Program Administration: Financing, IT, and Fraud & Abuse

October 26-27th, 2005

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Medicaid Commission Meeting

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Preview of Presentation

- Medicaid financing basics
- Concerns about Medicaid “maximization”
- Medicaid and IT
- Fraud & Abuse
- Preview of some key questions for the September 2006 session

Medicaid Financing Basics

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Medicaid is a program jointly financed by states and the federal government . . .

- Medicaid costs are shared:
  - For health services, a state's federal medical assistance percentage (FMAP) relates to a complex formula, that includes a factor for per capita income. FMAP range: 50-80%.
  - For admin services performed by states, the rates are the same for all states. Most administrative services are 50-50.
- Certain health services are incentivized by higher FMAPs:
  - Family planning is 90% federal
  - Services at Indian Health Services are 100% federal
- Medicaid expenditures constitute about 22% of state general funds, and about 8% of the federal budget

. . . with FMAPs that look like this.

Maryland and Virginia	50.00%
District of Columbia	70.00%
Mississippi (highest)	77.08%
On average	about 57 %
States ↑ 70%:	AL, AR, ID, LA, MS, MT, NM, OK, UT, WV
States at 50%:	CO, CT, IL, MD, MA, MN, NV, NH, NJ, NY, VA, WA

FY 2005

S-CHIP matching rates are an even better deal for the states.

- S-CHIP has an “enhanced” match rate to incentivize active participation by states
- In S-CHIP, the federal government picks up an additional 30% of the state’s “Medicaid” share
- Example:

Maryland’s FMAP (Medicaid)	50.00%
plus 30% of the state’s Medicaid share (50%)	15.00%
Maryland’s S-CHIP Federal Match	65.00%

Medicaid financing often pursues purposes in tension with paying the "lowest price" for services for Medicaid beneficiaries . . .

- Subsidizing safety-net providers that often serve a high number of uninsured:
  - Disproportionate share hospital (DSH) funds
  - IGT and UPL arrangements
  - Higher payments to FQHCs than private physicians (under the prospective payment system)
- Fulfilling the federal government's treaty obligations to tribes
  - Mandated inpatient and outpatient payment rates to Indian Health Services

. . . more purposes beyond paying for services for Medicaid beneficiaries.

- Training new physicians and supporting medical education:
  - Graduate medical education (GME)
  - Indirect medical education (IME)

- Subsidizing public providers that provide specialty services not available from private providers:
  - Special education
  - Foster care support
  - Juvenile justice support

Concerns about Medicaid "Maximization"

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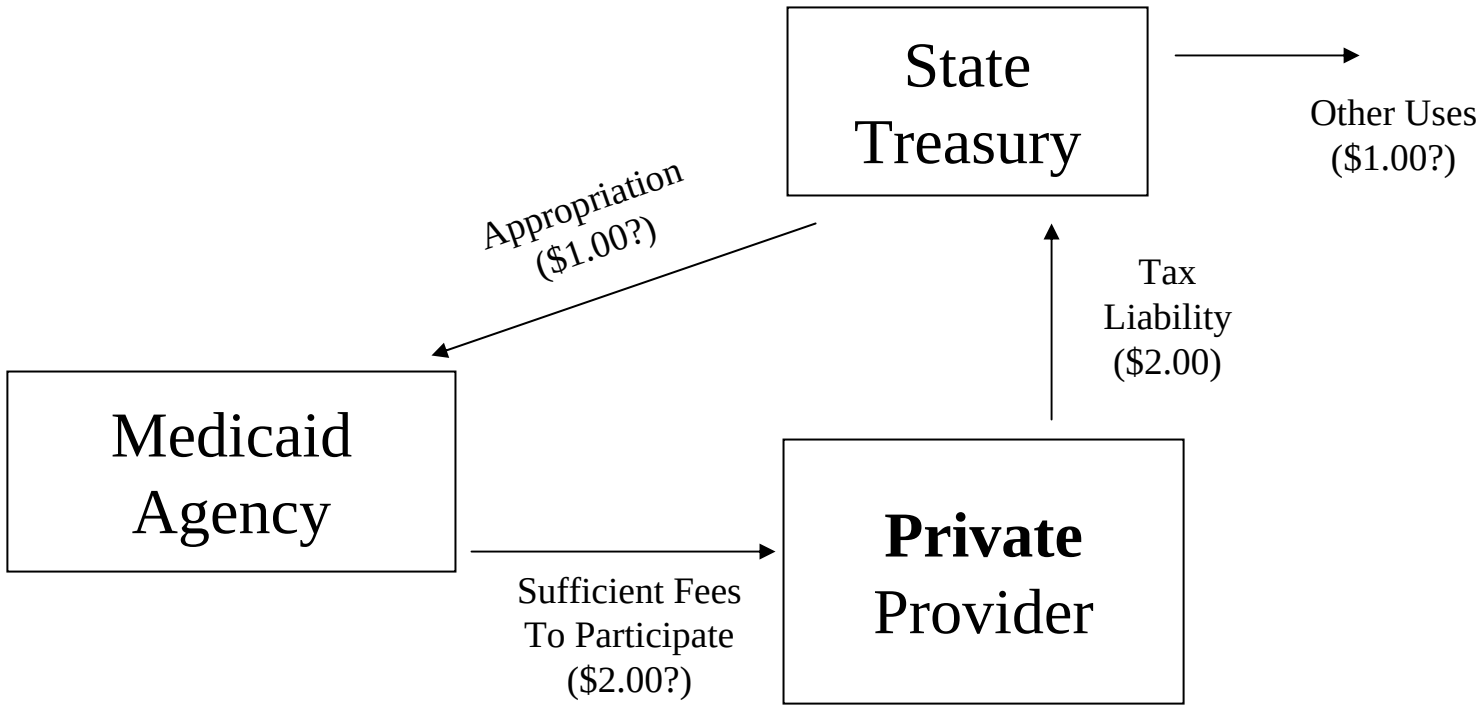
In general, there are two types of maximization of concern to the federal government.

