



# Chapter IV: MEDICAID ADMINISTRATION

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# HIGHLIGHTS

## MEDICAID ADMINISTRATION

**Medicaid is an entitlement program jointly administered by the federal government and states.** States administer the program on a day-to-day basis within broad federal guidelines set by the Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS). State participation in Medicaid is voluntary, but all states have chosen to participate. The federal government supports state administration by providing matching funds and establishing general programmatic guidelines.

**There is enormous variation from state to state as to how each state's Medicaid program is administered.** This variation arises because, although states must operate within federal guidelines, they retain broad flexibility in operating their programs. As a result of this flexibility, there are actually 51 separate and distinct Medicaid programs, one in each state and the District of Columbia. The flexibility allowed to states under federal Medicaid guidelines has resulted in significant variation in eligibility, benefits, and provider payment policies from state to state.

**The federal government provides matching funds to states for costs associated with purchasing covered health services and program administration.** These matching funds are provided on an open-ended basis. At the federal level, primary responsibility for overseeing the proper expenditure of these matching funds rests with CMS. In order for a state to receive federal matching payments, it must have in effect a state Medicaid plan approved by the Secretary of HHS.

**Generally, the federal government matches state administrative costs at a 50 percent rate.** Unlike the matching rates for the costs of covered services, which vary from state to state, the matching rates for administrative costs are uniform across all states. The costs of some administrative functions, such as operating management information systems, are matched at rates above 50 percent.

**The Center for Medicaid and State Operations (CMSO) within CMS is responsible for administering the Medicaid program at the federal level.** CMSO's duties include:

- Ensuring that states receive appropriate federal matching payments.
- Processing state Medicaid plan amendments and waiver requests.
- Interpreting federal statutory requirements for states, providers, and beneficiaries.
- Monitoring and enforcing state compliance with state Medicaid plans or waivers.
- Ensuring the efficient administration of the program by state and local agencies.
- Ensuring that federal matching funds are not spent improperly or fraudulently.
- Collecting accurate data on expenditure of federal funds.

**State Medicaid agencies administer the program on a day-to-day basis. Primary duties of a state Medicaid agency include:**

- Informing individuals who are potentially eligible and enrolling those who are eligible.
- Determining what benefits it will cover in which settings.
- Determining how much it will pay for covered benefits and from whom it will purchase services.
- Processing claims from fee-for-service providers and making capitation payments to managed care plans.
- Monitoring the quality of the services it purchases.
- Ensuring that state and federal health care funds are not spent improperly or fraudulently.
- Collecting and reporting information necessary for effective program administration and accountability.
- Resolving grievances by applicants, enrollees, providers and plans.

**Overall, a small percentage of federal and state resources are spent on Medicaid administration.** In total, states spent \$6.6 billion (federal and state funds combined) on program administration in FY 1997, representing 5 percent of total Medicaid spending. This is substantially less than the average 6.8 percent of premiums spent on administrative expenses by private insurers.



## INTRODUCTION

MEDICAID IS AN ENTITLEMENT PROGRAM under which the federal government makes matching funds available to states for the costs they incur in purchasing health and long-term care services for eligible low-income individuals. State participation is voluntary, and all states have chosen to participate. States administer the program on a day-to-day basis within broad federal guidelines. States are entitled to federal matching funds on an open-ended basis for the costs of the covered health and long-term care services that they purchase, as well as the allowable costs of administering the program. About five percent of total (federal and state) Medicaid spending in 1997 was attributable to administrative expenses.

In general, the federal government matches state administrative costs at a 50 percent rate. There are, however, certain administrative functions that are matched at higher rates. The federal government pays 100 percent of the costs incurred by states in operating the system for verifying immigration status of Medicaid applicants. The federal government pays 75 percent (and in some circumstances 90 percent) of the costs incurred by states in operating a management information system, surveying and certifying nursing homes, reviewing the quality of care in managed care organizations, and investigating and prosecuting fraud and abuse, among other functions.

