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Legislative Bulletin……..……April 22, 2008

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H.R. 5613—Protecting the Medicaid Safety Net Act
(*Dingell, D-MI*)

Please note the Conservative Concerns beginning on page 6, and those highlighted throughout the bulletin.

Order of Business: The bill is scheduled to be considered on Tuesday, April 22nd, under a motion to suspend the rules and pass the bill.

Summary: H.R. 5613 would extend certain existing moratoria on the Centers for Medicare and Medicaid Services (CMS), prohibiting the agency from promulgating rules related to the integrity of the Medicaid program until April 1, 2009. In particular, the bill would extend moratoria on proposed regulations placing restrictions on intergovernmental transfers and restricting payments for graduate medical education; the prohibitions were first enacted as part of last year's supplemental wartime appropriation (P.L. 110-28) and are scheduled to expire on May 25, 2008. The bill would also extend prohibitions on CMS regulations relating to rehabilitation services, as well as school-based administrative and transportation services; these prohibitions were first enacted in Medicare physician payment legislation (P.L. 110-173) last December, and are scheduled to expire on June 30, 2008.

In addition, H.R. 5613 would impose additional new moratoria on CMS relating to other proposed Medicaid regulations, also until April 2009. Specifically, the bill would prohibit the Secretary of Health and Human Services from imposing additional restrictions with respect to targeted case management payments, the definition of outpatient hospital services, and Medicaid provider taxes (with certain exceptions).

The bill also appropriates an additional $25 million per year to CMS for the purposes of anti-fraud enforcement activity within the Medicaid program.

H.R. 5613 includes two reports to Congress on the proposed regulations. By July 1, 2008, the Department of Health and Human Services (HHS) will report on its justification and authority for proposing the regulations. The bill also includes $5 million in appropriations for HHS to hire an independent contractor to produce a report by March 1, 2009, on the proposed regulations and their impact on states.

H.R. 5613 also extends a web-based asset verification system to all 50 states, effective by the end of fiscal year 2013. This provision would expand the Social Security Administration's Supplemental Security Income (SSI) pilot program, giving states a new tool for verifying the assets of Medicaid recipients. Currently, such a system only exists as a demonstration project in three states: California, New Jersey, and New York.

Additional Background on Changes Made in Committee: During consideration in the Energy and Commerce Committee, Chairman Dingell and Ranking Member Joe Barton (R-TX) reached agreement on several modifications to the legislation. The revised language incorporated at Subcommittee narrowed the scope of the proposed moratoria to permit CMS to engage in outreach activities with states. Over the past several years, CMS has used various state-level audits to reach agreements with state Medicaid agencies to curtail abusive and/or questionable financing tactics. The revised language in H.R. 5613 would permit CMS to continue these individual consent agreements with states, while maintaining the moratoria on CMS' ability to enact regulations prohibiting these activities permanently.

In addition, the substitute language adopted in Committee included the additional $25 million per year in anti-fraud enforcement, as well as an independent study assessing the need for the regulations and their potential impact on states. The Committee substitute also incorporated the web-based asset verification system to pay for the moratorium; the Administration had previously suggested that this program be extended as a savings mechanism to finance portions of the farm bill.

Additional Background on Proposed Regulations: During the past year, the Centers for Medicare and Medicaid Services (CMS) has attempted to move forward on several proposed regulations addressing specific issues and service areas within the Medicaid program. Many of these regulations respond to Government Accountability Office (GAO) studies and reports by the HHS Inspector General highlighting areas where the fiscal integrity of the Medicaid program needed improvement. A brief summary of each rule that would be halted by H.R. 5613 follows:

Intergovernmental Transfers: This rule would limit reimbursement for publicly-owned health providers to costs incurred, narrow the definition of unit of government, and require providers to retain all Medicaid payments, in order to restrain intergovernmental transfers designed primarily to maximize states' federal Medicaid payments. A final rule was issued on May 29, 2007; the moratorium currently in place expires on May 25, 2008. The Congressional Budget Office (CBO) scores this regulation as saving $9.0 billion in federal outlays over five years, and $22.0 billion over a decade.