- Provider (or MCO premium) taxes
  - In this arrangement, *private* entities are taxed, and their rates arguably are increased enough to compensate for the tax
- Inter-governmental transfers
  - In this arrangement, *public* providers move state or local funds to the Medicaid agency to be matched with federal funds to increase their own rates
  - This arrangement could arise in a number of areas (special education, upper payment limit [UPL], targeted case management, etc.)

Provider or MCO premium taxes work like this:



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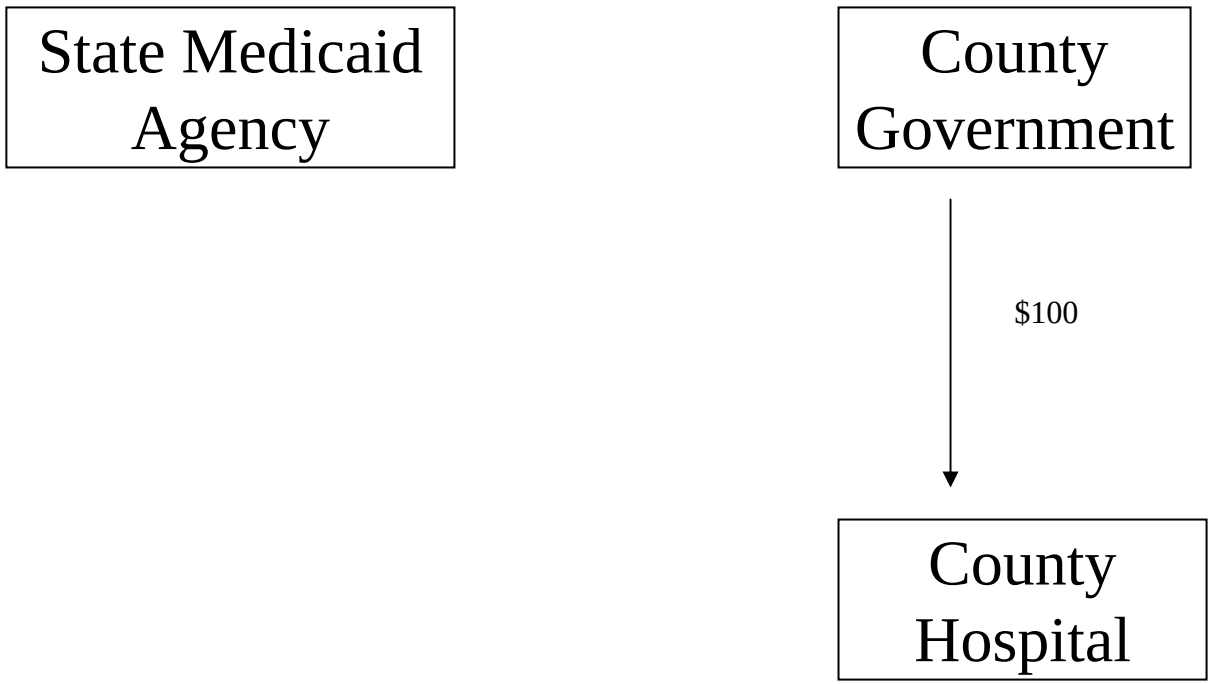
Three federal rules apply regarding provider taxes.

