

# Report to Congress on Medicaid and CHIP

**JUNE 2019**



**MACPAC**

Medicaid and CHIP Payment  
and Access Commission

## About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 USC 1396, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

# **Report to Congress on Medicaid and CHIP**

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Medicaid and CHIP Payment  
and Access Commission



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**June 15, 2019**

The Honorable Mike Pence  
President of the Senate  
The Capitol  
Washington, DC 20510

The Honorable Nancy Pelosi  
Speaker of the House  
The Capitol  
Washington, DC 20515

**Dear Mr. Vice President and Madam Speaker:**

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the June 2019 Report to Congress on Medicaid and CHIP.

This report presents the Commission's analysis of five Medicaid policy issues that are of critical interest to Congress: coverage of and spending on outpatient prescription drugs; payment for safety-net hospitals; strengthening state efforts to promote program integrity (PI); coverage of therapeutic foster care; and the challenges facing Puerto Rico's Medicaid program. Four chapters contain policy recommendations for statutory and regulatory changes. Two chapters respond directly to Congressional requests for analysis.

In Chapter 1, the Commission responds to state pharmacy and medical directors' concerns about the difficulty in complying with the requirement to cover new drugs as soon as they enter the market. We recommend that Congress enact legislation to provide states with a formal grace period of 180 days to cover a new drug following its approval by the Food and Drug Administration. This would provide states with more time to establish appropriate coverage criteria and prevent potential drug-related harm to patients.

The Commission also recommends eliminating the cap on rebates for outpatient prescription drugs. Under current law, manufacturer rebates to state Medicaid programs are capped at 100 percent of the average manufacturer price of a drug. A drug is likely to reach the rebate cap only if its price increases substantially over the rate of inflation; recently, however, a large number of drugs have reached the rebate cap. The Congressional Budget Office estimates that adopting our recommendation would decrease federal spending by \$15–\$20 billion over 10 years.

Chapter 2 lays out the issues associated with allowing hospitals to receive disproportionate share hospital (DSH) payments for costs that have already been paid for by other payers. The Commission recommends that Congress change the statutory definition of Medicaid shortfall to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer. This change would make more DSH funds available to hospitals that serve a high share of Medicaid and uninsured patients; avoid creating disincentives for hospitals to serve Medicaid patients with third-party coverage or help patients enroll in Medicaid; and promote administrative simplicity.

In Chapter 3, we present findings from our recent study on how states measure PI performance and return on investment. States have received little guidance on where or how to focus their PI efforts and investments and the Centers for Medicare & Medicaid Services should take a lead role in helping states identify which state-level policy design and implementation approaches lead to successful PI outcomes. We recommend that the Secretary of the U.S. Department of Health and Human Services (the Secretary) use existing authority to examine states' current PI activities, conduct pilots to test novel or improved PI strategies, and share these findings with the states.

Chapter 4 responds to a request by the U.S. House of Representatives Committee on Appropriations, asking the Commission to analyze whether a uniform definition of therapeutic foster care could improve care and treatment for the vulnerable children and youth who require these services. Our analysis finds that a uniform definition is not likely to achieve this goal and may also create unintended negative consequences. We recommend instead that the Secretary provide guidance to states on how to cover therapeutic foster care, potentially increasing the availability of this evidence-based approach.

Chapter 5 also responds to a House Appropriations Committee request, this one for an analysis of Medicaid in Puerto Rico. We find that the statutory financing arrangement for Puerto Rico's Medicaid program has resulted in chronic underfunding of its Medicaid program. Medicaid spending is constrained to a greater degree than in any state, reflected, for example, in more limited benefit packages, lower eligibility ceilings, and lower provider payment levels. In addition, the territory has high rates of poverty and a weak economy, conditions that were worsened by Hurricanes Irma and Maria in September 2017.

Puerto Rico's Medicaid program is currently projected to exhaust its federal funds in March of 2020. If Congress does not provide additional funding, territorial officials will be forced to make major cuts in benefits and enrollment. Although an additional time-limited allotment of federal funds might avert this fiscal cliff, it would not address the financing structure or support Puerto Rico's ability to plan, manage, and sustain an effective Medicaid program that offers long-term, reliable access to care for its beneficiaries. Ensuring such reliable, sustainable access to care will require policy changes that provide a higher level of federal investment over a longer period.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy, and we hope this report will prove useful to Congress as it considers future policy development affecting these programs. This document fulfills our statutory mandate to report each year by June 15.

Sincerely,



Melanie Bella, MBA  
Chair



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## Executive Summary: June 2019 Report to Congress on Medicaid and CHIP

In this June 2019 *Report to Congress on Medicaid and CHIP*, the Medicaid and CHIP Payment and Access Commission (MACPAC) responds to congressional requests for analysis and makes recommendations on several Medicaid issues including payment policy for outpatient prescription drugs, hospital payment, program integrity (PI), therapeutic foster care, and challenges facing Puerto Rico's Medicaid program.

Chapter 1 addresses improving prescription drug policy under Medicaid, making recommendations to support states in developing appropriate drug coverage criteria and to make changes in the federal drug rebate program that will reduce spending in a sector that is expected to experience one of the largest growth rates among health care goods and services over the next 10 years.

Chapter 2 reviews the implications of changing policy affecting disproportionate share hospital (DSH) payments. It also lays out the Commission's recommendations for statutory changes that will reverse the effects of a recent federal district court ruling and ensure that DSH payments do not pay for costs that are paid for by other payers.

Chapter 3 presents the Commission's recommendation to the Secretary of the U.S. Department of Health and Human Services (HHS) regarding how the federal government could better support states in their efforts to improve program integrity in their Medicaid programs, and for a statutory change to remove the mandate that all states procure a recovery audit contractor (RAC).

Chapter 4 responds to a request by the House Appropriations Committee, asking MACPAC to analyze whether a uniform definition of therapeutic foster care could promote more consistent care and treatment for children and youth who have serious emotional, behavioral, developmental, or medical conditions. The Commission recommends that the

HHS Secretary provide guidance to states on how to cover therapeutic foster care, potentially increasing the availability of this evidence-based approach.

Chapter 5, although it contains no recommendations, responds to a congressional request to examine how to ensure long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico.

A more detailed summary of each chapter in the June 2019 report to Congress follows.

### CHAPTER 1: Next Steps in Improving Medicaid Drug Policy

Chapter 1 presents two recommendations aimed at (1) supporting states in their efforts to develop appropriate prescription drug coverage criteria and (2) increasing rebates for outpatient prescription drugs, effectively reducing spending on Medicaid-covered prescription drugs, which are expected to experience one of the largest growth rates among health care goods and services over the next 10 years.

In its first recommendation, the Commission addresses state pharmacy and medical directors' concerns regarding the need to cover new drugs as soon as they enter the market—particularly when these are first-in-class drugs or are novel, complex treatments. States must go through a deliberative process to review the clinical evidence and establish appropriate coverage criteria for new drugs. Most states require prior authorization for drugs they have not yet reviewed, and in some cases, the prior authorization is so restrictive that beneficiaries essentially do not have access to the medication.

In response, the Commission recommends that Congress amend the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or new formulation of a drug has been approved by the Food and Drug Administration and entered the market. Creating a formal grace period would align Medicaid's time frame with that of other payers and provide states with more time to establish appropriate coverage criteria. In addition,

giving states time to review the literature regarding safety, efficacy, and clinical outcomes could help prevent potential drug-related harm to patients and would not likely create undue access restrictions.

MACPAC's second recommendation in Chapter 1 concerns the rebate cap under the Medicaid Drug Rebate Program. Under current law, rebates are limited to 100 percent of the average manufacturer price. A drug is likely to reach the rebate cap only if its price increases substantially over the rate of inflation. Recently, a large number of drugs have reached the rebate cap, suggesting that lifting the cap could produce substantial savings to Medicaid.

The Commission recommends that Congress should amend the Social Security Act to remove the cap on Medicaid drug rebates. This would lead to higher rebates on drugs with large price increases, which would create savings for Medicaid and allow states to maintain the same level of drug coverage at lower cost. The Congressional Budget Office (CBO) estimates that it would decrease federal spending by \$15–\$20 billion over 10 years.

## CHAPTER 2: Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

Recent lawsuits have challenged how states are allowed to calculate Medicaid shortfall for the purposes of making Medicaid DSH payments. Medicaid shortfall is the difference between a hospital's costs of care for Medicaid-eligible patients and the payments that the hospital receives for these services. DSH payments are statutorily required payments that help to offset this type of uncompensated care as well as the unpaid costs of care for uninsured individuals.

Most of the costs of care for Medicaid-eligible patients with third-party coverage are paid for by other payers because Medicaid is a payer of last resort. The Centers for Medicare & Medicaid Services (CMS) has generally instructed states to account for third-party payments when calculating

Medicaid shortfall; this policy was formalized in subregulatory guidance in 2010 and a final regulation in 2017. However, in March 2018, the U.S. District Court for the District of Columbia vacated CMS's policy nationwide, ruling that it is inconsistent with the plain language of the Medicaid DSH statute since the statute does not explicitly mention third-party payments. CMS is appealing this decision, but in the interim, the agency has instructed states that it will no longer enforce its 2010 guidance.

Chapter 2 presents the Commission's analysis of the potential impact of the district court ruling. In the Commission's view, the court ruling distorts DSH policy from its intended purpose because it allows hospitals to receive DSH payments for costs that have already been paid for by other payers. The court ruling also is expected to result in an increase in DSH spending in states with unspent federal DSH funding, and in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs.

Based on its analysis, the Commission recommends that Congress change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer. Although this policy is different from CMS's 2010 policy, it is both administratively simple and consistent with how many states were counting Medicaid shortfall before CMS's 2010 policy took effect. Furthermore, changes to the DSH definition of Medicaid shortfall do not affect the total amount of federal DSH funds (i.e., allotments) available to states. The Commission's annual analyses of DSH allotments to states and its recommendations for improving the structure of DSH allotment reductions are included in Chapters 1 and 3 of MACPAC's March 2019 *Report to Congress on Medicaid and CHIP*.

## CHAPTER 3: Improving the Effectiveness of Medicaid Program Integrity

Medicaid PI activities are meant to ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care, and to prevent and detect fraud, waste, and abuse. State Medicaid programs have primary responsibility for PI, which includes a wide range of activities primarily focused on PI, as well as those embedded in other program functions such as individual and provider enrollment, service delivery, and payment. CMS provides a regulatory framework for the Medicaid Integrity Program in addition to providing routine oversight and technical assistance.

States have received little guidance on where or how to focus their PI efforts and investments. Although there is widespread agreement that states should focus their PI resources on areas of risk and invest in approaches that are known to be effective, CMS has not concentrated on helping states understand which state-level policy design and implementation approaches lead to successful PI outcomes. States must make choices about which of Medicaid's optional activities to invest in and how to structure required activities, but they have little information regarding activities' effectiveness upon which to base their decisions. The Commission has repeatedly commented on the need to identify high-value PI activities; in Chapter 3, it shares findings from its recent study that collected information from states on how they measure PI performance and return on investment (ROI). The Commission found that states did not or could not calculate ROI because many PI activities are required, embedded in broader program functions, or generate benefits that are not easily quantifiable. It is the Commission's view that the federal government is in the best position to identify features that make PI approaches successful and disseminate this information to states. Consequently, in Chapter 3, the Commission recommends that the HHS Secretary should use his authority to conduct a rigorous examination of current activities and conduct pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations should be shared with the states.

Furthermore, because RACs have not been effective in all states, the Commission recommends that Congress change the statute to make participation in the RAC program optional. This would be a step forward in ensuring that PI efforts are efficient and do not place an undue burden on states or providers. Under this recommendation, CMS would no longer need to review requests from states for waivers of the RAC requirement. The CBO estimates that making the RAC program an optional activity would increase federal spending by a modest amount.

## CHAPTER 4: Mandated Report on Therapeutic Foster Care

The term therapeutic foster care generally refers to the practice of serving children and youth who have serious emotional, behavioral, mental health, intellectual or developmental disabilities, or medical conditions in a family-based setting, rather than in an institutional or group setting. However, because federal Medicaid statutes and regulations do not currently provide a uniform definition of the services that comprise therapeutic foster care, states vary in covering these services.

In the report accompanying the fiscal year (FY) 2019 Labor, Health and Human Services, and Education funding bill, the U.S. House of Representatives Committee on Appropriations requested that MACPAC examine therapeutic foster care, noting concerns about the lack of a uniform definition within Medicaid and commenting that a uniform definition "could improve the ability for more consistent care and treatment." It requested that, within 12 months, MACPAC:

- conduct a review for the development of an operational therapeutic foster care definition;
- examine the advantages of a uniform definition; and
- include a list of potential services to treat mental illness and trauma that would be within the scope of such a definition.

Chapter 4 responds to the congressional request. It begins by providing an overview of therapeutic foster care, including the common elements of the practice and the children served. It then describes the role Medicaid plays in covering such services and current state approaches to providing the services in Medicaid. Considerations for a uniform definition are then presented before concluding with the Commission's recommendation for clarifying guidance on the practice.

It is the Commission's view that a uniform definition of therapeutic foster care in Medicaid would not likely achieve the goal of more consistent care and treatment, and in fact, may have unintended negative consequences. Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. But because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. For these reasons, a uniform definition could limit states and providers in tailoring services to address these needs.

Nevertheless, additional guidance from CMS and its sister HHS agency, the Administration for Children and Families (ACF), could help states design or improve the coverage and provision of these services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth.

As such, the Commission recommends that the HHS Secretary engage CMS and ACF to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

## CHAPTER 5: Mandated Report— Medicaid in Puerto Rico

Puerto Rico's Medicaid program covers almost half of the island's population. Like state programs, Medicaid in Puerto Rico pays for important health care services to low-income children, adults, people with disabilities, and those over the age of 65. It is subject to most federal requirements and shares many of the same roles, responsibilities, and administrative structures as state Medicaid programs. Its financing structure, however, differs from that of programs on the mainland. Unlike the 50 states and the District of Columbia, the territory has a capped federal allotment that grows with the annual change in the consumer price index, but does not change in response to program costs. Territorial expenditures are statutorily matched at 55 percent up to the capped amount. If the matching rate were determined using the same formula used for states, the territory would receive the maximum allowable rate of 83 percent.

This financing arrangement has resulted in chronic underfunding for Puerto Rico's Medicaid program. Medicaid spending is constrained to a greater degree than any state, reflected in more limited benefit packages and lower eligibility levels than states, low provider payment levels, and slow adoption of key administrative systems and processes. In addition, the territory has high rates of poverty and a weak economy, conditions that were worsened by Hurricanes Irma and Maria in September 2017. Although Congress has at times provided Puerto Rico with additional federal Medicaid funding, these supplements have always been time-limited, reacting to immediate but not long-term needs. Puerto Rico is facing a major reduction in federal Medicaid funding beginning in September 2019 and full exhaustion of federal Medicaid funds as early as December 31, 2019.

In the report accompanying the FY 2019 Labor, Health and Human Services, and Education funding bill, the House Committee on Appropriations requested that MACPAC examine possible options for ensuring long-term sustainable access to care



for Medicaid beneficiaries in Puerto Rico in the report. Chapter 5 responds to the Appropriations Committee's request.

In addition to providing background on Puerto Rico, the health of its population, and its Medicaid program, Chapter 5 analyzes historical, current, and future spending from variety of different policy perspectives. The chapter discusses implications of the upcoming fiscal cliff, including major cuts to benefits and enrollment if Congress does not provide the program with additional funding; it also provides estimates of spending under different scenarios for FY 2020.

Although an additional time-limited allotment of federal funds would prevent a shock to the Puerto Rico health system in 2020, it would not address the financing structure or support Puerto Rico's ability to plan, manage, and sustain an effective Medicaid program that offers long-term, reliable access to care for its beneficiaries. Ensuring reliable, sustainable access to care for Medicaid beneficiaries will require policy changes that provide a higher level of federal investment over a longer period.



Chapter 1:

# Next Steps in Improving Medicaid Prescription Drug Policy

# Next Steps in Improving Medicaid Prescription Drug Policy

## Recommendations

- 1.1** Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or new formulation of a drug has been approved by the Food and Drug Administration and entered the market.
- 1.2** Congress should amend Section 1927(c)(2)(D) of the Social Security Act to remove the cap on Medicaid drug rebates.

## Key Points

- State and federal policymakers continue to look for ways to control prescription drug spending, which is expected to experience one of the largest growth rates among health care goods and services over the next decade with the anticipated growth of new high-cost treatments.
- Under the Medicaid Drug Rebate Program, a state is generally required to cover all of a participating manufacturer's products as soon as they have been approved by the Food and Drug Administration and have entered the market. Medicare Part D and exchange plans have up to 180 days after a new drug enters the market to make a coverage determination.
- States must follow a prescribed process to publish and implement formal coverage criteria. Generally, states use pharmacy and therapeutics committees to examine the clinical evidence and make recommendations on the extent of coverage of a new drug.
- Medicaid pharmacy and medical directors say current law does not provide sufficient time to assess the effectiveness of a drug or determine appropriate coverage and prior authorization criteria, especially when the drug under review is a first-in-class or novel, complex treatment.
- Creating a formal grace period would align Medicaid's time frame with that of other payers and provide more time for the lengthy process of establishing appropriate coverage criteria. Giving states time to review the literature regarding safety, efficacy, and clinical outcomes helps prevent potential drug-related harm and would not likely create undue access restrictions.
- Currently, the Medicaid drug rebate for a particular drug is capped at 100 percent of the drug's average manufacturer price. This rebate cap limits the effectiveness of the inflationary rebate and restricts the dollar amount of rebates that Medicaid can receive.
- Removing the rebate cap would allow the inflationary rebate to achieve its full effect and create substantial savings for Medicaid, relieving some fiscal pressure on states by allowing them to maintain the same level of drug coverage at a lower cost.

# CHAPTER 1: Next Steps in Improving Medicaid Prescription Drug Policy

In fiscal year (FY) 2017, Medicaid spent approximately \$64.0 billion on outpatient prescription drugs and collected \$34.9 billion in rebates, resulting in net drug spending of \$29.1 billion, or about 5.1 percent of total Medicaid benefit spending that year. While gross drug spending (i.e., before rebates) has been rising since FY 2014, net spending has slowed. In FY 2017, gross spending increased 5.2 percent while net spending actually decreased by 1.7 percent due to an increase in the amount of rebates collected (MACPAC 2019).

Even so, controlling prescription drug spending remains a focus for policymakers because prescription drugs are expected to experience one of the largest growth rates in average annual spending among major health care goods and services over the next 10 years, due in part to the anticipated growth of new high-cost treatments (Sisko et al. 2019). In fact, increased spending on brand drugs has offset much of the savings states gained by using more generic drugs. While brand drugs' share of total claims has decreased since FY 2014, their share of spending increased; average spending for a brand drug increased by 40 percent (MACPAC 2019).

The use of high-cost specialty drugs is contributing to the increased spending on brand drugs (Express Scripts 2018, Magellan 2017).<sup>1</sup> From 2010 to 2015, net spending on specialty drugs in Medicaid almost doubled, growing from \$4.8 billion to \$9.9 billion (CBO 2019). This trend is expected to continue.<sup>2</sup> Projections show specialty drug spending for all payers growing faster than spending for traditional drugs, with specialty drugs representing 50 percent of total pharmacy spending in the next few years (IQVIA 2018, Magellan 2017).

State Medicaid officials have expressed concern about the fiscal pressures that will be created by

the use of new specialty drugs. State officials have also stated that Medicaid's statutory requirement to cover new drugs as soon as they enter the market is challenging, particularly when these are first-in-class drugs or are novel, complex treatments (Williams 2017). Pharmacy and medical directors say that they do not have sufficient time to assess the effectiveness of a drug or determine coverage and prior authorization criteria that align with the drug's labeling and medically accepted indications. When assessing a drug, some states enact prior authorization criteria that are so restrictive that beneficiaries essentially do not have access to that product.

In terms of controlling spending, states have benefited from the statutory rebates under the Medicaid Drug Rebate Program, but a statutory cap restricts the amount of rebates Medicaid can receive. Currently, rebates are capped at 100 percent of a drug's average manufacturer price (AMP). This cap on rebates can limit the effectiveness of Medicaid's inflationary rebate in discouraging large price increases over time. Recently, a large number of drugs have reached the rebate cap, suggesting that lifting the cap could produce substantial savings to Medicaid and exert additional downward pressure on price increases.

This chapter presents the Commission's recommendations on authorizing a drug coverage grace period and removing the cap on Medicaid rebates. Specifically:

- Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or new formulation of a drug has been approved by the Food and Drug Administration and entered the market.
- Congress should amend Section 1927(c)(2)(D) of the Social Security Act to remove the cap on Medicaid drug rebates.

The chapter begins with an overview of the Medicaid Drug Rebate Program. It continues by

detailing Medicaid's drug coverage requirements, the challenges states face in meeting these requirements, and how these coverage requirements compare to those imposed on other federal payers. It then discusses the cap on Medicaid rebates and how the cap limits the amount of rebates Medicaid receives and the effectiveness of the inflationary rebate in discouraging steep price hikes. The chapter then presents the rationale for the Commission's recommendations for steps that Congress should take to mitigate these issues. The chapter concludes by outlining the Commission's plans for future work in this area, which includes examining Medicaid's existing ability to manage drug utilization and spending, exploring whether certain types and classes of drugs merit special consideration within the Medicaid program, and monitoring the development of new financing or payment strategies to manage spending on specialty drugs.

## Medicaid Drug Rebate Program

The Medicaid Drug Rebate Program was created under the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) with the purpose of ensuring that Medicaid pays a net price that is consistent with the lowest or best price that manufacturers charge other payers for the drug. Under the program, a drug manufacturer must enter into a Medicaid national drug rebate agreement with the Secretary of the U.S. Department of Health and Human Services (the Secretary) in order for states to receive federal funding for using the manufacturer's products (§ 1927(a)(1) of the Social Security Act (the Act)).<sup>3</sup> In exchange for the rebates, state Medicaid programs must generally cover all of a participating manufacturer's drugs when prescribed for a medically accepted indication, although states may limit the use of some drugs through preferred drug lists (PDLs), prior authorization, and quantity limits.<sup>4</sup>

## Statutory rebates

Medicaid drug rebates are calculated based on AMP. AMP is defined as the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to retail community pharmacies and by retail community pharmacies that purchase drugs directly from the manufacturer (§ 1927(k)(1) of the Act).<sup>5</sup>

The rebate formula for single source and innovator multiple source drugs (i.e., brand-name drugs) differs from the formula for non-innovator multiple source drugs (i.e., generic drugs).<sup>6</sup> For purposes of simplicity, this chapter refers to single source and innovator multiple source drugs as brand drugs and refers to non-innovator multiple source drugs as generic drugs or generics.

The rebate amount for covered outpatient drugs has two components: a basic rebate amount and an additional inflationary component. For most brand drugs, the basic rebate amount is either equal to 23.1 percent of AMP or AMP minus best price, whichever is greater.<sup>7</sup> Best price is statutorily defined as the lowest price available to any wholesaler, retailer, provider, or paying entity, excluding certain governmental payers (§ 1927(c)(1)(C) of the Act).<sup>8</sup> For generic drugs, the basic rebate amount is calculated as 13 percent of AMP with no best price provision.

An additional rebate based on an inflationary component is added if the increase in a drug's AMP exceeds the increase in the Consumer Price Index for All Urban Consumers (CPI-U) over time. The inflationary component is equal to the amount that the drug's current quarter AMP exceeds its baseline AMP trended to the current period by the CPI-U.<sup>9</sup> This inflationary rebate is designed to limit the increase in the net price of any drug to the rate of inflation. The total rebate amount (the sum of the basic and inflationary components) cannot exceed 100 percent of AMP (§ 1927(c)(2)(D) of the Act).

## Supplemental rebates

As of December 2018, almost all states (46 states and the District of Columbia) were receiving supplemental rebates on top of the mandated federal rebates (CMS 2018).<sup>10</sup> A state will negotiate with manufacturers to obtain supplemental rebates, which manufacturers provide to ensure that their products are placed on the state's PDL. Preferred drugs typically face fewer utilization management requirements (e.g., prior authorization) than therapeutically equivalent drugs that are not on the list, and this results in a shift in market share to the preferred drugs. Some states pursue supplemental rebate agreements on their own, while others have joined multistate coalitions for negotiation purposes (CMS 2018).

## Coverage of Drugs

Under the Medicaid Drug Rebate Program, a drug meets the definition of a covered outpatient drug if its manufacturer has a rebate agreement in place with the Secretary and the drug has been approved by the Food and Drug Administration (FDA) (§ 1927(k) of the Act). This means that a state is generally required to cover all of a participating manufacturer's products as soon as they have been approved by the FDA and enter the market—that is, when they are available for sale by the manufacturer in the state.<sup>11</sup> Although a state can use prior authorization, clinical criteria, or other utilization management tools to manage the use of a particular drug, the effect of these limitations “should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments” (CMS 2015).

The statutory requirement to cover new drugs upon market entry means that a state must quickly determine under what circumstances coverage is supported by the FDA label. For drugs within therapeutic classes for which extensive evidence is available and well known to state Medicaid officials and health care providers (e.g., statins), this requirement may be relatively easy to meet.

But for novel drugs or first-in-class therapies, state officials and providers may not know in advance what uses will be supported by its label or if there are additional clinical guidelines that should be followed in prescribing the drug. Additionally, some novel therapies are approved based on surrogate endpoints, a situation in which evidence about drug safety and efficacy is limited.<sup>12</sup> Due to the difficulty of evaluating a drug's safety, efficacy, and effectiveness immediately upon its entry into the market, most states require prior authorization for drugs they have not yet reviewed. If these prior authorization requirements are neither clearly defined nor publicly available, beneficiaries may not have a guaranteed path to coverage for the new therapy.

States must follow a prescribed process to publish and implement formal coverage criteria. Statute requires that the PDL must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor of the state (§ 1927(d)(4)(A) of the Act). To fulfill this requirement, states typically use a pharmacy and therapeutics (P&T) committee to develop their PDLs and make recommendations on appropriate utilization protocols, such as prior authorization, for each drug (Box 1-1).

The process of P&T committee deliberations varies from state to state. For example, in a few states, P&T committees meet on a monthly basis, but in many others, P&T committees meet quarterly. P&T committee meetings are typically open to the public for comment and testimony, and states may require public notice and the publication of the meeting agenda a few weeks in advance of the meeting. If a drug is introduced after the agenda for the next scheduled P&T meeting is announced in states with quarterly meetings and public notice requirements, the committee must wait at least 90 days (until the next scheduled meeting) to review the drug. In some states, it can take two meetings (held quarterly) to finalize any recommendations for new drug classes. Some states allow members of the public to comment for a period of time after a committee meeting (e.g., 30 days) before the state can implement the committee's recommendations.

## BOX 1-1. Pharmacy and Therapeutics Committees

States typically use a pharmacy and therapeutics (P&T) committee to make recommendations on coverage criteria and placement of drugs on the state's preferred drug list (PDL). There are no federal requirements for P&T committees. As such, the structure and operations of the committee—for instance, composition of members, frequency of meetings, opportunity for public comment, and conflict of interest policies—tend to vary by state.

The P&T committee examines the scientific literature (e.g., drug labeling, drug compendia, peer reviewed clinical literature, and professional association guidelines) for evidence that supports including a specific drug on the PDL based on the drug's safety, efficacy, and effectiveness relative to other drugs in its class. Price may also be considered once a drug's safety, efficacy, and effectiveness have been evaluated. For instance, inclusion on the PDL may be related to whether the state receives supplemental rebates from the drug's manufacturer. The P&T committee also makes recommendations on the appropriate utilization protocols, such as prior authorization or quantity limits for individual medications or for therapeutic categories.

The P&T committee may use a contractor, such as the state's pharmacy benefits manager or university, to assist in compiling and reviewing the evidence. Some states may use a drug utilization review board (§ 1927(g)(3) of the Act) instead of a P&T committee to fulfill some or all of these duties in developing the PDL and utilization management protocols.

If state policy is to restrict coverage of a new drug before it undergoes P&T committee review, the state might be, in effect, excluding coverage of that drug for an extended period of time, thus failing to meet its statutory obligation to cover the drug upon its entry into the market.

It typically takes from one to three months (although sometimes as long as six months to a year) for a state to evaluate a new drug and develop coverage criteria, depending on the resources available and the drug.<sup>13</sup> It can be much faster to review a new drug or new formulation of a drug in an existing class than to review a novel drug or first-in-class treatment.

### Other federal payers

In general, plans sold on health insurance exchanges and Medicare Part D plans have minimum requirements for drug coverage, but they are allowed to exclude coverage for some drugs.<sup>14</sup> Exchange plans and Medicare Part D plans are required to use P&T committees to develop their

formularies, and they are allowed a period of time following a new drug's release into the market to evaluate it and make coverage decisions. Exchange plans are required to make a reasonable effort to review new drugs within 90 days of approval and make coverage determinations within 180 days (HHS 2015). Medicare Part D plans are similarly required to make a reasonable effort to review new drugs within 90 days and make coverage decisions within 180 days of a drug's release into the market. If a drug is in one of the six protected classes, Medicare Part D plans are required to conduct an expedited review and render a coverage decision 90 days after it comes on the market. At the end of the 90-day period, the drug must be added to the plan's formulary (CMS 2016a).

### Cap on Medicaid Rebates

Under the Medicaid Drug Rebate Program, drug rebates are capped at 100 percent of a drug's



AMP (§ 1927(c)(2)(D) of the Act). A drug is likely to reach the rebate cap only if the price increases substantially over time and is thus subject to a large inflationary rebate.<sup>15</sup> This rebate cap limits the inflationary rebate and restricts the dollar amount of rebates that Medicaid can receive. Recently, a number of drugs covered by Medicaid have reached the rebate cap: MACPAC analyses of Centers for Medicare & Medicaid Services (CMS) drug rebate data from the fourth quarter of 2015 show that about 18.5 percent of brand drugs (at the national drug code level) reached the rebate cap in that quarter and that Medicaid would have received an additional \$690 million in rebates if there were no caps on the rebates (MACPAC 2018a).

Several drugs that have been on the market for decades have recently seen steep price hikes. For example, the price of Daraprim increased from \$13.50 per tablet to \$750 per tablet in 2015 and Eli Lilly and Novo Nordisk increased prices of insulin 450 percent above inflation over several years (Johnson 2016, Pollack 2015). Currently, Medicaid is largely insulated from these steep hikes by the inflationary rebate, which ensures that Medicaid programs receive a rebate equal to the amount that the price of the drug has increased over inflation. In other words, the Medicaid inflationary rebate ensures that net price increases for drugs purchased by Medicaid are limited to the rate of inflation. However, other payers and consumers, including those who are uninsured, are exposed to steep price increases.

Some policymakers have argued that the Medicaid inflationary rebate benefits other payers by penalizing steep price hikes. A manufacturer may choose to limit its price increases to avoid paying Medicaid a larger inflationary rebate. Once a drug hits the cap, however, the manufacturer can raise prices without being subject to a corresponding increase to its net rebate obligations to Medicaid. In other words, manufacturers would essentially receive no net revenue on Medicaid prescriptions (because the rebate would be equal to 100 percent of AMP), but they could increase the price even more to obtain greater revenues from other payers

without having to pay additional rebates on the Medicaid side.<sup>16</sup> The Administration has recently expressed interest in removing the cap on Medicaid rebates as a way to discourage manufacturers from implementing steep price hikes (HHS 2018).

## Commission Recommendations

In this chapter, the Commission recommends two changes to the Medicaid Drug Rebate Program. These should not be considered a package; that is, the adoption of one by Congress does not require the adoption of the other. The rationale and implications of these recommendations are described below.

### Recommendation 1.1

Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or new formulation of a drug has been approved by the Food and Drug Administration and entered the market.

#### Rationale

We recommend that Congress give states a set period of time to evaluate the clinical evidence for new drugs and determine appropriate coverage criteria for several reasons. First, providing states with this grace period has the potential to improve beneficiary safety. As discussed, the FDA approves drugs as safe and effective for the treatment of certain diseases in certain individuals. For other individuals, the same drug may present an unacceptable level of risk. Professional societies may also develop prescribing guidelines regarding appropriate dosing, potential drug interactions, and the need for additional clinical monitoring. Without time to evaluate the approved label indications and review the clinical literature, states risk either covering inappropriate uses of the drug or enacting utilization management protocols that do not

adhere to clinical guidelines developed by the relevant medical and professional associations. This is particularly relevant when innovative drugs are approved on the basis of surrogate outcomes and when there is little evidence available on long-term effects of treatment at the time of approval. Giving states time to review the literature regarding safety, efficacy, and clinical outcomes and assess real-world outcomes (on the chance that new adverse events are discovered postapproval) will help prevent potential drug-related harm.

