EXAMINING MEDICAID AND CHIP'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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EXAMINING MEDICAID AND CHIP'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE

WEDNESDAY, FEBRUARY 10, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Murphy, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Engel, Capps, Schakowsky, Castor, Sarbanes, Matsui, Luja AE1n, Schrader, Kennedy, Ca AE1rdenas, and Pallone (ex officio).

Staff present: Rebecca Card, Assistant Press Secretary; Paul Edattel, Chief Counsel, Health; Tim Pataki, Member Services Director; Graham Pittman, Legislative Clerk, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Santini, Policy Coordinator, Oversight and Investigations; Chris Sarley, Policy Coordinator, Environment and the Economy; Heidi Stirrup, Policy Coordinator, Health; Sophie Trainor, Policy Advisor, Health; Josh Trent, Deputy Chief Counsel, Health; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; and Andrew Souvall, Minority Director of Communications, Outreach, and Member Services.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chairman recognizes himself for an opening statement.

Today's hearing will provide an opportunity for members to discuss the Federal Medical Assistance Percentage or FMAP rate. The FMAP is the Federal statutory financing formula that is the basis for determining the federal government's financial share of most Medicaid and Children's Health Insurance Program expenditures, CHIP.

While exploring the FMAP may seem like a dense topic to some, today's hearing allows members to look under the cabinet to examine Medicaid's plumbing, how money flows throughout the system. It is important for members to understand how the FMAP works,

because it impacts how an estimated $545 billion in program expenditures will be spent this year.

Federal law specifies the formula for calculating Federal Medical Assistance Percentages and requires the Secretary of Health and Human Services to calculate and publish FMAP rates each year. The statutory formula compares the individual state's per capita income to the Nation's per capita income in order to determine the portion of Medicaid expenditures the federal government will finance in each state. The lower a state's per capita income, the greater the assistance the state receives from the federal government, so, the higher the state's FMAP.

Federal statute specifies that the basic Medicaid matching rate for states will go no lower than 50 percent or higher than 83 percent. Medicaid has used the basic FMAP formula since its creation, more than 50 years ago.

Since the creation of the Medicaid program, Congress has, over time, created several different levels of federal financial participation or federal matching for different services, benefits, and populations. These higher levels of federal matching are exceptions to the general FMAP.

For example, since the 1970s, the federal government has paid 100 percent for services furnished through Indian Health Services and tribal facilities and 90 percent for family planning services and supplies. These exceptions are higher than any state's regular FMAP and apply uniformly to all states. Today we will be discussing numerous other exceptions to the regular FMAP.

In recent years, Congress has twice increased FMAPs across the board to provide temporary fiscal relief to states during recessions. Most recently, Congress added a new level of increased federal matching through the Affordable Care Act's expansion of the Medicaid program to non-disabled childless adults. For new expansion states, the Affordable Care Act included a matching rate of 100 percent for the expansion population through this calendar year, after which federal matching levels decline over time to reach 90 percent by 2020 and remain at that rate, at least under current law.

I should also point out that the FMAP also serves as the basis for determining the federal government's share of expenditures for the Children's Health Insurance Program, CHIP. Section 2105(b) of the Social Security Act stipulates an Enhanced FMAP rate for both services and administration under CHIP. The E–FMAP rate reduces the state's share under the regular FMAP rate by 30 percent. Additionally, the Affordable Care Act increased the E–FMAP by 23 percentage points, not to exceed 100 percent, for fiscal years 2016 through 2019. As a result, the federal government is now financing 100 percent of the CHIP programs in 12 states.

Overall, I think today's hearing presents members with an important opportunity to better understand the FMAP rate that is hardwired into the heart of the program. I also hope members will grapple with the challenges created by the current FMAP formula, including the ways that the current patchwork of federal matching arrangements impacts the integrity of the federal and state cost-sharing relationship.

Today, we have one panel of knowledgeable experts from CRS, MACPAC, GAO, and HHS OIG who will present their ideas and recommendations on these issues and answer members' questions. I appreciate each of the witnesses being here today.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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Today we have one panel of knowledgeable experts from CRS, MACPAC, GAO, and HHS OIG who will present their ideas and recommendations on these issues and answer Members' questions.

I appreciate each of the witnesses being here today and will now yield to the Vice Chairman of the full committee, Mrs. Blackburn.

Mr. PITTS. And I yield back the balance of my time. I now recognize Mr. Schrader of Oregon for an opening statement.

Mr. SCHRADER. Thank you, Mr. Chairman. I will probably reserve most of my comments for the question period but I wanted to yield some time to Mr. Luja AE1n.

Mr. LUJA AE1N. Mr. Chairman, thank you so very much and to our ranking member, I really appreciate the time today.

I care deeply about these programs. As we see the impact to people all across America, this landmark program makes a difference in the lives of the poor, our seniors, people with disabilities, and truly provides them the peace of mind that they can access affordable care without fear of financial ruin. We have to be mindful of that.

One in three children in our country receive coverage through Medicaid and the Affordable Care Act's expansion of this program is strengthening coverage throughout the United States. In my home State of New Mexico, more than 250,000 people have benefitted from the ACA's Medicaid expansion.

In New Mexico, we have also recently seen what happens to people when they can't receive the care that they need. More than 2 years ago, New Mexico's Behavioral Health System was needlessly upended by the state when they suspended Medicaid payments to 15 providers. This resulted in disruptions and gaps in patients' care.

On Monday, just a few days ago or just 2 days ago, ten additional providers were cleared of fraud. In total, 13 have now been exonerated. This manufactured crisis which has impacted some of New Mexico's most vulnerable never should have occurred and left our Behavioral Health System in shambles.

It takes decades to build a strong system of care in New Mexico's largely rural underserved areas. Where sole providers become vital to the fabric of our community, those relationships and developing that trust with patients is critical and we have to rebuild that system now.

To achieve that goal, I am finalizing a bill that would encourage states like New Mexico to make the necessary investments in their Behavioral Health Systems when Congress ask states to update and modernize their infrastructure for enrollment. We provided states with an Enhanced FMAP to do just that. If we want states to invest in behavioral health, we should provide an enhanced federal matching rate to prioritize these investments. The United States has never supported mental health in this way. Especially with the expansion of Medicaid across the country, we must ensure that states continue to improve their capacity to provide mental health services.

I look forward to the testimony and discussing how we can use FMAP to strengthen our Behavioral Health System.

And with that, Mr. Chairman, I would yield back the balance of my time to Mr. Schrader.

Mr. SCHRADER. Thank you very much. Anyone else on the Democratic side? Ms. Matsui.

Ms. MATSUI. Thank you very much for yielding and I thank the witnesses for being here today and the chairman for having this hearing.

For the past 50 years, the Medicaid program has successfully improved the ability of lower income Americans to access essential health services. Today, more than 72 million Americans depend on Medicaid and CHIP for their health insurance. The vast majority of these enrollees are children, the disabled, or the elderly.

In addition to improving healthcare access, Medicaid is notable for its program efficiency. Medicaid provides more comprehensive benefits than private insurance and provides those benefits at lower out-of-pocket costs. In addition, Medicaid per beneficiary costs are lower than per beneficiary costs for Medicare and private insurance and those costs are growing far more slowly than either Medicare or private insurance.

The Medicaid program continues to improve its efficiency and its demonstration projects allow the states the flexibility to test new models of delivery that improve program value. Instead of talking about ways to reduce Medicaid, we should be talking about ways to strengthen Medicaid, to expand coverage, to improve quality of care and, in turn, improve health outcomes for millions of Americans. Thank you and I yield back to Dr. Schrader.

Mr. SCHRADER. Anyone else on the Democratic side? Mr. Pallone.

Mr. PITTS. You will get your full time.

Mr. SCHRADER. Mr. Pallone, I will give Mr. Sarbanes an opportunity then you will get your full time.

Mr. PALLONE. Oh, sure.

Mr. SCHRADER. Mr. Sarbanes.

Mr. SARBANES. I will be very quick. I am looking forward to the testimony.

I had the opportunity for about 18 years as an attorney to work with retirement communities, nursing homes, assisted living facilities in the State of Maryland and saw how critical the resource of Medicaid is for our seniors. And so keeping this program strong and also exploring opportunities to innovate with it and figure out how the program can support seniors in a number of different settings, as we move forward and the opportunity to do that in a way that can also save some of the costs and be efficient I think is something we want to explore.

So, it is a really important program and this particular formula for funding has worked overall very well. So, we look forward to your testimony so we can understand that more and think about the potential for future development of the program.

I yield back.

Mr. SCHRADER. I yield back our time, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I now recognize the vice chair of the full committee, Mrs. Blackburn, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I want to welcome you all and thank you for being here.

This is an issue that we continue to look at and review and it is appropriate that we do. When I am at home and in my district, one of the things I hear about most often are the efficiencies and the inefficiencies of working through the Medicaid delivery system which, in our state is TennCare. You all probably know it and know the stories of TennCare well.

What we need to do as we continue to review these funding formularies and the mechanisms, transparency is important, continued oversight is important, integrity in the program is something that is important. I think another thing that is a topic for discussion as we look at the formulary and what the basis ought to be is saying is it time to give Medicaid back to the states for the states to administer this program. That is another way to look at it. And we will be interested to hear your thoughts on that.

Many of our governors and many of our state elected officials would like to see us do that. They think they could be more efficient and Ms. Matsui mentioned the opportunity for some to innovate in their states. And yes, indeed, looking at new flexibilities that allow innovation is something that maybe we need to have greater discussion about that.

So, welcome to all of you and thank you. And Mr. Chairman, I will yield to Mr. Shimkus, it looks like, is seeking time. Yield to Mr. Shimkus.

Mr. SHIMKUS. Thank you. I appreciate my colleague from Tennessee.

I am just going to throw something on the table. I have got questions later on. But Mr. Chairman, I was visited by a delegation of businessmen from Puerto Rico last night and they have—and I just want to raise this because I think for the average member this financial crisis, we are now starting to at least know a little bit about it. But since we are on Medicaid, I was told that they have a $300 million cap on spending. They are not in the Medicaid system. They don't have FMAP. And there is an impending cliff coming in April of 2017 that I think is worthy of our attention and maybe a hearing and a discussion because if what I was told was true, it is an impending additional disaster for that part of our country that really doesn't have a voting member of the House of Representatives.

So with that, I will throw that out and I will yield back to my colleague.

Mrs. BLACKBURN. I thank the gentleman. Anyone else seeking time before I yield it back to the chairman?

Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentlelady and I recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman and thanks for holding the hearing for the witnesses being here today.

I believe the government exists to help all Americans succeed and improving and strengthening Medicaid for generations to come

continues to be a primary goal of mine. Medicaid is not a welfare program. It is a health insurance program that more Americans depend on than any other single federal health program. In fact, Medicaid provides more than one in three children with a chance at a healthy start in life and one in seven Medicare seniors are actually also Medicaid seniors. The truth is, the overwhelming majority of the more 71 million Medicaid beneficiaries are children, the elderly, the disabled, and pregnant women, all our most vulnerable populations.

Medicaid was designed at the federal level to expand and contract according to a state's need and that is a tenant we must protect and improve, not reverse. And despite the incredibly complex nature of its shared federal and state financing, Medicaid is an efficient program, its cost per beneficiary is substantially lower than private insurance and Medicare and in recent years, these costs have grown far more slowly.

The facts also show that Medicaid has a lower improper payment rate than many of our federal health programs, all of which cover less people.

Every single state Medicaid program has undertaken projects testing new models of care delivery that promote quality and value in the Medicaid program. In fact, the Medicaid program is often called the innovation incubator.

So, as you know more about Medicaid's financing structure or FMAP today, let's think how to build on these efforts. That is the right way to promote a value-based Medicaid program for the future. FMAP may not be perfect but merely looking at baselines, growth factors, and state contributions ignores the most critical issue, which is providing care in the most efficient way possible to some of our most complicated populations, the tens of millions of low-income vulnerable beneficiaries that rely on Medicaid and the healthcare providers and plans that serve them.

I yield back, unless someone else—I think our other members have all had an opportunity, Mr. Chairman, so I yield back.

Mr. PITTS. The chair thanks the gentleman.

That concludes the opening statements. As always, all members' written opening statements will be made a part of the record.

We have one panel with us today, four witnesses. Let me introduce them in the order of their testimony.

First of all, Allison Mitchell, Analyst in Health Care Financing, Congressional Research Service. Thank you for coming. Secondly, Dr. Anne Schwartz, Executive Director, Medicaid and CHIP Payment and Access Commission, MACPAC. Thank you for coming. Carolyn Yocom, Director of Health Care, Government Accountability Office, GAO. Thank you for coming. And John Hagg, is it? Hagg, Director of the Medicaid Audits, Office of Inspector General, U.S. Department of Health and Human Services.

Thank you all for coming. You will each be given 5 minutes to summarize your testimony. Your written testimony will be made a part of the record.

So, at this point, the chair recognizes Ms. Mitchell, for 5 minutes for her summary.

STATEMENTS OF ALISON MITCHELL, ANALYST IN HEALTH CARE FINANCING, CONGRESSIONAL RESEARCH SERVICE; ANNE SCHWARTZ, PH.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION; CAROLYN YOCOM, DIRECTOR OF HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND JOHN HAGG, DIRECTOR OF THE MEDICAID AUDITS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF ALISON MITCHELL

Ms. MITCHELL. Chairman Pitts, members of the subcommittee, thank you for the opportunity to appear before you today to provide an overview of the Federal Medical Assistant Percentage, or the FMAP, and the exceptions to the FMAP.

Medicaid is financed by both the federal government and the states and the federal share of Medicaid expenditures is determined by the FMAP. The FMAP varies by state and it has a minimum of 50 percent and a statutory maximum of 83 percent. And for a state with a 60 percent FMAP, the state gets 60 cents back from the federal government for every dollar it spends on its Medicaid program.

The FMAP is also used to determine the federal share of other federal programs, such as the Temporary Assistance for Needy Families contingency funds and the FMAP is also used to calculate the Enhanced FMAP or E–FMAP, which determines the federal share for the state Children Health Insurance Program or CHIP.

The FMAPs are calculated annually and they vary according to each state's per capita income. So, states with high per capita income receive lower FMAP or matching rates and states with low per capita income receive higher matching rates.

Currently, in fiscal year 2016, regular FMAP rates range from 50 percent in 13 states to 74 percent in Mississippi. And the E–FMAP used by CHIP is higher than the regular FMAP and it is determined by reducing the state share under the FMAP by 30 percent. And for fiscal year 2016 through 2019, there is a 23 percentage point increase in the E–FMAP. That means the current statutory range for the E–FMAP is 88 percent to 100 percent and in fiscal year 2016, 12 states are receiving that 100 percent E–FMAP.

The per capita income amounts used in the FMAP formula are equal to the average of the three most recent calendar years of data from the Department of Commerce. This helps to moderate the fluctuations in states' FMAP rates over time. Also, the per capita income amounts used to calculate the FMAP rates are several years old by the time the FMAP goes into effect.

The FMAP is impacted by each state's income and population relative to the national average. The impact of the national economic downturn or upturn on a particular state will be related to that structure of that state's economy.

The FMAP changes from year to year for most states and these changes are often within one percentage point. However, even these small changes can have major budgetary implications.

The exceptions to the regular FMAP have been made for certain states' situations, populations, providers, and services. There are currently more than 20 exceptions to the FMAP. Some of these are

quite old and some of them are newer. For instance, since the beginning of the Medicaid program, most administrative services have been matched at a 50 percent for all states and starting in the 1970s, services provided to Medicaid enrollees at Indian Health Service facilities have been reimbursed at 100 percent.

Also, the District of Columbia's FMAP rate is not determined according to the statutory formula. It is set in statute at 70 percent and that has been the case since 1998. And the Patient Protection and Affordable Care Act added a couple of new FMAP exceptions. The main one there is the FMAP for the matching rate for the newly eligible individuals under the ACA Medicaid expansion. For these individuals, states receive 100 percent matching for 2014 through 2016 and that phases down to 90 percent in 2020 and subsequent years.

The federal share of Medicaid expenditures used to be about 57 percent on average across all states in a typical year. However, with the exceptions to the FMAP added by the ACA, this has increased and in 2014, fiscal year 2014, the federal government paid about 60 percent of Medicaid expenditures on average across all the states.

This concludes my statement and I would be happy to answer questions at the appropriate time.

[The prepared statement of Alison Mitchell follows:]

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TESTIMONY

Statement of

Alison Mitchell
Analyst in Health Care Financing

Before

Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives

Hearing on

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

February 10, 2016

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CRS TESTIMONY
Prepared for Congress

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, my name is Alison Mitchell. I am an Analyst in Health Care Financing with the Congressional Research Service. Thank you for the opportunity to appear before you today to provide an overview of the federal medical assistance percentage (FMAP) and some exceptions to the FMAP.

Federal Medical Assistance Percentage

Medicaid is jointly financed by the federal government and the states. The federal government's share of most Medicaid expenditures is determined by the FMAP. The remainder is the state share.[1]

FMAP rates vary by state and have a statutory minimum of 50% and a statutory maximum of 83%. For a state with an FMAP of 60%, the state gets 60 cents back from the federal government for every dollar the state spends on its Medicaid program.

The FMAP is also used to determine the federal share of other programs, such as Temporary Assistance for Needy Families contingency funds and Foster Care Title IV-E Maintenance payments. The FMAP is used to calculate the enhanced FMAP (E-FMAP), which determines the federal share of the State Children's Health Insurance Program (CHIP) expenditures (subject to the availability of funds from a state's federal allotment for CHIP).

How FMAP Rates Are Calculated

The FMAP rates are calculated annually by the Department of Health and Human Services and vary according to each state's per capita income. The FMAP formula compares each state's per capita income with the average per capita income across all states. The formula provides higher rates to states with lower incomes and lower rates to states with higher incomes. For FY2016, regular FMAP rates range from 50% in 13 states to 74% in Mississippi.

The E-FMAP used for CHIP is higher than the FMAP, and it is calculated by reducing the state share under the regular FMAP by 30%. For FY2016 through FY2019, the E-FMAP for most CHIP expenditures is increased by 23 percentage points (not to exceed 100%). With this provision, the statutory range for the E-FMAP is 88% to 100%. In FY2016, 12 states have an E-FMAP of 100%.

Data Used to Calculate State FMAP Rates

The per capita income amounts used in the FMAP formula are equal to the average of the three most recent calendar years of data available from the Department of Commerce. The use of the three-year average helps to moderate fluctuations in states' FMAP rate over time. The per capita income amounts used to calculate FMAP rates for a given fiscal year are several years old by the time the FMAP rates take effect. For example, the FY2016 FMAP calculations are based on state per capita income data for 2011, 2012, and 2013.

Factors that Affect FMAP Rates

The FMAP is impacted by each state's income and population relative to the national average. The impact of a national economic downturn or upturn on a particular state will be related to the structure of the state economy and its business sectors. For example, a national decline in automobile sales, while having an

[1] For more information about the FMAP, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

impact on all state economies, will have a larger impact in states that manufacture automobiles as production is reduced and workers are laid off.

The FMAP changes from year to year for most states. Usually, this change is less than one percentage point. However, even these small changes to the FMAP can have major budgetary implications.

FMAP Exceptions

The federal government's share of most Medicaid expenditures is determined by the FMAP, but exceptions to the regular FMAP rate have been made under Medicaid for certain states, situations, populations, providers, and services. There are currently more than 20 exceptions to the regular FMAP. Some of these exceptions have been around for a while, and some exceptions have been added more recently.

Since the beginning of the Medicaid program, most administrative expenditures have been reimbursed at 50% for all states. Beginning in the 1970s, services provided to Medicaid enrollees at Indian Health Service facilities have been reimbursed at 100%.

The District of Columbia's FMAP rate has not been calculated according to the regular FMAP formula since 1998. Instead, the FMAP rate for the District of Columbia has been set in statute at 70% since that time for the purposes of Title XIX and XXI of the Social Security Act. However, for other purposes, the percentage for the District of Columbia is 50%, unless otherwise specified by law.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended) added a couple of new FMAP exceptions, including enhanced matching rates for states that have implemented the ACA Medicaid expansion. For individuals newly eligible for Medicaid due to the expansion, states receive 100% federal match for 2014 through 2016. This matching rate phases down to 90% for 2020 and subsequent years.

The federal share of Medicaid expenditures used to be about 57% on average in a typical year, which meant the state share was about 43% on average. However, with the exceptions to the FMAP added by the ACA, the federal share of Medicaid expenditures has increased. In FY2014, the federal share of Medicaid expenditures was 60% on average. It is expected to remain around 60% through at least FY2023.

This concludes my statement. I would be happy to answer any questions you may have at the appropriate time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes Dr. Schwartz, for 5 minutes for your summary.

STATEMENT OF ANNE SCHWARTZ

Ms. SCHWARTZ. Good morning, Chairman Pitts and the members of the subcommittee on Health. As MACPAC's Executive Director, my testimony today reflects the consensus views of the commission itself anchored in a body of analytic work over the past 5 years and we appreciate the opportunity to share MACPAC's views this morning.

At the request of the leadership of this subcommittee and your colleagues in the Senate, MACPAC is engaged in a long-term work plan focused on advising Congress about policies and financing reforms to ensure Medicaid sustainability. To date, we have focused on documenting trends in Medicaid expenditures, looking at the drivers of this spending and considering the incentives created by the current system of financing.

As others have already described, state Medicaid programs received federal fund to match the funds they spend on health services to Medicaid beneficiaries and its financing arrangement goes back to the program's very beginnings 50 years ago.

Today, the federal share is determined by the FMAP with higher matching rates to states that have lower per capita incomes relative to the national average and vice-versa with exceptions for certain populations, providers, and services. Spending for administration is general matched at 50 percent. CHIP has its own match rates, known as the Enhanced FMAP, which is substantially higher than those under Medicaid, in some cases at 100 percent.

At various points in the program's history, congressional regulatory action have increased the FMAP for specific activities. For example, to help execute certain program functions, such as implementation of modernized eligibility and enrollment systems to create stronger incentives for states to provide optional benefits and to encourage states to expand eligibility to optional groups, such as women diagnosed with breast and cervical cancer.

Enhanced match has also been used to provide fiscal relief to states during economic downturns or when affected by disasters. In addition, increasing the federal match can allow Congress to make policy changes without imposing additional costs on states, for example, as was the case with the required increase in payments to primary care physicians in 2013 and 2014.

As others on the panel will note, this system of financing has been criticized for providing open-ended amounts of federal funds and for not incentivizing states to be efficient. Moreover, it can encourage states to broaden Medicaid to include other health activities, where possible, in order to draw down federal funds.

On the other hand, these incentives, while strong, are not absolute. States may not claim federal share unless they spend state dollars, raised from legal sources, on activities that are legally matchable. Mindful of their own budget constraints, as well as other political and economic factors that shape their health care markets and the design of their Medicaid programs, states respond differently at different times and in different circumstances.

So, let me provide a few examples. States do make informed choices about the design of their programs and thus, they don't always take up the opportunity to draw enhanced match. Section 2703 of the ACA provided authority for states to create health homes integrating care for people with chronic conditions and mental health conditions and it provided a 90 percent federal match for 2 years and fewer than half of the states have done so, with only 20 states and the District of Columbia adopting the model as of December 2015.

Second, because states must raise state share, they do not always take advantage of all federal dollars that are available to them.

In the case of CHIP, of the $21.1 billion in federal funds appropriated for fiscal year 2015, only $11.3 billion was provided to states in allotments based on their prior year spending.

In addition to the other criticisms under the matching formula that will be discussed by others on the panel, I would add several other concerns that MACPAC has identified. First, the differential between the federal match for services and administration exerts downward pressure on states' willingness to invest in activities such as measuring utilization and quality, collecting and analyzing data, and ensuring program integrity. In the 37 states where health services are matched at greater than 50 percent, states can increase the total Medicaid budget by prioritizing spending for services over administration.

The federal government does provide enhanced matching funds for some administrative activities but enhanced match is not available for others that could improve efficiency and promote value. For example, the differential between the two match rates creates a disincentive for states to focus on prevention of fraud and abuse. Such functions are matched at 50 percent, while the activities of the Medicaid Fraud Control Unit which are aimed at detecting fraud and abuse after they have occurred are matched at 75 percent.

Over the next several months, MACPAC will be focusing intensively on program financing and design questions. Our analysis will consider design questions and will also consider the impact of these approaches on states, plans, providers and beneficiaries. We look forward to sharing this work in our June report.

[The prepared statement of Anne Schwartz follows:]

MACPAC

Advising Congress on
Medicaid and CHIP Policy

Statement of
Anne L. Schwartz, PhD, Executive Director

Medicaid and CHIP
Payment and Access Commission

Before the
Subcommittee on Health
House Committee on Energy and Commerce

February 10, 2016

Summary

At the request of the leadership of this Subcommittee, the Medicaid and CHIP Payment and Access Commission (MACPAC) is engaged in a long-term work plan focused on advising Congress about potential policies and financing reforms to ensure Medicaid's sustainability. To date, we have documented trends in Medicaid expenditures, analyzed spending drivers, and considered incentives under current law. It is in this context that MACPAC is looking at the Federal Medical Assistance Percentage (FMAP).

State Medicaid programs receive federal funds to match the amount they spend on health services and performing administrative tasks. Higher reimbursement is provided to states with lower per capita incomes relative to the national average and vice versa. This formula is intended to reflect states' differing abilities to fund Medicaid from their own revenues. There is a statutory minimum of 50 percent and a maximum of 83 percent although there are several exceptions affecting certain populations, providers, and services. An enhanced FMAP (E-FMAP) is provided for both services and administration under the State Children's Health Insurance Program (CHIP), subject to the availability of funds from a state's federal allotment for CHIP. Current E-FMAPs range from 88 to 100 percent. Matching for Medicaid administrative activities does not vary by state and is generally 50 percent.