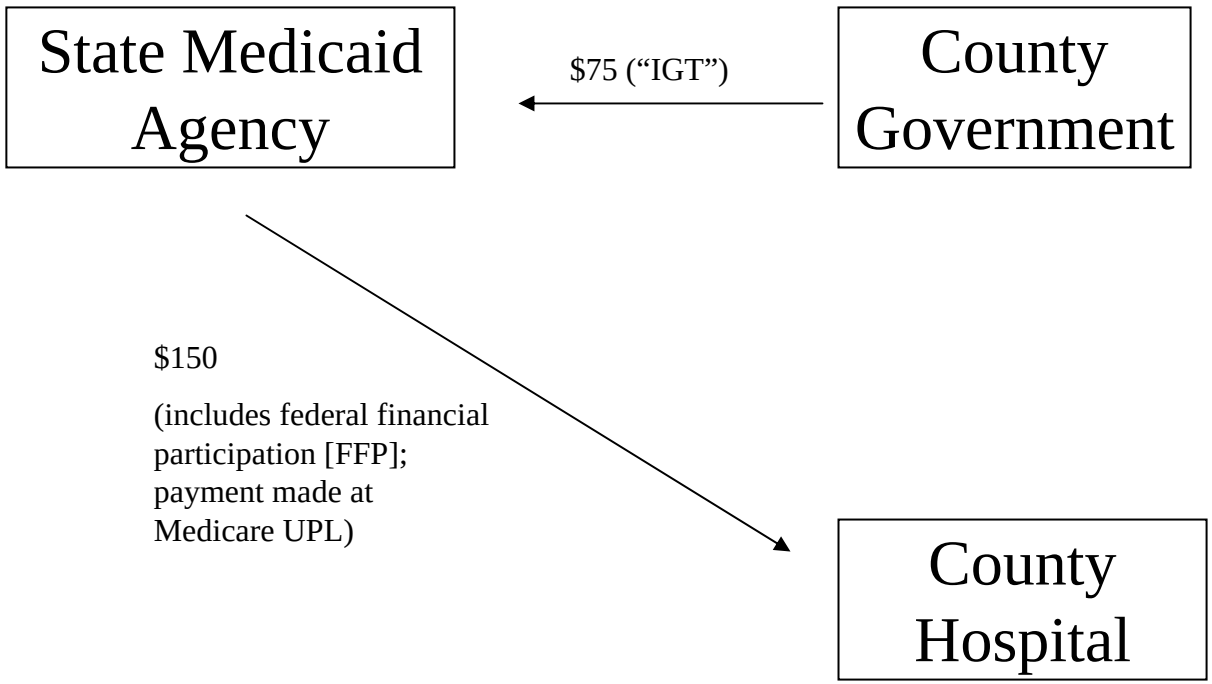
- Must be “broad-based” within class (I.e., tax applies to all payers)
- There cannot be a corresponding credit
- Cannot have a “hold harmless” provision (e.g., law creating tax cannot guarantee higher fees)

The Medicaid IGT and UPL issue explained in five slides. First, assume this is what it looks like pre-Medicaid involvement . . .



The general concept here also applies to other IGTs, like special education or targeted case management

. . . then assume that the county government instead sends local tax dollars to Medicaid . . .



"IGT" = Intergovernmental transfer
"UPL" = Upper payment limit, i.e., what Medicare would have paid for the same service