At the federal level, primary responsibility for overseeing the proper expenditure of federal Medicaid matching funds rests with the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB). Within CMS (formerly the Health Care Financing Administration, or HCFA), the Center for Medicaid and State Operations (CMSO) is responsible for administering the Medicaid program. CMSO's duties include: (1) ensuring that participating states receive federal matching payments on a quarterly basis for their allowable costs for services and administration; (2) processing state Medicaid plan amendments and waiver requests; (3) interpreting federal statutory requirements for states, providers, and beneficiaries; (4) monitoring and enforcing state compliance with state Medicaid plan (or waiver) requirements; (5) ensuring the quality of institutional services paid for with federal Medicaid funds; (6) ensuring the efficient administration of the program by state and local agencies; (7) ensuring that federal matching funds are not spent improperly or diverted by fraudulent providers; (8) ensuring compliance by participating providers, managed care plans, and state agencies with federal anti-discrimination laws; and (9) collecting accurate data on the expenditure of federal funds.

State Medicaid agencies are responsible for administering the Medicaid program on a day-to-day basis. Like any other health insurer, the state Medicaid agency must (1) inform individuals who are potentially eligible and enroll those who are eligible; (2) determine what benefits it will cover in which settings; (3) determine how much it will pay for the benefits it covers and whether it will buy those services from fee-for-service providers and/or managed care plans; (4) establish standards for the providers and managed care plans from which it will purchase covered benefits and enroll (or contract with) those which meet the standards; (5) process and pay claims from fee-for-service providers and make capitation payments to managed care plans; (6) monitor the quality of the services it purchases to ensure that beneficiaries are protected from, and that federal taxpayers are not subsidizing, substandard care; (7) ensure that state and federal health care funds are not spent improperly or diverted by fraudulent providers; (8) have in place a process for resolving grievances by applicants, beneficiaries, and providers; and (9) collect and report information necessary for effective administration and program accountability.

A long-standing Medicaid administrative issue is the lack of accurate, timely, and reliable Medicaid policy and program data at the national level. Although the Secretary of HHS does not administer Medicaid on a day-

to-day basis, the Secretary is accountable to the Congress for the expenditure of some \$130 billion in federal matching funds annually. Currently, Medicaid data systems are not capable of producing accurate and current information necessary to determine the extent to which Medicaid payments are being made for proper purposes and not lost to inadvertent error or fraud. In addition, current Medicaid data systems do not enable either federal policymakers or the public to obtain accurate, current information on the number and types of enrolled individuals in each state, the kinds of services they use, and the amounts paid for those services.

Administering the Medicaid program is as challenging a task as there is to be found in public service. The program's sheer scale—\$130 billion in federal outlays and perhaps as much as \$98 billion in state and local funds to purchase services on behalf of over 44 million beneficiaries in fiscal year 2001<sup>1</sup>—would in and of itself make Medicaid a formidable undertaking. What distinguishes Medicaid in degree of difficulty, however, is its varied and vulnerable beneficiary groups (low-income pregnant women, children, parents, frail elderly, and individuals with disabilities); its means-tested eligibility rules; the scope of its benefits package (spanning over 30 different categories of acute and long-term care services); its interactions with other payors (Medicare, the State Children's Health Insurance Program (SCHIP), and private health insurers); its financial, regulatory, and political transactions with a wide range of provider groups; its joint federal and state financing; and its state-by-state variation in policies and procedures.

States have developed innovative and unique responses to these myriad challenges, and several programs have received national recognition for their efforts.<sup>2</sup> How well the Medicaid program is administered has important implications for access to quality care for low-income Americans. Medicaid coverage, in and of itself, does not ensure access to quality care unless those eligible are actually enrolled and providers and health plans are willing to participate in the program and deliver quality care. If state outreach efforts are effective, and if enrollment procedures are consumer-friendly, more individuals who are eligible for Medicaid will enroll in their state's program.<sup>3</sup> If states pay providers and managed care plans adequate rates on a timely basis, more of them are likely to participate in the program, giving Medicaid beneficiaries more sites and more practitioners through which to access covered services.<sup>4</sup> If state monitoring of providers and managed care plans is effective, the incidence of poor quality care will be reduced. Finally, if state administrative systems are effective, then the amount of funds lost to fraud and other

