable estimate of the costs that would be paid under Medicare. As part of this effort we will conduct an audit of New York's developmental disability centers and also require the State to conduct an independent audit once a new payment system is in place. CMS also concurred with the HHS OIG 2012 report's recommendations about revising the payment methodology so the payment rate is consistent with efficiency and economy. As CMS and New York work together to revise the payment methodology, we are balancing our commitment to safeguarding taxpayer dollars, while protecting and providing for the ongoing needs of the vulnerable population served by New York State-run developmental centers. Balancing these efforts is not simple or easy, but CMS, in partnership with New York, will correct this problem.

Lessons Learned and Plans Going Forward

As discussed earlier in the testimony, CMS should not match New York payments for Medicaid beneficiaries and services at inflated levels. As CMS reviewed this problem, CMS identified a set of vulnerabilities that allowed this situation to occur. To address these vulnerabilities, CMS developed a plan of action that will drive future policy and guidance to States. In addition, CMS is implementing management controls to prevent this kind of situation from happening again.

The first lesson is that current methods CMS is using to enforce the UPL are not enough to protect Federal dollars. The purpose of the UPL is to ensure the Federal government does not match excessive rates paid by State governments to providers. In some cases, States have paid excessive rates to governmental providers in order to divert funds to other programs or uses or to recycle dollars for a higher Federal match. In New York, the UPL failed to control excessive rates. First, the State must demonstrate the payment will not exceed the UPL during the review process for State plan amendments. If States are not submitting State plan amendments modifying the provider payment at least annually, CMS does not require States to demonstrate that they have not exceeded UPL. In the case of New York, the initial UPL demonstration model had flaws that grew larger over time and the model did not include any procedure for correcting such flaws.

The second lesson is that defined payment methodologies do not necessarily ensure appropriate rates when the variable elements of those methodologies are not limited to ensure the payment methodology overall remains reasonable. This is particularly true if methodologies contain escalation factors or other automatic triggers that are not reviewed against a reasonable benchmark over time. In the case of New York, the original payment methodology CMS approved was acceptable at that point in time, but was interpreted in a way that, over time, resulted in a steep rise in payments over a period of years that exceeded the rise in actual costs.

The third lesson is that our State partners themselves must also bear responsibility and accountability to identify anomalous payments and expenditures and address them proactively, even if they are acting under approved State plans and waivers, when reasonable parameters of economy and efficiency are being breached. The information relevant for assessing the

reasonableness of a payment methodology (including payment amounts, costs, market conditions, and other relevant factors) is State-level data which States are better able to maintain and are in the best position to analyze. The States should have mechanisms and the responsibility to monitor compliance themselves within Federal law.

CMS takes these lessons seriously and intends to take the following actions as a result:

- To address our first and second lessons, CMS will better use its own data sources to identify payment and claim outliers, in order to provide technical assistance to States. Outliers and aberrations identified will be discussed with States, and CMS will potentially issue deferral of such amounts until the appropriateness of the claim or payment is supported by State information. To improve the quality of Federally available Medicaid data, CMS has been working with more than 10 States over the past year on a pilot project to define data and analytics requirements to improve capabilities for program and financial management as well as program integrity. In the next phase of the project, CMS will be issuing guidance to States requiring that they begin to submit the Transformed-Medicaid Statistical Information System (T-MSIS) dataset by the end of calendar year 2013. T-MSIS expands the currently required MSIS data set. By reviewing State data for the specific purpose of identifying outliers and anomalies, CMS will be able to identify rates, such as the rate in New York, which grew over several years from being within a reasonable UPL to being excessive.
- To address our third lesson, CMS will issue a State Medicaid Director letter to remind States they should be using their own data and information systems to identify payment and utilization aberrations. States should be reviewing utilization, payment rates, and expenditures by category of service, plan, and provider, on a regular basis to identify areas of concern proactively and to make appropriate adjustments. CMS will work with States to improve the timeliness and completeness of available Medicaid data.
- To address all three lessons, CMS plans to work with the National Association of Medicaid Directors to convene a workgroup of Medicaid Directors, and State program integrity subject matter experts, to consider improvements in program integrity and financial management at the Federal and State levels. In addition to using case studies, such as this one in New York, to identify improvement areas and best practices, members

of the work group will also provide input as CMS develops a framework for measuring Medicaid program integrity return on investment and identify ways to increase collaboration and alignment between Medicare and Medicaid program integrity efforts. This workgroup will allow CMS and its State partners to address problems, such as the rate in New York, in a collaborative, comprehensive manner.

Regional offices are working with each State to explore the feasibility of direct access into State systems that contain payment and provider data, in order to support processing of State plan amendments and waivers. This would allow analysts to consult data from such State systems, as the data are made available, to explore payment and expenditure histories that provide insight into the appropriateness of payment methodologies.

Again, we are committed to safeguarding taxpayer dollars in the Medicaid program and fighting fraud and abuse in collaboration with our State partners. CMS is fighting fraud and abuse in collaboration with our State partners, and providing technical assistance, guidance, and oversight in State-based efforts. Currently, through our collaborative efforts with States, we are conducting 175 Medicaid program integrity audits in 19 States. In New York specifically, CMS is conducting eight audits with the State. These audits identify and recover misspent taxpayer money, returning those funds to State and Federal budgets.

Conclusion

The Medicaid payments made to New York for the developmental centers were excessive. CMS is working to correct the payments to New York and to improve CMS' approval and monitoring processes to detect excessive payments more quickly and to prevent excessive payments from being made in the first place.

We appreciate the Subcommittee's interest in this matter and will continue to work with you as CMS makes improvements in the Medicaid program.

Mr. GOSAR. Thank you, Ms. Thompson.

I recognize myself for five minutes for questions.

Ms. Thompson, how many of CMS' 4,500 employees work in the program of integrity or financial review capacities?

Ms. THOMPSON. I don't have those figures off the top of my head. I mean, we do have some breakdowns that we can provide the Subcommittee following the hearing.

Mr. GOSAR. Do you have some idea of the percentages?

Ms. THOMPSON. There are about 500 individuals who work on Medicaid and CHIP issues throughout the agency, and the number that work on financial management with respect to Medicaid and CHIP are a portion of those.

Mr. GOSAR. Gotcha. Now, how is it possible that CMS was unaware of the high developmental center rates until 2007, given the massive amounts of Federal money going to these developmental centers? I mean, this should have been a lightning bolt that we should be seeing.

Ms. THOMPSON. I agree, and I think part of the problem here has been that at the Federal level the agency has not invested enough resources in the data infrastructures and the discipline of reviewing and assessing the results of that data in order to identify these kinds of outliers and anomalies on an ongoing basis. That is part of the work that we are doing to ensure that we can address that appropriately.

Mr. GOSAR. Well, I know that between 2007, when CMS identified the overpayment, how is it that these payments increased another $800?

Ms. THOMPSON. Well, let me preface my answer to that question by saying that I have not had the opportunity to speak directly to any of the officials in the prior Administration that made those decisions, so I don't want to represent their decision-making process inappropriately here. But we have had an opportunity to have a talk with some of the staff to try to understand why, once having discovered this issue, there wasn't rapid response.

And essentially, as far as we can reconstruct, it appears as though CMS agency staff thought that the regulation that had been developed and was awaiting finalization, which would have held Government providers to cost, would have been the appropriate enforcement mechanism for correcting the problem, and then when the Congress issued a moratorium preventing CMS from enforcing that rule, they believed that, out of an abundance of caution, perhaps an overabundance of caution, that to proceed on the basis of a cost argument with New York on its developmental centers would be a contradiction of the moratorium.

Mr. GOSAR. Do you think it was only because of the Poughkeepsie article that drew our attention that we actually are highlighting and actually are talking about this today?

Ms. THOMPSON. Well, it was certainly the first time it came to my attention was after a result of the Poughkeepsie Journal article, so once, even after having dispensed with the actions and issues associated with the cost regulation, we didn't have a mechanism by which to go back and re-review those issues which had been held in abeyance during that period. That was the first time that I became aware of the issue.

Mr. GOSAR. So when those employees, when you go back to review, when they knew about these overpayments in 2007, do you believe that those employees that knew about that should be disciplined? And how should they be disciplined?

Ms. THOMPSON. Well, no. Most of the employees that are currently in the agency that were involved in that issue at that time are mid-level employees. All of the decision-makers associated with that have left the agency.

Mr. GOSAR. Okay. And when you do audits, I mean, the IRS does audits pretty darn well, and they do sporadic audits throughout different agencies. Do you think there is something you could learn from the IRS in the way that you do your audits of agencies and States?

Ms. THOMPSON. Well, I think that there is a lot of lessons from a lot of people in terms of making sure that we have proper management controls and oversight. I think that we actually have a pretty good process for reviewing State claims. We take a number of deferrals and disallowances on a regular basis and conduct focused financial reviews. We have a partner, which is the Office of the Inspector General, that can help us with auditing claims when we need their assistance.

So I think the issue here was not so much the question of whether or not we had adequate auditing approaches as much as whether we had the right data and the right decision-making process to ensure issues were being addressed in a timely and comprehensive manner.

Mr. GOSAR. But it also seems to me like big-ticket items ought to be scrutinized in the highest——

Ms. THOMPSON. Absolutely.

Mr. GOSAR. And it seems like we had this discussion about Texas orthodontics, and now we are having this discussion about New York's service centers, so from that standpoint it seems like there are some common-sense applications so we could bypass some of this confusion.

