STATEMENT OF

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ON

MEDICAID FINANCIAL MANAGEMENT IN NEW YORK STATE DEVELOPMENTAL CENTERS

BEFORE THE

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Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the invitation to discuss Medicaid payments to New York's State-run developmental centers. The payments for these developmental centers are excessive and unacceptable. The Centers for Medicare & Medicaid Services (CMS) is currently working with New York to correct the payment rate so that it is an economic and efficient rate as required under section 1902 of the Social Security Act and is considering what further action may be needed specific to this situation. In addition, on a larger scale, CMS is reviewing and enhancing our data analytic capabilities and processes to increase accountability and to prevent similar excessive payments from remaining undetected in the future. As a former senior manager at the Department of Health and Human Services Office of the Inspector General (HHS OIG), as well as the former Director for Program Integrity at CMS, I can assure you the Administration is committed to safeguarding taxpayer dollars in the Medicaid program through rigorous financial management, as well as through comprehensive anti-fraud activities.

Background

Medicaid Program

Medicaid is the primary source of medical assistance for millions of low-income, disabled, and elderly Americans and is a central component of our nation's medical safety net, providing health coverage to many of those who would otherwise be unable to obtain health insurance. Medicaid is a partnership between the States and the Federal Government. The Federal government establishes minimum requirements and provides oversight for the program, and States design, implement, administer, and oversee their own Medicaid programs within the Federal parameters. In general, States pay for the health benefits provided, and the Federal government, in turn, matches qualified State expenditures based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent. Administrative expenses

are generally matched at a 50 percent rate for all States, although the rate is higher for certain administrative expenditures. For example, CMS matches the cost of Medicaid management information system design and operation, as well as some review activities, at a rate between 75 and 90 percent. On average, the Federal government expects to match State expenditures at a rate of nearly 58 percent in FY 2013 for Medicaid benefits.

State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to their unique health care, budgetary and economic environments. As a result, there is variation among the States in eligibility, services, and service delivery, as well as reimbursement rates to providers and health plans. The Federal government, in partnership with States, is responsible for oversight of program implementation.

The Federal government mainly oversees the State Medicaid program implementation through the State plan. The State plan is a contract between a State and the Federal government describing how that State administers its Medicaid program. The plan provides assurances that a State abides by Federal rules and may claim Federal matching fund for its Medicaid program activities. The State plan sets out groups of individuals to be covered, services to be provided, methodologies for provider payment rates, and the administrative requirements that States must meet to participate. States frequently send State plan amendments to CMS to review and approve. CMS also reviews managed care contracts and reported expenditures.

Rate-Setting and Program Oversight

As described above, the State plan sets out the methodologies for establishing the payment rate for providers. To change the way a State pays Medicaid providers, a State must submits a State plan amendment to CMS to review and approve. Before the amendment's effective date, the State must also issue a public notice of the change. The notification is to inform providers and other stakeholders of changes to Medicaid payment rates.

States develop their payment rates based on many factors, including consideration of local health care markets, the underlying costs of providing the services, and payment rates by Medicare or commercial payers in the local community. Payment rate methodologies often include

mechanisms to update the rates based on specified trending factors, including a State-determined inflation adjustment rate. CMS reviews State plan amendment reimbursement methodologies for consistency with the Social Security Act and other Federal statutes and regulations. Section 1902 of the Social Security Act requires that States "assure that payments are consistent with efficiency, economy, and quality of care."

To promote efficiency, economy, and quality of care, CMS sets an outer bound, the Medicaid Upper Payment Limit (UPL), for how much States can pay providers under certain fee-for-service arrangements. The UPL is not a limit on payments to individual providers, but is calculated in the aggregate for each affected category of Medicaid services and for each provider type (private, non-State government, and State government-owned). A State plan amendment proposing to increase payment rates for these services will require the State to demonstrate that the increase in payment rates will not result in total payments for any provider type exceeding the UPL for that category of services. If CMS finds while reviewing a State plan amendment the State's payment rate will result in payments that will exceed the UPL, then CMS requires the State to revise the amendment, so that the payment rate falls under the UPL. Consistent with that framework, aggregate payments for services provided by inpatient hospitals, outpatient hospitals, clinics, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, for each provider type cannot exceed a reasonable estimate of what Medicare would have paid for the same services.