Graduate Medical Education: This rule would eliminate Medicaid reimbursement for graduate medical education, on the grounds that reimbursements for medical training are outside the

statutory scope of the Medicaid program. A Notice of Proposed Rulemaking (NPRM) was issued on May 23, 2007; the current moratorium expires May 25, 2008. Five year estimated savings are $0.8 billion, and ten year estimated savings are $1.9 billion.

School-Based Administrative and Transportation Services: This rule would prohibit federal Medicaid payments for administrative activities performed by schools and transportation of children to and from school. In some instances, school districts bill Medicaid for transporting students to and from school, even though this is an educational expense, not a reimbursable medical expense. In addition, HHS audits found that schools were claiming capital and debt service as "administrative services" subject to Medicaid reimbursement. The proposed rule would not alter the current policy of reimbursing schools for *bona fide* medical expenses incurred on school property, such as speech therapy. A final rule was issued December 28, 2007; the current moratorium expires June 30, 2008. Five year estimated savings are $4.2 billion, and ten year savings are estimated at $10.2 billion.

Rehabilitation Services: This rule would restrict the scope of rehabilitation services subject to the federal Medicaid match and eliminate coverage of day habilitation services for individuals with developmental disabilities. In many instances, CMS has found that states have billed therapeutic foster care as a "bundled" payment, resulting in federal payments for activities related to foster care as opposed to direct medical expenses. In other cases, state plans for reimbursable expenses include recreational or social activities not directly related to rehabilitative goals. An NPRM was issued on August 13, 2007; the current moratorium expires on June 30, 2008. CBO scores this change as saving $1.4 billion over five years, and $3.5 billion over a decade.

Outpatient Hospital Services: This rule would restrict the scope of Medicaid outpatient hospital services and clarify the upper payment classification for outpatient services to align more closely with the Medicare definition of outpatient services. An NPRM was issued on September 28, 2007; no moratorium is currently in place. Five year savings are estimated at $0.3 billion, and ten year savings are estimated at $0.7 billion.

Targeted Case Management: This rule would restrict the scope of targeted case management services, and specify that Medicaid will not reimburse states for services where another third party is liable for payment. In many cases, HHS audits have found a lack of documentation related to targeted case management claims, or state plans for reimbursement that fall outside the scope of the Medicaid program's focus on medical services. A final rule was issued December 4, 2007, subject to an implementation date of March 3, 2008. The change would save an estimated $1.5 billion over five years, and $3.3 billion over ten.

Provider Taxes: This rule would reduce the permissible level of Medicaid provider taxes, as included in the Tax Relief and Health Care Act of 2006 (P.L. 109-432), and would also clarify the hold harmless provision for provider taxes with respect to the positive correlation between the level of provider taxes imposed by states and direct or indirect Medicaid payments from states back to providers. A final rule was issued February 22, 2008, subject to a compliance date of October 1, 2008. Five and ten year savings are estimated at $0.6 billion.

In total, the proposed regulations are collectively projected to result in approximately $16-18 billion in savings to the federal government over the next five fiscal years, and nearly $48 billion over a decade.[1] By point of comparison, these savings would constitute just over 1% of total federal spending on Medicaid, which over the next five years is estimated to total more than $1.2 trillion.[2]

Additional Background on GAO Reports of Medicaid Abuses: Since 1994, the Government Accountability Office (GAO) has compiled more than a dozen reports highlighting problems with Medicaid financing, and specifically the ways in which state governments attempt to "game" Medicaid reimbursement policies in order to maximize the amount of federal revenue funding state health care programs. The persistent shortcomings in federal oversight of these state funding schemes prompted GAO to add the Medicaid program to its list of federal entities at high risk of mismanagement, waste, and abuse in 2003.

