TESTIMONY OF

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CENTERS FOR MEDICARE & MEDICAID SERVICES

BEFORE THE

HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

ON

THE ADMINISTRATION'S REGULATORY ACTIONS ON MEDICAID: THE EFFECTS ON PATIENTS, DOCTORS, HOSPITALS, AND STATES

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CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of Dennis G. Smith
Director of the Center for Medicaid and State Operations at the
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Thank you for inviting me to discuss regulatory activities in 2007 by the Centers for Medicare & Medicaid Services (CMS) on a variety of Medicaid regulations, specifically our final rule on Cost Limits for Providers Operated by Units of Government, as well as Notices of Proposed Rulemaking on Health Care-Related Taxes; Graduate Medical Education; Rehabilitative Services; Medicaid Reimbursement for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School; and Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit.

Each of these rules is vitally important to ensure the integrity of the Medicaid program, that Medicaid beneficiaries are receiving the services for which Medicaid is paying, that those services are effective in improving the health outcomes of individuals with Medicaid, and that taxpayers are receiving the full value of their dollars that are spent through Medicaid.

Medicaid: A Partnership with States

Medicaid is a means-tested health care program for low-income Americans, administered by the States within a Federally defined framework. CMS provides matching payments to States and Territories to cover Medicaid services and related administrative costs.

State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. The Federal government's share of a State's Medicaid expenditures is called the Federal Medical Assistance Percentage (FMAP), which currently ranges between 50 percent and 76.9 percent.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. Accordingly, there is variation among the States in eligibility, services, and reimbursement rates to providers and health plans. In short, Federal dollars follow State dollars. Spending also reflects State demographics regarding age and the wellness of the State population. For example, a State with a "younger" population would generally spend less on Medicaid than a State with an "older" population. In 2005, the average per capita spending on a child in the Medicaid program was $1,608, while the average spending for a senior in the Medicaid program was $11,898. In FY 2005, 87 percent of children consumed less than $2,500 in services while 54 percent of seniors required Medicaid benefits in excess of $2,500.[1]

In Fiscal Year (FY) 2008, CMS estimates that approximately 50 million individuals in States and Territories across the country will be covered by the Medicaid program. However, I want to point out that Medicaid is actually at least four distinct programs. First, it functions as a health insurance program for an estimated generally healthy 35.3 million indigent children and their parents or caretaker relatives. Approximately 30 percent of Medicaid expenditures goes to this population. Second, Medicaid provides "Medi-Gap" and long-term care insurance benefits for over 5 million senior citizens. Approximately one-third of Medicaid spending is attributed to long-term care services and supports. Medicaid is estimated to spend over $11 billion in FY 2008 paying for Medicare premiums and cost sharing on behalf of low-income seniors and people with disabilities who qualify for Medicare. Approximately 20 percent of Medicaid payments

[1] These calculations are based on Medicaid Statistical Information System data for the year 2005. The denominator includes individuals enrolled in Medicaid at any point in the year.

are made on behalf of low-income seniors. Third, an estimated 8.6 million individuals with disabilities rely on the Medicaid program for both acute medical needs and long-term care services and supports, which together will account for about 45 percent of Medicaid expenditures in FY 2008. For individuals with disabilities, Medicaid is not just about access to medical care, but also provides supportive services that enable individuals with disabilities to live in their community as they choose. Finally, through the Disproportionate Share Hospital (DSH) payment program, Medicaid is expected to contribute approximately $17.3 billion in FY 2008 to hospitals to reimburse them for indigent care as well as to supplement Medicaid payment rates.

According to the most recent unadjusted State estimates, medical assistance payments, Federal, State, and local combined, are projected to total $345.6 billion in FY 2008, of which $196 billion will be provided by the Federal government. This is an increase of approximately six percent above spending for FY 2007.