Over time, congressional and regulatory action have increased the FMAP for specific activities to implement new administrative requirements, create stronger incentives for states to provide certain benefits, and encourage states to extend eligibility for optional groups. An enhanced match has also been used to provide fiscal relief to states during economic downturns or when affected by disasters. In addition, increasing the federal match has allowed Congress to implement federal policy changes without imposing additional costs on states.

Medicaid's current system of financing has been criticized for providing open-ended amounts of federal funds to states, depending upon what states spend, and thus potentially exposing the federal government to unlimited spending. This structure does not incentivize states to be efficient. Moreover, it generally does not encourage states to be innovative or achieve improvements in quality or access. Another concern is that states have an incentive to broaden Medicaid to include other state health functions in order to draw down federal funds.

On the other hand, while these incentives are strong, they are not absolute. States may not claim federal share unless they spend state dollars, raised from legal sources, on activities that are legally matchable. Mindful of their own budget constraints, as well as other political and economic factors that shape their health care markets and the design of their Medicaid programs, states respond differently at different times and in different circumstances.

In its work on administrative capacity, MACPAC has noted that the differential between the federal match for services and administration discourages states' willingness to invest in measuring utilization and quality, collecting and analyzing data, and ensuring program integrity. In the 37 states where health services are matched at greater than 50 percent, states are rewarded by prioritizing spending on services or other activities that have enhanced matching rates over administration.

MACPAC is now focusing intensively on financing and design questions associated with alternatives such as block grants, per capita caps, and capped allotments, including issues such as baselines, growth factors, and state contributions. We look forward to sharing this work with the Subcommittee as part of our June 2016 report.

Statement of Anne L. Schwartz, PhD, Executive Director

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Vice Chair Guthrie, Ranking Member Green, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of MACPAC, the Medicaid and CHIP Payment and Access Commission. As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS) and the states on issues affecting these programs. The insights I will share this morning reflect the consensus views of the Commission itself, anchored in a body of analytic work conducted over the past five years. We appreciate the opportunity to share MACPAC's views with the Subcommittee.

At the request of the leadership of this Subcommittee and your colleagues in the Senate, MACPAC is engaged in a long-term work plan focused on advising Congress about potential policies and financing reforms to ensure the sustainability of Medicaid. Our analysis to date has focused on documenting trends in Medicaid expenditures, looking at the drivers of this spending, and considering the incentives created by the design of financing under current law. It is in this context that the Commission is now discussing the role of the Federal Medical Assistance Percentage (FMAP), the statutory formula that determines the federal share of Medicaid costs, which is fundamental to any discussion of federal and state spending.

Federal Medical Assistance Percentage

State Medicaid programs receive federal funds to match the amount of money they spend on health services to Medicaid beneficiaries (in the form of payments to health care providers and managed care plans) and to perform administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and paying claims. This shared federal-state financing arrangement goes back to the program's very beginnings 50 years ago, which built on the Social Security Amendments of 1950 and the Kerr-Mills Act, passed in 1960, both of which provided federal matching funds to states for medical assistance.

Today, the federal share for most health care services is determined by the Federal Medical Assistance Percentage (FMAP). The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average and vice versa. This formula is intended to reflect states' differing abilities to fund Medicaid from their own revenues. Although alternative measures have been suggested, the use of per capita income reflects the information available at the time the funding formula was designed.

The FMAP has a statutory minimum of 50 percent and a maximum of 83 percent (Table 1). For example, in fiscal year (FY) 2015, the federal contribution ranged from just over 73.5 percent in Mississippi to 50 percent in New York and 12 other states. There are statutorily set FMAPs for the District of Columbia and the territories. Historically, the federal share of Medicaid spending has averaged about 57 percent although that share has begun to increase due to the higher matching rate for individuals newly eligible as a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

There are several exceptions to the regular FMAP affecting certain populations, providers, and services (Tables 2 and 3). For example, the federal government pays 100 percent of state Medicaid costs for certain newly eligible non-disabled adults through 2016; after 2016, the rate begins phasing down over several years to 90 percent in 2020 and thereafter. The newly eligible include adults who would not have been eligible for Medicaid in the state as of December 1, 2009, or who were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. Some states that expanded eligibility to low-income parents and adults without children prior to the ACA can also receive a higher matching rate for childless adults.

An enhanced FMAP (E-FMAP) is provided for both services and administration under the State Children's Health Insurance Program (CHIP), subject to the availability of funds from a state's federal allotment for CHIP. Because of CHIP, eligibility expansions to children since 1997 use CHIP funds from the state's federal allotment, and the E-FMAP applies. E-FMAPs were initially set by reducing the state share under the regular FMAP by 30 percent. Those rates were increased under the ACA, such that current E-FMAPs range from 88 to 100 percent.

The federal matching rate for Medicaid administrative activities does not vary by state and is generally 50 percent, although certain administrative functions have a higher federal match. These exceptions include activities that require medically trained personnel, the operation of information systems for eligibility and claims processing, certain fraud control activities, and administration of services that themselves have higher medical assistance match rates (Table 4). In many cases, higher administrative match rates are provided only for expenditures that meet certain conditions; for example, external quality review activities conducted by an organization that meets specific requirements can be matched at 75 percent, while the same activities conducted by other types of organizations can only be matched at 50 percent.

If a state contracts with managed care plans under a risk contract, amounts paid to the managed care plan to cover administrative functions are matched as a medical assistance cost at the applicable FMAP, not as an administrative cost (42 CFR 438.812). Administrative costs related to CHIP receive federal match at the state's E-FMAP rate for health care services, and therefore this match, unlike the administrative match under Medicaid, varies by state. However, administrative costs for CHIP are limited to 10 percent of the state's annual federal CHIP spending.

Exceptions

At various points in the program's history, congressional and regulatory action have increased the FMAP for specific activities, for example, to:

- help execute certain program functions, such as implementation of modernized eligibility and enrollment systems;
- create stronger incentives for states to provide certain benefits, such as making available to adults, without cost sharing, the full list of preventive services recommended by the U.S. Preventive Services Task Force; and
- encourage states to extend eligibility for optional groups, such as women diagnosed with breast and cervical cancer and children with incomes just above existing Medicaid eligibility levels via CHIP.

An enhanced match has also been used to provide fiscal relief to states during economic downturns or when affected by disasters. In addition, increasing the federal match has allowed Congress to implement federal policy changes without imposing additional costs on states, for example, as was the case with the required increase in payments for primary care services provided by primary care physicians in 2013 and 2014.

Concerns about the FMAP

Medicaid's current system of financing has been criticized for several reasons. It provides open-ended amounts of federal funds to states, depending upon what states spend, and thus potentially exposes the federal government to unlimited spending. This structure does not incentivize states to be efficient, as the more they spend, the more federal dollars they draw down. Moreover, with a few exceptions, it does not encourage states to pursue innovations nor reward them for achieving improvements in quality or access. Another concern is that states have an incentive to broaden Medicaid to include other state health functions where possible in order to draw down federal funds.

On the other hand, while these incentives are strong, they are not absolute. States may not claim federal share unless they spend state dollars, raised from legal sources, on activities that are legally matchable. Mindful of their own budget constraints, as well as other political and economic factors that shape their health care markets and the design of their Medicaid programs, states respond differently at different times and in different circumstances.

Let me provide a few examples. First, states make informed choices about the design of their programs, and thus do not always take up the opportunity to draw enhanced match. For example, Section 2703 of the ACA provided authority for state Medicaid programs to create health homes, integrating acute and behavioral health care for persons with chronic conditions or serious mental illness. In addition to giving states significant flexibility in the design of these programs, the law also provided an enhanced 90 percent federal match for two years. Representatives from the states of Missouri and Maine both testified at a public Commission meeting as to the importance of these additional funds in allowing their states to pursue this new model of care. And yet, as of

December 2015, fewer than half of states have done so with only 20 states and the District of Columbia adopting the model.

Second, because states must raise state share, they do not always take advantage of all the federal dollars that are potentially available to them. For example, in the case of CHIP, of the $21.1 billion in federal funds appropriated for FY 2015 and thus available to states to match spending on services provided to children covered by CHIP, only $11.3 billion was provided to states in allotments based on their prior year spending.

In addition, the current FMAP has been criticized for being unresponsive to changing economic conditions, and whether it should be based on per capita income or other measures. To these, I would add several other concerns that MACPAC has identified.

In its work on the challenges states face in administering the Medicaid program, the Commission has noted that the differential between the federal match for services and administration exerts downward pressure on states' willingness to invest in activities measuring utilization and quality, collecting and analyzing data, and ensuring program integrity. As noted in the Commission's June 2014 report to Congress, in the 37 states where health services are matched at greater than 50 percent, states can increase the total budget available for Medicaid by prioritizing spending on services over administration.

The federal government does provide enhanced matching funds for some administrative activities, including operation of an approved Medicaid Management Information System and updated eligibility systems. While these activities are important to the effective administration of high-performing Medicaid programs, enhanced match is not available for other activities that states undertake to improve efficiency and promote value.

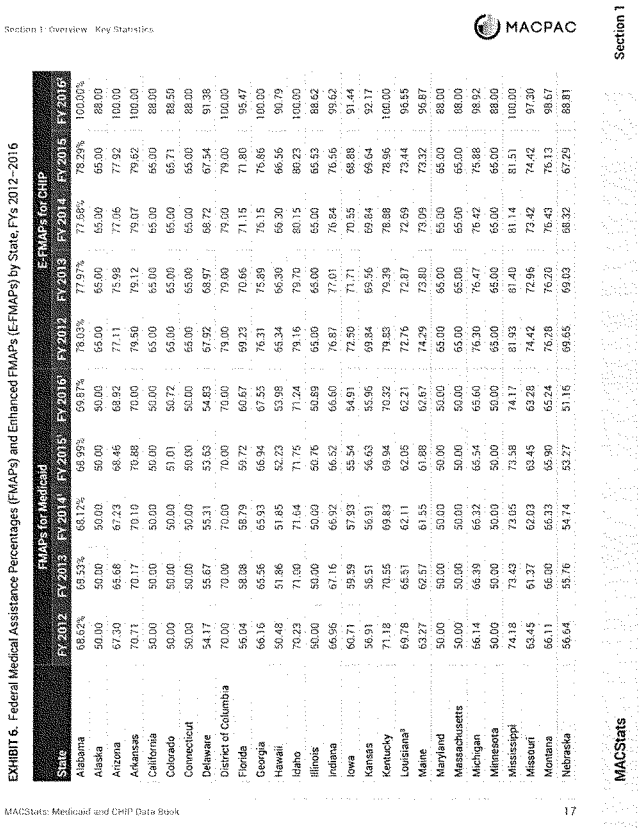
This differential between the two match rates also creates a disincentive for states to focus on prevention of fraud and abuse. Such functions are matched at 50 percent, while the activities of a state's Medicaid fraud control unit, aimed at detecting fraud and abuse after they have occurred, are matched at 75 percent.

Conclusion

Over the next several months, MACPAC will be focusing intensively on program financing and design questions associated with other financing alternatives such as block grants, per capita caps, capped allotments, and shared savings. These include issues such as baselines, growth factors, and state contributions. We look forward to sharing this work with the Subcommittee as part of the Commission's June report to Congress.

Again, thank you for this opportunity to share the Commission's work with this Subcommittee.

Table 1. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPSs (E-FMAPs) by State, FYs 2012-2016



Section 1: Overview - Key Statistics

MACPAC

Section 1

EXHIBIT 6. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, FYs 2012–2016

State	FMAPs for Medicaid						E-FMAPs for CHIP					
	FY 2012	FY 2013	FY 2014[1]	FY 2015	FY 2016[2]	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[2]
Alabama	68.62%	69.53%	68.12%	68.99%	69.87%	78.03%	77.97%	77.66%	78.29%	100.00%
Alaska	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Arizona	67.30	65.68	67.23	68.46	68.92	77.11	75.98	77.06	77.92	100.00
Arkansas	70.71	70.17	70.10	70.88	70.00	79.50	79.12	79.07	79.62	100.00
California	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Colorado	50.00	50.00	50.00	51.01	50.72	65.00	65.00	65.00	65.71	88.50
Connecticut	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Delaware	54.17	55.67	55.31	53.65	54.83	67.92	68.97	68.72	67.54	91.38
District of Columbia	70.00	70.00	70.00	70.00	70.00	79.00	79.00	79.00	79.00	100.00
Florida	56.04	58.08	58.79	59.72	60.67	69.23	70.66	71.15	71.80	95.47
Georgia	66.16	65.56	65.93	66.94	67.55	76.31	75.89	76.15	76.86	100.00
Hawaii	50.48	51.86	51.85	52.23	53.98	66.34	66.30	66.30	66.56	90.79
Idaho	70.23	71.00	71.64	71.75	71.24	79.16	79.70	80.15	80.23	100.00
Illinois	50.00	50.00	50.00	50.76	50.89	65.00	65.00	65.00	65.53	88.62
Indiana	66.96	67.16	66.92	66.52	66.60	76.87	77.01	76.84	76.56	99.62
Iowa	60.71	59.59	57.93	55.54	54.91	72.50	71.71	70.55	68.88	91.44
Kansas	56.91	56.51	56.91	56.63	55.96	69.84	69.56	69.84	69.64	92.17
Kentucky	71.18	70.55	69.83	69.94	70.32	79.83	79.39	78.88	78.96	100.00
Louisiana[3]	69.78	66.51	62.11	62.05	62.21	72.76	72.87	72.69	73.44	96.55
Maine	63.27	62.57	61.55	61.88	62.67	74.29	73.80	73.09	73.32	96.87
Maryland	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Michigan	66.14	66.39	66.32	65.54	65.60	76.30	76.47	76.42	75.88	98.92
Minnesota	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Mississippi	74.18	73.43	73.05	73.58	74.17	81.93	81.40	81.14	81.51	100.00
Missouri	63.45	61.37	62.03	63.45	63.28	74.42	72.96	73.42	74.42	97.39
Montana	66.11	66.00	66.33	65.90	65.24	76.28	76.20	76.43	76.13	98.67
Nebraska	56.64	55.76	54.74	53.27	51.16	69.65	69.03	68.32	67.29	88.81

MACStats

MACStats: Medicaid and CHIP Data Book

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EXHIBIT 6. (continued)

State	FMAPs for Medicaid						E-FMAPs for CHIP					
	FY 2012	FY 2013	FY 2014[1]	FY 2015[1]	FY 2016[1]	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[2]
Nevada	56.20%	59.74%	63.10%	64.36%	64.93%	69.34%	71.82%	74.17%	75.05%	98.45%
New Hampshire	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
New Jersey	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
New Mexico	69.36	69.07	69.20	69.65	70.37	78.55	78.35	78.44	78.76	100.00
New York	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
North Carolina	65.28	65.51	65.78	65.88	66.24	75.70	75.86	76.05	76.12	99.37
North Dakota	55.40	52.27	50.00	50.00	50.00	68.78	66.59	65.00	65.00	88.00
Ohio	64.15	63.58	63.02	62.64	62.47	74.91	74.51	74.11	73.85	96.73
Oklahoma	63.88	64.00	64.02	62.30	60.99	74.72	74.80	74.81	73.61	95.69
Oregon	62.91	62.44	63.14	64.06	64.38	74.04	73.71	74.20	74.84	98.07
Pennsylvania	55.07	54.28	53.52	51.82	52.01	68.55	68.00	67.46	66.27	89.41
Rhode Island	52.12	51.25	50.11	50.00	50.42	66.46	65.88	65.08	65.00	88.29
South Carolina	70.24	70.43	70.57	70.64	71.08	79.17	79.30	79.40	79.45	100.00
South Dakota	59.13	56.19	53.54	51.64	51.61	71.39	69.33	67.48	66.15	89.13
Tennessee	66.36	66.13	65.29	64.99	65.05	76.45	76.29	75.70	75.49	98.54
Texas	58.22	59.30	58.69	58.05	57.13	70.75	71.51	71.08	70.64	92.99
Utah	70.99	69.61	70.34	70.56	70.24	79.69	78.73	79.24	79.39	100.00
Vermont	57.58	56.04	55.11	54.01	53.90	70.31	69.23	68.58	67.81	90.73
Virginia	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Washington	50.00	50.00	50.00	50.03	50.00	65.00	65.00	65.00	65.02	88.00
West Virginia	72.62	72.04	71.09	71.35	71.42	80.83	80.43	79.76	79.95	100.00
Wisconsin	60.53	59.74	59.06	58.27	58.23	72.37	71.82	71.34	70.79	93.76
Wyoming	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
American Samoa	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Guam	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
N. Mariana Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Puerto Rico	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Virgin Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50

EXHIBIT 6. (continued)

Notes: FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. ACA is Patient Protection and Affordable Care Act (P.L. 111-148, as amended). The federal government's share of most Medicaid service costs is determined by the FMAP, with some exceptions. For Medicaid administrative costs, the federal share does not vary by state and is generally 50 percent. The E-FMAP determines the federal share of both service and administrative costs for CHIP, subject to the availability of funds from a state's federal allotments for CHIP.

FMAPs for Medicaid are generally calculated based on a formula that compares each state's per capita income relative to U.S. per capita income and provides a higher federal match for states with lower per capita incomes, subject to a statutory minimum (50 percent) and maximum (83 percent). The general formula for a given state is: FMAP = 1 − [(state per capita income)² × 0.45].

Medicaid exceptions to this formula include the District of Columbia (set in statute at 70 percent) and the territories (set in statute at 55 percent). Other Medicaid exceptions apply to certain services, providers, or situations (e.g., services provided through an Indian Health Service facility receive an FMAP of 100 percent). Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent and adding 23 percentage points (see note 2).

[1] For certain newly eligible individuals under the Medicaid expansion beginning in 2014, there is an increased FMAP (100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and subsequent years). An increased FMAP is also available for certain states that previously expanded eligibility to low-income parents and non-pregnant adults without children prior to enactment of the ACA.

[2] Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAP is increased by 23 percentage points, not to exceed 100 percent, for all states.

[3] Louisiana received a disaster-recovery state FMAP adjustment for the fourth quarter of FY 2011 and FYs 2012–2014.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for various years.

Table 2. Current Exceptions to Standard Federal Match Rates

Statutory exception	Federal match rate	Social Security Act and other citations	Notes
Territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands)	55 percent	1905(b); 1108(f), (g)	Subject to federal spending caps. Also applies for purposes of computing the CHIP E-FMAP.
District of Columbia	70 percent	1905(b)	Without this exception, would be at statutory minimum of 50 percent. Also applies for purposes of computing the CHIP E-FMAP.
Adjustment for disaster recovery	Varies	1905(aa)	As of CY 2011, a disaster recovery FMAP adjustment is available for states that have experienced a federally-declared disaster and where the FMAP has declined by a specified amount.
Adjustment for certain employer contributions	Varies	P.L. 111-3 § 614; *Federal Register* 75, no. 199 (October 15): 63480	As of FY 2006, significantly disproportionate employer pension and insurance fund contributions are excluded from calculation of Medicaid FMAPs.[1]
Newly eligible individuals enrolled in new eligibility group through 138 percent FPL	CY 2014–CY 2016 = 100 percent CY 2017 = 95 percent CY 2018 = 94 percent CY 2019= 93 percent CY 2020+ = 90 percent	1905(y)	As of CY 2014, applies to expenditures for the new eligibility group for non-elderly, non-pregnant adults with incomes at or below 133 percent FPL, who would not have been eligible for Medicaid in the state as of December 1, 2009 or were eligible under a waiver but not enrolled due to limits or caps on waiver enrollment.
Expansion state individuals enrolled in the new eligibility group through 133 percent FPL	CY 2014 = at least 75 percent CY 2015 = at least 80 percent CY 2016 = at least 85 percent CY 2017 = at least 86 percent CY 2018 = at least 90 percent CY 2019 = 93 percent CY 2020+ = 90 percent	1905(z)(2)	As of CY 2014, applies to expenditures for individuals who are enrolled in the new eligibility group for non-elderly, non-pregnant adults with incomes at or below 133 percent FPL in states that had already expanded eligibility to parents and non-pregnant childless adults at least through 100 percent FPL as of March 23, 2010 (when the ACA was enacted).
Certain women with breast or cervical cancer	Applicable state E-FMAP	1905(b)	Applies to expenditures for an optional group of certain women with breast or cervical cancer who do not qualify for Medicaid under a mandatory eligibility pathway and are otherwise uninsured.

Statutory exception	Federal match rate	Social Security Act and other citations	Notes
Individuals in the Qualifying Individuals program	100 percent	1933(d)	Applies to expenditures for Medicare Part B premiums for Medicare beneficiaries with incomes between 120 percent and 135 percent FPL and limited assets, up to a specified dollar allotment.
Indian Health Service facility services	100 percent	1905(b)	Applies to expenditures for services provided through an Indian Health Service facility.
Family planning services	90 percent	1903(a)(5)	Applies to expenditures for family planning services and supplies.
Certain preventive services and immunizations	FMAP plus 1 percentage point	1905(b)	Applies to expenditures for certain clinical preventive services and certain adult immunizations in states that cover these services, beginning in CY 2013.
Smoking cessation services for pregnant women	FMAP plus 1 percentage point	1905(b)	Applies to expenditures for smoking cessation services that are mandatory for pregnant women in states that cover certain clinical preventive services and certain adult immunizations, beginning in CY 2013.
Health homes	90 percent	1945(c)(1)	Applies to expenditures for optional health home and associated services for certain individuals with chronic conditions; available beginning in CY 2011 for the first eight quarters the health home option is in effect in the state.
Home and community-based attendant services and supports	FMAP plus 6 percentage points	1915(k)(2)	Applies to expenditures for new optional home and community-based attendant services and supports for certain individuals with incomes at or below 150 percent FPL, or a higher income level applicable to those who require an institutional level of care.

Notes: FY is fiscal year. CY is calendar year. FMAP is Federal Medical Assistance Percentage. E-FMAP is Enhanced Federal Medical Assistance Percentage. FPL is federal poverty level. ACA is Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

[1]Employer contributions to insurance and pension funds are among the components of state per capita personal income that HHS uses to calculate the FMAP. Other components of state per capita personal income include wages and salaries; dividends, interest, and rent; and government social benefits such as Social Security, Medicare, Medicaid, and state unemployment insurance.

Table 3. Expired Exceptions to Standard Federal Medical Assistance Percentages (FMAPs)

Congress created temporary exceptions for special situations, such as state fiscal relief, that have now expired. For example, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provided a temporary increase in each state's FMAP from October 2008 through December 2010, that was later extended at lower levels through June 2011. Expired exceptions are described in the table below.

Expired Statutory Exception	FMAP	Citations	Notes
Alaska	Varies	P.L. 105-33 § 4725(a); P.L. 106-554 Appendix F § 706; P.L. 109-171 § 6053(a)	From FY 1998–FY 2000 Alaska's FMAP was set in statute at 59.80%, alternative formula used to calculate Alaska's FMAP from FY 2001–FY 2005, and was held at the FY 2005 level for FY 2006–FY 2007. Also applied for purposes of computing the CHIP E-FMAP.
State fiscal relief, FY 2003–FY 2004	FMAP plus 2.95 percentage points	P.L. 108-27 § 401(a)	FMAPs for the last two quarters of FY 2003 and the first three quarters of FY 2004 were not allowed to decline and were increased by 2.95 percentage points (did not apply to certain expenditures).
State fiscal relief, FY 2009–FY 2011	FMAP plus 6.2, 3.2, or 1.2 percentage points	P.L. 111-5 § 5001, as amended by P.L. 111-226 § 201	FMAPS were increased from the first quarter of FY 2009 through the third quarter of FY 2011. FMAPs were not allowed to decline and were increased by 6.2 percentage points until the last two quarters of the period, at which point they were increased by 3.2 percentage points and then 1.2 percentage points. Certain qualifying states received an additional unemployment-related increase. Territories received 30% increases in their spending caps in lieu of a percentage point increase in the FMAP and small increase in the spending cap.
Adjustment for Hurricane Katrina	Varies	P.L. 109-171 § 6053(b); 72 *Federal Register* 3391 (January 25, 2007) and 72 *Federal Register* 44146 (August 7, 2007)	Has not technically expired but the methodology does not allow for adjusting FMAPs after FY 2008.
Other expansion state individuals	FMAP plus 2.2 percentage points	1905(z)(1)	During CY 2014 and CY 2015 expansion states that meet certain criteria could receive an FMAP increase of 2.2 percentage points for those who are not newly eligible individuals.

Expired Statutory Exception	FMAP	Citations	Notes
Primary care payment rates	100 percent	P.L. 111-148, as amended by P.L. 111-152; SSA § 1902(a)(13)(C)	During CY 2013 and CY 2014 states were required to provide Medicaid payments at or above Medicare rates for primary care services furnished by certain types of primary care providers; 100% FMAP applied to any difference between the Medicaid payment rate in effect on 7/1/2009 and the Medicare payment rates for CY 2013 and CY 2014.
State balancing incentive payments	FMAP plus 5.0 percentage points	P.L. 111-148, as amended by P.L. 111-152, § 10202	During FY 2011–FY 2015 qualifying states could receive a two to five percentage point increase in their FMAP for non-institutional long term services and supports for increasing the proportion of payments made for non-institutional long term services and supports to a specified target level.

