MACPAC

Advising Congress on
Medicaid and CHIP Policy

Statement of
Trish Riley, Commissioner

Medicaid and CHIP
Payment and Access Commission

Before the
Subcommittee on Health
House Committee on Energy and Commerce

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Medicaid and CHIP Payment
and Access Commission
www.macpac.gov

Summary

The Medicaid and CHIP Payment and Access Commission shares this Subcommittee's interest in ensuring federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. When designed and implemented well, program integrity policies and procedures should ensure that eligibility decisions are made correctly; prospective and enrolled providers meet federal and state participation requirements; services provided to enrollees are medically necessary and appropriate; and provider payments are made in the correct amount and for appropriate services.

The Commission has identified and shared with you through our reports to Congress a number of challenges associated with implementation of an effective and efficient Medicaid program integrity strategy, including: overlap between federal and state responsibilities; insufficient collaboration and information sharing among federal agencies and states; diffusion of authority among multiple federal and state agencies; and lack of both information on the effectiveness of program integrity initiatives and appropriate performance measures. We also identified concerns about lower federal matching rates for state activities not directly related to fraud control; incomplete and outdated data; and few program integrity resources for delivery system models other than fee for service.

Specifically, the Commission recommended that the Secretary of the U.S. Department of Health and Human Services should collaborate with states to create feedback loops to simplify and streamline program integrity requirements, determine which current federal program integrity initiatives are most effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective.

In addition, in order to enhance states' abilities to detect and deter fraud and abuse, the Commission has recommended that the Secretary should develop methods for better quantifying the effectiveness of program integrity activities. The Secretary should assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective. In addition, the department should improve dissemination of best practices in program integrity, and enhance program integrity training programs.

The measures before the Subcommittee today also speak to other policy objectives of interest to the Commission, including simplification, transparency, and alignment of policies across federal health programs. Even so, I want to clarify that MACPAC has neither reviewed nor expressed its views on the merits of the six specific initiatives that are the focus of today's hearing. This statement provides technical comments on the potential implications and issues that could be addressed as the Subcommittee considers the following proposals:

- H.R. 1570: Medicaid and CHIP Territory Transparency and Information Act
- H.R. 1771: Changes to Counting of Income from Annuities
- H.R. 2339: Treatment of Lottery Winnings and Other Lump Sum Income
- Requiring Electronic Visit Verification System for Personal Care Services under Medicaid
- Ensuring Terminated Providers are Removed from Medicaid and CHIP
- Medicaid and CHIP Territory Fraud Prevention Act

Statement of Trish Riley, Commissioner

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Green, and Members of the Subcommittee on Health. I am Trish Riley and I have served as a Commissioner of MACPAC, the Medicaid and CHIP Payment and Access Commission, since it was created in 2010.

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. I am one of 17 members, led by Chair Diane Rowland and Vice Chair Marsha Gold, appointed by U.S. Government Accountability Office (GAO). While I am also executive director of the National Academy for State Health Policy, the insights I will share this morning reflect the work and approach of MACPAC. We appreciate the opportunity to be here today as this subcommittee considers changes to the Medicaid program.

The Commission shares this Subcommittee's interest in ensuring federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. When designed and implemented well, program integrity policies and procedures should ensure that eligibility decisions are made correctly; prospective and enrolled providers meet federal and state participation

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Specifically, the Commission recommended that the Secretary of HHS should collaborate with states to create feedback loops to simplify and streamline program integrity requirements, determine which current federal program integrity initiatives are most effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective.

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H.R. 1570: Medicaid and CHIP Territory Transparency and Information Act

This legislation would require the Centers for Medicare & Medicaid Services (CMS) to publish and periodically update the following information regarding Medicaid and CHIP programs in the five U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands):

- income levels for program eligibility;
- the number of enrollees in Medicaid and CHIP;
- state plan amendments (SPAs) and waivers in effect under Medicaid and CHIP;
- Medicaid and CHIP expenditure information;
- the systems in place for "the furnishing of health care items and services" under Medicaid and CHIP;
- the design of CHIP; and
- any other information that CMS posts with respect to states.

While such information is currently available for state Medicaid programs, it should be noted that Medicaid operates differently in the U.S. territories than it does in the states. In the five U.S. territories, federal Medicaid

spending is limited to annual spending caps. (In fiscal year 2014, Puerto Rico accounted for about 90 percent of Medicaid spending in the territories.) The federal Medicaid statute explicitly exempts territories from a variety of provisions affecting eligibility and payment rules. In addition, for American Samoa and the Northern Mariana Islands, current law allows the Secretary to waive almost any federal Medicaid requirement that applies to states with the exception of the federal matching rate, capped grant amount, and the requirement that payment can be made only for services otherwise coverable by Medicaid (§1902(j) of the Social Security Act).