Ms. THOMPSON. You are right about that. And I will also say that one of the other discussions that we are having is how Medicaid integrity contractors, who are supported by dedicated funds to protect the program against fraud, waste, and abuse, can be better employed to help us address some of these issues.

Mr. GOSAR. Thank you.

My time is up. I would like to recognize the gentleman from Illinois, the Ranking Member Mr. Davis, for his questions.

Mr. DAVIS. Thank you, Mr. Chairman.

Before I begin I would like to ask unanimous consent to insert into the record this New York Times editorial: New York's Medicaid Reforms.

Mr. GOSAR. So ordered.

Mr. DAVIS. Thank you.

Mr. Hagg and Ms. Thompson, thank you both for being here.

President Obama directed you to initiate unprecedented law enforcement efforts to detect fraud in Medicare and Medicaid. Could you describe the impact and benefit of multi-jurisdictional and multi-agency investigations on the recoupment of Federal Medicaid dollars?

Mr. HAGG. Thank you, Mr. Davis.

Certainly there are additional PI tools, program integrity tools, that are used by the OIG as part of ACA. For this specific issue in Medicaid, this is something that the issue, similar issues like we found in New York, that are happening in New York, we have been involved with these type issues going back to about 2001. Going back to that period between 2001 and 2005, we conducted a series of audits that identified similar issues with county-operated nursing homes and hospitals. Based on that work from that time period, we made recommendations that the payments for public providers be limited to the cost of providing services.

We still feel strongly about that recommendation. We feel like it makes sense. If somewhere along the line it had been implemented, the issue in New York wouldn't have been able to happen, and if it had, then there would have been a clear link for the Federal Government to get funding back that exceeded the actual cost of providing services.

Mr. DAVIS. Ms. Thompson?

Ms. THOMPSON. Well, to go back to your question about the tools and the approach that the President has asked us to start employing in order to address program integrity and financial management across programs, some of those additional tools have been extremely important from new ways of doing provider screening, to new ways of collecting and utilizing and analyzing data, to the use of predictive analytics, to the use of contractors and support services in new and innovative ways in order to protect the integrity of the program. We have seen great results from a number of those activities.

Mr. DAVIS. Thank you. When Budget Committee Chairman Paul Ryan unveiled his budget for fiscal year 2012, it called for repealing the Patient Protection and Affordable Care Act, turning Medicaid into a block grant. As a result, Federal oversight activities and investigations under the Department of Health and Human Services and the Department of Justice would come to a halt. The job of protecting Federal monies from fraud and misuse would devolve entirely to State officials. No more Federal program integrity initiatives, no more coordination of anti-fraud activities across Medicare and Medicaid, no more collaboration across State lines. The Ryan budget considers that a budget savings.

Let me ask you, what would be the impact of cutting Federal funding in the areas of oversight, management, and anti-fraud efforts?

Mr. HAGG. Well, certainly if program integrity tools that are a part of ACA were cut, they would need to be someplace. You know, those tools would need to be somewhere so that we could continue to do the work that we are doing in trying to root out fraud, waste, and abuse within the HHS programs.

Mr. DAVIS. Ms. Thompson?

Ms. THOMPSON. Well, this is a case in which I think how I would describe the problem that we are talking about this afternoon is a failure of management controls, so I don't think the answer to a failure of management controls is less management control.

There was a press report after this Subcommittee's last hearing on Medicaid in April that describes the Subcommittee's message as

being that States are as accountable for the stewardship of Federal funds as they are for the stewardship of State funds, and I thought that was a very important and accurate characterization of what the Subcommittee was trying to say and I can't associate myself with it more strongly.

So I think that, regardless of how Federal funding flows to States, there needs to be appropriate oversight and controls to ensure those Federal funds are being used properly and for approved purposes under the statute.

Mr. DAVIS. Would it be accurate to suggest or state that if the resources are not available then it is virtually impossible to do the oversight that is necessary to prevent or to further prevent fraud and abuse?

Ms. THOMPSON. Well, certainly, and I will let John chime in too on this question, certainly the proper protection and oversight of any programmatic activities or funding requires both people and technology and the appropriate kinds of financial and management controls that are necessary to protect the program against abuses.

Mr. HAGG. Yes, we would need appropriate funding and appropriate tools so that we are able to perform the work that we perform.

Mr. DAVIS. Thank you very much, Mr. Chairman. I yield back.

Mr. GOSAR. I thank the gentleman.

I now recognize my colleague, Dr. DesJarlais from Tennessee.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

I thank you both for appearing here today.

First, I would like to ask unanimous consent to put the editorial: State's Medicaid Abuses Cannot Stand, from the Poughkeepsie Journal, into the record.

Mr. GOSAR. So ordered.

Dr. DESJARLAIS. Ms. Thompson, the Committee learned that CMS' plan as of two and a half months ago was to continue to allow the overpayments in the case of New York. Is that still CMS' position?

Ms. THOMPSON. No. We have been very open and transparent with the Subcommittee staff about our thinking and the progression of our talks with the State. We were in a place where we were considering that, for a variety of different reasons, but ultimately concluded, I think, as the Subcommittee demonstrated in its report, that the proper thing to do here, especially given the longstanding nature of this problem and the fact that it is taking us a little bit of time to work with the State to resolve it, even from the last time that we started expressing our concerns, was simply to move to make the payment level or payment methodology as appropriate and leveled-out as possible on an as-soon-as-possible basis.

Dr. DESJARLAIS. Okay. So this may be redundant. Is it a factor in CMS' current negotiation with the New York's developmental centers that they have received Federal overpayments in excess of $15 billion over the past two decades?

Ms. THOMPSON. Well, it is certainly true that, because of the way that we have been allowing New York to draw down these dollars, that the abrupt cessation of those payments will require some considerable adjustment on the State's part, but that is an adjustment they have been prepared for.

I will say that we talked earlier about the fact that this has been a longstanding problem, in addition to the fact that I think certainly this Administration is committed to solving it. I am happy to report that we also have a State Administration that is at the table, recognizes this is the problem and is committed to solving it.

Dr. DESJARLAIS. Can CMS issue an immediate deferral so that the overpayments cease until a reasonable rate is restored?

Ms. THOMPSON. That is a tool that is available to us.

Dr. DESJARLAIS. Okay.

Ms. THOMPSON. So that, you know, if we continue to be unable to reach a proper conclusion in a short amount of time, we can consider making deferrals.

Dr. DESJARLAIS. Let me ask this, and this is not directed at you, but I have just been here two years, came out of the practice of medicine for 20 years, and I think for everyone sitting in the room, if this was your business and this was identified and that was money coming out of your bank account, would you be dragging your feet or making the same type of considerations for New York if that was your business?

And Mr. Davis is talking about the oversight that is needed in the Federal Government to ensure these programs shouldn't go to the States and let the States handle them. I mean, my gosh, from what I am hearing here, maybe that is the best thing that could happen, because if this is an example of how we do oversight in the Federal Government, then when I am told that $0.48 on every $1 that comes in from our taxpayers is wasted, this seems to make sense.

So if this were your business, would you be waiting or would you be doing it yesterday?

Ms. THOMPSON. I appreciate the question, and I think the answer to that is, as we look at what we are trying to accomplish here, we tried to be cognizant of two things: one has been the payment rate, themselves, and what is making them reach these levels and what are the underlying dynamics and data that we need to be looking at, which has taken us more time than we would like to sort out with the State; but the other is a concern that the State has made assertions that the abrupt cessation of these payments will cause tremendous dislocation for the State's DD system, and so we try to take that into account.

Dr. DESJARLAIS. This is again not directed to you, but if I have an employee in my office and they have been embezzling from me for two decades, and I find out that that is the case but they tell me if I abruptly stop that that would create a real hardship because they couldn't pay for their Cadillac and their boat, you know, that is kind of I look as a taxpayer when they look at something like this, a case like this. How do we justify that?

Ms. THOMPSON. Well, unfortunately, in this case it is not a matter of buying a Cadillac as it is supporting services to very vulnerable beneficiaries, so that is our concern. It is really the concern about the beneficiaries. It is not a concern about whether it is convenient or inconvenient for the State.

Dr. DESJARLAIS. So the beneficiaries——

Ms. THOMPSON. But, having said that, I will say that we have ultimately concluded that this is not the proper place for that consideration.

Dr. DESJARLAIS. Okay.

Ms. THOMPSON. And if the State has some needs that it wants to submit to us for consideration, we can deal with that on its own merits in a separate conversation.

Dr. DESJARLAIS. Thank you. What is the per patient payment rate that CMS believes satisfies the legal requirement that Medicaid payments be efficient and economical?

Ms. THOMPSON. We are still finalizing those methodologies and numbers, and that is one of the reasons we are not at completion yet, but I think you can expect to see a rate that is at about one-fifth of its current levels.

Dr. DESJARLAIS. Okay. I see my time has expired.

Mr. GOSAR. We can go a second round.

Dr. DESJARLAIS. Keep going?

Mr. GOSAR. You can do it in the second round.

Dr. DESJARLAIS. Okay. I will yield back. Thank you.

Mr. GOSAR. Well, we are going to go along those same lines, Ms. Thompson. Dr. DesJarlais started talking about how we are going to get to that number, and you said about one-fifth. Is it the same per patient payment rate that would satisfy Medicaid upper payment limit requirement?

Ms. THOMPSON. Yes. The mechanism by which we would actually enforce this payment rate is through a new methodology associated with an upper payment limit.