Second, states need sufficient time to complete the lengthy process of reviewing the scientific literature and establishing appropriate coverage criteria. States must use a committee to develop the PDL and to make recommendations on appropriate utilization protocols. A 180-day period would allow most states to maintain their existing procedural timelines for the P&T committee to review drugs and develop coverage decisions. In addition, this would align Medicaid's time frames with those of Medicare Part D and exchange plans.

Finally, a statutory grace period would not be a huge departure from current state practices that may already result in limited access for new drugs for some period of time. States generally require prior authorization on a new drug before it has been reviewed by the P&T committee and coverage criteria have been established. It may not be clear to the beneficiary and prescribing physician that the drug is available, particularly if prior authorization is done on a case-by-case basis or claims are routinely denied for drugs that have not yet been reviewed for the PDL. In fact, the requirements to get the drug may be so rigorous that the state is essentially not covering it.

Given these circumstances, a statutory grace period may primarily serve to codify a practice that is already taking place informally. In addition, it may have an added benefit for beneficiaries and providers by clarifying what state actions are permissible.

It is important to note that although this recommendation provides states with the option to exclude or restrict coverage for up to 180 days,

it does not require them to do so. Nothing in this recommendation would prohibit a state from implementing its coverage policy earlier than the deadline. For new formulations of existing products or new drugs in an existing therapeutic class, states have shown that they can evaluate the product quickly and implement a coverage policy much faster than 180 days. Thus, CMS may wish to issue guidance that aligns the grace period with Medicare Part D standards and requires states to make a reasonable effort to review a new drug within 90 days (CMS 2016a). Nor would the recommendation prohibit a state from providing some level of coverage while it is developing its policies. The Commission expects states to have an exceptions process in place that allows beneficiaries in critical need to obtain early access to a medication.

The Commission makes this recommendation with the expectation that states will use the grace period to make informed coverage decisions based on clinical guidelines and not as a license to simply delay access to drugs. In implementing the grace period, it would be desirable for CMS to issue regulatory or subregulatory guidance to standardize the operations of P&T committees across states, to ensure that processes are fair and transparent to the beneficiary, and to ensure the time is used to formulate coverage policies that meet statutory requirements. For example, CMS could establish a minimum frequency for P&T committee meetings (e.g., quarterly), a period for public comment, and a requirement that coverage criteria be published at the end of the grace period. These requirements would reinforce the proper role and function of the P&T committee and provide a clear timeline to ensure appropriate beneficiary access to new drugs.

The Commission also sees the need for CMS to exercise its oversight role by actively monitoring state compliance with drug coverage requirements. Current CMS practice is largely reactive; when the agency becomes aware of compliance issues, it may contact state officials informally to attempt to resolve issues, but there can be a substantial time lag before it takes formal action.

The Medicaid experience with Sovaldi shows why more active monitoring of state coverage policies is needed. When Sovaldi was first introduced as a treatment for hepatitis C, some states were essentially denying coverage, either by not making formal coverage decisions or by instituting extremely restrictive prior authorization requirements. It took CMS nearly two years after Sovaldi's approval in December 2013 before it sent a letter reminding states of their coverage obligations (CMS 2015). It was May 2016 before a federal judge in the Western District of Washington issued a preliminary injunction that led the Washington State Medicaid program to loosen coverage restrictions and cover hepatitis C treatments more broadly.<sup>17</sup>

### Implications

**Federal spending.** The Congressional Budget Office (CBO) estimates that this recommendation would produce modest savings, decreasing federal spending by less than \$25 million over 10 years compared to the current law baseline. The savings primarily result from delaying the start of the coverage period and shifting some spending to a later time period.

**States.** States have indicated that a grace period would help alleviate their administrative burden by providing sufficient time to determine appropriate prior authorization and coverage criteria for newly approved drugs.

**Enrollees.** A grace period has the potential to improve beneficiary safety by giving states time to develop appropriate prescribing guidelines that could reduce drug-related harm. A grace period also could affect beneficiary access to medications and result in delayed access to some drugs; however, current state practices may already result in limited access for new drugs. Beneficiary protections would be enhanced by issuance of new CMS guidance to ensure that P&T processes are fair and transparent and that CMS is actively monitoring state compliance with coverage requirements.

**Drug manufacturers.** This recommendation could delay the availability of a manufacturer's drug in the Medicaid market. Manufacturers may already be experiencing some delays in the coverage of their products based on current state practices, but we expect that manufacturers would prefer there not be a formal waiting period in which states are legally allowed to exclude coverage.

### Recommendation 1.2

Congress should amend Section 1927(c)(2)(D) of the Social Security Act to remove the cap on Medicaid drug rebates.

#### Rationale

Removing the rebate cap would allow the inflationary rebate to achieve its full effect and lead to higher rebates on drugs with large price increases, which would reduce the net price for these products and create savings for Medicaid. These savings would relieve some fiscal pressure on states by allowing them to maintain the same level of drug coverage at a lower cost.

Removing the rebate cap would also reinforce the downward pressure that the Medicaid inflationary rebate already exerts on price increases. A drug manufacturer is likely to reach the rebate cap only if it increases its price substantially over time and therefore has to pay a large inflationary rebate. Removing the rebate cap could change the calculation for manufacturers considering a large increase in the market price of their products because there would be no limit on the Medicaid rebates and larger price increases would result in larger Medicaid rebate obligations for manufacturers. Manufacturers would have the incentive to lower list prices on current drugs as well as curtail price increases on future drugs.

Manufacturers strongly oppose changes to the rebate cap. As noted in its comments on the Administration's *Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs*, the Pharmaceutical Research and Manufacturers of America, a trade

group, referred to the proposal as a tax on drug manufacturers and said it would lead to further market distortions (e.g., cost shifting) (PhRMA 2018).<sup>18</sup> Manufacturers may threaten to leave the Medicaid program or reduce research on drugs that disproportionately benefit Medicaid enrollees, such as treatments for cystic fibrosis. However, the Medicaid drug rebate agreement applies to all of a manufacturer's drugs, so a manufacturer cannot choose to withdraw only one or a select few of its products from the program. Although the possibility of such manufacturer retaliation cannot be dismissed, such actions would represent a considerable shift for drug manufacturers, likely requiring major changes to their business operations.

Removing the rebate cap would not address the issue of high launch prices. If the rebate cap were removed, manufacturers would have an incentive to launch their products at a higher price and, in so doing, avoid annual price increases that would outpace inflation and trigger the inflationary rebate. However, this strategy may not be an option for all drugs because drug launch prices are determined based on a variety of factors, including existing therapeutic competition, anticipated insurance coverage and formulary tier assignments, and anticipated provider prescription rates. Moreover, some economists believe that pharmaceutical manufacturers already launch their new drugs at the highest price they think the market will bear (Kaltenboeck and Bach 2018, Kesselheim et al. 2016).

In its deliberations on this issue, the Commission considered whether to remove the cap or to raise it to 125 percent of AMP, which would produce about half as much savings. The discussion of these options focused on the pressure each option would exert on manufacturers to limit price increases as well as any potential negative consequences. Although some Commissioners initially expressed optimism that raising the cap would provide an opportunity to evaluate the market response, all ultimately agreed that it would be difficult to evaluate the effect of the policy on drug prices in isolation. After weighing the two approaches, the Commissioners concluded that it would be preferable to place the greatest possible

amount of pressure on manufacturers to limit price increases, and so they recommended removing the cap completely.

## Implications

**Federal spending.** Removing the rebate cap would increase the rebates Medicaid receives from manufacturers. The CBO estimates that this recommendation would decrease federal spending by \$15–\$20 billion over 10 years compared to the current law baseline. These savings would help offset the projected \$2–\$3 billion annual increases in Medicaid drug spending (OACT 2019).

**States.** State spending would decrease because states would receive the non-federal share of any increases in rebate amounts. Based on the average federal share of Medicaid rebates in recent years, this would amount to approximately \$7–\$10 billion in state savings across all states over 10 years. This change could affect supplemental rebate agreements; however, it is unlikely that states have supplemental rebate agreements on drugs that have reached the rebate cap as states are already receiving these drugs at essentially no cost.

**Enrollees.** This recommendation is unlikely to have a measureable effect on Medicaid beneficiaries.

**Drug manufacturers.** Manufacturers would be required to pay larger Medicaid rebates should they increase prices substantially faster than the rate of inflation. Manufacturers would need to take the potential for larger rebates into account as they establish their market prices.

## Next Steps

Although implementation of these recommendations will provide states with additional time to make coverage decisions and generate savings for Medicaid by increasing rebates, states will still face a number of challenges in managing the prescription drug benefit. The Commission therefore plans further work in this area. For example, we are currently examining how Medicaid's

existing tools for managing drug utilization compare to Medicare Part D and commercial plans. Based on our initial findings, Medicaid tends to cover more drugs than Medicare or commercial plans, but also may place more restrictions on drugs. However, most formularies across all three payers include restrictions through prior authorization, step therapy, or quantity limits for the majority of the drugs in a class (MACPAC 2018b). We are continuing this analysis to determine how different coverage policies affect actual utilization of specific medications across payers.

The Commission has also heard that existing drug utilization management tools are ineffective at containing costs associated with high-cost specialty drugs and that additional authorities and policy options might be necessary (Brown 2017). MACPAC is currently examining whether certain value-based arrangements or financing models (e.g., subscription-based models for curative treatments) could be used more broadly. A few states have just started implementing these value-based and alternative financing arrangements, so it will take some time before we can assess the effectiveness of these initiatives.

The Commission may also consider whether certain drugs or therapeutic classes that have unique characteristics (e.g., curative treatments, gene or cell therapy) should receive separate consideration apart from other covered outpatient drugs.

## Endnotes

<sup>1</sup> Magellan, a large national pharmacy benefits manager (PBM), reported that for its contracted Medicaid fee-for-service programs, net spending per claim (net of federal and supplemental rebates) decreased 5.1 percent for traditional drug classes but increased 20.5 percent for specialty drug classes from 2015 to 2016; the share of net spending attributed to specialty drugs increased by almost 5 percentage points during this period, from 31.8 percent to 36.5 percent (Magellan 2017). Express Scripts, another large national PBM, reported that specialty medications accounted for 42.3 percent of their total Medicaid drug

spending in 2017, increasing 7.4 percent in per-member, per-year spending compared to 2016 (Express Scripts 2018).

<sup>2</sup> About 80 percent of the drugs approved by the U.S. Food and Drug Administration (FDA) in 2017 could be classified as specialty drugs under most definitions (CBO 2019).

<sup>3</sup> In addition to executing a Medicaid drug rebate agreement as a condition for Medicaid coverage of their products, drug manufacturers must also enter into an agreement that meets the requirements of Section 340B of the Public Health Service Act (P.L. 102-585) and a master agreement with the Secretary of Veterans Affairs (§ 1927(a)(1) of the Act). A drug not covered under a rebate agreement may be eligible for federal funding in limited circumstances if the state has determined that the drug is essential to the health of its beneficiaries.

<sup>4</sup> A medically accepted indication means any use for a covered outpatient drug that is approved under the Federal Food, Drug, and Cosmetic Act (P.L. 75-717) or that is supported by one or more citations included or approved for inclusion in one of the following three compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, or the DRUGDEX Information System (§ 1927(k)(6) of the Act).

<sup>5</sup> The covered outpatient drug rule finalized in 2016 included a separate definition of AMP for the so-called 5i drugs—inhalation, infusion, instilled, implanted, or injectable drugs. These drugs are not generally sold through the same distribution channels as non-5i drugs, so the AMP for 5i drugs includes sales of a type not included in AMP calculations of non-5i drugs.

<sup>6</sup> Generally, an innovator drug is a drug produced or distributed under a new drug application approved by the FDA. Single source drugs are innovator drugs manufactured by only one company and innovator multiple source drugs are innovator drugs that have at least one generic equivalent available. Non-innovator multiple source drugs are multiple source drugs that are not innovator drugs—generally, these are drugs that have been approved by the FDA under an abbreviated new drug application.

<sup>7</sup> For blood clotting factor drugs and drugs approved by the FDA exclusively for pediatric indications, the rebate percentage is 17.1 percent of AMP instead of 23.1 percent of AMP.

<sup>8</sup> Best price excludes certain governmental payers such as the Indian Health Service, Department of Veterans Affairs, Department of Defense, Public Health Service (including 340B), Federal Supply Schedule, and Medicare Part D plans.

<sup>9</sup> The baseline AMP is the AMP during the quarter before the Medicaid Drug Rebate Program was started or, for new drugs, the first full quarter after the drug's market date. For generic drugs marketed on or before April 1, 2013, the baseline AMP is equal to the AMP for the third quarter of 2014, and the baseline CPI-U is the CPI-U for September 2014. For generic drugs marketed after April 1, 2013, the baseline AMP is equal to the AMP for the fifth full calendar quarter after which the drug is marketed as a drug other than a brand drug, and the baseline CPI-U is equal to the CPI-U for the last month of the baseline AMP quarter (CMS 2016b).

<sup>10</sup> In accordance with Section 2501(c) of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), 20 states—Arizona, Arkansas, California, Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Nebraska, New Hampshire, New York, North Dakota, Oregon, Texas, Virginia, Washington, and West Virginia—are expanding supplemental rebate collections to include drugs dispensed to beneficiaries who receive drugs through a managed care organization (MCO). Minnesota limits its collection of supplemental rebates for MCO enrollees to direct-acting antivirals for the treatment of hepatitis C (CMS 2018).

<sup>11</sup> A drug manufacturer must have a signed Medicaid drug rebate agreement in place in order for its products to be covered by Medicaid. If a manufacturer does not have a rebate agreement with the Secretary, then a state does not have to cover that manufacturer's products until the rebate agreement is effective.

<sup>12</sup> The accelerated approval pathway allows the FDA to approve a drug based on whether the drug has an effect on a surrogate endpoint that is reasonably likely to predict a clinical benefit (§ 506(c) of the Federal Food, Drug, and Cosmetic Act). A surrogate endpoint is a marker—a laboratory measurement, radiographic image, physical sign, or other measure that is thought to predict clinical benefit, but is not itself a measure of clinical benefit.

<sup>13</sup> To learn more about how states develop clinical coverage criteria for new drugs, we sent a set of focused questions

to state Medicaid pharmacy directors and conducted informal interviews with four states and received written survey responses from five states. Some states said that they typically can review the clinical evidence and develop guidelines within a matter of weeks; one state said it takes six months. However, most states that responded said it normally takes two to three months, and one said that it takes six months to a year.

<sup>14</sup> For Medicare Part D formularies, each drug category or class must include at least two drugs (regardless of the classification system utilized), and Part D plan formularies must include all or substantially all drugs for the following six protected classes: immunosuppressants (for prophylaxis of organ transplant rejection), antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics (CMS 2016a). Exchange plans must cover one drug in every United States Pharmacopeia category and class, or the same number of drugs in each category and class as the state benchmark plan (45 CFR 156.122(a)(1)).

<sup>15</sup> A study by the Pew Charitable Trust estimated that brand drugs with price increases of more than 433 percent above inflation in 2017 would exceed the rebate cap when the basic rebate is 23.1 percent of AMP (Dickson 2019).

<sup>16</sup> The 340B program would also get these drugs at essentially no cost. Additionally, some companies offer assistance to low-income and insured patients in the form of coupons and reduced prices.

<sup>17</sup> *B.E. v. Teeter*, C16-227-JCC (W.D. Wash. 2016).

<sup>18</sup> The full publication, *HHS blueprint to lower drug prices and reduce out-of-pocket costs*, is available at <https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0075-0001&contentType=pdf>.

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## Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC § 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on improving Medicaid prescription drug policy. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 1.1 and Recommendation 1.2 on April 11, 2019.

### Next Steps in Improving Medicaid Prescription Drug Policy

1.1 Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or new formulation of a drug has been approved by the Food and Drug Administration and entered the market.

Yes: Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno

16	Yes
1	Not present

Not present: Cerise

1.2 Congress should amend Section 1927(c)(2)(D) of the Social Security Act to remove the cap on Medicaid drug rebates.

Yes: Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno

16	Yes
1	Not present

Not present: Cerise



Chapter 2:

# Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

# Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

## Recommendation

**2.1** To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

## Key Points

- Medicaid disproportionate share hospital (DSH) payments help to offset two types of hospital uncompensated care: Medicaid shortfall and unpaid costs of care for uninsured individuals.
- Recent lawsuits have challenged how Medicaid shortfall is calculated for Medicaid-eligible patients with third-party coverage, such as Medicare and private insurance. The chronology of events is as follows:
  - In 2010, the Centers for Medicare & Medicaid Services (CMS) issued guidance that third-party payments should be counted when calculating Medicaid shortfall.
  - In March 2018, the U.S. District Court of the District of Columbia vacated CMS's policy nationwide because the Medicaid DSH statute does not explicitly mention third-party payments.
  - CMS is appealing this decision, but in the interim, the agency has instructed states that it will no longer enforce its 2010 guidance.
- The March 2018 district court ruling will substantially increase the amount of Medicaid shortfall that hospitals report, allowing them to receive DSH payments for costs that are paid for by other payers.
- Although the court ruling does not affect the amount of DSH funds allotted to states, it is expected to result in an increase in DSH spending in states with unspent DSH allotments as well as in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs.
- In the Commission's view, the court ruling distorts DSH policy from its intended purpose of paying for uncompensated care costs that are not paid for by other payers.
- Although the March 2018 decision is currently under appeal, MACPAC focused its work on what the preferred policy should be, not the legal issues under consideration by the courts.
- Congress can improve upon CMS's 2010 policy by changing the DSH definition of Medicaid shortfall to only count costs and payments for patients for whom Medicaid is the primary payer.
- If enacted, the Commission's recommendation would remove a disincentive for hospitals to help privately insured patients enroll in Medicaid.
- The approach we recommend is administratively simple and is likely to result in larger DSH payments to hospitals that serve more patients who are uninsured or whose only source of coverage is Medicaid.

## CHAPTER 2: Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

Recent lawsuits have challenged how Medicaid shortfall is calculated for the purposes of Medicaid disproportionate share hospital (DSH) payments. Specifically, there is disagreement over what costs and payments can legally be counted as shortfall for Medicaid-eligible patients with third-party coverage, such as Medicare and private insurance. Although these lawsuits are still under appeal, they have raised questions about whether the statute should be changed to ensure that DSH payments do not pay for costs that are paid for by other payers.

DSH payments are statutorily required payments to safety-net hospitals that help to offset two types of uncompensated care: Medicaid shortfall and unpaid costs of care for uninsured individuals. In general, Medicaid shortfall is defined as the difference between a hospital's costs of care for Medicaid-eligible patients and the payments that the hospital receives for these services. For Medicaid-eligible patients with third-party coverage, most of the costs of care for these patients are paid for by other payers because Medicaid is a payer of last resort.

Since at least 2010, the Centers for Medicare & Medicaid Services (CMS) has held that third-party payments should be counted when calculating Medicaid shortfall.<sup>1</sup> However, in March 2018, the U.S. District Court for the District of Columbia vacated CMS's policy nationwide, ruling that it is inconsistent with the plain language of the Medicaid DSH statute since the statute does not explicitly mention third-party payments.<sup>2,3</sup> CMS is appealing this decision, but in the interim, the agency has instructed states that it will no longer enforce its 2010 guidance (CMS 2018).

With the March 2018 decision in effect, the amount of Medicaid shortfall that hospitals can report is

substantially increased because they are permitted to count as shortfall costs for Medicaid-eligible patients that are paid for by other payers. The ruling is expected to result in an increase in DSH spending in states with unspent federal DSH funding and in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs. Although the court ruling is currently being appealed, we have already observed some of the early effects of the ruling in states that were among the first to file lawsuits against CMS's 2010 policy.

This chapter presents the Commission's analysis of the potential impact of this court ruling and our recommendation for how Medicaid shortfall should be defined for DSH purposes. The Commission examined the effects of changing the statute to allow CMS to implement its 2010 policy and changes that Congress could make to that policy to advance the following policy goals:

- making more DSH funds available to hospitals that serve a high share of Medicaid and uninsured patients;
- not creating a disincentive for hospitals to either serve Medicaid-eligible patients with third-party coverage or help patients enroll in Medicaid; and
- promoting administrative simplicity.

Based on this analysis, the Commission recommends that Congress change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer. Although this policy differs from CMS's 2010 policy, it is both administratively simple and consistent with the way in which many states calculated Medicaid shortfall before CMS's 2010 policy took effect.

Changes to the DSH definition of Medicaid shortfall do not affect the total amount of federal DSH funds available to states, which are referred to as allotments. The Commission's annual analyses of

DSH allotments to states and its recommendations for improving the structure of DSH allotment reductions are included in Chapters 1 and 3 of MACPAC's March 2019 *Report to Congress on Medicaid and CHIP* (MACPAC 2019a, 2019b).

## Background

State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid and other low-income patients (referred to as deemed DSH hospitals); states may also make DSH payments to other hospitals in the state that meet minimum eligibility

criteria. DSH payments to an individual hospital cannot exceed the hospital's uncompensated care costs for Medicaid and uninsured patients, which is referred to as the hospital-specific limit. In addition, total federal funding for DSH payments in each state is limited by federal allotments (Box 2-1).

In state plan rate year (SPRY) 2014, 45 percent of U.S. hospitals received DSH payments totaling \$17.8 billion.<sup>4</sup> DSH hospitals reported a total \$34.0 billion in uncompensated care on DSH audits, of which \$23.5 billion (69 percent) was attributed to unpaid costs of care for uninsured individuals and \$10.4 billion (31 percent) to Medicaid shortfall (Figure 2-1).<sup>5</sup> Although most DSH hospitals received

### BOX 2-1. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

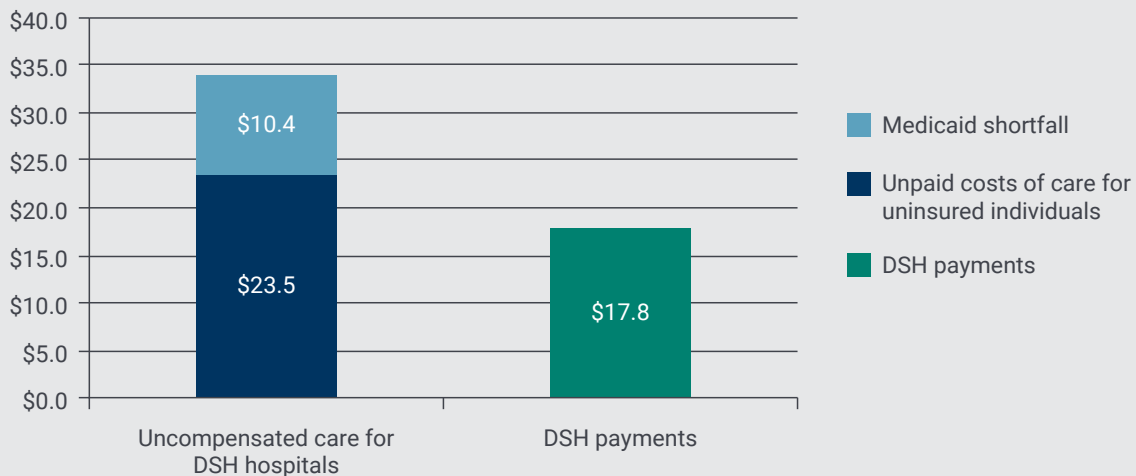
**DSH hospital.** A hospital that receives disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments; that is, a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions for rural and children's hospitals).

**Deemed DSH hospital.** A DSH hospital with either (1) a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or (2) a low-income utilization rate that exceeds 25 percent. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act (the Act)).

**State DSH allotment.** The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other Medicaid service expenditures. If a state does not spend the full amount of its allotment for a given year, the unspent portion is not paid to the state and does not carry over to future years. Allotments are determined annually and are generally equal to the prior year's allotment, adjusted for inflation (§ 1923(f) of the Act).

**Hospital-specific DSH limit.** The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

**Medicaid DSH audit.** A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-five percent of U.S. hospitals were included in DSH audits in 2014, the latest year for which data are available.

**FIGURE 2-1. DSH Payments and Uncompensated Care for DSH Hospitals, SPRY 2014 (billions)**


**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. The analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

**Source:** MACPAC, 2019, analysis of as-filed SPRY 2014 DSH audits.

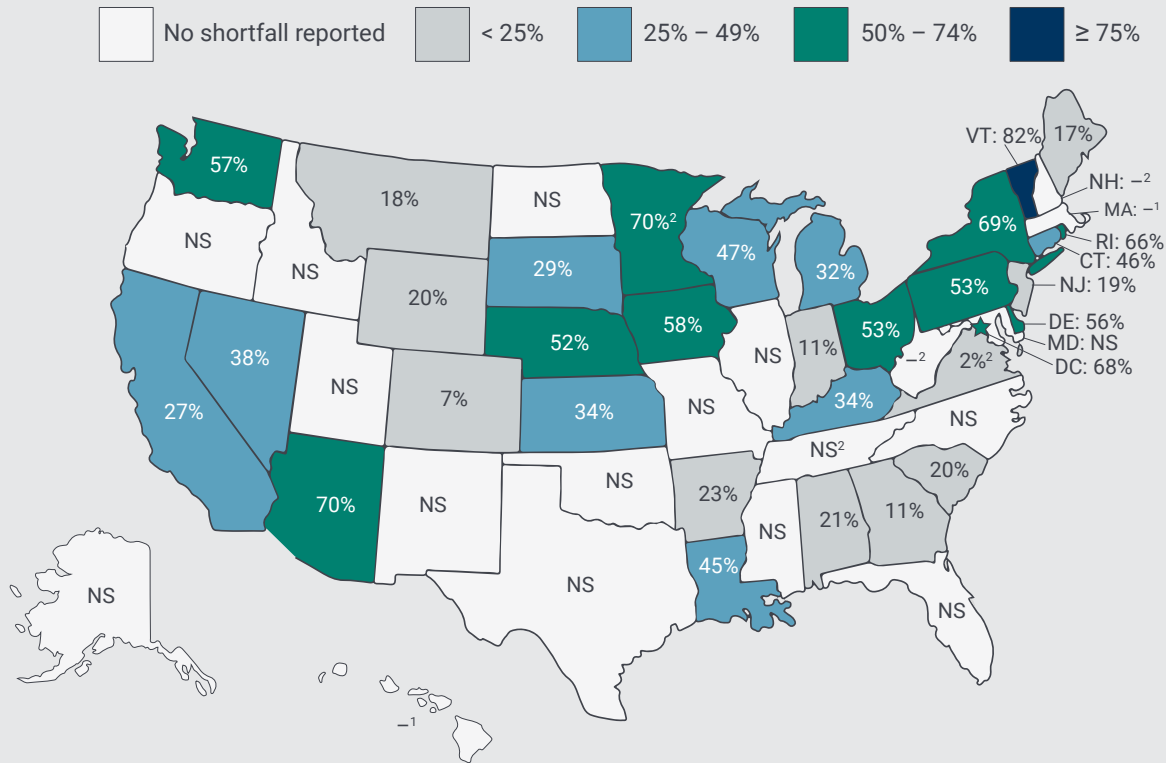
DSH payments well below their hospital-specific limit, 20 percent of DSH hospitals received DSH payments that were greater than 95 percent of their uncompensated care costs in SPRY 2014.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 2-2). In SPRY 2014, 15 states reported no Medicaid shortfall for DSH hospitals and 12 states reported shortfall that exceeded 50 percent of total DSH hospital uncompensated care. Although Medicaid base payments for hospital services are typically below hospital costs, many states make large non-DSH supplemental payments that reduce or eliminate the amount of Medicaid shortfall reported on DSH audits. Complete state-by-state data on Medicaid shortfall and other uncompensated care costs are included in Chapter 3 of MACPAC's March 2019 report to Congress, and more information about other types of Medicaid payments to hospitals is provided in MACPAC's issue brief, *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2019b, 2019c).

As a result of the coverage expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the amount of hospital unpaid costs of care for uninsured individuals is declining and Medicaid shortfall is increasing. For hospitals that received DSH payments in SPRY 2013 and SPRY 2014, the increase in Medicaid shortfall reported on DSH audits (\$4.0 billion) outpaced the decline in unpaid costs of care for uninsured patients (\$1.6 billion) for those years.<sup>6</sup>

Changes in the broader health insurance market have also affected other types of hospital uncompensated care that Medicaid DSH payments do not pay for. For example, between 2006 and 2016, the share of private-sector enrollees in high-deductible health plans grew from 11.4 percent to 46.5 percent; if patients cannot pay their deductibles or other forms of cost sharing, these amounts often become bad debt expenses for hospitals (Miller et al. 2018). Also, although the number of physicians employed by hospitals has grown in recent years, uncompensated care costs for physician services are not included in the DSH definition of uncompensated care.<sup>7</sup>

**FIGURE 2-2.** Medicaid Shortfall as a Share of Total Uncompensated Care Costs for DSH Hospitals, SPRY 2014



**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. NS is no shortfall reported.

– Dash indicates no data available.

<sup>1</sup> Hawaii and Massachusetts did not submit SPRY 2014 DSH audits because they did not make any DSH payments in SPRY 2014.

<sup>2</sup> Analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

**Source:** MACPAC, 2019, analysis of as-filed SPRY 2014 DSH audit data.

## Medicaid-Eligible Patients with Third-Party Coverage

Individuals can be eligible for Medicaid even if they have other insurance. Many Medicaid enrollees with disabilities and those age 65 and older are also eligible for Medicare; Medicaid funds cover their Medicare premiums and cost sharing. Privately insured individuals with disabilities that affect their ability to live independently may seek Medicaid

coverage to access long-term services and supports even if their private insurance covers their acute health care needs. In some cases, a patient’s medical condition can make a patient eligible for Medicaid; for example, low-birthweight babies are eligible for Supplemental Security Income (SSI), which confers automatic eligibility for Medicaid as well.<sup>8</sup>

In 2017, 18.4 million Medicaid enrollees had third-party coverage (Table 2-1). About two-thirds of these enrollees had Medicare coverage, which is



**TABLE 2-1.** Number of Medicaid Enrollees with Third-Party Coverage, 2017 (millions)

Source of third-party coverage	Number	Share of total Medicaid enrollees
<b>All sources of third-party coverage</b>	<b>18.4</b>	<b>27%</b>
Medicare	11.5	17%
Private <sup>1</sup>	8.8	13%
Veterans' and military health programs	1.8	3%
Indian Health Service	0.6	1%

**Notes:** Estimates are based on self-reported information from the American Community Survey. Individuals may report multiple types of coverage. All estimates shown have relative standard errors of less than 3 percent.

<sup>1</sup> In our analysis, private sources of health insurance include employer-sponsored, union-sponsored, and individually purchased health insurance.

**Source:** SHADAC 2019.

the most common type of third-party coverage for Medicaid enrollees with disabilities and those age 65 and older, and about one-half had private insurance coverage, which is the most common type of third-party coverage for children and adults under age 65 who are eligible for Medicaid on a basis other than disability.

Medicaid is generally the payer of last resort, meaning that other payers must pay claims under their policies before Medicaid will pay for services provided to an eligible individual. Medicare is the primary payer for hospital services for patients dually enrolled in Medicaid and Medicare, but some other public programs, such as the Indian Health Service, are statutorily designated as payers of last resort after Medicaid.

States are statutorily required to coordinate benefits for Medicaid enrollees with any potential third-party coverage. Typically, states will require providers to submit claims to the primary payer first, and then Medicaid will pay any difference between what was paid for by that payer and the amount that Medicaid would have paid for the same service. Because Medicaid often pays lower rates than other insurers, providers may not receive any additional payment from Medicaid. As a result, a provider may choose not to submit a claim to Medicaid for a Medicaid-eligible patient if a third-party payer has already paid for the service in question. This scenario is

most common for individuals with private insurance coverage because private payers typically pay much more than Medicaid.