Of the five territories, Puerto Rico is the only territory for which information on enrollment, eligibility, and SPAs that is comparable to states is now available on Medicaid.gov.

H.R. 1771: Changes to Counting of Income from Annuities

In the case of payment of income from a qualifying Medicaid annuity (described below), this bill would consider one-half of the annuity income as being available to an institutionalized spouse regardless of whether the payment was made in the names of both the institutionalized spouse and the community spouse, or solely in the name of the community spouse. In the case where payment is made in the names of the community spouse and another person or persons, one-half of the proportion of the community spouse's interest in such income would be considered as available to the institutionalized spouse.

Annuities are used as a vehicle for protecting community spouse assets while still qualifying for Medicaid coverage of long-term services and supports (LTSS), particularly for couples in which one spouse remained in the community. Because Medicaid does not count a community spouse's income (within state-specific limits) in

determining the institutionalized spouse's Medicaid eligibility, by converting assets to income via an annuity a couple can conserve more of their resources for the community spouse.

Currently, annuities conforming with certain rules that make them Medicaid-compliant can reduce the amount of countable assets that are used to determine Medicaid eligibility for an institutionalized spouse. Typically a couple would need to "spend down" a portion of their assets (determined by their state's spousal impoverishment limits) in order for the institutionalized spouse to qualify for Medicaid. By converting their assets to an annuity, couples are reducing the amount they need to spend down.

This legislation would tighten Medicaid eligibility by requiring that couples make more of their assets countable as income. In addition, it might serve as a disincentive for couples to purchase annuities in the future and at present increase payments to the Medicaid program. No data are readily available to indicate how many people would be affected by this measure or the financial impact on the Medicaid program. Given that Supplemental Security Income and the Medicaid spousal impoverishment standard allow a maximum community spouse resources minimum of $23,844 and a maximum resource standard of $119,220, the number of couples for whom Medicaid-compliant annuities are currently advantageous is likely quite small.

H.R. 2339: Treatment of Lottery Winnings and Other Lump Sum Income

This bill would provide states with a new option in their Medicaid and CHIP programs regarding the treatment of lump-sum payments, including lottery winnings, under federal income-counting rules known as modified adjusted gross income (MAGI). While lump sums for Medicaid and CHIP purposes are currently treated under MAGI as

income solely in the month they are received, the bill would allow states to prorate lump sums of at least $20,000 over multiple months. The two approaches available to states would depend on the amount of the lump-sum income:

- if the income is less than $50,000, the amount could be divided over 12 months; and
- if the income is at least $50,000, the amount could be divided over a period specified by the state, not to exceed 240 months (20 years).

This bill would likely reduce the number of lottery winners and lump-sum beneficiaries who would otherwise qualify for Medicaid or CHIP in the month(s) after receiving their payments. It is worth noting, however, that during the first month in which the lump sum is counted, the revised policy would make such individuals more likely to be determined eligible than under current law because only a prorated amount would be considered income for that month. We are not aware of any data on the number of individuals who would be affected.

As this subcommittee is no doubt aware, one of the purposes of the move to using MAGI for eligibility determinations was to eliminate state-based differences in income counting rules, simplifying program rules and facilitating alignment of determinations between Medicaid, CHIP, and exchange coverage. Because the bill creates a new state option for counting income, it would introduce state variation in MAGI, thus requiring exchange-based determinations to take state-specific income-counting policies into account. In addition, new guidance would be needed from both HHS and the U.S. Department of the Treasury for situations where gaps in coverage could occur because of differing income-counting rules.

Requiring Electronic Visit Verification System for Personal Care Services under Medicaid

This legislation would reduce the federal medical assistance percentage (FMAP) for home and community-based services (HCBS) provided under a state plan or waiver for states that do not implement electronic visit verification systems for personal care services. States would have until January 1, 2018 to implement electronic visit verification (EVV) systems before FMAP reductions begin. After that date, the amount of FMAP reduction for states not implementing the systems increases over time, from a reduction of 0.25 percentage points for calendar quarters in 2018 and 2019, up to a reduction of 1 percentage point for calendar quarters in 2022 and beyond.

Personal care services are nonmedical services (such as assistance with activities of daily living like bathing and dressing) provided by a personal care attendant. Currently, all 50 states and the District of Columbia offer such services either as a state plan option or through waivers or demonstrations. These services allow frail elderly and people with disabilities to stay in their homes rather than rely on institutional care. In FY 2013, Medicaid spent $11.9 billion on personal care services, accounting for 16 percent of all Medicaid-financed home and community-based services and 8.2 percent of Medicaid-financed long-term services and supports.