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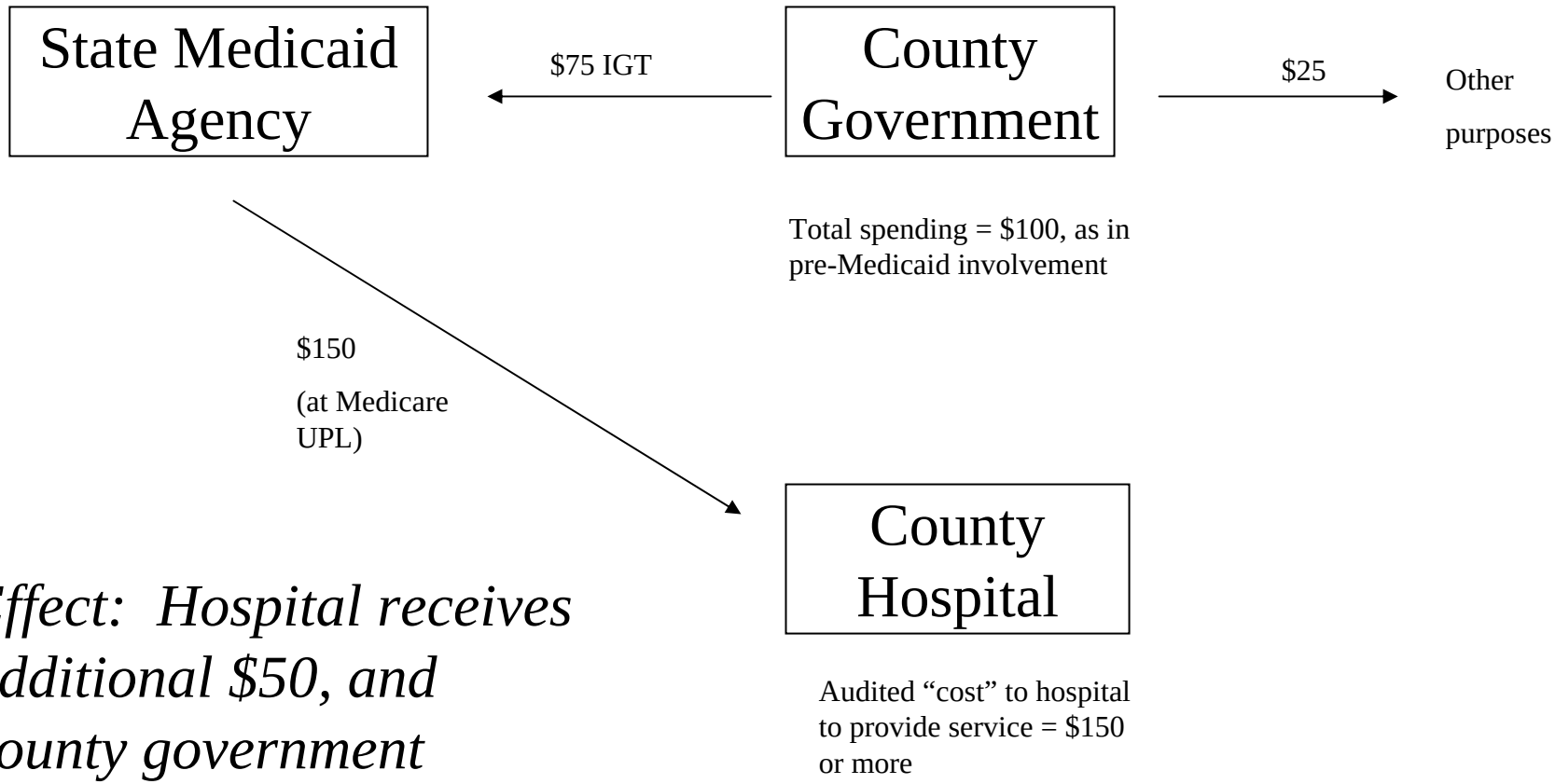
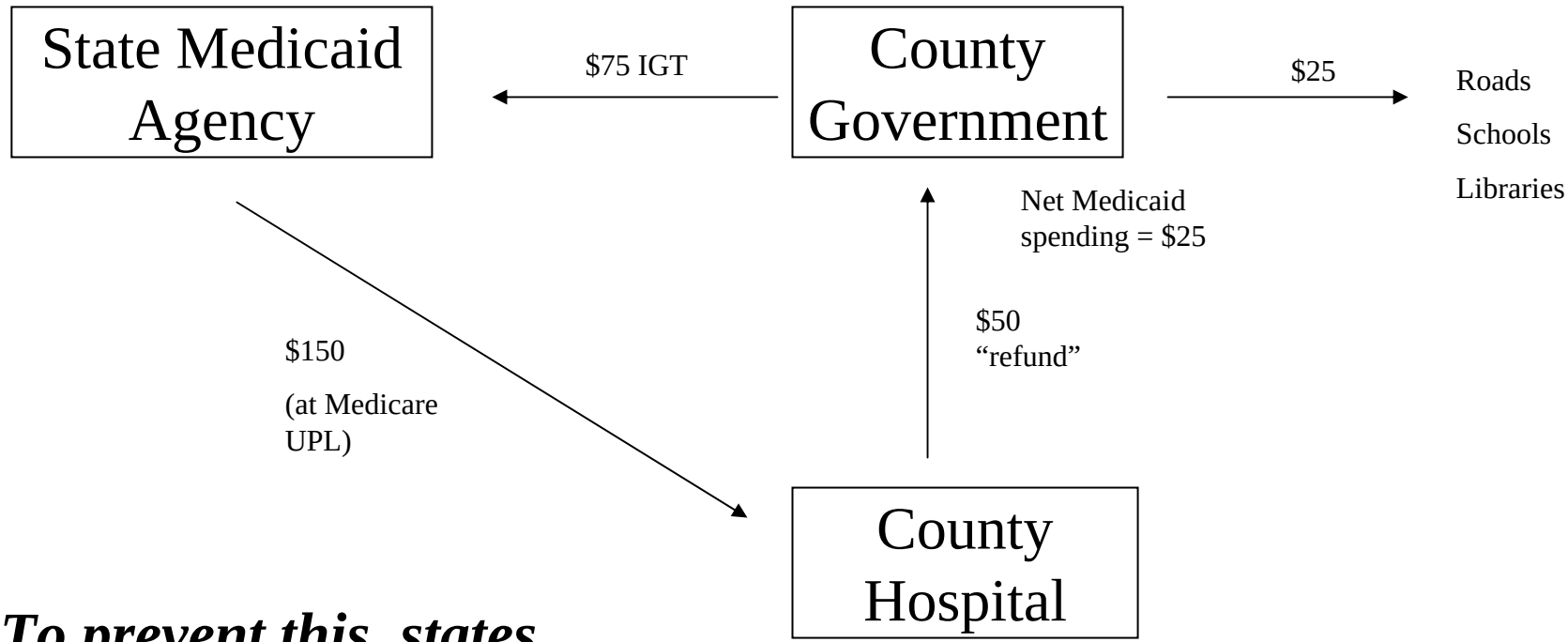
Under the Bush Administration budget proposal, this IGT/UPL arrangement would be okay . . .