## History of the DSH Definition of Medicaid Shortfall

DSH payments were initially established in 1981 to account for “the situation of hospitals which serve a disproportionate number of low-income patients with special needs” (§ 1902(a)(13)(A) (iv) of the Act), and in 1993, Congress established hospital-specific limits for DSH payments based on a hospital’s overall uncompensated care costs for Medicaid-enrolled and uninsured patients. Hospital-specific limits received renewed attention in 2003, when Congress required states to audit and report DSH hospital uncompensated care costs annually. CMS finalized regulations implementing the audit requirements in 2008 and required states to make DSH payments based on this rule for SPY 2011 and subsequent years. These regulations describe how uncompensated care costs should be reported, including which hospital services should be included, how uninsured individuals should be counted, and how Medicaid shortfall should be calculated (CMS 2008).<sup>9</sup>

Prior to the 2008 DSH audit rule, states used a variety of methods to account for third-party payments when calculating Medicaid shortfall. Some states subtracted payments received from third-party payers, and some did not. Other states entirely excluded both costs of and payments for Medicaid-eligible patients with third-party coverage from the calculation of Medicaid shortfall. These various methods can now be categorized as following the CMS 2010 policy; following the March 2018 district court decision that vacated the CMS policy; or following the method that would apply if the Commission’s recommendation is taken (Table 2-2).

In 2010, CMS issued subregulatory guidance in the form of frequently asked questions (FAQs) to clarify the 2008 rule, including instructions on how to account for the costs and payments of Medicaid-eligible patients with third-party coverage. These FAQs set out CMS’s policy that the costs of patients with third-party coverage should be included in DSH audits and the amount of third-party payments received for these patients should be subtracted when calculating Medicaid shortfall (CMS 2018). For example, under this guidance, Medicaid shortfall for patients dually eligible for Medicare and Medicaid would be calculated as the total hospital cost of treating the patient, less the amount that Medicare and Medicaid paid for the service provided.

**TABLE 2-2.** Components of Medicaid Shortfall for Enrollees with and without Third-Party Coverage Under Different Calculation Methods

Method of calculating Medicaid shortfall	Medicaid-eligible patients with third-party coverage			Medicaid-only patients	
	Medicaid payments	Third-party payments	Costs	Medicaid payments	Costs
Count all payments and costs (CMS 2010 policy)	X	X	X	X	X
Do not count third-party payments, but count third-party costs (March 2018 district court ruling)	X		X	X	X
Do not count payments or costs for patients with third-party coverage (MACPAC recommendation)				X	X

**Notes:** CMS 2010 policy refers to the policy described in CMS’s 2010 subregulatory guidance (CMS 2018). March 2018 district court ruling refers to the policy described in *Children’s Hospital Association of Texas v. Azar*. Components marked with an X are included in calculations for that method.

In states that were not previously counting third-party payments, CMS’s 2010 policy as set out in the FAQs reduced the amount of DSH funds that hospitals were eligible to receive and resulted in state and federal recoupments of DSH payments made to some hospitals. Overall, according to as-filed SPRY 2011 DSH audits, \$0.7 billion of the \$16.6 billion in DSH payments made that year were subject to recoupment or redistribution to other providers because, as recalculated under CMS’s

2010 policy, the payments were made in excess of the hospital-specific limit.<sup>10</sup>

In response to these recoupments, several hospitals challenged CMS’s policy on two main fronts. First, on procedural grounds, hospitals argued that the subregulatory guidance issued as FAQs represented a change in policy that was not made through formal rulemaking. Second, on the substance of the policy, hospitals argued that the

statute did not provide CMS with the authority to consider third-party payments in the calculation of Medicaid shortfall.

In response to procedural concerns about the FAQs, CMS issued a notice of proposed rulemaking in August 2016 formalizing the policy that all costs and payments for patients with third-party coverage should be included in the Medicaid shortfall calculation. This rule was finalized in April 2017 and became effective for DSH payments made on or after June 2, 2017 (CMS 2017).

Several hospitals also challenged CMS's final rule. In March 2018, the U.S. District Court for the District of Columbia vacated the 2017 rule nationwide, calling the policy "inconsistent with the plain language of the Medicaid Act".<sup>11</sup> Other district courts and appellate courts have also ruled against CMS on both its FAQs and its final rule (Eyman Associates 2018).<sup>12</sup> CMS is appealing the March 2018 decision and other related rulings; in the interim, it has withdrawn the relevant FAQs and stated that it will not enforce the 2017 rule while the March 2018 decision is operative in its current form (CMS 2018).

## Effects of the Court Ruling on Medicaid Shortfall

In comparison with calculations made under CMS's 2010 policy, calculations of Medicaid shortfall made under the March 2018 district court decision are substantially higher because third-party payments are no longer counted. Early data are available for New Hampshire and West Virginia, which reported shortfall based on the court ruling in their SPRY 2014 DSH audits: in New Hampshire, shortfall increased from \$61 million to \$149 million, and in West Virginia, shortfall increased from \$122 million to \$589 million from SPRY 2013 to 2014 for hospitals that received DSH payments in both years. Although both New Hampshire and West Virginia also expanded Medicaid to the new adult group in 2014, the increase in shortfall that these states reported between SPRY 2013 and SPRY 2014 was much larger than the 36 percent increase in

shortfall reported in other expansion states that did not change the definition of Medicaid shortfall used during this period (MACPAC 2019b).<sup>13</sup>

The court ruling's effect on the amount of shortfall reported for Medicaid-eligible patients will be different for those enrolled in Medicare and those with private insurance because payments from Medicare are typically lower than payments from private insurance. Below, we examine how Medicaid shortfall was reported for patients in these coverage scenarios under CMS's 2010 policy and how it is expected to change as a result of the district court ruling.

### Shortfall for Medicare patients

In 2013, 10.7 million people were dually eligible for Medicare and Medicaid. This number includes individuals who were eligible for different levels of Medicaid coverage for Medicare cost sharing:

- 6.9 million qualified Medicare beneficiaries (QMBs) who received Medicaid assistance with Medicare premiums and cost sharing;
- 2.2 million full-benefit Medicaid enrollees who were not enrolled in the QMB program but still received assistance with Medicare cost sharing; and,
- 1.6 million specified low-income Medicare beneficiaries (SLMBs) and qualified individuals (QIs) who were not eligible for full Medicaid benefits or Medicaid assistance with Medicare cost sharing but received Medicaid assistance with Medicare Part B premiums (MACPAC 2015).<sup>14</sup>

Although CMS's 2010 policy instructs hospitals to report costs for all Medicaid-eligible patients, DSH audits often exclude partial-benefit SLMB and QI enrollees. Because Medicaid does not pay for cost sharing for these patients, they may not be identified as Medicaid-eligible to the hospital, making it administratively difficult for hospitals to track costs for them. As a result, Medicaid shortfall is typically only reported for full-benefit Medicaid enrollees and those enrolled in the QMB program.<sup>15</sup>

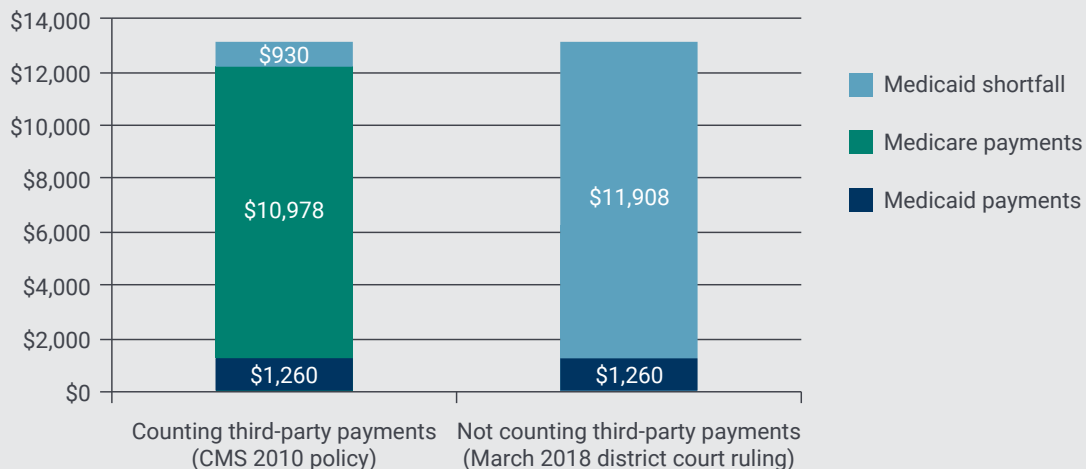
States have the option to determine how much Medicare cost sharing they cover for QMB program enrollees. According to MACPAC’s 2018 review of state policies, most states pay either the Medicare cost sharing amount or the amount that Medicaid would have paid for the same service, whichever is less (referred to as a lesser-of policy). Specifically, 41 states have lesser-of policies for inpatient hospital services and 38 states and the District of Columbia have lesser-of policies for outpatient hospital services (MACPAC 2018a).

Because Medicare is the primary payer for patients dually eligible for Medicare and Medicaid, not counting third-party payments for these patients substantially increases the amount of Medicaid shortfall. For example, Medicare paid hospitals approximately 92.9 percent of costs in 2015, resulting in a \$930 shortfall on the average Medicare inpatient stay under CMS’s 2010 policy.<sup>16</sup> However, if Medicare payments were not counted, the amount of shortfall reported would be more than 10 times higher (Figure 2-3).

Under both CMS’s 2010 policy and the district court ruling, shortfall increases if Medicaid does not pay the full amount of Medicare cost sharing (including the inpatient deductible).<sup>17</sup> If Medicaid does not pay the full amount of the Medicare cost sharing, hospitals are prohibited from billing patients for the difference. However, hospitals can receive Medicare bad debt payments to cover 65 percent of the unpaid amount.

The amount of shortfall that hospitals report for Medicare patients varies by hospital type. In 2017, deemed DSH hospitals reported an aggregate Medicare payment-to-cost ratio of 92.8 percent, which was higher than the Medicare payment-to-cost ratio for other hospitals (90.6 percent) (MedPAC 2019).<sup>18</sup> One reason why deemed DSH hospitals report less shortfall for Medicare patients than other types of hospitals may be because safety-net hospitals are eligible for additional payments from Medicare, such as Medicare DSH payments.<sup>19</sup>

**FIGURE 2-3.** Illustrative Example of Medicaid Shortfall for Patients Dually Eligible for Medicare and Medicaid Under Different Methods of Counting Third-Party Payments, 2015



**Notes:** CMS 2010 policy refers to the policy described in CMS’s 2010 subregulatory guidance (CMS 2018). March 2018 district court ruling refers to the policy described in *Children’s Hospital Association of Texas v. Azar*. The numbers used in this figure are based on data from 2015. At that time, the average hospital cost for a Medicare inpatient stay was \$13,168 and the Medicare Part A deductible was \$1,260.

**Source:** MACPAC, 2019, analysis of MedPAC 2018, AHRQ 2017, and CMS 2015.

## Medicaid shortfall for privately insured patients

In 2017, 8.8 million Medicaid enrollees were also enrolled in private insurance (SHADAC 2019). This number includes individuals who had private insurance for their acute medical needs but had Medicaid coverage for services not covered by their private insurance, such as home- and community-based services. Also included were individuals who were automatically eligible for Medicaid based on their health status, most notably low-birthweight babies.

Individuals not enrolled in Medicaid at the time of hospital discharge are not typically counted in DSH audits because it is administratively difficult for hospitals to know that these patients are Medicaid-eligible.<sup>20</sup> If a hospital helps a patient enroll in Medicaid while hospitalized, the patient must be counted on the hospital's DSH audit even though private insurance might cover the hospitalization. Although hospitals are not required to do so, enrolling high-need patients in Medicaid while they are hospitalized might help the patient gain access to services after discharge that are not covered by most private insurance plans.

Payments from private insurers often exceed the costs of hospital care, but the cost sharing required for private insurance is often much higher than Medicaid. In 2016, payments to hospitals from private insurance and self-pay patients totaled 144.8 percent of hospital costs (AHA 2018). In 2018, the average insurance deductible was \$1,573 and the average hospital coinsurance was 19 percent for single-coverage employee plans (KFF 2018).<sup>21</sup> Any co-payments and deductibles that patients do not pay by the time the DSH audit is conducted are not counted as hospital revenue and thus increase the amount of shortfall that hospitals report for Medicaid-eligible patients with private coverage.<sup>22</sup>

Under CMS's 2010 policy, any surpluses a hospital received from Medicaid-eligible patients with

private coverage were subtracted from the Medicaid shortfall the hospital reported for Medicaid-only patients. For example, according to an amicus brief filed by the Children's Hospital Association in support of hospitals opposing CMS in its appeal of the March 2018 district court ruling, data reported by the Children's Hospital of the King's Daughters in Virginia showed that the hospital's \$13.1 million surplus from Medicaid-eligible patients with private insurance reduced the amount of DSH payments that the hospital was eligible to receive from \$16.4 million (the hospital's shortfall for Medicaid-only patients) to \$3.3 million in 2013 (Table 2-3).<sup>23</sup> For some other children's hospitals, the CMS 2010 policy entirely eliminated the amount of DSH funding that the hospital was eligible to receive (CHA 2018).

In contrast, under the district court ruling, a hospital is able to report the full costs of care for hospital services provided to Medicaid-eligible patients with private insurance coverage, and it does not have to reduce its Medicaid shortfall by the amount of the private insurance payments received for these services. For the Children's Hospital of the King's Daughters, the court ruling would have substantially increased the amount of Medicaid shortfall it reported in 2013, from \$3.3 million to \$37.0 million (CHA 2018).

Hospitals with neonatal intensive care units are particularly affected by this policy because, as noted above, low-birthweight babies are automatically eligible for Medicaid and often have complex medical needs that require costly hospital stays. A small number of low-birthweight babies can have a large effect on overall hospital costs. For example, in 2013, the Children's Hospital of the King's Daughters served 2,199 Medicaid-eligible children with private coverage and 108,347 children covered only by Medicaid. The average cost of care for children with Medicaid and private insurance at this hospital was \$9,367 per patient, which was more than nine times the average cost of care for children with Medicaid only (\$1,006 per patient) (CHA 2018).

**TABLE 2-3. Illustrative Example of Medicaid Shortfall for Medicaid-Eligible Patients with Private Coverage Under Different Methods of Counting Third-Party Payments (millions)**

Method of calculating Medicaid shortfall	Medicaid-eligible patients with private coverage				Medicaid shortfall for Medicaid-only patients	Total Medicaid shortfall
	Medicaid payments	Private insurance payments	Medicaid allowable costs	Medicaid shortfall (surplus)		
	A	B	C	D = C - A - B		
Count all payments and costs (CMS 2010 policy)	\$0	\$33.7	\$20.6	(\$13.1)	\$16.4	<b>\$3.3</b>
Do not count third-party payments, but count third-party costs (March 2018 district court ruling)	0	N/A	20.6	20.6	16.4	<b>37.0</b>
Do not count payments or costs for patients with third-party coverage (MACPAC recommendation)	N/A	N/A	N/A	N/A	16.4	<b>16.4</b>

**Notes:** N/A is not applicable. CMS is Centers for Medicare & Medicaid Services. CMS 2010 policy refers to the policy described in CMS's 2010 subregulatory guidance (CMS 2018). March 2018 district court ruling refers to the policy described in *Children's Hospital Association of Texas v. Azar*. Illustrative example is based on 2013 costs and payment data for the Children's Hospital of the King's Daughters in Virginia included in an amicus brief filed by the Children's Hospital Association in support of hospitals opposing CMS in its appeal of the March 2018 district court ruling. The brief also noted that the Virginia hospital had \$3 million in costs for Medicaid-eligible patients with third-party coverage and \$22 million in costs for Medicaid-only patients that were not recognized as Medicaid allowable costs.

**Source:** MACPAC, 2019, analysis of CHA 2018.

## Effects of the Court Ruling on States and Providers

Although the March 2018 district court decision does not affect DSH allotments to states, it has the potential to change the distribution of DSH funding within states by changing the total amount of funding that individual DSH hospitals are eligible to receive. Specifically, states with unspent DSH funds are expected to spend more of their DSH allotments and the distribution of DSH payments is expected to change in states that distribute DSH payments based on hospital uncompensated care as defined on DSH audits.

## Changes in total state DSH spending

Although the court ruling does not change the total amount of DSH funds allotted to states, it is expected to increase DSH spending in states that have not previously spent their full DSH allotment. In FY 2016, \$1.2 billion in federal DSH funds went unspent, and about half of these unspent funds were attributable to four states (Connecticut, New Hampshire, New Jersey, and Pennsylvania) and the District of Columbia. All of these states had DSH allotments that were larger than the total amount of uncompensated care in their state, as reported by hospitals on Medicare cost reports.<sup>24</sup> Because the court ruling is increasing the amount of shortfall reported, it could increase the amount of DSH funds these states can spend. However, it is important to note that states must provide their non-federal share of such payments to draw down additional federal DSH funds.

## Changes in the distribution of DSH payments

The court ruling is also expected to change the distribution of DSH payments within states that currently distribute DSH payments based on hospital uncompensated care costs. Based on MACPAC's compendium of state hospital payment policies in 2018, about half of states (24) distributed DSH payments based on hospital uncompensated costs (MACPAC 2018b).<sup>25</sup> For example, Ohio distributes DSH payments to a hospital based on its share of total uncompensated care in the state as reported on DSH audits. Thus, hospitals that report more uncompensated care under the court ruling will receive larger DSH payments in this state.

In Texas, which also distributes DSH payments and other uncompensated care supplemental payments based on hospital uncompensated care costs, early reports suggest that the court ruling will result in large shifts in the distribution of payments within the state.<sup>26</sup> For example, Texas Children's Hospital reported \$45 million in additional revenue in 2018 as result of the court ruling, because the ruling allowed the hospital to retain DSH payments that were previously subject to recoupment (Texas Children's 2018). In contrast, the state's preliminary estimates project a \$166 million decline in uncompensated care payments to large public hospitals between 2017 and 2018, a 25 percent decline (THOT 2018).<sup>27</sup> Although many of the children's hospitals and large public hospitals in Texas are deemed DSH hospitals, children's hospitals tend to serve more Medicaid-eligible patients with third-party coverage and thus report more Medicaid shortfall as a result of the court ruling. Prior to CMS's 2010 guidance, Texas did not count payments or costs for Medicaid eligible patients with third-party coverage when calculating Medicaid shortfall for Medicaid DSH purposes (HHSC 2019).

States can change their method of distributing DSH payments if they want to minimize the district court ruling's expected redistribution of DSH payments, but we have not identified any states that have done so. Specifically, states can use

factors other than uncompensated care costs to distribute DSH payments or they can choose to distribute DSH payments using a different definition of uncompensated care than the one used to audit compliance with the hospital-specific limit.

## Commission Recommendation

In this chapter, the Commission recommends that Congress make a statutory change to reverse the effects of the recent court ruling and ensure that DSH payments do not pay for costs that are paid for by other payers. The rationale and implications of this recommendation are described below.

### Recommendation 2.1

To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

#### Rationale

The intended purpose of Medicaid DSH payments is to pay for hospital uncompensated care costs that are not paid for by other payers. However, the U.S. District Court for the District of Columbia decision in *Children's Hospital Association of Texas v. Azar* allows hospitals nationwide to receive DSH payments to cover costs that are paid for by third-party payers, such as Medicare and private insurance. The court's decision was based on a strict reading of the DSH statute and did not fully consider the potential effects of this policy change on DSH payments to providers.

Although this decision and others from related cases are currently under appeal, the court ruling is already affecting DSH payments in some states. Overall, the ruling is expected to increase DSH spending in states that have not previously spent their full DSH

allotment and result in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs (about half of all states).

A statutory change to clarify the treatment of third-party payments in the DSH definition of Medicaid shortfall is needed to avoid this redistribution of DSH funding. Action by Congress would also provide more certainty to states and providers about how uncompensated care should be calculated. Even if the district court decision is reversed on appeal, such a decision would likely be appealed further, continuing to create uncertainty for states and providers.

In developing this recommendation, the Commission considered how the DSH definition of Medicaid shortfall could be changed to advance additional policy goals. Specifically, instead of counting all payments and costs for all patients with third-party coverage as under CMS's 2010 policy, the DSH definition of Medicaid shortfall could be revised to exclude some or all Medicaid-eligible patients with third-party coverage from the DSH Medicaid shortfall calculation.

The Commission separately examined the effects of counting shortfall for Medicare and privately insured patients in relation to three policy goals:

- making more DSH funds available to hospitals that serve a high share of Medicaid and uninsured patients;
- not creating a disincentive for hospitals to either serve Medicaid-eligible patients with third-party coverage or help patients enroll in Medicaid; and,
- promoting administrative simplicity.

Ultimately, the Commission concluded that it would be preferable to have a policy that does not count payments or costs for any Medicaid-eligible patients for whom Medicaid is not the primary payer. Such a policy would remove the disincentive for hospitals to help privately insured patients enroll in Medicaid and it is administratively simple because it removes

the need for DSH auditors to collect information about third-party payments. Moreover, in states that distribute DSH payments based on hospital uncompensated care costs, this policy is likely to result in larger DSH payments to hospitals that serve more Medicaid-only and uninsured patients.

During the discussion, some Commissioners raised concerns that not counting shortfall for patients who are dually eligible for Medicare and Medicaid could create a disincentive for hospitals to serve these patients. However, we do not have any evidence that Medicaid DSH payment policy affects hospital decisions to serve dually eligible patients. Furthermore, Medicare already makes several special payments to hospitals to help offset hospital costs for these patients, including Medicare DSH and bad debt payments.

**Design considerations.** In most third-party coverage scenarios, Medicaid is the payer of last resort. However, this is not the case for services provided by the Indian Health Service, the Ryan White HIV/AIDS Program, and state and local indigent care programs, in which Medicaid is the primary payer. Under the Commission's recommended policy, hospitals could continue to receive DSH payments for Medicaid-eligible patients in these programs, for whom Medicaid is the primary payer.

The same rules that are used to determine when Medicaid is a primary payer for the purposes of third-party liability could be used to determine whether Medicaid is a primary payer for DSH purposes (42 CFR 433.139). In general, private insurance is the primary payer for hospital services even if the patient does not pay the deductible or cost sharing required by the private plan. However, existing regulations establish a process for Medicaid to pay claims in circumstances where the third party does not pay for the service at all. The Commission's recommendation is not intended to change Medicaid's obligation to pay its share of costs for Medicaid-eligible patients with third-party coverage.

If Congress adopts MACPAC's recommendation, any statutory change to the DSH definition



of uncompensated care would likely apply prospectively to DSH payments made in future years. Thus, the outcome of *Children's Hospital Association of Texas* would continue to have an effect on any audits of DSH payments made before the statute is changed. DSH audits are not due until three years after DSH payments are made, so it will take time to observe the hospital-level effects of any policy change.

In MACPAC's March 2019 report to Congress, the Commission made several recommendations to restructure pending DSH allotment reductions, including a recommendation to apply DSH allotment reductions to unspent DSH funding first (MACPAC 2019a). In general, changes to the DSH definition of Medicaid shortfall do not affect DSH funding allotted to states. However, the district court decision in *Children's Hospital Association of Texas v. Azar* has the potential to reduce the amount of unspent DSH funding in some states, which could affect the distribution of DSH allotments among states under MACPAC's recommended policy.

## Implications

**Federal spending.** The Congressional Budget Office (CBO) estimates that this policy will have an insignificant effect on federal spending. Specifically, although the policy may affect total DSH spending, particularly in states with unspent DSH allotments, the effect is too small for CBO to estimate.

**States.** The Commission's recommendation will not change the total amount of DSH funding allotted to states, but it may affect DSH spending in some states that historically have not spent their full DSH allotment because their DSH allotments were larger than the total amount of uncompensated care in their state. By increasing the amount of uncompensated care that hospitals report, the court ruling is expected to increase DSH payments in these states. The Commission's recommendation is expected to return the total amount of uncompensated care that hospitals report to levels similar to those previously reported under CMS's 2010 policy. This change is also expected to return state DSH spending to its previous levels.

**Enrollees.** It is difficult to predict how this change will affect enrollees because its effect depends on how states and hospitals respond. In theory, the Commission's recommendation removes the disincentive for DSH hospitals to help privately insured patients enroll in Medicaid and it may create a disincentive for DSH hospitals to serve patients dually eligible for Medicare and Medicaid. However, hospital behavior is affected by many different factors, and we do not have any evidence that it is affected by the DSH definition of Medicaid shortfall.

**Providers.** The Commission's recommendation will avoid the expected consequence of the district court ruling, that is, a large redistribution of DSH payments to providers in states that distribute DSH payments based on hospital uncompensated care costs. The Commission's recommendation is expected to result in more DSH payments for hospitals that serve a higher share of Medicaid-only and uninsured patients than were paid to these hospitals under CMS's 2010 policy.

## Endnotes

<sup>1</sup> In subsequent rulemaking on this issue, CMS notes that it first clarified how shortfall should be calculated for patients with third-party coverage in a 2002 letter to state Medicaid directors (CMS 2017). However, CMS's 2010 subregulatory guidance addressed this issue more explicitly, and as a result, CMS's 2010 guidance has been the subject of recent lawsuits.

<sup>2</sup> *Children's Hospital Association of Texas v. Azar*, 300 F. Supp. 3d 190 (D.D.C. 2018), appeal docketed, No. 18-5135 (D.C. Cir. May 9, 2018).

<sup>3</sup> Section 1923(g)(A) of the Social Security Act states that DSH payments cannot exceed "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section and by uninsured patients)." The phrase "under this title" refers to Medicaid (Title XIX) and the statute does not explicitly mention payments received by third-party payers. CMS's 2010 policy has also been challenged in other courts, but references in this chapter to the district court ruling refer to the March 2018 decision in *Children's Hospital*

*Association of Texas v. Azar* by the U.S. District Court for the District of Columbia.

<sup>4</sup> States report hospital-specific DSH data on a SPRY basis, which often corresponds to the state fiscal year and may not align with the federal fiscal year.

<sup>5</sup> This analysis is limited to hospitals that reported Medicaid shortfall based on CMS's 2010 policy. The analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

<sup>6</sup> These data do not reflect the full effects of ACA coverage expansions because SPRY 2014 ended on June 30, 2014, for most states. Additional analyses of the effects of the ACA on uncompensated care are provided in Chapter 3 of MACPAC's March 2019 report to Congress (MACPAC 2019b).

<sup>7</sup> For example, between July 2012 and January 2018, the number of hospital-employed physicians increased 70 percent (PAI 2019). The DSH definition of uncompensated care includes hospital costs for inpatient and outpatient hospital services only and does not include costs for physician and clinic services.

<sup>8</sup> SSI eligibility for children is based on income and disability status. A newborn is presumed to have a disability if its weight is lower than a set threshold, and if a child is hospitalized for more than 30 days, the family's income has no bearing on the child's SSI and Medicaid eligibility.

<sup>9</sup> Most notably, the DSH audit rule clarified that DSH-eligible uncompensated care costs were limited to inpatient and outpatient hospital services and did not include the costs of physician services, clinics, or other services that hospitals provide. In addition, the rule defined uninsured individuals as those having no health insurance or any other source of third-party coverage. This definition was later broadened to include individuals who have health insurance but do not have coverage for the particular service that is uncompensated (CMS 2014).

<sup>10</sup> In many states, recouped DSH funds are made available to other DSH hospitals in the state that have not exceeded their hospital-specific limit. DSH payments may exceed the hospital-specific limit for many reasons. For example, the

amount of uncompensated care that a hospital projects when the state is making DSH payments may be different from the actual amount of uncompensated care determined from retrospective DSH audits.

<sup>11</sup> *Children's Hospital Association of Texas v. Azar*.

<sup>12</sup> As of December 2018, CMS had lost four federal appellate cases related to the 2010 FAQs and three district court decisions related to the final rule, and other cases were pending in six states. The DC district court decision was the only one that applied nationwide (Eyman Associates 2018).

<sup>13</sup> New Hampshire expanded Medicaid on July 1, 2014, so the effects of Medicaid expansion are not reflected in DSH audits for SPRY 2014, which in New Hampshire ended on June 30, 2014.

<sup>14</sup> In addition, fewer than 200 individuals were enrolled in the qualified disabled and working individuals (QDWI) program, which provides Medicaid assistance with Medicare Part A premiums (MACPAC 2015). More information about all of the Medicare savings programs is available on MACPAC's website at <https://www.macpac.gov/subtopic/medicare-savings-programs/>.

<sup>15</sup> Hospitals cannot track the costs of individuals who, although eligible for the QMB program, are not enrolled in it. In 2009 and 2010, only 53 percent of individuals eligible for the QMB program were enrolled (MACPAC 2017).

<sup>16</sup> Analysis is limited to hospitals paid under the prospective payment system (PPS) and excludes critical access hospitals, which are paid 101 percent of allowable costs for most services. In 2016, Medicare paid PPS hospitals 91.2 percent of costs (MedPAC 2018).

<sup>17</sup> The deductible for a Medicare inpatient stay was \$1,260 in 2015. Medicare enrollees are also required to make a co-payment for hospital stays that exceed 60 days.

<sup>18</sup> This analysis excludes critical access hospitals and Maryland hospitals. Payment-to-cost ratios are based on Medicare-allowable costs, similar to how the Medicare Payment Advisory Commission calculates Medicare margins for all hospitals (MedPAC 2018).

<sup>19</sup> Medicare DSH payments follow different rules than Medicaid DSH payments. Medicare also makes

uncompensated care payments for hospital charity care and bad debt. Many deemed DSH hospitals also receive other additional payments from Medicare that are not related to the share of low-income patients that a hospital serves, such as graduate medical education payments and indirect medical education payments.

<sup>20</sup> According to the statute, Medicaid DSH audits are supposed to include Medicaid shortfall for all individuals who are eligible for Medicaid, but in practice, hospitals can only track payments and costs for individuals who are enrolled. The category Medicaid-eligible also includes incarcerated individuals who would be eligible for Medicaid if they were not inmates of a public institution.

<sup>21</sup> This analysis excludes plans that did not have deductibles or coinsurance for hospital care. In 2016, 85 percent of employees with employer-sponsored coverage had a general annual deductible and 68 percent had coinsurance for hospital care (KFF 2018). Deductibles are typically higher for family coverage than for single coverage.

<sup>22</sup> DSH audits are completed three years after the end of the state plan rate year for which uncompensated care is calculated.

<sup>23</sup> The Children's Hospital of the King's Daughters also noted that it incurred \$25 million in costs for Medicaid-eligible patients with third-party coverage that were not recognized as Medicaid allowable costs; had these costs been allowed, the hospital would not have had any Medicaid surplus (CHA 2018).

<sup>24</sup> Medicare cost reports define uncompensated care as charity care and bad debt, including uncompensated care for individuals with insurance, which is not part of the Medicaid DSH definition of uncompensated care. Medicare cost reports do not include reliable information on Medicaid shortfall, which is part of the Medicaid DSH definition.

<sup>25</sup> Other methods that states use to distribute DSH payments to providers include lump-sum payments to particular providers based on a defined amount of a fixed percentage of the total DSH allotment (MACPAC 2017).

<sup>26</sup> Texas has an uncompensated care pool authorized under its Section 1115 demonstration that makes payments for uncompensated care according to Medicaid DSH definitions. Although these payments are made in addition to DSH payments to hospitals, they provide early evidence of how

DSH payments may change in other states as a result of the district court ruling.

<sup>27</sup> Large public hospitals in Texas are defined as the seven largest public health systems that collectively provide more than one-third of hospital unpaid costs of care to uninsured individuals.

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## Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC § 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation on changing the definition of Medicaid shortfall in Section 1923 of the Social Security Act. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 2.1 on April 11, 2019.

### Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

2.1 To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

Yes: Bella, Burwell, Carter, Davis, Douglas, George, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno

Abstain: Gordon

Not present: Cerise

15	Yes
1	Abstain
1	Not present

Chapter 3:

# Improving the Effectiveness of Medicaid Program Integrity

# Improving the Effectiveness of Medicaid Program Integrity

## Recommendations

- 3.1** The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.
- 3.2** To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

## Key Points

- Medicaid program integrity (PI) activities aim to ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care and preventing and detecting fraud, waste, and abuse.
- State Medicaid programs have primary responsibility for PI, which includes activities spanning a continuum from front-end controls to recoupment. PI activities may also be embedded in other programmatic functions.
- MACPAC has repeatedly commented on the need to identify high-value PI activities; in this report, we share findings from our efforts to collect information from states on how they measure PI performance and return on investment (ROI).
- The Commission found that states have little incentive to calculate ROI because many PI activities are federally required, embedded in broader program functions, or generate benefits that are not easily quantifiable.
- States must make choices about which optional activities to invest in and how to structure required activities, but they have little information about what works in Medicaid upon which to base their decisions.
- It is the Commission's view that the federal government is in the best position to take the lead in identifying features that make PI approaches successful and in disseminating this information to states. The Secretary should use his authority to conduct a rigorous examination of current activities and conduct pilots to test new strategies or improvements to existing strategies.
- Because the recovery audit contractor (RAC) program—mandatory in Medicaid—has not been effective in all states, MACPAC recommends that Congress change the statute to make participation in the RAC program optional. This would be a step forward in ensuring that PI efforts are efficient and do not place an undue burden on states or providers.