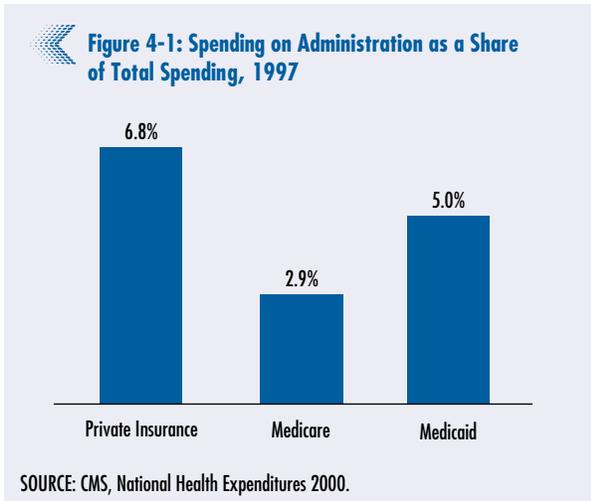
improper payments will be minimized. State and federal Medicaid funds not paid out to substandard or fraudulent providers or plans will be available for the purchase of needed services, the enhancement of reimbursement to quality providers and plans, and other program improvements.

This chapter begins with an overview of the federal-state framework within which Medicaid is administered and the different tasks that must be performed.<sup>5</sup> It then examines the federal-state matching arrangements and the resulting expenditures for various administrative functions. The chapter concludes by discussing some current issues in Medicaid program administration, including the shortcomings in program and policy data at the national level. This chapter does not discuss administrative arrangements specific to particular states.<sup>6</sup> Nor does it discuss the role of federal or state courts in enforcing the statutory responsibilities of federal or state administrative agencies.<sup>7</sup> The footnotes in the chapter are designed to provide a roadmap for readers seeking further information on particular issues.

## I. OVERVIEW

Medicaid is an entitlement program under which the federal government makes matching funds available to states for the costs they incur in paying health care providers for delivering covered services to eligible low-income individuals.<sup>8</sup> State participation is voluntary, and all states have chosen to participate. The Medicaid entitlement runs to individuals as well as to participating states. Low-income Americans who meet their state's Medicaid eligibility criteria are entitled to have payment made on their behalf for covered services. States are entitled to federal matching funds for their costs of this coverage, including the costs of administration.

Day-to-day responsibility for administration of Medicaid rests with the states. While states must operate within federal guidelines in order to receive federal matching funds for their administrative costs, these guidelines give the states broad flexibility in operating their programs. As Tallon and Brown have observed, "Medicaid was, after all, born devolved and, national exertions and intrusions notwithstanding, still leaves the states vast discretion over decisions on eligibility, benefits, and more."<sup>9</sup> The result, predictably, is enormous variation from state to state as to how each state's Medicaid program is administered, and by whom. For example, an August 2000 survey by the American Public Human Services Association (APHSA) found that states have placed their Medicaid agencies in different bureaucratic configurations. In 17 states, the Medicaid agency also administers the state's Temporary



Assistance for Needy Families (TANF) cash assistance program; in ten states, the Medicaid agency is part of the public health department; in 12 states, it is located within an “umbrella” public health and human services agency; and in 12 states the Medicaid program is considered “stand-alone” because it is not administered in conjunction with either the public health or TANF programs.<sup>10</sup>

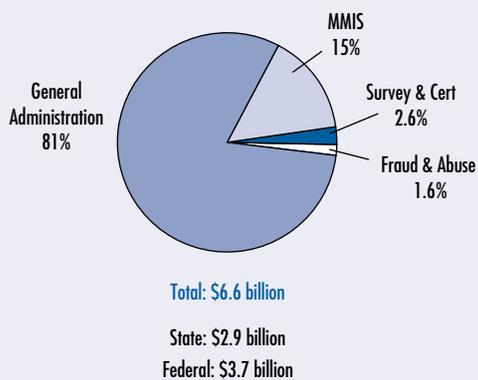
Given the broad scope of Medicaid’s responsibilities, a surprisingly small percentage of federal and state resources are spent on administration. As shown in Figure 4-1, about 5 percent of total (federal and state) Medicaid spending in 1997 was attributable to administrative costs.<sup>11</sup> This is substantially less than the average 6.8 percent of total spending that private insurers devote to administrative expenses, although it is substantially more than the 2.9 percent of spending on Medicare that goes to administrative costs. Comparing administrative costs across these insurers is imprecise because different types of insurers have different administrative requirements. For example, neither private insurers nor Medicare purchase as broad an array of acute and long-term care services as Medicaid does, nor do they bear the costs of duplication inherent in a decentralized program administered by 50 states, the District of Columbia, and five territories, each with its own set of agencies and information systems. And unlike Medicaid, neither private insurers nor Medicare are required to determine (or redetermine) the income and (in many cases) resources of each of their enrollees. In addition, the administrative costs of private insurers contain elements such as marketing, sales commissions, and profit that are unique to the private market.

