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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE

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MEMORANDUM

February 8, 2016

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Subcommittee Hearing on "Examining Medicaid and CHIP's Federal Medical Assistance"

On **Wednesday, February 10th, at 10:00 a.m., in Room 2123 of the Rayburn House Office Building**, the Subcommittee will hold a hearing examining the federal share of the Medicaid program's financing formula, known broadly as the Federal Medical Assistance Percentage (FMAP). At the hearing, the Congressional Research Service (CRS) will be on hand to speak technically to how Medicaid financing works in practice; MACPAC will speak to their recent analysis of the FMAP; and the Department of Health and Human Services' Office of the Inspector General (OIG) and the U.S. Government Accountability Office (GAO) will both present testimony based on past reports on different aspects of the FMAP.

I. BACKGROUND

Medicaid exists as a jointly operated program between the Federal and State governments. Broadly speaking, states administer the program under certain federal requirements, and program expenses are jointly financed.[1] In general, states are entitled to receive matching funds for expenses made in the Medicaid program. Specifically, the FMAP rate" is used to calculate the Federal share of expenditures.[2]

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[1] Congressional Research Service (CRS), *Medicaid Financing and Expenditures* (December 14, 2015) (online at http://www.crs.gov/reports/pdf/R42640).

[2] CRS, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016* (January 5, 2015) (online at http://www.crs.gov/reports/pdf/R43847).

Today, Medicaid and the Children's Health Insurance Program (CHIP) provide coverage to nearly 71 million individuals.[3] As many as an estimated 83 million individuals were covered by Medicaid at some point in the course of 2015.[4] The overwhelming majority of Medicaid's enrollees are children, the disabled, and the elderly. Medicaid covers 33 million children, which account for over one third of the nation's children.[5]

Meanwhile, one in every seven (1 in 7) elderly Medicare beneficiaries are also Medicaid beneficiaries.[6] For the elderly and those with disabilities, Medicaid plays a particularly important role.[7] In FY 2012, elderly and disabled enrollees accounted for 21 percent and 42 percent, respectively of Medicaid expenditures. Medicaid is also the primary payer of long term services and supports (LTSS), which represented slightly more than half (51 percent) of total national LTSS spending in 2013.[8]

Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private. Medicaid's costs per beneficiary are substantially lower than private insurance and Medicare, and in recent years these costs have grown far more slowly than per-beneficiary costs under both private employer coverage and Medicare. In fact, in Medicaid, the already slow growth in real per beneficiary costs seen in recent years has given way to trending reductions in growth in per beneficiary costs from 2010 to 2013.[9] While per enrollee Medicaid spending growth picked up slightly in the past year in line with the health care marketplace as a whole, it has remained at a relatively low absolute level—

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[3] Department of Health and Human Services (HHS), *Medicaid and CHIP: November 2015 Monthly Applications, Eligibility Determinations and Enrollment Report* (Jan 27, 2016) (online at https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/november-2015-enrollment-report.pdf).

[4] Congressional Budget Office (CBO), *Detail of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline* (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf).

[5] Kaiser Family Foundation (KFF), *Distribution of Medicaid Enrollees by Enrollment Group* (2011) (online at http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/).

[6] *Id.*

[7] HHS, *FY2016 Budget in Brief: CMS Medicaid Services* (online at http://www.hhs.gov/about/budget/budget-in- brief/cms/medicaid/index.html#services).

[8] KFF, *Medicaid and Long-Term Services and Supports: A Primer* (May 8, 2015) (online at http://kff.org/medicaid/report/medicaid-and-long-term-services-and- supports-a-primer/).

[9] Executive Council of the President of the United States, *Trends in Health Care Cost Growth and the Role of the Affordable Care Act* (Nov 2013) (online at https://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf).

and far lower still than other payers.[10] In 2014, Medicaid represented 16 percent of national health expenditures; in that year, private health insurance and Medicare accounted for 33 percent and 20 percent of national health expenditures, respectively.[11] Despite the program's broad reach in coverage, Medicaid is a remarkably efficient program.

Medicaid provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost to beneficiaries, but lower payment rates to health care providers and lower administrative costs make the program very efficient financially. It costs Medicaid (and thus the federal government) much less than private insurance — 27 percent less for children and 20 percent less for adults — to cover people of similar health status.[12]

In addition, states are using their existing flexibility to take innovative steps that further lower costs, while improving the health of beneficiaries. For example, states are reducing emergency room use, better coordinating care for individuals with chronic conditions through accountable care organizations and health homes, and encouraging work through supportive employment services.