Table 4. Federal Match Rates for Medicaid Administrative Activities

Medicaid administrative activity	Federal match rate	Social Security Act citation	Regulation (all citations are to 42 CFR)
General Medicaid administration	50 percent	1903(a)(7)	432.50, 433.15
General Medicaid eligibility determination and redetermination processes	50 percent	1903(a)(7)	435.1001
Determining presumptive eligibility for children and providing services to presumptively eligible children	50 percent	1903(a)(7)	435.1001
Costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled for eligibility purposes	50 percent	1903(a)(7)	435.1001
Activities conducted by skilled professional medical personnel (and their direct support staff), including training	75 percent	1903(a)(2)	432.50(b)(1);432.50(d); 433.15(b)(5)
Preadmission screening and resident review (PASRR) for individuals with mental illness or mental retardation who are admitted to a nursing facility	75 percent	1903(a)(2)(C), 1919(e)(7)	Part 483, subparts C and E; 433.15(b)(9)
Survey and certification of nursing facilities	75 percent	1903(a)(2)(D)	No corresponding regulation
Translation and interpretation services for children in families for whom English is not the primary language	75 percent	1903(a)(2)(E)	No corresponding regulation
Operation of an approved Medicaid management information system (MMIS) for claims and information processing	75 percent	1903(a)(3)(B)	433, subpart C; 432.50(b)(2); 433.15(b)(3), (4); 433.116; 433.117(c)
Medical and utilization review activities performed by an external quality review organization (EQRO) or quality improvement organization (QIO)	75 percent	1903(a)(3)(C)	433.15(b)(6)
Quality review of Medicaid managed care organizations performed by a EQRO	75 percent	1903(a)(3)(C)(ii)	438.358, 438.320
Operation of a state Medicaid fraud control unit (MFCU)	75 percent	1903(a)(6)(B); 1903(b)(3)	1007.19
Implementation of a state MFCU	90 percent	1903(a)(6)(A); 1903(b)(3)	1007.19
Implementation of an MMIS	90 percent	1903(a)(3)(A)(i)	433 subpart C, 432.50 (b)(3)
Administration of family planning services	90 percent	1903(a)(5)	432.50(b)(5); 433.15(b)(2)
Operation of an approved updated system for eligibility determinations	90 percent	1903(a)(3)(A)(i)	433.112(c)
Administration of incentive payment programs for the adoption of electronic health records (EHR)	90 percent	1903(t)	495 subpart D
Implementation and operation of immigration status verification systems	100 percent	1903(a)(4)	No corresponding regulation

Medicaid administrative activity	Federal match rate	Social Security Act citation	Regulation (all citations are to 42 CFR)
Incentive payments to eligible providers for the adoption of EHR	100 percent	1903(a)(3)(F)	495.320-495.322, 495.326-495.362
MMIS modifications necessary for collection and reporting on child health measures	Equivalent to state FMAP rate	1903(a)(3)(A)(iii)	

Notes: SSA is Social Security Act. CFR is Code of Federal Regulations. FMAP is Federal Medical Assistance Percentage (the standard federal Medicaid match rate).

If the SSA or CFR describes an administrative activity for which the match rate is 50 percent, it is not included in the table (even though the match rate may be specifically mentioned in statute or regulation). If the SSA or CFR describes a match rate that is no longer applicable or applies to a service or activity that is no longer applicable, it is not included in the table (e.g., 1903(a)(3)(D), which describes a 75 percent match for costs incurred between 1991 and 1993 to adopt a drug use review program).

Mr. PITTS. The chair thanks the gentlelady and now recognizes Ms. Yocom, for 5 minutes for her summary.

STATEMENT OF CAROLYN YOCOM

Ms. YOCOM. Thank you. It is a pleasure to be here today to discuss the Medicaid formula, and GAO's work surrounding this issue.

As we have talked about, the FMAP formula is based on a state's per capita income in relation to the national average. And it is over a 3-year period, which smooths out the fluctuations in the business cycle and focuses on longer-term trends. This is helpful to states in terms of their budgets and budgetary planning.

In prior work, we have noted concerns regarding how FMAP formula allocates funds across the states, including during times of recession or economic downturn. My statement today focuses on the FMAP and options for more equitably allocating Medicaid funds across states and methods of better targeting increased assistance to states during an economic downturn.

With regard to the more equitable allocation of Medicaid funds across states, per capita income is a poor proxy for states' fiscal capacity, as well as for the size and composition of a state's population in need of Medicaid. First, per capita income does not fully measure state resources. It includes some things, like wages, grants, and interest, but it does not include other resources such as corporate income.

Second, per capita income does not take into account differences across the states in the health care service needs of low-income people, nor does it include any measure of geographic difference in the cost of providing such services.

As an alternative to per capita income, GAO has identified three measures that could be used to allocate Medicaid funding more equitably. Two of these measures account for service demand and they also account for geographic cost differences. This improves equity among beneficiaries by ensuring that the level of services across states has the ability to offer a comparable level of services for each person in need. The third measure accounts for state resources and this improves taxpayer equity by ensuring that taxpayers in poorer states are not more heavily burdened than those in wealthier ones. These three measures could be combined to provide a basis for allocating Medicaid funds in a more equitable manner than what currently occurs using the FMAP.

With regard to targeting increased assistance to states during recessions and other economic downturns, Congress has acted on multiple occasions to provide states with temporary increases in the FMAP. Such assistance is important, for during economic downturns, Medicaid enrollment often increases, while available state revenues decline.

At the request of Congress, GAO was asked to consider methods of assisting states during economic downturns. We recommended that Congress consider enacting an FMAP formula that provides automatic timely and temporary FMAP assistance to states in response to an economic downturn. We developed a prototype formula that would automatically start and end assistance and it would target the amount of such assistance based on the extent to which each state is affected by a particular downturn.

Our prototype formula uses a monthly employment to population ratio and it begins when a threshold number of states experience declines in this ratio. This automatically triggers the start of the FMAP assistance. And once triggered, the assistance is calculated based on two factors. First, on increases in state unemployment. This serves as a proxy for changes in Medicaid enrollment. And then secondly for decreases in wages and salaries and this serves as a proxy for declines in available state revenue.

Ending the temporary FMAP would be based on the employment-to-population ratio but with the ability to gradually return states to their regular FMAPs.

In conclusion, our work has found that alternatives to the current FMAP could more equitably allocate funds to states and provide additional support during the economic downturns.

This concludes my prepared statement. I would be pleased to answer questions at the appropriate time.

[The prepared statement of Carolyn Yocom follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

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MEDICAID

Changes to Funding Formula Could Improve Allocation of Funds to States

Statement of Carolyn L. Yocom
Director, Health Care

GAO Highlights

Highlights of GAO-16-377T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid, a joint federal-state health care program for low income and medically needy individuals, is a significant component of federal and state budgets, with estimated outlays of $529 billion in fiscal year 2015. States and the federal government share in the financing of the Medicaid program, with the federal government matching state expenditures for Medicaid services on the basis of the FMAP formula. The FMAP is the percentage of expenditures for most Medicaid services that the federal government pays. In prior reports, GAO has examined multiple concerns regarding how the FMAP formula allocates funds among states, including during times of economic downturn, and has suggested possible improvements.

This statement highlights (1) alternative measures for allocating Medicaid funds across states, and (2) better allocating financial assistance to state Medicaid programs during economic downturns. This testimony is based on GAO reports issued between 2003 and 2015 on federal financing of the Medicaid program.

What GAO Recommends

To ensure that federal funding efficiently and effectively responds to Medicaid's countercyclical nature, GAO recommended that Congress could consider enacting an FMAP formula that targets variable state Medicaid needs and provides automatic, timely, and temporary assistance in response to national economic downturns.

View GAO-16-377T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

February 10, 2016

MEDICAID

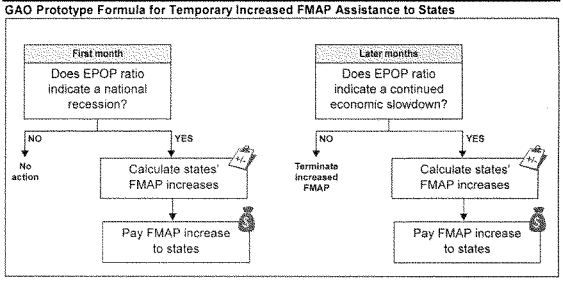
Changes to Funding Formula Could Improve Allocation of Funds to States

What GAO Found

In prior work, GAO identified alternative measures that could be used to allocate Medicaid funding to states more equitably than the current Federal Medical Assistance Percentage (FMAP) formula, which uses per capita income (PCI) to calculate each state's federal matching rate. GAO found that PCI is a poor proxy for both the size of a state's population in need of Medicaid services and the ability of a state to fund Medicaid. GAO identified data sources, such as nationally representative federal surveys, which could be used to develop measures of the demand for Medicaid services, geographic cost differences, and state resources. These measures could be combined to provide a basis for allocating funds more equitably among states than the current FMAP.

GAO has found that, during economic downturns—when Medicaid enrollment can rise and state economies weaken—the FMAP formula does not reflect current state economic conditions, and that past efforts to provide states with temporary increases in the FMAP were not as timely or responsive as they could have been. To be effective at stabilizing states' funding of Medicaid programs during such periods, assistance should be provided—or at least authorized—close to the beginning of a downturn. Additionally, to be efficient, funds should be targeted to states commensurate with their level of need due to the downturn. To help ensure that federal funding efficiently and effectively responds to states' needs during economic downturns, GAO developed a prototype formula that offers an option for providing temporary automatic, timely, and targeted assistance during a national economic downturn through an increased FMAP. The formula's automatic trigger would use readily available economic data (e.g., the monthly employment-to-population ratio or EPOP) to begin assistance. Targeted state assistance would be calculated based on (1) increases in state unemployment and (2) reductions in total wages and salaries.

GAO Prototype Formula for Temporary Increased FMAP Assistance to States



Source: GAO. | GAO-16-377T

Improving the responsiveness of federal assistance to states during economic downturns would facilitate state budget planning, provide states with greater fiscal stability, and better align federal assistance with the magnitude of the economic downturn's effects on individual states.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Medicaid program, more specifically our work examining the Federal Medical Assistance Percentage—the FMAP. The federal government and states share in the financing of the Medicaid program, with the federal government matching most state expenditures for Medicaid services on the basis of the FMAP formula.[1] The FMAP is the percentage of expenditures for most Medicaid services that the federal government pays; the remainder is referred to as the state share. Under the FMAP, the federal government pays a larger portion of Medicaid expenditures in states with low per capita incomes (PCI) relative to the national average, and a smaller portion for states with higher PCIs. PCI is used in the formula as a proxy for both state funding ability and the low-income population in need of Medicaid services in each state.[2] The FMAP formula uses a 3-year average of PCI, the effect of which is to smooth out fluctuations in state PCI so that it reflects longer-term trends rather than short-term fluctuations of the business cycle. This smoothing effect helps minimize year-to-year changes in federal matching funds, which could be disruptive to states' budget planning. However, states can struggle to

[1]The FMAP is calculated annually using the following formula: FMAP = 1.00 – 0.45 (state per capita income (PCI) / U.S. PCI)^2. PCI is calculated by the U.S. Bureau of Economic Analysis. Federal law specifies that the FMAP will be no lower than 50 percent and no higher than 83 percent. See 42 U.S.C. § 1396d(b). The Department of Health and Human Services is required to publish FMAPs for states between October 1 and November 30 of each fiscal year. 42 U.S.C. §§ 1301(a)(8)(B). For fiscal year 2016, states' FMAPs range from 50.00 percent to 74.17 percent. Under the Patient Protection and Affordable Care Act (PPACA), state Medicaid expenditures for certain Medicaid enrollees, newly eligible under PPACA, are subject to a separately calculated FMAP, which is higher than the regular FMAP—the "PPACA-expansion FMAP." Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010). States also receive an FMAP above the state's regular FMAP, but below the PPACA-expansion FMAP, for their Medicaid expenditures for the state-expansion enrollees—those who would not have been eligible for Medicaid prior to PPACA except that they were covered under a state's pre-PPACA "expansion" of eligibility through, for example, a Medicaid demonstration. The formula used to calculate the state-expansion FMAP rates is based on a state's regular FMAP rate. In this statement, we use the term FMAP to refer to the regular FMAP rate. We use the term increased FMAP to refer to temporary FMAP increases above the regular FMAP, as authorized under federal law, that provided states with additional Medicaid funding during national recessions.

[2]Squaring PCI has the effect of making PCI appear in the formula twice as an attempt to reflect both state resources and the population in need of Medicaid services.

finance their Medicaid programs during economic downturns, when program enrollment increases and available state revenues decline.

My remarks today focus on the FMAP and options for (1) more equitably allocating Medicaid funds across states, and (2) better targeting assistance to states to address increased Medicaid expenditures during economic downturns.

My remarks are based on GAO's body of work on this issue since 2003, including our July 2015 report on key issues facing the Medicaid program, our May 2013 report on alternative measures for allocating Medicaid funds across states, and our November 2011 report on financial assistance to state Medicaid programs during economic downturns.[3] Those reports provide further details on our scope and methodology. We conducted all of the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid is designed as a federal-state partnership, and both the federal government and the states play important roles in working to finance the program and meet the health care needs of the low-income and medically needy populations it serves. Medicaid is financed jointly by the federal government and states, administered at the state level, and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services. Medicaid is the

[3]See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003); *Federal Assistance: Temporary State Fiscal Relief*, GAO-04-736R (Washington, D.C.: May 7, 2004); *Medicaid: Improving Responsiveness of Federal Assistance to States during Economic Downturns*, GAO-11-395 (Washington, D.C.: March 31, 2011); *State and Local Governments: Knowledge of Past Recessions Can Inform Future Federal Fiscal Assistance*, GAO-11-401 (Washington, D.C.: March 31, 2011); *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns*, GAO-12-38 (Washington, D.C. Nov. 10, 2011); *Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably*, GAO-13-434 (Washington, D.C.: May 10, 2013); and *Medicaid: Key Issues Facing the Program*, GAO-15-677 (Washington, D.C.: July 30, 2015).

nation's largest health program as measured by enrollment and the second largest health program, after Medicare, as measured by expenditures. It is a significant component of federal and state budgets, with estimated outlays of $529 billion in fiscal year 2015, of which $320 billion was expected to be financed by the federal government and $209 billion by the states.[4] By 2023, the CMS Office of the Actuary projects that Medicaid expenditures will total $835 billion, with federal expenditures alone totaling $497.4 billion.

Compared with the FMAP Formula, Alternative Funding Measures Exist that Could More Equitably Allocate Medicaid Funds across States

In our May 2013 report, we identified alternative measures that could be used to allocate Medicaid funding to states more equitably than the current FMAP formula, which is based solely on PCI. In our July 2003 report, we found that PCI is a poor proxy for the size of a state's population in need of Medicaid services, as two states with similar PCIs can have substantially different numbers of low-income residents.[5] Moreover, we found that PCI does not take into account differences across states in the health care service needs of this population, nor does it include any measure of geographic differences in the costs of providing health care services, which can vary widely. Finally, we found that although PCI measures the income received by state residents—such as wages, rents, and interest income—it does not include other components of a state's resources that affect its ability to finance Medicaid, such as corporate income produced within the state, but not received by state residents.

To be equitable from the perspective of beneficiaries and allow states to provide a comparable level of services to each person in need, we have reported that a funding allocation mechanism should take into account the demand for services in each state and geographic cost differences among states. To be equitable from the perspective of taxpayers, we have reported that an allocation mechanism should ensure that taxpayers

[4]Centers for Medicare & Medicaid Services, Office of the Actuary, *2014 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

[5]For example, we reported in 2003 that the District of Columbia and Connecticut had similar per capita incomes, but the share of the District's population in poverty was more than twice Connecticut's. The District of Columbia is one of two states that receive special federal matching rates set in statute that give them higher matching rates than they would have received solely on the basis of PCI. See GAO-03-620.

in poorer states are not more heavily burdened than those in wealthier ones, by taking into account state resources.

We reported that revisions to the current FMAP formula could more equitably allocate Medicaid funds to states. We identified multiple data sources that could be used to develop measures of the demand for Medicaid services, geographic cost differences, and state resources.[6] We reported that these measures could be combined in various ways to provide a basis for allocating Medicaid funds more equitably among states than the current FMAP.

- **Demand for services**. A measure of the demand for Medicaid services should account for both the size of the target population in need of services and the health service needs of that population. Nationally representative federal surveys, such as the U.S. Census Bureau's American Community Survey and Current Population Survey, are available data sources that can be used to directly estimate the number of persons residing in each state with incomes low enough to qualify them as potentially in need of Medicaid services. These estimates can then be adjusted to reflect variation in health service needs within the identified population, using available information from the surveys or from data sources external to the surveys, such as Medicaid data on enrollment or spending.

- **Geographic cost differences.** A measure of geographic cost differences should account for all components of health care costs, including the cost of the personnel who provide services, the cost of medical equipment and supplies, and the rental cost of facilities in which the services are provided. Of these three components, personnel costs represent the greatest share of total costs. National data that can be used to estimate average wages for health care personnel by state include the Occupational Employment Statistics survey conducted by the Bureau of Labor Statistics.

- **State resources.** A measure of state resources should account for all income—regardless of whether the state taxes the income or not. While PCI includes the personal income of state residents, it excludes other taxable income, such as undistributed corporate profits. In contrast, the Total Taxable Resources (TTR) measure, as generated

[6]See GAO-13-434.

by the Department of the Treasury from multiple data sources, comprises not only the income included in PCI, but also other significant sources of taxable income. As a result, nationwide, the TTR measure of income was 42 percent larger on a per capita basis than PCI in 2010, and provided a more comprehensive measure of state resources.

Measures of the demand for services, geographic cost differences, and state resources could be combined in various ways to provide a basis for allocating Medicaid funds equitably among states. For example, when determining states' ability to fund Medicaid services, rather than simply considering total state resources or state resources per capita, a funding formula could reflect state resources in relation to the population in need of Medicaid services—that is, in relation to demand for services. This would result in a more equitable allocation of funding, because two states with similar resources and populations may have very different numbers of residents in need of Medicaid services.

A Revised Medicaid Financing Formula Could Better Target Assistance to States during Economic Downturns

We reported in 2011 that the FMAP formula does not reflect states' current economic conditions, and that efforts to provide states with temporary increases in the FMAP during economic downturns were not as timely or responsive to states' unique economic conditions as they could have been.[7]

During periods of national recessions, Medicaid enrollment and the state funding needed to support the program increase when the number of people with incomes low enough to qualify for Medicaid coverage rises as states' economies weaken.[8] Moreover, as the economy weakens, states

[7]See GAO-11-395.

[8]States have some flexibility in the design of their Medicaid programs within broad federal parameters. For example, under federal law, states generally must enroll certain mandatory categories of individuals, which include pregnant women and children up to 6 years of age with family income at or below 133 percent of the federal poverty level (FPL), and children ages 6 to 19 with a family income at 100 percent or less of the FPL. States may choose to cover additional categories of individuals, such as pregnant women and infants between 133 and 185 percent of the FPL. Under federal law, states generally are required to cover a specified set of benefits for their mandatory and optional Medicaid populations, such as inpatient and outpatient hospital services. In addition, states may choose to cover optional benefits, such as dental and physical therapy services, for these populations. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a).

have reduced revenues with which to fund their share of the Medicaid programs in place prior to the recession. To help states meet additional Medicaid program needs, and to provide fiscal relief, Congress established temporary FMAP increases for states in 2003, 2009, and 2010.[9] Increased FMAPs help states maintain their Medicaid programs during downturns. They may also free up funds states would otherwise have used for Medicaid and make them available to address other state budget needs. The FMAP is a readily available mechanism for providing temporary assistance to states because assistance can be distributed quickly, with states obtaining funds on a quarterly basis through Medicaid's existing payment system.

However, we have reported that each state can experience different economic circumstances—and thus different levels of change in Medicaid enrollment and state revenues during a downturn.[10] As a result, we found that efforts to provide states with temporary increases in the FMAP were not as responsive to states' unique economic conditions as they could have been.[11] We reported that states that experience greater stress in their Medicaid programs—due to increased enrollment or decreased revenues—should receive a larger share of aid than states less severely affected by the economic downturn.

To be effective at stabilizing states' funding of Medicaid programs during times of economic stress, we have found that assistance should be provided—or at least authorized—close to the beginning of a downturn.[12] Additionally, to be efficient, funds should be targeted to states

[9]Congress provided for increases in the regular FMAPs for states through the Jobs and Growth Tax Relief Reconciliation Act of 2003 and the American Recovery and Reinvestment Act of 2009 (Recovery Act). Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108-27, § 401, 117 Stat. 752, 764 (2003); Recovery Act, Pub. L. No.111-5, Div. B. Tit.V, § 5001, 123 Stat. 115, 496 (2009). The increased FMAP authorized under the Recovery Act was subsequently extended, subject to certain modifications, by the Education, Jobs, and Medicaid Assistance Act. Pub. L. No. 111-126, Tit. II, Subtit. A, § 201, 124. Stat. 2389, 2393 (2010).

[10]See GAO-11-395.

[11]See GAO-04-736R, GAO-11-395, and GAO-11-401.

[12]As we noted in GAO-11-395, starting assistance closer to the onset of an economic downturn could help states avoid Medicaid program cuts. If states can anticipate assistance, the funds do not need to be received or "in the pipeline" in order to produce the desired effect on state fiscal behavior.

commensurate with their level of need due to the downturn. Automatically providing increased federal financial assistance to states affected by national economic downturns—through an increased FMAP—could help provide timely and targeted assistance that is more responsive to states' economic conditions than what has been provided through legislation in the past. In addition, economists at the Federal Reserve Bank of Chicago have described the ideal countercyclical assistance program as one having an automatically activated, prearranged triggering mechanism that could remove some of the political considerations from the program's design and eliminate delays inherent in the legislative process.[13]

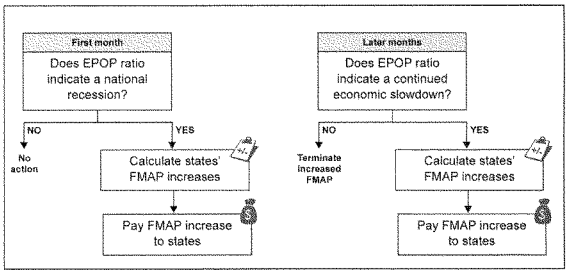
To ensure that federal funding efficiently and effectively responds to the countercyclical nature of the Medicaid program, we have recommended that Congress could consider enacting an FMAP formula that is targeted for variable state Medicaid needs and provides automatic, timely, and temporary increased FMAP assistance in response to national economic downturns.[14] In our November 2011 report, the prototype formula we presented offers such an option. (See fig. 1.) Our prototype formula uses the monthly employment-to-population (EPOP) ratio and a threshold number of states to identify the start of a national economic downturn, and to automatically trigger the start of the increased FMAP assistance.[15] The automatic trigger would use readily available economic data to begin assistance rather than rely on legislative action at the time of a future national economic downturn. Once the increased FMAP is triggered, targeted state assistance would be calculated based on (1) increases in state unemployment, as a proxy for increased Medicaid enrollment; and (2) reductions in total wages and salaries, as a proxy for decreased revenues for maintaining state Medicaid programs. The increased FMAP would end when the EPOP ratio indicated that less than the threshold number of states was in an economic downturn.

[13]Countercyclical aid, such as the Recovery Act's increased FMAP, is intended to assist states experiencing revenue declines and expenditure increases that are associated with economic downturns. R. Mattoon, V. Haleco-Meyer, and T. Foster, "Improving the impact of federal aid to the states," *Economic Perspectives*, vol. 34, no. 3 (2010).

[14]See GAO-12-38.

[15]The employment-to-population ratio is the ratio of the number of jobs in a state to the working age population aged 16 and older. Our prototype formula identifies the start of a national recession and triggers assistance when 26 states show a decrease in their 3-month average EPOP ratio, compared to the same 3-month period in the previous year, over 2 consecutive months.

Figure 1: GAO Prototype Formula for Temporary Increased FMAP Assistance to States



Source: GAO. | GAO-16-377T

Note: The employment-to-population (EPOP) ratio is the ratio of the number of jobs in a state to the working age population aged 16 and older. The Federal Medical Assistance Percentage (FMAP) is used to determine the percentage of federal assistance for most state Medicaid expenditures.

Our prototype formula improves the starting and ending of assistance, accounts for variations in state economic conditions, and responds to state Medicaid needs by providing a baseline for full funding of state Medicaid needs during a downturn. However, the level of funding and other design elements—such as the choice of thresholds for starting, ending, and targeting assistance—are variables that policymakers could adjust depending on circumstances such as competing budget demands, macroeconomic conditions, and other state fiscal needs beyond Medicaid. Improving the responsiveness of federal assistance to states during economic downturns would facilitate state budget planning, provide states with greater fiscal stability, and better align federal assistance with the magnitude of the economic downturn's effects on individual states.

In summary, our past work has found that alternatives to the current FMAP could more equitably allocate funds to states and provide additional support during economic downturns. We also have ongoing work examining Medicaid financing and other aspects of the program, and we look forward to continuing to work with the Congress to further identify improvements.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals who made key contributions to this statement include Robert Copeland, Assistant Director; Emily Beller; Robin Burke; Sandra George; and Drew Long.

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GAO Highlights

Highlights of GAO-16-377T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid, a joint federal-state health care program for low income and medically needy individuals, is a significant component of federal and state budgets, with estimated outlays of $529 billion in fiscal year 2015. States and the federal government share in the financing of the Medicaid program, with the federal government matching state expenditures for Medicaid services on the basis of the FMAP formula. The FMAP is the percentage of expenditures for most Medicaid services that the federal government pays. In prior reports, GAO has examined multiple concerns regarding how the FMAP formula allocates funds among states, including during times of economic downturn, and has suggested possible improvements.

This statement highlights (1) alternative measures for allocating Medicaid funds across states, and (2) better allocating financial assistance to state Medicaid programs during economic downturns. This testimony is based on GAO reports issued between 2003 and 2015 on federal financing of the Medicaid program.