The Director of the Center for Medicaid and CHIP Services (CMCS) and the Medicaid regional administrators share the authority to ensure State plans and amendments meet the requirements provided under relevant Federal statutes and regulations. Specifically, the Director of CMCS reviews all State plan amendments that amend institutional payment rates. Approval is based on applicable law, as interpreted in policy statements and precedents previously approved by the CMS Administrator. The CMS Administrator, in consultation with the HHS Secretary, can deny a State plan or amendment.

New York's Medicaid Program and Developmental Centers

In New York State, the Office for People with Developmental Disabilities (OPWDD) provides services to both Medicaid and non-Medicaid eligible individuals with intellectual and developmental disabilities under a cooperative agreement with the New York Department of Health, which administers New York's Medicaid program. OPWDD is responsible for coordinating services for over 126,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other disabilities. It provides services directly and through a network of nearly 700 nonprofit service-providing agencies; about 80 percent of services are provided by private nonprofits and 20 percent are provided by State-run services. The people served by OPWDD often present with multiple physical or cognitive conditions that require specialized or intensive treatment. Some individuals have dual diagnosis, autism spectrum disorder, and medical frailty. Individuals who are medically frail have multiple medical conditions, which result in high self-care needs, profound motor challenges, and more intensive staff support. This population is 5.5 percent of all of the individuals served by OPWDD in 2011.[1]

OPWDD oversees the State-run developmental centers for individuals with intellectual and developmental disabilities. These developmental centers are residential treatment options designed for individuals whose disabilities severely limit their ability to live independently. The developmental centers provide 24-hour onsite assistance and training, intensive clinical and direct-care services, supervised activities, and a variety of therapies.

New York State Developmental-Center Payment-Rate Calculation

In January 1986, CMS approved a New York State plan amendment which established a methodology for determining the provider payment rate for the State-run developmental centers described above. This methodology was retroactive to April 1984 based on the date the State plan amendment was submitted. In 1990, the State submitted a State plan amendment, which changed the original payment rate methodology. The payment methodology that CMS approved in 1986 updated the payment rate based on the trended actual base year costs. The revised

[1] OPWDD Statewide Comprehensive Plan: 2011-2015. October 1, 2011. http://www.opwdd.ny.gov/node/1384

payment methodology CMS approved in 1990 updated the payment rate based on the trended operating costs included in the prior year payment rates, instead of the trended actual base year costs. In 1994, New York submitted another State plan amendment, which modified the rates paid to the open developmental centers to include those net operating costs from closed developmental centers. This adjustment was intended to ensure that annual decreases in head count at a developmental center did not cause a center to lose operating funds needed to support its fixed costs. The State provided written assurances through the amendment review process the rates were still cost based and would not exceed the Medicare cost principles described above.

Since that time, the State made Medicaid payments and received Medicaid matching funds from the Federal government based on its 1994 reimbursement methodology. The payment rate calculation adopted in 1994 allowed New York State to continue to include in the calculation of the rate a majority of costs associated with beneficiaries no longer in a developmental center. It also allowed New York State to include in the calculation of the rate costs associated with centers when they were operating more beds. Both of these methodologies effectively inflated the starting point for the rate calculation each year based on the, apparently incorrect, assumption that actual costs would not decrease as the developmental centers shrank in size. When approving the reimbursement methodology, it is not clear if CMS completely understood how the State would implement the new methodology or the methodology's future impact if actual operating costs were to shrink dramatically year over year. Over subsequent years, this methodology generated rates that appear to have deviated substantially from actual, incurred costs. New York submitted the last State plan amendment related to these facilities in 2006.

According to the HHS OIG, the growth of the daily Medicaid reimbursement rate for State developmental centers has significantly outpaced those of privately operated developmental centers and New York claimed significantly more for the State-run developmental center services than its actual costs.[2] The daily rate for a Medicaid beneficiary to reside in a developmental center grew from $195 per day in 1985 to $4,116 in 2009, vastly outgrowing the Medicaid daily rate for private developmental centers.