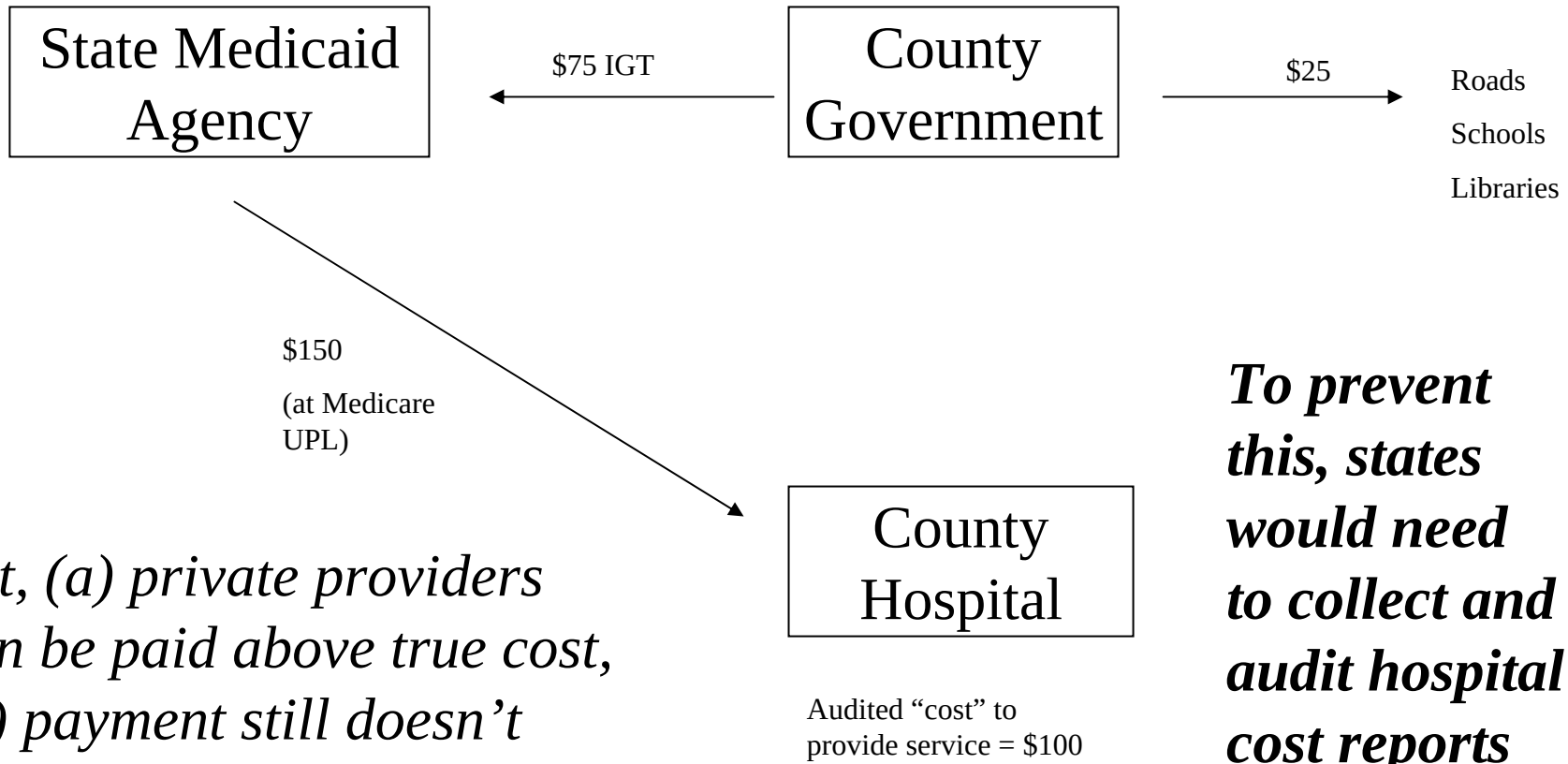
Effect: Hospital receives additional $50, and county government spends $25 on non-health care purposes