## CHAPTER 3: Improving the Effectiveness of Medicaid Program Integrity

Medicaid program integrity (PI) activities are meant to ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care and to prevent and detect fraud, waste, and abuse. State Medicaid programs have primary responsibility for PI, which includes a wide range of activities—dedicated PI activities as well as those embedded in other program functions (such as individual and provider enrollment, service delivery, and payment). The Centers for Medicare & Medicaid Services (CMS) provides a regulatory framework for the Medicaid Integrity Program, conducts routine oversight, and provides technical assistance to state Medicaid programs. However, CMS has not focused efforts on helping states understand which state-level policy design and implementation approaches lead to successful PI outcomes. Thus, although there is widespread agreement that states should focus their PI resources on areas of risk and invest in approaches known to be effective, they have little guidance on where or how to focus (GAO 2015).

Over time, multiple requirements for what states must do to reduce fraud, waste, and abuse have been added to statute and regulation. States must make their own choices about how to invest limited resources, for staff and contractors with legal, clinical, audit, or data expertise, and for tools such as data analytics. However, they have little information on which optional approaches lead to successful Medicaid PI activities. Moreover, there may be perceived advantages to pursuing approaches that are mandated or that result in postpayment recoveries, but there is no clear method for ascertaining which approaches are the most efficient application of resources.

In 2018, building on past work aimed at improving the effectiveness of state Medicaid PI activities, the Commission collected information from states on how they measure performance and return on investment (ROI) from a number of PI approaches, which could in turn help to identify high-value activities across the Medicaid program. The study findings were inconclusive for a number of reasons:

- states have little incentive to calculate ROI for many activities;
- states could not estimate the costs associated with PI activities embedded in broader program functions; and
- some PI activities generate benefits (such as a reduction in patient harm) that are not easily or readily quantifiable.

In 2012, and again in 2017, the Commission recommended that “CMS should enhance states’ abilities to detect and deter fraud and abuse by developing methods for better quantifying the effectiveness of program integrity activities, by improving dissemination of best practices in program integrity, and by enhancing program integrity training programs” (MACPAC 2017, 2012). The Commission’s recent study, however, shows that little action has been taken. For example, we found multiple concerns regarding statutory requirements that states contract with a recovery audit contractor (RAC). Many states have been unable to procure a RAC, forcing them to seek waivers from CMS. Other states are finding diminishing returns from RAC contracts, which also overlap with newer postpayment review activities.

As we have noted in prior reports, states must continually strike a balance between pursuing effective PI strategies and addressing other program goals, particularly ensuring access to a sufficient network of providers and efficiently administering multiple components of a complex program (MACPAC 2012). The federal government is in the best position to collect information across

states to identify the features that make specific approaches successful, especially those mandated by statute.

Given the inconclusive findings of our study, the Commission makes two recommendations aimed at improving the effectiveness of state PI activities:

- The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.
- To provide states with flexibility in choosing PI strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act (the Act) to make the requirement that states establish a RAC program optional.

## Background on Medicaid Program Integrity Activities

The federal government has the responsibility to protect the integrity of the Medicaid program by “providing effective support and assistance to states to combat provider fraud and abuse” (§ 1936 of the Act). CMS currently supports state Medicaid integrity efforts by defining in regulation the parameters for how states must address statutory requirements and conducting oversight to ensure compliance. CMS also provides educational opportunities, such as the Medicaid Integrity Institute. In addition, it provides one-on-one technical assistance to states (CMS 2016). These activities are worthwhile at the state level, but the benefits are not transferrable to other states.

State agencies have a number of tools to identify and address fraud, waste, and abuse in Medicaid, some of which are statutorily required and some of which are optional. PI activities span a continuum from front-end controls to recoupments, and corrective actions related to these activities may be embedded in other programmatic functions (e.g., eligibility determination, provider screening and enrollment, claims payment, and managed care oversight). Other PI activities are undertaken primarily to ensure that public dollars are appropriately spent (e.g., prepayment and postpayment reviews and audits) (Table 3-1).

**TABLE 3-1.** Continuum of State Medicaid Program Integrity Activities

Medicaid payments	Program integrity activities
Beneficiary enrollment	<ul style="list-style-type: none"> <li>• Determine eligibility</li> <li>• Collect third-party liability (TPL) information and coordinate benefits</li> <li>• Verify reported information</li> <li>• Check the Public Assistance Reporting Information System to verify that beneficiaries are not receiving duplicate federal and state benefits</li> <li>• Conduct monitoring and auditing activities</li> <li>• Conduct Medicaid Eligibility Quality Control and Payment Error Rate Measurement (PERM) eligibility reviews</li> </ul>
Provider enrollment	<ul style="list-style-type: none"> <li>• Screen and enroll eligible providers, reenroll providers, and revalidate providers</li> <li>• Check exclusion lists and other verification databases in accordance with state and federal screening requirements</li> </ul>

**TABLE 3-1.** (continued)

Medicaid payments	Program integrity activities
Provider enrollment	<ul style="list-style-type: none"> <li>● Ensure appropriate disclosures are reported by providers and fiscal agents</li> <li>● Implement moratoria on providers when federally approved or mandated</li> <li>● Report any adverse provider application actions to the U.S. Department of Health and Human Services Office of Inspector General</li> </ul>
Service delivery	<ul style="list-style-type: none"> <li>● Develop and document coverage, billing, and payment policies</li> <li>● Lock in certain beneficiaries to certain providers or pharmacies to prevent so-called pharmacy or doctor shopping</li> <li>● Develop program integrity provisions for managed care contracts</li> <li>● Verify receipt of service using electronic visit verification</li> <li>● Review prior authorization requests consistent with state policy</li> <li>● Review prospective drug utilization review requests</li> </ul>
Payment	<ul style="list-style-type: none"> <li>● Develop, implement, and evaluate prepayment edits and audits</li> <li>● Apply TPL information</li> <li>● Use predictive modeling and other advanced data analytics to flag potential errors</li> <li>● Suspend payments to providers based on credible allegations of fraud</li> <li>● Adjudicate final payments</li> <li>● Issue explanation of benefits statements</li> <li>● Submit claims for federal matching funds</li> </ul>
Postpayment review	<ul style="list-style-type: none"> <li>● Create and implement methods and criteria for identifying suspected fraud cases</li> <li>● Conduct preliminary or full investigation on referrals of fraud or abuse</li> <li>● Establish and maintain a timely beneficiary verification procedure</li> <li>● Refer suspected fraud to law enforcement and collaborate with fraud investigations</li> <li>● Coordinate with Medicaid Fraud Control Unit and assist with prosecutions</li> <li>● Participate in federal PERM fee-for-service and managed care reviews</li> <li>● Pursue third-party payments when available</li> <li>● Perform retrospective reviews of care</li> <li>● Conduct surveillance and utilization reviews</li> <li>● Audit payments or ask providers to conduct self-audits</li> <li>● Support federal Unified Program Integrity Contractor audits</li> <li>● Procure and support recovery audit contractors</li> <li>● Supply data for Medicare-Medicaid matches and process results</li> </ul>
Reporting and follow-up	<ul style="list-style-type: none"> <li>● Terminate fraudulent providers and contracts and report such actions to appropriate parties</li> <li>● Recoup overpayments from providers</li> <li>● Return federal share of overpayments</li> <li>● Calculate return on investment</li> <li>● Compile program integrity statistics</li> <li>● Calculate and report payment suspensions due to credible allegations of fraud</li> <li>● Participate in state program integrity reviews (focused and desk reviews)</li> <li>● Identify and implement corrective actions and sanctions</li> <li>● Oversee managed care organization program integrity contract compliance</li> <li>● Report the identification and collection of overpayments due to waste, fraud, and abuse</li> <li>● Report annually the use of payment suspensions based on credible allegations of fraud</li> <li>● Report administrative expenses associated with program integrity activities</li> </ul>

**Sources:** MACPAC, 2018, analysis of state Medicaid program integrity activities.

## MACPAC Study on State PI Performance

In 2018, the Commission collected information from states on how they measure performance and ROI from a number of PI approaches. We reviewed state and federal agency websites, annual reports, and oversight reports as well as relevant laws, regulations, and policies. We conducted interviews with CMS, subject matter experts, and officials in eight states: Florida, Illinois, Kentucky, New Mexico, Ohio, Utah, Virginia, and Wyoming. We also held a listening session with a number of states in the spring of 2018 to get additional insights on the challenges and successes associated with Medicaid PI.

There are many ways to assess program performance, but we used ROI because it measures the return from both cost recovery and cost avoidance relative to the investment in the approach. As a ratio, ROI simplifies differences across states and approaches, and it allows direct comparison among states. To calculate cost recovery, states add up recovered payments, for example, overpayments or erroneous payments to providers or managed care organizations (MCOs) for previously paid claims or capitation payments. To calculate cost avoidance, states determine savings from payments avoided or administrative actions prevented, for example, prepayment reviews, provider termination, program suspensions, or when inappropriate or medically unnecessary services are restricted or avoided.

We found from our study that states face challenges in assessing their performance and lack the information needed to identify effective state PI activities, including those that are statutorily required. Many states do not quantify the effectiveness of various approaches, such as by calculating an ROI, for a variety of reasons. States, therefore, have little information on the relative value of their current PI activities, which can result in misapplication of their limited resources. Nevertheless, they have expressed interest in additional information on the policy design and implementation features that lead to success

across the broad spectrum of PI approaches available.

### Approaches studied

We selected 10 state approaches to PI based on a review of publicly available documentation on implementation and operation within the state; documentation on cost avoidance, cost recovery, or other ROI measures; and the extent to which the state had some experience with the approach (Table 3-2).

**Data mining.** Suspicious patterns and aberrations found in payment data can be used to audit specific providers. Although data mining as a strategy is not federally mandated, it is one approach states may apply in meeting the mandate that all state Medicaid programs conduct postpayment reviews. Most states conduct data mining using state PI staff, a contractor, or a combination of the two, because it can be difficult to hire and retain state staff with sufficient knowledge to support advanced data modeling. Data mining may overlap with other postpayment review activities, such as the RAC program, provider audits, or audits of prior authorization activities.

Data mining analyses can be targeted toward specific items of interest, such as data outliers or high-risk areas, and targeted to specific types of data, including peer comparisons (to identify billing outliers); services provided after death (to identify services not rendered); duplicate payments (to identify potentially unnecessary services or services not rendered); and eligibility (to identify individuals ineligible for coverage). In addition, data mining is used to analyze both managed care and fee-for-service (FFS) claims, although not all states have access to accurate, usable encounter data. Such activities require not only data systems capable of storing and analyzing patterns of claims data but also personnel with statistical, medical, and investigative expertise.

The primary ROI measure for data mining is the amount of money recovered based on audits triggered by suspicious patterns, for instance,

recoveries from overutilization. Results may also lead to cost avoidance measures, such as state policy changes that result in fewer improper claims. Challenges states face in implementing data mining approaches include coming up with the resources for ensuring the validity of the statistical sampling, extrapolation, or analytic approach and for covering the legal expenses associated with defending demands for provider recoveries.

**Electronic visit verification.** As a PI strategy, electronic visit verification (EVV) is meant to ensure that services billed were rendered and to streamline paperwork and reduce duplication of records. Implementing EVV requires the use of data systems that allow providers to check in from the site of service by phone, through geographic positioning systems or mobile applications, or by other means.

The 21st Century Cures Act (P.L. 114-255) requires all states to implement EVV for certain services, beginning with personal care by 2020 and home health by 2023. PI staff, Medicaid or sister agency staff, MCO staff, or designated contractors may each have a role in EVV, depending on the state. States are currently in varying stages of EVV implementation, and most have not yet begun to report ROI for this approach.

States may ultimately be able to calculate cost avoidance and cost savings captured through two mechanisms. If the EVV system is linked to claims processing and adjudication systems on the front end, then a state can calculate cost avoidance and ROI for claims that are denied for failure to have a verified visit. If the EVV system is not linked to the claims system, then data can be used to identify services not rendered, which could result in the identification of and recoveries from overpayments.

**Provider screening and enrollment.** As a PI approach, provider screening and enrollment can identify questionable providers before they are allowed to provide Medicaid services. As a condition of enrollment, states must conduct criminal background checks, including fingerprinting, particularly if a provider is considered high risk, such as when they face a credible

allegation of fraud, waste, or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid program within the previous 10 years. Providers that do not pass the background check cannot participate in the program.

Provider screening and enrollment can be conducted by the state or by a contractor on behalf of the state. Before 2016, providers participating in Medicaid managed care plans but not FFS did not have to enroll separately in the Medicaid program, but a final rule that went into effect that year (42 CFR 438) required all providers serving Medicaid beneficiaries to be enrolled with the state Medicaid agency by July 2018. In addition to preventing fraud and abuse, provider screening and enrollment supports functions such as monitoring to ensure there is a sufficient number of providers and services available in the geographic area.

Quantifying ROI for provider screening and enrollment is challenging because the primary ROI measure is cost avoidance. Some states have noted the difficulty of calculating savings associated with continuous provider screening and enrollment, which involves keeping good providers continually enrolled, reducing unnecessary administrative costs associated with reenrollment, and efficient verification processes. Some states report cost recoveries when providers are terminated and are fined by the state. However, there is no standard methodology for calculating ROI that captures the costs avoided with provider screening and enrollment, and states often lack the resources to develop their own.

**Recovery audit contractors.** In 2002, following successful efforts in several states, CMS issued guidance encouraging states to contract with vendors to examine Medicaid claims and pursue recovery from overpayments, third-party liability (TPL), credit balance collections, and other activities, to be compensated on a contingency basis (CMS 2011). In 2005, a three-year Medicare RAC demonstration began, which ultimately identified over \$1 billion in overpayments and

underpayments. To build on the success of these individual state efforts and the Medicare experience, and to maximize the potential returns to the federal government, Congress included a provision in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) making RAC programs mandatory for all state Medicaid programs as of December 31, 2010.

States have some flexibility regarding the design, procurement, and operation of their RAC programs. CMS has established a maximum contingency rate from amounts recovered which may not exceed the contingency rate for a Medicare RAC: currently 12.5 percent for all services except durable medical equipment, which is 17.5 percent (CMS 2011). Federal regulations also require the Medicaid RAC to work with the state to develop an education and outreach program, which includes notifying providers of RAC audit policies and protocols. The RAC must notify providers of overpayment findings within 60 calendar days of identification and must refer suspected cases of fraud or abuse to the state in a timely manner, as defined by the state.

RACs, which often bear the risk of covering the program's up-front expenses before any recoveries are realized, increasingly find it difficult to maintain a sustainable program given that recoveries have been inconsistent and are declining. States have the authority to include managed care encounters in their RAC program. Many states with high managed care penetration have relatively few FFS claims, which limits a RAC vendor's ability to achieve profitable recovery amounts. As a result, states obtain waivers of some or all of the RAC requirements, or vendors limit the resources they invest, choose to not bid on a state's RAC program at all, or choose not to renew past engagements.

States can calculate the ROI for their RAC programs by balancing recoveries of overpayments identified by the vendor, collection of outstanding credit balances, and TPL recoveries against the investment required to implement RAC programs. States are required to report recoveries from their RAC programs on form CMS-64, the Quarterly

Medicaid Statement of Expenditures for the Medical Assistance Program.

**Unified Program Integrity Contractors.** CMS contracts with Unified Program Integrity Contractors (UPICs) to perform fraud, waste, and abuse detection, deterrence, and prevention activities (§ 1936 of the Act). CMS contracts with UPICs in five regions to perform PI activities associated with Medicare Parts A and B, durable medical equipment (DME), home health, hospice, and Medicaid claims. CMS's UPIC contractors are required to coordinate with each state in their region to identify and investigate providers.<sup>1</sup>

At the state level, UPICs may also act to ensure that inappropriate payments are prevented or recouped, whether related to billing for services not rendered, deliberate duplication of services, altering claims through up-coding or unbundling codes, kickbacks or rebates for patient referrals, and billing for non-covered services. The extent to which states participate is at the state's discretion.

States in our study cited initial challenges in working with UPICs, including state liability for the federal share of overpayments reported by the UPIC even if they are not recovered, a program requirement that could deter states from using UPICs altogether. States also expressed concerns that federal contractors had previously attempted to apply Medicare guidelines or other inappropriate benchmarks when analyzing Medicaid data rather than building knowledge of the state Medicaid policy. Lastly, states indicated that they see the CMS UPIC program as duplicative of the RAC program, even though UPICs have a wider scope that includes investigations of possible fraud (also involving Medicare), regional assignments, and greater access to data, and—unlike RACs—are paid on a cost-plus fee basis. Eventually, states may be able to calculate ROI for UPICs, but to date, they have minimal quantifiable evidence for this new program.

**Provider self-audits.** A provider may audit itself either at the state's request or because the provider identified an issue that warrants further investigation, such as an overpayment. In most

cases, self-audits are initiated when the provider identifies inappropriately paid claims that do not involve concerns of fraud or abuse. In doing so, they often avoid false claims penalties, which could include up to triple damages, investigative expenses, criminal penalties, and interest. When providers identify incorrect billing patterns or policies, corrective actions or procedures should lead to fewer incorrect payments, resulting in additional cost avoidance. Results of provider self-audits can also be used to identify other providers with similar problems or compliance concerns who can be further investigated through the program. States we interviewed indicated that provider self-audits are successful when the state has clear, well-supported policy guidelines that can be easily followed by the provider performing the self-audit.

States can calculate ROI for provider self-audits by balancing the costs of supporting provider self-audit activities against recoveries from overpayments and claims adjustments or cost avoidance resulting from clear and up-to-date billing policies and improved provider practices and education. None of the states we interviewed calculated ROI from provider self-audits.

#### **Public Assistance Reporting Information System.**

Operated by the federal Administration for Children and Families, the Public Assistance Reporting Information System (PARIS) is a process that matches data from certain public programs to find beneficiaries who receive benefits in more than one state, receive duplicate federal and state benefits, or may be eligible for but are not enrolled in other programs, such as Medicaid or veterans' and military health programs. PARIS helps to ensure appropriate enrollment and retention in public programs and reduces the opportunity for improper payments.

Under the Qualifying Individual Program Supplemental Funding Act of 2008 (QIFA, P.L. 110-379), as of October 1, 2009, all states are required to submit data to PARIS as a condition of receiving federal funding for their Medicaid Management Information Systems (MMIS). States can use this information to evaluate past or continuing eligibility. However, while all states are required to submit data

to PARIS and can generate an ROI when they avoid costs associated with duplicative enrollment such as overlapping services, they are not required to use the results to reduce the expenses of their own state programs.

Each state we interviewed indicated that it used PARIS results to varying degrees and some reported large recoveries. For example, states have found a positive return when using PARIS data to check on duplication of benefits with the Department of Veterans Affairs (VA). If a veteran is 70 percent to 100 percent service-connected disabled and receives care in a VA facility, the VA covers 100 percent of the costs. Surviving spouses and dependents of veterans who had a 100 percent service-connected disability receive comprehensive VA coverage, which pays 80 percent of all medical care (including skilled nursing care) and 100 percent of prescription drugs. When cases are identified, Medicaid can potentially recoup some of these funds retroactively (typically up to one year of costs can be recovered for retroactive eligibility) and might also be able to close these cases to avoid future unnecessary expenditures. Eligible veterans are often unaware that they can receive their full earned benefits with just two years of honorable service. A number of states have used PARIS data to identify Medicaid beneficiaries receiving long-term services and supports who were eligible for but not enrolled in veterans' benefits. Receipt of such benefits can also alleviate costs incurred to the veteran or spouse and reduce the chances of Medicaid estate recovery.<sup>2</sup>

Concerns expressed by states about PARIS had to do with not having enough staff to handle results or to verify data (necessitating hiring contractors), not trusting the validity of the data generally, and doubts about the accuracy and reliability of the matches. Thus, although all states are required to submit data to PARIS and can generate an ROI when they avoid costs associated with duplicate enrollment, if they do not use the system to generate savings on an ongoing basis, then ROI is difficult to calculate.

**Lock-in programs.** Beneficiary lock-in programs (also called restricted card programs) assign

certain Medicaid beneficiaries to specific providers or pharmacies to prevent so-called pharmacy or doctor shopping. Lock-in programs allow states to act when they identify patterns of service misuse by a beneficiary (e.g., shopping behavior), as well as when providers are billing inappropriately or not following standard medical practice. Although lock-in programs are not federally mandated, most states (including all those interviewed for our study) have at least one for pharmacy benefits. Implementing and operating these programs requires considerable resources, such as medical and legal professionals for review and appeals, as well as oversight throughout the lock-in period.

Several states we interviewed cited challenges in operating an effective lock-in program in a managed care environment. For example, the state must decide whether to maintain a centrally operated program or to allow MCOs to operate their own programs. Having multiple lock-in programs makes it challenging to prevent beneficiaries from changing plans to avoid restrictions.

Lock-in programs could be measured by the costs of the program and the cost avoidance associated with decreases in unnecessary prescriptions, ancillary tests, and claims for hospital, pharmacy, physicians, and emergency department visits. States cited challenges in measuring program performance because there is no consensus on the appropriate time period (pre- and post-lock-in period) to include when accounting for the savings.

**Prior authorization.** Services that often require prior authorization in Medicaid include non-emergency transportation, inpatient and outpatient hospital services, behavioral health services, private duty nursing, adult day care, and DME. States may opt to use prior authorization to help control utilization and avoid unnecessary procedures. Each state we interviewed noted that prior authorization is in place to some degree, but their policies vary as to which services and prescriptions must be authorized.

States may use contractors to conduct prior authorization reviews because the process can be human-resource intensive and would otherwise

require staff with clinical knowledge, whom states have difficulty attracting and retaining. In FFS programs, the state often handles prior authorization through one contractor for medical services and a second contractor for pharmacy. Under managed care, each plan typically uses separate prior authorization contractors, each with its own internal processes, resulting in multiple contractors per MCO. This can be challenging for the MCO's providers, who must navigate the different contractors and processes to obtain authorization for services and prescriptions.

Prior authorization policies may lead to cost avoidance through denied claims for unnecessary services. Recoveries can also occur through a retrospective review of paid claims for services that were provided even though prior authorization was not obtained. However, the states we interviewed did not report on the ratio of costs avoided and costs recovered relative to their investments to determine whether there was a positive ROI for prior authorization.

**Third-party liability and estate recovery.** Federal statute requires states to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid beneficiaries (§ 1902(a)(25)(A) of the Act). Because Medicaid is generally the payer of last resort, TPL processes give state Medicaid agencies the ability to pursue third-party payers and thereby reduce Medicaid payments. States track recoveries of payments from private health or liability insurance, Medicare, worker's compensation, veterans' benefits, and court settlements. State Medicaid agencies are also required to recover the costs of providing care from the estate of any beneficiary over age 55 after the beneficiary either is admitted to a facility or after the beneficiary's death (§ 1917(b) of the Act).<sup>3</sup>

Compared to other state PI activities, states may find it easier to calculate ROI for TPL and estate recovery because they are required to track and report significant TPL and estate recoveries on the CMS-64. Therefore, states must dedicate staff to work on data collection and reporting.



**TABLE 3-2. State Program Integrity Approaches: Mandatory versus Optional and Primary ROI Measure**

Approach	Mandatory vs. optional and authorizing legislation	Primary ROI measure
Data mining	Optional	Cost recovery
Electronic visit verification	Mandatory per the 21st Century Cures Act (P.L. 114-255)	Cost recovery and cost avoidance
Provider screening and enrollment	Mandatory per the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)	Cost avoidance
Recovery audit contractors	Mandatory per the ACA	Cost recovery and cost avoidance
Unified Program Integrity Contractors	Optional	Cost recovery and cost avoidance
Provider self-audits	Optional	Cost recovery and cost avoidance
Public Assistance Reporting Information System	Reporting is mandatory but its use is optional per the Qualifying Individual Program, Supplemental Funding Act of 2008 (P.L. 110-379)	Cost avoidance
Lock-in programs	Optional	Cost avoidance
Prior authorization	Optional	Cost recovery and cost avoidance
Third-party liability and estate recovery	Mandatory per the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	Cost recovery and cost avoidance

**Notes:** ROI is return on investment. CMS is mandated to implement the Unified Program Integrity Contractors program per the Deficit Reduction Act of 2005 (P.L. 109-171).

**Source:** MACPAC, 2018, analysis of federal and state program integrity approaches.

## Findings

The Commission's goal in collecting information from states on how they measure performance and ROI for certain PI approaches was to identify high-value activities across the Medicaid program. We predicted that a comparison of state procedures used and ROI obtained for these PI approaches would help states and the federal government make better decisions about how to efficiently allocate limited resources, particularly between PI activities that target cost recovery after payments have been made and PI activities devoted to cost avoidance by preventing payments that would otherwise have to be recovered.

As noted above, our findings were inconclusive. We discuss our specific findings below.

## Challenges states face in measuring program integrity activities

There are several practical and structural reasons why it is challenging to gather usable ROI information on the full range of PI activities underway in states.

**Lack of information on the expense of and return from PI activities.** ROI is most easily calculated when there are clearly identifiable resources used to conduct the activity and when the results include countable recoveries by the state. Thus, discrete activities focusing on recoveries (e.g., data mining resulting in provider audits, RACs, and TPL and estate recovery) are most likely to be measurable with an ROI metric.

It is worth noting that two of these three approaches are federally required and have special reporting requirements that may facilitate ROI calculations. RACs are paid on a contingency

basis, so the return (the amount recovered) and the investment (fee paid to the RAC) are known and can be used to calculate ROI. TPL and estate recovery are specialized activities that are typically conducted by dedicated state staff or contractors, and staff and contractor costs can generally be identified and quantified. The costs avoided and recovered from these activities must be measured and reported separately on the CMS-64, thus making it easier to calculate ROI.

Other activities, including EVV and UPICs, might also generate results that can be used to calculate ROI because both are operated with dedicated resources and are intended to result in monetary recoveries. However, at the time this study was conducted, most states had insufficient experience with these approaches to be able to provide quantitative results. Moreover, given that these activities are mandated, states have little incentive to track the investments required for or returns obtained from these programs.

States reported that the structure of their operations was a complicating factor in tracking and reporting the costs and returns from various PI activities. In some states, PI operations are divided between the Medicaid agency and a state inspector general. Within a state Medicaid agency, some of the approaches included in this study, such as provider screening and enrollment, PARIS, TPL, and beneficiary lock-in programs, are managed by operational areas outside of PI. This division of responsibility complicates efforts by PI staff to identify and assign cost recoveries and cost avoidance needed to calculate the ROI of specific PI approaches.

**Lack of consistent methodology for calculating return from PI activities resulting in cost avoidance.** The return on PI investments can include both cost recovery and cost avoidance. While cost recoveries can be measured in dollar amounts, states use different methods to measure cost avoidance; these differences make it difficult to make direct comparisons across states.

Cost avoidance is an important component of many PI approaches, such as TPL and EVV. It is also the primary result of provider screening and enrollment, PARIS, beneficiary lock-in programs, and prior authorization. For some approaches, the methodology for calculating cost avoidance is straightforward. For example, TPL cost avoidance (which must be reported to CMS) is typically built into the claims adjudication system or MMIS. States use TPL edits to apply eligibility information and deny claims when a primary responsible party is identified (full cost avoidance), or calculate the allowable Medicaid paid amount when Medicaid is the secondary payer (partial cost avoidance).

For other PI approaches, there is little guidance from CMS or information that can be gleaned from Medicaid programs in other states. Moreover, states do not have consistent parameters for the cost avoidance calculation. For example, cost avoidance for beneficiary lock-in programs can be calculated by monitoring a period of avoided unnecessary physician, hospital, and pharmacy claims, but not all states use the same time period when accounting for savings. When measuring the return from provider screening and enrollment, some states consider claims avoided from a terminated provider as an ROI, while other states do not include avoided claims in their ROI calculations under the assumption that beneficiaries would have accessed those services from a legitimate provider and the state will incur the same cost. The differences among state methodologies for calculating return on cost avoidance strategies impede direct comparisons of ROI for these approaches.

**Application of different performance metrics limits cross-state comparison.** States measure PI outcomes to meet federal reporting requirements and to assess their own performance. In many cases, when given the option to develop their own metrics, states use measures that inform state priorities but do not support cross-state comparison or ROI calculation.

From a state management perspective, the overall effectiveness of PI activities may be the most important thing to measure. Activities do not exist

independently; for example, a single claim can be subject to both prior authorization and TPL review; a provider investigation can lead to an overpayment recovery and a termination. These situations make it difficult for a state to attribute costs or allocate recoveries to particular interventions. States may choose to report more easily quantifiable metrics, such as the number of cases that are referred to law enforcement for prosecution, as opposed to tracking which PI intervention was the source of the referral.

In addition, certain PI activities, such as provider screening and enrollment, EVV, TPL, and RACs are all federally required regardless of the investment required or ROI. Therefore, a state may not want to invest resources in tracking the results or calculating the ROI because it will not change the state's decision about continuing that activity. The state may instead track other measures of performance, such as the number of providers excluded from participation in a given year.

#### **Non-quantifiable benefits of PI approaches.**

PI is important not only for detecting and reducing fraud but also for addressing abuse and neglect of beneficiaries. Prepayment approaches that keep bad actors out of the system, such as enhanced provider screening and enrollment procedures, prevent improper payments and protect patients from receiving substandard care. EVV can help ensure that personal care and home care providers are physically present to deliver services when the site of care is a patient's home; prior authorization processes help ensure that beneficiaries receive services that are medically necessary; and lock-in programs can prevent beneficiaries from receiving excessive quantities of prescribed drugs or other services. Although the costs avoided from these activities can be difficult to quantify for the methodological reasons outlined above, the improvements in patient safety and beneficiary health outcomes are of value.

States also incorporate PI findings into ongoing program improvement. For example, postpayment reviews may identify loopholes or inconsistent policies that providers can manipulate in the

claims system. States can use findings to identify trends and make policy changes, deliver additional provider education, or recommend system edits to prevent future improper payments. States can also use findings to enhance existing automated fraud detection algorithms, provider screening tools, and other strategies.

States have expressed concern that a preference for cost recovery (which is easier to measure than cost avoidance) has led to overinvestment in postpayment approaches and less focus on prepayment and program management approaches. In addition, when recoveries can be quantified, these activities can be scored by the Congressional Budget Office (CBO) as budget savings, making them appear more beneficial than other activities when Congress makes policy decisions.

### **Opportunities to improve state PI strategies**

In our March 2012 report to Congress, MACPAC noted concerns about whether PI efforts were making efficient use of public resources and recommended that the Secretary of the U.S. Department of Health and Human Services (the Secretary) take steps to determine which federal PI activities are most effective and eliminate redundant and outdated programs. In addition, the Commission called on the Secretary to develop methods for better quantifying the effectiveness of different PI strategies (MACPAC 2012). More recently, in its June 2017 report to Congress, MACPAC reiterated these recommendations in a chapter focused on PI in managed care (MACPAC 2017). CMS has yet to act on the Commission's 2012 recommendation.

These recommendations remain relevant and are consistent with the U.S. Government Accountability Office (GAO) framework for managing fraud risk in federal programs, which encourages program managers to consider the benefits and costs of activities and make investments in PI activities that offer the most cost-effective investment of resources (GAO 2015). In addition, the Office of

Inspector General of the U.S. Department of Health and Human Services (OIG) placed ensuring PI and effective administration as number 3 on its list of the top 12 management and performance challenges facing the department in 2018 (OIG 2018).

CMS has neither taken a leading role in filling the information gaps identified by our research, nor an active role in identifying the design and implementation features that result in effective programs. The RAC program is an example of a federally mandated activity that would benefit from further examination by CMS to identify the features of policy design and implementation associated with success.

**Federal responsibility to protect the integrity of the Medicaid program.**

As noted in prior MACPAC reports, the federal role in Medicaid PI is constrained by the fact that eligibility and payment processing occur at the state level. As such, federal strategies contain few details or focus on assisting or auditing single states. CMS itself has noted the challenges in providing detailed guidance to states given the differences among state coverage, pricing policies, and payment systems.