The range of administrative responsibilities facing state Medicaid programs is sobering. These include: conducting eligibility determinations and enrolling beneficiaries; defining the scope of covered benefits; administering fair hearings to resolve disputes regarding eligibility or coverage; credentialing individual practitioners and surveying and certifying institutional providers; establishing reimbursement rates for fee-for-service providers; contracting with, and overseeing the performance of, managed care organizations; conducting quality assurance activities in both fee-for-service and managed care sectors; paying Medicare premiums and cost-sharing for dually eligible beneficiaries; collecting reimbursements from liable third parties; maintaining a management information system; detecting and prosecuting fraud and abuse; and submitting claims for federal matching payments (and related supporting data). In particular, the transition from fee-for-service to managed care purchasing has created significant new administrative challenges for states.<sup>12</sup>

States are entitled to federal Medicaid matching funds for all of their allowable administrative costs. There is no ceiling on the amount of federal matching funds a state may claim for allowable administrative costs. In general, the federal government will match these costs at a 50 percent rate. There are, however, certain administrative functions that are matched at higher rates. The federal government pays 100 percent of the costs reasonably incurred by states in operating the system for verifying immigration status of Medicaid applicants. The federal government pays 75 percent (and in some cases 90 percent) of the costs reasonably incurred by states in surveying and certifying nursing homes, reviewing the quality of care in managed care organizations, investigating and prosecuting fraud and abuse, and operating a management information system, among other functions. In FY 1997, the latest year for which reliable data are available, the federal government and the states spent \$6.6 billion on Medicaid program administration. Figure 4-2 breaks down this spending by function. (For a detailed description of how these estimates were derived, see *Exhibit B: Estimating Medicaid Administrative Spending*, p. 153).

At the federal level, primary responsibility for overseeing the proper expenditure of federal Medicaid matching funds rests with the CMS in HHS and the OMB. Within CMS the CMSO is responsible for Medicaid administration. Of CMS’s 4,570 employees in FY 2000,

**Figure 4-2: Total Spending on Medicaid Administration, Fiscal Year 1997**



SOURCE: Fiscal Year 1997 HCFA-64 report, 1997 HCFA survey and certification, fraud and abuse estimates

about 425, or nine percent, are assigned to CMSO's central office and throughout the ten CMS regions; most of the remaining staff are involved in administration of Medicare. (There are no national data on the number or cost of state personnel (or contract employees) involved in administering Medicaid.) Other federal agencies with oversight responsibilities include: the HHS Office of Inspector General (OIG), which enforces federal fraud and abuse laws; the HHS Office of Civil Rights (OCR), which enforces federal anti-discrimination laws; and the Department of Justice, which has responsibility for enforcement of both fraud and abuse and civil rights laws.

Since Medicaid's enactment in 1965, its federal-state design has virtually guaranteed tension between the two levels of government. As the amount of federal funds spent through the Medicaid program has increased and as the role of federal Medicaid matching funds in state budgets has grown, the fiscal and political stakes for both the federal and state governments have risen substantially. Disputes between states and CMS over the propriety of state claims for federal matching funds are formally determined by the HHS Departmental Appeals Board (DAB) and, ultimately, the federal courts. Some of these disputes, however, find their way into the Congressional arena. For example, the 1999 dispute over the propriety of state claims for administrative costs relating to the provision of school-based services triggered a GAO report and a Congressional hearing.<sup>13</sup>