Mr. GOSAR. And so it will comply along with the Federal Government regulation?

Ms. THOMPSON. That is right.

Mr. GOSAR. Does CMS still plan on giving New York five years to bring these payment rates into compliance?

Ms. THOMPSON. No.

Mr. GOSAR. So we are going to have an abrupt cut

Ms. THOMPSON. Yes.

Mr. GOSAR. Okay. Do you believe that New York's Medicaid program deserves specific scrutiny from CMS, and additionally the individuals?

Ms. THOMPSON. Well, New York——

Mr. GOSAR. I mean like politicians and those supervising this process? I mean, this is deceiving and fleecing of the American taxpayer.

Ms. THOMPSON. Well, in terms of how we treat New York, it is on its merits as any other State, if that is the question. I have never been a part of any conversations that would suggest that our considerations are other than programmatic and financial and consistent with the statute.

Mr. GOSAR. But you do know that in New York politicians have been charged with Medicaid fraud over the past decade? You know there have been six of them: Guy Verelli, Joseph Bruno, Anthony Samarino, William Boilen, Carl Krueger, and Pedro Espada. Are you aware of that?

Ms. THOMPSON. No, I wasn't specifically aware of that.

Mr. GOSAR. I think it is very crucial that we know those individuals because of the predication that this has been going on. And this should also be a highlight for CMS to be noting the politicians and those directors that are indicted based upon their previous actions.

Are you aware that the two former New York Senate majority leaders have been indicted on Medicaid fraud: Joseph Bruno and Pedro Espada?

Ms. THOMPSON. No.

Mr. GOSAR. I think these are real glaring issues that we ought to continue to pay attention to.

In a 2010 news article, a deputy commissioner for fiscal and administrative solutions at the Office for People with Developmental Disabilities, James Morin, said, "I am not saying reimbursement doesn't exceed cost by any stretch. Quite honestly, the reimbursement is what it is. CMS has supported it." What do you say to New York State officials that have said CMS supported the high developmental center payment rates?

Ms. THOMPSON. Well, again, I am cautious about not characterizing prior Administration's or decision-makers' comments, but certainly since the moment that it came to our attention, New York State was quite aware we were not in support of those rates or methodologies.

Mr. GOSAR. You weren't, but previous individuals in your position definitely have been?

Ms. THOMPSON. It is actually hard for me to believe that they would have been, and I think the——

Mr. GOSAR. Well, no action was taken, so by abdication they were doing it.

Ms. THOMPSON. Well, again, it is hard for me to speak for them, but I actually think that, had they been aware as we are today of the dollars involved and where the rates are, that they would have taken different action.

Mr. GOSAR. Has the State of New York been real cooperative?

Ms. THOMPSON. They have under the current administration. Yes.

Mr. GOSAR. So let me ask you more about this payment mechanism. You know, you are from this obviously cost-shifting scenario and now we are going to cut it off, and we were talking about somewhere, one-fifth of that compensation. This is a big chunk of change.

Ms. THOMPSON. Yes.

Mr. GOSAR. What kind of conversation has New York expressed, or have they expressed any kind of dire consequences for other types of services that this was compensating for?

Ms. THOMPSON. Well, indeed they did originally appreciate that they had a problem, that it was a bad problem, that it needed to be solved, but they were expressing this concern about the impact on State budgets and how that would reverberate through the health care system in New York, and that was why we were giving some consideration at one point in time to the idea of some kind of transition.

But ultimately I think the argument has to be placed back on New York that if it has a claim for Medicaid funding it needs to

meet the requirements of the Medicaid statute, and we ought to be talking together and dealing out on those issues on that basis.

Mr. GOSAR. So individuals should be held accountable in those actions? I'm getting back to accountability.

Ms. THOMPSON. Yes.

Mr. GOSAR. Because Main Street America—I am from Arizona and this amount of money is huge in our State.

Ms. THOMPSON. Yes.

Mr. GOSAR. I mean, we are cutting services right and left, and I come from one of the poorest Districts in the Country. I have got lots of Native Americans where our dollars are really spread thin. So we have got to have a common-sense application in making sure that people in the know and those making decisions are held accountable for what is right and what is wrong; wouldn't you agree?

Ms. THOMPSON. Yes.

Mr. GOSAR. Well, I am running out of time. I am going to acknowledge my good friend, Mr. Davis from Illinois.

Mr. DAVIS. Thank you very much, Mr. Chairman.

On page nine of the majority report it states, "The Obama Administration has not taken any serious actions to prevent inappropriate State leveraging of Federal Medicaid money; rather, the stimulus bill made it more advantageous for States to figure out how to game the Federal Medicaid reimbursement since it contained the massive increase in each State's F-map."

I would like to ask you, Ms. Thompson, to respond to this allegation. How does CMS respond to the assertion that the stimulus bill encourages fraud?

Ms. THOMPSON. Well, certainly the purpose of the enhanced match under the stimulus bill for States was a reflection of the fact that States were facing dire fiscal and economic conditions and were in desperate need of additional Federal funding to continue and stabilize their Medicaid programs.

I will go back to the point that I made earlier, which is that, regardless of what the level of Federal funding is or how the underlying financing works, State officials have responsibilities for the stewardship of those Federal funds, and there were no changes made in our act to the requirements on States to claim dollars appropriately or to our structure or controls under which they could claim those dollars.

Mr. DAVIS. Page 12 of the report asserts that CMS failed to take any specific actions for three years after it admitted to having identified the problem. Is this a fair characterization, to your knowledge, and can you explain to the Subcommittee what actions were taking place from 2007 to 2010?

Ms. THOMPSON. Well, again, I want to characterize this carefully, because some of that time was in the prior Administration with prior officials making some of those decisions, but, again, it was, in my understanding, the view of the staff at the time that the cost regulation that was being finalized would be the appropriate enforcement mechanism to solve the problem.

Indeed, I think Mr. Hagg made that point that if we had such a regulation that that would have prevented these excessive payments. But that subsequent moratoria on enforcing that regulation issued by the Congress constrained further action on CMS' part.

Mr. DAVIS. Are you comfortably satisfied that there has been enough review of what may have been taking place that, if there were gaps, if there were opportunities, have those been closed sufficiently or closed to the point where you know that the kind of things that may have been taking place would have as much opportunity to do so?

Ms. THOMPSON. Well, I think specifically in the case of New York, that is one of the things that has taken some time to work through, because we don't want to place a new payment methodology or payment rate inside the New York State plan. We don't want that and the State officials don't want that. That doesn't actually solve the problem. So part of what we have been doing is actually pulling apart together, both the Federal and State side, what the methodology does, how it works, and what the underlying data tells us about how that is played out in terms of overall costs and rates.

In the case of the Nation, we are really taking New York as a case study and determining what additional steps we might need to take to improve our management controls overall so that we don't see this kind of situation occurring again, and so we are sure that we have looked and determined that no other similar situations are already in existence.

Mr. DAVIS. I thank you both for your testimony.

Thank you, Mr. Chairman. I yield back.

Mr. GOSAR. Thank you, my colleague

I have just got two more questions if you will bear with us.

So I want to make sure, for the record, that we are going to scale payments back to one-fifth of what they currently are?

Ms. THOMPSON. We would be happy to keep you informed on the actual rates and methodologies that arise. That is an approximation based on the best estimates that I have right now.

Mr. GOSAR. Okay. I just wanted to make sure I had that. And do you agree with the Inspector General's recommendation that limits the reimbursement rate of State-operated providers such as the New York developmental centers to actual cost?

Ms. THOMPSON. So that was the regulation. Regulation to actually effectuate that kind of a policy was issued by CMS in 2007 to great consternation on the part of the Congress on a bipartisan basis, which led to two moratoriums and a sense of the Congress that CMS should not proceed on that basis, so we have had some experience going down that route.

Having said that, I think we would be happy to have more conversations and discussions with the Inspector General's office as well as with the Subcommittee staff and cognizant Congressional staff to discuss that in more detail.

I will say in this case effective enforcement of the upper payment limit would have prevented this problem from occurring, as well, so I think part of the conversation should also be talking together about how we are going to improve the ongoing monitoring of our upper payment limit as also another mechanism by which to avoid these kinds of problems.

Mr. GOSAR. Mr. Hagg, would you agree with that statement, because I know in your testimony you alluded to it.

Mr. HAGG. Well, as part of our audit work we did not determine whether or not the State was or was not in compliance with the upper payment limit rules. Certainly it would appear, since the rates are so high, they may not be in compliance with those rules.

That being said, based on the example in New York and based on previous work that we have performed, we believe strongly that paying the public providers or limiting payments to public providers to the cost of providing the services is something that is needed because it will bring a higher level of accountability and transparency and make it much easier to see how Medicaid funds are used.

Mr. GOSAR. That sounds wonderful.

Mr. Davis, do you have any other questions?

Mr. DAVIS. No, Mr. Chairman.

Mr. GOSAR. Well, first of all, Ms. Thompson, I want to commend you. This is an action well deserved, and boy, you are right on top of it, so I would like to commend you for those actions and, Inspector General, as far as looking at the whole scenario, and we would like you to keep it up. This is about services, but it is also about accountability and making sure that dollar goes to the proper places, so I do want to commend you for that.

I would also like to keep in touch to make sure we are understanding how that rate looks, to make sure we have some accountability from our oversight.

With that, I would like to thank our witnesses for taking the time out of their busy day and schedules to appear before us today.

The Committee stands adjourned. Thank you.