For much of the program, Medicaid looks like a typical third-party payer as it reimburses for inpatient and outpatient hospital services, physician services, laboratory and radiological services and prescription drugs. But Medicaid has also been given unique roles for the special populations who depend on the program. Medicaid is the largest single source of direct payment for nursing home services at a projected cost of $50 billion in FY 2008. Medicaid is the largest single source of direct payment for mental health services. States project spending nearly $11 billion on "personal care" services, another $13.8 billion for intermediate care facilities for the mentally retarded, and $31.4 billion for home and community-based services for individuals at risk of institutional care. CMS classifies 28 distinct service categories of spending in our budget reporting forms that States are required to submit each quarter. In addition, there is a "catch-all" spending category of "All Other." In FY 2008, "All Other" will represent $13.2 billion in spending on other care services that may include non-emergency transportation, physical and occupational therapy, dentures, eyeglasses, and other diagnostic, screening, rehabilitative, and preventative services and emergency hospital services. Notably, this does not include the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit,

States are instructed specifically to report screenings for children under EPSDT as a separate category.

In addition, another $18.6 billion will be spent on administrative costs, of which the Federal government will provide approximately $10 billion. Administrative costs are broken down by categories including computer systems, skilled professional medical personnel, external quality reviews, Immigration Status Verification System, and out stationed eligibility workers. Eligibility workers and State and local personnel managing the program make up the bulk of these costs. But we also know that some States also include expenditures for school-based administrative costs, non-emergency transportation, and targeted case management into this item.

My purpose for providing this detail of Medicaid expenditures is to provide a backdrop for the specific regulatory actions we are discussing today. I hope it is helpful for the Committee to understand that there are many different rooms in the Medicaid program and it is often a challenge for CMS to track what may be occurring among the States. Also, to give the Committee appropriate context for today's discussion, I want to clarify that the combined total of these CMS regulatory actions represent approximately one percent of annual Federal spending on Medicaid.

Preserving the Medicaid Partnership

Unfortunately, there is a long and complicated history that is marked by States seeking to shift funding of the Medicaid program to the Federal government; Federal recognition of this occurrence dates back to at least 1991 when Congress enacted prohibitions on provider taxes and donations. Each of the regulations that are the subject of today's hearing has previously been the subject of Congressional scrutiny over the years. Many of the policies that are reflected in these regulations have been advocated or supported by the Government Accountability Office (GAO) in the past or at least acknowledged by GAO as a source of potential Federal fiscal vulnerability.

The essence of these regulations is that Medicaid is a financial partnership and that it is inappropriate for States to shift their matching responsibilities to either the Federal government or to providers.

While we work to protect the integrity of Medicaid as a matching program, we have worked cooperatively with States to resolve funding disputes through a deliberative approach in order to avoid major disruption of State budgets. CMS was successful in ending impermissible funding arrangements in 30 States without creating major funding problems for those States.

The recent financial management actions taken by CMS are in line with the previous Administration. Between FY 1993 and 2000, the previous Administration took 990 deferrals totaling $3.1 billion and 162 disallowances totaling $2.2 billion (table attached). Between FY 2001 and 2007, CMS has taken 757 deferrals totaling $4.7 billion and 189 disallowances totaling $2.9 billion. There are two caveats to these figures. First, our increased dollar amounts are also on a significantly larger Medicaid program than was the case in the period of FY 1993-2000. Additionally, the $1.6 billion amount attributed to FY 2001 was in large part due to actions taken by my predecessor against five States related to provider taxes that the Agency eventually lost at the Departmental Appeals Board.

Thus, our actions have caused no major disruptions on State budgets or in the delivery of services to Medicaid recipients. CMS' actions are geared to identifying and preventing the spread of new loopholes that could be used by States to inappropriately shift costs to the Federal government. Medicaid is already an open-ended Federal commitment for Medicaid services for Medicaid recipients; it should not become a limitless Federal account for State and local programs and agencies. To this end, the GAO has provided Congress with numerous reports on how consultants in various areas assist States in maximizing Federal revenues.

Final Medicaid Cost Rule

CMS issued the final rule regarding the Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership (Cost Rule) on May 25, 2007 with a July 30, 2007 effective date. The final rule implements the President's FY 2007 Budget proposal to strengthen the fiscal integrity of the Medicaid program by: (1) limiting governmentally-operated health care providers to reimbursement that does not exceed the cost of providing Medicaid covered services to Medicaid individuals; (2) reiterating that only units of government are able to participate in the financing of the non-Federal share of Medicaid payments; (3) establishing specific cost reporting requirements that build upon existing requirements for documenting cost when using a certified public expenditure; and (4) reaffirming that all health care providers receive and retain the total computable amount of their Medicaid payments.