Medicaid's federal-state design has also complicated efforts to ensure accountability for program results. With at least two (and in some states three) levels of government involved in the administration of the program, and with multiple agencies having statutory or

regulatory authority at each of these levels, there is ample opportunity for deflection or obfuscation of responsibility as well as basic confusion. For example, a 1999 study of state Medicaid and SCHIP outreach and enrollment strategies found that, in California, efforts to simplify the Medicaid program at the state level were undercut by implementation problems in the 58 counties that administer program eligibility: "... while the Medi-Cal asset test for children has officially been waived, many county eligibility workers still request asset information, either because they do not understand the new policy or they believe that files without this information will be considered incomplete."<sup>14</sup> Similarly, a study of implementation of welfare-to-work policies by counties in California found that specialization of staff in welfare issues resulted in "isolated and ill-informed [county welfare] staff who could not adequately promote Medi-Cal enrollment to families enrolling in and/or terminating from [welfare]."<sup>15</sup>

## II. FEDERAL-STATE FRAMEWORK

In contrast to Medicare, which is administered by the federal government through CMS, Medicaid is administered jointly by federal and state governments. State participation in Medicaid is voluntary, and all states have chosen to offer Medicaid coverage to their residents. In order to receive federal Medicaid matching payments for the costs of providing covered services to eligible individuals, a state must have in effect a state Medicaid plan that has been approved by the Secretary of HHS as satisfying the requirements of Title XIX of the Social Security Act. A participating state's basic responsibility is to administer its Medicaid program in accordance with an approved state Medicaid plan. The Secretary's basic responsibility is to ensure that federal Medicaid matching funds are paid to participating states in compliance with the requirements of Title XIX. State Medicaid plans are posted on CMS's web site.<sup>16</sup>

### State Responsibilities

There are 63 separate statutory requirements that state Medicaid plans must meet.<sup>17</sup> About a third of these relate directly to administration (see Exhibit A, p. 151). When Medicaid was first enacted in 1965, there were only 22 such requirements, ten of which related directly to administration.<sup>18</sup> As the scale of the Medicaid program has grown to accommodate population and health system growth, state administrative responsibilities have increased. Despite the numerous federal regulatory requirements, however, states retain substantial flexibility in administering their Medicaid programs.

Since the enactment of Medicaid in 1965, a fundamental policy premise has been the primary role of the states in its day-to-day administration. Each state, in its state Medicaid plan, must set forth what the statute terms “methods of administration.” The statute expressly prohibits the Secretary from exercising any authority with respect to “the selection, tenure of office, and compensation of any individual employed [by the state under its merit personnel system] in accordance with such methods.”<sup>19</sup> On paper, the Secretary has authority to disapprove “methods of administration” that the Secretary finds are not “necessary for the proper and efficient operation of the plan.” However, this authority has rarely, if ever, been invoked, and CMS has never issued any regulations specifying what “methods of administration” are in its judgment “necessary for the proper and efficient operation” of a state’s program.<sup>20</sup>

A state must designate a “single state agency” to “administer or supervise the administration” of its Medicaid program.<sup>21</sup> The “single state agency” is strictly a statutory concept; in reality, most state Medicaid programs are administered by several state and local agencies as well as private contractors. This is because the “single state agency” may delegate to other state agencies, to localities, or to private entities, any of its administrative responsibilities other than the issuance of policies, rules, or regulations.<sup>22</sup> An August 2000 APHSA survey found wide variation among the states with respect to operational responsibility for 16 key administrative functions ranging from eligibility policy to fraud and abuse. In only five states (Colorado, Illinois, Massachusetts, Minnesota, and Nebraska) does the Medicaid agency administer (or share in the administration of) all 16 functions. In the remaining states one or more of the functions was delegated to other state agencies, local agencies, or private contractors. A total of 29 states reported contracting out one or more of these 16 functions to the private sector; the function most commonly contracted out was Medicaid management information systems (MMIS) operations.<sup>23</sup>

All state Medicaid agencies are subject to one structural requirement regarding provider and beneficiary input. Under CMS regulations, the agency director must appoint a “Medical Care Advisory Committee” consisting of physicians and other health professionals, Medicaid beneficiaries, and the director of the public health or welfare agency.<sup>24</sup> The Committee “must have opportunity for participation in policy development and program administration.” Costs of maintaining and staffing this Committee are eligible for federal matching funds at the general administrative 50 percent rate.

