

ONE HUNDRED FOURTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
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WASHINGTON, DC 20515-6115

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**MEMORANDUM**

**November 01, 2015**

**To: Subcommittee on Health Democratic Members and Staff**  
**Fr: Committee on Energy and Commerce Democratic Staff**  
**Re: Hearing on “Examining Legislation to Improve Medicare and Medicaid”**

On Tuesday, November 3<sup>rd</sup>, at 10:15 A.M, in Room 2322 of the Rayburn House Office Building, the subcommittee will hold a hearing entitled, “Examining Legislation to Improve Medicare and Medicaid.” This hearing will examine one bill amending Part B of the Medicare program, and four bills that amend various parts of the Medicaid program.

**I. LEGISLATION**

**A. H.R. \_\_\_\_\_, Quality Care for Moms and Babies Act**

The discussion draft under consideration by the subcommittee, offered by Rep. Engel (D-NY) and Rep. Stivers (R-OH), would build on the Pediatric Quality Measures Program by authorizing \$31 million for the Department of Health and Human Services (HHS) to identify and publish quality measures for maternal and infant health, and to award grants to develop or expand collaborative activities related to maternity and infant care quality.

Established through the Children’s Health Insurance Reauthorization Act of 2009<sup>1</sup>, the purpose of the Pediatric Quality Measures Program is to improve, strengthen and expand on pediatric quality measures. The Pediatric Quality Measures Program is the only program that targets quality performance measurement reporting in Medicaid and CHIP, but notably, it does

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<sup>1</sup> The Children’s Health Insurance Reauthorization Act (Pub. L. 111-3), which added Section 1139A(a) to the Social Security Act, which requires the development of a Pediatric Quality Measures Program (PQMP).

not include a maternal and infant quality core set. This legislation would provide a much-needed focus on maternity care quality and health outcomes for mothers and infants in the Medicaid program.

**B. Amendment to H.R. 1361, the Medicaid HOME Improvement Act**

H.R. 1361, the Medicaid HOME Improvement Act, introduced by Rep. Brett Guthrie (R-KY) would restrict state flexibility to determine the maximum level of home equity allowed for purposes of receiving Medicaid coverage for long-term care services and supports.

The financial eligibility criteria for Medicaid long-term care eligibility are based on an individuals' assets—income and resources together. The Medicaid statute requires states to use specific income and resource standards in determining eligibility. The Deficit Reduction Act of 2005 enacted new rules excluding individuals with an equity interest in his or her home. Specifically, through 2010, federal law limited eligibility for Medicaid LTSS if the applicant's equity interest in the home was greater than \$500,000. At a state's option, this threshold could be as high as \$750,000. Starting in 2011, these thresholds increased each year based on the percentage increase in the consumer price index for all urban consumers (CPI-U), rounded to the nearest \$1,000. Thus, for 2015, the home equity limit is currently set to \$552,000, with a state option to allow for home equity of up to \$828,000.<sup>2</sup>

The proposed legislation would eliminate the state option to consider applicants with home equity above \$552,000 (when adjusted for inflation).

**C. Amendment to H.R. 1362, Medicaid REPORTS Act**

H.R. 1362, the Medicaid REPORTS Act, introduced by Rep. Brett Guthrie (R-KY), would require states to submit an annual report on the amount and sources of funds used to finance the nonfederal share of Medicaid.

Funding for the nonfederal, or state share of Medicaid comes from a variety of sources: at least 40 percent must be financed by the state and up to 60 percent may come from local governments.<sup>3</sup> Each state makes its own decisions, within federal requirements, regarding how to finance its share of the Medicaid program. In state fiscal year 2012, 69 percent of funds came from state general revenues, 16 percent from local governments (including intergovernmental transfers and certified public expenditures), 10 percent from health care related taxes, and 5

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<sup>2</sup> 2015 SSI and Spousal Impoverishment Standards. (online at <http://medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-ssi-and-spousal-impoverishment-standards.pdf>).

<sup>3</sup> §1902(a)(2) of the Social Security Act.

percent from other sources.<sup>4</sup> The extent to which states rely on funding sources other than general revenue varies considerably and may be influenced by states' traditional sources of general revenue and approaches to financing health care for low-income individuals. The types of financial transfers used, particularly by local public sources, has been the focus of increased federal scrutiny. Fundamentally, however, Medicaid enrollment increases and state revenues decrease during economic downturns. These developments, coupled with short state budget periods often puts enhanced pressure on states to find increasingly complicated methods to finance their share of the Medicaid program in these challenging contexts and circumstances.<sup>5</sup>

**D. H.R. 2151, Improving Oversight and Accountability in Medicaid Non-DSH Supplemental Payments Act**

H.R. 2151, introduced by Rep. Collins (R-NY), would require CMS to issue guidance to states that would identify permissible methods for calculation of non-DSH supplemental payments. The bill would also establish annual reporting requirements for states making non-DSH supplemental payments by provider and category of service, and would require states to conduct and submit to CMS an annual independent audit.