[2] HHS OIG. "Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive." A-02-11-01029. May, 2012. http://oig.hhs.gov/oas/reports/region2/21101029.asp

In 2007, the CMS New York Regional Office began working with the State to gain access to their Medicaid Management Information Systems (MMIS) data warehouse to assist CMS with its ongoing monitoring of State claims information; it was not specifically related to monitoring of payment rates. However, as the Regional Office began running data-mining reports, they noticed the payment rates for two cost-based developmental centers appeared to be very high. As discovered below, although CMS identified the possibility of excessive payments through the data review, CMS did not begin working with New York to address the situation fully until 2010. Since then, CMS has been working with the State to understand the circumstances around the inflated rate and more fully address this problem.

At the same time as the high payment rates were being identified, CMS was developing regulations to limit reimbursement to individual governmental health care providers to the cost of treating Medicaid patients. That regulation would have limited the maximum government-provider payment rate, thereby addressing the high payment rate to New York's State-run developmental centers. In May 2007, as CMS was issuing the final rule, Congress imposed a moratorium prohibiting CMS from taking any action to finalize or otherwise implement the cost rule. Congress extended this moratorium through April 1, 2009, and a Federal district court struck down the final rule and ruled it had been issued in violation of the moratorium.

Currently, CMS is aggressively working to resolve this issue. We are working with the State to develop a rate that meets the statutory requirements of efficiency and economy and is within a reasonable estimate of the costs that would be paid under Medicare. As part of this effort we will conduct an audit of New York's developmental disability centers and also require the State to conduct an independent audit once a new payment system is in place. CMS also concurred with the HHS OIG 2012 report's recommendations about revising the payment methodology so the payment rate is consistent with efficiency and economy. As CMS and New York work together to revise the payment methodology, we are balancing our commitment to safeguarding taxpayer dollars, while protecting and providing for the ongoing needs of the vulnerable population served by New York State-run developmental centers. Balancing these efforts is not simple or easy, but CMS, in partnership with New York, will correct this problem.

Lessons Learned and Plans Going Forward

As discussed earlier in the testimony, CMS should not match New York payments for Medicaid beneficiaries and services at inflated levels. As CMS reviewed this problem, CMS identified a set of vulnerabilities that allowed this situation to occur. To address these vulnerabilities, CMS developed a plan of action that will drive future policy and guidance to States. In addition, CMS is implementing management controls to prevent this kind of situation from happening again.

The first lesson is that current methods CMS is using to enforce the UPL are not enough to protect Federal dollars. The purpose of the UPL is to ensure the Federal government does not match excessive rates paid by State governments to providers. In some cases, States have paid excessive rates to governmental providers in order to divert funds to other programs or uses or to recycle dollars for a higher Federal match. In New York, the UPL failed to control excessive rates. First, the State must demonstrate the payment will not exceed the UPL during the review process for State plan amendments. If States are not submitting State plan amendments modifying the provider payment at least annually, CMS does not require States to demonstrate that they have not exceeded UPL. In the case of New York, the initial UPL demonstration model had flaws that grew larger over time and the model did not include any procedure for correcting such flaws.

The second lesson is that defined payment methodologies do not necessarily ensure appropriate rates when the variable elements of those methodologies are not limited to ensure the payment methodology overall remains reasonable. This is particularly true if methodologies contain escalation factors or other automatic triggers that are not reviewed against a reasonable benchmark over time. In the case of New York, the original payment methodology CMS approved was acceptable at that point in time, but was interpreted in a way that, over time, resulted in a steep rise in payments over a period of years that exceeded the rise in actual costs.

The third lesson is that our State partners themselves must also bear responsibility and accountability to identify anomalous payments and expenditures and address them proactively, even if they are acting under approved State plans and waivers, when reasonable parameters of economy and efficiency are being breached. The information relevant for assessing the

reasonableness of a payment methodology (including payment amounts, costs, market conditions, and other relevant factors) is State-level data which States are better able to maintain and are in the best position to analyze. The States should have mechanisms and the responsibility to monitor compliance themselves within Federal law.