. . . and this would not be okay: it would violate the "IGT" provision due to recycling, which alters 50/50 to 75/25 . . .



To prevent this, states would need to track dollars <u>after</u> receipt by provider

. . . and this would not be okay: it would violate the "UPL" provision, because the hospital would be paid above its costs.



Yet, (a) private providers can be paid above true cost, (b) payment still doesn't exceed Medicare, and (c) safety net mission fulfilled

To prevent this, states would need to collect and audit hospital cost reports

How States view all forms of "creative financing"

- They are legal, like tax planning, and shouldn't be vilified.
- Unfunded federal mandates burden state budgets, so states must seek federal funds where available (any port in a storm):
  - No Child Left Behind
  - Bioterrorism preparedness
  - Election reforms
  - HIPAA
  - Underfunding of special education
  - Medicare Part D
- "We cannot run a deficit like the federal government."
- Existing subsidy programs (e.g. DSH) have not kept up with Medicaid enrollment growth

Medicaid and IT

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Medicaid's IT Platform historically has been a payment and reporting system

- The Medicaid Management Information System (MMIS) developed to measure, count and report units of service and payment
- The MMIS model has intimately been tied to Medicaid fee-for-service: pay individual-level claims
- The typical MMIS never was intended to be a strong tool for quality, population health, or performance measurement

CMS now is promoting "MITA" as the next generation MMIS . . .

- MITA, or "Medicaid Information Technology Architecture" is a set of design principles:
  - Interoperability across states and payers
  - Web-based applications
  - More nimble
  - Better linkages to non-payer databases, such as public health (e.g., immunization records)
  - Secure

. . . and MITA-based systems are still in the early adoption phase

- MITA is a concept that is only three years old
- States have invested a lot of resources in reconfiguring MMIS platforms (Y2K, HIPAA compliance, new capitated managed care modules), and are reluctant to embark on new investments in MITA
- MITA cross-state and cross-payer applications have yet to be significantly tested, but offer a promising future

Fraud & Abuse

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Medicaid fraud, waste and abuse activities have many forms . . .

- Cost avoidance
- “Pay and chase” third-party insurance
- Recoveries (tort and estate)
- Provider audits and settlements

. . . including inter-agency efforts . . .

- Federal task forces in many states include state Medicaid, FBI, DEA, Postal IG, Treasury, state AG, and federal US Atty.