II. VARIOUS FMAP RATES

A. Regular FMAP Rate

In general, FMAP is designed to provide a larger proportion of Federal matching dollars to states with lower per-capita incomes. The matching dollar amount is set by a fixed formula in statute, with a minimum of 50 percent and a statutory maximum of 83 percent.[13]

Each year, FMAP rates for states are announced. For 2016, regular FMAP rates range from 50 percent to 74.17 percent, and the average state FMAP is 57 percent.[14] To calculate a state's given per capita income, the average of the three most recent calendar years with data

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[10] The White House, *Historically Slow Growth in Health Spending Continued in 2013, and Data Show Underlying Slow Cost Growth is Continuing* (Dec 3, 2014) (online at https://www.whitehouse.gov/blog/2014/12/03/historically-slow-growth-health-spending-continued-2013-and-data-show-underlying-slo).

[11] Congressional Research Service (CRS), *Medicaid Financing and Expenditures* (Dec 14, 2015) (online at http://www.crs.gov/reports/pdf/R42640).

[12] Center on Budget and Policy Priorities (CBPP), *Frequently Asked Questions About Medicaid* (Jan 21, 2016) (online at http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid).

[13] *See* Section 1905(b) of the Social Security Act.

[14] CMS, *Medicaid.gov: Financing & Reimbursement* (online at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html).

available from the Department of Commerce are taken. For instance, for the FY2016 FMAP calculations, HHS used state per capita personal income data for 2011, 2012, and 2013 that became available from the Department of Commerce's Bureau of Economic Analysis (BEA) in September 2014. The use of a three-year average helps to moderate fluctuations in a state's FMAP rate over time, but also means that FMAP rates for any given fiscal year are based on data that is several years old by the time the rates take effect.

In real terms, annual variation in FMAP rates for states are generally quite small; however, the difference of even one percentage point can amount to millions of dollars in federal funds to a state. Several outside factors can affect a state's FMAP rate in any given year. The most obvious factor is that of a state's economy, and ability to respond to economic downturns. The economy, inherently, affects a state's per capita income. Further, the FMAP formula relies on per capita income relative to the national average per capita income. This means that because the national average per capita income is reflective of the sum of states' responses to economic change, if more states (or larger states) experience an economic decline, the national economy reflects this decline to some extent and more quickly; but by the same token, the national decline can also be lower than some states' declines, or take longer to reflect, because the total decline has been offset by states with smaller decreases or even increases.

FMAP is not only used for purposes of the Medicaid program; notably, the FMAP rate is also used in determining the contribution for Medicare Part D, the federal share of certain child support enforcement collections, Temporary Assistance for Needy Families (TANF) contingency funds, a portion of the Child Care and Development Fund (CCDF), and foster care and adoption assistance under Title IV-E of the Social Security Act.[15]

B. FMAP Exceptions

Although the formula above generally captures state FMAP rates, several exceptions exist. These exceptions fall under the categories of territories, special situations, certain patient populations, certain providers, certain services, and administrative activities.[16] Notably, not all FMAP exceptions represent a higher valuation; for example, the majority of administrative activities the state undertakes to run the program properly are only given a standard 50 percent FMAP.

Most prominently among these exceptions is the "newly eligible" population of low-income adults as part of Medicaid expansion enacted under the Affordable Care Act (ACA). This population is guaranteed a matching rate of 100 percent through the year 2016, and gradually declines to 90 percent by 2020. The ACA provided increased federal matching rates for a primary care payment rate increase and state balancing incentive payments. The ACA further specified preventive services and immunizations, smoking cessation services for pregnant

[15] CRS, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016* (Jan 5, 2015) (online at http://www.crs.gov/reports/pdf/R43847).

[16] *Id.*

women, specified home and community-based services, health home services for certain people with chronic conditions, home and community-based attendant services and supports. For states that experience a major, statewide disaster, the ACA also included a provision providing a disaster-recovery FMAP adjustment.[17] Some of these FMAP exceptions were for a time-limited period of years, while others were made a permanent part of the program

A variety of services have historically received a higher FMAP, including family planning, certain preventive services and immunizations, and certain measures surrounding home and community-based services. Regarding providers, those practicing in an Indian Health Services Facility receive 100 percent federal reimbursement for those rendered services.

While the majority of administrative services are at a 50 percent FMAP, certain administrative activities such as operating Fraud Control Units, survey and certification of nursing homes, developing claims and eligibility systems, and translation or interpretation systems all have specified FMAP valuations that are higher.