The HHS Office of Inspector General (OIG) and others have raised concern over improper payments and fraud, waste, and abuse related to personal care services. Among its concerns, OIG has noted the lack of documentation for billed services. For example, a 2008 OIG study found that claims for personal care services often did not specify the dates when services were provided. In addition, in many instances, overlapping claims could not be identified due to the practice of so-called span billing which allows agencies to submit claims for services provided over a certain time period (e.g., a week or month) without specifying the dates when services were

actually provided. OIG has also found cases where claims were in excess of 24 hours a day. Moreover, in many states, personal care attendants are not required to be registered with state Medicaid programs or have a unique identifier for claims.

Electronic visit verification systems require personal care attendants to confirm the beginning and end of a service visit for a particular beneficiary, typically by calling into a telephone system or by using an electronic device. They may also collect additional information such as the exact global positioning system (GPS) location where system was accessed to confirm that the attendant was at the beneficiary's home, or wherever services were authorized to be provided. Thus, these systems ensure that beneficiaries receive services that are authorized and that visits being claimed were actually provided.

States that have implemented these systems include Florida, Illinois, Louisiana, New York, Ohio, South Carolina, Tennessee, Texas, and Washington. However, some have done so for a limited time (for example, Texas only completed implementation statewide this past June) and thus there is little research about effectiveness of implementing such system on reducing improper payments. States have projected savings; for example, a Louisiana official recently estimated that the state Medicaid program will save $16.7 million and the Texas Health and Human Services Commission estimates 3 to 5 percent savings from implementation of electronic verification.

Ensuring Terminated Providers are Removed from Medicaid and CHIP

This legislation would require states to submit to CMS within 14 days of the termination of any individual or entity:

- the name of the individual or entity;

- the provider type and specialty;
- the date of birth, address, Social Security number or taxpayer identification number, national provider identifier, and state license or certificate number;
- the reason for the termination; and
- a copy of the notice sent to the provider.

States would also be required to add terms to contracts with Medicaid managed care organizations (MCOs) requiring that any provider terminated for cause from Medicare, Medicaid, or CHIP be terminated from participation in Medicaid or CHIP provider networks.

Within 14 business days of notification by the state, CMS will include each provider termination in a termination notification database or similar system developed pursuant to section 6401(b) (2) of the Patient Protection and Affordable Care Act (ACA; P.L.111-148). Two years after enactment, states will be required to repay the federal share of any payments made to a provider (including payments made through an MCO) who was terminated from Medicaid or CHIP more than 60 days after the date in which the termination information was made available in the database.

Federal rules (42 CFR 455 Subpart B) already require states to terminate the enrollment of any provider that is terminated on or after January 1, 2011 by Medicare or by Medicaid or CHIP in any other state. These rules also require states to routinely check a number of federal databases, including the List of Excluded Individuals and Entities mandated by the HHS OIG. However, states are not currently required to report information on Medicaid and CHIP provider terminations to a national database, nor are there standardized reasons for terminations that facilitate cross-state comparisons. CMS developed a database to make exclusion information available to all state Medicaid agencies to facilitate compliance with section 6401 of the ACA. In 2014, the HHS OIG reviewed this

voluntary system and reported that many states did not report information to the national database and that the data that was reported was often insufficient or inaccurate.

This bill would facilitate state termination of providers terminated by Medicare or by Medicaid or CHIP in other states. It would also provide an additional incentive for states to conduct timely checks of the database by requiring the return of the federal share of payments made to providers more than 60 days after the date by which states have access to information on their termination by Medicare or another state.

States are not currently required to ensure that all MCO contracted providers are enrolled in Medicaid or CHIP or subject to the screening requirements of 42 CFR 455 Subpart B. CMS has proposed a new rule that would require states to enroll all MCO providers that are not otherwise enrolled with the state to provide services to Medicaid beneficiaries under fee for service, including all applicable screening and disclosure standards. This bill would provide statutory authority for CMS to require Medicaid and CHIP managed care plans to terminate providers who are terminated from Medicare or other state Medicaid and CHIP programs.

Medicaid and CHIP Territory Fraud Prevention Act

This bill amends Section 1108(g)(4) of the Social Security Act to exclude expenditures associated with the establishment or operation of a Medicaid Fraud Control Unit (MFCU), as described in 1903(a)(6), from the explicit limits on federal financial participation for the territories. Such exclusions would be similar to existing exclusions for operation of an approved Medicaid Management Information System and electronic health record incentive payments.

Because Medicaid funding to the territories is capped, territories routinely use the full amount of that funding to pay for Medicaid services and essential administrative functions and historically have not wanted to divert funds to establish an MFCU. None of the five territories has established such a unit, although Puerto Rico has recently expressed interest in doing so.

The HHS OIG has proposed encouraging the territories to establish MFCUs by eliminating the existing financial disincentive, and the President's FY 2015 budget proposed appropriating funding to establish and operate a MFCU while retaining the same amount of appropriated dollars for Medicaid services and essential administrative functions.