[Whereupon, at 3:15 p.m., the subcommittee was adjourned.]

U.S. House of Representatives

Committee on Oversight and Government Reform

The Federal Government's Failure to Prevent and End Medicaid Overpayments

STAFF REPORT
U.S. HOUSE OF REPRESENTATIVES
112TH CONGRESS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
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Executive Summary

In a May 2012 report, the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS) revealed that New York State developmental centers, which treat and house individuals with developmental disabilities, received $1.5 million per year per resident in Medicaid reimbursement in fiscal year (FY) 2009. Total Medicaid payments to New York's State-operated developmental centers in FY 2009 totaled nearly $2.3 billion, an amount OIG found to be $1.7 billion beyond the facilities' reported costs. Medicaid payment rates to the developmental centers were ten times higher than Medicaid payment rates to New York's privately-run Intermediate Care Facilities, which OIG found to be comparable to the developmental centers. OIG found that these overpayments have occurred for two decades and are still occurring. By FY 2011, the daily payment rate at New York's developmental centers had increased another 24 percent, to $5,118, or the equivalent of $1.9 million per year for a *single* patient.

The daily payment rate has skyrocketed because of a feature in the formula governing Medicaid payment rates for patients in the developmental centers. The formula allows the State-operated facilities to retain nearly two-thirds of the total Medicaid reimbursement when an individual leaves the facility. According to OIG, this formula feature means taxpayers are paying twice for individuals who leave the developmental centers since most of them are transitioned into settings, such as group homes, also financed by Medicaid. In addition to the massive waste represented by these overpayments, Medicaid's payments to the developmental centers are also likely illegal because they violate the Medicaid Upper Payment Limit (UPL) requirement. Medicaid's UPL requirement caps State Medicaid reimbursements at an amount not greater than what Medicare would have paid for the equivalent service. The Committee on Oversight and Government Reform estimates that Medicaid payments to New York State developmental centers in FY 2009 were more than six times greater than what Medicare would have paid.

Overwhelming evidence suggests that the Federal Government has failed to question New York State's excessive developmental center payment rates adequately. In fact, it appears that until 2010, neither the Center for Medicare and Medicaid Services (CMS) nor its predecessor agency, the Health Care Financing Administration (HCFA), ever attempted to do so. CMS's failure to question Medicaid's excessive payments to New York developmental centers is inexcusable given that Medicaid payments to New York State's developmental centers exceeded the entire Medicaid budgets of 14 States during this time period. The failure of both HCFA and CMS suggests an institutional failure and a pattern of irresponsible actions that have cost taxpayers billions.

Given the dire budget situation faced by the nation, CMS must prevent Medicaid overpayments on the scale of the New York State developmental center overpayments. Instead of acting to defend taxpayer funds, however, CMS is currently negotiating with New York State on a plan that allows the developmental centers to continue receiving billions in overpayments over the next five years. Since the State of New York has already received overpayments from Federal taxpayers of at least $15 billion over the last two decades through its developmental centers, any Federal solution that does not immediately end the overpayments violates the law.

I. Excessive Medicaid Payment Rates at New York State's Developmental Centers

On May 17, 2012, the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS) released a report regarding Medicaid overpayments to New York State-operated developmental centers, which are facilities that treat and house Medicaid enrollees with developmental disabilities.[1] The OIG report revealed that the State's eleven developmental centers[2] received nearly $1.7 billion in Medicaid payments beyond the facilities' reported costs in fiscal year (FY) 2009 alone.[3] Moreover, the OIG found that these overpayments have occurred for two decades and are still occurring.[4]

According to the OIG report, "the State's reimbursement rate for developmental centers has [increased] . . . from $195 per day in SFY [State Fiscal Year] 1985 to $4,116 per day in SFY 2009, which is the equivalent of $1.5 million per year for one Medicaid beneficiary."[5] Medicaid payment rates for New York's State-operated developmental centers were ten times higher than Medicaid payment rates to New York's privately-run, Intermediate Care Facilities (ICFs), which OIG found to be comparable to the developmental centers in both the population they serve and the type of services they provide.[6] By SFY 2011, the daily payment rate at the State-operated developmental centers increased another 24 percent, to $5,118, or the equivalent of $1.9 million per year for a *single* patient.[7]

The OIG report also compared the payment rates received by the developmental centers to the "actual costs" reported by the State for the developmental centers, finding:

> [I]f the State had used actual costs in calculating the Medicaid daily rate for developmental centers, its reimbursement would have totaled $858 million ($429 million Federal share) in SFY 2009, a difference of $1.41 billion ($701 million Federal share).[8]

However, even OIG's reported $701 million Federal overpayment does not accurately reflect the actual Federal overpayments in FY 2009. Calculations in the OIG report used a 50 percent Federal Medical Assistance Percentage (FMAP), which is the percentage of State Medicaid spending reimbursed by Federal taxpayers. However, in SFY 2009, New York had an FMAP of over 54 percent as a result of the American Recovery and Reinvestment Act (ARRA), the "stimulus" bill.[9] Correcting for the actual FMAP increases the OIG estimated overpayment

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[1] OFFICE OF INSPECTOR GEN., DEPT. OF HEALTH & HUMAN SERVS., A-02-11-01029, MEDICIAD RATES FOR NY STATE-OPERATED DEVELOPMENTAL CENTERS MAY BE EXCESSIVE (2012), *available at* http://oig.hhs.gov/oas/reports/region2/21101029.pdf [hereinafter OIG Report].

[2] New York State's eleven developmental centers are the Brooklyn Developmental Center (DC), Staten Island DC, B Fineson Hillside DC, B Fineson Corona DC, Wassaic DC, OD Heck DC, Sunmount DC, Valley Ridge DC, Broom DC, Monroe DC, West Seneca DC (which has closed since the OIG report).

[3] According to the OIG report, New York claimed Medicaid reimbursement totaling $2,266,625,233 in SFY 2009 and the State's actual costs for the developmental centers that year totaled $577,684,725.

[4] *See* OIG Report, *supra* note 1.

[5] *Id.* at 4.

[6] *Id.*

[7] *Id.*

[8] *Id.*

[9] 74 Fed. Reg. 75 (Apr. 21, 2009); 74 Fed. Reg. 234 (Dec. 8, 2009); *See* The American Recovery & Reinvestment Act of 2009, Pub. L. No. 111-5, Title V, § 5001, 123 Stat. 115, 496 (2009).

to nearly $770 million.[10] Moreover, this amount understates the true overpayment for two reasons. First, instead of using reported costs to calculate the overpayment, the OIG used reimbursable costs, which were nearly $300 million greater than reported costs.[11] Second, the State's reported costs, which formed the basis for the calculation of reimbursable costs, were not verified or audited by either OIG or the CMS.[12] In fact, the actual costs reported by the State for its developmental centers – which amounted to slightly more than $1,000 per patient per day for each center – are more than twice the average Medicaid payment rate received by ICFs operating in the State.[13]

Title XIX of the Social Security Act mandates that State Medicaid payment rates must be consistent with "efficiency, economy and quality of care" and comparable to the services available to the general public.[14] New York State's Office for People with Developmental Disabilities (OPWDD) administered and set Medicaid payment rates for services provided in the developmental centers. OPWDD uses a complex formula that has generated the extraordinarily high reimbursement claims by the State. The formula includes a factor that allows the developmental centers to maintain nearly two-thirds of the payment for a patient *even after* this individual leaves the facility.[15] According to the OIG Report:

> The volume variance adjustment was intended to ensure that annual decreases in headcount at a developmental center did not cause a center to lose operating funds needed to support its fixed costs. The volume variance adjustment achieved this by allowing the State to retain 64 percent of the costs associated with beneficiaries no longer in a developmental center.[16]

The volume variance adjustment resulted in the dramatic increase in the Medicaid payment rate per person as enrollment in the facilities decreased. Such rates are clearly inconsistent with principles of efficiency and economy, and resulted in OIG's probe into the State's compliance with the Federal requirement. Additionally, OIG confirmed with staff of the House Oversight and Government Reform Committee that taxpayers are paying twice for individuals who leave the developmental centers since most of them are transitioned into settings, such as group homes, also financed by Medicaid.[17]

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[10] The ARRA (stimulus bill) raised State FMAP rates. For State fiscal year 2009, New York's FMAP was 50% for the first and second quarters and 58.78% for the third and fourth quarters. The average FY 2009 FMAP was 54.39%. The OIG report found that the total overpayment was $1.41 billion in FY 2009. Using an FMAP of 54.39% means the Federal share alone of the overpayments was $767 million.

[11] *See* Appendix A in the OIG Report, *supra* note 1.

[12] Briefing with Centers for Medicare & Medicaid Services (June 28, 2012); Phone briefing with Department of Health and Human Services Office of Inspector General (September 5, 2012).

[13] According to Appendix A in the OIG Report, the total reported developmental center costs for SFY 2008 were $580,689,833. Dividing that number by 559,974 patient days yields $1,037 in reported costs per patient day.

[14] *See* Social Security Act §1902(a)(30)(A).

[15] According to the OIG Report, "[t]he volume variance adjustment was intended to ensure that annual decreases in headcount at a developmental center did not cause a center to lose operating funds needed to support its fixed costs. The volume variance adjustment achieved this by allowing the State to retain 64 percent of the costs associated with beneficiaries no longer in a developmental center."

[16] *See* OIG Report, *supra* note 1.

[17] Phone briefing with Department of Health and Human Services Office of Inspector General (September 5, 2012).