Conducting a rigorous assessment of PI efforts across multiple states would be more useful in helping identify which optional PI strategies have high value, and in providing guidance in designing and implementing both optional and mandatory activities for maximum effect. In addition, the federal government is best positioned to test new models and improvements to existing programs and to share this information in a way that helps states invest in policies and strategies that work and eliminate potentially ineffective, redundant, and outdated programs.

CMS, however, is not focused on making specific improvements to methods for calculating ROI in state Medicaid PI programs, instead concentrating its efforts on Medicare. For example, in its 2016 annual report to Congress on Medicare and Medicaid integrity programs, CMS highlighted its methodology for evaluating the ROI in Medicare PI but did not offer an ROI methodology for Medicaid

(CMS 2016). CMS officials we interviewed indicated that the agency works directly with states to help them develop their own ROI methodologies but provided few details.

In June 2018, CMS announced “new and enhanced initiatives that will create greater transparency in and accountability for Medicaid program integrity performance, enable increased data sharing and robust analytic tools, and seek to reduce Medicaid improper payments across states” (CMS 2018). These activities focus on audits of states, reviews of eligibility determinations, and the availability of improved data. The announcement did not mention how CMS and states will measure the performance, such as the ROI, of these new and enhanced initiatives; rather, it cites plans to continue to focus on the overall Medicaid improper payment error rates (CMS 2018).

The agency provides states with technical assistance on Medicaid PI activities but has not focused on measuring the effectiveness of these activities or broadly sharing information about them. CMS officials noted that they have not developed a methodology or guidance for calculating ROI in Medicaid, citing the complexity and variation across state Medicaid programs and payment systems. In addition, interviews conducted with state officials as part of our study found that most states rely on informal channels for learning about other states’ practices. For example, the Washington State Health Care Authority reported over \$70 million in cost avoidance attributed to its PARIS-Veterans Benefit Enhancement program, which identifies Medicaid beneficiaries receiving long-term services and supports who are eligible for but not enrolled in veterans’ benefits, but other states we spoke with either did not know about the Washington results or had only learned about it directly from that state.

CMS collects information from states on PI activities (e.g., focused state PI reviews, reports on collections from overpayments, payment suspensions due to credible allegations of fraud) and could use the data to compare PI strategies,

especially those that demonstrate substantial ROI, such as the PARIS-Veterans Benefit Enhancement Program in Washington and the Long Term Care-Asset Discovery Investigation program in Illinois as well as states with sustainable RAC programs. States would be in a better position to make informed PI program investments if CMS disseminated this information to all states.

**Many state RAC programs are not sustainable.** Our study also provided evidence that the RAC program is not effective in all states. It was initially assumed that if the RAC approach worked for Medicare and a small number of state Medicaid programs, then it would work for all states, but this has not borne out.

The RAC approach grew out of efforts by a small number of states to increase returns from postpayment reviews at little cost. By contracting with auditors on a contingency basis, states were able to offer contractor incentives for finding and recovering overpayments with minimal input needed from the state for data and policy support.

For a number of reasons, however, an increasing number of states now struggle to comply with the statutory requirement to operate a RAC program because contractors are having difficulty sustaining profitability. In some cases, states have made policy decisions in line with overarching PI or administrative goals (e.g., choosing not to pursue collection of certain overpayments, prohibiting the use of extrapolation), and these decisions make a RAC contract unsustainable. In other cases, program limitations (e.g., three-year look-back periods, low volume of FFS claims) reduce potential returns. RAC contracts are contingency-based and require an up-front investment, so contractors may be hesitant to take on the risk of bidding for a contract in a state where conditions are not favorable to earning contingency fees.

A review of CMS-64 data for eight states shows declining RAC recoveries, from \$3.90 million in 2013 to \$0.58 million in 2017. This is mainly because RACs focus on FFS claims and there is an insufficient volume of FFS claims for them to review

in many states. States have the option to allow their RAC vendor to review managed care encounters, but CMS does not require states to do so. State Medicaid programs that predominately enroll beneficiaries in managed care, and consequently have a low number of FFS claims, must still seek a waiver. Because they work on a contingency basis, no vendor will bid unless the potential recoveries are anticipated to at least cover costs. This has resulted in contractors declining to respond to new bid requests or turning down offers to renew Medicaid RAC contracts in several states.

For all of these reasons, several states have been unable to procure a RAC to comply with the federal mandate, or they have requested a waiver of certain aspects of the requirement. Under current law, states unable to procure a RAC must seek CMS's permission to waive the statutory requirements. The time-limited waivers are granted for a two-year period, at which time states are required to resubmit their waiver request with an updated justification. In the past few years, 25 states have sought waivers from the RAC program: currently, 8 states have waivers due to procurement issues, 16 states have waivers due to low volume of FFS claims, and 1 state we interviewed was denied a waiver.

## Commission Recommendations

### Recommendation 3.1

The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.

## Rationale

The federal government should take a lead role in developing and disseminating information on the effectiveness of Medicaid PI approaches. Specifically, as part of its statutory authority to protect the integrity of the Medicaid program, CMS should examine current state activities and establish pilot projects for new approaches to identify the policy design and implementation features that best help states reduce fraud, waste, and abuse, and provide specific information to states on PI activities that have high rates of return on investment.

The federal government currently works with all state Medicaid PI programs on a one-on-one basis. Such activity may be worthwhile, but it does not necessarily benefit other states. Conducting a rigorous assessment of PI efforts across multiple states would be useful for helping states identify which optional PI strategies have high value and for helping them design and implement both optional and mandatory activities to achieve maximum effect. In addition, the federal government is best positioned to test new models and improvements to existing programs and to share this information in a way that helps states invest in policies and strategies that work and identify potentially ineffective, redundant, and outdated programs to eliminate.

## Implications

**Federal spending.** The Secretary would have to devote existing resources to collect information from states, determine which features of policy design and implementation contribute to the effectiveness of certain PI approaches, and disseminate the results to states. To improve the effectiveness of Medicaid PI strategies, the Secretary may also consider involving other U.S. Department of Health and Services divisions, such as the OIG or the Assistant Secretary for Planning and Evaluation.

**States.** This change is intended to provide states with additional information on the effectiveness of various PI efforts, which presumably would help

them invest in strategies with better outcomes. Some level of state effort would be needed to supply the Secretary with data, assess current strategies, and test new ones. The level and nature of that effort would depend upon how pilot programs and program assessments are conducted by the Secretary.

**Enrollees.** Although there would be no direct effects on beneficiaries, presumably beneficiaries would see improvements in care from states that are effective in preventing fraud, waste, and abuse, and when payments are properly made for high-quality provider services. PI strategies could improve outcomes for beneficiaries and avoid any burden on providers that may ultimately limit access or impede benefits for enrollees.

**Plans.** The effect on MCOs will depend upon the strategies the Secretary studies and promotes in relation to the current practices of those MCOs; for instance, whether the MCOs will have to modify their operating procedures or conduct more reporting activities, such as providing reliable and timely encounter data.

**Providers.** The identification of effective features for policy design and implementation could lead to a reduction of the administrative burden on providers and ensure the state's PI activities are efficient and focused on making appropriate payments for covered services.

## Recommendation 3.2

To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

## Rationale

Under the RAC program, states must contract with auditors to conduct postpayment reviews of Medicaid claims to identify overpayments. These

vendors are charged with finding and recovering overpayments and they are paid on a contingency basis, receiving as compensation a portion of their collections. The program requires minimal investment from the state, but the state does need to comply with the requirement of engaging a RAC.

The RAC program was made mandatory for all state Medicaid programs in 2010. After some years of successful implementation, however, RAC recoveries declined by about 85 percent from 2013 to 2017, and states are now having difficulty finding RACs willing to partner with them, forcing these states to seek waivers.

For many states, the RAC program has become an administrative burden due to the time and resources it takes to solicit a RAC vendor, manage procurements (many of which have failed), and prepare waiver applications and renewals.

Given the challenge many states have in contracting with RACs and the necessity of obtaining waivers from the statutory requirement, it is the Commission's view that Congress should change the statute and make participation in the RAC program optional, as it was prior to the passage of the ACA. This is consistent with MACPAC's 2012 recommendation to ensure that PI efforts make efficient use of federal resources and do not place an undue burden on states or providers (MACPAC 2012).

We believe, however, that states that want to implement a RAC program should still have this option. The RAC program is an example of a mandated activity that would benefit from further examination by CMS to identify the features of policy design and implementation associated with success.

### Implications

**Federal spending.** Under this recommendation, CMS would no longer need to review requests from states for waivers of the RAC requirement. CBO estimates that making the RAC program an optional state activity would increase federal spending by a modest amount: less than \$50 million over one year and less than \$1 billion over

five years. It is important to note that CBO provides ranges rather than point estimates for MACPAC recommendations; this is the lowest cost range for a policy change that would affect federal spending.

**States.** This recommendation would give states the option of implementing a RAC program. States would no longer be required to procure a RAC vendor or pursue a waiver if they are unable or choose not to implement a RAC program. As a result, some states would be relieved of the administrative burden associated with failed procurements and the waiver application process.

**Enrollees.** Although there would be no direct effects on beneficiaries, the reduced state administrative burden could potentially free up resources that could be directed to Medicaid beneficiaries.

**Plans.** We do not anticipate this change would have a measurable effect on Medicaid MCOs.

**Providers.** Removing the mandate may result in the elimination of the RAC program in some states. This may, in turn, reduce the burden on some states' providers due to fewer claims requests and audits. There would be no change for providers in states that continue to operate a RAC program.

## Endnotes

<sup>1</sup> UPICs were formerly known as Zone Program Integrity Contractors, program safeguard contractors, Medicare-Medicaid data match contractors, and Medicaid Integrity Contractors.

<sup>2</sup> In 1993, the Omnibus Budget Reconciliation Act (P.L. 103-66) required state Medicaid agencies to recover some of the costs for providing care to a beneficiary over the age of 55 from the beneficiary's estate, either once admitted to a facility or after death.

<sup>3</sup> The estate of a Medicaid beneficiary is used to pay for services rendered until death. Undue hardship and other policies are in place to protect a surviving spouse or any surviving child who is blind or has a disability and who requires use of the assets.

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## Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC § 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on improving the effectiveness of Medicaid program integrity. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 3.1 and Recommendation 3.2 on April 11, 2019.

### Improving the Effectiveness of Medicaid Program Integrity

3.1 The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.

Yes:	Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno	16	Yes
		1	Not present

Not present: Cerise

3.2 To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

Yes:	Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weil, Weno	15	Yes
		1	Abstain
		1	Not present

Abstain: Thompson

Not present: Cerise



Chapter 4:

# Mandated Report on Therapeutic Foster Care

# Mandated Report on Therapeutic Foster Care

## Recommendation

**4.1** The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

## Key Points

- The term therapeutic foster care generally refers to the practice of serving children and youth who have serious emotional, behavioral, mental health, intellectual or developmental disabilities, or medical conditions in a family-based setting, rather than in an institutional or group setting. However, as there currently is no uniform definition of the services that comprise therapeutic foster care in federal Medicaid statute or regulation, states vary in covering these services.
- In the report accompanying the fiscal year 2019 Labor, Health and Human Services, and Education funding bill, the U.S. House of Representatives Committee on Appropriations requested that MACPAC examine therapeutic foster care, noting concerns about lack of a uniform definition within Medicaid and commenting that a uniform definition “could improve the ability for more consistent care and treatment.”
- After examining the role Medicaid plays in covering therapeutic foster care services and the potential implications of a uniform definition of therapeutic foster care in Medicaid for children who need such services and current state practices, the Commission concluded that a uniform definition would not likely achieve the goal of more consistent care and treatment, and in fact, may have unintended consequences.
- Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. Because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. A uniform definition could limit the ability of states and providers to tailor services to address these needs.
- Additional federal guidance could help states design or improve the coverage and provision of therapeutic foster care services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth.

## CHAPTER 4: Mandated Report on Therapeutic Foster Care

Therapeutic foster care is typically described as the practice of serving children and youth who have serious behavioral health or medical needs in a family-based setting, rather than in an institutional or group setting. Although the term can be used to describe various constellations of services, common elements include the clinical services provided (such as crisis support, behavior management, medication monitoring, individual and family counseling, and case management); heightened treatment plan intensity; and higher levels of parent training, supervision, and payment than routine foster care arrangements. A number of the clinical services considered to be part of therapeutic foster care can be covered by Medicaid, although coverage of these services varies by state.

In the report accompanying the fiscal year (FY) 2019 Labor, Health and Human Services, and Education funding bill, the U.S. House of Representatives Committee on Appropriations requested that MACPAC examine therapeutic foster care, noting concerns about the lack of a uniform definition within Medicaid and commenting that a uniform definition “could improve the ability for more consistent care and treatment” (Committee on Appropriations 2018). It requested that, within 12 months, MACPAC:

- conduct a review for the development of an operational therapeutic foster care definition;
- examine the advantages of a uniform definition; and
- include a list of potential services to treat mental illness and trauma that would be within the scope of such a definition.

This chapter responds to the congressional request. It begins by providing an overview of therapeutic foster care, including the common elements of the

practice and the children served. It then describes the role Medicaid plays in covering such services and current state approaches to providing the services in Medicaid. Considerations for a uniform definition are then presented before concluding with the Commission’s recommendation for clarifying guidance on the practice.

It is the Commission’s view that a uniform definition of therapeutic foster care in Medicaid would not likely achieve the goal of more consistent care and treatment, and in fact, may have unintended negative consequences. Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. Because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. Thus, use of a uniform definition could limit the ability of states and providers to tailor services to address these needs.

However, additional federal guidance from the Secretary of the U.S. Department of Health and Human Services (HHS)—specifically, the Centers for Medicare & Medicaid Services (CMS) and the Administration for Children and Families (ACF)—could help states design or improve the coverage and provision of these services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth. As such, the Commission recommends that the Secretary of Health and Human Services should engage CMS and ACF to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

## What is Therapeutic Foster Care?

The term therapeutic foster care refers to the practice of serving children and youth who have serious emotional, behavioral, mental health, intellectual or developmental disabilities, or medical conditions in a family-based setting, rather than in an institutional or group setting (ASPE 2018 and 2016, Boyd 2013, SAMHSA 2013). Although some view the practice as a more intensive form of foster care, children outside the child welfare system may benefit from and receive these services.<sup>1</sup> There currently is no uniform definition of the services that comprise therapeutic foster care (sometimes referred to as treatment foster care or treatment family care) in either federal Medicaid or child welfare statute or regulation. As such, states have determined what services to include, with variation in the practice.

## Common elements of therapeutic foster care

Although there is no uniform definition of therapeutic foster care, common elements include the type of services, intensity of treatment planning, and level of parent training and payment (Box 4-1). The services provided under the practice typically include crisis support, behavior management, medication monitoring, counseling, and case management. Children in therapeutic foster care receive an individualized treatment plan and their treatment team meets on a more frequent basis than the teams for children in standard foster care situations (ASPE 2018, SAMHSA 2013). Compared to other foster parents, foster parents serving these children receive higher levels of training, payments, and case worker support, and are considered part of the treatment team. Many states have multiple levels of therapeutic foster care, with different

### BOX 4-1. Common Elements of Therapeutic Foster Care

States often describe therapeutic foster care in state agency administrative rules or contractual requirements. A review of 14 states indicated that the following therapeutic foster care elements are often included:

**Treatment planning.** An individualized treatment plan is designed to guide and coordinate the provision of services. Treatment teams meet every 30 to 90 days to help ensure that the services are responsive to the changing needs of the children. The treatment team includes the therapeutic foster parents, case managers, biological or other family members, skills coaches, and clinicians.

**Specialized training.** Therapeutic foster care requires highly trained caregivers who are responsible for implementation of the child's treatment plan. Therapeutic foster parents receive additional preservice and ongoing training compared to traditional foster parents. They are also provided more frequent supervision by trained caseworkers and clinicians.

**Crisis support.** Therapeutic foster parents and children are provided with crisis support that can include crisis planning, respite care, and access to a case manager or clinician 24 hours a day.

**Structured activities.** Activities are designed to teach or reteach social skills and coping skills to help children in therapeutic foster care deal effectively with the circumstances or conditions that created the need for treatment.

**Behavioral health services.** An array of behavioral health services, including individual, group, and family therapy; day treatment; crisis intervention; behavior management; and medication monitoring may be provided (ASPE 2018).

payment levels to families depending on the intensity of a child's needs (ASPE 2018).<sup>2</sup>

## Evidence supporting therapeutic foster care

Although much research has been conducted regarding the needs of children in foster care generally, less is known about the outcomes associated with specific treatment methods and services (SAMHSA 2013). Studies have found positive outcomes for children and youth with complex needs who receive therapeutic foster care; however, the generalizability of these findings is limited because studies have focused on specific subpopulations (e.g., youth in juvenile justice) (SAMHSA 2013, Macdonald and Turner 2008). As such, an expert panel has called for additional research about the effectiveness of various approaches to therapeutic foster care (SAMHSA 2013).

Two evidence-based models of therapeutic foster care have demonstrated positive outcomes: Treatment Foster Care Oregon and Together Facing

the Challenge (Box 4-2). Other models have not been rigorously evaluated.<sup>3</sup> Given the costs and difficulty of fully implementing these intensive models, most states have incorporated just some of the programs' elements into their therapeutic foster care programs (ASPE 2018).

## Children Served by Therapeutic Foster Care

Children receiving therapeutic foster care most often have serious emotional or behavioral health needs that cannot be appropriately addressed in their own home; or, in the case of children that are in the child welfare system, within a standard foster care arrangement. Some of these children may also have serious medical conditions, although that is less common. Children receiving therapeutic foster care services have often experienced trauma due to child abuse and neglect, being removed from their homes, or other situations. These children are most often adolescents, and are typically in child welfare custody. Therapeutic foster care provides a

### BOX 4-2. Evidence-Based Approaches to Therapeutic Foster Care

**Treatment Foster Care Oregon (TFCO)** provides an alternative to institutional or group care placements for children with severe emotional and behavioral disorders. Formerly called Multidimensional Treatment Foster Care, TFCO was originally designed to serve youth involved in the juvenile justice system but now serves other populations, including preschoolers and children and adolescents not involved in the juvenile justice system. It focuses on structured behavioral management techniques and a high level of supervision. For example, adolescents face increasing expectations for self-management of behavior as they move through a point system that monitors and rewards their behavior. Children and youth enrolled in TFCO typically stay in a treatment home for nine months. Staff in these homes receive initial and ongoing training, daily monitoring, weekly group support, and coaching (TFCO 2018, Child Trends 2016).

**Together Facing the Challenge** is a hybrid approach combining TFCO and other practice models, focusing on training for therapeutic foster care parents and therapeutic foster care supervisors. The training focuses on building therapeutic relationships, performing and teaching cooperation, implementing effective parenting techniques (such as setting expectations and reinforcing positive behaviors), teaching youth independence skills, and creating a positive home environment (CEBC 2017, SAMHSA 2013).

less restrictive environment than congregate care settings and allows the needs of the children to be met in the community (ASPE 2018, SAMHSA 2013).

There is no national data source that provides the number of children and youth receiving therapeutic foster care or their characteristics (e.g., age, gender,

diagnoses) (SAMHSA 2013).<sup>4</sup> A recent study examining the use of behavioral health services by children enrolled in Medicaid found that only 0.5 percent of children covered by Medicaid used therapeutic foster care in 2011, declining from 2005 (Table 4-1). The rates of use of therapeutic

**TABLE 4-1. Rates of Use of Therapeutic Foster Care in Medicaid, Selected Years**

Child characteristics	2005		2008		2011	
	Percent	Number	Percent	Number	Percent	Number
All children	0.8%	14,758	0.9%	17,531	0.5%	11,711
<b>Age</b>						
0–5	0.8	1,815	0.9	3,001	0.5	2,397
6–12	0.5	4,093	0.6	5,629	0.3	3,603
13–18	1.0	8,850	1.1	8,901	0.6	5,711
<b>Gender</b>						
Female	–	–	0.9	7,611	0.5	5,206
Male	–	–	0.8	9,919	0.4	6,505
<b>Race/ethnicity</b>						
White	–	–	0.8	8,343	0.5	6,094
Black/African American	–	–	0.9	4,694	0.4	2,588
American Indian/Alaska Native	–	–	2.4	815	1.8	645
Asian	–	–	0.6	75	0.2	41
Hispanic/Latino	–	–	0.4	840	0.2	629
Native Hawaiian/Pacific Islander	–	–	0.4	12	0.2	10
<b>Eligibility category</b>						
Poverty	0.3	3,306	0.3	3,729	0.2	4,069
Foster care	3.0	8,918	3.8	10,442	1.7	4,915
SSI/disability	0.7	2,534	0.9	3,360	0.6	2,727
<b>Diagnosis</b>						
ADHD	–	–	0.9	6,403	0.5	4,954
Conduct disorder	–	–	1.3	8,308	0.7	6,275
Mood disorder	–	–	1.2	7,185	0.7	5,654
Anxiety	–	–	1.0	3,679	0.6	3,114
PTSD	–	–	3.4	3,530	2.0	3,088
Developmental disability	–	–	0.7	714	0.5	650
Psychosis	–	–	1.3	707	0.9	606
Substance use disorder	–	–	0.9	1,110	0.7	1,138
Other diagnosis	–	–	2.4	2,147	1.3	1,682
No diagnosis	–	–	1.3	4,084	0.7	2,183

**Notes:** SSI is Supplemental Security Income. ADHD is attention deficit hyperactivity disorder. PTSD is post-traumatic stress disorder. – Dash indicates information not available.

**Source:** Pires et al. 2018.



foster care services are higher among adolescents, females, and children and youth who are eligible for Medicaid as a result of their child welfare involvement. Children with post-traumatic stress disorder, psychosis, and conduct disorder had the highest rates of therapeutic foster care use (Pires et al. 2018). However, due to differences in Medicaid coding and billing practices across states, the use of therapeutic foster care by Medicaid enrollees may be understated if those services are covered in other Medicaid benefits, such as targeted case management, as discussed in the next section.

## Medicaid Coverage of Therapeutic Foster Care Services

For the purposes of Medicaid, therapeutic foster care is not a specific benefit identified in the statute or regulations; however, a number of services considered to be part of therapeutic foster care can be covered by Medicaid. States have taken different approaches, but have typically identified therapeutic foster care services as either a Medicaid state plan rehabilitative service or targeted case management service; others have adopted coverage of therapeutic foster care services through waivers. Even if therapeutic foster care services are not explicitly identified in a state plan, the clinical and therapeutic services that comprise the practice may still be paid by Medicaid. For example, a state may provide case management services in the state plan, but not label these as therapeutic foster care services. Furthermore, in covering the services in Medicaid, some states only allow limited types of services, whereas others provide a broader array of benefits.

Some components of therapeutic foster care cannot be covered by Medicaid. These include room and board, and training and supervision of therapeutic foster parents. States cover these with state-only funds or other sources, such as federal child welfare funds (ASPE 2018).

## Rehabilitative services

In Medicaid, rehabilitative services are an optional state plan benefit. This benefit encompasses a variety of services to treat behavioral or physical health conditions designed to return children to function at an age-appropriate level (§ 1905(a)(13)(C) of the Social Security Act (the Act)).<sup>5</sup> States often elect to cover certain behavioral health services, such as therapy and counseling, under rehabilitative services. Such services can be provided in a variety of community-based settings, and by a broad range of qualified providers, including licensed and non-licensed practitioners, if they meet any applicable state and federal qualifications. This flexibility allows states to offer a variety of rehabilitative services in both clinical and non-clinical settings or from non-traditional providers (Crowley and O'Malley 2007).<sup>6</sup>

Most states cover therapeutic foster care services in their state plans under the auspices of rehabilitative services. In a survey of states conducted in 2012, 31 of 38 states responding reported having specific Medicaid billing codes for therapeutic foster care under rehabilitative services (BUSSW 2012). For example, South Carolina and Virginia define therapeutic child care and therapeutic group home services (the terms used by these states instead of therapeutic foster care) as rehabilitative services (CMS 2017a, 2017b). States have also covered therapeutic foster care services as behavioral health services within the rehabilitative services category. In North Carolina, for example, therapeutic foster care is considered a covered behavioral health service in the state plan (CMS 2017c). Although not defined in the state plan, Illinois state regulations define specialized foster care as a behavioral health service (ASPE 2018).

## Targeted case management

Case management services assist individuals living in the community in accessing needed medical, social, educational, and other services. Case management activities include assessment of individual needs; development of a care plan; and

referrals and related activities to link the individual with medical, social, and educational providers and programs (42 CFR 440.169). States may also offer targeted case management services, limiting case management services to a subset of beneficiaries within a state.<sup>7</sup>

Some states cover therapeutic foster care services in their state plans under targeted case management. Twenty-two states (including several that also reported having billing codes under rehabilitative services for purposes of therapeutic foster care) reported having specific therapeutic foster care billing codes under the targeted case management option (BUSSW 2012). For example, in North Dakota, targeted case management assists children and youth in the child welfare system in gaining access to needed medical, social, educational, and other necessary services (ASPE 2018, ND DHS 2016).

## Waivers

Some states use waiver authority to provide therapeutic foster care services. For example, New York uses a Section 1915(c) home- and community-based services waiver to create a bundle of services, such as care coordination, respite, and family support, provided to children with severe emotional disturbances. These may be provided in the child's home or community. Additional home- and community-based services are provided through New York's Section 1115 research and demonstration waiver (ASPE 2018, NY 2017).<sup>8</sup>

## Evolution of coverage

As with many benefits, state coverage of services under therapeutic foster care is not static. There are a number of factors that influence these changes, including state and federal policy and advances in the field.

Oklahoma has provided therapeutic foster care as part of its Medicaid program for more than two decades. Over that time, the needs of the children, the systems serving them, and the requirements

facing these systems have all changed. The state has long identified therapeutic foster parents as paraprofessionals in the state plan, which allows them to bill for their services. Under the current design, the benefit is structured with limitations on the types of therapies and hours of services available. There is a daily upper limit on unbundled services, with providers documenting and billing for every individual service on a fee-for-service basis. The state is moving away from this approach to one that is more evidence based and that provides a broader array of services (McGaugh 2019, ASPE 2018, Boyd 2013).

In response to a 2011 settlement agreement, California is in the process of implementing therapeutic foster care as a specialty mental health service. The state has developed a Medicaid manual regarding specialty mental health services provided under therapeutic foster care, intensive care coordination, and intensive home-based services. The state has also developed an integrated core practice model guide that describes how the county-based child welfare and mental health systems and service providers can work together (DHCS 2019, DHCS and CDSS 2018).

## Limitations on Medicaid funding

Although Medicaid funding is available for a wide variety of services, there are some services, such as room and board, that cannot be covered by Medicaid. As they do for other health services provided to children involved in the child welfare system, states often use Medicaid funds to pay for the clinical aspects of therapeutic foster care, such as behavioral health treatment, and child welfare funds to pay for living expenses, such as room and board, administrative costs, and recruitment and training of foster parents (ASPE 2018, MACPAC 2015). Depending on the nature of the program, states may also use other behavioral health or juvenile justice funds to support the service (ASPE 2018).

Medicaid is the payer of last resort and can only pay when third parties—including other public programs, private insurers, and certain other entities—do not

have a legal obligation to do so (CMS 2014a, 2014b). As a result, states may claim federal Medicaid funding only for services that are not the specific responsibility of a child welfare or other agency.

States generally cannot limit Medicaid benefits to certain groups of children. When provided in the state plan, services must be based on individual assessments of medical necessity, and all children in the state with similar health needs must be provided the same level of assistance. This is true even if particular services would seem appropriate only for a specific group of children (such as children in foster care) because of their high levels of need and potential to benefit from such specialized care. As such, if a state Medicaid program covers therapeutic foster care through its state plan, then the state must also indicate how similar services are covered for children who are not involved with the child welfare system. Furthermore, for all children under age 21, Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit requires Medicaid coverage of any service allowed under Section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate a physical or behavioral health condition (CMS 2014c).

In light of the requirement to provide medically necessary services to all children with Medicaid coverage, states may choose to finance therapeutic foster care through a Medicaid waiver as described above or choose to use other funding sources, such as child welfare or juvenile justice in order to provide therapeutic foster care to targeted groups of children.

## Considerations for a Uniform Definition of Therapeutic Foster Care in Medicaid

In its request to MACPAC, the House Appropriations Committee expressed concern regarding the lack of a uniform definition of therapeutic foster care in Medicaid, and suggested that such a definition could

result in more consistent care.<sup>9</sup> In addition, some stakeholders have supported a universal definition as a means to improve the quality, consistency, and professionalism of therapeutic foster care services (ASPE 2018, Boyd 2018, Sciamanna 2018). Below we analyze these perspectives.

### Consistency of covered benefits across states

The effect of creating a uniform definition of therapeutic foster care would depend upon whether it is considered a mandatory or optional Medicaid state plan benefit. Designating therapeutic foster care as a mandatory benefit would require all states to cover the service, and could ensure that all states provide a prescribed set of services under the therapeutic foster care umbrella. It may also require states currently providing therapeutic foster care to alter their approach to come into compliance. Adding therapeutic foster care as an optional benefit would not require states to provide therapeutic foster care, but may provide states that do not currently offer these services with a simpler way to provide a consistent package of services, as opposed to piecing together therapeutic foster care from other available benefits, such as rehabilitative services and targeted case management.

It is important to note that designating therapeutic foster care as a benefit under Section 1905(a) of the Act, whether mandatory or optional, could also create new EPSDT-related obligations for states. EPSDT requires states to provide any medically necessary service named in the Medicaid statute—including optional services not otherwise covered by the state—without caps or other limits.

On the other hand, establishing a uniform definition of therapeutic foster care would not necessarily result in a more consistent approach across states for several reasons. First, if therapeutic foster care was added to the statute as an optional benefit, states could choose whether or not to adopt it. States may view their current approach as the most appropriate for their circumstances, and may not wish to adopt the standard definition. As

discussed above, all states currently provide some form of therapeutic foster care or the services that comprise it and, as is the case for many other Medicaid policies, the existing variation in the practice likely reflects both the needs of enrollees and state decisions regarding available resources. Second, regardless of whether therapeutic foster care was considered a mandatory or optional benefit, states would continue to have the flexibility to define medical necessity criteria and the amount, duration, and scope of the benefit.

Finally, a uniform definition may have unintended consequences. If the definition is too prescriptive, it may not be sufficient to meet the unique needs of children now receiving these services. For example, a definition in the statute or regulations that describes specific services or qualified providers could restrict existing state and provider flexibility, and limit the services available to children. In addition, it would be difficult to define the practice to account for future practice changes as therapeutic foster care evolves. For example, new research on the negative effects of trauma on individuals' health and well-being is leading to development and adoption of trauma-informed treatment approaches (CHCS 2017). As researchers, states, and providers gain knowledge about children's needs, particular approaches to providing services, and outcomes associated with specific methods, a uniform definition could limit state Medicaid programs from responding to this evolving evidentiary base.

## Quality and appropriateness of services provided

A uniform definition of therapeutic foster care may assist in improving the quality and appropriateness of services to the extent that states, federal agencies, advocates, and researchers are better able to assess access to and quality of these services. The provision of therapeutic foster care in Medicaid has not been widely studied and, given the various ways states have implemented their programs, it is difficult to develop a complete understanding of the services provided and the children and youth receiving those services. A uniform definition may

provide an avenue for future research into the quality and effectiveness of therapeutic foster care interventions and monitoring access to services and compliance with standards of care.

On the other hand, a uniform definition in Medicaid would not, in and of itself, address other concerns regarding the availability of therapeutic foster care, including the need for highly skilled and committed caregivers. Although therapeutic foster care programs provide additional training, support, and payment for these parents, recruitment and retention are challenging in most states. Concerns have also been raised regarding the quality of therapeutic foster care providers and agency screening of foster parents (Committee on Finance 2017). In addition, therapeutic foster parents need support from qualified caseworkers and clinical staff. Training and accreditation are not generally considered Medicaid-covered services.<sup>10</sup>

It is important to note that children in need of or receiving therapeutic foster care services are typically served by multiple agencies, including Medicaid, child welfare, juvenile justice, behavioral health, and education. Furthermore, as therapeutic foster care is not typically a permanent placement, the need for coordination of services may be heightened as children and youth transition home or to adulthood. For example, parental training and coaching may be necessary when a child returns home so that the ongoing needs of the child can be met. Parent education and training may be covered by Medicaid only if the services are for the direct benefit of the child. As children exit child welfare custody to adulthood, Medicaid coverage can continue up to age 26 for these former foster youth and the child welfare agency is responsible for developing a transition plan that includes specific options related to health insurance coverage (MACPAC 2015).<sup>11</sup> Given the complex needs of children receiving therapeutic foster care and their transitions between placements, collaboration across agencies is important to coordinate the services they receive and finance these services appropriately. Nevertheless, a uniform definition of therapeutic foster care within Medicaid would not address these issues.