C. Congressional Increase of Regular FMAP Dollars

Medicaid often suffers from the paradoxical problem that as more people need the program (as in an economic downtown), a state is usually suffering the effects of the same economic downturn and cannot raise their share as easily. Accordingly, Congress has adjusted the regular FMAP twice in taking these economic downturns into account:

- State fiscal relief, FY2003-FY2004**:** FMAP rates for the last two quarters of FY2003 and the first three quarters of FY2004 were not allowed to decline (i.e., were held harmless) and were increased by an additional 2.95 percentage points. States had to meet certain requirements in order to receive an increase.[18]

- State fiscal relief, FY2009-FY2011**:** FMAP rates were increased from the first quarter of FY2009 through the third quarter of FY2011. All states received a hold harmless to prevent any decline in regular FMAP rates and an across-the-board increase of 6.2 percentage points until the last two quarters of the period, at which point the across-the-board percentage point increase phased down to 3.2 and then 1.2; qualifying states received an additional unemployment-related increase. States were required to meet certain requirements in order to receive the increase.[19]

Congress also allowed for an adjustment for Hurricane Katrina and there is currently the disaster-recovery adjusted FMAP available to states.

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[17] *Id.*

[18] P.L. 108-27 §401(a)).

[19] P.L. 111-5 §5001, as amended by P.L. 111-226 §201.

- Adjustment for Hurricane Katrina: In computing FMAP rates for any year after 2006, for a state that the Secretary of HHS determines has a significant number of Hurricane Katrina evacuees as of October 1, 2005, the Secretary was instructed to disregard such evacuees and their incomes. Although it was labeled as a "hold harmless for Katrina impact," the provision language required evacuees to be disregarded even if their inclusion would increase a state's FMAP rate. Due to lags in the availability of data used to calculate FMAP rates, FY2008 was the first year to which this provision applied.[20]

- Adjustment for disaster recovery**:** Beginning in CY2011, a disaster-recovery FMAP adjustment is available for states in which (1) during one of the preceding seven years, the President declared a major disaster under the Stafford Act and every county in the state warranted at least public assistance under that statute, and (2) the regular FMAP rate declines by a specified amount. Louisiana is the only state that was eligible for the disaster-recovery adjusted FMAP from the fourth quarter of FY2011 (when the adjustment was first available) through FY2014. No state has met the requirements since FY2014.[21]

D. How States Receive Matching Dollars

The majority of state spending (about 95 percent) is for health care services provided to enrollees. States spend the remaining roughly 5 percent of Medicaid funds for performing administrative tasks like eligibility determinations, enrollment activities, or paying claims.[22]

At the most basic of levels, the Medicaid financing structure distributes matching dollars to States using a combination of prospective payment through grants and real-time payments.[23] In practice, the Center for Medicare and Medicaid Services (CMS) prospectively grants states funding for a portion of their expected Medicaid expenses at the beginning of every fiscal quarter. As the quarter passes in time, States can draw down matching dollars through commercial banks and the Federal Reserve system as they accrue Medicaid expenditures. At the completion of every quarter, CMS reviews each State's projected expenses with their actual expenditures. Any difference between these two amounts is then reconciled between CMS and each State.

E. Program Integrity

Some have raised concerns that the FMAP structure is complicated by, or misleading through, creative accounting mechanisms that states may use to draw down more federal funds.

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[20] P.L. 109-171.

[21] P.L. 111-148, as amended by P.L. 111-152, P.L. 112-96 P.L, and 112-141.

[22] CRS, *Medicaid Financing and Expenditures* (Dec 14, 2015) (online at http://www.crs.gov/reports/pdf/R42640).

[23] *Id.*

It is important to note that legislation enacted in 1991, 1993, 1997, 2000, and 2005, as well as various federal regulations and guidance over the years, have imposed wide-ranging restrictions on states' ability to draw down additional federal Medicaid funds through creative accounting. Past major legislation in this area includes:

- Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234)
- Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)
- Balanced Budget Act of 1997 (PL 105-33)
- Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (PL 106-554)
- Deficit Reduction Act of 2005 (PL 109-171)

Some have also raised concerns that FMAP's complexity results in improper claiming of enhanced rates, but this works both ways. States are often reimbursed less money than they are due for any number of reasons, including overpayments and increasing identification of improper Medicaid payments. In FY 2015, the improper payment rate in Medicaid increased from 6.7 percent in FY 2014, to 9.78 percent in FY 2015.[24]

It is important to note the vast majority of improper payments are not fraud; they are legitimate payments that were improper due to coding mistakes or other issues. The ACA took significant steps forward in program integrity in Medicaid. The increase in improper payments is due to the increased difficulties state agencies are having with new provider enrollment and screening requirements that were mandated under the ACA. Without those, CMS estimates the improper payment rate would have actually decreased to 5.1 percent.[25] However, continued vigilance with respect to compliance on the ACA program integrity provisions is important.