Several of the GAO reports discuss state reimbursement efforts for several of the services CMS proposes to change in its new regulations. For instance, testimony in June 2005 analyzed the ways in which 34 states—up from 10 in 2002—employed contingency-fee consultants to maximize federal Medicaid payments. The report found that from 2000-2004, Georgia obtained $1.5 billion in additional reimbursements, and Massachusetts $570 million.[3] The report concluded that the states' claims for targeted case management "appear to be inconsistent with current CMS policy" and claims for rehabilitation services "were inconsistent with federal law."[4] In other areas, GAO found potentially inappropriate behavior—higher reimbursements for school-based health and administrative services that were not fully passed on to the relevant school districts, and questionable administrative costs, such as a 100% claim on a Massachusetts state official's salary as a Medicaid administrative cost, even though the official worked on unrelated projects for other states designed to increase their own Medicaid reimbursements.[5]

The GAO reports also demonstrate states' use of intergovernmental transfers to maximize federal Medicaid reimbursements. In these schemes, local-government health facilities transfer funds to the state Medicaid agency. The Medicaid agency in turn transfers funds back to the local-government facility—but not before filing a claim with CMS to obtain federal reimbursement. Although permissible under current law in many cases, GAO found that these schemes "are inconsistent with Medicaid's federal-state partnership and fiscal integrity."[6]

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[1] Because CMS proposals with respect to rehabilitation services (estimated savings of $1.4 billion over five years), graduate medical education ($0.8 billion estimated savings), and the definition of outpatient hospital services ($0.3 billion estimated savings) are at the proposed rulemaking stage, CBO assigns a baseline weighting factor of 50% to the proposed regulations, reflecting the uncertainties of the rulemaking process. Thus, while CBO estimates a total of $17.8 billion in savings over five years if all rules were implemented as currently issued, a permanent prohibition on these seven rules would require $16.5 billion in savings under House PAYGO rules.

[2] Office of Management and Budget, *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2009*, available online at http://www.whitehouse.gov/omb/budget/fy2009/pdf/spec.pdf (accessed April 1, 2008), p. 383.

[3] Government Accountability Office, "Medicaid Financing: States' Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlights Need for Increased Federal Oversight," (Washington, Report GAO-05-748, June 2005) available online at http://www.gao.gov/new.items/d05748.pdf (accessed March 31, 2008), p. 4.

[4] Ibid., p. 19.

[5] Ibid., pp. 27-29.

[6] Ibid., p. 24.

Many of the GAO reports over the past decade—whose titles are listed at the bottom of this bulletin—have included calls for additional federal oversight around various state Medicaid reimbursement initiatives, particularly the need for clear and consistently applied guidance from CMS about the permissiveness of various financing arrangements.[7] Several of CMS' proposed regulations attempt to remedy this problem, and restore clarity and fiscal integrity to the Medicaid program.

Additional Background on Medicaid Waste and Fraud: Although much of the debate surrounding the proposed CMS regulations has centered on the proper scope and limits of covered services within the Medicaid program, it is also worth noting the considerable amount of waste and criminal fraud present within some state Medicaid programs. An extensive investigation published by *The New York Times* in July 2005 revealed several examples of highly questionable activity within the New York Medicaid program:

- A Brooklyn dentist who billed Medicaid for performing 991 procedures in a single day;
- One physician who wrote 12% of all the prescriptions purchased by New York Medicaid for an AIDS-related drug to treat wasting syndrome—allegedly so the steroid could be re-sold on the black market to bodybuilders;
- Over $300 million—far more than any other state Medicaid program—in spending on transportation services, some of which involved rides for seniors mobile enough to rely on public transportation and other services which investigators believe may not have been performed at all; and
- A school administrator in Buffalo who in a single day recommended that 4,434 students receive speech therapy funded by Medicaid—part of $1.2 billion in improper spending by the state on speech services, according to a federal audit.