Medicaid payment policies are developed by each state, with federal review limited to the general principles set forth in Section 1902(a)(30)(A) of the Social Security Act. This provision requires that provider payments “be consistent with efficiency, economy, quality, and access and safeguard against unnecessary utilization.” Thus, payment rates to providers are set by states, with significant variation in payment policy and methods, and reflecting individual state policy decisions, geographic differences in costs, and practice patterns.<sup>6</sup>

Generally, in fee-for-service Medicaid, a state's base payment rate to providers may be supplemented by (depending on provider type), Medicaid Disproportionate Share Hospital (DSH) payments and/or Upper Payment Limit (UPL) supplemental payments. DSH payments to hospitals are intended to supplement payment rates for serving low-income populations. UPL Supplemental payments, the subject of the legislation under consideration, comprise the difference between Medicaid payments for services and the maximum payment level allowed under the UPL for those services to which such rules apply.

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<sup>4</sup> Government Accountability Office (GAO), *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* (July 29, 2014) (online at <http://www.gao.gov/products/GAO-14-627>).

<sup>5</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), *Non-federal Financing* (online at <https://www.macpac.gov/subtopic/non-federal-financing/>).

<sup>6</sup> MACPAC, *MACFacts, Key Findings on Medicaid and CHIP: Medicaid UPL Supplemental Payments* (November 2012) (online at [https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-UPL-Payments\\_2012-11.pdf](https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-UPL-Payments_2012-11.pdf)).

In general, so long as a state operates its Medicaid program within federal requirements, it is entitled to receive federal matching funds toward allowable Medicaid expenditures. Historically, Upper Payment Limits were enacted as the Medicaid program's payment policies became increasingly de-linked from the Medicare program. Essentially, federal regulations prohibit federal matching funds for Medicaid fee-for-service payments in excess of what would have been paid under Medicare payment principles for certain types of providers. However, UPL's are not set or reported to the federal government on a claim-by-claim basis, but rather limit the aggregate amount of Medicaid payments that a state can make to a class of providers. As a result, states may make—and receive federal matching dollars for—payments that are not necessarily tied to the number of services provided by any institution, so long as total Medicaid payments do not exceed the UPL for the specific group of institutions. Therefore, in practice, UPL supplemental payment rules simply ensure that Medicaid does not pay a class of providers in the aggregate more than Medicare would have paid for the same or comparable services delivered by those same institutions. Further, because UPLs are tied to the services rendered by entire classes of providers, rather than by individual providers, states have discretion in allocating these supplemental payments among individual institutions within the class.<sup>7</sup>

Medicaid base payment rates are low, thus Medicaid DSH and Supplemental lump sum payments are an incredibly important source of revenue for hospitals and other eligible providers that serve a significant portion of Medicaid enrollees and uninsured individuals. However, because these payments are not necessarily associated with specific services or enrollees and are not reported to CMS at the individual provider level, it is difficult for state and federal policymakers to compare total Medicaid payments across individual providers and enrollment groups and ensure that payment levels overall are sufficient to providers to ensure access to services for Medicaid beneficiaries, in compliance with federal statute.

**E. H.R. 2878, to provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2015**

H.R. 2878, introduced by Rep. Jenkins (R-KS) and Rep. Loebsack (D-IA), would extend through calendar year 2015, the instruction to not enforce Medicare's direct supervision requirements for outpatient therapeutic services furnished at critical access hospitals and small rural hospitals. The Senate companion to this legislation, S. 1461, was approved by the Senate Finance Committee on June 24, 2015.

In the 2009 outpatient prospective payment system (OPPS) final rule, CMS clarified existing policy for physician supervision of outpatient therapeutic services as a condition of

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<sup>7</sup> MACPAC, *Medicaid UPL Supplemental Payments* (November 2012) (online at <https://www.macpac.gov/publication/mac-facts-medicaid-upl-supplemental-payments/>).

payment which has been in place since 2001.<sup>8</sup> CMS policy requires direct supervision by an appropriate physician or non-physician practitioner in the provision of all therapeutic services to hospital outpatients. “Direct supervision” means the physician or other practitioner has to be immediately available while the service is being provided. This does not necessarily mean a supervising professional must be within the four walls of the facility, but rather that the professional must be “immediately available to furnish assistance and direction throughout the performance of the procedure.”

Concerns over supervision requirements have been raised that mandated direct supervision may result in a decrease in available healthcare providers in critical access hospitals (CAHs), thus limiting patient access to care.<sup>9</sup> As a result of these concerns, CMS delayed the enforcement of the supervision requirements in a non-enforcement instruction on March 15, 2010, for critical access hospitals and small rural providers. This policy was extended by the 113<sup>th</sup> Congress through calendar year 2014.<sup>10</sup>

## **II. WITNESSES**

Panel 1:

**The Honorable Lynn Jenkins (KS-2)**  
Member of Congress

Panel 2:

**Katherine Iritani**  
Director, Health Care  
Government Accountability Office

**Anne Schwartz, PhD**  
Executive Director  
Medicaid and CHIP Payment and Access Commission

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<sup>8</sup> Federal Register, *Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates*, Vol. 74, No. 223. Friday Nov 20, 2009. (online at <http://edocket.access.gpo.gov/2009/pdf/E9-26499.pdf>).

<sup>9</sup> American Hospital Association, *Supervision of Hospital Outpatient Therapeutic Services: Fact Sheet* (2015) (online at <http://www.aha.org/content/13/fs-supervisionHOTservices.pdf>).

<sup>10</sup> Public Law 113-198. (online at <https://www.congress.gov/113/plaws/publ198/PLAW-113publ198.pdf>).