CMS is responsible for overseeing Medicare and Medicaid and preventing fraud, waste, and abuse in both programs. Unfortunately, negligence at CMS and its predecessor agency, the Health Care Financing Administration (HCFA), over a period exceeding 25 years is largely to blame for the excessive payment rates received by New York's State-operated developmental centers. According to the OIG report:

> CMS did not adequately consider the impact of State plan amendments on the developmental centers' Medicaid daily rate. Specifically, CMS approved more than 35 State Plan Amendments related to the . . . rates, including some that pertained only to developmental centers. CMS reviewed the proposed amendments and, in some cases, asked the State for additional information to address concerns CMS had about the rate-setting methodology. However, CMS's efforts did not prevent the rate from increasing to its current level.[18]

II. Developmental Center Overpayments Violate the Law

State Medicaid spending is reimbursed by the Federal Government at a percentage determined by State per capita income, with the Federal Government reimbursing about 60 percent of Medicaid spending in the aggregate.[19] The open-ended Federal reimbursement of State Medicaid expenditures provides States with a large incentive to maximize Washington's contribution to their State program.[20] A previous Committee staff report explained how States can create the appearance of actual State Medicaid expenditures without actually spending any State money:

> The most common type of State technique requires providers, such as nursing homes, to contribute money to the State. The State will take the provider contribution and spend the money back on the provider. While this may not make sense, since the State is now spending the money it can submit a receipt for the spending to CMS. CMS will then provide the State a refund based on the State's Medicaid reimbursement rate, and the State will then share the Federal refund with the provider. As this example illustrates, the scheme enables the State to compensate the provider without any net contribution of State tax dollars.[21]

These schemes are not new and are well-known. In fact, the U.S. Government Accountability Office has written numerous reports detailing these techniques and the need for greater Federal oversight over Federal reimbursement of State Medicaid expenditures.[22] The Federal Government does place certain restrictions on the ability of States to leverage the Federal

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[18] *See* OIG Report at ii.
[19] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy, Aged, Blind or Disable Persons for FY 2012," November 10, 2010. *Available at*: http://aspe.hhs.gov/health/fmap12.shtml.
[20] *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*, U.S. House Committee on Oversight and Government Reform (April 25, 2012).
[21] *Id.*
[22] *See*, e.g. U.S. GOV'T ACCOUNTABILITY OFFICE (GAO): CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (2008), *available at* http://www.gao.gov/new.items/d08614.pdf.

Medicaid reimbursement with artificial State contributions. One restriction is called Medicaid upper payment limits (UPLs).[23] According to health care expert Kip Piper:

> [T]he Upper Payment Limit is the maximum a given State Medicaid program may pay a type of provider in the aggregate, Statewide in Medicaid fee-for-service. State Medicaid programs cannot claim Federal matching dollars for provider payments in excess of the applicable UPL. . . . To create an upper bound to Medicaid spending on fee-for-service hospital rates, Congress imposed an Upper Payment Limit based on what Medicare would have paid facilities for the same services.[24]

Medicaid payments to the State's developmental centers, which exceeded $5,100 per patient per day in SFY 2011, appear to have violated UPL requirements for the better part of the last two decades. By way of comparison, Medicaid's FY 2009 reimbursement rate of $4,116 for New York's developmental centers was more than five times higher than the rate paid by Medicare for the most costly individuals residing in a skilled nursing facility (SNF) in New York City.[25] According to the Committee's calculations, between 1991 and 2011, the Medicaid program made payments to New York's developmental centers of nearly $30 billion beyond the Medicaid UPL,[26] or the amount that Medicare would have otherwise paid for residents in these facilities. (Please see the Appendix for a discussion of the methodology used in calculating this figure.) Since the Federal Government generally finances half of New York's Medicaid expenditures, Federal taxpayers would have therefore paid around $15 billion to the State's developmental centers beyond what the law allowed. When asked by the Oversight Committee for information relating to this abusive use of Federal taxpayer dollars, an aide to New York Governor Andrew Cuomo responded, "We aren't sure responding to the Committee's request at this time when we are working through these issues serves the best interests of the State."[27]

III. Federal Inaction on Developmental Center Overpayments is Inexcusable

In 1990, CMS's predecessor agency, HCFA, approved an amendment to New York's Medicaid State plan which affected developmental center reimbursement.[28] According to a memo on May 11, 1990, HCFA was assured that the aggregate payments for facilities under this

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[23] 42 C.F.R. 447.272.

[24] Kip Piper, *Medicaid Upper Payment Limits: Understanding Federal Limits on Medicaid Fee-for-Service Reimbursement of Hospitals and Nursing Homes*, The Piper Report, April 25, 2012.

[25] Medicare's payment for skilled nursing facility (SNF) care varies based upon the beneficiary's case-mix and the location of the SNF. In 2009, the average Medicare SNF daily payment rate was only $373. The case-mix group with the highest Medicare reimbursement rate is within the Rehabilitation Plus Extensive Services (RUX) group, because beneficiaries classified under RUX generally have complex needs and require more assistance with activities of daily living, a greater amount of physical therapy, occupational therapy, and/or speech-language pathology services, and more complex clinical care. For a SNF in New York City, the daily RUX reimbursement rate was $748 in FY 2009.
Source: Emails from Scott Talaga, Congressional Research Service employee, to Brian Blase, professional staff member on the Committee on Oversight and Government Reform, September 11, 2012.

[26] The Committee's estimate is in 2011 dollars.

[27] Email from Alexander Cochran, Special Counsel to the Governor, to Brian Blase, professional staff member on the Committee on Oversight and Government Reform, September 4, 2012.

[28] Memo from Associate Regional Administrator at HCFA's Division of Medicaid to Anthony C. Lovecchio, Director of Alternative Payment Systems at HCFA (May 11, 1990).

amendment would fall under the UPL.[29] The memo also indicated that HCFA would routinely monitor and assess the State's compliance with Federal law.[30] HCFA's indication of routine assessment is consistent with Mr. Piper's analysis that "CMS routinely examines and questions State modeling, assumptions, and data to ensure compliance with the Federal UPLs."[31]

Overwhelming evidence suggests that the Federal Government failed to adequately monitor or assess Medicaid payments to New York's developmental centers. In fact, it appears that until 2010, neither HCFA nor CMS raised any questions about the out-of-control payment rate. This failure is inexcusable given that Medicaid payments to New York State's developmental centers exceeded the entire Medicaid budgets of more than a dozen States during this period.[32] In fact, total Medicaid's payments to New York's developmental centers that served about 1,700 residents in 2009 was roughly the same as total payments made on behalf of the 372,522 enrollees in Kansas's Medicaid program.[33] Given the magnitude of this failure, the Committee has serious concerns about CMS's institutional capabilities to assure program integrity and protect taxpayer dollars.

Moreover, neither New York State nor CMS dispute the fact that the State's developmental centers are significantly overpaid. During a briefing with Committee staff on June 28, 2012,[34] Penny Thompson, CMS's Deputy Director of the Center for Medicaid and CHIP Services, Stated that CMS uncovered the State's high reimbursement rate for developmental centers through a financial review of the State's Medicaid Management Information System in 2007.[35] It is difficult to believe that CMS was unaware of high developmental center payment rates in New York State prior to 2007. For instance, a book was published in 2005 that detailed the high developmental center payment rates and how the excessive rates caused the State to delay plans to close its developmental centers by 2000.[36] Moreover, the amount of Federal money flowing to New York State through the developmental centers was so massive, it is surprising that not one of CMS's 4,500 employees[37] started asking relevant questions.

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[29] *Id.*
[30] *Id.*
[31] Kip Piper, *Medicaid Upper Payment Limits: Understanding Federal Limits on Medicaid Fee-for-Service Reimbursement of Hospitals and Nursing Homes*, The Piper Report, April 25, 2012.
[32] In SFY 2009, the Medicaid spent $2.267 billion on about 1,400 enrollees through New York's developmental centers. In FY 2009, Kansas spent $2.366 billion on Medicaid on 372,522 enrollees. 14 States had Medicaid budgets less than what New York received through the developmental centers. In FY 2009, Wyoming's Medicaid program spent $528 million on 82,365 enrollees, North Dakota's Medicaid program spent $573 million on 75,328 enrollees, South Dakota spent $709 million on 128,063 enrollees, Montana spent $845 million on 114,958 enrollees, Vermont spent $971 million on 182,045 enrollees, Alaska spent $1.065 billion on 121,290 enrollees, New Hampshire spent $1.111 billion on 159,262 enrollees, Delaware spent $1.232 billion or 207,243 enrollees, Nevada spent $1.245 billion on 290,435 enrollees, Hawaii spent $1.271 billion on 247,246 enrollees, Idaho spent $1.289 billion on 227,849 enrollees, Nebraska spent $1.538 billion on 253,474 enrollees, Utah spent $1.615 billion on 294,903 enrollees, and Rhode Island spent $1.755 billion on 204,829 enrollees. Kaiser Family Foundation, *Total Medicaid Enrollment, FY 2009*, and Kaiser Family Foundation, *Distribution of Medicaid Payments by Enrollment Group, FY 2009*.
[33] *Id.*
[34] Briefing with Centers for Medicare & Medicaid Services (June 28, 2012).
[35] *Id.*
[36] Paul J. Castellani, *From Snake Pits to Cash Cows: Politics and Public Institutions in New York*, State University of New York Press, 2005.
[37] U.S. Department of Health and Human Services, *HHS: What We Do*, *available at* http://www.hhs.gov/about/whatwedo.html (September 12, 2012).