What GAO Recommends

To ensure that federal funding efficiently and effectively responds to Medicaid's countercyclical nature, GAO recommended that Congress could consider enacting an FMAP formula that targets variable state Medicaid needs and provides automatic, timely, and temporary assistance in response to national economic downturns.

View GAO-16-377T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

February 10, 2016

MEDICAID

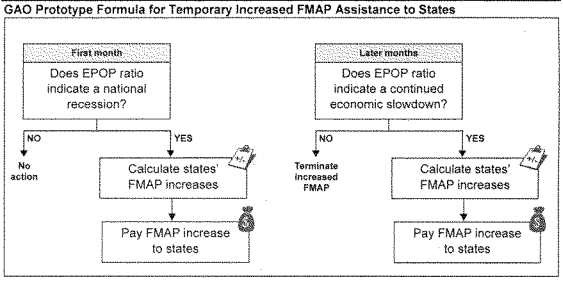
Changes to Funding Formula Could Improve Allocation of Funds to States

What GAO Found

In prior work, GAO identified alternative measures that could be used to allocate Medicaid funding to states more equitably than the current Federal Medical Assistance Percentage (FMAP) formula, which uses per capita income (PCI) to calculate each state's federal matching rate. GAO found that PCI is a poor proxy for both the size of a state's population in need of Medicaid services and the ability of a state to fund Medicaid. GAO identified data sources, such as nationally representative federal surveys, which could be used to develop measures of the demand for Medicaid services, geographic cost differences, and state resources. These measures could be combined to provide a basis for allocating funds more equitably among states than the current FMAP.

GAO has found that, during economic downturns—when Medicaid enrollment can rise and state economies weaken—the FMAP formula does not reflect current state economic conditions, and that past efforts to provide states with temporary increases in the FMAP were not as timely or responsive as they could have been. To be effective at stabilizing states' funding of Medicaid programs during such periods, assistance should be provided—or at least authorized—close to the beginning of a downturn. Additionally, to be efficient, funds should be targeted to states commensurate with their level of need due to the downturn. To help ensure that federal funding efficiently and effectively responds to states' needs during economic downturns, GAO developed a prototype formula that offers an option for providing temporary automatic, timely, and targeted assistance during a national economic downturn through an increased FMAP. The formula's automatic trigger would use readily available economic data (e.g., the monthly employment-to-population ratio or EPOP) to begin assistance. Targeted state assistance would be calculated based on (1) increases in state unemployment and (2) reductions in total wages and salaries.

GAO Prototype Formula for Temporary Increased FMAP Assistance to States



Source: GAO. | GAO-16-377T

Improving the responsiveness of federal assistance to states during economic downturns would facilitate state budget planning, provide states with greater fiscal stability, and better align federal assistance with the magnitude of the economic downturn's effects on individual states.

Mr. PITTS. The chair thanks the gentlelady and now recognizes Mr. Hagg, for 5 minutes for his opening statement.

STATEMENT OF JOHN HAGG

Mr. HAGG. Good morning, Chairman Pitts and other distinguished members of the committee. Thank you for the opportunity to testify about the Officer of Inspector General's work associated with the Federal Medical Assistance Percentage Matching Rates. My statement describes two vulnerabilities associated with the federal-state partnership that governs the financing of the Medicaid program.

First, in certain areas of enhanced matching rates, OIG has seen states claim federal reimbursement for expenditures that do not qualify. Second, in some instances, we have seen states use financing mechanisms to shift costs to the federal government. I will briefly discuss each of these issues.

Most Medicaid expenditures are eligible for federal reimbursement at their regular matching rate. The regular FMAP rate varies by state and, as said earlier today, cannot be lower than 50 percent or higher than 83 percent. There are numerous exceptions, however, that allow for the use of enhanced rates. For example, family planning services are reimbursed at a 90 percent FMAP rate. Enhanced FMAP rates provide states with additional federal funding for specified populations and services but they also create vulnerabilities that expenditures could be claimed incorrectly.

The OIG has conducted audits to determine if expenditures were included in the correct enhanced rate categories. In general, we have found instances where states incorrectly claimed expenditures in one of the enhanced rate categories, instead of properly claiming the expenditures at the lower regular FMAP rate. As an example, we have found many cases where states use the 90 percent enhanced family planning rates for services that were Medicaid eligible but did not qualify as family planning. In total, we identified more than $82 million that states received inappropriately.

In addition to vulnerabilities that exist with enhanced FMAP categories, the shared nature of Medicaid financing provides opportunities for states to shift cost and distort the federal-state cost-sharing partnership. While mechanisms such as provider taxes, intergovernmental transfers, and inflated payment rates increase state funds, they distort statutorily determined FMAP rates and undermine the federal-state partnership in financing the Medicaid program.

In the 2014 review of health care provider taxes, we found that a gross receipts tax on Medicaid managed care organizations in one state appeared to be an impermissible health care related tax under federal requirements. Using this tax, the state obtained nearly $1 billion in federal Medicaid funds from 2009 to 2012. CMS issued guidance to states in July 2014 to clarify its policy. We are currently performing work to determine if states are in compliance with this guidance.

State policies that inflate federal costs for Medicaid are not new. In a series of reports from 2000 to 2005, we found numerous examples in which states used intergovernmental transfers to increase the amount of Medicaid expenditures the federal government would

pay. In some cases, states transferred the additional federal money to their general treasury to be used for other purposes. Both Congress and CMS took action to close this loophole. While the changes dramatically improved the situation, they did not entirely eliminate the problem. Collectively, the findings of our work over a number of years suggest that improvements are still needed to safeguard federal Medicaid funds, including a definitive regulation linking payments for public providers to the actual cost of providing a service.

In conclusion, the federal and state governments share responsibility for operating the Medicaid program and for the integrity of the dollars invested. Given projected growth in Medicaid, it is critical that CMS and states focus on strengthening program integrity. OIG is committed to providing effective oversights to help ensure that inappropriate payments are detected and that eligible beneficiaries receive the needed and appropriate health care services.

I would be happy to answer your questions.

[The prepared statement of John Hagg follows:]

Testimony Before the United States House of Representatives
Committee on Energy and Commerce:
Subcommittee on Health

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

Testimony of:

John Hagg
Director of Medicaid Audits
Office of Audit Services
Office of Inspector General
Department of Health and Human Services

February 10, 2016
10am
Location: Rayburn House Office Building, Room 2123

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

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

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

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

The Medicaid Federal-State Partnership

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

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

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

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

Ensuring the Accuracy of Enhanced State Matching Rates

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

Expenditures Charged to Incorrect FMAP Categories—Family Planning Services

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

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

Expenditures Charged to Incorrect FMAP Categories—Indian Health Service

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

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

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

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

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

Incorrect FMAP for Federal Share Adjustments

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

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

Ongoing and Planned OIG Reviews—ACA Enhanced FMAP Areas

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

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

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

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

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

State Policies That Result in Inflated Federal Costs

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

Health-Care Provider Taxes

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

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

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

Intergovernmental Transfers and Upper Payment Limits

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

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

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

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

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

Inflated Payment Rates

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

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

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

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

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

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

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

Conclusion

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

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

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

Mr. PITTS. The chair thanks the gentleman. That concludes the opening statements of the witnesses. I will begin the questioning and recognize myself for 5 minutes for that purpose.

Ms. Yocom, GAO has offered alternatives for allocating federal Medicaid funding in a more equitable way. Can you explain how GAO considers equity when thinking about the Medicaid funding formula? And can you explain how or why some states are advantaged and others are disadvantaged by the current FMAP formula?

Ms. YOCOM. Yes, we look at equity from two perspectives. The first is that of the beneficiary and making sure that the state has the capacity to provide the same level of service as across all the states. It doesn't mean that the state chooses to but it does mean that that capacity is there.

And then secondly, we look from the perspective of the taxpayer and so that you make sure that a wealthier state is not paying more or less than a poorer state, that it is in relation to what is available for the state to fund the program.

With regard to advantages and disadvantages of the formula itself, yes, right now the floor, as I believe Dr. Schwartz mentioned, the 50 percent floor of the FMAP does mean that some states are propped up with more assistance than other states. To date, no state has reached the top of the matching rate. There also is some research out there that shows that the matching formula is showing more and more compression to that 50 percent level.

So, it is a mixed bag for the states.

Mr. PITTS. Thank you.

Dr. Schwartz, almost a year ago, I, along with Chairman Upton and Chairman Hatch asked MACPAC to engage in developing policy options to ensure the sustainability of the Medicaid program. However, it was not until MACPAC's most recent meeting a few weeks ago that staff even briefed the commissions on old Medicaid ideas from the 1980s and 1990s. And with all due respect, why has this taken so long? What could be more important than developing solutions to strengthen Medicaid and CHIP?

Ms. SCHWARTZ. Thank for that question.

We began our discussion of financing alternatives actually beginning in February of last year with this session to discuss a range of alternatives. And in that particular session, we spoke a lot about shared savings. Subsequent to that, we spent time at every commission meeting since then: May, September, October, December, and again, as you say in January, focusing on spending trends, helping understand the context, understanding the policy levers that are available to state and federal governments, to address concerns about spending, and to understand the drivers of that spending.

So, I have a long list of activities that we have undertaken, some issue briefs that we have published, the work that is leading up for our publication in our report to Congress in June and I would be happy to share that with you and brief your staff in detail about those activities.

Mr. PITTS. All right, thank you.

Mr. Hagg, your testimony noted that multiple Inspector General audits found repeated state errors in claiming the 90 percent Enhanced Family Planning Match and, as a result, OIG recommended

that 19 states return more than $82 million to taxpayers. Was this money ever returned?

Mr. HAGG. I believe it has been. Our reports are issued to the states. We make recommendations to the states. And if we found overpayments, we would recommend they pay that money back. CMS, as the action official, would work with the states to get that money back, assuming CMS concurs with our recommendations. And I think in most cases, they have.

Mr. PITTS. Do you know why CMS didn't catch states' errors in claiming federal financial participation before the claims were paid?

Mr. HAGG. Not definitively. CMS has different controls in place. They could probably more fully answer that question as to why they wouldn't catch errors. Based on what I know, they have staff located throughout the country who receive expenditures from the state on a quarterly basis. They are the front line for trying to review and identify any problems that might be out there. But of course, it is billions of dollars and they have a short amount of time to——

Mr. PITTS. Yes, maybe part of the problem could be a lack of specific federal statutory and regulatory definition of what family planning services are.

Ms. Mitchell, the Speaker, the President, and members of the House have noted the financial crisis in Puerto Rico. Mr. Shimkus earlier mentioned Medicaid in Puerto Rico. Can you briefly discuss how Puerto Rico's program compares or is different than an average state's Medicaid program?

Ms. MITCHELL. Sure. So, Puerto Rico and all five territories, the Medicaid program is financed a bit differently. Rather than the open-ended funding that states receive, the territories get caps on the funds. So, they have an annual cap. The ACA provided some additional funding that is available to the territories, and I believe that was the fiscal cliff that was referred to earlier is due to that funding. It was about $6.5 billion and the territories have through 2019 to spend that money but it looks like Puerto Rico is going to spend through that faster than that. And their matching rate for the territories is set at 55 percent. It does not go through the statutory formula for the FMAP.

Mr. PITTS. Thank you. My time has expired.

The chair recognizes Mr. Schrader for 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. I appreciate that.

Ms. Mitchell, would you say that the rates for Medicaid reimbursement are primarily cost-based?

Ms. MITCHELL. Sorry, could you say that?

Mr. SCHRADER. The rates that are set for Medicaid reimbursement are primarily cost-based?

Ms. MITCHELL. The provider rates?

Mr. SCHRADER. Yes.

Ms. MITCHELL. Well, states set their own provider rates. They have a lot of discretion in setting their provider rates.

Mr. SCHRADER. I apologize. No, I am talking about when you reimburse a state, it is based on the costs that are submitted by the state. Is that correct?

Ms. MITCHELL. Oh, yes. I am sorry. Yes, so there is a quarterly process where states, for every quarter, submit estimates on how much they are going to spend and they are provided an amount of money to draw down throughout the quarter.

Mr. SCHRADER. Right.

Ms. MITCHELL. And at the end of the quarter, they have to submit documentation for the actual expenditures.

Mr. SCHRADER. I get that.

Ms. Schwartz, do you think that is a good way to reimburse, just based on cost rather than quality or what they are actually getting for the type of service that you are paying for?

Ms. SCHWARTZ. I guess as I noted in my testimony, that the FMAP, with the exception of the exceptions, is neutral on the type of spending. And you could certainly move to a system in which you valued certain services higher. It would be complicated but it is an area that could be tested on a smaller scale. I think doing that nationally would be exceedingly difficult across the many populations and the many services the Medicaid program offers.

Mr. SCHRADER. I think that is why we have a number of waivers, so that each state can figure out what program probably works best for them, as long as it is officially audited, I think.

Ms. Yocom, I am actually concerned about your report. Your report focuses on paying more for costs. And I think it is going to be a big additional cost to the United States taxpayer. The geographic diversity is purely cost-based. Where is the geographic diversity in your report regarding better quality of care in certain parts of the country versus other parts of the country for the dollars that are actually spent? That would be, I think, of great interest to the consumer, both the person getting the health care, as well as the taxpayer.

Ms. YOCOM. Yes. Our report does focus on geographic differences. And to a certain extent, state spending itself reflects some of those differences.

Mr. SCHRADER. But that just reflects the cost. It doesn't reflect what you are getting for that. Is that correct?

Ms. YOCOM. That is correct.

Mr. SCHRADER. OK. I think that is the problem, Mr. Chairman and members of the committee, that we need to be focusing on. Say what you will about the ACA but regardless of that, I think the focus of health care going forward in our country is going to be about getting bigger bang for the buck. The reports from OIG and GAO, I think try and get at that in some ways but I think they are a little outmoded. Nowadays for health care, we need to be looking at better ways to do things.

The coordinated care model pioneered in my state and several other states I think is something I would like to see some of these reports start to focus on. It is complicated. The formula proposed by Ms. Yocom is also pretty complicated, if I look at it closely. So, I would like to look at that quality part of the reimbursement.

Mr. Hagg, given some of the uses of the Medicaid dollars you have identified that don't seem to fit the classic category of Medicaid services, does seem kind of a play on what the chairman is talking about. Does CMS Medicaid actually have adequate revenues to police the program?

Mr. HAGG. Well, that is a big job, for sure. As I said before, CMS could probably provide a better answer about the resources they have and the way they use those resources right now to oversee state expenditures or additional resources they might need.

I know they have staff located throughout the country who receive the state expenditures on a quarterly basis. They are the front line for the first review but, again, we are talking about hundreds of billions of dollars in a short amount of time that they have to review those expenditures.

Mr. SCHRADER. But it sounds like they could use a few more dollars.

Out of the five or six recommendations you make, are there two or three you would like or think Congress should particularly focus on in working with CMS to review?

Mr. HAGG. Well, specifically, if you are talking about trying to make sure expenditures are in the correct enhanced FMAP categories, bottom line, it really comes down to states doing a better job and taking better care and making sure that those expenditures are claimed appropriately. It is the state's job to do that. There is no way that CMS or any oversight is going to be able to get to every single layer that might be out there. So, states need to know their responsibilities and make sure that they claim properly.

From CMS' standpoint, it probably would be good for CMS to try to reinforce with the states what the states' responsibilities are so the states clearly know the importance of properly claiming.

Mr. SCHRADER. Very good. With that, I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chair of the full committee, Mrs. Blackburn, for 5 minutes for questioning.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Ms. Yocom, I want to come to you. I thank you for being so persistent and consistent in coming to us.

Let's go back to the formulary issue. In looking at the FMAP, I want to hear from you when you look at the per capita or the total taxable resources, what do you think is the better option and why would that option be your choice?

Ms. YOCOM. From GAO's perspective, total taxable resources are a much better indicator of a state's available resources to finance the program. I just looked at this yesterday and there is about a 40 percent difference between the total taxable revenue and per capita income. So, 40 percent more additional spending is included within total taxable resources. And what happens is you have inequities across states in terms of what is reflected in the per capita income. States with a lot of people who work in one location and live in another, those kinds of things don't always get counted in the correct manner. Corporate gains and corporate taxes and then also high-energy states are other areas where the allocations aren't necessarily consistent.

Mrs. BLACKBURN. OK, thank you for that.

Let's talk about additional assistance that is sometimes available during an economic downturn and how that affects a state and how would that affect the states' incentives and how should we approach that. Because you want to be helpful but you don't want to

have a system where they are dependent on this and just say oh, well.

Ms. YOCOM. Right. Well, states, in the 50-year history of the program, have always been in a bind during an economic downturn. People lose their jobs and their children, at least, and sometimes the adults, qualify for Medicaid. So you have an increase in Medicaid enrollment. And then along with that, tax revenues go down because it is a recession or a downturn. So, they have more people in the program and less money to pay for it.

One of the advantages of a federal-state partnership is the federal government offering that balancing of those circumstances.

Mrs. BLACKBURN. Let me ask you this. States that have accessed those funds, once the economy recovers, how quickly do they go about removing those individuals from the rolls?

Ms. YOCOM. It honestly varies a great deal.

Mrs. BLACKBURN. OK.

Ms. YOCOM. And probably the hardest part of any kind of automatic assessment, adjustment like we are talking about, is when to turn off the assistance. Unemployment tends to be a lagging economic indicator so recovery can be slow.

Mrs. BLACKBURN. All right, thank you for that.

Ms. Schwartz, MACPAC has publicly supported the extension of the Enhanced Federal Matching Rate for Medicaid Eligibility Systems. Talk to me about the criteria that MACPAC uses for assessing whether to support an enhanced federal matching rate, just if you will quickly articulate that.

Ms. SCHWARTZ. Sure. In our letter commenting on that role, the criteria that compelled the commission in that instance to be supportive of the continued Enhanced FMAP were that the FMAP rate would be tied to concrete performance standards by the state and that these would improve the eligibility in the enrollment process, both from the perspective of the beneficiary and from program administrators who enhance data collection reporting and improve administrative capacity. And I think this enhanced rate also recognizes that Congress already approves enhanced match for mechanized systems and increasingly enrollment in eligibility processes, which would have once been largely administered face-to-face are no mechanized systems as well. So, those are the criteria used in that respect.

Mrs. BLACKBURN. OK, thank you. I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentlelady from California, Ms. Matsui, for 5 minutes for questions.

Ms. MATSUI. Thank you, Mr. Chairman.

Dr. Schwartz, I want to ask you about long-term and FMAP enhancements. The majority of seniors and people with disabilities want to remain at home to receive long-term services and supports, instead of going to a nursing home or an institution. Research demonstrates that this is more cost-effective. Yet, despite some success, many states lag behind in providing services at home because of Medicaid institution bias, where nursing home coverage is mandatory and home and community-based services are optional.

Congress has passed several FMAP incentives to fix this problem, such as Community First Choice, the Balancing Incentive Pro-

gram, and Money Follows the Person. Some have expired or will expire soon. I believe this committee should absolutely be having a conversation on reauthorization of these programs, which are overwhelmingly bipartisan.

Dr. Schwartz, how well have those FMAP incentives worked?

Ms. SCHWARTZ. The Balancing Incentives Program was focused on targeting states that spent less than half of their long-term services and supports money on home and community-based services to help them make this shift from facilities community-based services. And states were invited to submit a budget and a plan for how they would do that.

Of the 17 states that had participated in the first quarter, 11 exceeded that threshold. It is not possible for me to say whether it was the Enhanced FMAP that did that or some of the other supports that were provided as part of that program and states may continue to make progress toward their goals, even though the enhanced match has expired.

In addition, stats have many other avenues by which they can shift services from a nursing facility to home and community-based services, both through state plan options and through waiver services.

So, there are a variety of approaches that states can take and tailor to their specific needs and populations.

Ms. MATSUI. Can you comment on some of the organizations you would have to improve upon the incentives that we have to states to show that people can remain at home?

Ms. SCHWARTZ. MACPAC has not made a recommendation on creating a financial incentive to do that. We closely monitor what is going on in the long-term services and support state space but are encouraged by the shift to home and community-based services, which is both fiscally promising and also responsive to patient and family needs and desires.

And one area where we are closely monitoring is the move to manage long-term services supports, which we are still learning about and we still are looking forward to some of the outcome measures about how that shift is going.

Ms. MATSUI. Thank you. I think you will realize how much interest there is in long-term care delivery, especially in a population that is growing and the families willing to in some way accede to the wishes of their parents.

And so I think it is something where long-term delivery in this country, which Medicaid, the single largest payer, deserves a lot of our attention on this committee.

Ms. Yocom, the committee has been very interested in GAO's proposal for automatic trigger. I think the idea of making FMAP even more responsive to states leads to a worthwhile discussion. I have a couple of additional questions to clarify this proposal.

Why does a prototype formula focus on providing increased assistance during national economic downturns and not regional downturns?

Ms. YOCOM. Sure. The big issue with the regional downturn is it is not always regional. For example, if there is a recession that is association with energy, it can be spread across states, all the way across the country from Alaska to Texas, to Wyoming, and so

on. And it is much more difficult to think about targeting a small group of states like that. So, our focus has been more on the national downturn.

Ms. MATSUI. Could we look at that a little bit more? Because I am thinking about our recent recession which was caused by the housing crisis. And there are certain areas of the country that were really hit harder than others. I think if you look on a map, you can kind of identify those areas. I am just saying that I think that is something to look at because I think if you wait to look at the national model, we will miss those really hard-hit regional areas.

Ms. YOCOM. Yes.

Ms. MATSUI. Something to consider with any discussion are the winners and losers of the policy, whether some states may benefit more on their policy than others. And I think, to a certain degree, we are talking about this when I talk about the regional downturn.

So, what type of variation can be seen with the enactment of your emergency trigger proposal?

Ms. YOCOM. Well, there is a lot of variation. That is maybe the bad news from your perspective. The good news is the variation is very dependent on which states are affected by the downturn and it changes from recession to recession.

In our work, we looked at four different downturns and the differing effects that happened on states. So, while one state may not get an additional FMAP, it would be because they didn't need it that particular time.

Ms. MATSUI. OK, thank you very much.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the vice chair of the subcommittee, Mr. Guthrie, for 5 minutes for questions.

Mr. GUTHRIE. Thank you. Thank you, Chairman, for calling this hearing. I know it is a very complex financing system we have. And I think a couple of things, one of its states it appears, you know what Mr. Hagg you have found is just improper billing. Another thing is just trying to find ways to maximize the way the FMAP formula works in ways that probably we didn't intend but it is not necessarily wrong on their point.

But in your testimony, you did note that provider taxes, intergovernmental transfers and upper payment limits have the effect of distorting the FMAP rates and "undermine the federal-state partnership in financing health care."

While this is a long-standing concern of OIG, can you comment on what degree you think this distortion may have increased in recent years, given the budget challenges states are facing?

Mr. HAGG. Well, we haven't studied the extent of which those mechanisms have increased in recent years. So, I don't know definitively. I think it is safe to say, at least, generally speaking what we see specifically involving health care provider taxes, I think those have been on the rise in recent years.

Mr. GUTHRIE. And Ms. Yocom, do you have any comments that shed light on that question?

Ms. YOCOM. I can't give you a specific number. I do know that our work has shown an increase in provider taxes and an increase in supplemental payments and these can be used to have an influence on the amount of federal money that is received.

Mr. GUTHRIE. Thank you for that. And then Ms. Yocom, I have a question for you as well.

I would be interested to learn more about the assistance distributed under GAO's prototype formula. Am I correct that this prototype formula would have been less costly than the assistance provided through the Recovery Act?

Ms. YOCOM. Yes, you are. We tested it over several recessions and it ranged from providing $9 billion in assistance to about $36 billion, which was under the big recession.

The reality is, though, that the Recovery Act was attempting to do more than make Medicaid whole. They used Medicaid as a vehicle to provide additional state support.

Mr. GUTHRIE. OK. And am I correct in understanding that if Congress were to implement the prototype formula compared to current law, not the Recovery Act but the current law, this change would need to be offset, since it would increase federal outlays during a downturn?

Ms. YOCOM. I believe so. You would really have to work with CBO on that. They are the experts.

Mr. GUTHRIE. OK, it appears to be.

And Dr. Schwartz, when MEDPAC presents this committee with recommended changes to the Medicare program, it routinely also provides the committee with recommended policies to adopt to offset the changes. Unfortunately, MACPAC does not offer ideas about ways to offset Medicaid or CHIP changes. If MACPAC wants us to be able to move forward on your recommendations, why doesn't MACPAC mirror MEDPAC's practice?

Ms. SCHWARTZ. To that point, I would first note that a number of our recommendations have had no budgetary impact and in that case, a no-saver would be needed.

We are now engaging, as part of our work on children's coverage, in particular, and the work that we would be doing for you on financing, looking to see what kinds of saving options might be out there. And we do always try to work with CBO in understanding the fiscal effects of the recommendations. And that has certainly affected the commission's decision-making when considering different options.

Mr. GUTHRIE. All right, thank you.

And I will just close with this statement. I was in the state government in Kentucky and we do a biannual budget. So, just general revenue budget, my first one was the year 2000, so, for 2001 and 2002. And our biannual budget in Kentucky is about $13 billion. That is not exact but it is close. And since then, talking about the strains on state budgets, since then I know we have cut universities, we have had a lot of strain. And I think last year's biannual budget was close to $19 billion. So, it has gone up a third in a decade or whatever. And so it has been consumed, a large part, there is other things, drivers of the debt, but a large part of it is Medicaid. And so as these states are looking, I think, for opportunities to maximize FMAP and to make their budgets balance, it is just Medicaid is continuing to consume more and more of our federal deficit and more and more of what states do.