Over the last few years, CMS has been closely examining Medicaid institutional and non-institutional reimbursement State plan amendments (SPAs) and their associated funding arrangements due to agency concerns about questionable methods of State Medicaid financing. The GAO and the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) have expressed similar concerns about Medicaid financing practices. In fact, in 2003 GAO placed Medicaid on its list of "high risk" programs for the first time in the Medicaid program's history in part due to these questionable methods of State financing. Additionally, GAO cited in a recent report, "For more than a decade, we have reported concerns relating to actions by some states that result in excessive federal reimbursement. We have also reported concerns that CMS's oversight of states' claims for reimbursement and CMS's efforts to detect and reduce improper payments in the Medicaid program."[2]

Prior to the effective date of the Cost Rule, payments to individual State and local governmentally-operated health care providers were not limited to the amount it actually costs to provide these services. Instead, regulations defining the Medicaid Upper

[2] GAO, *Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts.* GAO-06-705, June 22, 2006, page 1.

Payment Limit (UPL) established aggregate limits on what Medicaid will pay to a group of facilities based on estimates of the amounts that would be paid for similar services using Medicare payment rules. The result of such an aggregate limit would permit a particular governmentally-operated health care provider to receive Medicaid revenue in excess of its Medicaid costs.

By requiring that Medicaid payments to governmentally-operated health care providers not exceed an individual provider's cost, the Cost Rule will ensure that the Federal government pays only its share for Medicaid services delivered by that provider. This reform is critical to strengthening program accountability, consistent with GAO and OIG recommendations.

Some have criticized this rule for potentially having a negative impact on providers. If such an impact were to negatively affect providers, it would be due to decisions made by State and/or local governments, not by CMS. State responsibility for funding has in the past been pushed onto providers. CMS does not believe such maneuvers are appropriate, nor do they meet the matching requirements of the Medicaid program. It is also important to note that non-governmentally operated health care providers, including many of the "public" safety net providers, are not affected by the cost limit provision and therefore, may continue to receive Medicaid payments in excess of the cost of providing services to Medicaid individuals, within existing Federal requirements.

Clarification of Outpatient and Clinic Upper Payment Limit

The proposed regulation intends to clarify the current vague regulatory language in order to define the scope of Medicaid outpatient hospital services and the UPL for those services. Clarifications were made to regulatory language at 42 CFR 440.20 and 42 CFR 447.321. The rule recognizes services paid under the Medicare outpatient prospective payment system or paid by Medicare as an outpatient hospital service under an alternative payment methodology as Medicaid outpatient hospital services. The scope of Medicaid outpatient hospital services may not include a service reimbursed under a distinct State plan payment methodology for another Medicaid covered service. The rule

also limits the facilities that may provide outpatient hospital services to hospitals and departments of an outpatient hospital as defined at 42 CFR 413.65.

In addition, the rule would codify HHS policy regarding the UPL for Medicaid outpatient hospital services in private facilities by referencing accurate data sources and the formula to calculate a reasonable estimate of the amount that would be paid for outpatient hospital service furnished by hospitals and outpatient departments of hospitals under Medicare payment principles.

The regulation intends to prevent an overlap between outpatient hospital services and other covered benefits. The potential overlap could result in circumstances in which payment for services is made at the high levels customary for outpatient hospital services instead of the levels associated with the same services under other covered benefits.

By clarifying the UPL definition, CMS seeks to provide additional guidance on accurate data resources and formulas to help States demonstrate compliance with 42 CFR 447.321. CMS has issued this guidance informally to States in the past. However, a number of States have requested the guidance be issued through regulation. Further, CMS does not anticipate a major impact on providers or beneficiaries under this regulation as we do not believe attempts to inflate UPLs through this manner are widely used currently, but we do believe it is important to clarify this policy.

Elimination of Reimbursement for Administrative Claiming and Transportation Costs for School-Based Services

CMS issued a proposed regulation, published in the Federal Register on September 7, 2007, clarifying that administrative activities performed by schools are not necessary for the proper and efficient administration of the State Medicaid plan. The proposed rule also specifies that transportation of students from home to school and back is not within the scope of allowable Medicaid-related transportation recognized by the Secretary. Therefore, under the proposed rule, funding for the costs of these activities or services performed would no longer be available under the Medicaid program.