## Commission Recommendation

In this report, the Commission makes one recommendation that HHS more clearly inform states of their options related to Medicaid coverage of therapeutic foster care services.

### Recommendation 4.1

The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

#### Rationale

As discussed above, the Commission does not find that a uniform definition of therapeutic foster care in Medicaid would necessarily result in more consistency in covered services or improve the quality and appropriateness of the services provided. In addition, establishing a uniform definition may have unintended consequences that limit services provided to particular children or impede state flexibility and practice improvement. As such, it is the Commission's view that development of a uniform definition of therapeutic foster care in Medicaid is not advisable.

This recommendation calls for subregulatory guidance in the form of an informational bulletin from HHS to assist states in designing therapeutic foster care services that meet the diverse needs of children within the existing program structure.<sup>12</sup> Further direction from the Secretary could help provide important clarification to states on how they can use the benefit design flexibility already afforded them in Medicaid to cover therapeutic foster care services and provide states examples

of what can be considered a Medicaid-financed service, while still leaving flexibility for states to operationalize the benefit and for the practice of therapeutic foster care to evolve over time.

The Commission recognizes that therapeutic foster care is an important set of services for a vulnerable population, the services provided should meet the needs of the children, and a continuum of services provided by multiple agencies may be necessary and appropriate depending upon the child's needs. Although there is a role for congregate care along the continuum of care, a consensus exists across multiple stakeholders that most children and youth are best served in a family setting (Children's Bureau 2015). Moreover, the Americans with Disabilities Act (P.L. 101-336) requires states to provide services to individuals with disabilities in the most integrated setting possible. In addition, the Families First Prevention Services Act (P.L. 115-123), federal child welfare legislation enacted in 2018, focuses on ensuring that children in foster care are placed in the least restrictive and most family-like setting possible.<sup>13</sup> As federal and state policymakers work to reduce the reliance on congregate care, therapeutic foster care may provide an alternative for those children and youth who need greater levels of care, and additional information could help states meet these requirements.

The subregulatory guidance should be developed jointly between CMS (which administers Medicaid) and ACF (which administers federal child welfare programs).<sup>14</sup> Children in need of or receiving therapeutic foster care services are typically served by multiple agencies, including Medicaid and child welfare, as well as juvenile justice, behavioral health, and education. Although not all children in need of or receiving therapeutic foster care are in child welfare custody, state child welfare agencies are typically responsible for certifying therapeutic foster homes and federal child welfare funds may pay for living expenses, such as room and board, administrative costs, and recruitment and training of foster parents.

At a minimum, such guidance should:

- clarify which therapeutic foster care services can be covered under Medicaid and which services can be provided using federal child welfare funds (under Title IV-E of the Act) and how these and other funding streams can be blended together to serve children;
- share examples of current state approaches to providing therapeutic foster care using Medicaid;
- highlight the use of evidence-based practices and trauma-informed services, as well as other promising practices in therapeutic foster care and parent recruitment, training, and retention; and
- describe ways to effectively coordinate services with other agencies serving the same high-need children and youth, including child welfare, juvenile justice, education, and behavioral health agencies.

In making this recommendation, the Commission points to other instances in which multiple HHS agencies have collaborated to provide subregulatory guidance. For example, CMS and the Substance Abuse and Mental Health Services Administration previously released joint informational bulletins that described Medicaid coverage of behavioral health services for children with significant mental health conditions or substance use disorders, including how the services can be offered through existing authorities and state examples of how the authorities have been used (CMS and SAMHSA 2015, 2013). CMS and ACF could build on these earlier efforts to provide direction for states regarding therapeutic foster care.

### Implications

**Federal spending.** This recommendation would not have a direct effect on federal Medicaid spending.

**States.** Additional guidance related to Medicaid coverage of therapeutic foster care services may assist states in designing a benefit package

to address the needs of children with complex behavioral health or medical needs in the least-restrictive setting possible. It could also clarify which services can be billed to Medicaid and which are the responsibility of other agencies and how best to coordinate these services.

**Beneficiaries.** Guidance may help beneficiaries and their families understand what Medicaid services may be available to meet their needs.

**Plans and providers.** This recommendation may assist plans and providers in understanding appropriate coverage and billing practices for therapeutic foster care services and the responsibilities of various agencies.

## Endnotes

<sup>1</sup> Children in traditional foster care are in the custody of a child welfare agency because they have experienced abuse or neglect. Therapeutic foster care may be provided to children in child welfare, juvenile justice, or parental custody. Some states use a term other than therapeutic foster care to make it clear that a child who meets medical necessity criteria for the service does not have to be in foster care.

<sup>2</sup> In traditional foster care, foster parents provide care and supervision; in therapeutic foster care, parents also provide care and supervision, but are expected to implement the child's treatment plan in the home (ASPE 2018). States typically require that therapeutic foster care be provided in a home, and not, for example, in a residential setting with staff serving as therapeutic parents in shifts.

<sup>3</sup> Evidence-based models have demonstrated improved outcomes through rigorous evaluation; evidence-informed models are based on research and follow strict implementation standards, but have not been rigorously evaluated (ASPE 2018).

<sup>4</sup> Federal Adoption and Foster Care Analysis and Reporting System data on child welfare only include children in foster care and do not distinguish children and youth receiving therapeutic foster care from those receiving other types of child welfare services (SAMHSA 2013).

<sup>5</sup> Rehabilitative services are services to help individuals restore or relearn skills lost due to illness or injury. Habilitative services are not explicitly defined in Medicaid but are generally considered to be services that help individuals attain skills or developmental milestones not yet acquired. Examples of habilitative services may include speech therapy or physical therapy.

<sup>6</sup> A 2007 proposed rule would have further defined the scope of rehabilitative services. However, Congress placed a moratorium that prohibited the HHS Secretary from imposing criteria that were more restrictive than those in effect on July 1, 2007, effectively halting implementation. The rule was later withdrawn (CRS 2010).

<sup>7</sup> Targeted case management services can be provided without regard to the standard Medicaid requirements related to statewideness (meaning the service is provided in all geographic areas in a state) or comparability (meaning the service is provided to all enrollees). However, for children under age 21, a state must provide case management to any child for whom the service has been determined medically necessary under the early and periodic screening, diagnostic, and treatment (EPSDT) requirements. The Deficit Reduction Act of 2005 (P.L. 109-171) narrowed the definition of targeted case management. Final regulations issued in June 2009 rescinded certain provisions of an earlier interim final rule that were thought to restrict beneficiary access and limit state flexibility (CRS 2010).

<sup>8</sup> New York also has Section 1915(c) waivers to provide home- and community-based services for children with physical disabilities, intellectual or developmental disabilities, autism, and traumatic brain injuries (CMS 2018).

<sup>9</sup> The Senate Finance Committee issued a report in October 2017 examining the lack of oversight of private providers in foster care. One recommendation among many in the report was that HHS establish a common definition of therapeutic foster care for the purposes of Medicaid and Title IV-E (Committee on Finance 2017).

<sup>10</sup> States can mandate the use of evidence-based training programs for foster parents (such as the Incredible Years program), as well as accreditation and licensing of foster care agencies.

<sup>11</sup> The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) required states to continue providing

Medicaid coverage to youth under age 26 aging out of foster care (either Title IV-E or non-Title IV-E) who were receiving Medicaid, with the option of covering youth who have aged out in other states. The Support for Patients and Communities Act (P.L. 115-271) updated this provision, requiring that states cover youth who aged out of foster care in other states, beginning January 1, 2023. States also may cover former foster care children up to age 21 without requiring them to have prior Medicaid enrollment or be in foster care in the same state in which they currently reside (known as the Chafee option).

<sup>12</sup> Center for Medicaid and CHIP Services Informational Bulletins share information, address operational and technical issues, and highlight initiatives or related efforts. They do not establish new policy or issue new guidance.

<sup>13</sup> The Families First Prevention Services Act was enacted in February 2018 as part of the Bipartisan Budget Act of 2018 (P.L. 115-123).

<sup>14</sup> Programs authorized under Title IV-E of the Act are administered by the Children's Bureau, which is an office of ACF.

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## Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation that the Secretary issue guidance regarding therapeutic foster care services in Medicaid. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on the recommendation in this chapter on April 11, 2019.

- 4.1 The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

Yes: Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno

16	Yes
1	Not present

Not present: Cerise

Chapter 5:

# Mandated Report— Medicaid in Puerto Rico

# Mandated Report—Medicaid in Puerto Rico

## Key Points

- Medicaid is central to health care in Puerto Rico, covering almost half of the population in 2017.
- Puerto Rico is generally considered a state for Medicaid purposes. It is subject to most federal requirements and shares many of the same roles, responsibilities, and administrative structures as other Medicaid programs.
- Medicaid in Puerto Rico operates in a challenging environment of widespread poverty, high prevalence of chronic illness, and poor economic conditions worsened by hurricanes in September 2017.
- The statutorily defined Medicaid financing parameters—a capped allotment and a 55 percent federal matching rate—have resulted in chronic underfunding of the program.
- Underfunding has led Puerto Rico to establish more limited benefit packages and lower income eligibility levels, set lower provider payment levels, and adopt and upgrade key administrative systems and processes more slowly than other states.
- Additional federal funds provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) and the Bipartisan Budget Act of 2018 (P.L. 115-123) have allowed Puerto Rico to continue providing services to enrollees and strengthen its administrative capacity.
- Despite this additional federal funding, spending remains constrained. For fiscal year (FY) 2020, projected spending per full-year equivalent enrollee is 38 percent lower than the state with the lowest spending, even after adjusting for differences in enrollment mix and covered benefits.
- Expiration of these additional funds in September and December 2019 will result in a federal funding shortfall of at least \$1.01 billion in FY 2020.
  - At current enrollment, Puerto Rico could eliminate optional prescription drug and dental benefits and still not achieve the level of savings needed.
  - To continue benefits at current levels, Puerto Rico would have to reduce enrollment by 36 to 53 percent.
- Although full exhaustion of federal funds may not occur until March 2020, Medicaid will be affected earlier due to uncertainty about future availability of funds.
- An additional infusion of temporary funds would keep Medicaid afloat but would not address underlying issues with the program or its financing structure, and would not support program administrators in planning and implementing program improvements.
- Over the long term, reliable, sustainable access to care for the Medicaid population will likely require changes to the existing financing arrangement that provide a higher level of federal investment over a longer period of time than past interventions.

## CHAPTER 5: Mandated Report—Medicaid in Puerto Rico

In the report accompanying the fiscal year (FY) 2019 Labor, Health and Human Services, and Education funding bill, the House Committee on Appropriations requested that MACPAC examine possible options for ensuring long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico. Puerto Rico’s Medicaid program operates in a challenging environment, characterized by high rates of poverty and poor economic conditions that were worsened by Hurricanes Irma and Maria in September 2017. In particular, the program’s financing structure has resulted in chronic underfunding. The territory has a capped federal allotment that does not change in response to internal or external program cost drivers; moreover, territorial expenditures are statutorily matched at only 55 percent up to the capped allotment amount. As a result, Puerto Rico has historically taken on a larger share of program costs than would be expected given its statutory matching rate; moreover, total spending is constrained to a greater degree than any state. Although Congress has at times provided Puerto Rico with additional federal Medicaid funding, these supplements have always been time-limited, reacting to immediate needs without addressing long-term needs.

This chapter responds to the Appropriations Committee’s request by analyzing Puerto Rico’s Medicaid program and the factors affecting its future. We begin by providing background information on Puerto Rico, including its relationship to the federal government of the United States, the economic and fiscal challenges it is experiencing, and health indicators of its population. We then describe Puerto Rico’s Medicaid program, focusing on program administration, eligibility, covered benefits, and the delivery system. We also highlight its financing arrangement and how it differs from the one used in the 50 states and District of Columbia. Subsequent sections analyze historical and future spending in a variety of different policy

scenarios. Given that Puerto Rico is facing a major reduction in federal Medicaid funding beginning in September 2019 and full exhaustion of federal Medicaid funds as early as December 31, 2019 (also referred to as the fiscal cliff), we also highlight the implications of the spending reductions expected to occur if Congress does not act, including major cuts to benefits and enrollment.

The fiscal cliff has important implications for Puerto Rico’s ability to provide services to Medicaid beneficiaries over the long-term. Puerto Rico faced similar financing challenges in 2011, 2017, and 2018, when additional temporary federal funds were set to expire or be exhausted; these challenges were averted with last-minute infusions of federal funds. These cycles of crisis and congressional response have caused a great deal of uncertainty and make it difficult for the Puerto Rico to make long-term plans or improvement efforts. Although an additional time-limited allotment of federal funds would prevent a fiscal cliff and shock to Puerto Rico’s health system in 2020, it would not address existing challenges with Puerto Rico’s Medicaid financing structure or support Puerto Rico’s ability to plan, manage, and sustain an effective Medicaid program that offers long-term, reliable access to care for its beneficiaries.

### Background

Puerto Rico is the oldest and most populous U.S. territory with a population of 3.2 million in 2018 (Census 2019). It is comprised of one main island and six smaller ones.

### Relationship to the federal government

Puerto Rico’s relationship to the federal government has evolved over time. It was declared an unorganized territory of the U.S. in 1898 following the Spanish-American War, and Puerto Ricans were granted U.S. citizenship in 1917 with the passage of the Jones Act (P.L. 64-368). Puerto Rico was established as a commonwealth of the United States in 1948 after Congress approved the Constitution of Puerto Rico (Webber 2017).

As a U.S. territory, Puerto Rico is subject to congressional authority, though it retains authority for most matters of internal governance. In general, U.S. law applies to Puerto Rico unless otherwise indicated. Puerto Ricans may travel to or establish residency in any state on the mainland without restriction. While residing in the territory, they cannot vote in U.S. presidential elections and do not have a voting representative in Congress. Puerto Ricans generally do not pay federal income taxes except on income over a filing threshold from sources outside of Puerto Rico; however, they pay most other federal taxes, including Medicare and Social Security taxes imposed by the Federal Insurance Contributions Act and unemployment taxes imposed by the Federal Unemployment Tax Act (IRS 2016). They are eligible for many federal programs, including Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP), but are ineligible for others including Supplemental Security Income (GAO 2014).

Historically, Congress has determined whether and how to apply federal laws or programs to Puerto Rico on a case-by-case basis (GAO 2018). Many of the decisions about the treatment of Puerto Rico were made in the early and middle portions of the 20th century, and have not been adjusted since.

## Economy

Although the effects of Hurricane Maria on Puerto Rico's economy and infrastructure have garnered media attention, Puerto Rico has long experienced significant structural, fiscal, and economic challenges.

**Economic decline.** Puerto Rico's economic challenges have compounded over the last two decades. The commonwealth experienced a major economic decline beginning in 2006. A key contributor to this decline was the phasing out of federal tax breaks important to the private sector beginning in the mid-1990s (FOMB 2018, Perreira et al. 2017). In every year since 2005, the economy has contracted: between 2005 and 2015, real gross domestic product (GDP) decreased by 8 percent

and labor force participation decreased by 9 percent (IMF 2018, ASPE 2017). Today, manufacturing remains Puerto Rico's most important economic sector, accounting for approximately half of GDP in 2017 (BDE 2019). However, manufacturing employment has declined in every year since 2006 and is projected to decline by over 10 percent between 2014 and 2024. Other sectors, including construction and government, have also experienced employment losses (DOLETA 2017).

Puerto Rico's population also declined almost 12 percent between 2010 and 2017, predominantly driven by outmigration of young, working-age adults (FOMB 2018, ASPE 2017). In 2012, individuals age 16–30 made up one-third of those leaving Puerto Rico and one-fifth of the population overall (Abel and Deitz 2014). In 2016, the average age of a person leaving Puerto Rico was 29 (Velázquez-Estrada 2018). This has contributed to the aging of Puerto Rico's population; for example, in 2017, 20 percent of the population was age 65 or older, 4 percentage points higher than the U.S. average and higher than in all states except Florida and Maine (Census 2017). Consistent with this overall trend, Puerto Rico expects the Medicaid population to shift into older age brackets over the next several years (FOMB 2018). Outmigration trends have become even more pronounced following the hurricanes: between 2017 and 2018, Puerto Rico lost an estimated 123,399 residents to outmigration, almost double the amount observed in the previous three years (Census 2017).

**Debt burden.** The government of Puerto Rico faces a substantial debt burden. As tax revenue declined, Puerto Rico used bonds to finance services and general government operations, including its share of Medicaid program costs. By 2017, this amounted to \$74 billion in bond debt and an additional \$49 billion in unfunded pension obligations (FOMB 2018, Kobre & Kim 2018).

In response to the growing debt crisis, Congress passed the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA, P.L. 114-187) in June 2016. PROMESA created the Financial

Oversight and Management Board (FOMB), which was given discretion over the territory's budget and financial plans and the power to force debt restructuring with bondholders and other creditors.<sup>1</sup> As part of the fiscal plan certified in October 2018, the board established significant spending reduction targets across a wide range of areas and programs, including Medicaid (FOMB 2018).<sup>2</sup> Many stakeholders have expressed concern that these austerity measures, along with other actions taken by the board, are too aggressive, and will impede Puerto Rico's economic recovery (Torres 2018, Varney and Heredia Rodriguez 2018, Rosello 2017). Although the board signaled its willingness to reduce some spending reduction targets (including those for Medicaid) in March 2019, negotiations to establish revised targets are ongoing (AAFAF 2019a, b; FOMB 2019).

**Economic indicators.** Key economic indicators are significantly worse for families in Puerto Rico than in the United States overall. For example, in 2017:

- the unemployment rate was 16.4 percent in Puerto Rico versus 5.3 percent in the United States overall;
- the poverty rate was 44.4 percent versus 13.4 percent; and
- the median household income was \$19,343 versus \$60,336 (Census 2017).

It is important to note that the cost of living in Puerto Rico is high. The overall cost of living in the San Juan metropolitan area is currently slightly higher (0.6 percent) than the average of other metropolitan areas of the U.S. This represents a decrease from previous years: between 2015 and 2017, the cost of living in San Juan ranged from 6.7 to 15.4 percent higher than in other areas of the United States. San Juan consistently ranks in the top four most expensive cities in the United States for public utilities (surpassed only by cities in Hawaii and Alaska) and among the top 15 for supermarket items (IEPR 2015-2018).

**Future growth.** The government of Puerto Rico, FOMB, and others have described proposals to generate economic growth, including investments in infrastructure, reforms to public programs such as nutritional assistance, implementation of a local earned income tax credit program, and policies to promote ease of doing business. Many have pointed to the tourism industry as a potential source for economic growth, which currently generates 7 percent of GDP (WTTC 2019, FOMB 2018, Resnick-Ault and Brown 2018). However, Puerto Rico is still working to rebuild its infrastructure following Hurricanes Maria and Irma, including infrastructure needed to support tourism. Other factors inhibiting economic growth include an inadequate power grid, the current set of labor market regulations, and the commonwealth's exclusion from the capital market (FOMB 2018).

## Health indicators and insurance coverage

Health indicator status among Puerto Ricans is mixed. Their life expectancy is similar to that of the overall U.S. population (79.3 years compared to 79.7 in 2015) (ASPE 2017). However, they have a higher infant mortality rate and higher prevalence of many chronic conditions—including hypertension, diabetes, and cardiovascular disease—than residents in most or all mainland states. Their self-reported health status is worse than in any mainland state (Table 5-1).

Puerto Rico has a lower overall uninsured rate than the United States as a whole (6.9 percent versus 8.7 percent in 2017), which is largely driven by higher rates of Medicaid coverage (Census 2017). Compared to the mainland, in 2017:

- the share of Puerto Ricans covered by Medicaid was more than twice as high (46.9 percent compared with 20.6 percent);
- the share of Puerto Ricans covered by Medicare was 40 percent higher (24.3 percent compared with 17.3 percent);

**TABLE 5-1.** Selected Health Indicators for Puerto Rico compared to U.S. Mainland States, Selected Years

Indicator	Puerto Rico	State median	State minimum	State maximum
Infant mortality rate, 2015 (per 1,000 live births)	7.6	5.9	4.2	9.3
Self-reported health status, 2017 (percent reporting fair or poor health)	37.1	17.7	10.8	25.9
Chronic disease prevalence, 2017				
Hypertension	44.7	32.3	24.4	43.5
Diabetes	17.2	10.5	7.1	14.2
Cardiovascular disease	7.2	3.9	1.9	7.4

Sources. ASPE 2017, CDC 2019a, b.

- 61.3 percent of Puerto Ricans had some form of public health insurance coverage compared with 35.5 percent of Americans overall; and
- only 38.9 percent of Puerto Ricans had private insurance (employer-sponsored or direct purchase) compared with 67.6 percent of the U.S. population (Census 2017).<sup>3</sup>

Due in part to the high insurance coverage rate, Puerto Ricans generally report being able to afford health care services when they are available (ASPE 2017).

## Overview of Puerto Rico’s Medicaid Program

Medicaid is a central part of the safety net and health care system in Puerto Rico, covering almost half (47 percent) of the population in 2017, or 1.6 million people (Census 2017). This figure is comprised of approximately 1.3 million enrollees covered by Medicaid (including about 250,000 dually eligible individuals) plus approximately 88,000 Medicaid-expansion CHIP enrollees plus an additional 145,000 enrollees covered with commonwealth-only funds (DS 2018).<sup>4</sup>

In general, Puerto Rico is considered a state for the purposes of Medicaid unless otherwise indicated (§ 1101(a)(1) of the Social Security Act (the Act)).

The Medicaid program in Puerto Rico is subject to most federal requirements and shares many of the same roles, responsibilities, and administrative structures as other Medicaid programs. For example:

- Medicaid provides health insurance coverage to enrolled individuals;
- eligibility for Medicaid is determined on an individual basis using modified adjusted gross income (MAGI);
- the commonwealth contracts with managed care organizations (MCOs) to deliver covered health services to enrolled populations; and
- the commonwealth oversees managed care plans, carries out program integrity functions, and reports data and other information to the Centers for Medicare & Medicaid Services (CMS).

The most significant difference in Puerto Rico’s Medicaid program from Medicaid programs in the 50 states and District of Columbia is the capped allotment financing structure. Additionally, Puerto Rico has a statutorily defined federal medical assistance percentage (FMAP) of 55 percent. Although this financing structure also applies to the other four U.S. territories, there are significant differences in the design and structure of their programs (Box 5-1).



## BOX 5-1. Medicaid in the U.S. Territories

Medicaid and the State Children’s Health Insurance Program (CHIP) operate in the five U.S. territories—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. The Medicaid financing structure works similarly in all five: each territory has an annual Section 1108 capped allotment and a statutorily specified federal medical assistance percentage (FMAP) of 55 percent. However, the territories have chosen to operate their programs differently.

Guam and the U.S. Virgin Islands share similar program structures to Puerto Rico and the states: they use modified adjusted gross income (MAGI) to determine eligibility and cover individuals with income up to 133 percent of the local poverty level. Medicaid functions as health insurance coverage to these individuals, and services are delivered through fee-for-service Medicaid. They are subject to most federal Medicaid rules unless otherwise specified.

The Northern Mariana Islands and American Samoa operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them (§ 1902(j) of the Social Security Act). This provision allows the Secretary of Health and Human Services to waive or modify almost any Medicaid requirement, and allows these two territories to use alternative program structures.

- In American Samoa, Medicaid eligibility is not determined on an individual basis and there is no enrollment process. Instead, federal Medicaid and CHIP funds pay for care provided in the territory in proportion to the population of American Samoans with income that would have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent of the federal poverty level (FPL).
- The Northern Mariana Islands, the only territory participating in Supplemental Security Income (SSI), uses that program’s income and asset standards to determine Medicaid eligibility, covering individuals who meet up to 150 percent of income and resource requirements for SSI but are not necessarily disabled.

In American Samoa, Guam, and the Northern Mariana Islands, the vast majority of all services are provided by each territory’s one public hospital. Only Guam provides all mandatory Medicaid benefits, though all offer some optional benefits such as dental services and outpatient prescription drugs.

The financing arrangement has been historically insufficient to fund the federal share of Medicaid in all four of these territories, as in Puerto Rico. They similarly struggle with financing the nonfederal share needed to draw down their Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) allotments, administrative capacity issues, and building and sustaining health care systems that promote access and quality of care. For more on the other four territories, see [Medicaid and CHIP in the Territories](#) and individual territory-specific fact sheets (MACPAC 2019b).

### Program administration

Puerto Rico’s Departamento de Salud administers the territory’s public health programs and services,

and the Administración de Seguros de Salud de Puerto Rico (ASES) administers the Government Health Insurance Program (GHIP), also called Vital, previously called Mi Salud and Reforma. GHIP

serves as an umbrella program for Medicaid, CHIP (operated as a Medicaid-expansion CHIP program), the Medicare Platino program (a Medicare Advantage program that provides wraparound services and cost sharing assistance for dually eligible individuals), coverage for enrollees whose income is too high to qualify for Medicaid (funded through Puerto Rico-only funds), and optional buy-in coverage for employees or retirees of the commonwealth government (ASPE 2017). GHIP was established in 1993 by the Puerto Rico Health Insurance Administration Act (Law 72) that also shifted much of the publicly financed health care system to the private sector. Prior to this, Puerto Rico provided health care to the vast majority of the population through a decentralized, government-financed system of local and regional hospitals and clinics (HHS 2013).

In recent years, Puerto Rico has taken steps to improve its program administration. It recently completed development of a Medicaid management information system (MMIS), which became operational in 2018 and is compliant and certified to report information to the Transformed Medicaid Statistical Information System (T-MSIS). In early 2019, it established a Medicaid fraud control unit (MFCU) responsible for investigating and prosecuting Medicaid provider fraud and patient abuse and neglect (CMS 2018a). Puerto Rico has also established a recovery audit contractor program, responsible for identifying and correcting improper Medicaid payments (ASES 2019g).<sup>5</sup>

These actions respond to concerns previously identified by Congress, the U.S. Government Accountability Office (GAO), and others. For example, a 2016 GAO report noted that increased federal funding to Puerto Rico merited establishment of a MFCU and reporting of service-level expenditure data (GAO 2016). In the Bipartisan Budget Act of 2018 (BBA, P.L. 115-123), \$1.2 billion of the \$4.8 billion of additional Medicaid funds was conditional on Puerto Rico making reasonable progress toward establishing methods of collecting and reporting reliable T-MSIS data, and establishing a MFCU

(§ 20301(a)(2) of the BBA). Puerto Rico has met these targets on schedule and will receive the full amount of BBA funds (CMS 2018a).

## Eligibility

Eligibility rules in Puerto Rico's Medicaid program differ in some ways from those in the states. Puerto Rico is permitted to use a local poverty level to establish income-based eligibility for Medicaid. The Puerto Rico Poverty Level (PRPL) is established in the Medicaid state plan and can be changed by the commonwealth government with CMS approval. Currently, Puerto Rico covers individuals with income up to 138 percent of the PRPL, which is \$11,736 annually for a family of four or approximately 46 percent of the federal poverty level (FPL) for a family of the same size in 2019 on the mainland (ASES 2019c, ASPE 2019).

Through Medicaid-expansion CHIP, Medicaid covers children under age 19 whose incomes are below 271 percent PRPL (\$23,052 for a family of four in 2019), which was approximately 90 percent FPL for a family of the same size in 2019 (ASES 2019c, ASPE 2019).<sup>6,7</sup> Because individuals residing in Puerto Rico are ineligible for SSI, Medicaid coverage for aged, blind, and disabled individuals is provided through the medically needy option, with a medically needy income level of \$400 per month for an individual plus \$95 for each additional family member (ASES 2019c).<sup>8</sup>

Additional individuals with incomes up to \$22,344 for a family of four, or approximately 87 percent FPL for a family of the same size, are covered through commonwealth-only Medicaid; spending for this population is not matched by the federal government (ASES 2019c, ASPE 2019). Though Puerto Rico could seek CMS approval for policy changes that would permit receipt of federal matching funds for services provided to this population, given the commonwealth's relatively low uninsured rate, it has chosen to use its limited federal Medicaid funding for other priorities (ASES 2019g).

## Covered benefits

Although the federal rules for Medicaid benefits generally apply to Puerto Rico, Puerto Rico currently provides only 10 of Medicaid’s 17 mandatory benefits, citing insufficient funding and lack of infrastructure. For example, it does not cover nursing facility services (as few such facilities exist), or non-emergency medical transportation. It does, however, provide certain optional benefits, including dental services and prescription drugs (Table 5-2).<sup>9</sup> Small copayments for most services are charged to Medicaid and CHIP beneficiaries with incomes above 50 percent PRPL (CMS 2018a, CMS 2012, CMS 2014a).

Puerto Rico provides some cost sharing assistance to individuals who are dually eligible for Medicare and full Medicaid benefits. It does not provide Medicare cost sharing assistance to individuals who

otherwise would qualify as partial dually eligible individuals through Medicare Savings Programs in the states because these programs are not available in Puerto Rico (HHS 2013).

## Delivery system

Puerto Ricans tend to access health care in the same ways that people on the U.S. mainland do: in physician offices, health centers, and hospitals. As in many states, benefits are delivered through a managed care delivery system. ASES oversees and directly contracts with MCOs to provide services to beneficiaries.<sup>10</sup> MCOs provide commonwealth-wide acute, primary, specialty, and behavioral health services. They are paid risk-based capitated payments. MCOs contract with primary medical groups, which in turn create preferred provider networks (PPNs) (AAFAF 2018).

**TABLE 5-2. Mandatory and Optional Medicaid Benefits Covered by Puerto Rico, FY 2018**

	Mandatory Medicaid benefits	Optional Medicaid benefits
Covered	<ul style="list-style-type: none"> <li>• EPSDT services for individuals under age 21</li> <li>• Inpatient hospital services</li> <li>• Laboratory and X-ray services</li> <li>• Medical or surgical services by a dentist</li> <li>• Outpatient hospital services</li> <li>• Physician services</li> <li>• Tobacco cessation for pregnant women</li> <li>• Family planning services</li> <li>• FQHC services</li> <li>• Rural health clinic services</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic services</li> <li>• Dental services</li> <li>• Eyeglasses and prosthetics</li> <li>• Outpatient prescription drugs</li> <li>• Physical therapy and related services</li> <li>• Diagnostic, screening, preventive, and rehabilitative services</li> <li>• Inpatient psychiatric hospital services for individuals under age 21</li> <li>• Inpatient hospital services for individuals age 65 or over in an IMD</li> </ul>
Not covered	<ul style="list-style-type: none"> <li>• Home health services for those entitled to nursing facility services</li> <li>• NEMT</li> <li>• Certified pediatric and family nurse practitioner services</li> <li>• Nurse midwife services</li> <li>• Nursing facility services for individuals age 21 and over</li> <li>• Emergency services for legalized aliens and undocumented aliens</li> <li>• Freestanding birth center services</li> </ul>	<ul style="list-style-type: none"> <li>• Hospice care</li> <li>• Private duty nursing services</li> <li>• Intermediate care facility for individuals with intellectual disabilities</li> <li>• Personal care services</li> <li>• Targeted case management services</li> </ul>

**Notes:** EPSDT is early and periodic screening, diagnostic, and treatment. FQHC is federally qualified health center. FY is fiscal year. IMD is institution for mental diseases. NEMT is non-emergency medical transportation. Eyeglasses are provided only under the EPSDT benefit.

**Source:** GAO 2016.

Effective November 2018, Puerto Rico is implementing a major managed care system restructuring. Under the previous structure, plans provided coverage only to their own specific geographic region and rarely contracted with providers outside the region. Enrollees were not able to make changes to their assigned plan and needed to seek referrals for specialists or out-of-network services, creating access barriers. Under the new structure, plans provide commonwealth-wide coverage. Enrollees are auto-assigned to a health plan but may switch once per year, and no longer need referrals for specialists in their PPN. Enrollees appear to be exercising these new options; however, some reports have noted confusion among beneficiaries about the plan selection and referral processes (ASES 2019g, Rudowitz et al. 2019). Additionally, although plans have met network adequacy standards to date, they have noted challenges recruiting providers and building commonwealth-wide networks because of limited provider supply, constraints on provider payments, and low capitation rates (ASES 2019g, MMAPA 2018, Molina 2018). It is too early to assess the overall effect of the reforms on access, unmet need, or program efficiency.