So, this is helpful for us so we can get a handle on this. If we don't there is going to be no discretionary money for states to spend

in educating our children and it is going to be difficult for us to ever get our budget balanced, if we don't do so.

So, your information today has been very helpful and I appreciate that very much. I yield back.

Mr. PITTS. The chairman thanks the gentleman. And now I will recognize the gentleman from New Mexico, Mr. Luja AE1n, for 5 minutes for questions.

Mr. LUJA AE1N. Mr. Chairman, thank you very much.

As we all know, Medicaid is a lifeline to so many but as I noted in my opening statement, New Mexico's Behavioral Health System is in crisis as well. I described the upheaval that has resulted in the Susana Martinez administration going after so many of these providers. And as I said today, there were just on Monday ten more of those providers that had allegations against them of fraud were exonerated. And contractors were brought in from outside of the state to take over a system. The current infrastructure was dismantled and we need a lot of support there.

But with that being said, during the New Mexico delegation's many conversations with CMS on the crisis and its impact in New Mexico, we, the delegation, asked CMS to provide us with data that CMS was receiving from the State of New Mexico that they are collecting from them. We hope that the data could provide us with something insightful, with a better look at what was happening on the ground and not happening on the ground. Unfortunately, after months and months of delay, the response that the delegation from New Mexico received from CMS was that CMS admitted that the stated-provided data had, and I quote, "significant limitations." This left CMS largely unable to determine which, "areas and populations may be experiencing decreases in utilization."

So, the data being collected right now, at least from the State of New Mexico, is not able to help anyone make any decisions. So, without access to meaningful data, how is it possible for the people of New Mexico or us here to make decisions and how can people hold policymakers accountable?

Without access to meaningful data, no one can know if enough is being done to ensure that the most vulnerable are protected and without access to meaningful data, we can't determine how best to strengthen the program for the most vulnerable. That is why I am interested in determining how we can use FMAP to help states build out and prioritize behavioral health infrastructure, data, and access.

So, Dr. Schwartz, if we want states to build and maintain strong behavioral health systems, are there ways we can use FMAP to do so?

Ms. SCHWARTZ. I would say first to the point of data, the issue of data is one that MACPAC has consistently noted and noted concern about the need for data for many purposes, for program integrity purposes, for the purposes of improving value and monitoring quality and improving quality. And this is an area where CMS has been working to change its system to something called the T–MSIS, the Transformed MSIS, which has been going much more slowly than anyone would have anticipated.

There are many things that states could do to strengthen behavioral health systems. Of course, states might prefer Enhanced

FMAP. States have many options in the types of benefits that they can provide in behavioral health and states are, there is wide variation in how they do that. They have a wide variation in how they structure their systems in terms of the providers that they have, their use of managed care for behavioral health. So, a whole range of strategies.

MACPAC's work at the moment is trying to look at whether there are barriers and whether those barriers are in the practice environment, the state environment, or the federal environment for integration of behavioral health services with physical health services. Because for many of these populations, regular contact with a physical health provider is their major point of contact with the health system.

Mr. LUJA AE1N. And so you answered the next question that I was going to pose, which was if you could speak how Congress has used FMAP to incentivize states to prioritize health care delivery systems. And one of the areas that it seems that Enhanced FMAP has worked is the long-standing family planning enhanced match, which appears to have drastically improved Medicaid access to families.

But with that being said, the bill that I am working on provides an Enhanced FMAP to states that prioritize investments and infrastructure access and data collection. I would be curious to hear what types of suggestions you have about the interventions that are important that would maybe be most successful to help this program.

Ms. SCHWARTZ. I would be happy to take a look at that for you and get back to you on the details of it. There may be some technical assistance that we can provide in that regard.

Mr. LUJA AE1N. I appreciate that Dr. Schwartz.

And Mr. Chairman, thank you so much for this important hearing today and I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman. I know recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. If Graham would put the slide up.

Every time I deal with a Medicaid debate, of course, Ms. Yocom, you know you have seen this numerous times, the red is what the CBO would say is the mandatory spending, the blue is the discretionary budget. When we have a budget fight and there is a threatened shutdown, it is on the blue that the fight is about. So, this is a simple question but it is one that we, here out in the district, we use that term mandatory or we use the word for portions of the red, not all of them, as entitlement spending.

Anyone want to comment on those two words as good words or bad words to use? Ms. Mitchell. What should they be called? Are they good?

Ms. MITCHELL. I don't know. I don't know that I am qualified to answer that.

Mr. SHIMKUS. OK.

Ms. MITCHELL. But entitlement, meaning that Medicaid is an entitlement, meaning that both the states are entitled to Medicaid funding and individuals are entitled to Medicaid coverage, so that means there is no cap and states cannot put on——

Mr. SHIMKUS. And that makes it mandatory because they are entitled to the coverage.

Ms. MITCHELL. Yes.

Mr. SHIMKUS. Dr. Schwartz?

Ms. SCHWARTZ. Yes, all these——

Mr. SHIMKUS. These are important. It might sound like a goofy talk but it is really out there. People get confused. And if we are trying to deal with what Mr. Guthrie was talking about, the national debt, part of the national debt is our promises to pay entitled people with mandatory spending.

Ms. SCHWARTZ. You know the labels are all extremely value-laden but you point out correctly that when states spend money on these services that are authorized within the statute, populations who are entitled to those services and deemed eligible by those states, those funds flow through and the federal share is mandatory. It is not subject to an appropriation.

Mr. SHIMKUS. Great, thank you.

Ms. Yocom, did I fairly, accurately talk through that?

Ms. YOCOM. Yes, I think that your statement is accurate.

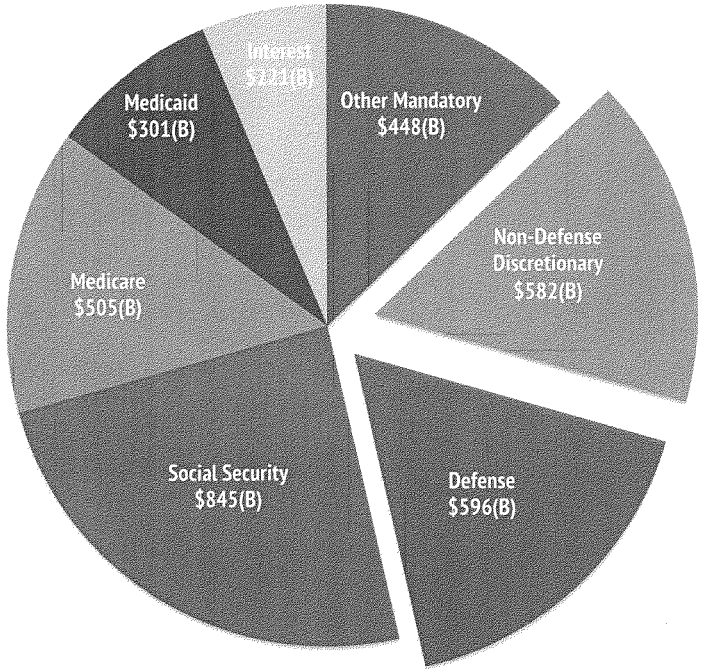
Mr. SHIMKUS. Mr. Hagg?

Mr. HAGG. I am not sure I would have anything new to add. Obviously, Medicaid is a very important program. For the people who receive their health insurance through it, it is a tremendously important program.

Mr. SHIMKUS. Right but this is a 2014 pie chart of $3.5 trillion of federal spending and then, again, the discretionary portion is anywhere between $1 trillion and $1.2 trillion and the rest is, as you have identified entitled or mandatory payment to meet the entitlement. So, I appreciate that.

[Slide shown.]

FY2014 TOTAL SPENDING
$3.5 TRILLION



Source: CBO

Mr. SHIMKUS. We had a discussion. In fact, Mr. Luján also mentioned this 90 percent enhanced family planning match that we discussed based upon it.

Mr. Hagg, does the OIG have the capacity to continually audit all states' claimed federal matching for family planning services?

Mr. HAGG. No, we don't have that capacity.

Mr. SHIMKUS. Given that the Medicaid program is a shared federal and state responsibility and given OIG's limited resources, is it fair to say that states have a responsibility to do audits and prioritize oversight where there are known vulnerabilities?

Mr. HAGG. Yes, I think that is fair to say. You know it starts with the states. The states have the responsibility to make sure that the expenditures they claim are accurate, in the case of family planning or other enhanced FMAP categories that the correct expenditures are in those categories.

Mr. SHIMKUS. Great, thank you.

And Dr. Schwartz, in your testimony, you noted one concern with the FMAP is that states have an incentive to broaden Medicaid to include other state health functions, where possible, in order to draw down federal funds. Can you elaborate and give an example of what you mean?

Ms. SCHWARTZ. I think when state resources are tight, there are incentives to look for other sources of revenue, whether it is for school-based services, transportation, or public health services.

From MACPAC's perspective, our focus has always been on looking for policies to make sure that the eligibility decisions are made correctly, that the services are provided to, enrollees are medically necessary and appropriate and the providers meet the federal and state participation requirements.

Mr. SHIMKUS. So, states are dipping into Medicaid dollars for other services that may not be appropriate, based upon the definition of Medicaid. They are gaming the system.

Ms. SCHWARTZ. That is the distinction that I want to make. And I am sure that the gentleman from the OIG may speak to this as well. From MACPAC's perspective, when states claim federal match, those services must be legally matchable from legal sources of revenue, even if they are provided in different settings.

Mr. SHIMKUS. And that is your recommendation. Your recommendation is that they follow that.

Ms. SCHWARTZ. Yes.

Mr. SHIMKUS. OK, that is it. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I know recognize the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you. Thank you, Mr. Chairman.

The importance of Medicaid just simply can't be overstated. I want to start with that because just yesterday the CDC released new data showing that states that have expanded Medicaid have an uninsured rate of ten percent for adults age 18 to 64, probably still too many, but yet compared to an uninsured rate of 17.3 percent for non-expansion states.

However, many states, including my home state of Illinois, received FMAP rates very close to the statutory minimum of 50 percent. In fact, Illinois receives an estimated 3.1 percent of annual

FMAP funding that covers 4.8 percent of the nation's Medicaid beneficiaries.

And I would like unanimous consent to enter into the record a document prepared by the Illinois Hospital Association which highlights the importance of Medicaid to Illinois.

Mr. PITTS. Without objection, so ordered.

Ms. SCHAKOWSKY. It is well-known that Medicaid payment rates are low, especially compared to the payment rates of Medicare and the private industry, private insurance. The need to adequate payments to Medicaid providers is incredibly important in providing stability in our healthcare system and ensuring access to providers for Medicaid beneficiaries. States have the flexibility of providing supplemental payments to providers and I believe this flexibility should be maintained.

So, Ms. Schwartz, let me ask you. While some of the testimony today has focused on supplemental payments made to providers, I am more concerned about ensuring that providers receive adequate payments for services provided under Medicaid. Are underpayments to providers a systemic problem in the Medicaid program?

Ms. SCHWARTZ. I think that on the physician side, the literature has really consistently shown a relationship between fees and physician participation. And when fees are lower, physicians are less willing to participate and, therefore, the potential for access problems. The lower rate that Medicaid generally pays for a physician's services relative to Medicare is also well-documented and that was part of the thinking behind the primary care payment increase in 2013 and 2014.

On the hospital side, it is significantly more complicated because states can pay hospitals through many different mechanisms, including their base payment rates, non-DSH supplemental payments, and DSH payments.

The degree to which total payments to hospital in the aggregate varies considerably across states and we don't know a lot about hospital-specific payments. And for that reason, MACPAC has recommended 2 years ago and more recently in the DSH report that we released on February first that we need more data to better understand how hospitals are being paid. We recommended that the secretary collect and report hospital-specific data on all types of Medicaid payments that they receive and on the sources of the nonfederal share so we can determine net Medicaid payment and we can help answer the kinds of questions that are you are raising.

Ms. SCHAKOWSKY. I am sorry. What happened February first, did you say?

Ms. SCHWARTZ. On February first, MACPAC released a statutorily required report to look at Medicaid payments to Disproportionate Share Hospitals.

Ms. SCHAKOWSKY. OK, thank you.

States, including Illinois, use intergovernmental transfers or IGTs to legitimately, I believe, fund their Medicaid programs. Medicaid statute, since its inception, requires states to use state general funds to pay for 40 percent of their share of Medicaid funding. States are afforded flexibility to fund their portion and draw down the federal share. In addition, many states use provider assessments to ensure stability in their Medicaid programs. Without pro-

vider assessments, Illinois' Medicaid program would cover less than 70 percent of the cost for Illinois hospitals to care for the state's most vulnerable population.

So, Ms. Schwartz, is there a component of these legitimate payment mechanisms that—isn't it really the states and the providers that are willing to put up their share and shifts the burden really to them, a burden that they are willing to accept, which I see as a good thing?

Ms. SCHWARTZ. I guess just to build on what I said previously, states are allowed to use intergovernmental transfers. We know much less about those intergovernmental transfers than I think we would like to know and that is part of the rationale for our recommendation to collect more data on that. We have been relying on some work GAO did that is illustrative of the issue but not nearly as comprehensive that you would need to make a significant policy change in that area.

Ms. SCHAKOWSKY. But isn't it sort of obvious that if the states' ability to creatively finance their Medicaid programs are further restricted, that it would led to cost them services and benefits for the beneficiaries?

Ms. SCHWARTZ. It is hard for me to predict how states would react. States may have other sources and I couldn't comment on the specific reaction that states would have to such a change.

Ms. SCHAKOWSKY. And so you are looking more carefully into this. And when do we expect to know something?

Ms. SCHWARTZ. Well, I think legislation is needed for the Secretary to collect those data.

Ms. SCHAKOWSKY. I yield back.

Mr. PITTS. The chairman thanks the gentlelady.

Ms. SCHWARTZ. Excuse me. I am sorry, sir.

Mr. PITTS. Yes.

Ms. SCHWARTZ. I just need to correct what I said. The Secretary doesn't need legislation but the Secretary has been reluctant to and, therefore, it might be wise on the part of the congress to actually direct the Secretary to do that.

Mr. PITTS. The chair thanks the gentlelady. I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes for questions.

Mr. GRIFFITH. Thank you very, Mr. Chairman.

Ms. Yocom, I have tremendous appreciation for the work that GAO does to evaluate policies and advise the committee. However, I am concerned that the current that the current process for appointing commissioners for MACPAC may be fundamentally flawed.

For example, the MACPAC statute explicitly allows for Medicaid directors to serve on the commission, however, there is not one single Medicaid director serving on the commission today but Medicaid is supposed to be a federal-state partnership. So, I ask, why hasn't GAO put someone on the commission who is actually running a Medicaid program today?

Ms. YOCOM. Sir, I know that the Comptroller General is working on a response to the committee's request and I would like to defer until that comes to you.

Mr. GRIFFITH. I appreciate that.

And Dr. Schwartz, I have got to tell you, as an attorney, I am very troubled by an apparent conflict of interest from some of the commissioners. Having read Ms. Rosenbaum's reply to Chairman Upton and Pitts, I have to tell you it was unsatisfactory in my judgment. In my opinion, when you read that letter carefully, it is a clear conflict under legal ethical standards that the chairwoman, even though she wasn't chairwoman at the time, would sign onto a case adverse to the House of Representatives when she is a sitting MACPAC commissioner. It doesn't matter whether she was chair or not at the time.

And when you look at her letter, not only is she an attorney, which is clear in the letter, but she goes on to state that this case that she got herself involved in is "the focus of my life's work." It is so core to her that that is her number one concern. If that is not the appearance of impropriety or a conflict of interest in the standard legal definition, I, frankly, don't know what is.

And then she goes on in her letter to say that but now that I am chairwoman, I am not going to do any more work on that case. Well, if she has a conflict now as a chairwoman which she feels means she shouldn't work on that case, she shouldn't have worked on that case in the first place.

And the issue is not resolved on the conflict of interest issue but it is also not exclusively her problem. One of the current commissioners sits on the board of a nonprofit which is involved in legal advocacy and has been involved in at least one class action suit against a state Medicaid program. Now, I have got to tell you, I can't see how these are not conflicts of interest in the sense of I understand there is a financial conflict of interest people talk about. I am talking about a judgment conflict of interest. In the legal standards, as an attorney, one of them is not just that you have a direct conflict but that there is an appearance of impropriety. There is an appearance of impropriety. And I think that it ought to be of concern and you all ought to be disturbed at MACPAC that you didn't anticipate that this would be a problem for the public and for members of congress.

We need, as Congress, we need objective recommendations for strengthening Medicaid and CHIP. Given the concerns that the committee leaders have raised, I hope you understand my worry that MACPAC recommendations will be viewed as somewhat tainted, that there may be some conflict in there and that we can't rely on that, as we ought to be able to, as credible or objective in all cases.

Now you know I know folks are good people and I don't know Ms. Rosenbaum but when you look at her letter, this is my life's work. That is the sign of a good person. But in this case, there was a mistake made, an appearance of impropriety, and she shouldn't be doing both her life's work and filing briefs or amicus briefs in opposition to the United States House of Representatives.

As members of this committee know, and as others who have followed me through the years know, it is not a new position for me to recommend that we change the way we do things and that perhaps these appointments ought to be made directly by Congress. I plan to introduce a bill that will make MACPAC directly appointed by both parties. It is not a partisan bill, in that sense. Both parties,

majority and minority would get appointments, House and Senate would get appointments. And I believe that is a proper way for us to proceed going forward.

I look forward to working with folks to try to make that better. If they don't like the way we have the numbers configured, that is obviously something that can be discussed. But as a legislative advisory panel, we need to know we are getting the right stuff and that people don't have conflicts so steeped in their own personality that they would write a letter back to us and, in defense, say, "But this is my life's work."

I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from California, Mrs. Capps, for 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman, and thank you to the panelists for your testimony today.

While I always appreciate the chance to talk about the importance of Medicaid and CHIP. To both families and communities, it is critical that any proposed changes do not undermine the program's important role in our health care safety net. Unfortunately, we continue to see plans from some of my colleagues to cap services or to block the program, both ideas that would not make health care more affordable but would, instead, leave some of those who need the program without it and shift the cost to states and localities. This would undermine the fundamental principles of the program and I cannot express enough how damaging that would be to patients and my constituents. But we can all agree that there are ways to make the program more responsive on the financial end.

Studies show that when the current federal formula for FMAP uses per capita income as a proxy to reflect a state's financial resources and Medicaid needs, it is a poor proxy for both. This misrepresentation sustains significant funding disparities among states taxed by the federal government with serving the health needs of their low-income residents. And states like California that have relatively higher financial resources but also relatively higher poverty rates, are misunderstood as having lower Medicaid cost pressures than the already do.

In fact, one study undertaken by California Common Sense, a nonpartisan research group in my state, found that by using a more accurate measure of poverty and need, California should be receiving a 15 percent higher FMAP rate.

Dr. Mitchell, how does the current FMAP under-reimburse states like California who have higher Medicaid cost pressures than are reflected?

Ms. MITCHELL. Well, GAO has done a lot of work in this area but you know with the current formula, they are only looking at the per capita income. So, they are not taking into consideration the number of poor people in the state, the number of people eligible for Medicaid. None of those factors are taken into account.

Mrs. CAPPS. Without this more accurate measure that looks at the financial—well, maybe I should just stop and say does GAO want to respond.

Ms. YOCOM. Ms. Mitchell is correct. Our work has shown one of the ways that it plays out is you can have two states with the same per capita incomes and the way it translates into the Medicaid pro-

gram has a really different effect. For example, a state with a high number of disabled and elderly individuals is going to be struggling to finance their program more than a state that is primarily comprised of children and families.

Mrs. CAPPS. OK, thank you.

So, without this more accurate measure that looks at the financial resources and Medicaid needs of the state, states like mine, California, have worked with their health care providers to maintain a stable functioning safety net health care system. One way they have done so is through our state's provider fee, that is used to help pay for the non-federal share of their Medicaid program.

Federal Medicaid law requires that provider assessments be broad-based and uniformly imposed and federal laws and regulations guard against the misuse of provider assessments by states that seek to receive higher federal matching rates than statutorily allowed.

In California, the provider community is strongly supportive of the fee, even non-safety net providers. The fee has been approved by CMS and is used right. Money that comes from the state health care system goes right back into it, targeting the providers who provide the most under and uncompensated care. Over the years, however, we have heard rumblings against the program. To be clear, cutting provider fees would hurt all individuals in the state, not just working families.

Before the California fee went into effect, a dozen safety net hospitals were about to close their doors, not because they didn't have patients to care for but because they couldn't afford to stay open. The provider fee has given them new life so that they are there in the community for both Medicaid patients but also any community member who needs care.

And with that, Mr. Chairman, I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Missouri, Mr. Long, for 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman.

Ms. Yocom, why is it that the current FMAP formula isn't sufficient for dealing with economic downturns?

Ms. YOCOM. A lot of it has to do with the timing and the fact that, as Ms. Mitchell talked about, the data that are represented by the FMAP calculation, in addition to not be complete enough, are also old. So, when you are in a steady economic time or a time of growth, it doesn't cause a problem. It is during a downturn that the real effects take place because the FMAP is reflecting economic circumstances that were several years ago.

Mr. LONG. OK, have you assessed how well the prototype formula would have worked in these previous downturns?

Ms. YOCOM. We have. Our first effort to create a model like this addressed about 90 percent of recession-related costs. And where we found that it was lacking was for states that were slow to enter a downturn and slow to recover. And so then we adjusted the way that we end the assistance period, based on states' activities and, did some slight improvement. I don't think we calculated the per-

centage of cost coverage since then but we believe it is a pretty strong formula.

Mr. LONG. You believe it is what?

Ms. YOCOM. It is a pretty strong formula for assessing states with their financial needs.

Mr. LONG. OK, my next question here is for you or Dr. Schwartz, whoever wants to take it first.

What type of other policy proposals have been proposed in the past replacing FMAP and improving financing to the Medicaid program?

Ms. YOCOM. What types of policies have been proposed?

Mr. LONG. Yes, what type of policy proposals have been proposed in the past for replacing the FMAP and improving financing in the Medicaid program?

Ms. YOCOM. There was, at one point, legislation looking at adjusting the FMAP during a downturn. I do not know how far it got in the statutory path.

Mr. LONG. Dr. Schwartz.

Ms. SCHWARTZ. MACPAC has just conducted an historical review of major reform proposals and we are working on cleaning that up so that we can share it with the members of the committee and your staffs. Some of the ideas that have been talked about over the past 20 to 30 years include block grants, as have been stated earlier, per capita caps, capped allotments. Those are some of the proposals that we will be looking at going forward but we will provide you an analysis of some of those ideas.

Mr. LONG. And how would those options change the incentives and disincentives facing states?

Ms. SCHWARTZ. Well, they differ from each other in how they are designed but, in general, they change the nature of the relationship between the federal government and the states in providing more fiscal discipline in limiting the resources either in total or based on the number of enrollees or other mechanisms of that type.

Mr. LONG. OK, so there would be incentives and disincentives for states.

Ms. SCHWARTZ. Yes.

Mr. LONG. OK, thank you all. I appreciate your testimony here today. With that, I yield back.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from New York, Mr. Engel, for 5 minutes for questions.

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

Mr. Hagg, I just have a couple of quick questions for you, based on the issues you have raised regarding my home State of New York. In your testimony, you noted past issues regarding reimbursement for developmental centers and residential habilitation centers. And in both of these instances, it was clear that both our state and CMS made administrative errors that resulted in overpayments for these services and, in both instances, all parties involved, including the State of New York and CMS largely agreed with OIG's findings. Is that not correct?

Mr. HAGG. Yes, I think that is correct.

Mr. ENGEL. Yes. It is my understanding that, following this report, New York and CMS worked cooperatively to both fix the prob-

lem in the future, as well as agreed upon a financial settlement to resolve the issue. That is true as well.

Mr. HAGG. That is correct, yes. Initially it was trying to fix the problem moving forward and then it required some audit work looking backwards to figure out the scope of the problem, the extent of the problem. And then yes, the state and CMS worked closely together to reach that settlement. Yes.

Mr. ENGEL. Thank you. Your testimony today also included the results of many investigations and my reading of these reports would indicate that nearly all ended with cooperation between the states and CMS to resolve the issues at hand. Is that correct?

Mr. HAGG. Well, are you talking about the audits involving some of the Enhanced FMAP claiming areas?

Mr. ENGEL. Yes.

Mr. HAGG. Yes, I think, I don't have a list in front of me but I would think most, if not all, of those audits, CMS concurred with the recommendations that we made. I think in a lot of cases, the states agreed with our findings and recommendations as well. So, yes, CMS, as the action official, would work with the states to help implement those recommendations.

Mr. ENGEL. OK. And finally, would you agree that most investigations on issues similar to New York's are addressed in a generally cooperative manner that improves the program integrity in the long-run?

Mr. HAGG. I am sorry. Could you repeat that again?

Mr. ENGEL. That the investigations on issues similar to the ones we have in New York, as you pointed out New York wasn't the only state, that those issues are generally addressed in a cooperative manner that improves program integrity in the long-run?

Mr. HAGG. Generally speaking, yes. If CMS agrees with the recommendations we make in the states then, yes, there is a cooperative effort to try to help the program moving forward. Sometimes there are disagreements where states disagree with the findings that we have, with the recommendations that we make. Sometimes CMS disagrees with us. But by and large, when there is agreement, yes, there is a cooperative effort to help improve the programs moving forward.

Mr. ENGEL. All right. Well, thank you. I just wanted to get those clarifications on the record. OIG has done very good, in my opinion, to ensure that reimbursements in the Medicaid program remain accurate and certainly, OIG has raised issues in the past but it is clear that these issues are solvable and always nearly end with both long-term program improvement and amicable agreement between the federal and state government. So, I just wanted to get that on the record.