I want to strongly emphasize, as there has been some misunderstanding about the proposed rule, that this rule is not a limitation on medical services provided by schools. States will continue to receive reimbursement under the Medicaid program for school-based Medicaid service costs under their approved State plans under current law. For example, if a child is Medicaid-eligible and receives physical therapy, this rule does not change the benefit or the level of reimbursement.

CMS has had long-standing concerns about improper billing under the Medicaid program by school districts for administrative costs and transportation services. Both HHS' OIG and the GAO have identified these categories of expenses as susceptible to fraud and abuse. Congress has also expressed concern over the dramatic increase in Medicaid claims for school-based administrative costs and transportation services, which were the subject of two U.S. Senate Finance Committee hearings.

States reported a total of $849 million of expenditures for administration and training in FY 2006, of which the Federal share was $428 million. Most of this spending was concentrated on a handful of States. Specifically, two States accounted for 40 percent of the entire claims submitted for administration and training. Eight States accounted for 80 percent of the claims. Between FY 2002 and FY 2006, two States went from $0 in claims to more than $30 million in claims. Conversely, another State went from $84 million in claims to $3.5 million in claims during the same period. Some States have made larger claims for administration and training costs than they claimed for actual medical assistance services.

In an audit of one county, the OIG determined that $5.8 million out of $12.5 million claimed for administrative costs were in fact not allowable. Medicaid was improperly charged for nearly $4 million in capital expenditures.

Rehabilitative Services

CMS issued a proposed regulation, published in the Federal Register on August 13, 2007, that clearly defines allowable services that may be claimed as "rehabilitative services."

Rehabilitation services are optional Medicaid services typically offered to individuals with special needs or disabilities to help restore a lost function and improve their health and quality of life. In recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a "catch all" phrase. "Rehabilitative services" have become so broad that it has become meaningless and States have taken advantage of the ambiguity and confusion to bill Medicaid for a wide variety of services outside the scope of medical assistance.

CMS believes our regulation will improve the quality of care provided to the individuals who need these rehabilitative services. Our proposed rule is clinically based, and is patient centered.

CMS' recent history in dealing with SPAs reveals that States themselves often have difficulty in identifying what is actually meant by rehabilitative services and what their reimbursement rates are based upon. Medicaid will benefit from greater clarity and should not be left open to other programs, no matter how important, in search of a funding source.

Proposed Rule on Graduate Medical Education

For several years, many States have developed a pattern of using Medicaid to subsidize the costs of physician training programs. We believe that paying for Graduate Medical Education (GME) is outside the scope of Medicaid's role, which is to provide medical care to low-income populations. There is no explicit authorization under the Medicaid statute to subsidize the training of physicians. In a time of limited Federal and State resources, it is important to prioritize Medicaid spending and target it to its primary purpose.

Proposed Rule on Provider Taxes

The President's FY 2007 Budget Request proposed to reduce the reliance on health care related taxes as a source of the State's share of financing the Medicaid program. The

Administration proposed to reduce the amount of tax collected from health care providers from 6 percent of net patient services revenue to 3 percent. However, before the Administration could proceed with the proposal, Congress took action through the Tax Relief and Health Care Act of 2006 to temporarily reduce the allowable amount from 6 to 5.5 percent of net patient service revenue, effective January 1, 2008 through September 30, 2011.

On March 23, 2007, CMS published a notice of proposed rulemaking (NPRM) to implement the Congress' direction regarding the allowable amount of health care related tax collections. The NPRM also did the following: (1) Clarified the standard for determining the existence of a hold harmless arrangement; (2) Clarified the definition of a managed care organization (MCO) as a permissible class of health care service as enacted by the Deficit Reduction Act of 2005; (3) Proposed to remove language related to "similar services furnished by community-based residences for the mentally retarded under a waiver of section 1915(c) of the Act, in which, as of December 24, 1992, at least 85 percent of such facilities were classified as intermediate care facilities for persons with mental retardation (ICF/MRs) prior to the grant of the waiver" associated with the permissible class of service listed in statute as services of ICF/MRs; and (4) Removed obsolete transition period regulatory language.

Conclusion

We believe these rules reflect the long-standing work of CMS and others such as GAO and the OIG to restore greater accountability to the Medicaid program while safeguarding limited resources for actual services to those individuals who rely on the Medicaid program. CMS understands that Medicaid is one of the largest programs in State budgets, generally accounting for more than 20 percent of a State's total spending When the Federal government presents a significant disallowance against a State, the effects ripple through State government. Nevertheless, Medicaid is fundamentally a partnership that relies on both sides to contribute their share to the cost of the program.