The George W. Bush Administration initiated rule-making in 2007 that would have limited Medicaid reimbursements to public providers to the cost of providing services.[38] The rule attempted to increase program integrity by clarifying the types of permissible State techniques to finance Medicaid costs and requiring certain providers to retain all the Medicaid reimbursements they receive.[39] A Federal court found that the rule was "improperly promulgated" and vacated the rule.[40] The current Administration has taken the opposite approach. The first major law signed by President Obama, the American Recovery and Reinvestment Act of 2009 (the "stimulus" bill), contained a provision that it was the "sense of Congress" that the Secretary of Health and Human Services should not promulgate final regulations limiting Medicaid reimbursements to public providers to cost.[41] Moreover, the Obama Administration has not taken any serious actions to prevent inappropriate State leveraging of Federal Medicaid money. Rather, the stimulus bill made it more advantageous for States to figure out how to game the Federal Medicaid reimbursement since it contained a massive increase in each State's FMAP.[42]

CMS's failure to specifically address the New York developmental center overpayments resulted in taxpayers continuing to overpay by nearly $1 billion per year without even asking New York officials to answer any questions about the overpayments. CMS acted only after an in-depth story regarding the developmental center overpayments appeared in the *Poughkeepsie Journal* on June 20, 2010.[43] The article quoted Michael Melendez, regional branch manager for CMS's division of Medicaid and children's health, that a "focused financial review" had not been done in his four years in office, but that a review may take place "now that you've brought this to our attention."[44]

About three weeks after the initial developmental center overpayment article in the *Poughkeepsie Journal*, three years after CMS officials told the Committee that the agency learned of the overpayment problem, and 17 years after the overpayments began,[45] CMS finally sent New York State officials a letter.[46] According to CMS spokesman Jeffrey Hall, CMS's inquiry was a "result of what [the *Poughkeepsie Journal*] brought to our attention."[47] The letter Stated that "[i]t has come to CMS' attention that several New York State-operated developmental centers currently claim for ICR-MR services at daily Medicaid rates in excess of

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[38] HHS, CMS, Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Federal Register 29748 (May 29, 2007).
[39] *Id.*
[40] *Alameda County Medical Center v. Leavitt*, 559 F. Supp. 2d (D.D.C. 2008).
[41] Elicia J. Herz and Vanessa K. Burrows, Congressional Research Service, Select Bush Administration Medicaid Rulemakings: Congressional and Administrative Actions (July 30, 2010), *available at* http://www.crs.gov/Products/rl/pdf/RL34764.pdf.
[42] The American Recovery & Reinvestment Act of 2009, P.L. 111-5, Title V, § 5001, 123 Stat. 115, 496 (2009).
[43] Mary Beth Pfeiffer, *At $4,556 a Day, N.Y. Disabled Care No. 1 in Nation*, POUGHKEEPSIE JOURNAL, June 20, 2010.
[44] *Id.*
[45] The graph in the OIG report shows Medicaid daily rates for developmental centers and three privately operated ICFs. Between 1985 and 1990, the rates for all four institutions were similar. However, beginning in 1990, the payment rates for the developmental centers began to steadily outpace the payment rates for the ICFs. In 1995, the gap was about $600 per day; by 2000, the gap was about $1,500 per day; by 2005, the gap was about $2,500 per day; and by 2009, the gap was about $3,500 per day.
[46] Letter from Sue Kelly, CMS's Regional Administrator for the region covering New York, to Donna Frescatore, the Deputy Commissioner of the New York State Department of Health, July 13, 2010.
[47] Mary Beth Pfeiffer, *Feds Probe Payouts to 9 State Facilities*, POUGHKEEPSIE JOURNAL, July 16, 2010.

$4,500 per beneficiary."[48] Two months later, the State acknowledged in its response to CMS that "the approved rate methodology does result in institutional payments that exceed the costs of operating the facilities."[49]

During a briefing with Committee staff, Ms. Thompson admitted that CMS failed to adequately monitor the rate taxpayers were paying to New York's State-operated developmental centers for the past two decades.[50] Despite recognition of the overpayments, both CMS and the State failed to stop the daily reimbursement rate from increasing to $5,118 per year by SFY 2011.[51] Moreover, CMS has not taken the necessary corrective action. CMS has not yet taken disciplinary actions against any employees for the agency's failure to prevent this massive loss of tax dollars. CMS officials also informed Committee staff that New York and CMS are in negotiations to develop a corrective action plan regarding the developmental center payment rates.[52] However, at the briefing, Ms. Thompson explained that the corrective action plan would allow New York to continue to receive billions of dollars in overpayments for at least the next five years because the State has grown dependent on the excess Federal funds.[53]

The Committee found the corrective action plan outlined by CMS officials to be grossly inadequate. Rep. Darrell Issa (R-CA), Chairman of the Committee on House Oversight and Government Reform Committee, and Rep. Trey Gowdy (R-SC), Chairman of the Subcommittee on Health Care, District of Columbia, Census and the National Archives, sent a letter to Marilyn Tavenner, Acting Administrator of CMS, on July 11, 2012, urging her to end the overpayments immediately:

> [The corrective action] plan, which is grossly unfair to Federal taxpayers, indicates CMS is cavalier with taxpayer resources. . . . The Committee requests that you act in accordance with the law to ensure that State Medicaid payment rates are consistent with efficiency, economy and quality of care comparable to the services available to the general public.[54] Specifically, the Committee urges you to ensure the corrective action plan with the State of New York includes the immediate cessation of excessive reimbursement rates for the State's developmental centers. Rather than enabling the State to continue overcharging Federal taxpayers, we urge you to assess your ability to recover the billions in improper payments that was sent to the State over the past two decades through the State-operated developmental centers.[55]

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[48] Letter from Sue Kelly, Assoc. Regional Administrator, Centers for Medicare & Medicaid Services., to Donna Fescatore, Deputy Commissioner, New York State Dept. of Health (July 13, 2010).
[49] Letter from Donna Frescatore, Deputy Commissioner, State of New York Dept. of Health, to Sue Kelly, Assoc. Regional Administrator, Centers for Medicare & Medicaid Services. (Sept. 14, 2010).
[50] Briefing with Centers for Medicare & Medicaid Services. (June 28, 2012).
[51] *See* OIG Report, *supra* note 1.
[52] *Id.*
[53] *Id.*
[54] *See* Social Security Act §1902(a)(30)(A).
[55] Darrell Issa, Chairman of the Committee on House Oversight and Government Reform Committee, and Trey Gowdy (R-SC), Chairman of the Subcommittee on Health Care, District of Columbia, Census and the National Archives, Letter to Marilyn Tavenner, Acting Administrator of CMS, July 11, 2012.

IV. Developmental Center Overpayments Delay Needed Reform

Over the past two years, there have been several reports indicating many patients in New York's developmental centers have received substandard care, and many advocates of the disabled in New York support the closure of the developmental centers.[56] According to the *Poughkeepsie Journal*, "[t]he closing of the [developmental centers], once a certainty, has been delayed for a decade as reimbursement rates have soared; closing would shut off a gushing faucet of cash in a State dogged by deficits."[57] In 1991, Elin Howe, then-Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, and New York Governor Mario Cuomo called for the closure of New York State developmental centers by 2000.[58] According to Howe, "[i]ndependent fiscal analyses of closure demonstrate that it is the most cost-effective course to take."[59] Former New York State Senator Nicholas A. Spano, then-Chairman of the Committee on Mental Hygiene, concurred, recommending that "all developmental centers in the State of New York be permanently closed by the year 2000."[60]

When high-ranking New York officials recommended closing the developmental centers in the early 1990s, payment rates for the centers were 95 percent lower than today's rates and were in line with the costs of delivering services in those facilities. As rates rose throughout the 1990s, however, New York reneged on its plans to close its developmental centers. Given the enormous fixed costs at these facilities, which house a very small fraction of the thousands of residents they once housed, common sense budgeting would have suggested eliminating or consolidating the developmental centers. For example, because the campuses of the State's developmental centers are so vast, energy costs are enormous: $14,000 a year for each resident at a Wassaic developmental center, $14,300 per person at a Rochester developmental center, and $21,000 at a developmental center in Erie County.[61] The huge overpayments received by New York State, which one State official called "cash cows,"[62] disincentivized the State from eliminating or consolidating the developmental centers.

In fact, the enormous overpayments resulted in New York State "rebuilding an entire 120-bed campus in Queens for $97 million and spending about $40 million at two others in Brooklyn and Broome County that soon will serve just 300 people combined" since 2006.[63] Additionally, the Wassaic developmental center, which at one point housed 4,500 residents, now houses about 100 residents, and was supposed to close a decade ago, has received about $30 million over the past seven years to repair the facility's infrastructure.[64] CMS's failure to end the developmental center overpayments has therefore led to a massive amount of Federal taxpayer dollars propping up outdated facilities that ought to have closed a decade ago.