Thank you, Mr. Chairman. I yield the remainder of my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, for 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. I want to thank the panel for their testimony.

GAO has listed Medicaid as a high-risk program for more than a decade. I am sure that you know that. The IG's Office's 2015 Top

Management and Performance Challenge Report has Medicaid fraud, waste, and abuse listed in the number one spot.

Mr. Hagg, this week the Energy and Commerce Committee sent a letter to the IG's office asking for additional information on Medicaid payments related to deceased beneficiaries and deceased providers. Do you know the size and scope of the problem, how much money is being wasted, there shouldn't be any money wasted as far as I am concerned, what services or payments are being made, and why life status cannot be determined in a timely or accurate way?

And I think it should be pretty simple but if you can answer that question, I appreciate it.

Mr. HAGG. Yes, I don't have an answer to the scope of the problem or the magnitude of the problem.

Over the years, we have conducted various audits going back a number of years, where we would identify Medicaid payments that were made for people that were deceased. We currently have some ongoing work looking at a few different states, trying to determine the extent of the problem for those individual states. It wouldn't be a national look but it would for individual states determine the extent of which payments are made for people that are deceased.

Mr. BILIRAKIS. Well, why wouldn't we look at all 50 states in this case?

Mr. HAGG. That is a resource issue. It is a lot of data to crunch and review. And once you have things that look like errors, there is specific work that needs to be done to look behind to make sure that we are actually talking about someone who is deceased. So, it just requires a lot of resources.

Mr. BILIRAKIS. Well, it is my understanding we have had spot checks before and it just hasn't done anything. Why not a comprehensive look at the problem? As far as I am concerned, it is a big issue.

Mr. HAGG. Well, I don't disagree with you. And you would think it would be something that over time we would be able to get correct.

Mr. BILIRAKIS. How do you engage with the states?

Mr. HAGG. How do we engage with the states?

Mr. BILIRAKIS. Yes.

Mr. HAGG. Well, anytime——

Mr. BILIRAKIS. Get the information necessary for the analysis.

Mr. HAGG. Well, just like all of our work, we try to look at areas that we believe are high-risk areas of vulnerabilities, whether it is across states or in specific states. We decide, once we see those vulnerabilities, to conduct audit work that would address those specific areas, those vulnerabilities. If we decide to audit a specific state, we obviously meet with the state and talk to them about the audit we are going to perform, the scope that it would entail, and the methods that we would use. And we work with the state to get the data we need to make determinations to fulfill our objectives.

Mr. BILIRAKIS. How many states have you identified so far?

Mr. HAGG. For payments for deceased beneficiaries?

Mr. BILIRAKIS. Yes, and how much money is involved?

Mr. HAGG. Well, currently, I don't know the extent of the errors. We have ongoing work in two or three states, one that work is com-

pleted. We can talk about our findings more. Right now, I don't have any findings to report because the work isn't completed.

Going back 10 years or more, there would be audits conducted by us and other groups that would find Medicaid payments for deceased beneficiaries. I think the amounts would vary from a million or two million here or there to higher amounts like in twenty-five million or more.

Mr. BILIRAKIS. That is outrageous as far as I am concerned. OK, well please keep me informed——

Mr. HAGG. We would be glad to do that.

Mr. BILIRAKIS [continuing]. Because I need to follow up on this. Thank you very much. I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Indiana, Dr. Bucshon, for 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman.

Medicaid is a critical program. I was a physician in my previous career. I am still a physician but now I am here. But in my view, it needs broad reform and we are talking about some aspects of the law today.

In many states, having Medicaid does not guarantee access to health care, other than through the emergency room and that is true today as it has been for quite a while. As the costs continue to rise overall in health care, more stress will be put on this critical program.

One of the failures of the ACA is addressing coverage and not addressing cost. And without honestly looking at some of the things that are driving the cost and solving those, we are going to continue to be talking about coverage when we are missing the boat because it doesn't guarantee access.

Price transparency for the consumer in health care doesn't exist. Quality transparency is getting better. The combination of those two is the value that you get from a service.

Looking at tort laws, antitrust and stark law reforms, and many other things to try to help decrease the costs in our health care system will be imperative to the other things that we look at structurally within the Medicaid program.

And this question goes to Dr. Schwartz or Ms. Yocom. Has anyone looked at Medicaid recipients and their ability to find access to a primary care physician, other than through the emergency room? So, for example, you have a Medicaid population. Has anybody surveyed them and found out the percentage of them that can't find a primary care physician to take care of them?

Ms. SCHWARTZ. There are a number of different surveys that have been done to look at access for Medicaid beneficiaries. One is using the National Health Interview Survey and asking a number of questions about access. Unfortunately, using that survey, we can't get state estimates. So, some of the variables that would be important about how states design their programs, you can't tell.

Another approach that has been taken more recently by a group of researchers at the University of Pennsylvania is to do what they call Secret Shopper and call and pose as a private insurance patient or Medicaid patient and to see what the access barriers are. And they do see some differentials. In that study, they were also

looking at difference in fees and found that states that had higher fees in the Medicaid program did have fewer barriers to access.

Ms. YOCOM. There is another national survey. Again, we cannot get down at the state level, which shows that from the perspective of the beneficiaries Medicaid access is viewed as comparable to that of private insurance with regard to initial primary care. And the difficulties reported in obtaining care get higher when you are talking about specialty care or behavioral health services, in particular.

Now, what we don't know is the frame of references of those individual respondents, if they were previously uninsured and being on Medicaid may make things easier.

Mr. BUCSHON. Yes, I understand the study but amongst the community that I represent, we hear all the time about difficulty finding physicians and we are hearing more about Medicare patients, finding access to primary care physicians because physician practices are closed to those populations, based on the low reimbursement rates.

Mr. Hagg, when the state claim a higher federal matching rate than they are entitled, what is the process for the federal government to be made whole?

Mr. HAGG. Well, specifically tied to the work that we performed, if the state agrees and CMS agrees, it could be a fairly quick process. And the next quarter, the state would return the funds.

Mr. BUCSHON. That is the question. So, the next quarter of the payment can be rectified?

Mr. HAGG. If the state agrees that it is an overpayment. Now, if they disagree, there are certain appeal rights that they have that they can go through. Once those appeal rights are exhausted and it is still determined to be a legitimate overpayment, an overpayment that CMS agrees with, as the action official, CMS would issue a disallowance letter to the state. That may take several quarters to actually get the money back at that point, then.

Mr. BUCSHON. OK, great. And Ms. Yocom, obviously, there is a tradeoff between complexity and accuracy involved in alternative measures to determine and to allocate Medicaid funding to the states. Can you just briefly comment on that?

Is there any not complex, accurate way to do this or is it just a balance?

Ms. YOCOM. Unfortunately, there probably isn't. There is a tradeoff, though, between how complex you want your formula to be versus how simple it is to implement.

I think really, at the end of the day, it is a congressional policy decision of how important it is to be as equitable as possible across the states.

Mr. BUCSHON. Thank you. My time is up. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Collins, for 5 minutes for questioning.

Mr. COLLINS. Thank you, Mr. Chairman.

Let me explain, perhaps, a problem I have and then we will ask a little input. I am from Buffalo, New York, Erie County, New York, one of the poorest cities in the United States of America and hence, one of the poorest counties, with a very high percentage of Medicaid.

So, it is my understanding that there are about 13 states out of 50, New York being one, that forced the counties to pick up a large piece of the state's share. Now in 37 out of 50 states, the state picks up their share, the federal picks up their share, and that is it. And that reimbursement rate is dependent on the state income level, compared to the national average.

In New York and I think 12 other states, though, the state forces a big piece, as much as half of that state share down to the 62 counties in New York. So, New York being considered a wealthy state because of New York City, Westchester County, we are at the lowest level. We are reimbursed 50 percent. But in a poor county, then, like Erie County, the largest upstate county in New York, that share comes back to the county. We are only getting 50 percent. Yes, Mississippi, which has the same relative income level, gets 74 percent. So, you can see where yes, it is a state issue, perhaps, but I believe this reimbursement was to protect, if you will, the taxpayers of the poor states. Well, think of Erie County as a state. We are a very poor county, yet we are only reimbursed at 50 percent because of that.

So, my thought would be having a state like New York that is 62 counties that forces it back on the counties, we should have 62 different reimbursement rates that accept that Erie County is a very poor county.

And to put it in perspective, the county, little county, well it is a big county, but our county share of Medicaid was give or take $120 million a year, $120 million. Our entire county property tax was only $110 million. One hundred percent of our county property tax would not even cover our Medicaid portion. So, we had to dip into our sales tax collections to cover that. And then everything else in our budget from highways to all other services, jails, was covered by sales tax.

So, I think you can see the dilemma we have as being one of the states where the state is forcing substantial costs, what they call the state share but in New York it is state and county share, and that we are a poor county.

So, I guess the question, I don't know, perhaps to Ms. Mitchell, I have to assume it wouldn't be that hard to have 62 reimbursement rates, one for each county in New York. The data is easily available, I would presume. I know it would take a bill in Congress to say for those states which push it back to the local level, we will look at each county as a separate entity and recalculate that rate.

And I know that is different than what we have now, but that wouldn't be that difficult to do, would it?

Ms. MITCHELL. I believe it could be possible to do that and unfortunately, at this point, those sort of decisions are made on a state level. States have a lot of discretion in how they design their program and how they fund their Medicaid program.

Mr. COLLINS. But if a state did like New York, though, you could then go back to the federal government and say here is New York State's program so, in this case, let us recalculate for the 62 counties. I know it would take an act of Congress to do that but I think you can sense my frustration, as the county executive of a very poor county, being treated like we were from Westchester County,

or Suffolk County, or Nassau County but we weren't, you know home to the City of Buffalo, third poorest city in the United States.

So, would anyone else want to comment on that? Have you heard this argument from others? I mean there are 12 or 13 other states that do likewise. A lot of people have no idea this even happens.

So, with that, I guess I will yield back the balance of my time but my thought would be if you could get Congress to move, the first question would be how hard would it be? And I don't think it would be that hard to calculate 62 different rates for New York, just the press of a spreadsheet button and there you go.

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

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentlelady from Indiana, Mrs. Brooks, for 5 minutes for questions.

Mrs. BROOKS. Thank you, Mr. Chairman and thank you to the witnesses for your testimony.

I want to commend, actually, my home State of Indiana for taking the lead in developing a groundbreaking approach in what is known as Healthy Indiana Plan, HIP 2.0. And it is an innovative, consumer-drive, health insurance program, as you know, designed to empower members to take personal responsibility for the health care decisions. And just as HIP 2.0 encourages individuals to take responsibility, FMAP should encourage states to take responsibility of their financial health of the state Medicaid program.

I would like to just talk about, because I think this is an important discussion, on how we maximize the federal dollars to provide for the best health outcomes for our nation's most vulnerable populations. And Ms. Schwartz, last Congress, I joined a bipartisan group of colleagues from the Women's Caucus to urge the renewal of CHIP. And moving forward, I want to ensure that we continue to provide care for those roughly 8 million children and pregnant women around the country, including roughly 84,000 children in Indiana.

MACRA extended CHIP through the end of next September and the ACA increased CHIP's already enhanced FMAP by 23 percent. So, under MACRA, the federal government is paying, as you said, all the costs for CHIP in 12 states and paying 90 percent of the costs in an additional 20 states.

So, the last time that the MACPAC commented on CHIP, there was a 2-year extension. And now that there is a more in-depth examination, I hope the commission is examining as to what degree a lack of a state contribution may affect the state incentives to ensure that Medicaid payments are appropriate and accurate. Can you comment on that?

Ms. SCHWARTZ. Certainly. The commission has a very aggressive work plan and is very focused and has committed to having a package of recommendations for Congress by the end of this calendar year, so that when Congress turns its attention again to funding for CHIP in the next Congress, that MACPAC's recommendations will be available. We are looking at many different aspects of the program, benefits, affordability, state administration and financing. And all of these will fold into those recommendations. You can see that that will be on the agenda, consume a considerable amount of the commission's time at every meeting over the course of this year.

Mrs. BROOKS. And is MACPAC evaluating incentives in CHIP's current program financing?

Ms. SCHWARTZ. Yes.

Mrs. BROOKS. And what, if any actions, has CMS taken to ensure the accuracy and the appropriateness of federal and state payments?

Ms. SCHWARTZ. I can't speak to what CMS' actions have been in this area. I can check into that and get back to you.

Mrs. BROOKS. OK, thank you.

Mr. Hagg, the list of top management challenges for HHS identified protecting the Medicaid program from waste, fraud, and abuse as the number one challenge. When do you expect OIG report of the findings on this issue will be made public and can you talk about will your analysis review whether individuals whose medical services were financed at the enhanced matching level were actually eligible under the statute? And you talked a bit about that in your testimony. Can you expand on that?

Mr. HAGG. Well, yes, a few different things. One, the list of top management challenges is really to highlight for the Department and others, external parties, the areas that we believe have large vulnerabilities. It doesn't tie to a specific report that we would put out to say specific problems have been solved or not. We have a body of work in Medicaid covering a lot of different areas and the results that we find leads us to the conclusion that Medicaid is a high-risk area. So, that is one thing.

As far as some of the Enhanced FMAP rate categories, the one specifically you are talking about for the newly eligible population, we have some work ongoing. It is two different tracts, really. The first is some audit work that my team is doing. It is focused on states and the actions they are taking and claiming. The second tract is being done by our Office of Evaluations and Inspections. They are looking at CMS' oversights and their responsibilities and the action that CMS is taking.

We anticipate that work being done sometime later this year. For the audit work as early as, well, probably not before the end of this calendar year. For the work that focuses on CMS, probably no earlier than maybe late summer.

Mrs. BROOKS. Is there a report that those of us who are working on Congressman Guthrie's Medicaid Task Force Reform efforts, is there a report that you can point to where we can dig in on the waste, fraud, and abuse recommendations that OIG has made?

Mr. HAGG. Yes. Well, one, you have seen the top management challenges. That will lay out some of the things that we found. We have a semi-annual report that we put out, obviously, that highlights some of the areas of the bigger issues that have been identified.

We have a compendium of unimplemented recommendations that talk about specific things that we think can still be done to help improve the program. And then beyond that, I would be glad to try to provide some of reports involving some of the bigger impact or higher risk areas that we have identified issues.

Mrs. BROOKS. Thank you. Thank you all for your work. I yield back.

Mr. PITTS. The chair thanks the gentlelady. That concludes the questions of members present.

There will be follow-up questions that we will send. We will send those to you in writing. We ask that you please respond promptly.

Mr. Schrader.

Mr. SCHRADER. Thank you, Mr. Chairman. I just briefly want to recognize that Medicaid basically insures almost 40 percent of the children in the United States of America. So, the impact of Medicaid on children should not be far from our minds. We have heard a lot of testimony today to that effect.

So, I would like to ask unanimous consent to submit a statement from the American Academy of Pediatrics for the record, sir.

Mr. PITTS. Without objection, so ordered.

Mr. SCHRADER. Could I make just one final comment?

Mr. PITTS. Yes, sir.

Mr. SCHRADER. Just to keep the hearing in perspective, I appreciate the hearing. It is very timely, very important. At this point in time, it is pretty clear that there has been an uneven economic recovery. The good vice chair alluded to the fact that Medicare enrollments have increased over the last few years and I think that is indicative of the fact that a lot of folks are struggling to keep up, despite the fact that unemployment is way down and we are getting back our mojo, I think, as a country, but it is uneven at best.

So, Medicaid provides I think a very important role. I would also like to point out that despite the complexity and although we have heard a lot about some of the unclear rules maybe from CMS in how the Medicaid money should be administered. And OIG and GAO have done a good job, I think, in pointing out some of the potential problems with interpretations program, no one has done anything wrong.

So, at the end of the day, I would just like to point out that as far as a government program goes, Medicaid has the lowest improper payment rates of any federal health program. So, let's keep it in perspective and talk about what we need to be doing.

Last comment, sir, thank you for your indulgence, is that the real answer to driving the cost down is, again, quality-based reimbursement. That is how you get the biggest bang for the buck without hurting the people that need the program the most.

So, I am hoping that we have that opportunity to talk about this and some of the other ideas that come out of this hearing. And I really appreciate the fact that we have had this hearing.

I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. Does the gentleman from Massachusetts seek recognition?

Mr. KENNEDY. Yes, if I may.

Mr. PITTS. The gentleman is recognized for 5 minutes for questioning.

Mr. KENNEDY. Thank God. I apologize to all that were waiting and letting me catch my breath.

Chairman, thank you for holding the hearing. To our witnesses, thank you for being here. Thank you for your testimony.

Mr. Hagg, I wanted to direct the first question at you sir, if I may. One report that OIG has highlighted was a review of Med-

icaid claim adjustments in Massachusetts between 2008 and 2010. I wanted to take a moment with you to discuss the report. The main finding, as I understand of the report was that our state over claimed federal revenue around the time of the American Recovery and Reinvestment Act.

So, to start, the Recovery and Reinvestment Act was implemented in 2009. Is it true that nearly at the same time the Commonwealth implemented a new Medicaid management information system around that as well?

Mr. HAGG. I believe that is correct.

Mr. KENNEDY. And so is it correct that after OIG's findings were raised that the Commonwealth agreed to address the issues, so long as CMS agreed with OIG's interpretation?

Mr. HAGG. I would have to go back and look at the report. At this point, I am not sure I remember specifically exactly what the state comments were on our findings.

Mr. KENNEDY. OK. So, if I jogged the memory, and said that if OIG reported the Commonwealth overcharged by $106 million, does that strike you as——

Mr. HAGG. Yes, those were our findings. I just don't recall what Massachusetts' reaction was to those findings.

Mr. KENNEDY. So my understanding, sir, is that under OIG's interpretation on the other end of the ARA period, Massachusetts would have been undercharged by $108 million. Does that part ring a bell?

Mr. HAGG. Well, I don't know that our audit period looked through that far. I don't think it covered that much. We focused on a specific period of time and the adjustments the state made during that time period.

If the state believed that at the end of the period, the opposite effect would occur, then certainly, CMS, as the action official, would work with the state to take that into consideration and correct it.

Mr. KENNEDY. I appreciate that. I think the issue was, looking at one time period, the state had overcharged the federal government $106 million but looking at another time period, was in fact overcharged by $108 million. And you are saying you don't recall it but would look.

Mr. HAGG. Well, again, CMS is going to be the action official on this. I am pretty sure that CMS concurred with our findings and recommendations.

Now, without looking at that specific period that you are talking about or the state is talking about with an under claim, I really don't have the answer to that, whether that is accurate or not.

Mr. KENNEDY. Understood.

Mr. HAGG. It really would be up to CMS, as the action official, to look at the information. If they wanted to come back and ask us to look at it, too, we would do that. But it would be up to CMS to try to resolve our findings and then the additional information, I guess, that the state has

Mr. KENNEDY. Great. And I come at this from the perspective that I agree with you wholeheartedly that program integrity is absolutely critical.

And to the extent that the Commonwealth of Massachusetts OIG and CMS are able to work together to address the issue and didn't, I think it is fantastic. I think it is an isolated issue that ended up coming from a series of concurrent changes, such as the new information systems launch and, at the same time, a one-time stimulus. Hopefully, those challenges are behind us.

Ms. Mitchell, if I can ask, you noted in your report that the FMAP is utilized to determine the federal share of other programs in the government as well. I was hoping you could comment on this and lay out a few of them.

Ms. MITCHELL. About what?

Mr. KENNEDY. The ways that FMAP is used for other programs.

Ms. MITCHELL. Sure. The regular FMAP is used to determine the federal share of a number of programs. And the ones that I am recalling right now are the Temporary Assistance for Needy Families Contingency Funds and the Foster Care Title IV–E funding.

Mr. KENNEDY. And so, ma'am, if our committee were to adjust FMAP funding in any way, we would also be affecting the funding for those programs as well. Is that right?

Ms. MITCHELL. I think it depends on how the legislation is written. If it is specific to the Medicaid program and you maintain the FMAP for the other programs, you could do that or it could apply to the other programs.

Mr. KENNEDY. OK. Thank you very much. And I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman, Mr. Ca AE1rdenas, 5 minutes for questions.

Mr. CA AE1RDENAS. Thank you very much, Mr. Chairman.

I thank you all for joining us today. We appreciate your knowledge and your expertise on these matters.

My first question is for Mr. Hagg. One report that OIG has highlighted was a review of federal reimbursement for family planning services in California, specifically in the San Diego area. I would like to take a moment to discuss a portion of the report.

In this report, over half of the improper claims were noted to be for visits that included testing for sexually transmitted infections. Is it true that after this report, CMS released guidance clarifying that STI testing is classified as family planning services for the purpose of calculating the FMAP?

Mr. HAGG. I am not sure that is true. I would have to look back at that.

CMS put out a letter to the state Medicaid directors in 2014. I probably would need to refer back to that letter. I know it clarified some previous guidance and I think it revised some previous positions that CMS had taken. I should look back at the letter but I think that would have been, sexually transmitted infections would have been, classified as family planning-related, which would be claimed at the regular FMAP rate, not at the enhanced family planning rate.

Mr. CA AE1RDENAS. OK, thank you. I appreciate that, Mr. Hagg.

I also think it is also worth noting that as a result of OIG's recommendations, we have made programmatic changes to maximize program integrity moving forward, such as implementing an ICD-

based reimbursement system. OIG's oversight has, indeed, provided worthwhile suggestions beyond STIs, which we are appreciative of.

On the whole, I am pleased that this discrepancy in interpretations between the states and OIG has been resolved. I hope that with this administrative issue resolved, we can continue to move past this and past the simple difference of opinions and towards further actions that strengthen Medicaid for all of our beneficiaries.

I have another one. My next question is for Dr. Schwartz. Again, thank you for joining us, doctor.

I would like to ask you a question regarding upcoming work you noted in your testimony. In the summary sections, you noted that MACPAC is now focusing intensively on financing and design questions associated with alternatives, such as block grants, per capita caps, and capped allotments. I was somewhat alarmed that the sentence went on to describe that it would examine issues related to these alternatives, specifically baselines, growth factors, and state contributions. Were these three items only made as brief examples or does MACPAC plan to examine other effects of financing changes as well?

Ms. SCHWARTZ. Yes, they are both design issues to consider, which are those that were mentioned in my written statement as well as issues of impact. And a work plan analysis will also look at the impact on states, plans, providers, and beneficiaries. And another type of impact that we intend to look at is how changes in financing could affect other programs that rely on Medicaid to finance medical care for populations they serve, such as child welfare and special education.

Mr. CA AE1RDENAS. OK, so you are cognizant of what could occur as a result of these alternative financing mechanisms and how they would affect system deliveries amongst all of our states.

Ms. SCHWARTZ. Yes, that is part of our work plan.

Mr. CA AE1RDENAS. OK. One concern that has been raised is that alternatives to restructure Medicaid financing are often intended to reduce federal Medicaid expenditures. This subsequently places a larger burden on states and providers. I am concerned this could have a negative effect on access to care. Will this consideration be included in the June report?

Ms. SCHWARTZ. Yes.

Mr. CA AE1RDENAS. OK. When you say yes, to what effect do you elaborate on that? Do you give examples? Do you extrapolate out on previous examples where we have done cuts in the past?

Ms. SCHWARTZ. I think our analysis will do both. We certainly have the experience from what states do now, when facing constrained spending. We can use data to help us look at the impact of different assumptions and so we can do both qualitative and quantitative analyses to look at those questions.

Mr. CA AE1RDENAS. And are there potential examples where cuts have had negligible to beneficial effects on local output of services and do we have examples that you could actually point to that have had negative effects in the past?

Ms. SCHWARTZ. The states have sort of a defined tool kit in which they currently use to address issues of spending growth. They can address enrollment. They can addresses, prices, payment rate. They can address covered benefits and they can also do innovations

to change the delivery of care and all of those provide good examples for helping us think about future approaches to finance.

Mr. CA AE1RDENAS. Thank you so much, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I believe that concludes questioning now.

I remind members they have 10 business days to submit questions for the record. So, they should submit their questions by the close of business on Wednesday, February 24th.

Good hearing. Very complicated issue. Important to educate all the members and the public. Thank you very much for your testimony. Without objection, the subcommittee is adjourned.

[Whereupon, at 12:08 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Illinois Health and Hospital Association

Statement by the Illinois Health and Hospital Association
Energy and Commerce Subcommittee on Health
Hearing on Examining Medicaid and CHIP's Federal Medical Assistance Percentage
February 10, 2016

The Illinois Health and Hospital Association (IHA), which represents more than 200 hospitals and nearly 50 health systems throughout the state of Illinois, appreciates the Energy and Commerce Committee's commitment to ensuring the health of the Medicaid program. Residents throughout the state of Illinois rely on Medicaid for their health and well-being. The care provided by Illinois hospitals to Medicaid beneficiaries is cost effective and provides taxpayers with a significant return on investment.

Illinois' Federal Medicaid matching rate of 50.89% is one of the lowest in the nation, despite being the 5th largest Medicaid provider by volume in the country. The state of Illinois currently receives an estimated 3.1% of annual Federal Medical Assistance Percentage (FMAP) funding but covers 4.8% of the nation's Medicaid beneficiaries. IHA believes that the FMAP that Illinois receives does not recognize the fact that Illinois is providing insurance coverage for one in four Illinoisans and one out of every two children in the state.

Moreover, Illinois hospitals provide care for residents of surrounding states that have a substantially higher FMAP rate which creates an inequity in reimbursements for providers. This disparity has proven to be a challenge in recruiting and retaining talented providers.