As Medicaid competes for resources at the State level against all the other demands that are present, an erosion in the confidence in the integrity of the Medicaid program ultimately is not good for Medicaid nor for the people who rely on it. These rules will provide for greater stability in the program and equity among the States.

Medicaid Financial Management Activity - FYs 1993-2007

Deferrals Taken

Year	Count	ADM	MAP	Total
1993	107	$8,071,237	$387,948,189	$396,019,426
1994	160	$374,669,404	$462,695,169	$837,364,573
1995	155	$202,314,112	$1,096,527,593	$1,298,841,705
1996	118	$116,328,864	$297,941,051	$414,269,915
1997	109	$55,003,803	$115,590,773	$170,594,576
1998	125	$42,175,540	$148,332,770	$190,508,310
1999	126	$105,424,160	$135,127,527	$240,551,687
2000	90	$219,977,710	$180,545,634	$400,523,344
Total	**990**	**$240,551,687**	**$2,824,708,706**	**$3,065,260,393**
2001	92	$225,493,003	$302,394,015	$527,887,018
2002	95	$42,604,723	$1,036,763,709	$1,079,368,432
2003	146	$48,970,624	$1,292,657,243	$1,341,627,867
2004	101	$24,760,441	$364,385,047	$389,145,488
2005	98	$63,038,290	$304,224,182	$367,262,472
2006	148	$64,764,445	$555,926,543	$620,690,988
2007*	77	$21,791,205	$338,944,114	$360,735,319
Total	**757**	**$491,422,731**	**$4,195,294,853**	**$4,686,717,584**

* Only quarters 1 through 3

Disallowances Taken

Count	Total
44	$316,997,995
28	$239,798,011
31	$706,604,156
32	$723,666,946
10	$13,269,819
8	$40,506,729
3	$1,664,251
6	$114,612,193
162	**$2,157,120,100**
22*	$1,625,258,650
13	$272,808,879
14	$60,229,051
38	$213,982,813
28	$216,094,464
25	$121,107,073
49	$453,117,461
167	**$2,962,598,391**

*portion of FY2001 amount includes disallowances taken between 10/1/00 - 1/19/01, including 5 health care related tax disallowances totaling $950 million.

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CENTERS for MEDICARE & MEDICAID SERVICES

DENNIS SMITH
Director of the Centers for Medicaid and State Operations

As the Director of the Center for Medicaid and State Operations (SMSO), Dennis Smith provides leadership in the development and implementation of national policies governing Medicaid, the State Children's Health Insurance Program, survey and certification, and the Clinical Laboratories Improvement Act (CLIS). The Center also serves as the focal point for all CMS interactions with states and local governments.

Mr. Smith has been the Director of CMSO since July 29, 2001. Since that time, the Administration has fostered a noteworthy increase in access to coverage for uninsured low-income Americans, and an improvement in the delivery of health care services to Medicaid beneficiaries. Mr. Smith has overseen multiple initiatives in partnership with the governors to expand coverage to more individuals through the Health Insurance Flexibility and Accountability Initiative (HIFA), to improve access to prescription drugs through the Pharmacy Plus demonstrations, and to ensure that elderly and disabled individuals have choice and control over the services they receive through the Independence Plus demonstrations and other home and community-based initiatives. These various initiatives overseen by Mr. Smith are all in support of the bold 21st-century plan articulated in the President's fiscal year 2006 budget to modernize Medicaid and improve access to health insurance coverage.

Prior to his appointment as Director of CMSO, Mr. Smith serves on the Bush-Cheney transition team as chief liaison to the U.S. Department of Health and Human Services.

Previously he served as the Director of the Department of Medical Assistance Services for the Commonwealth of Virginia. As Director, he was accountable for an agency with a $3 billion budget and staff of 270. The Department is responsible for several health insurance programs including Medicaid, the State Children's Health Insurance Program, the Indigent Health Care Trust Fund and the State and Local Hospitalization Trust Fund.

Mr. Smith has a Master's Degree in public administration from George Mason University and a degree in political science from Illinois State University. He is married and he and his wife have four daughters.

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