Medicaid continues to maintain a lower improper payment than Medicare, and it is important to note that improper payments also increased in Medicare Parts C and D. By way of comparison, Medicare's Parts A and B improper payment rate for 2015 is 12.1 percent, compared to 12.7 percent in 2014; Medicare's Part C improper payment rate for 2015 is 9.5 percent, compared to 9.0 percent in 2014; and Medicare's Part D improper payment rate is 3.6 percent in 2015, compared to 3.3 percent in 2014.[26]

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[24] CMS, *CMS Financial Report: Fiscal Year 2015* (Nov 9, 2015) (online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2015_CMS_Financial_Report.pdf).

[25] Modern Healthcare, *Improper Medicaid Payments Have Nearly Doubled Since Fiscal Year 2013* (Nov 19, 2015) (online at http://www.modernhealthcare.com/article/20151119/NEWS/151119851).

[26] CMS, *CMS Financial Report: Fiscal Year 2015* (Nov 9, 2015) (online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2015_CMS_Financial_Report.pdf).

III. GAO WORK ON FMAP

Given the size and scope of the Medicaid program, GAO has maintained substantial interest in the financing structure of the program. Accordingly, they have released several reports describing manners in which the FMAP system could be improved. GAO will focus mainly on two previously-released reports at this hearing:

A. GAO Approach to a More Equitable Allocation of Medicaid Funding

In 2013, GAO released a report suggesting changes that might improve the equitable allocation of federal dollars in the Medicaid program to States.[27] As a basis of this report, GAO proposes that Medicaid funds could be better tailored to the needs of the states and beneficiaries by basing the FMAP on measures beyond solely per capita income. They argued that per capita income alone does not capture all aspects of a state's Medicaid needs because of state-by-state variation in demand for services, geographic cost differences and state resources.

Overall, GAO recommended that a combination of measures may create a superior formula for calculating FMAP. Specifically, they noted that data from the American Community Survey may be used to calculate state levels of poverty. Additionally, they recommended categorizing each state's enrollees by age or disability categories using CMS data. This is intended to direct funding more precisely to states that have a larger proportion of high-cost Medicaid patients such as the disabled or aged. To address geographic cost differences, GAO recommends utilizing the Bureau of Labor Statistics' Occupational Employment Statistics to address differences in wages. Finally, given differences in state tax policy that may not be captured in per capita income, GAO recommend utilizing the state's Total Taxable Resources as it includes a variety of incomes such as corporate income or capital gains.

B. GAO Approach to Economic Downturns

Given the nature of the Medicaid program and the patients it serves, economic downturns place a significant burden on state budgets. As an economic reality, a recession places a dual burden on state budgeting by both decreasing tax revenues and increasing program enrollment.[28] In order to relieve these pressures, Congress has traditionally increased states' FMAP during times of economic recession. However, these temporary increases rely on legislative action and may be delayed by logistical and political factors.

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[27] GAO, *Alternative Measures Could be Used to Allocate Funding More Equitably* (May 2013) (online at http://www.gao.gov/products/GAO-13-434).

[28] GAO, *Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs* (July 2010) (online at http://www.gao.gov/assets/310/308437.pdf).

In order to be proactive in addressing this situation, GAO issued a report recommending instituting an automatic trigger to increase state FMAPs during economic recessions.[29] This mechanism would rely on a trigger based on labor market data rather than legislative action. Specifically, the increases would be triggered once 26 states nationally show a sustained decrease in their employment-to-population ratio. For individual states, the enhanced FMAP would be calculated based on both increases in unemployment as well as reductions in wages. Overall, the formula is designed to accurately and smoothly increase the Federal Medicaid share at the start of a recession, and then gradually decrease that share to baseline levels during economic recovery.

IV. OIG WORK ON FMAP

Along with GAO, OIG has also monitored program integrity of distributing the Federal share of Medicaid expenditures. The OIG has recently highlighted many areas of Medicaid financing which have benefited from reforms to the federal matching system.[30] The majority of these changes resulted from areas in the law or regulations in which states either intentionally or unintentionally drew down Federal matching dollars in a manner that minimized state contributions.