Illinois ranks 49th in the U.S. in average Medicaid per spending per enrollee, and Illinois hospitals are reimbursed far less than the cost to care for the state's most vulnerable population. Despite these challenges, Illinois hospitals provide high quality care for the state's nearly 13 million people, and generate nearly 500,000 direct and indirect jobs with an economic impact of $88.8 billion annually.

While IHA believes the current FMAP calculation may need to be updated, we strongly oppose recent proposals to reform the Medicaid program, such as converting the federal reimbursement into a block grant. IHA believes such drastic changes would adversely affect and limit the state and provider's ability to provide quality healthcare during economic downturns.

IHA stands ready to partner with Congress to enhance the value that the Medicaid program brings to the residents of the state of Illinois.

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FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Medicaid Policy Statement

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS
Medicaid, Child Health Insurance Program, benefits, coverage, financing, payment, eligibility, outreach, enrollment, managed care, quality improvement

ABBREVIATIONS
AAP—American Academy of Pediatrics
AARA—American Recovery and Reinvestment Act
ACA—Patient Protection and Affordable Care Act
CHIP—Children's Health Insurance Program
CMS—Centers for Medicare and Medicaid Services
CPT—*Current Procedural Terminology*
DHHS—Department of Health and Human Services
EHB—essential health benefits
EPSDT—Early and Periodic Screening, Diagnosis and Treatment
FMAP—federal medical assistance percentage
FPL—federal poverty level
HMO—health maintenance organization
MCO—managed care organization
MOE—maintenance of effort
PCMH—patient-centered medical home

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

Medicaid insures 39% of the children in the United States. This revision of the 2005 Medicaid Policy Statement of the American Academy of Pediatrics reflects opportunities for changes in state Medicaid programs resulting from the 2010 Patient Protection and Affordable Care Act as upheld in 2012 by the Supreme Court. Policy recommendations focus on the areas of benefit coverage, financing and payment, eligibility, outreach and enrollment, managed care, and quality improvement. *Pediatrics* 2013;131:1–10

HISTORY OF MEDICAID PROGRAM

The Medicaid program was enacted in 1965 as Title XIX of the Social Security Act with funding streams derived from both federal and state governments. All states have participated in this voluntary program since Arizona joined in 1982. Federal law designates which groups of people must be eligible for Medicaid enrollment and what core medical benefits must be provided. Each state may then expand eligibility criteria, enhance benefits, contract with managed care organizations (MCOs) to administer the Medicaid program, and apply for waivers to develop specialized programs for particular populations. For instance, states have had the option to enroll children whose families have an income at or below 200% of the federal poverty level (FPL) in Medicaid, although only 6 states had chosen to do so by 1997 when the State Children's Health Insurance Program (CHIP) was enacted by Congress as Title XXI of the Social Security Act.

By 2009, total Medicaid enrollment had grown to include 34.2 million infants, children, and adolescents younger than 21 years. Medicaid provided benefits to 39% of the US pediatric population and covered 48% of all births. In 2009, Medicaid payments to providers for all age groups had expanded to $326.0 billion.* Although children younger than 21 years represented 53% of all Medicaid enrollees, they

*These figures differ from the Medicaid data provided by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary[1] for several reasons. The higher CMS estimate of total Medicaid costs for fiscal year 2009 of $380.6 billion includes nonprovider expenses such as disproportionate share hospital payments, administration costs, the Vaccines for Children Program, and other adjustments. Calculated costs per participant also differ for 3 reasons: (1) CMS uses estimated "person-year equivalents" (50.1 million) for fiscal year 2009 rather than "ever participants" (62.9 million unique participants covered by Medicaid for at least 1 month) as the basis for the calculation; (2) the AAP considers 19- and 20-year-old participants to be children, whereas CMS considers them to be adults; and (3) CMS segregates both children and adults who are blind and/or disabled into a separate "disabled" category.

accounted for only 29% of all Medicaid provider payments. In 2009, Medicaid expenditures averaged $2630 per child younger than 21 years compared with $6459 per adult between the ages of 21 and 64 years and $11 812 per senior citizen 65 years or older.[2]

Except for a few special programs (eg, family planning services, American Indian/Alaskan Native populations, administrative costs), the federal government funds a different proportion of each state's Medicaid budget.[3] This federal medical assistance percentage (FMAP) for each state is based on a formula that relates the 3-year rolling average per capita income in the state to that for the entire United States. By law, the minimum and maximum FMAPs are 50% and 83%, respectively.[3] Before the passage of the 2009 American Recovery and Reinvestment Act (ARRA: Pub L No. 111-5), the FMAP varied across states from 50% to 76%. Under ARRA and other FMAP "extension legislation" (Education, Jobs, and Medicaid Assistance Act of 2010 [Pub L No. 111-226]), FMAPs temporarily increased through June 2011 (eg, to a range of 62%–85% in the second quarter of fiscal year 2010). These enhanced FMAPs transiently decreased state Medicaid expenditures for fiscal year 2009 through fiscal year 2011. However, with the sunset of ARRA FMAP legislation and more Medicaid beneficiaries due to continued poor economic conditions and other factors, state Medicaid costs increased sharply in fiscal year 2012 and are expected to continue to climb through fiscal year 2019.[4]

[2]Beginning in 2020, the federal government will still fund 90% of the additional costs associated with newly eligible participants under the ACA. If the ACA Medicaid expansion were to be adopted by all states, the Congressional Budget Office had estimated that the total increased cost of the Medicaid program attributable to Medicaid expansion from 2014 to 2019 would be $564 billion dollars, of which $500 billion, or 89%, would have been funded by the federal government.[3]

IMPACT OF THE ACA AND THE 2012 SUPREME COURT DECISION ON THE MEDICAID PROGRAM

Passage of the Patient Protection and Affordable Care Act (ACA)[3] in 2010[4] profoundly changed the Medicaid program through its expansion of Medicaid eligibility to all legal residents younger than 65 years with individual or family incomes at or below 138% of the FPL.[5] Hence, the ACA not only added a large population of adults (ages 19 through 64) who became newly eligible for Medicaid, but in many states, the expansion also increased the number of eligible children (through age 18) by mandating a higher minimum income eligibility.[6] The ACA directed the federal government to fund Medicaid expansion in full through 2016 and then at lower but still significant levels thereafter (tapering to 90% funding by 2020). The landmark Supreme Court decision upheld the constitutionality of the ACA with respect to the contested "individual mandate" for every American to obtain health insurance by a 5 to 4 margin.[5] However, the Court also struck down as unconstitutional an enforcement provision of the ACA that would have allowed the Department of Health and Human Services (DHHS) to withhold all federal Medicaid funding from states that declined to participate in Medicaid expansion. By a 7 to 2 majority, the Court ruled that this provision constituted undue coercion on states by the federal government; in a remedy, however, the Court upheld the constitutionality of the Medicaid expansion as an individual state option.

Legal scholars generally agree that the narrowly written Court decision did not invalidate other changes made by the ACA to the Medicaid program that pertained to existing populations.[6] The constitutionality of 3 provisions in particular has special importance for the pediatric population. First, Section 2001(b) of the ACA imposes a "maintenance of effort" (MOE) requirement that disallows states from restricting eligibility or reducing benefits for current child Medicaid beneficiaries until 2019. Second, Section 2001(a) (5) (b) expanded Medicaid eligibility for children under 19 by raising the minimum qualifying family income level to 138% of the FPL. Third, the ACA required states to improve outreach to and simplify enrollment of any person currently eligible for Medicaid.[6]

Many children now covered by Medicaid lose health insurance as they become young adults, so that how states choose to respond to the opportunity afforded by the ACA to participate in the adult Medicaid expansion can have a great impact on many pediatric patients. It is likely that additional negotiations will ensue in the future between the secretary of the federal DHHS and state Medicaid agencies that have initially

[3]Encompassing the Patient Protection and Affordable Care Act and the amendment law associated with that act, the Health Care and Education Reconciliation Act (Pub L No. 111-152).

[5]The ACA established a new national floor of Medicaid coverage at 133% of the FPL with a standard 5% of income disregard that constituted part of a simplified modified adjusted gross income calculation designed to harmonize means-tested eligibility (Medicaid disregards the first 5% of one's income before calculating the proportion to the FPL). The ACA had mandated a minimum income level for Medicaid eligibility at 138% of the FPL beginning in 2014.

[6]The number of children newly eligible for Medicaid in a given state as a result of the change in qualifying FPL will depend on that state's current choice of percentage of FPL as the eligibility criterion for Medicaid for older children as well as that state's implementation of and enrollment within CHIP. There are currently 2.8 million children below 138% of the FPL who are not currently insured by Medicaid or by CHIP. In addition, an unknown number of children with family incomes between 100% and 138% of the FPL who are currently insured by CHIP would rollover to Medicaid coverage and about 4.3 million children with family incomes between 100% and 138% of the FPL who are now covered by private insurance would potentially be eligible for Medicaid.

signaled reluctance to pursue full-scale Medicaid expansion.[6]

This revision of the American Academy of Pediatrics (AAP) Medicaid Policy Statement advocates for the provision and funding of children's services in the Medicaid program and highlights changes in or new opportunities for state advocacy efforts as a result of the passage of the ACA and the 2012 Supreme Court decision.

The AAP continues to voice strong support for the Medicaid program and over the years has offered a continuing series of recommendations aimed at enhancing care and improving outcomes for children.[7] In particular, the AAP has long advocated innovative approaches to care (such as pediatric medical homes) that aim to achieve better health outcomes while reducing costs of care. The AAP stands ready to support newer population health-based programs (eg, Medicaid accountable care organizations) that seek to attain those same objectives. AAP members have been integral providers in both regular Medicaid and in state-specific Medicaid waiver programs and consequently have working experience with reform efforts of varying success.

BENEFITS AND MEDICAL HOME

Beyond a core set of mandated benefits, federal guidelines provide states with wide discretion in benefit design. The AAP recommends that all state Medicaid agencies:

1. Provide all children at a minimum the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and all other mandatory and optional benefits as outlined in the AAP statement "Scope of Health Care Benefits for Children From Birth Through Age 26."[8] Ensure that the medical necessity definitions used by each state for purposes of justifying medical services covered by Medicaid payment are consistent with the EPSDT policy. Furthermore, each state's process for determining medical necessity should rely on the expertise of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Ensure that in the process of making decisions on the basis of medical necessity, the medical, behavioral health, and developmental care needs of the child are fully considered and that appropriate comprehensive benefits are available to address the full range of these needs.[9]

   Develop appropriate benefits that address the needs of pregnant women. Pregnant women should be afforded the full range of maternity care (preconception, prenatal, labor, delivery, and postpartum) recommended in the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. Detail the full scope of pediatric Medicaid benefits in consumer brochures, on Web sites, and, most importantly, in state plan documents and managed care contracts. State agencies should provide a clear comparison of pediatric Medicaid benefits and networks among managed care plans so that families can choose a plan that is most appropriate for the needs of their child(ren).
2. Provide pharmacy benefits appropriate for children and broad enough to pay for medicines and specialized nutritional products required for children with special health care needs and for children with rare diseases. State Medicaid Pharmacy and Therapeutics committees should populate and operate a pediatric formulary with the recognition that less expensive (usually generic) drugs may not be as effective as alternative but more costly (usually brand name) drugs of the same class in all patients under all circumstances. Pharmacy benefits should acknowledge that many medications are appropriately prescribed to children in the absence of a pediatric label indication or dosing information. Optimally, states should mandate that all Medicaid MCOs operating in the state adopt the same state pediatric Medicaid formulary to ensure continuous and consistent treatment of patients (especially those with special health care needs or rare diseases) because they often transition between Medicaid insurers.
3. Ensure that all children have timely access to appropriate services from those qualified pediatric medical subspecialists and pediatric surgical specialists who are needed to optimize their health and well-being.
4. Ensure that Medicaid provider networks are sufficient to guarantee that children who transition from pediatric to adult care providers do not experience disruption in services.
5. Adopt periodicity schedules as defined in the AAP guidelines.[10] Immunization schedules should also be consistent with national guidelines as periodically revised by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians.[11]

New or continuing efforts in which the AAP and its members can participate that can result in enhanced benefits for children enrolled in Medicaid programs include the following:

1. Develop and then facilitate the implementation of a working pediatric medical home model that

incorporates Bright Futures guidelines[12] and treatment services as codified in EPSDT.

2. Work with Medicaid and private insurance companies to standardize parameters for the medical home concept.[13,14] The wide variation in both panel size and family demographics encountered across pediatric practices suggests that a variety of models may be needed.
3. Develop and direct a program that educates parents, patients, and physicians about the advantages of a pediatric medical home.[15]
4. Partner with AAP state chapters, other pediatric health care providers, and families with children who are Medicaid beneficiaries to monitor and recommend improvements to state Medicaid programs and to the Centers for Medicare and Medicaid Services (CMS).
5. Assist parents, patients, and physicians to understand the full scope of Medicaid benefits.

FINANCING AND PAYMENT

Medicaid fee schedules and capitated payments to primary care and subspecialty providers are significantly lower than payments for comparable services from Medicare and private insurance companies. Low Medicaid payment is the primary reason that physicians limit participation in the program with resulting barriers to patient access for primary care and subspecialty health care services.[16–22] Even at academic medical centers that serve as "safety nets" for uninsured or underinsured patients, reduced access may be reflected by significantly longer wait times for subspecialty care.[23] Hence, the initial intent of Title XIX to provide truly equal access to quality primary and subspecialty care has not been fulfilled. Other documented reasons why providers decline or limit participation in Medicaid include delayed or unpredictable payments, confusing or burdensome payment policies and paperwork, and nonadherence to scheduled visits.[17,18,22]

Although the MOE provision in the ACA proscribes states from restricting their current Medicaid eligibility rules until 2019 for children, states may choose instead to reduce their expenses by limiting nonmandatory services for adults, trimming payments for services, revoking any higher payments to specific groups of physicians, and cutting hospital payments. States have voiced alarm that high unemployment rates and increasing numbers of families enrolled in Medicaid will critically affect their budgets. In addition, as the US population ages, the growing number of seniors who become eligible for Medicare will also swell the ranks of seniors dually eligible for Medicaid coverage. The CMS Office of the Actuary has estimated that if each state fully implemented the ACA Medicaid expansion, state Medicaid expenditures would more than double over the decade from 2009 to 2019, from $132.3 billion to $313.3 billion.[24] To the extent that any state chooses to participate in the ACA Medicaid expansion, it will be vital that federal and state governments not compromise necessary coverage for children nor fail to provide adequate payment for pediatric care. In addition, states must be cognizant that ACA discontinued federal disproportionate share hospital payments to all states, anticipating that Medicaid expansion to the adult population would provide replacement revenue for safety net hospitals. Hence, states that choose not to participate in Medicaid expansion may risk the viability of some safety net hospitals.

In 2011, Medicaid payments for evaluation and management services across all states averaged ~64% of the Medicare rates and lagged even farther behind payments by private insurers.[25] The ACA provides federal funding to Medicaid programs and state-financed Medicaid managed care plans to pay eligible physicians at Medicare rates for certain evaluation and management services, preventive care, and immunization administration during 2013 and 2014 (but not subsequently), including well-child ("checkup") codes (*Current Procedural Terminology* [CPT] codes 99381–99385; 99391–99395). Payment at this level should be sustained beyond 2014 and expanded to include all Medicaid services. This will require intense federal and state-specific advocacy.

The AAP proposes the following recommendations for federal and/or state action:

1. Ensure that Medicaid payments to providers for the goods and services involved in caring for children not only pay for the related work and practice expenses but also provide a sufficient return to make continued operation of a practice or facility economically feasible. In a broader context, payments should be sufficient to enroll enough providers and facilities so that, as required by federal law, Medicaid patients have "equal access" to care and services as do nongovernmentally insured patients in that geographic region. Failure to provide this fair level of payment will lead to continued early attrition of current pediatric providers as well as failure to attract physicians to pursue careers in primary or subspecialty pediatric care. To achieve this aim, the AAP recommends the following:
    a. Increase base Medicaid payment rates for all CPT codes, including pediatric specific CPT codes (eg, well-child checkup,

counseling, and developmental assessment), to all providers to the 2012 or 2009 regional Medicare fee schedule rate, whichever is higher, or, in the case of preventive services without a Medicare payment, to a rate calculated by applying Medicare fee schedule methodology to the published values of work, practice expense, and professional liability insurance relative value units adjusted for the geographic region. These payment rate principles should be made permanent (ie, extended beyond the 2014 termination date) with the minimum level of payment per CPT code established as the greater of the 2012 Medicare actual or calculated rate or the current year's rate.

b. Establish a methodology to provide additional fair payment to a practice that recognizes the extra resources that might be invested on behalf of its Medicaid patients to promote wellness (eg, to pay for more vigorous outreach to increase participation rates with well-child checkups) and to provide care coordination of infants and children with complicated physical and/or mental health illnesses (eg, to pay for care coordinators, social workers, extended office hours, home visitations, dental care, durable medical equipment, etc). At present, fee-for-service payments (even if increased to Medicare rates) and current Federally Qualified Health Center payments do not fully pay for these extra resources.

c. Reward practices that meet or exceed AAP-approved predefined quality and performance metrics with incentive payments.[26]

d. Require Medicaid managed care plans to determine payment based on the principles outlined in (a) and (b) so that pediatric providers and patient-centered medical home (PCMH) programs are appropriately compensated. Similarly, require managed care plans to make providers eligible for additional incentive payments, as in (c), if, for instance, providers demonstrate improved outcomes, reduction of total Medicaid costs, and robust efforts to transition children with special health care needs to adult care. Provide input to Medicaid managed care plans about possible designs and implementations of structured incentive programs based on quality and performance parameters advocated by the AAP.

e. Explore the feasibility of adjusting fee-for-service or capitated payments to a provider on the basis of a risk-adjustment mechanism that accounts for the extra costs associated with caring for children with chronic conditions and other key pediatric diagnoses among the children in the provider panel.

f. Establish a mechanism within state Medicaid agencies and Medicaid MCOs for rapid adjustment of fee-for-service or capitated payments to providers for recommended new vaccines and other new technologies that rapidly achieve translation from clinical trials to standard clinical practice.

g. Require that paperwork in support of claims is not unduly burdensome and that clean claims are paid within 30 to 45 days of submission, so that practices can meet their cash flow obligations.

2. Oppose the conversion of Medicaid financing to an annual allotment or block grant programs with a fixed budget. Block grant proposals typically result in cost shifting from federal to state budgets and do not reduce overall health costs or improve quality of care. In fact, institution of block grants in combination with revocation of the MOE provision in ACA would likely restrict eligibility and reduce benefits for children to result in the loss of the individual child's guarantee to access Medicaid services. Recently, the concept of using "per capita caps" to control Medicaid expenditures has resurfaced, but ultimately, this mechanism of funding poses the same risks for children as do block grants.

3. Work with the AAP to study the feasibility of implementing pediatric-specific accountable care organizations through carefully structured demonstration projects.[27,28]

4. Pay primary care physicians for behavioral health services that physicians are qualified and competent to provide. Eliminate carve-outs for behavioral health coverage.

5. Mandate that states perform an in-depth assessment of the fiscal viability of any health plan before contracting with that plan to administer a Medicaid program and conduct annual audits to verify continued fiscal stability of the health plan. Require states that contract with MCOs to publish their physician payment methodologies and rates for each child eligibility group on an annual basis.

6. Advocate for federal and state agencies to partner with organizations, such as the AAP, to educate

physicians about programmatic changes in Medicaid fee-for-service or managed care environments (eg, pay-for-performance and PCMH programs). Physicians should understand the quality and cost control objectives of new initiatives and the linkage between fully documenting achievement of these goals and payments to physician practices.

7. Pay for the administration of immunizations (including multiantigen vaccines) and for counseling using the current CPT code set. Payments for vaccines should be at least 125% of the current Centers for Disease Control and Prevention private sector price list and payment for immunization administration should be, at minimum, 100% of the Medicare rate for each vaccine administration CPT code.
8. Ensure, wherever possible, the availability of at least 2 financially viable Medicaid MCOs in every region to allow for patient choice. Requests for proposals for organizations to serve as Medicaid third-party administrators and the ensuing selection process should be fully transparent.
9. Explore innovative methods to establish trust funds to support graduate medical education specific to the provision of primary and subspecialty care for Medicaid participants that will help maintain a qualified pediatric provider workforce.
10. Require Medicaid to provide full payment for trained interpreter services for patients with limited English proficiency. This will assist in thorough and accurate communication between provider and participant, increased accuracy of diagnosis and more appropriate treatment plan, and increased participant understanding and adherence to treatment, thus avoiding adverse clinical consequences.
11. Pay for observational care, urgent care, day medicine services, and necessary interhospital transport services, including transport of neonates from tertiary or quaternary neonatal or pediatric intensive care units to step-down convalescent units.
12. Implement policies and procedures to ensure equitable and prompt payment to providers and facilities for pediatric services rendered to Medicaid patients out of state. States should work together and with the federal government to achieve uniform and seamless processes to pay for these services.
13. Require all payers to report financial data on an annual basis so that the medical loss ratios (the percentage of total funding that is spent on patient care functions) are clearly delineated and transparent to the public.
14. Require states to develop clear and transparent rules and regulations related to ACA provisions for recovery audit contracting processes. Each state must ensure that physicians who are licensed and have practiced in the state supervise the work of certified professional coders with expertise in pediatric primary and subspecialty care. Key stakeholders, including physicians and the public, must have direct input in the process to avoid flawed statistical analysis. Payment errors due to both undercoding and overcoding should be included in a final reconciliation report. A clear and fair appeals procedure that is accomplished in a timely manner must be part of the formal recovery audit contracting process.

ELIGIBILITY

The AAP endorses the ACA-mandated expansion of Medicaid eligibility to include all children who live in families with an income below 138% of FPL.[¶] The AAP recommends that states implement the following additional measures to facilitate enrollment of children eligible for Medicaid or CHIP benefits:

1. Remove the 5-year waiting period for eligible children and/or pregnant women who are lawfully residing in the United States consistent with the provisions of the CHIP Reauthorization Act (Pub L No. 111-3).
2. Identify uninsured children who are not financially eligible for Medicaid and if possible facilitate enrolling them in CHIP.
3. Ensure that children who are moved by the state into a foster care program are tracked and immediately enrolled in and covered by Medicaid until age 21 using the Chafee option.[#] In 2014, if chosen by the foster child alumna, Medicaid coverage becomes mandatory under the ACA until age 26.
4. Ensure that newborn infants eligible for Medicaid are assigned to a specific plan immediately after birth so that timely provision of services in the first few months of life is not impeded by anticipated difficulties in payments of claims.

OUTREACH, ENROLLMENT, AND RETENTION

The AAP recommends that states strengthen their outreach, enrollment, and retention efforts to enroll all eligible uninsured children in Medicaid, CHIP, or exchange coverage.

[¶] For fiscal year 2012, the FPL thresholds are $15 415 for a single adult and $31 809 for a family of 4, with the exception of Alaska and Hawaii, where thresholds are 25% and 15% higher, respectively.

[#] A Medicaid option, known as the Chafee option, allows states to extend Medicaid to former foster children but only up to age 21. Currently, there are 21 states that use the Chafee option to provide health care coverage to former foster youth (Chafee Foster Care Independence Act of 1999).

1. Use multiple sites and replicate other effective strategies as have been implemented in CHIP to maximize and maintain enrollment of individuals eligible for Medicaid.
2. Optimize coordination of Medicaid, CHIP, and exchange program outreach through the use of streamlined eligibility determination, redetermination and enrollment processes including the use of short and easily understood common application forms, and expanded use of online enrollment. Once a child is enrolled, coverage should continue for 12 months.
3. Consider using the medical home to enroll patients and provide a fair payment for the administrative expense of this procedure.
4. Adopt practices that result in a "no wrong doors" approach to enrollment. All venues for Medicaid, CHIP, and exchange program enrollment should be able to evaluate an applicant's eligibility for any of these programs and to process the appropriate application.
5. Advocate support for federal policies to provide incentives to states to increase enrollment and retention in Medicaid and to continue those incentives for CHIP programs.

MANAGED CARE

In recent years, fiscal and policy considerations have encouraged states to contract with MCOs to administer the Medicaid program. As of fiscal year 2009, an estimated 61% of Medicaid beneficiaries 0 through 20 years of age were enrolled in a Medicaid health maintenance organization (HMO).[2] The AAP recommends that all MCOs should adopt a pediatric medical home model for all children that adequately addresses their needs, including those with special health care needs. Network adequacy should be determined by periodic evaluation of the number of Medicaid providers whose panels are open to all new Medicaid patients.[29]

The AAP recommends that states adopt the following minimum set of practices and standards in their approach to Medicaid MCOs:

1. Ensure that MCOs (these may be either HMOs or provider-sponsored networks) provide educational materials to families that are culturally effective and written at literacy levels and in languages used by Medicaid recipients. The use of audiovisual aids should be encouraged.
2. Provide appropriate written, oral, and Web-based information and counseling to Medicaid eligible patients that allow informed patient choice of MCO-based network options for primary care physicians, pediatric medical subspecialists and pediatric surgical specialists, and pediatric hospital and ancillary services.
3. Assign Medicaid participants to an MCO that allows retention of the patient's medical home.
4. Recognize that pediatricians are primary care physicians who are eligible for pediatric patient assignment in all default enrollment systems.
5. Ensure that the provider network of all Medicaid MCOs contains the following components:
   a. Sufficient numbers of providers trained in primary care and subspecialty pediatrics, as well as pediatric surgical specialists.
   b. Sufficient numbers of physicians and other licensed providers of oral health, mental health, developmental, behavioral, and substance-abuse services so that medically necessary services are accessible within a reasonable length of time.
   c. When possible, a minimum of 1 hospital that specializes in the care of children.
   d. Vendors of durable medical equipment and home health care agencies that have experience caring for children, especially those with special health care needs.
6. License an MCO as a pediatric Medicaid provider only if its comprehensive pediatric network can provide children with quality care across the full continuum of care and hold that MCO accountable.
7. For Medicaid programs to be responsive to the needs of both patients and providers, it is essential that the programs be subject to either competition among at least 2 and when possible 3 MCOs in a region or to regulation that is regularly updated to reflect continuing input from patients and providers. Provider service networks (not-for-profit organizations created and governed by providers) should be evaluated and approved on a level playing field with HMOs.
8. Require that Medicaid administrative processes such as site visits and audits are simplified to minimize the burden for providers and office staff. Results of these processes should be available as a report card and transparent to prospective Medicaid enrollees.
9. Implement dedicated planning and oversight when MCOs contract for care delivery to children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and foster care children).
10. Establish an All Payer Claims Database and require MCOs to participate fully in reporting encounter

data. This would allow health policy analysts and researchers in government, academia, and the private sector to examine regional patterns of utilization, access to care, and quality of care and inform efforts to construct "best practice" models of care.