A former state investigator of Medicaid abuse estimated that fraudulent claims totaled approximately 40% of all Medicaid spending in New York—nearly $18 billion per year, which may help explain why New York's Medicaid expenditures greatly exceed California's, despite a smaller overall population and fewer Medicaid beneficiaries.[8]

However, other audits emphasize that in some cases, providers can be victims of state efforts to reclaim additional federal Medicaid dollars. A 2004 report from the Department of Health and Human Services' Inspector General found that New York state required a nursing home to return more than half of its Medicaid revenues to the state, resulting in net revenues to the nursing home that were $20 million less than its operating costs. The report noted:

> The state's upper-payment-limit funding approach benefited the state and the county more than the nursing home. The state received $20 million more than it expended for the nursing home's Medicaid residents without effectively contributing any money, and

[7] See ibid., p. 30.
[8] Clifford Levy and Michael Luo, "Medicaid Fraud May Reach into Billions," *The New York Times* 18 July 2005, available online at http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?_r=1&pagewanted=print&oref=slogin (accessed March 29, 2008).

> the county was reimbursed 100 percent for its upper-payment-limit contribution. We are concerned that the federal government in effect provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the federal and state governments.

The audit went on to note that the high level of Medicaid payments the nursing home was required to return to the state—and the operating losses the nursing home incurred on its Medicaid patients as a result—led to significant levels of understaffing that may have affected the quality of care provided to patients.[9]

Other HHS audits reflect Medicaid reimbursement submissions by states that either lack appropriate documentation for the claims or represent inappropriate use of Medicaid resources. For example, one May 2003 claim for Medicaid targeted case management reimbursement included the following notation from the case manager explaining her contact with the beneficiary:

> Phone call with mother. Discussed the outstanding warrant for [name redacted]. She does not know where he is. She will call police when he shows up.

While it may represent good public policy for this type of contact—which attempted to locate a juvenile for whom an outstanding arrest warrant existed—some conservatives would argue that such actions lie outside the scope of the Medicaid program's intent and represent a far-from-ideal expenditure of federal matching dollars.

Committee Action: On March 13, 2008, the bill was introduced and referred to the Energy and Commerce Committee. On April 16, 2008, the full Energy and Commerce Committee reported the bill to the full House by a vote of 46-0.

Possible Conservative Concerns: Numerous aspects of this legislation may raise concerns for conservatives, including, but not necessarily limited to, the following:

- Process. H.R. 5613 is being brought to the House floor under suspension of the rules, a procedure generally reserved for minor authorizations and smaller pieces of legislation, such as the naming of post offices. Some conservatives may be concerned that a bill costing over a billion dollars is being rushed through House floor consideration under expedited procedures.

- Budgetary Gimmick. In order to comply with PAYGO rules, H.R. 5613 would impose a moratorium on CMS action until April 2009—and the legislation contains provisions offsetting the cost to the federal government for all savings not realized through that date. However, staff for Energy and Commerce Committee Chairman Dingell have publicly stated that H.R. 5613 is intended to delay the implementation of the Medicaid rules just long enough so that a future Administration can withdraw them. Because withdrawing

[9] "Adequacy of Medicaid Payments to Albany County Nursing Home," (Washington, DC, Department of Health and Human Services Office of the Inspector General Report #A-02-02-01020), available online at http://oig.hhs.gov/oas/reports/region2/20201020.pdf (accessed April 20, 2008), pp. 6-7.

the regulations would result in approximately $16-18 billion in lost savings to the federal government over five years, and because action taken by a future Administration would not be subject to PAYGO, some conservatives may believe that H.R. 5613's sponsors intend to violate the spirit, if not the letter, of the PAYGO requirement under House rules.

- Undermine Previous Republican Efforts to Reform Medicaid. In December 2005, 212 Members of Congress—all Republicans—voted for legislation (P.L. 109-171) that generated less than $4.8 billion in savings from the Medicaid program as a first attempt to restore its fiscal integrity. However, if the moratoria remain intact, those modest reductions in Medicaid's growth rate would be more than exceeded by the $16-18 billion in foregone savings associated with the regulations' repeal.