## Financing

Like states, Puerto Rico must contribute its non-federal share of Medicaid spending to access federal funds. However, unlike states, Puerto Rico may draw down federal dollars only up to the annual cap, referred to as the Section 1108 cap.

Puerto Rico's matching rate is set in statute at 55 percent (§ 1905(b) of the Act). Were it determined using the same formula used for states, its FMAP would be the maximum allowable rate of 83 percent (GAO 2014).<sup>11</sup> There are some exceptions to this FMAP: although Puerto Rico cannot claim the newly eligible FMAP available to states expanding to the new adult group, it receives the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as

amended), which is 93 percent in calendar year 2019 (§ 1905(z)(2) of the Act, CMS 2016). Its matching rate for almost all program administration is 50 percent, although it is eligible for the enhanced matching rate for activities such as MMIS and MFCU implementation and operation and administration of electronic health record incentive payment programs (CMS 2019b, MACPAC 2019a).

Puerto Rico's annual cap was originally set in 1968 and is updated annually by the medical component of the Consumer Price Index for Urban Consumers (CPI-U). It is not clear what factors Congress considered when it initially set the cap. There are some exceptions to the cap, including spending for the establishment of electronic health record incentive program payments; and establishment and operation of eligibility systems and the MFCU. Puerto Rico also receives a separate allotment for the Enhanced Allotment Plan (EAP), which can be used solely to help low-income beneficiaries purchase Medicare Part D prescription drugs.<sup>12</sup> However, in general, Puerto Rico must cover the entirety of any Medicaid costs above the annual cap. As a result, Puerto Rico's FMAP has historically been effectively lower than 55 percent; at times, it has been 20 percent or lower (Muñoz et al. 2011; Acevedo-Vilá 2005).

**Additional time-limited federal funds.** Congress has provided additional federal Medicaid funds to Puerto Rico on a temporary basis on several occasions. For example, the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) raised Puerto Rico's annual cap by 30 percent for the period between October 1, 2009 and June 30, 2011 (§ 5001(d) of ARRA). Following the expiration of these additional funds, the ACA provided Puerto Rico with an additional \$6.3 billion in federal Medicaid funds: Section 2005 of the ACA provided \$5.4 billion, available to be drawn down between July 2011 and September 2019; and Section 1323 of the ACA provided an additional \$925 million, available January 1, 2014 through December 30, 2019.<sup>13</sup>

Congress has since added to this additional funding on two occasions. Because Puerto Rico exhausted its Section 2005 allotment in late FY 2017 (earlier

than anticipated), the Consolidated Appropriations Act of 2017 (P.L. 115-31) added \$295.9 million to Puerto Rico's ACA Section 2005 funds. Additionally, in response to the effects of Hurricane Maria on Puerto Rico's health system, Congress provided an additional \$4.8 billion to be used in FYs 2018 and 2019 under the BBA (Box 5-2). Most of this funding—\$3.6 billion—was provided without conditions. As noted above, the remaining \$1.2 billion is dependent on the territory meeting certain conditions related to data reporting and program integrity, which the territory has met (CMS 2018a). These funds have a 100 percent federal matching rate, meaning Puerto Rico does not have to put up any territorial funding to access them.

These additional funds allow Puerto Rico to continue to access federal Medicaid matching funds after reaching the annual cap. For example, in FY 2019, the cap is \$366.7 million, and federal Medicaid expenditures were projected at \$2.58 billion (ASES 2019b, CMS 2018b).

### **Implications of the financing arrangement.**

Despite the infusion of temporary additional funds, Puerto Rico's Medicaid financing arrangement has constrained available resources, resulting in more limited benefit packages and lower eligibility levels than states, low provider payment levels, and slow adoption of key administrative systems and processes. Puerto Rico's Medicaid spending is lower than in all 50 states and the District of Columbia, even after adjusting for Puerto Rico's enrollment mix and excluding spending on long-term services and supports (LTSS), a costly benefit that Puerto Rico does not provide. (See the appendix for a description of our methodology.)

For FY 2020, Puerto Rico's projected federal spending per full-year equivalent (FYE) enrollee is \$1,495. This is 38 percent lower than the state with the lowest federal spending per FYE (\$2,402), 67 percent lower than the median (\$4,550), and 85 percent lower than the state with the highest spending (\$10,243). Moreover, Puerto Rico's total spending per FYE (at \$2,144) is lower than the federal spending per FYE in all states, meaning that even if the federal government paid 100 percent of

Puerto Rico's Medicaid costs, it would still spend less per FYE than in any state (Figure 5-1).

## **Challenges**

The ACA and BBA funds have allowed Puerto Rico to continue providing services to eligible individuals, enhance program operations, and implement managed care reforms intended to improve access and promote efficiency. However, the island continues to face access and provider availability challenges due to outmigration of health professionals and chronically low provider payment rates. Although its managed care capitation rates are low compared to those in states, as reflected in benefit spending per FYE (Figure 5-1), the program has been directed by the Financial Oversight Management Board to achieve additional savings in per member per month (PMPM) costs over the next five years.

**Access to health care facilities.** As of 2015, Puerto Rico had 64 hospitals, or 2.68 beds per 1,000 people; this is similar to the United States overall, which had 2.9 beds per 1,000. There was considerable variation in hospital capacity across different regions of the territory. For example, in the San Juan metropolitan area, there were 4.2 beds per 1,000 people, while in the neighboring Bayamón region, there were just 1.3 beds. Puerto Rico's hospitals had few intensive care unit beds—70.1 per 1 million compared to 290.6 on the mainland—and just one trauma center (ASPE 2017). Because Puerto Rico does not have a federal disproportionate share hospital (DSH) allotment, hospitals serving a large share of Medicaid or uninsured patients do not receive DSH payments.<sup>14</sup>

The health system in Puerto Rico is particularly reliant on federally qualified health centers (FQHCs) compared to the U.S. overall; in 2015, 10 percent of the population received care from them compared to 7.5 percent nationally (ASPE 2017). Reliance on FQHCs has grown following the 2017 hurricanes: nearly three-quarters of centers experienced an increase in patients served, and one in 10 reported an increase of 10 percent or greater (Sharac et al. 2018).

## **BOX 5-2. Medicaid’s Role in Responding to Disasters**

Medicaid has served as an important tool in state responses to the health care needs resulting from disasters and emergencies, including hurricanes. In some cases, Congress has also authorized additional federal Medicaid funding to respond to increased need following a disaster, such as the funds provided to Puerto Rico and the U.S. Virgin Islands through the Bipartisan Budget Act of 2018 (BBA, P.L. 115–123).

Additionally, a variety of flexibilities under the state plan and waivers under Sections 1135 and 1115 of the Social Security Act (the Act) allow states to provide a heightened response, for example by facilitating short-term changes to program rules affecting eligibility, benefits, and provider payment. The U.S. Department of Health and Human Services took a number of administrative actions to support the response to Hurricanes Irma and Maria, including declaring a public health emergency, which enabled the Centers for Medicare & Medicaid Services (CMS) to waive some conditions of participation and other requirements for providers under Section 1135 of the Act (CMS 2017b). CMS also granted a Section 1115 waiver allowing Puerto Rico to pay for off-island services for Medicaid beneficiaries eligible for the Federal Emergency Management Agency (FEMA) Transitional Shelter Assistance Program who were temporarily relocated to the states of New York and Florida, effective from November 12, 2017 to January 27, 2018. These individuals otherwise only would have received coverage for emergency services (CMS 2017a). CMS also allowed Puerto Rico to suspend eligibility redeterminations through June 2018, which meant that anyone who lost eligibility between September 2017 and June 2018 was automatically re-enrolled for another year (ASES 2019c).

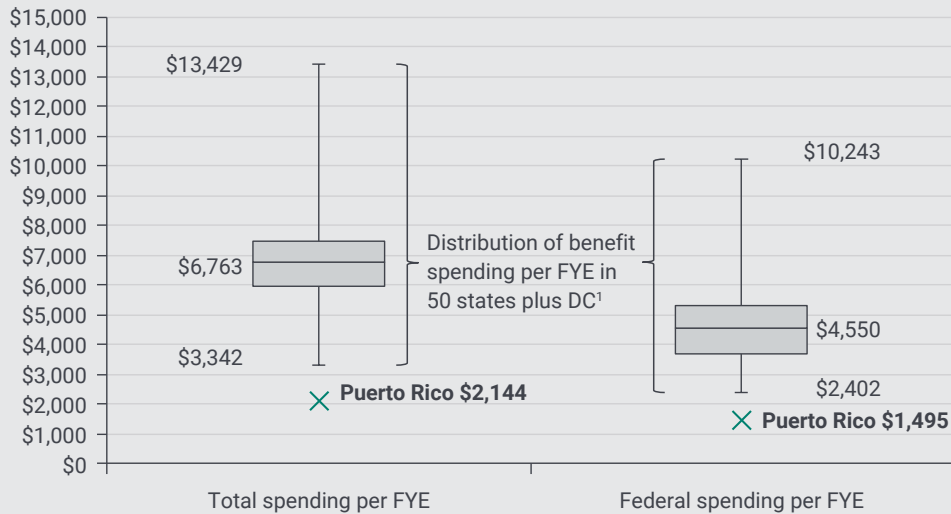
Congress and CMS have taken similar measures in responding to other disasters. Following Hurricane Katrina in 2005, CMS approved demonstration waiver programs for 32 states seeking to provide temporary eligibility to evacuees, which included streamlined eligibility processes and allowing self-attestation of eligibility factors (Katch et al. 2017, OIG 2007). Eight of these demonstrations included provisions for uncompensated care pools that allowed providers to be paid for providing necessary services to evacuees without insurance coverage (CMS 2005).

In February 2006, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) authorized the Secretary to pay the non-federal share of certain health care-related expenses to states with approved hurricane-related demonstration projects. Overall, the DRA made \$2 billion available for services delivered to individuals by June 30, 2006, and for uncompensated care costs incurred by January 31, 2006. Of these funds, approximately \$1.5 billion was allocated to Alabama, Louisiana, and Mississippi, the three states affected directly, for the nonfederal share of expenditures for existing Medicaid and CHIP enrollees (GAO 2007).

Although the measures taken in response to hurricanes in Puerto Rico are often compared to those taken in response to Hurricane Katrina in Louisiana and other states, it is important to note several key differences. Relief and recovery efforts have been more difficult in Puerto Rico due to its geographic isolation, disadvantaged infrastructure (including a weak power grid), and already strained health care system. In addition, Puerto Rico’s capped Medicaid financing structure and upcoming fiscal cliff left it constrained financially until February 2019, when the BBA was enacted.

For more examples and further detail, see [Medicaid’s Role in Disasters and Public Health Emergencies](#) (MACPAC 2018c).

**FIGURE 5-1.** Projected Medicaid Benefit Spending per FYE in Puerto Rico Compared to Distribution of Projected Medicaid Benefit Spending per FYE in 50 States and DC, FY 2020



**Notes:** FYE is full-year equivalent. FY is fiscal year. DC is District of Columbia. Total spending includes federal and state funds. Excludes Medicaid-expansion CHIP enrollees. Excludes spending for administration and long-term services and supports (LTSS). FY 2013 benefit spending from Medicaid Statistical Information System (MSIS) data were adjusted to reflect CMS-64 totals. See <https://www.macpac.gov/macstats/data-sources-and-methods/> for additional information. FY 2013 spending per FYE for each eligibility group was trended forward to FY 2020 using CMS Office of the Actuary (OACT) projected growth rates for that eligibility group. For adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, FY 2017 benefit spending per FYE calculated from CMS-64 spending and enrollment data was trended forward to FY 2020 using OACT projections. To adjust for differences in enrollment mix across states and Puerto Rico, the enrollment mix across eligibility groups in each state was reweighted to match the distribution of enrollees across eligibility groups in Puerto Rico.

<sup>1</sup> Excludes Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.

**Sources:** ASES 2019h, i. OACT 2018. MACPAC 2019 analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of June 2016; CMS-64 FMR net expenditure data as of July 20, 2018 and CMS-64 enrollment reports as of September 19, 2018.

**Access to physicians and specialists.** Though primary care physician, general surgeon, and dentist availability in Puerto Rico has tracked closely with the United States as a whole, provider availability varies across geographic regions (AAMC 2017, 2013). For example, 72 of Puerto Rico’s 78 municipalities are designated as medically underserved areas, and 32 of them are designated as primary care shortage areas (HRSA 2019). Puerto Rico also lacks an adequate supply of certain types of specialists. Prior to Hurricane Maria, 23 percent of municipalities had a shortage of pediatricians and 68 percent had a shortage of

obstetrician-gynecologists. In 2017, the supply of emergency room physicians, neurosurgeons, plastic surgeons, and ear nose and throat specialists was less than half the rate on the mainland (ASPE 2017). The availability of behavioral health services has been of particular concern following Hurricane Maria; a 2018 survey of health centers found that over 80 percent reported an increase in patients with depression, anxiety, and other mental health issues (Sharac et al. 2018). However, data to measure access or unmet need for these services are not available.

Concerns about Puerto Rico's declining physician workforce, a result of outmigration, predates Hurricane Maria. One report estimated that in 2014, 361 physicians moved out of Puerto Rico, and another found that in 2015, 500 physicians left (ASPE 2017). Reasons for outmigration among physicians include low salaries compared to the cost of living in Puerto Rico and salaries for similar positions on the mainland, as well as a lack of training opportunities. Anecdotal reports suggest that the trend is continuing, though there are no data for the period following the hurricane (Torres 2018, Perreira et al. 2017). Program administrators and others have struggled to adequately measure provider availability, in part because some providers leaving the island retain active licenses (ASES 2019g).

**Lack of LTSS.** Puerto Rico does not have an LTSS sector comparable to the mainland and, as noted above, LTSS are not covered as a Medicaid benefit. Few LTSS facilities exist in Puerto Rico (ASPE 2017). Though program administrators and other stakeholders have noted that the Medicaid population could be well served through home- and community-based services, such services are not covered due to lack of funds (ASES 2019g, MMAPA 2018).

**Low provider payments for key types of service.** Like other states, when faced with decisions about budget costs, Puerto Rico has often applied reductions to provider payment rates because other program costs (e.g., medical equipment or drugs) are relatively fixed (MMPHA 2018, Perreira et al. 2017). As a result, Medicaid physician fees are low in Puerto Rico compared to other states for certain services, including primary care and maternity services. For example, from July 2016 to July 2017 Medicaid physician fees were 19 percent of Medicare for primary care services and 50 percent of Medicare for maternity services, compared to the national average of 66 percent of Medicare for primary care and 81 percent of Medicare for obstetric care (ASES 2019d, Zuckerman et al. 2017).<sup>15</sup>

Specialists are better compensated. Certain specialties, such as cardiology, laboratory, and radiology, were paid at or above Medicare rates for the July 2016 to July 2017 period. Prior to the

BBA, Puerto Rico's fiscal board proposed caps on physician payment at 70 percent of the FY 2016 Medicare fee schedule (ASES 2019d, FOMB 2018). These reductions were temporarily relaxed in light of the BBA funding for FYs 2018 and 2019; instead, Puerto Rico adopted a nonbinding guideline of 70 to 80 percent of the 2018 Medicare fee schedule, depending on the specialty.<sup>16</sup> However, Puerto Rico and FOMB have noted that the proposed reductions could be reinstated in the absence of additional federal Medicaid funds in FY 2020 (ASES 2019g, FOMB 2018).

Puerto Rico has indicated that the delivery system cannot support further reductions in provider payment rates, and may not be sustainable at current provider rates (ASES 2019g). It has worked to stabilize the situation by increasing payment rates, but has been constrained by the federal oversight board's restrictions on additional spending and by availability of federal funds. It is seeking to increase investment in provider payment rates by \$170 million in FYs 2020 and 2021 by setting a payment floor of 70 to 80 percent of the Medicare fee schedule (AAFAF 2019b, ASES 2019g).

**Pressure to further reduce spending from the Financial Oversight Management Board.** In its fiscal plan certified in October 2018, the FOMB imposed mandatory spending reductions for the Medicaid program, starting with \$122 million for FY 2019, rising to \$827 million by FY 2023 (FOMB 2018). Most of these savings were to come from the new managed care system (see below); additional savings were assumed from Puerto Rico's improved ability to identify and address fraud, waste, and abuse, and adoption of new prescription drug cost controls. However, ASES, the government of Puerto Rico, and other stakeholders expressed concern that such changes would fail to achieve the required level of savings, necessitating dramatic reductions in benefits, coverage, or increases in cost sharing (ASES 2018, AAFAF 2019a).

Acknowledging these concerns, the board expressed willingness to revise targets to scale up to \$671 million by FY 2023 (AAFAF 2019a, FOMB 2019). Puerto Rico's proposed revisions to the



fiscal plan, submitted in March 2019, include the same \$122 million target for FY 2019, scaling up to a significantly lower target of \$272 million by 2023 (AAFAF 2019b). These targets are still being negotiated.

Although they disagree on the amount of savings that can be achieved, the government of Puerto Rico and the FOMB both anticipate that the majority of savings will come from the new managed care system, which implemented additional requirements for plans intended to improve efficiency and produce savings:

- substantial changes to the capitation rate structure, which created 37 different rate cells to reflect eligibility pathway, age, gender, and medical condition, replacing the previous structure that paid one rate for all beneficiaries (ASES 2019i, AAFAF 2018);
- new care coordination requirements for beneficiaries with medically complex conditions; and
- an increased medical loss ratio (MLR) requirement of 92 percent.<sup>17</sup>

If medical expenses comprise less than 92 percent of the premium, plans must pay back the difference between the actual MLR and the MLR requirement. The new MLR requirement is 7 percentage points higher than the federal minimum and higher than the average MLR in all but eight states in 2017 (Palmer et al. 2018).

## Medicaid Spending in Puerto Rico

Puerto Rico has used the additional funds provided by Congress in every year available. Although total Medicaid spending has grown in recent years, per person spending remains significantly lower than in states. At \$2,144 in FY 2020, per person spending is projected to be 68 percent lower than the median for the 50 states and the District of

Columbia. As Congress considers future funding needs, it is useful to consider spending by year and source of funds in the years since passage of the ACA, spending trends, and how spending would have been affected by alternative financing policies. The figures presented do not include Puerto Rico's spending on the commonwealth-only Medicaid population, which was \$306 million in FY 2018 and not matched with federal funds (ASES 2019h).

### Spending by year and source of funds

In all years from FY 2011 to FY 2018, federal spending for Medicaid in Puerto Rico exceeded the annual Section 1108 cap; spending in FY 2019 is also projected to exceed it (Figure 5-2). For FYs 2011–2017, this spending reflects use of the additional funds available under Sections 2005 and 1323 of the ACA, as well as a small amount of spending not subject to the cap (i.e., spending for EAP, electronic health record incentive program payments, and establishment and operation of eligibility systems and the MFCU).

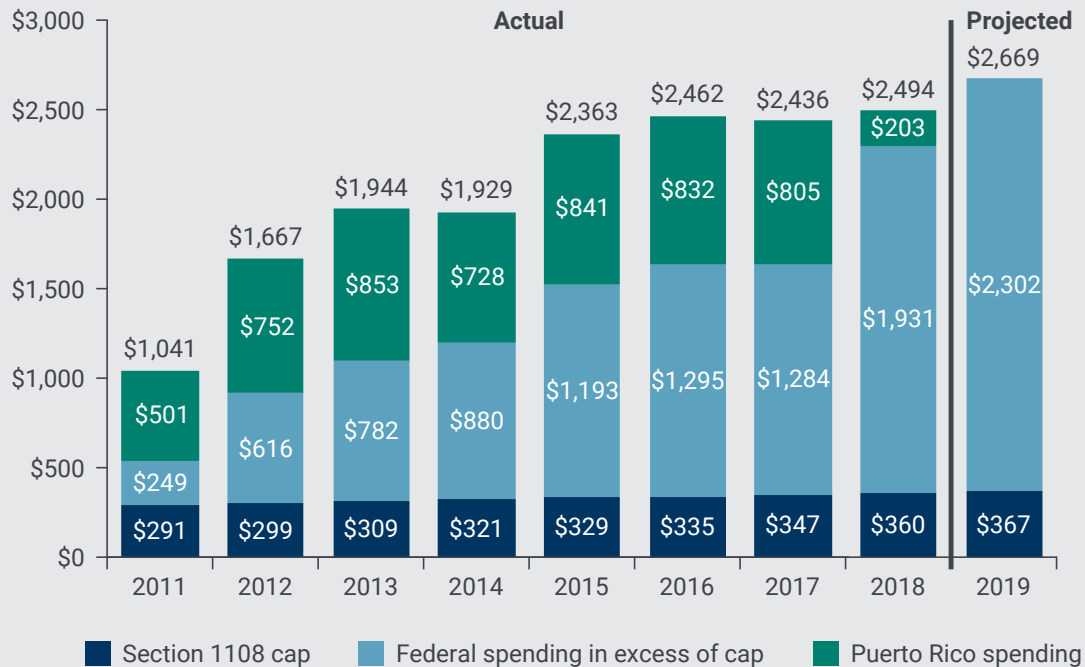
For FY 2018, Puerto Rico used funds available under the Section 1108 cap and a small amount of ACA Section 2005 funds. Because funds provided under the BBA are matched at 100 percent, Puerto Rico began using these funds as the sole federal Medicaid funding source when they became available in January 2018. The commonwealth plans to continue doing so through their expiration date at the end of FY 2019 (Figure 5-2).

### Spending trends

Total spending in Puerto Rico grew between FYs 2011 and 2018. The largest increases occurred between FYs 2011 and 2012 (the year in which additional federal funding became available under the ACA) and between 2014 and 2015 (when the commonwealth adopted a managed care overhaul).

Following Hurricanes Irma and Maria in fall 2017, which caused significant damage to the commonwealth's health care infrastructure and disrupted the provision of services, Medicaid

**FIGURE 5-2.** Medicaid Spending in Puerto Rico by Year and Source of Funds, FYs 2011–2019 (millions)



**Notes:** FY is fiscal year. The Section 1108 cap refers to the annual cap on federal funds that territories receive under Section 1108(g) of the Social Security Act, whereas additional federal spending reflects utilization of the allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), as well as spending not subject to the cap (including enhanced allotment plan (EAP) spending, which cannot be backed out for these years using available data). Spending data for FYs 2011–2018 is actual spending; spending data for FY 2019 is projected. Spending projections for FY 2019 assume a federal matching rate of 100 percent for all types of Medicaid spending. For FY 2019, Puerto Rico is using only Bipartisan Budget Act (P.L. 115-123) funds, though the Section 1108 allotment is shown for illustrative purposes.

**Sources:** MACPAC, 2019, analysis of ASES 2019h and CMS-64 financial management report net expenditure data; CMS 2017c, 2016.

claims and utilization decreased (ASES 2019e). However, total spending increased by 2.2 percent, as spending per FYE increased by 3.1 percent. Although the growth rate was higher than in the previous year for Puerto Rico, it was significantly slower than the national annual trend in Medicaid spending per FYE, estimated at 5.8 percent (OACT 2018). Additionally, although outmigration accelerated, its Medicaid enrollment did not decline substantially, in part because eligibility redeterminations were suspended for up to one year (ASES 2019f, g). Moreover, no data are available on the rates of outmigration among Medicaid enrollees

specifically. However, reductions in Medicaid enrollment are expected to lag overall outmigration trends (FOMB 2018).

Total spending is projected to grow by 7 percent between FYs 2018 and 2019; average premiums paid to plans will increase by 8 percent (ASES 2019h).<sup>18</sup> Enrollment is projected to decrease slightly; when redeterminations resumed in July 2018, enrollment began to decrease and continued to do so in six of the subsequent nine months. These decreases coincided with implementation of MAGI methodology for establishing income-based eligibility, which

has led to coverage losses (ASES 2019g, Pares Arroyo 2019). However, Puerto Rico is projecting relatively stable enrollment for the remainder of the fiscal year (ASES 2019a, h). In FY 2020, spending is projected to grow by 4.5 percent, rising to \$2.8 billion. The average increase in premium expenditures is projected at 5.3 percent, with an enrollment decline of less than 1 percent (ASES 2019h).

### Spending under alternative policies

Puerto Rico spends more of its own funds than it would were its FMAP determined by the same formula as used for states (i.e., 83 percent). Between FYs 2011 and 2017, the federal share of Puerto Rico's Medicaid expenditures ranged from 51.9 percent in 2011 to 66.4 percent in FY 2017 (Table 5-3).<sup>19</sup>

If Puerto Rico had received the statutory FMAP of 83 percent, its overall FMAP for the FY 2011–2017 period would have ranged from 82 to 84 percent. Assuming that Puerto Rico's total Medicaid benefit spending remained the same and that adequate federal Medicaid funds were available, federal Medicaid spending would have been \$2.9 billion higher than under current law (Table 5-3).

## Financing and Spending in FY 2020 and Beyond

Under current law, Puerto Rico is facing a federal funding shortfall in FYs 2020 and 2021. Below we examine possible financing scenarios for FY 2020, and show examples of benefit or enrollment reductions that would need to take place in the absence of additional federal funds. These analyses rely on spending and enrollment data and projections provided to MACPAC in January 2019. We also assume that CMS will permit Puerto Rico to access Section 1323 funds prior to its regular Section 1108 allotment in the first quarter of FY 2020, an assumption Puerto Rico has made in its projections; however, CMS has not yet confirmed that it will do so.<sup>20</sup> The analyses do not take into account the FOMB spending reduction targets because the final targets are still under discussion, and it is unclear how targets would change if Congress provided additional federal funds.

### FY 2020 financing scenarios

Going into FY 2020, Puerto Rico will have a Section 1108 allotment of approximately \$374 million, available for the full fiscal year. Puerto Rico will also have access to approximately \$586 million

**TABLE 5-3.** Federal Share of Puerto Rico's Medicaid Spending under the Alternative FMAP (millions)

Fiscal year	Total benefit spending	Federal spending		Federal share of spending		Difference in federal spending
		Current law	FMAP 83 percent	Current law	FMAP 83 percent	
2011	\$991.1	\$514.7	\$822.6	51.9%	83.0%	\$307.9
2012	1,613.8	888.0	1,339.4	55.0	83.0	451.4
2013	1,837.5	1,011.0	1,525.1	55.0	83.0	514.1
2014	1,841.7	1,139.1	1,509.2	61.9	81.9	370.1
2015	2,280.4	1,467.4	1,887.1	64.3	82.7	419.7
2016	2,393.9	1,587.5	2,008.4	66.3	83.9	420.9
2017	2,317.7	1,540.0	1,955.9	66.4	84.4	415.8
<b>2011-2017</b>						<b>2,899.8</b>

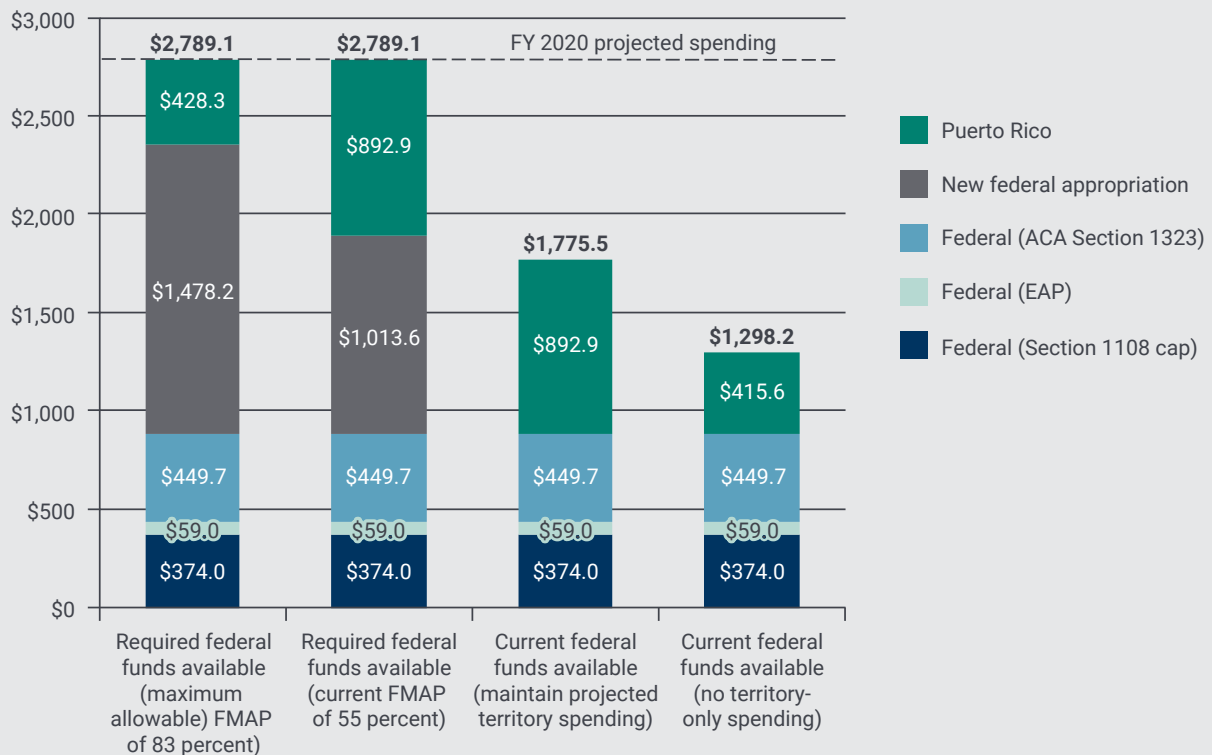
**Note:** FMAP is federal medical assistance percentage.

**Source:** MACPAC, 2019, analysis of CMS-64 financial management report net expenditure data.

in remaining ACA Section 1323 funds, available through December 2019.<sup>21</sup> Based on projected spending, Puerto Rico will face a federal funding shortfall of \$1.01 billion in FY 2020, exhausting available funds by sometime in March 2020 (Figure 5-3). If Section 1108 funds must be drawn down first, shortfall would increase by

approximately \$374 million, and the date of funding exhaustion would move up to December 31, 2019. In FY 2021, Puerto Rico will have only its Section 1108 allotment of approximately \$382 million available, resulting in a federal funding shortfall of \$1.54 billion (ASES 2019h).

**FIGURE 5-3.** Projected Medicaid Spending in Puerto Rico under Different Funding Scenarios by Source of Funds, FY 2020 (millions)



**Notes:** FY is fiscal year. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Section 1108 cap are the federal funds available under the annual ceiling on federal financial participation specified in Section 1108(g) of the Social Security Act (the Act). EAP is the Enhanced Allotment Plan, which can only be used to help pay for prescription drugs for low-income dually eligible beneficiaries (§ 1935(e) of the Act). ACA Section 1323 funds are additional federal funds provided under Section 1323 of the ACA, \$925 million of which was directed to Puerto Rico. ACA Section 1323 funds are only available through December 2019. Required federal funds available are scenarios in which Congress has appropriated enough federal funds to fully match all projected spending in FY 2020. Current federal funds available are scenarios that reflect the amount of federal funds currently available to Puerto Rico for FY 2020. These funds currently include the Section 1108 cap funding, the EAP, and ACA Section 1323 funds available through December 2019. The maintain projected territory spending scenario assumes that Puerto Rico would spend up to the projected \$892.9 million in territory spending even though not all of those funds would be matched with federal dollars. The no territory spending beyond matched funds scenario assumes that Puerto Rico would stop spending territory funds once all the available federal funds were exhausted.

**Sources:** MACPAC, 2019, analysis of ASES 2019h, i.

If no additional federal funds are available, Puerto Rico must either increase its own contribution to Medicaid to make up for the gap in federal funds, or reduce total spending by the same amount. In the period before ACA funds became available, Puerto Rico was able to use territory-only funds to make up for shortfalls in federal funding. However, raising the non-federal share has become more challenging than in the past due to a variety of factors, including diminished tax revenue caused by continued outmigration by working-age individuals, a damaged economy following Hurricane Maria, and loss of access to the capital market (Kobre and Kim 2018). Thus Puerto Rico will likely need to make substantial reductions in total spending, the size of which will depend on the commonwealth's own contribution. In FY 2020, if Puerto Rico maintains its expected contribution of \$892.9 billion in FY 2020, it would need to reduce spending by \$1.01 billion. If it only spends territory funds to the extent that these can be matched by federal funds, it would need to reduce total expenditures by a total of \$1.49 billion (Figure 5-3).