- In addition, every state must have a “Medicaid Fraud Control Unit”, operating outside Medicaid, usually at an AG’s office

“Perfecting” fraud and abuse prevention is difficult and ongoing work, given the link to access . . .

Was the care appropriate?	Did Medicaid pay for the care? Yes	Did Medicaid pay for the care? No
Yes	Correct	Type II Error
No	Type I Error	Correct

Type I Error: Medicaid paid for medically-inappropriate care. Fraud and abuse problem.

Type II Error: Medicaid did not pay for medically-appropriate care. Access problem.

. . . improving fraud and abuse prevention risks denial of appropriate care . . .

Was the care appropriate?	Did Medicaid pay for the care? Yes	Did Medicaid pay for the care? No
Yes	Correct	Type II Error
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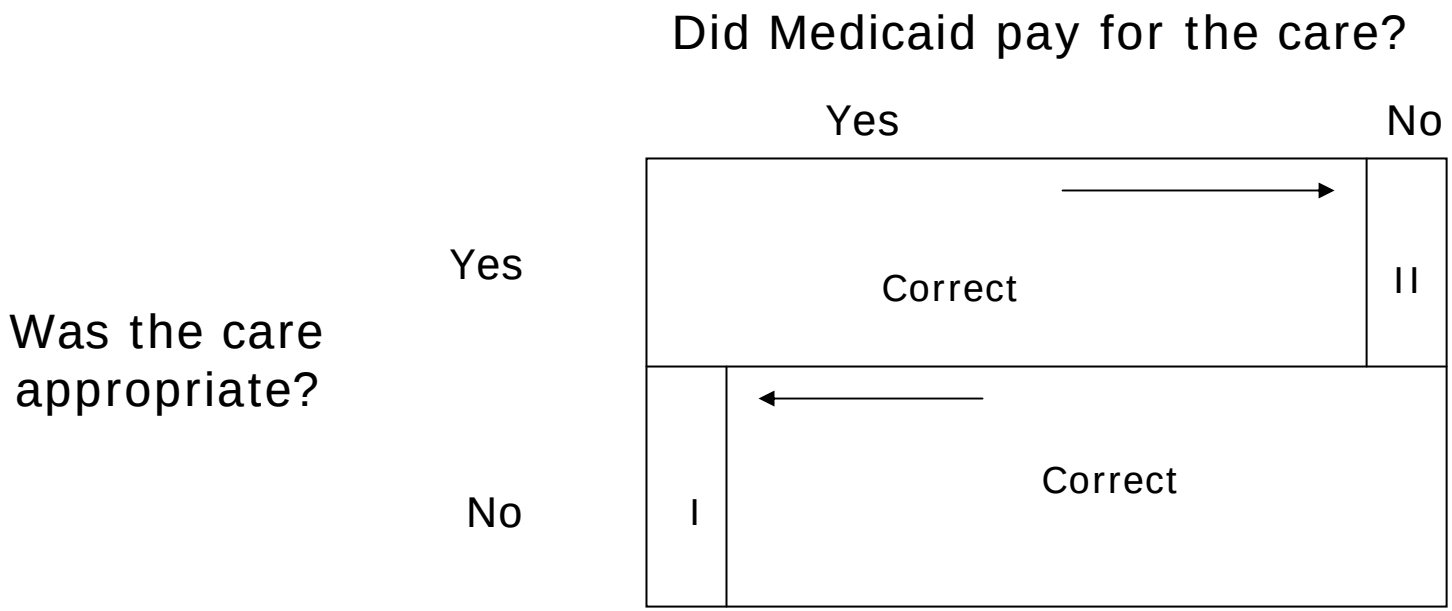
Type I Error: Medicaid paid for medically-appropriate care. Fraud and abuse problem.

Type II Error: Medicaid did not pay for medically-appropriate care. Access problem.

. . . to discern whether care should be paid requires good data on whether the care is appropriate for that patient.



Type I Error: Medicaid paid for medically-appropriate care.
Fraud and abuse problem.

Type II Error: Medicaid did not pay for medically-appropriate care.
Access problem.

Preview of Some Key Questions for the September 2006 Session

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Key recommendations in "program administration" from the Commission will include:

- Should Medicaid's current financing arrangements be altered?
- If Medicaid's subsidies are removed, should anything be developed as a substitute?
- Should Medicaid's IT platform be altered (e.g. adoption of MITA)?
- If so, should federal financing follow that?
- Should Medicaid's fraud and abuse framework be altered?

Questions

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