- Encourage State Efforts to "Game" the Medicaid Program. As highlighted above, nearly three dozen states have in recent years hired contingency fee consultants designed to maximize the portion of Medicaid costs paid for by the federal government. Blocking regulations designed to respond to funding mechanisms which states and their consultants have established—and more than a dozen GAO reports over nearly 15 years have criticized—may only further encourage states to take steps that increase federal costs and undermine Medicaid's fiscal integrity.

- Harm Hospitals and Other Providers. As explained above, HHS Inspector General reports have revealed that various funding mechanisms designed to increase federal Medicaid revenues for states have often had the ancillary effect of reducing net payments to providers. H.R. 5613, by blocking regulations designed to ensure that payments to Medicaid providers do not become ensnared in various schemes by states to increase federal Medicaid spending, may prevent some providers from seeing their net Medicaid payments rise when the proposed regulations take effect.

Administration Position: Although the Statement of Administration Policy (SAP) was not available at press time, Health and Human Services Secretary Leavitt has previously written to Energy and Commerce Chairman Dingell and Ranking Member Barton indicating that the Administration strongly opposes H.R. 5613 and would recommend a Presidential veto.

Cost to Taxpayers: A final score of the bill was not available at press time. However, a preliminary CBO estimate indicated that H.R. 5613's moratorium through April 2009 on the issuance of seven proposed regulations would cost taxpayers $1.65 billion over five and ten years. However, as noted above, this score presumes the full implementation of the regulations in April 2009 under a new Administration. Outright repeal of the regulations would cost $16.5 billion over five years—ten times the cost of H.R. 5613.

Additional mandatory spending—both $25 million annually for CMS anti-fraud enforcement activity with respect to Medicaid, and $5 million for an independent study on the proposed regulations—would cost $129 million over five years, and $254 million over ten.

H.R. 5613 would pay for this spending by extending an asset verification pilot program currently operating in three states to all 50 states, saving $1.0 billion over five years and $4.5 billion over ten. The bill would also make adjustments to the Physician Assistance and Quality Improvement (PAQI) fund to comply with five-year PAYGO scoring rules, and deposit the additional savings over and above the ten-year cost of the moratoria. Reports indicate that the $2.6 billion in additional ten-year savings will be withdrawn from the PAQI fund later this year to help finance Medicare physician reimbursement legislation.

Does the Bill Expand the Size and Scope of the Federal Government?: Yes, the bill would prohibit CMS from taking administrative actions (which are already built into CBO's budgetary baseline) to prevent states from expanding the scope of the Medicaid program.

Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?: No.

Does the Bill Comply with House Rules Regarding Earmarks/Limited Tax Benefits/Limited Tariff Benefits?: A Committee report citing compliance with House earmark disclosure rules was unavailable at press time.

Constitutional Authority: A Committee report citing constitutional authority was unavailable at press time.

Additional Background: For further information on this issue see:

- *RSC Policy Brief: Medicaid and the States*
- *RSC Policy Brief: Medicaid Funding Issues*
- *New York Times Article: New York Medicaid Fraud May Reach into Billions*
- *November 2007 GAO Testimony: Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*
- *March 2007 GAO Report: Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*
- *June 2006 GAO Report: Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts*
- *June 2005 GAO Testimony: Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*
- *June 2005 GAO Testimony: Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*
- *March 2004 GAO Testimony: Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*
- *February 2004 GAO Report: Medicaid: Improved Federal Oversight of State Financing Schemes Needed*
- *October 2001 GAO Report: Medicaid: HCFA Reversed its Position and Approved Additional State Financing Schemes*
- *September 2000 GAO Testimony: Medicaid: State Financing Schemes Again Drive Up Federal Payments*

- *April 2000 GAO Report: Medicaid in Schools: Improper Payments Demand Improvement in HCFA Oversight*
- *June 1999 GAO Testimony: Medicaid: Questionable Practices Boost Federal Payments for School-Based Services*
- *August 1994 GAO Report: Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*

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