In the early 2000s, OIG released a series of reports describing activities in numerous states resulting in intergovernmental transfers that increased their Federal drawdown of Medicaid dollars. In general, these states provided enhanced payments to entities such as county nursing facilities or hospitals and subsequently received a larger amount of matching dollars.[31] Because of this work, both CMS and Congress worked in tandem to introduce upper payment limits and prevent States from receiving excess matching funds. OIG reports that this change resulted in approximately $79 billion in savings.[32]

Beyond intergovernmental transfers, OIG has highlighted areas of administrative miscalculation resulting in misapplication of the FMAP formula. During the recent economic recession, states were provided with an enhanced FMAP percentage in the American Recovery and Reinvestment Act (ARRA) to offset budgetary strain. During this time, OIG investigated the

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[29] GAO, *Prototype Formula Would Provide Automatic, Targeted Assistance to States During Economic Downturns* (Nov 2011) (online at http://www.gao.gov/assets/590/586185.pdf).

[30] Office of Inspector General (OIG), *Spotlight on… Medicaid: State Policies That Result in Inflated Federal Costs* (online at http://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp).

[31] OIG, *Review of Medicaid Enhanced Payments to Local Public Providers and the use of Intergovernmental Transfers* (Sept 2001) (online at http://oig.hhs.gov/oas/reports/region3/30000216.pdf).

[32] OIG, *Spotlight on… Medicaid: State Policies That Result in Inflated Federal Costs* (online at http://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp).

Medicaid claims in the state of Massachusetts.[33] In this study, it was discovered that there was a discrepancy between the time the medical services were provided and the time the claim was submitted. This resulted in a subset of claims that received the enhanced FMAP, rather than the pre-ARRA FMAP. In response, the state concurred with the findings and agreed to return the excess payments so long as CMS concurred with the ruling.

Finally, OIG has spent a significant amount of time examining the proper billing of services which are afforded a higher FMAP. One such service is family planning, which is matched at a 90 percent rate.[34] Nearly half of poor U.S. women of reproductive age rely on Medicaid for their care.[35]

OIG has investigated these services in multiple states including Oregon,[36] California,[37] and Washington State.[38] It is important to note that CMS released a clarification correcting the OIG's interpretation of Medicaid statute with respect to much of the agency's family planning work.[39]

V. MACPAC WORK ON FMAP

MACPAC has done a significant amount of work, both general and specific, on the FMAP financing mechanism. The most utilized technical resources include:

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[33] OIG, *Massachusetts did not Always Make Correct Medicaid Claim Adjustments* (Sept 2014) (online at http://oig.hhs.gov/oas/reports/region1/11300003.pdf).

[34] CRS, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016* (Jan 5, 2015) (online at http://www.crs.gov/reports/pdf/R43847).

[35] Guttmacher Institute, *Publicly funded family planning services in the United States* (July 2015) (online at http://www.guttmacher.org/pubs/fb_contraceptive_serv.html).

[36] OIG, *Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project* (Jan 2012) (online at http://oig.hhs.gov/oas/reports/region9/91102010.pdf).

[37] OIG, *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County* (Dec 2012) (online at http://oig.hhs.gov/oas/reports/region9/91102040.pdf).

[38] OIG, *Review of Family Planning Services Claimed by Washington State During the Period October 1, 2005, Through September 30, 2008,* (Feb 2011) (online at http://oig.hhs.gov/oas/reports/region9/90900049.pdf).

[39] CMS, *Family Planning and Family Planning Related Services Clarification* (April 16, 2014) (online at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf).

- Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State: https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-FMAPs-and-Enhanced-FMAPs-E-FMAPs-by-State-FYs-2012–2016.pdf
- Discussion of federal medical assistance percentages for services and federal financial participation for Medicaid administrative activities: https://www.macpac.gov/subtopic/matching-rates/
- Table of exceptions to current federal match rates for certain populations, providers, and services: https://www.macpac.gov/federal-match-rate-exceptions/
- Table listing federal match rates for various administrative activities: https://www.macpac.gov/federal-match-rates-for-medicaid-administrative-activities/
- Building Capacity to Administer Medicaid and CHIP, Chapter 4, June 2014: https://www.macpac.gov/wp-content/uploads/2015/01/Building_Capacity_to_Administer_Medicaid_and_CHIP.pdf

In addition, MACPAC has done extensive research on specific FMAP increases in certain areas, including long term care and the primary care bump.

VI. WITNESSES

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