## Federal Responsibilities

While primary responsibility for the day-to-day administration of Medicaid rests with state Medicaid agencies, the Secretary of HHS, through CMS, has a number of important administrative responsibilities. These fall into nine broad areas: (1) ensuring that participating states receive federal matching payments on a quarterly basis for their allowable costs for services and administration; (2) processing state Medicaid plan amendments and waiver requests; (3) interpreting federal statutory requirements for states, providers, and beneficiaries; (4) monitoring and enforcing state compliance with state Medicaid plan (or waiver) requirements; (5) ensuring the quality of institutional services paid for with federal Medicaid funds; (6) ensuring the efficient administration of the program by state and local agencies; (7) ensuring program integrity; (8) ensuring compliance by participating providers, managed care plans, and state agencies with federal anti-discrimination laws; and (9) collecting accurate data on the expenditure of federal funds. In addition, CMS carries out a few uniquely federal tasks, including administration of more than \$2.5 billion in rebates paid annually to states and the federal government by about 500 manufacturers under the Medicaid drug rebate program,<sup>25</sup> as well as implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) “administrative simplification” requirements that are designed to standardize electronic claims and payment transactions among Medicaid and other government programs, private insurers and managed care plans, and health care providers.<sup>26</sup>

**Administering matching payments.** CMS is responsible for making quarterly payments of federal matching funds to participating states for their allowable expenditures for services and administration. The states submit, on a quarterly basis, a form (HCFA-64) that sets forth their Medicaid expenditures by category. CMS reviews these expenditures to determine whether they are allowable.<sup>27</sup> If, in CMS’s judgment, a particular state expenditure is not allowable, or if there is insufficient information to determine whether it is allowable, CMS either defers payment on that expenditure to a subsequent quarter or disallows the expenditure and withholds payment altogether. In the event of a disallowance, states have the opportunity to appeal to the Departmental Appeals Board (DAB) within the Office of the Secretary,<sup>28</sup> and eventually to the federal courts. As a practical matter, disallowances are rarely taken.<sup>29</sup> The GAO has expressed concerns regarding CMS’s oversight of state spending of federal Medicaid funds in certain areas.<sup>30</sup>

**Processing state Medicaid plan amendments and waivers.** In order for a state to receive federal matching payments, it must have in effect a state Medicaid plan approved by the Secretary.<sup>31</sup> A state that wants to change the way it administers its program—for example, by adding an optional service, dropping an optional eligibility group, or changing a provider reimbursement methodology—must submit a state plan amendment (SPA) to CMS for a determination as to whether the proposed change complies with the requirements of Title XIX. Similarly, if the Congress amends Title XIX to impose a new state plan requirement—for example, to require all states to extend Medicaid coverage to pregnant women and infants with family incomes at or below 133 percent of the federal poverty level—the state Medicaid agency must submit an SPA to cover this population. States that wish to receive federal matching funds for services or populations not allowable under Title XIX must request a waiver from CMS.<sup>32</sup> Although as a formal matter CMS is the decision-making agency, because most state waiver requests have federal budget implications, the Office of Management and Budget (OMB) is usually involved in their review. In the case of high visibility waivers, such as Tennessee’s “TennCare” statewide managed care demonstration, the negotiations involve not only CMS and OMB but White House staff as well.<sup>33</sup>

**Interpreting federal statutory requirements for states and providers.** As a federal agency, one of CMS’s responsibilities is to interpret the federal laws it administers. The complexity of the Medicaid statute makes this a particularly important task: states and participating providers need to understand what is expected of them, and beneficiaries need to understand what it is they are entitled to. CMS has three formal mechanisms for interpreting the Medicaid statute: (1) regulations published in the Federal Register after notice and comment;<sup>34</sup> (2) transmittals compiled in the State Medicaid Manual (HCFA Pub. 45);<sup>35</sup> and (3) letters to State Medicaid Directors.<sup>36</sup> Occasionally, CMS also issues guidances to states on particular issues, such as school-based services,<sup>37</sup> fraud in managed care,<sup>38</sup> and outreach and enrollment.<sup>39</sup>