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[56] *See*, e.g. Danny Hakim, *A Disabled Boy's Death, and a System in Disarray*, NEW YORK TIMES, June 5, 2011.
[57] Mary Beth Pfeiffer, *At $4,556 a Day, N.Y. Disabled Care No. 1 in Nation*, POUGHKEEPSIE JOURNAL, June 20, 2010.
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] Mary Beth Pfeiffer, *Institutions Prop Up System – But at What Cost to State*, POUGHKEEPSIE JOURNAL, September 5, 2010.
[62] Mary Beth Pfeiffer, *State Won't Release Wassaic Resident Data*, POUGHKEEPSIE JOURNAL, October 30, 2010.
[63] Mary Beth Pfeiffer, *'Confidential' paper: Quality of care for developmentally disabled would fall without overpayments*,' POUGHKEEPSIE JOURNAL, Sept. 5, 2010.
[64] Mary Beth Pfeiffer, *Tragedy to Triumph: A Wassaic Tale*, POUGHKEEPSIE JOURNAL, June 20, 2010.

V. CMS's Failures to Stop Egregious Overpayments Must End

CMS and its predecessor agency HCFA failed on multiple counts with respect to oversight of Medicaid's excessive payments to New York State's developmental centers. First, HCFA approved the State's developmental center payment methodology and the changes to this methodology that dramatically increased payment rates. Second, both HCFA and CMS consistently failed to comprehend the impact that New York's many State plan amendments would have on developmental center payment rates. Third, both HCFA and CMS failed to identify these overpayments, which began in 1990 and progressively increased thereafter, until 2007. Fourth, CMS failed to take any specific actions for three years after it admitted to having identified the problem – and only after a newspaper in New York reported on the large overpayments. Fifth, despite writing an initial letter to the State in July 2010, CMS has not yet obtained necessary information from the State relating to the overpayments. Sixth, CMS is negotiating with New York on a plan that allows the developmental center to continue receiving billions in overpayments over the next five years.

In 2012, for the fourth year in a row, the Federal budget deficit will exceed $1 trillion. Since 2009, the United State's debt has increased nearly $5.5 trillion. Given the extraordinarily dire Federal budget situation, CMS's failure to prevent the massive Medicaid overpayments flowing to New York State's developmental centers needs to be corrected immediately. Although remedying past mistakes and having New York State return improperly received Medicaid funds to the U.S. Department of the Treasury would be extremely difficult, fixing the problem moving forward must be a top priority for CMS. In addition to fixing an out-of-control problem, the agency must demonstrate that it plans on prioritizing the financial integrity of the Medicaid program.

Appendix: Committee's Methodology for Calculating Medicaid Overpayments

On July 19, 2012, the Committee sent a letter to Dr. Nirav Shah, Commissioner of the New York State Department of Health, asking for detailed information regarding overpayments received by New York State-operated developmental centers. Despite initial assurances from State officials that New York would respond to the Committee's request for information, the State decided not to comply. Because the State refused to comply with its request, the Committee compiled as much available information as possible from reliable sources in order to estimate the amount of overpayments received by New York State's developmental centers since 1990.

The Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS) supplied the Committee with a significant amount of information on these overpayments. Chiefly, OIG provided the actual payments received by New York developmental centers for State fiscal year (SFY) 2007 ($1.828 billion), SFY 2008 ($2.107 billion), and SFY 2009 ($2.267 billion), as well as the daily Medicaid payment rate per patient for New York's developmental centers over the entire period. Using the actual payments received by New York's developmental centers and OIG's calculations for reimbursable expenses, OIG estimated Medicaid overpaid the State developmental centers by $1.41 billion in SFY 2009, $1.359 billion in SFY 2008, and $1.063 billion in SFY 2007. The Committee requested that OIG estimate the developmental center overpayments over the past two decades using the same methodology it employed for its 2007-2009 estimates; however, OIG lacked the necessary information (the same information the State of New York has refused to provide the Committee) in order to perform the calculations.

It is important to note that OIG's calculation of overpayments relies upon the State's reported costs, and the State's reported costs were not verified or audited by either OIG or CMS. There is a complex formula with many supplementary and substantial add-ons that convert a prior year's reported costs into a current year's reimbursable costs. For example, New York's total reported costs for SFY 2008 were $581 million. After adding the various supplementary factors, OIG calculated the reimbursable cost for SFY 2009 was $858 million, about 48 percent higher than New York's reported costs for the previous year.

Therefore, there is reason to believe that the reimbursable costs calculated by OIG are significantly higher than are necessary to serve the State's developmental center population. According to the OIG report, the total reimbursement cost per patient was $1,532 per day for SFY 2009. Since OIG reported that the average rate received by similar, privately-operated Intermediate Care Facilities (ICFs) was $444 in SFY 2009, a $1,532 rate appears very high. Since OIG's report calculates overpayments by subtracting these inflated "reimbursable costs" from the payments received by State-operated developmental centers, the overpayments calculated by OIG for SFY 2007, SFY 2008, and SFY 2009 are likely substantially too low.

To avoid the shortcomings involved with OIG's somewhat nebulous "reimbursable costs," the Committee calculated the developmental center overpayments as the amount received by New York State-operated developmental centers in excess of the Medicaid Upper Payment Limit (UPL). According to Federal Medicaid law, the UPL is the maximum a given State

Medicaid program can pay to Medicaid providers in the aggregate. To satisfy UPL requirements, Medicaid payments must not exceed what the Medicare program would pay for the same services. The Committee therefore estimated the Medicaid UPL using the most expensive Medicare payment category (see Footnote ii in the Table). Since the Committee's estimates used Medicare rates for the most costly patients in skilled nursing facilities (SNFs) and not all of the developmental center patients would fall into this category, the Committee's Medicaid UPL is almost certainly too high. Therefore, since the Committee is estimating the overpayments in excess of Medicaid UPL amounts and the Committee assumed the highest possible Medicare reimbursement rates, the Committee's estimates of the overpayments received by New York developmental centers are probably too low.

Medicare's reimbursement rates also vary by geographic location, and the State of New York has 14 geographic areas. The Committee calculated a weighted average of Medicare reimbursements using the geographic breakdown of the State's developmental centers in 2010. (This was the only year the Committee found an accounting of each developmental center's payment). Using developmental center population from that year, the Committee assigned Medicare payment regions the following weights: 37.19% to New York City, 21.10% to Binghamton, 15.81% to Rural New York State, 10.73% to Poughkeepsie, 8.75% to Rochester, 3.25% to Albany, and 3.18% to Buffalo. The Medicaid UPL estimates shown in the Table below for SFY 1999 through SFY 2011 were estimated using weighted average calculations. The Medicare payment information was easily obtainable only for the years after 1998. The average price change from 1999 to 2005 in Medicare's reimbursement rate for the most expensive patients in SNF was $12. Therefore, for purposes of the Committee's estimates, the Medicare UPL was increased $12 each year from SFY 1991 to SFY 1998.

In order to calculate the estimated payments received by New York developmental centers, the Committee multiplied daily Medicaid payment rates per patient by the estimated number of patients residing in developmental centers at one point during the SFY. OIG provided the daily Medicaid payment rates and the Committee relied on reports issued by New York's Office for People with Developmental Disabilities (OPWDD) and its predecessor agency, the Office of Mental Retardation and Developmental Disabilities (OMRDD), to estimate patient numbers.[65] The fifth column in the Table shows the Committee's estimate of the amount Medicaid paid New York State-operated developmental centers beyond the Medicaid UPL (the amount Medicare would have otherwise paid). The second to last column is the present value of each year's estimated overpayment calculated using the consumer price index. Totaling up the overpayments from 1991 to 2011 yields a net estimated overpayment of nearly $28.8 billion beyond what was allowed by the Medicaid UPL. Finally, the last column shows the Federal share of the overpayments since the Federal government reimburses at least half of New York's Medicaid expenditures. The total Federal overpayment (in present value terms) between 1991 and 2011 was approximately $15 billion.

[65]OMRDD reports from 1999 to 2006 contained annual counts of the total residents in the State's developmental centers and OIG provided the actual reimbursements received by the State-operated developmental centers for 2007 through 2009. The sources for 1991, 1994, 2010, and 2011 are contained in the footnotes below the Table showing the estimated overpayments by year. For the remainder of the years (1992, 1993, 1995, 1996, 1997, and 1998), the Committee used a linear interpolation to estimate the number of developmental center residents.

Table: Estimated Medicaid Overpayment to New York State-Operated Developmental Centers

State Fiscal Year	Estimated Dev. Center Patients	Daily Dev. Center Pay Rate[i]	Estimated Medicaid UPL[ii]	Over-payment	Overpayment Present Value (2011 $)[iii]	Federal Share of Overpayment[iv]
1991	6,350[v]	$389	$319	$162.2M[vi]	$267.9M	$134.0M
1992	5,437	$442	$331	$220.3M	$353.2M	$176.6M
1993	4,524	$552	$343	$345.1M	$537.2M	$268.6M
1994	3,611[vii]	$654	$355	$394.1M	$598.1M	$299.1M
1995	3,294	$936	$367	$684.2M	$1,009.9M	$504.9M
1996	2,978	$1,093	$379	$776.0M	$1,112.6M	$556.3M
1997	2,661	$1,310	$391	$892.7M	$1,251.1M	$625.5M
1998	2,345	$1,522	$403	$957.6M	$1,321.5M	$660.8M
1999	2,028[viii]	$1,729	$415	$972.6M	$1,313.2M	$656.6M
2000	2,020[ix]	$1,930	$426	$1,108.9M	$1,448.5M	$724.3M
2001	1,711[x]	$2,165	$435	$1,080.4M	$1,372.3M	$686.1M
2002	1,692[xi]	$2,434	$474	$1,210.4M	$1,513.7M	$756.8M
2003	1,599[xii]	$2,723	$457	$1,322.5M	$1,617.1M	$808.6M
2004	1,610[xiii]	$2,934	$483	$1,440.3M	$1,715.1M	$882.9M
2005	1,696[xiv]	$3,063	$490	$1,592.8M	$1,834.5M	$944.4M
2006	1,700[xv]	$3,284	$594	$1,669.1M	$1,862.4M	$931.2M
2007	X[xvi]	$3,715	$613	$1,526.3M	$1,655.9M	$827.9M
2008	X[xvii]	$3,736	$658	$1,736.1M	$1,813.8M	$906.9M
2009	X[xviii]	$4,116	$645	$1,911.4M	$2,004.1M	$1,090.0M
2010	1,417[xix]	$4,556	$645	$2,022.8M	$2,086.6M	$1,277.9M
2011	1,313[xx]	$5,118	$751	$2,092.9M	$2,092.9M	$1,274.3M
Total					**$28,781.6M**	**$14,993.8M**