Congress could address this funding shortfall by providing Puerto Rico with additional federal Medicaid funds. It would have to make several choices about how these would be structured, including regarding the amount, matching rate, and time period available. For FY 2020, it would need to provide at least \$1.01 billion to allow Puerto Rico to access federal matching funds at the 55 percent FMAP available under current law. If Puerto Rico's FMAP were also raised to the maximum available level of 83 percent, the amount of federal funds needed would rise to \$1.48 billion (Figure 5-3).

## Effects of spending reductions in FY 2020 under different scenarios

If Congress does not appropriate more federal Medicaid funds, Puerto Rico will have to reduce spending by cutting benefits, enrollment, or both. It is unlikely that spending reductions of this size would be realizable in Puerto Rico without

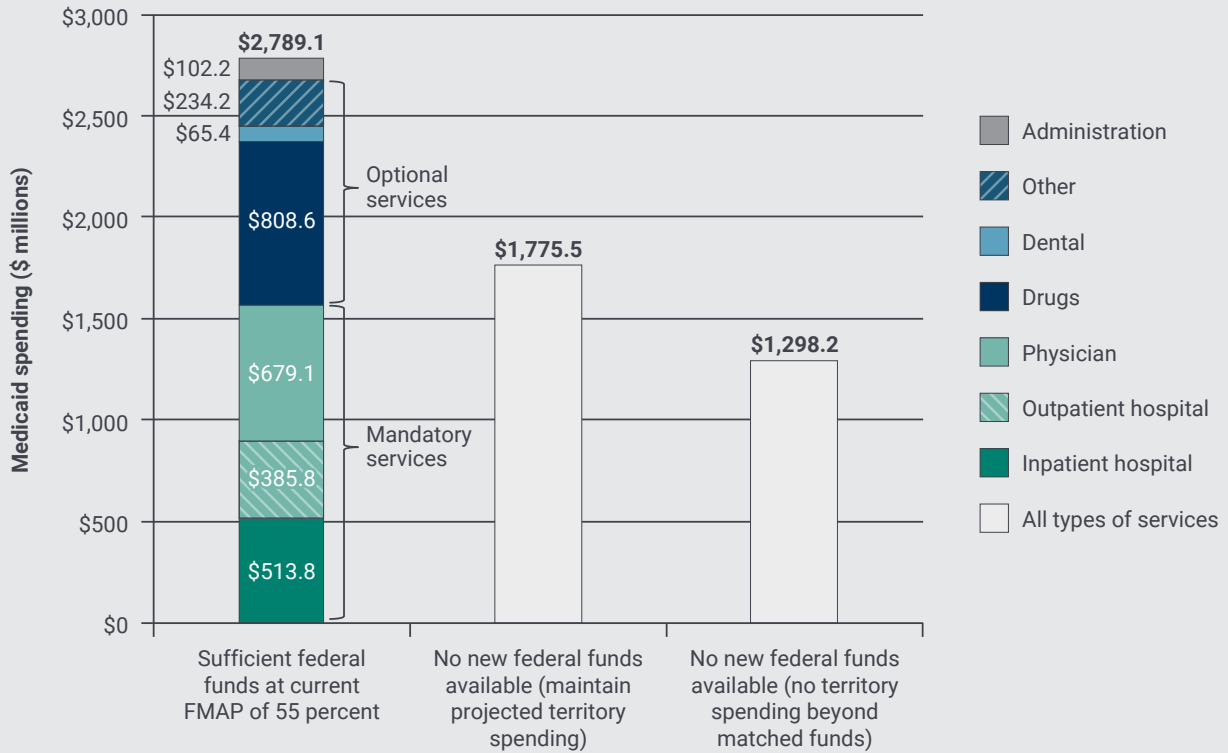
substantial rollbacks of both eligibility and benefits. For instance, because actions such as eliminating outpatient prescription drugs and dental benefits would likely increase spending on inpatient or outpatient hospital services, Puerto Rico would need to combine such a benefit reduction with enrollment reductions. The effects shown below are intended to illustrate the magnitude of spending reductions that would need to occur, but do not represent policies that program administrators are likely to adopt. Neither do these constitute recommendations by MACPAC.

**Benefits.** To achieve spending reductions without decreasing enrollment, Puerto Rico could eliminate optional benefits or reduce the amount, scope, or duration of mandatory benefits. Puerto Rico's largest benefit category in terms of spending is outpatient prescription drugs. Gross federal spending for drugs (i.e., before rebates) is projected at \$808.6 million for FY 2020, or 29 percent of spending for the fiscal year (Figure 5-4).<sup>22</sup> This is significantly higher than the national average, which is 13 percent (after excluding LTSS spending from the denominator). However, Puerto Rico's gross spending (i.e., before rebates) per FYE is more in line with other states: In FY 2017, it was about \$497 per FYE, which was 21 percent below the 25th percentile of the 50 states and the District of Columbia and 32 percent below the median (ASES 2019j, MACPAC 2018b). This suggests that the high share of Puerto Rico's spending attributable to drugs is due to low spending in other categories.

Eliminating the entire optional prescription drug and dental benefits would still not achieve the level of savings needed. If Puerto Rico chose to stop spending territory funds once all available federal funds were exhausted, it would need to find additional savings through further reductions in benefits or administrative expenses (Figure 5-4).

**Enrollment.** Puerto Rico could choose to achieve savings by covering fewer people instead of reducing or eliminating benefits. Assuming no reductions in benefits, no additional federal funds,

**FIGURE 5-4.** Projected Medicaid Spending in Puerto Rico under Different Funding Scenarios by Category of Service, FY 2020 (millions)



**Notes:** FY is fiscal year. FMAP is federal medical assistance percentage. Sufficient federal funds refers to a scenario in which Congress has appropriated enough federal funds to fully match all projected spending in FY 2020 at the 55 percent FMAP. No new federal funds available are scenarios that reflect the amount of federal funds currently available to Puerto Rico for FY 2020. The maintain projected territory spending scenario assumes that Puerto Rico would spend up to the projected \$892.9 million in territory spending even though not all of those funds would be matched with federal dollars. The no territory spending beyond matched funds scenario assumes that Puerto Rico would stop spending territory funds once all the available federal funds were exhausted.

**Sources:** MACPAC, 2019, analysis of ASES 2019h, i.

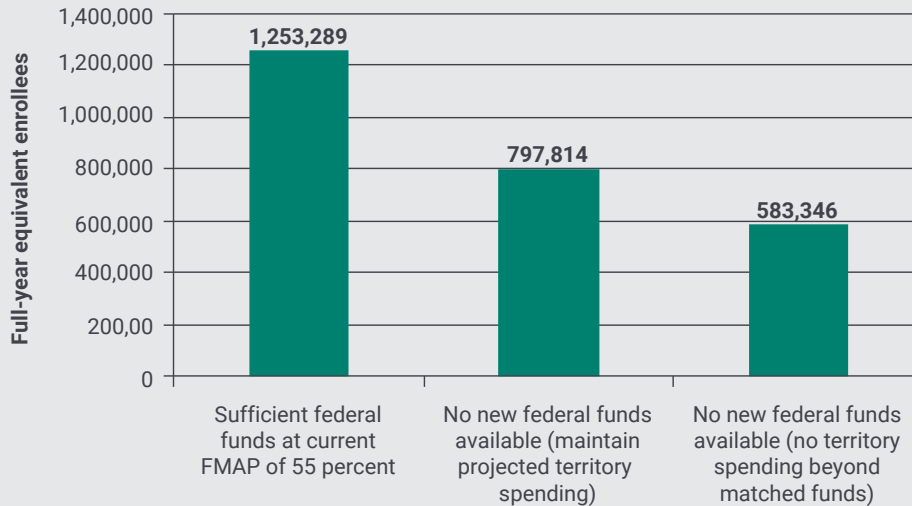
and the same territorial contribution, Puerto Rico would need to reduce enrollment by 455,475 beneficiaries (36 percent). If Puerto Rico stopped spending territory funds once all the available federal funds were exhausted, it would need to reduce enrollment by 669,943 beneficiaries (53 percent) (Figure 5-5).

### Timeline for federal funding exhaustion

Puerto Rico has relied on additional federal funding sources to supplement funds available under the

Section 1108 cap since they became available in FY 2011. Puerto Rico projects that available funding under the BBA will continue to be sufficient through FY 2019, but that it will experience a federal funding shortfall sometime in FY 2020. Annual funding under the FY 2020 Section 1108 allotment and remaining ACA Section 1323 funds are expected to last through at least December 2019, and as late as March 2020, depending on the order in which Puerto Rico is permitted to draw down these two funding sources. If CMS allows Puerto Rico to access ACA Section 1323 funds before its annual Section 1108

**FIGURE 5-5.** Projected Medicaid Full-Year Equivalent Enrollees in Puerto Rico under Different Funding Scenarios, FY 2020



**Notes:** FY is fiscal year. FMAP is federal medical assistance percentage. Sufficient federal funds is a scenario in which Congress has appropriated enough federal funds to fully match all projected spending in FY 2020 at the 55 percent FMAP. Spending assuming no new federal funds available are scenarios that reflect the amount of federal funds currently available to Puerto Rico for FY 2020. The maintain projected territory spending scenario assumes that Puerto Rico would spend up to the projected \$892.9 million in territory spending even though not all of those funds would be matched with federal dollars. The no territory spending beyond matched funds scenario assumes that Puerto Rico would stop spending territory funds once all the available federal funds were exhausted.

**Sources:** MACPAC, 2019, analysis of ASES 2019 h, i.

allotment, Puerto Rico will be able to use these prior to their expiration in December and then switch to Section 1108 funds in January until their exhaustion sometime in March. If CMS requires that Puerto Rico exhaust its Section 1108 allotment before accessing ACA Section 1323 funds, no federal Medicaid funds will be available beyond December 2019.<sup>23</sup> In FY 2021 (beginning October 1, 2020), Puerto Rico will have access to only its annual Section 1108 allotment of approximately \$382 million. It expects these funds to be sufficient only until sometime in December 2020 (ASES 2019h).

Although Puerto Rico may not exhaust all federal Medicaid funds until March 2020, its Medicaid program will be affected earlier. Specifically, both ASES and managed care plans report that the uncertainty around availability of funds affects their ability to negotiate adequate and efficient rates

for the contract year that begins in October 2019. They have also noted considerable uncertainty among providers about whether they would agree to continue to participate in the program if Puerto Rico cannot guarantee payment after a certain date (ASES 2018, MMAPA 2018).

## Looking Ahead

Congress has provided Puerto Rico with additional federal funding on multiple occasions, allowing Puerto Rico access to federal funds past its Section 1108 cap since 2011. It has taken additional steps such as extending enhanced matching rates for various populations (e.g., non-elderly, non-disabled adults) and administrative functions to Puerto Rico, and exempting certain types of spending from the cap (e.g., spending for establishment and operation

of the MFCU and MMIS). These measures have made it possible for Puerto Rico to strengthen its Medicaid program and enhance accountability and oversight capacity while also allowing it to expand Medicaid and continue providing services to covered populations.

However, the significant uncertainty about future availability of funds remains, as do financial pressures from within and outside the Medicaid program. These factors have significant implications for Puerto Rico's ability to operate its Medicaid program, which rests on the ability of program administrators to make and implement plans, the willingness of health plans and providers to participate, and the availability of health services for Puerto Rico's citizens. Uncertainty about the availability of funding past December 2020 threatens the progress the Medicaid program has made. It would almost certainly result in major benefit rollbacks, enrollment reductions, or both; worsen provider access for enrollees and services that remain covered; and reduce the commonwealth's administrative capacity.

An additional infusion of temporary funds would keep the Medicaid program afloat. In the long-term, reliable, sustainable access to care for the Medicaid population will likely require changes to the existing financing arrangement that provide a higher level of federal investment than what is currently available under the Section 1108 cap, and over a longer period of time than past interventions.

## Endnotes

<sup>1</sup> FOMB is made up of seven members chosen by the President of the United States from lists submitted by the Speaker and Minority Leader of the House of Representatives and the Majority and Minority Leaders of the Senate (§ 101(e) of PROMESA). The board's authorities to impose fiscal controls and force debt restructuring have been the subject of multiple lawsuits. In August 2018, a federal judge upheld the board's ability to enforce budgetary reforms but stated that the board cannot compel Puerto Rico to adopt, modify, or repeal laws that would allow for their

implementation (Valentin Ortiz 2018). Another case, brought by bondholders and credit holders over the constitutionality of the appointment process for board members and seeking dismissal of the commonwealth's bankruptcy cases, is ongoing (Valentin Ortiz and Pierog 2019).

<sup>2</sup> The board's certified fiscal plan includes major spending reductions that the board has conceded may not be realizable. It is in the process of working with the Office of the Governor of Puerto Rico to revise the specific spending targets (FOMB 2019).

<sup>3</sup> Provisions in Title I of the ACA, including reforms to the group and individual markets and small business and premium tax credits, do not apply to Puerto Rico. Puerto Rico chose not to establish its own health insurance exchange, and residents of Puerto Rico are not eligible to purchase health insurance through the federal exchange (CMS 2014c).

<sup>4</sup> Most of these enrollees are eligible based on their income, but approximately 10,000 of them are police officers receiving coverage through the government health plan (GHP). Although other public employees and pensioners may buy into GHP, only a small number choose to do so (ASES 2019a).

<sup>5</sup> Puerto Rico received an exception from the recovery audit contractor program in 2010, but since then has voluntarily established one (Melendez 2011, ASES2019e).

<sup>6</sup> Puerto Rico is statutorily exempt from requirements to extend poverty-related eligibility to children, pregnant women, (§ 1902(l)(4)(B) of the Act) (though these individuals are covered through the primary eligibility pathways for Medicaid and CHIP) and qualified Medicare beneficiaries (§ 1905(p)(4)(A) of the Act).

<sup>7</sup> Puerto Rico is the only territory currently authorized to use its CHIP allotment to cover children from families whose incomes are too high to qualify for Medicaid; the other territories use CHIP funds to cover children in Medicaid (HHS 2013).

<sup>8</sup> Under the medically needy option, individuals with higher incomes can spend down to the medically needy income level by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes.

<sup>9</sup> Puerto Rico does not currently provide coverage for hepatitis C medications except for patients with HIV (ASES 2019e).



<sup>10</sup> ASES also directly contracts with and regulates Medicare Platino plans (i.e., Medicare Advantage plans) (ASPE 2017).

<sup>11</sup> In 2014, CMS calculated a predicted FMAP of 91 percent based on Puerto Rico's per capita income; however, the federal FMAP limit is 83 percent (§ 1905(b) of the Act, GAO 2014).

<sup>12</sup> Puerto Rico does not receive a Medicaid disproportionate share hospital allotment (GAO 2014).

<sup>13</sup> With the funds from ACA Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. Neither Puerto Rico nor the other territories chose to establish an exchange.

<sup>14</sup> Puerto Rico hospitals can receive Medicare DSH payments, which are different from Medicaid DSH payments and are made under a different formula. Medicare DSH payments are made based on a hospital's Medicare and SSI patient days, but because Puerto Rico residents are ineligible for SSI, hospitals in Puerto Rico are disadvantaged relative to hospitals in the 50 states and District of Columbia (ASPE 2017).

<sup>15</sup> Although Puerto Rico's Medicare fee schedule is generally in line with, and in some cases slightly higher than, the national average, many have noted that rates should be higher, citing the high costs of practicing medicine in Puerto Rico and disadvantaged treatment under the Medicare geographic practice cost index (GPCI) formula (Perreira et al. 2017, Pierluisi 2015). Critics of the way that the GPCI has been applied for Puerto Rico note that it has not properly considered factors affecting the cost of practicing medicine in Puerto Rico. Specifically, they note that the high cost of utilities has not been factored in; that the national average cost of medical supplies is inadequate for Puerto Rico given the cost of shipping supplies to the island; and that the formula's reliance on residential rent data is inappropriate for Puerto Rico, which has a limited residential rental market (Pierluisi 2015). CMS acknowledged these issues and aligned Puerto Rico's GPCI values with the national average beginning in calendar year (CY) 2017, increasing the Medicare physician fee schedule. At the time of this change, GPCIs for the U.S. Virgin Islands were already aligned with the national average, and those for the three Pacific territories were already aligned with Hawaii (CMS 2016a).

<sup>16</sup> The change from the 2016 to the 2018 Medicare fee schedule is particularly notable because it captures

changes made to the Medicare GPCI formula effective in CY 2017, which were intended to increase Medicare physician payments in Puerto Rico.

<sup>17</sup> The MLR requirement was 91.4 percent in FY 2018 and 90 percent in FY 2017 and 2016 (FOMB 2018).

<sup>18</sup> Spending projections for FY 2019 can vary based on the source of data and timing of when the projection was made. For example, Puerto Rico projected total spending of \$2.4 billion on its February 2019 CMS 37 budget report submission, and \$2.8 billion on its November 2018 CMS 37 budget report submission. To maintain consistency with the other projections of spending presented in this report, the \$2.67 billion figure we show for FY 2019 is a projection based on detailed enrollment and spending data provided to MACPAC by ASES in January 2019.

<sup>19</sup> Although Puerto Rico's statutory FMAP under current law is 55 percent, it was 50 percent prior to July 1, 2011 (§ 2005(c)(2) of the ACA). Additionally, beginning in CY 2014, Puerto Rico was eligible for the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which was 78.6 percent in CY 2014 and has risen to 93 percent in calendar year 2019 (§ 1905(z)(2) of the Act). The enhanced matching rate for this population has caused the overall federal share of spending to increase.

<sup>20</sup> Current CMS policy is that Puerto Rico should draw down BBA funds first, Section 1108 allotments second, ACA Section 2005 funds third, and ACA Section 1323 funds last (CMS 2019a). Puerto Rico has requested that CMS allow it to use Section 1323 to cover spending in the first quarter of FY 2020 (prior to these funds' December 31, 2019 expiration) before switching to Section 1108 funds in January 2020. If CMS does not allow this, shortfall would increase by \$374 million, and the date of the shortfall would move up to December 31, 2019.

<sup>21</sup> Puerto Rico expects to be able to use \$449.65 million of this prior to the expiration date, leaving \$136.7 million unspent (ASES 2019h).

<sup>22</sup> While Puerto Rico does not currently participate in the Medicaid Drug Rebate Program (MDRP), it has territory-specific rebates and purchasing arrangements with manufacturers. The Medicaid covered outpatient drug rule

in February 2016 changed the definition of states to include the territories, which would extend the rebates and coverage requirements of the MDRP to the territories beginning on April 1, 2017. Subsequently, the U.S. Department of Health and Human Services (HHS) issued an interim final rule on November 15, 2016 that delays the inclusion of the territories in the MDRP until April 1, 2020 (81 FR 80003). HHS has stated that the territories may waive out of the MDRP. Puerto Rico is evaluating whether or not it would benefit from joining the rebate program (ASES 2018).

<sup>23</sup> Current CMS policy is that Puerto Rico should draw down BBA funds first, Section 1108 allotments second, ACA Section 2005 funds third, and ACA Section 1323 funds last. Puerto Rico has requested that CMS allow it to use ACA Section 1323 funds first in FY 2020, but CMS has not yet confirmed that it will do so (CMS 2019a).

<sup>24</sup> MACPAC, 2019, analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report net expenditure data as of June 2016.

<sup>25</sup> MACPAC, 2019, analysis of CMS-64 Financial Management Report net expenditure data as of July, 20, 2018, and CMS-64 enrollment reports as of September 19, 2018.

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## APPENDIX 5A: Methodology

MACPAC used data from several sources to calculate Puerto Rico's projected Medicaid spending and compare its spending per full-year equivalent (FYE) to other states. Below we describe the data sources and adjustments used in this analysis.

For Puerto Rico spending, we used actuarial and financial data provided by the Puerto Rico Health Insurance Administration (ASES). These data included current enrollment and capitation rates by rate cell and population group for July 2017 through October 2018. Information related to capitation rates included information on the proportion of the rate attributable to major types of services such as inpatient hospital, outpatient hospital, physician services, and drugs. ASES also provided projections of enrollment and spending by population group for November 2018 through September 2021. For spending, the data included premium spending (i.e., capitation spending), non-premium benefit spending is paid outside of the capitation rate, and administrative spending. For rate cells that may include Medicaid populations with CHIP or other state-only groups (e.g., foster children), we allocated spending to Medicaid based on the proportion of Medicaid enrollees in that rate cell. For non-premium benefits paid outside of the capitation rate, we allocated spending based on the proportion of total Medicaid enrollment. After these allocations, we calculated overall Medicaid spending per FYE in FY 2020. We estimated the split between federal and commonwealth spending using the federal medical assistance percentage (FMAP) applicable to each rate cell and month. While Puerto Rico receives the statutory FMAP of 55 percent for most populations, it receives the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) which is 93 percent in calendar year (CY) 2019 and 90 percent in CY 2020. Based on the projected share of enrollment and spending for adults without dependent children, we calculated Puerto Rico's average federal share to be approximately 68 percent.

To calculate benefit spending per FYE in the 50 states and the District of Columbia, we used FY 2013 Medicaid Statistical Information System (MSIS) data as of December 2016 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2016. FY 2013 MSIS data are the most recent data available that include enrollment and spending by eligibility group for the majority of the states. The MSIS data are adjusted to match total benefit spending reported by states in the CMS-64 data (MACPAC 2018a).<sup>24</sup> Because Puerto Rico does not provide long-term services and supports (LTSS), LTSS spending was excluded from the FY 2013 data. The FY 2013 non-LTSS spending per FYE in each state was trended forward to FY 2020 using projected trends for each eligibility group from the CMS Office of the Actuary (OACT) 2017 Actuarial Report on the Financial Outlook for Medicaid.

Because the MSIS data are from FY 2013 and do not yet include information on the new adult group, we used FY 2017 CMS-64 FMR net expenditure data as of July 20, 2018 and CMS-64 enrollment reports as of September 19, 2018 to calculate spending per FYE for the new adult group.<sup>25</sup> LTSS spending was removed from these data. The FY 2017 non-LTSS spending per FYE for the new adult group was trended forward to FY 2020 using OACT's projected growth rates for this group.

To adjust for differences in enrollment mix between Puerto Rico and the states, each state's enrollment was reweighted to match the enrollment mix in Puerto Rico. Using FY 2017 total Medicaid enrollment from the CMS-64 enrollment report, we distributed enrollment to children, adults, disabled, aged, and newly eligible adults based on the proportion of enrollment in Puerto Rico. For non-expansion states, we used Puerto Rico's distribution of enrollment excluding the new adult group to allocate enrollment to the child, adult, disabled, and aged eligibility groups. The FY 2020 spending per FYE estimates for each eligibility group were then multiplied by the FY 2017 enrollment estimates for each group to calculate an overall spending per FYE for each state that matched the enrollment mix of Puerto Rico.





# Appendix

## Authorizing Language from the Social Security Act (42 USC 1396)

### Medicaid and CHIP Payment and Access Commission

- (a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as “MACPAC”).
- (b) DUTIES.—
- (1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—
- (A) review policies of the Medicaid program established under this title (in this section referred to as “Medicaid”) and the State Children’s Health Insurance Program established under title XXI (in this section referred to as “CHIP”) affecting access to covered items and services, including topics described in paragraph (2);
  - (B) make recommendations to Congress, the Secretary, and States concerning such access policies;
  - (C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and
  - (D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.
- (2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:
- (A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—
    - (i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;
    - (ii) payment methodologies; and
    - (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).
  - (B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

- (C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.
  - (D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.
  - (E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.
  - (F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.
  - (G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.
  - (H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.
- (3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—
- (A) review national and State-specific Medicaid and CHIP data; and
  - (B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.
- (4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.
- (5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—
- (A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary’s report to Congress, shall submit to the appropriate committees of

Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

- (B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.
- (6) AGENDA AND ADDITIONAL REVIEWS.—
- (A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC’s agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.
  - (B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—
    - (i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).
    - (ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:
      - (I) Data relating to changes in the number of uninsured individuals.
      - (II) Data relating to the amount and sources of hospitals’ uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.
      - (III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services.
      - (IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.
    - (iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.
    - (iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

- (7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.
- (8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term “appropriate committees of Congress” means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.
- (9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.
- (10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.
- (11) CONSULTATION AND COORDINATION WITH MEDPAC.—
- (A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as “MedPAC”) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.
- (B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.
- (12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.
- (13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.
- (14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC’s authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP.
- (c) MEMBERSHIP.—
- (1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.
- (2) QUALIFICATIONS.—

- (A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.
  - (B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.
  - (C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.
  - (D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).
- (3) TERMS.—
- (A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.
  - (B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.
- (4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member’s regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.
- (5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a

member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

- (1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);
- (2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;
- (3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));
- (4) make advance, progress, and other payments which relate to the work of MACPAC;
- (5) provide transportation and subsistence for persons serving without compensation; and
- (6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

- (1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.
- (2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—
  - (A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;
  - (B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and
  - (C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

- (3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.
  - (4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.
- (f) FUNDING.—
- (1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.
  - (2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.
  - (3) FUNDING FOR FISCAL YEAR 2010.—
    - (A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$9,000,000.
    - (B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, \$2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.
  - (4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.



## Biographies of Commissioners

**Melanie Bella, MBA (Chair)**, is head of partnerships and policy at Cityblock Health, which facilitates health care delivery for low-income urban populations, particularly Medicaid beneficiaries and those dually eligible for Medicaid and Medicare. Previously, she served as the founding director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS), where she designed and launched payment and delivery system demonstrations to improve quality and reduce costs. Ms. Bella also was the director of the Indiana Medicaid Program, where she oversaw Medicaid, the State Children's Health Insurance Program (CHIP), and the state's long-term care insurance program. Ms. Bella received her master of business administration from Harvard University.

**Charles Milligan, JD, MPH (Vice Chair)**, is the national dual eligible special needs plans executive director for UnitedHealthcare Community & State. Previously, he was chief executive officer (CEO) of UnitedHealthcare's Community Plan in New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories. Mr. Milligan is a former state Medicaid and CHIP director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland at Baltimore County, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley, and his law degree from Harvard Law School.

**Thomas Barker, JD**, is a partner at Foley Hoag, LLP, where he specializes in Medicaid and Medicare regulatory, coverage, and reimbursement issues and is a member of the executive committee. He also has a pro bono law practice focusing on health care issues facing immigrants. Previously, he held numerous positions within the U.S. Department of Health and Human Services (HHS), including acting general counsel, counselor to the Secretary of HHS,

chief legal officer for CMS, and senior health policy counselor to the administrator of CMS. Mr. Barker received his law degree from Suffolk University School of Law.

**Tricia Brooks, MBA**, is an associate research professor at the McCourt School of Public Policy at Georgetown University and a senior fellow at the Georgetown University Center for Children and Families (CCF), an independent, non-partisan policy and research center whose mission is to expand and improve health coverage for children and families. At CCF, Ms. Brooks focuses on issues relating to the policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Prior to joining CCF, she served as the founding CEO of New Hampshire Healthy Kids, a legislatively created non-profit corporation that administered CHIP in the state and served as the Medicaid and CHIP consumer assistance hub. Ms. Brooks holds a master of business administration from Suffolk University.

**Brian Burwell** recently left Watson Health, where he was a senior executive in the government health and human services unit, to join Ventech Solutions, where he will serve as vice president, healthcare policy. Mr. Burwell conducts research and provides consulting services, policy analysis, technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. He received his bachelor of arts degree from Dartmouth College.

**Martha Carter, DHSc, MBA, APRN, CNM**, is the founder and former CEO of FamilyCare Health Centers, a community health center that serves four counties in south-central West Virginia. Dr. Carter practiced as a certified nurse-midwife in Kentucky, Ohio, and West Virginia for 20 years. She is a member of the West Virginia Alliance for Creative Health Solutions, a practice-led research and advocacy network, and she serves as the chair of the Quality Leadership Committee of the West Virginia Primary Care Association. Dr. Carter was a Robert Wood Johnson Foundation Executive Nurse

Fellow in 2005–2008 and received the Robert Wood Johnson Foundation Community Health Leader award in 1999. She holds a doctorate of health sciences from A.T. Still University in Mesa, Arizona, and a master of business administration from West Virginia University in Morgantown, West Virginia.

**Frederick Cerise, MD, MPH**, is president and CEO of Parkland Health and Hospital System, a large public safety-net health system in Dallas, Texas. Previously, he oversaw Medicaid and other programs for the state of Louisiana as secretary of the Department of Health and Hospitals. Dr. Cerise also held the position of medical director and other leadership roles at various health care facilities operated by Louisiana State University. He began his career as an internal medicine physician and spent 13 years treating patients and teaching medical students in Louisiana's public hospital system. Dr. Cerise received his degree in medicine from Louisiana State University and his master of public health from Harvard University.

**Kisha Davis, MD, MPH**, is a family physician at CHI Health Care in Rockville, Maryland, as well as Maryland medical director for VaxCare Corporation. Previously, Dr. Davis was program manager at CFAR in Philadelphia, Pennsylvania, where she supported projects for family physicians focused on payment reform and practice transformation to promote health system change. Dr. Davis has also served as the medical director and director of community health at CHI and as a family physician at a federally qualified health center (FQHC) in Maryland. As a White House Fellow at the U.S. Department of Agriculture, she established relationships among leaders of FQHCs and the Women, Infants, and Children nutrition program. Dr. Davis received her degree in medicine from the University of Connecticut and her master of public health from Johns Hopkins University.

**Toby Douglas, MPP, MPH**, is senior vice president, national Medicaid, at Kaiser Permanente. Previously, Mr. Douglas was senior vice president for Medicaid solutions at Centene Corporation, and prior to that, a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He

served as director of the California Department of Health Care Services and was director of California Medicaid for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a CHIP director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

**Leanna George** is the parent of a teenager with a disability who is covered under Medicaid and a child covered under CHIP. A resident of Benson, North Carolina, Ms. George is the chair of the North Carolina Council on Educational Services for Exceptional Children, a special education advisory council for the North Carolina State Board of Education. She also serves as the secretary of the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

**Darin Gordon** is president and CEO of Gordon & Associates in Nashville, Tennessee, where he provides health care-related consulting services to a wide range of public- and private-sector clients. Previously, he was director of Medicaid and CHIP in Tennessee for 10 years, where he oversaw various program improvements, including the implementation of a statewide value-based purchasing program. During this time, he served as president and vice president of the National Association of Medicaid Directors for a total of four years. Before becoming director of Medicaid and CHIP, he was the chief financial officer and director of managed care programs for Tennessee's Medicaid program. Mr. Gordon received his bachelor of science degree from Middle Tennessee State University.

**Christopher Gorton, MD, MHSA**, was formerly president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire, as well as CEO of a regional health plan that was acquired by the Inova

Health System of Falls Church, Virginia. Other positions held include vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver Spring, Maryland. After beginning his career as a practicing pediatrician in FQHCs in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

**Stacey Lampkin, FSA, MAAA, MPA**, is an actuary and principal with Mercer Government Human Services Consulting, where she has led actuarial work for several state Medicaid programs. She previously served as an actuary and assistant deputy secretary for Medicaid finance and analytics at Florida's Agency for Health Care Administration and as an actuary at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's uninsured work group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow of the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

**Sheldon Retchin, MD, MSPH**, is professor of medicine and public health at The Ohio State University in Columbus, Ohio. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2015 until 2017, he was executive vice president for health sciences and CEO of the Wexner Medical Center. From 2003 until 2015, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization, Virginia Premier, with approximately

200,000 covered lives. Dr. Retchin received his medical and public health degrees from The University of North Carolina at Chapel Hill, where he was also a Robert Wood Johnson Clinical Scholar.

**William Scanlon, PhD**, is a consultant for the West Health Institute. He began conducting health services research on the Medicaid and Medicare programs in 1975, with a focus on such issues as the provision and financing of long-term care services and provider payment policies. He previously held positions at Georgetown University and the Urban Institute, was managing director of health care issues at the U.S. Government Accountability Office, and served on the Medicare Payment Advisory Commission. Dr. Scanlon received his doctorate in economics from the University of Wisconsin, Madison.

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## Biographies of Staff

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**James Boissonault, MA**, is the chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

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**Moira Forbes, MBA**, is a policy director focusing on payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and the State Children's Health Insurance Program (CHIP). Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. At Lewin, Ms. Forbes worked with every state on issues relating to program integrity and eligibility quality control in Medicaid and CHIP. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

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