QUALITY IMPROVEMENT AND PROGRAM INTEGRITY

The AAP recommends that, as appropriate, CMS and the AAP, or state Medicaid agencies and state AAP chapters, should work collaboratively to develop and/or enhance quality-improvement activities that can benefit all children.

1. CMS should encourage collaboration among the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, the National Quality Forum, the AAP, and the CHIP Reauthorization Act Pediatric Healthcare Quality Measures Centers of Excellence. These organizations can evaluate current quality and performance measures with a goal of recommending modifications or achieving consensus around new measures that pertain to pediatric patients, including children with special health care needs. These measures should align with the recommendations outlined in the AAP policy statement "Principles for the Development and Use of Quality Measures."[26]
2. States should require health plans to use the core set of pediatric quality improvement measures that were created as part of the CHIP Reauthorization Act. These measures quantitate access to care, utilization of services, effectiveness of care, patient outcomes, and satisfaction of both patients and providers related to preventive, primary, acute, and chronic care for children. States should develop mechanisms for public reporting of these measures that allow Medicaid beneficiaries to compare outcomes among MCOs. Consistent with federal statute, states should require that all Medicaid programs provide access to quality primary and subspecialty pediatric care that is equal to that achieved through private payers ("equal access" mandate).
3. At a minimum, states should establish Medicaid Advisory Committees whose membership includes pediatric primary care and subspecialty providers. These committees can advise state Medicaid agencies on issues related to the identification, implementation, and evaluation of quality measures and improvement programs as well as issues related to eligibility, enrollment, formulary, network adequacy, access, and medical necessity. To achieve maximal benefit, each state Medicaid agency should employ a physician with pediatric expertise who can continuously assist the agency with these issues as they relate to pediatrics.
4. Federal and state agencies should work with the AAP to develop tools and measures to monitor potential changes in the quality of pediatric care and the outcomes of the pediatric population. These tools and measures will be helpful in evaluating the effect of PCMHs and the impact of reform on children with special health care needs.
5. States should assume central responsibility for key administrative procedures that pertain to all Medicaid providers. These procedures could include meaningful provider assessment, education (eg, fraud and abuse training), and credentialing activities that would apply for all payers within the Medicaid or CHIP programs.
6. States should report results of peer review and reviews of medical records in a timely manner to providers, plans, and beneficiaries consistent with applicable federal and state laws related to confidentiality, peer review privilege, and care review privilege.
7. States should monitor enrollment patterns and develop prospective means to assess reasons for changes in enrollment to ensure that MCOs do not encourage children with a high level of need to switch to other plans.
8. States should provide timely, meaningful, linguistically and culturally appropriate summaries of quality and performance measure and programs to beneficiaries to guide their choice of Medicaid plan.

CONCLUSIONS

By 2019, if the ACA Medicaid expansion were to be implemented by all states, 16 million additional individuals would gain insurance coverage through Medicaid and CHIP. Regardless of state variations in participation in the ACA Medicaid expansion, Medicaid will remain as the largest single insurer of children.[10] Additional legal proceedings and federal/state negotiations may clarify how DHHS will implement Medicaid expansion in the new adult population. In the meantime, the AAP supports state chapter advocacy efforts to expand Medicaid to the newly eligible population. Although AAP chapters might not take the lead in advocacy, they can provide pediatric expertise to coalition efforts and highlight the positive effects expansion will have on young adults.

To date, governmental health policy on both state and federal levels has not adequately met the medical, behavioral, and developmental needs of children. The ACA has provided a framework to redress some of these deficiencies. The AAP, through its network of chapters, sections, committees, councils, and staff and in partnership with other

allied organizations, can collaborate with both federal and state agencies to monitor implementation of those aspects of the ACA that promise to enhance the care and outcomes of children and young adults and perhaps suggest refinements for future regulations. Success in these endeavors will not only enhance the health and well-being of the children for whom pediatricians care but also will enrich our ability to provide the quality of care to which we aspire.

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Medicaid Policy Statement

COMMITTEE ON CHILD HEALTH FINANCING
Pediatrics; originally published online April 1, 2013;
DOI: 10.1542/peds.2013-0419

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Medicaid Policy Statement

COMMITTEE ON CHILD HEALTH FINANCING

Pediatrics; originally published online April 1, 2013;
DOI: 10.1542/peds.2013-0419

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

February 10, 2016

Statement for the Record
Benard Dreyer, MD, FAAP, President

On behalf of the
American Academy of Pediatrics

Before the
US House of Representatives Energy and Commerce Committee Health Care Subcommittee

American Academy of Pediatrics • Department of Federal Affairs
601 13th Street NW, Suite 400 North • Washington, DC 20005
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On behalf of the 64,000 primary care pediatricians, pediatric subspecialists and pediatric surgical specialists of the American Academy of Pediatrics, thank you for the opportunity to comment on the US House Energy and Commerce Health Subcommittee Hearing entitled "Examining Medicaid and CHIP's Federal Medical Assistance Percentage." Medicaid is a critical program for children, as it insures close to two in five children in the United States. Pediatricians know that Medicaid works to address the needs of children, and is critical to the health of close 2 of every 5 children in the United States.

Variable FMAPs and Complexity Generally

Medicaid is a complex program, however, pediatricians know that even with this complexity, Medicaid finances critical services for the most vulnerable children in the United States. Children are not just little adults, and pediatricians are intimately familiar with situations in which they are assumed to be. In particular, pediatricians confront the reality that work to help children and families thrive is valued and financed less than work for other populations. Federal and state investments in children are lower than for almost all other US populations. From the perspective of the American Academy of Pediatrics, this prioritization is reversed. Investments in children redound to the benefit of the country. Helping children achieve their full potential will create a "multiplier effect" beyond that normally associated in Medicaid academic literature that is focused on community economic activity, and sometimes used to bolster the argument for temporary increases in Medicaid federal matching percentages (FMAPs) during economic downturns. Investments to enable children to reach their full potential will generate more job creators, strengthen US military might and incubate new ideas by creating a healthy, resilient, creative, and better-informed future society.

Except for a few special programs (eg, family planning services, American Indian/Alaskan Native populations, administrative costs), the federal government funds a different proportion of each state's Medicaid budget. This FMAP for each state is based on a formula that relates the 3-year rolling average per capita income in the state to that for the entire United States. By law, the minimum and maximum FMAPs are 50% and 83%, respectively. Before the passage of the 2009 American Recovery and Reinvestment Act (ARRA: Pub L No. 111-5), the FMAP varied across states from 50% to 76%. Under ARRA and other FMAP "extension legislation" (Education, Jobs, and Medicaid Assistance Act of 2010 [Pub L No. 111-226]), FMAPs temporarily increased through June 2011 (eg, to a range of 62%–85% in the second quarter of fiscal year 2010). These enhanced FMAPs transiently decreased state Medicaid expenditures for fiscal year 2009 through fiscal year 2011. However, with the sunset of ARRA FMAP legislation and more Medicaid beneficiaries due to continued poor economic conditions and other factors, state Medicaid costs increased sharply in fiscal year 2012 and are expected to continue to climb through fiscal year 2019.[1]

Medicaid is a state-federal partnership that provides unprecedented flexibility to states to craft their program based on federal standards. States across the country have used that flexibility to mold their state's Medicaid to address the needs of their low-income and disabled populations.

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[1] COMMITTEE ON CHILD HEALTH FINANCING, "Medicaid Policy Statement," PEDIATRICS, March 2013

Policy prescriptions

Exciting Medicaid system reform efforts have been implemented across the country, and more system improvements are just around the corner. Medical home models are being funded by Medicaid in Arkansas, Colorado, Connecticut, Louisiana, Maine Vermont, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Jersey and Maryland, New Mexico, New York, North and South Carolina, Ohio, Oklahoma, Oregon, Rhode Island, and Wyoming.[2] In many instances, Medicaid is working quite well.

The Academy would recommend changes to the Medicaid program, which are captured in the attached Medicaid policy statement. Most notably, the Academy would recommend changes to improve benefits in a child's medical home; financing and payment; eligibility; and outreach, enrollment and retention; interaction with managed care; and quality improvement and program integrity. More information regarding these specific recommendations is contained in the attached Medicaid Policy Statement.

Thank you for your attention to the views of the American Academy of Pediatrics.

[2] See http://www.nashp.org/state-delivery-system-payment-reform-map/.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

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March 11, 2016

Dr. Anne L. Schwartz
Executive Director
Medicaid and CHIP Payment and Access Commission
1800 M Street, N.W.
Washington, DC 20036

Dear Dr. Schwartz:

Thank you for appearing before the Subcommittee on Health on February 10, 2016, to testify at the hearing entitled "Examining Medicaid and CHIP's Federal Medical Assistance Percentage."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on March 25, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

MACPAC | Medicaid and CHIP Payment and Access Commission

Response to Questions for the Record

Examining Medicaid and CHIP's Federal Medical Assistance Percentage
Hearing before the Health Subcommittee
Energy and Commerce Committee
February 10, 2016

Anne L. Schwartz, PhD
Medicaid and CHIP Payment and Access Commission

The Honorable Leonard Lance

Q: GAO and OIG have made several useful recommendations to modify Medicaid and CHIP's current financing to improve efficiency and accountability. In your testimony, you explain that in coming months, MACPAC will be "focusing intensively on program financing and design questions associated with other financing alternatives such as block grants, per capita caps, capped allotments, and shared savings." So is MACPAC planning to make any concrete, specific recommendations to modify Medicaid or CHIP's current financing to ensure the sustainability and accountability of the program?

A: At the request of the leadership of the Health Subcommittee, the full Committee on Energy and Commerce, and your colleagues in the Senate, MACPAC is engaged in a long-term work plan focused on advising Congress about potential policies and financing reforms to ensure the sustainability of Medicaid. At every Commission meeting since we received the congressional request, we have dedicated time to some aspect of this issue. Our work to date has focused on documenting trends in Medicaid expenditures, looking at the drivers of this spending, considering the incentives created by the design of financing under current law, and analyzing various financing alternatives. We have also reviewed major reform proposals put forward by blue ribbon commissions, think tanks, governors' associations, and foundations going back to the 1990s, as well as reform proposals included in Presidents' budgets going back to President Reagan.

At the Commission's upcoming meeting, it will review three related chapters on these topics to be included in its June report to Congress: one presenting detailed information on Medicaid spending trends, one analyzing the major approaches to financing reform, and one discussing the tools available to states to meet the spending limits anticipated under reforms such as per capita caps and block grants. Staff also anticipate that members of the Commission will provide feedback and direction on analyses that it will need as it considers making recommendations to Congress in 2016 and beyond. We look forward to sharing the results of that discussion with you, other Members of the Subcommittee, and your staff.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

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March 11, 2016

Ms. Carolyn Yocom
Director
Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Yocom:

Thank you for appearing before the Subcommittee on Health on February 10, 2016, to testify at the hearing entitled "Examining Medicaid and CHIP's Federal Medical Assistance Percentage."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on March 25, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

March 25, 2016

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Subject: Responses to Questions for the Record; Hearing Entitled *"Examining Medicaid and CHIP's Federal Medical Assistance Percentage."*

This letter responds to your March 11, 2016, request that I address questions for the record related to the Subcommittee's February 10, 2016, hearing on Medicaid. My responses to the questions, which are in the enclosure, are based on GAO's previous work and knowledge on the subjects raised by the questions.

If you have any questions about the responses to your questions or need additional information, please contact me at (202) 512-7114 or yocomc@gao.gov.

Sincerely yours,

Carolyn L. Yocom
Director, Health Care

Enclosure

The Honorable Michael Burgess

GAO has said that PCI does not take into account differences among states in relative size or health care need of a population, such as the proportion of beneficiaries who are elderly or disabled. Would a system in which the amount of funding is based on the category or type of beneficiary be more equitable?

Achieving the equitable allocation of Medicaid funds across states poses significant challenges. Under the current Medicaid financing system, the federal share for most expenditures is determined by the Federal Medical Assistance Percentage (FMAP) formula on the basis of state per capita income (PCI), such that the federal government pays a larger portion of Medicaid expenditures in states with low PCIs relative to the national average, and a smaller portion for states with higher PCIs. We have reported that PCI is a poor proxy for the size of a state's population in need of Medicaid services, as two states with similar PCIs can have substantially different numbers of low-income residents.[1]

With regard to distributing funds based on category or type of beneficiary enrolled, our work has also found that differences between states in the distribution of enrollees among the four major eligibility groups do not fully explain the variation among states in overall per-enrollee Medicaid spending, as states also vary in spending for each of the four eligibility groups.[2] Our work suggests that a combination of measures that account for variations in (1) the demand for Medicaid services, (2) geographic differences in the costs of providing health care services, and (3) state resources could provide a basis for allocating Medicaid funds more equitably among states than the current FMAP.

What are the effects of the current FMAP floor and ceiling on the equitable distribution of funds? For example, a 2003 report by GAO noted that two of the 11 states that then benefitted the most from the 50 percent "floor" receive matching rates that were 35 and 20 percentage points higher, respectively, than the rates they would receive based solely on their PCI.

Federal law specifies that the FMAP will be no lower than 50 percent (referred to as the FMAP floor) and no higher than 83 percent (referred to as the FMAP ceiling). (See 42 U.S.C. § 1396d(b)). In our 2003 report, we measured states' ability to fund Medicaid services by dividing each state's financial resources potentially subject to state taxation by its number of low-income residents, adjusted for the cost of providing health care to them.[3] We then compared states' funding ability from their own resources with their funding ability after their resources have been augmented to include the value of the federal share they receive under the FMAP. Based on this comparison, we reported that the FMAP floor of 50 percent generally further increases the funding ability of states that already have higher than average funding ability based on their own resources. Specifically, 11 states received higher FMAPs in fiscal year 2002 because of the 50

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[1]See GAO, *Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably,* GAO-13-434 (Washington, D.C.: May 10, 2013).

[2]See GAO, *Medicaid; Assessment of Variation among States in Per Enrollee Spending,* GAO-14-456 (Washington, D.C.: June 16, 2014).

[3]See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened,* GAO-03-620 (Washington, D.C: July 10, 2003).

percent FMAP floor than they would have if their FMAPs had been based only on their PCI, and 10 of the 11 states already had higher than average funding ability based on their own resources. With regard to the FMAP ceiling, no state is currently receiving the maximum FMAP of 83 percent. The highest FMAP for fiscal year 2016 is 74.17 percent. In fiscal year 2016, 13 states have FMAPs of 50 percent; however, we have not analyzed what these states' FMAPs would have been without the FMAP floor.

The Honorable Leonard Lance

When there is a national economic downturn, which would also affect federal revenues, why does GAO think it preferable for the federal government to provide the increased funding rather than the states? How does this impact the Federal-State partnership?

Whether to provide increased federal funding during a national economic downturn is a policy decision under the purview of the Congress. During previous economic downturns, however, Congress has, on multiple occasions, elected to provide increased Medicaid funding to assist states experiencing revenue declines and expenditure increases that are associated with the downturns. For example, in response to the U.S. recession that occurred from December 2007 to June 2009, the American Reinvestment and Recovery Act of 2009 (Recovery Act) temporarily increased the federal share of Medicaid funding to help states maintain their Medicaid programs and provide states with general fiscal relief. The Recovery Act also included a provision for GAO to study options for providing a temporary increased FMAP in response to future recessions. We developed a prototype formula that would provide a baseline of funding for state Medicaid needs during an economic downturn by offering automatic, timely, and targeted assistance to states.[4]

The assistance provided under the American Recovery and Reinvestment Act included "hold harmless" and "across the board" increases. Why are these not included in GAO's formula?

The inclusion of across the board increases and hold-harmless provisions in the assistance provided under the Recovery Act reduced the extent to which funds were targeted to states most in need because these provisions did not take into account how states were differently affected by the economic downturn.[5] Thus, past efforts were not as responsive to state Medicaid needs as they could have been. In the development of our prototype formula outlined in our November 2011 report, we made a number of choices about specific elements of the

[4]See GAO, *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns*, GAO-12-38 (Washington, D.C.: Nov. 10, 2011).

[5]The Recovery Act formula incorporated three components for calculating the increased FMAP: (1) a hold-harmless provision that maintained each state's regular FMAP to at least its highest rate since fiscal year 2008; (2) an across-the-board increase of 6.2 percentage points; and (3) an additional increase in each state's FMAP based on a qualifying increase in the state's rate of unemployment. The hold-harmless provision maintained the regular FMAP regardless of changes in PCI. As a result the largest increases in FMAP due to the hold-harmless provision went to states with improving economic conditions relative to the national average, as measured by PCI. The across-the-board increase provided an equal percentage point increase in FMAP, which disproportionately benefits states with higher regular FMAP rates.

formula design for improving the timing and targeting of funds.[6] In contrast to the Recovery Act, which provided funds for broad state fiscal relief in addition to supporting state Medicaid programs, our formula was calibrated to provide a baseline of funding only for state Medicaid needs during a downturn.[7] The prototype formula uses two targeting components: (1) unemployment, and (2) wages and salaries. The amount of Medicaid assistance states receive would be commensurate with their increases in unemployment and decreases in wages and salaries.

[6]See GAO-12-38.

[7]However, this formula could be scaled up to address broader state needs or scaled down to meet only a portion of state Medicaid needs.

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ONE HUNDRED FOURTEENTH CONGRESS

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March 11, 2016

Mr. John Hagg
Director of Medicaid Audits
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Hagg:

Thank you for appearing before the Subcommittee on Health on February 10, 2016, to testify at the hearing entitled "Examining Medicaid and CHIP's Federal Medical Assistance Percentage."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on March 25, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment

The Honorable Michael Burgess

1. **Under the Affordable Care Act, the federal government is paying 100 percent of the costs for Medicaid expansion populations. In addition, due to the ACA's 23 percent bump in the enhanced FMAP, the federal government is currently paying all of the costs for CHIP in 12 states. Does OIG have any concerns that the lack of state contribution will affect state incentives to ensure that Medicaid payments are appropriate and accurate?**

   States share accountability for the integrity of the Medicaid program with the Federal Government. In situations in which the Federal Government is financing 100 percent of costs for Medicaid services, States could have less incentive to devote scarce oversight resources to ensuring the accuracy of Medicaid payments. We would consider areas in which the Federal Government pays 100 percent of costs to be higher risk than areas in which States share in costs.

The Honorable Frank Pallone, Jr.

Mr. Hagg, during the Energy and Commerce Health Subcommittee Hearing on "Examining Medicaid and CHIPS's Federal Medical Assistance Percentage" on February 10, 2016, you were asked a question by Mr. Cardenas which we request clarification on your response. During the hearing, Mr. Cardenas asked you, "One report that OIG has highlighted is a review of Federal reimbursement for family planning services in California, specifically in the San Diego area… …In this report, over half of the improper claims were noted to be for visits that included testing for sexually transmitted infections. Is it true that after this report, CMS released guidance clarifying that STI testing is classified as family planning services for the purpose of calculating the FMAP?"

In April 2014, CMS issued a State Medicaid Director's letter clarifying policy regarding the coverage of family planning related services. The letter states "[f]amily planning services receive Federal financial participation at an enhanced rate of 90 percent, while family planning *related* services are matched at the [S]tates' regular Federal medical assistance percentage." CMS further states it has determined that services such as the "diagnosis and treatment of an STI are always provided 'pursuant to' a family planning service. These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit."

In your response, you acknowledged that CMS released a letter on the topic to State Medicaid directors in 2014, but with the caveat that you would be able to more accurately answer the question if you were able to review the letter. Subsequently, you stated that you believed that testing for "sexually transmitted infections would have been classified as family planning related, which would be billed at the regular FMAP rate and not the enhanced family planning FMAP rate."

1. **Mr. Hagg, can you please verify the accuracy of your previous response? Is it true that in 2014, CMS released a letter that clarified STI testing should be classified as family planning services for the purposes of calculating the FMAP?**

   In its April 2014 State Medicaid Director letter regarding Family Planning and Family Planning Related Services Clarification, CMS provided clarification regarding the coverage of family planning related services provided to individuals eligible under the optional categorically needy state plan group created by section 2303 of the Affordable Care Act. The letter states "[f]amily planning services receive Federal financial participation at an enhanced rate of 90 percent, while family planning *related* services are matched at the [S]tates' regular Federal medical assistance percentage." CMS further states it has determined that services such as the "diagnosis and treatment of an STI are always provided 'pursuant to' a family planning service. These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit." Therefore, it is my understanding that under this policy clarification, STI testing services would be matched at the State's regular FMAP.

2. **In the San Diego report, OIG claimed that 23 out of the 29 claims surveyed were not eligible for *any* federal reimbursement (not even the regular federal match) because the "primary purpose of the visit was not family planning," even though the vast majority of these claims were related to testing and treatment for sexually transmitted infections. The Centers for Medicare and Medicaid Services released a Dear State Medicaid Director Letter on April 16, 2014 clarifying that STI services are always related to family planning. This makes sense, particularly since some STIs, if left untreated, could result in infertility. Given the recent Dear State Medicaid Director Letter, wouldn't you agree that OIG's earlier determination that STI services do not qualify for federal reimbursement because they are unrelated to family planning was incorrect?**

   When OIG conducts audits, it performs those audits to determine compliance with the rules and regulations that are in place at the time of the audit. At the time OIG conducted the audit in question, the rules in place governing family planning services did not allow for Federal reimbursement for testing for STIs. When CMS issued its April 2014 letter, the agency changed policy and "determined that services such as the diagnosis and treatment of an STI are always provided 'pursuant to' a family planning service. These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit." From April 2014 moving forward, OIG would use the CMS guidance in all audits of family planning claims.

3. **I am concerned that OIG may be misinterpreting federal statute and implementing federal guidance regarding family planning when it conducts audits. For example, in addition to the reports you cite to today, OIG also conducted an audit of family planning claims in North Carolina. In that audit report, OIG determined that a majority of pharmacy claims for birth control did not qualify for the 90 percent match because they were prescribed for purposes other than contraception, such as to help regulate menstruation. Isn't it true, though, that regardless of a patient's reasons for using birth control that birth control still works to prevent pregnancy? Why would a**

patient's reasons for using a contraceptive negate the 90 percent match provided by federal statute when birth control is clearly a family planning service?

Yes, it is true that regardless of a patient's reasons for using birth control it works to prevent pregnancy. However, pursuant to section 4270(B)(2) of the CMS *State Medicaid Manual*, "only items and procedures clearly provided or performed for family planning purposes may be claimed at the 90 percent rate." Section 4270(B) also states Congress' "intent of placing emphasis on the provision of services to 'aid those who voluntarily choose not to risk an initial pregnancy,' as well as those families with children who desire to control family size." It is our understanding that birth control medication can be provided to treat numerous medical conditions such as, but not limited to, acne, endometriosis, and polycystic ovarian syndrome.

4. **It is my understanding that Medicaid reimbursement works in two stages. At the first stage, the provider submits a claim to the state (or managed care plan). The state (or managed care plan) reviews the claims and reimburses the provider accordingly. At the second stage, the state seeks the federal match for its expenditures. Is it correct that providers do not directly receive reimbursement from the federal government, and that it is a state's responsibility – not a provider's responsibility – to ensure that only eligible claims receive the enhanced federal match?**

   It is correct that the providers are paid by the States and not directly by the Federal Government. States withdraw Federal funds from the Department of the Treasury Payment Management System to pay the Federal share of Medicaid expenditures. Additionally, States report expenditures and the associated Federal share to CMS on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The State is responsible for claiming FMAP at the correct rate.

5. **OIG conducts audits on other services, and has found, for example, that Texas was overpaid more than $30 million in federal funds for non-emergency transportation services and New York was overpaid nearly $77 million for disability services. While these services are valuable, family planning care has proven to have tremendous cost-savings, with every $1 spent on publicly-funded contraceptive care saving more than $7 in other costs. Is it fair to say that OIG routinely conducts audits for a variety of Medicaid services, that claims for unallowable costs for family planning services are relatively low when compared to other Medicaid services, and that the federal and state governments still benefit from the cost-savings generated from the provision of family planning services?**

   It is fair to say that OIG routinely conducts audits of a variety of Medicaid services. These services can include family planning services, dental services, transportation services and many other services.

   OIG has identified large amounts of unallowable claims for service areas other than family planning. Based on our recent work involving family planning services, we have identified unallowable payments totaling over $82 million, or about 9.3 percent of all family planning costs that we have reviewed. While the $82 million in unallowable

payments may be low compared to some other service areas, we consider the error rate of 9.3 percent to be high.

OIG does not have information about, and is not in a position to opine on, the cost-savings generated from the provision of family planning services.

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