CMS takes these lessons seriously and intends to take the following actions as a result:

- To address our first and second lessons, CMS will better use its own data sources to identify payment and claim outliers, in order to provide technical assistance to States. Outliers and aberrations identified will be discussed with States, and CMS will potentially issue deferral of such amounts until the appropriateness of the claim or payment is supported by State information. To improve the quality of Federally available Medicaid data, CMS has been working with more than 10 States over the past year on a pilot project to define data and analytics requirements to improve capabilities for program and financial management as well as program integrity. In the next phase of the project, CMS will be issuing guidance to States requiring that they begin to submit the Transformed-Medicaid Statistical Information System (T-MSIS) dataset by the end of calendar year 2013. T-MSIS expands the currently required MSIS data set. By reviewing State data for the specific purpose of identifying outliers and anomalies, CMS will be able to identify rates, such as the rate in New York, which grew over several years from being within a reasonable UPL to being excessive.
- To address our third lesson, CMS will issue a State Medicaid Director letter to remind States they should be using their own data and information systems to identify payment and utilization aberrations. States should be reviewing utilization, payment rates, and expenditures by category of service, plan, and provider, on a regular basis to identify areas of concern proactively and to make appropriate adjustments. CMS will work with States to improve the timeliness and completeness of available Medicaid data.
- To address all three lessons, CMS plans to work with the National Association of Medicaid Directors to convene a workgroup of Medicaid Directors, and State program integrity subject matter experts, to consider improvements in program integrity and financial management at the Federal and State levels. In addition to using case studies, such as this one in New York, to identify improvement areas and best practices, members

of the work group will also provide input as CMS develops a framework for measuring Medicaid program integrity return on investment and identify ways to increase collaboration and alignment between Medicare and Medicaid program integrity efforts. This workgroup will allow CMS and its State partners to address problems, such as the rate in New York, in a collaborative, comprehensive manner.

Regional offices are working with each State to explore the feasibility of direct access into State systems that contain payment and provider data, in order to support processing of State plan amendments and waivers. This would allow analysts to consult data from such State systems, as the data are made available, to explore payment and expenditure histories that provide insight into the appropriateness of payment methodologies.

Again, we are committed to safeguarding taxpayer dollars in the Medicaid program and fighting fraud and abuse in collaboration with our State partners. CMS is fighting fraud and abuse in collaboration with our State partners, and providing technical assistance, guidance, and oversight in State-based efforts. Currently, through our collaborative efforts with States, we are conducting 175 Medicaid program integrity audits in 19 States. In New York specifically, CMS is conducting eight audits with the State. These audits identify and recover misspent taxpayer money, returning those funds to State and Federal budgets.

Conclusion

The Medicaid payments made to New York for the developmental centers were excessive. CMS is working to correct the payments to New York and to improve CMS' approval and monitoring processes to detect excessive payments more quickly and to prevent excessive payments from being made in the first place.

We appreciate the Subcommittee's interest in this matter and will continue to work with you as CMS makes improvements in the Medicaid program.

Penny Thompson

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Penny Thompson has been the Deputy Director of the Center for Medicaid and CHIP Services (CMCS), within the Centers for Medicare & Medicaid Services (CMS), since August 2009. Penny leads activities related to Medicaid and CHIP policy, program operations, and financial management. Penny also leads coordination and planning efforts to prepare for the 2014 Medicaid expansion.

Penny has over 20 years of experience both within and outside government working on Medicaid and Medicare program issues, including over a dozen years in two previous stints at the U.S. Department of Health and Human Services. In 2000 and 2001, she served as Deputy Director and Acting Director for the Center for Medicaid and State Operations (now CMCS). She was also formerly the Director for Program Integrity at CMS. Penny has also held senior management positions at the U.S. Department of Health and Human Services' Office of Inspector General, where she conducted program and organizational evaluations on Medicare and Medicaid and authored dozens of reports on program operations, beneficiary satisfaction and experiences, and program integrity.

Penny also has more than a decade of private sector experience. She has provided expert advice and leadership on health care industry matters to a number of different organizations and companies, including public policy organizations, consulting organizations, and health care technology and service companies.

Ms. Thompson received a B.A. from the University of Virginia and holds an M.P.A. from The George Washington University.