[i] Development Center payment rates were Office of Inspector General (OIG), Department of Health and Human Services

[ii] The Committee estimated the Medicaid UPL using the Medicare case-mix group with the highest reimbursement rate. For FY 2006 to FY 2011, this group was the Rehabilitation Plus Extensive Services (RUX) group. Beneficiaries classified under RUX generally have complex needs and require more assistance with activities of daily living, a greater amount of physical therapy, occupational therapy, and/or speech-language pathology services, and more complex clinical care. For FY 1999 to FY 2005, the group with the highest reimbursement was the Ultra-High Rehab group (RUC) from the Rehabilitation case-mix group. Medicare's reimbursement rates also vary by geographic location and the State of New York has 14 geographic areas. The Committee calculated a weighted average of the Medicare reimbursement using the geographic breakdown of the developmental centers in 2010. The following weights were assigned: New York City 37.19%, Binghamton 21.10%, Rural New York State 15.81%, Poughkeepsie 10.73%, Rochester 8.75%, Albany 3.25%, Buffalo 3.18%. Therefore, the estimates in this category from FY 1999 to FY 2011 were estimated using weighted average calculations. We used the average historical price change from 1999 to 2005 of $12 to estimate that Medicaid UPL increased $12 each year from FY 1991 to FY 1998.

[iii] This column adjusts the overpayment column for 2011 values using the Consumer Price Index.

[iv] This calculation uses the State's Federal Medicaid Assistance Percentage (FMAP). Generally, New York's FMAP is 50%. In fiscal years 2004, 2005, 2009, 2010, and 2011, the Federal government increased the FMAP so the Federal share of the State's Medicaid expenditures in those years is higher. New York's FMAP in SFY 2004 and SFY 2005 was 51.48%. In SFY 2009, New York's FMAP was 54.39%. In SFY 2010, New York's FMAP was 61.24%. In SFY 2011, New York's FMAP was 60.89%.

[v] Paul J. Castellani, From Snake Pits to Cash Cows: Politics and Public Institutions in New York, State University of New York, 2005, page 249.

[vi] All of the figures in the table are in the millions. This particular figure is $162.2 million.

[vii] *Id.*, page 259

[viii] The 1998-99 Budget for the New York State Office of Mental Retardation and Developmental Disabilities

[ix] A Summary of the 1999-2000 Executive Budget Recommendation

[x] 2000-01 Executive Budget Recommendation for the New York State Office of Mental Retardation and Developmental Disabilities

[xi] 2001-02 Fiscal Year Executive Budget Recommendations for OMRDD.

[xii] 2002-03 Fiscal Year Executive Budget Recommendations for OMRDD.

[xiii] 2003-04 Fiscal Year Executive Budget Recommendations for OMRDD.

[xiv] 2004-05 Fiscal Year Executive Budget Recommendations for OMRDD.

[xv] 2005-06 Fiscal Year Executive Budget Recommendations for OMRDD.

[xvi] According to information provided by the OIG to the Committee, Medicaid made payments of $1,827,939,932 for State developmental centers in SFY 2007. Therefore, the Committee did not have to know the number of developmental center residents this year.

[xvii] According to information provided by the OIG to the Committee, Medicaid made payments of $2,107,245,318 for State developmental centers in SFY 2007. Therefore, the Committee did not have to know the number of developmental center residents this year.

[xviii] According to information provided by the OIG to the Committee, Medicaid made payments of $2,266,625,233 for State developmental centers in SFY 2007. Therefore, the Committee did not have to know the number of developmental center residents this year.

[xix] Mary Beth Pfeiffer, *At $4,556 a Day, N.Y. Disabled Care No. 1 in Nation*, POUGHKEEPSIE JOURNAL, June 20, 2010.

[xx] OPWDD Statewide Comprehensive Plan: 2011-2015.

HOUSE OVERSIGHT & GOVERNMENT REFORM
SUBCOMITTEE ON HEALTH CARE
HEARING ON
"Medicaid and New York Development Centers"

September 20, 2012

This is the answer for the record to be inserted into the transcript for this hearing:

MR. GOSAR: Thank you Ms. Thompson. I recognize myself for five minutes for questions. Ms. Thompson, how many of CMS's 4,500 employees work in the program of integrity or financial review capacities?

INSERT – Page 6

MS. THOMPSON: The CMS Center for Medicaid and CHIP Services and CMS Regional Offices currently have 188 FTEs working on Medicaid financial review activities. Additionally, CMS has 71.6 FTEs in the Center for Program Integrity working on Medicaid program integrity; this staff performs a variety of program integrity related functions.

The New York Times

September 17, 2012

New York's Medicaid Reforms

New York State has substantially changed its Medicaid program in the past year and a half in ways likely to improve the health of its poorest residents and rein in the program's enormous costs.

Now the state is asking the federal government to let it use $10 billion in projected federal savings from its reforms to modernize hospitals and clinics serving the poor and to expand primary and preventive care. If spent wisely, that investment could turn New York into a model on how to cut Medicaid without harming the beneficiaries.

New York's Medicaid program, the nation's costliest, spends more than $54 billion a year to cover some five million people, about a quarter of the state's population. Roughly half the cost is paid by the federal government and the other half by state and local governments.

New York faces the same problem as many other states: its share of the costs of this state-federal insurance program for the poor has been rising steadily, limiting its ability to pay for other urgent needs, like education.

Last year, Gov. Andrew Cuomo, working in collaboration with health care providers and labor leaders, pushed through a budget that seems to be easing the stress. It places a cap on what the state can spend on most Medicaid programs, cuts payments to health care providers and managed care plans and sets up a mechanism to make further cuts to provider payments to stay below the cap, which, so far, has not been breached.

The cap started at $15.3 billion last year and is allowed to rise by only 4 percent a year, bringing it to $15.9 billion for the current 2012-13 budget year. The state's total budget for Medicaid, including noncapped programs, is $20.8 billion for the current year.

The reforms do not impose higher cost-sharing on beneficiaries or make significant cuts in benefits except in a few programs, like home care visits for housekeeping services or unlimited rehabilitative services.

Most important for the long term, the budget accelerates movement from unc for-service care to managed care, from high-priced specialists to primary care

from high-cost institutions to care in the community through grants, technical support and financing for health information technology. Most providers have agreed to accept lower payments in return for having a say in the reforms, rather than having them dictated by Albany. The state estimates its reforms should save the federal government $17 billion over the next five years.

The Centers for Medicare and Medicaid Services should allow New York to plow $10 billion from money the federal government will save if New York's projections of future Medicaid savings are as plausible as they look at first glance. The agency should also look hard at New York's plans to track and measure how well its reforms work and to obtain independent evaluations from outside experts. New York could serve as a model to other states if it can show which reforms work, which don't, and what their combined effects are on statewide spending.

Editorial: State's Medicaid abuses cannot stand

Oct 11 poughkeepsiejournal.com

Astonishing. Simply astonishing.

It completely boggles the mind that the state has been able to overcharge the federal government $10 billion in Medicaid costs — and officials on both ends essentially have looked the other way for years.

But the matter finally came to light in a Poughkeepsie Journal investigation that should right the reimbursement rate and force the state to honor some long-held promises.

Good.

The Journal unearthed a scheme in which the state has been receiving an inflated Medicaid rate to provide care for those in large developmental centers, including the Wassaic campus of the Taconic Developmental Disabilities Service Offices. Documents show Medicaid officials realized the overpayments as early as 2007, but did nothing to stop them.

The state has been using the extra money to subsidize other segments of its operations.

But this appalling funding scheme also may explain why the state has long reneged on its promises to close the big development centers and move more people into community group homes or some other better setting. Clearly, the state should be making these decisions based on what's best for the patients — not on dubious practices that bilk the Medicaid system.

To his credit, Gov. Andrew Cuomo has announced that Wassaic and several other developmental centers will be closed, staggering those dates over the course of several years so the system can accommodate these profound changes.

The ongoing congressional investigation undoubtedly will lead to changes in the reimbursement rate, perhaps sooner than the state has anticipated. Darrell Issa, R-Calif., chairman of the House Oversight and Government Reform Committee, has called the overpayments "alarming." He has demanded they stop "immediately" — and further states federal officials should see if the money in question can be recovered. Who could blame him?

Medicaid, which provides health care to the poor and elderly and enables those with disabilities to get help in institutional settings or group homes, is an incredibly important program. But it has blown holes to federal, state and even county budgets for years, and it must be run responsibly to stay solvent for the generations ahead.

Cost-containment is imperative, and neither New York nor those supposedly providing federal oversight have properly done the job.