The Secretary has broad authority to issue regulations “as may be necessary to the efficient administration of the functions with which [he] is charged under Title XIX.”<sup>40</sup> In some cases, the Medicaid statute directs the Secretary to implement a specific policy by regulation,<sup>41</sup> but in most cases the statute is silent. But this does not mean that CMS will not issue a regulation. For example, the statute contains very broad language stipulating that payments to providers must be consistent with “efficiency, economy, and quality of care;” CMS has grafted onto this language a regulatory construct known as upper payment limits

(UPLs).<sup>42</sup> In other cases, however, CMS has elected not to provide any formal interpretation (i.e., the state plan requirement that care and services be provided “in a manner consistent with simplicity of administration and the best interests of the recipients”).<sup>43</sup>

**Monitoring and enforcing state compliance.** As discussed above, if CMS finds that a state expenditure is not allowable under the Medicaid statute, it has the authority to disallow the federal matching funds claimed by the state (subject to administrative and judicial review). However, there are numerous state Medicaid plan requirements that are not directly tied to state expenditures, such as the requirement that states provide “fair hearings” to applicants or beneficiaries who are denied enrollment in the program or who are denied coverage for a particular service.<sup>44</sup> In these circumstances, CMS has the statutory authority to initiate a “compliance” proceeding. Under the statute, if the Secretary finds that “in the administration of the [state Medicaid] plan there is a failure to comply substantially with any [state plan requirement],” the Secretary may, after notice and hearing for the state, withhold some or all federal Medicaid matching payments to the state until it no longer fails to comply.<sup>45</sup> CMS has not brought a compliance proceeding against a state for at least the last decade.

**Ensuring efficient administration by state Medicaid agencies.** The federal government has two interests in the efficient administration of Medicaid by state (and local) agencies and their contractors. First, the Secretary is only authorized to make federal matching payments to states for their administrative costs if those costs are “necessary ... for the proper and efficient” administration of the program. At the current level of federal commitment for such costs—nearly \$7 billion per year and projected to grow at 10 percent annually<sup>46</sup>—the question as to which expenditures are “proper and efficient” is of obvious financial consequence to the states, their contractors, and the federal government. It should be noted that inefficient administration involves not just excessive or redundant spending but also the failure to make necessary investments in new information or quality assurance technologies.

Second, inefficient administrative practices—whether they involve too much or too little spending—have implications beyond federal matching funds for administrative costs. They can also result in inappropriate federal spending on benefits. Thus, one of CMS’s administrative duties is to monitor state compliance with the statutory standard that benefits payments attributable to individuals erroneously determined to be eligible not exceed three percent of a state’s total Medicaid spending.

(State implementation of this so-called “Quality Control” standard is discussed below.)

**Ensuring the quality of institutional care.** As a general rule, the federal government relies on state licensure to ensure that providers participating in Medicaid offer care of a quality consistent with professional standards.<sup>47</sup> However, the long history of substandard care in nursing facilities, combined with the significant federal expenditures for services in these institutions, led the Congress in 1987 to authorize and require the Secretary to play a more aggressive role in their regulation.<sup>48</sup> State survey agencies have the primary responsibility for ensuring that nursing facilities meet federal requirements for participation, but they must use a standard protocol developed by CMS in conducting those surveys.<sup>49</sup> The Secretary is required by statute to conduct annual, onsite “look behind” or “validation” surveys of nursing facilities (using the same standard protocol) in order to ensure the accuracy of the state surveys.<sup>50</sup> CMS may, on the basis of its survey findings, impose civil money penalties or other intermediate sanctions on a substandard facility or terminate the facility’s participation in Medicaid altogether.<sup>51</sup> Moreover, if the Secretary determines, based on the validation surveys, that a state’s survey and certification performance is “not adequate,” the Secretary is required to reduce the federal matching payments to the state for its administrative costs.<sup>52</sup>

There has been considerable concern on the part of GAO regarding the effectiveness of state survey and certification activities, and CMS oversight of those activities, in ensuring quality of care received by nursing facility residents at federal (and state) expense.<sup>53</sup> In response to Congressional interest, CMS, with the support of increased appropriations, has expanded its monitoring and enforcement activities:

“In 1997 and 1998, we spent considerable time assessing the effect of the 1995 regulations and considering what changes needed to be made in order to realize more fully the objectives of the OBRA 1987 reforms. We presented our findings to the Congress in a July 1998 Report. We concluded that State-run nursing home inspections were too predictable, with inspectors frequently appearing on Monday mornings and rarely visiting on weekends or during evening hours, allowing nursing homes to prepare for inspections. Several States had rarely cited any nursing homes for substandard care. Nursing home residents were suffering unnecessarily from easily prevented clinical problems such as bed sores, malnutrition, and dehydration. We were also

concerned that residents were still experiencing physical and verbal abuse, and neglect.”<sup>54</sup>

The results of annual inspections of facilities by state survey and certification agencies, as well as the results of state investigations of complaints against particular facilities, are reported to CMS and compiled in databases that are available for public analysis.<sup>55</sup> Information about each nursing facility participating in Medicaid (and Medicare) is then posted on CMS’s website.<sup>56</sup> A 2001 survey identified the need for improvement in federal regulatory procedures in order to strengthen state enforcement of quality standards.<sup>57</sup>

**Ensuring program integrity.** As the disburser of federal Medicaid matching funds, CMS has the responsibility for minimizing the amount of improper federal Medicaid matching payments to providers, plans, and other contractors. Improper payments include both payments made for uncovered services due to inadvertent errors as well as payments made to fraudulent providers for services billed but not actually provided. Efforts to detect and secure improper payments after they have been made are, in GAO’s experience, “often costly and typically recover only a small fraction of the identified misspent funds.”<sup>58</sup> These unrecovered improper payments are unavailable for the purchase of covered services for program beneficiaries. According to GAO, “Medicaid is at risk for billions of dollars in improper payments. The exact amount is not known because few states measure the overall accuracy of their payments.”<sup>59</sup> (The amount of improper Medicare payments is estimated at seven percent.)<sup>60</sup> An audit of CMS’s FY 2000 financial statement by Ernst & Young noted as a reportable condition that “[n]o methodology currently exists for estimating the range of improper Medicaid payments on a national level” and that CMS is therefore “unable to draw any conclusions at a national level on improper Medicaid payments.”<sup>61</sup>

The OIG, in conjunction with the Department of Justice, has responsibility for monitoring and enforcing compliance with federal fraud and abuse laws that apply to providers and managed care plans participating in Medicaid.<sup>62</sup> Violations of these laws, including the submission of false or fraudulent claims and the furnishing of services that are unnecessary or that do not meet standards of care, may be sanctioned through the imposition of civil money penalties, and/or exclusion from the Medicaid (and Medicare) program. The OIG also carries out the Secretary’s duty to certify annually that each state’s Medicaid fraud control unit (MFCU) meets federal statutory requirements regarding investigation and prosecution of fraud under State law.<sup>63</sup>

Although OIG has principal responsibility at the federal level for detection and prosecution of Medicaid fraud, CMS also furnishes technical assistance to state Medicaid agencies.<sup>64</sup>

**Ensuring compliance with Federal anti-discrimination laws.** OCR has responsibility for monitoring and enforcing compliance with federal anti-discrimination laws that apply to recipients of “federal financial assistance,” such as federal Medicaid matching funds. Recipients of federal Medicaid matching funds include state Medicaid agencies, providers participating in Medicaid and managed care plans, fiscal agents, and other entities contracting with state Medicaid agencies for program-related purposes. Among the laws enforced by OCR are Title VI of the Civil Rights Act of 1964,<sup>65</sup> which bars discrimination in federal programs on the basis of race, color, or national origin, and the Americans with Disabilities Act of 1990,<sup>66</sup> which bars discrimination on the basis of disability in the administration of federal programs. In 2000, OCR issued detailed guidelines regarding the obligations of participating providers and managed care plans with respect to persons with limited English proficiency.<sup>67</sup> OCR is also involved in the implementation of the Supreme Court’s 1999 ruling in *Olmstead v. L.C. ex. rel. Zimring*, which requires placement of persons with mental disabilities in community settings rather than institutions under certain circumstances, as that ruling relates to Medicaid.<sup>68</sup>

**Collecting accurate data on the expenditure of federal funds.** The Secretary is accountable to the Congress for the proper expenditure of federal Medicaid matching funds. CMS submits annual reports to House and Senate Appropriations Committees providing some detail on program expenditures.<sup>69</sup> Much of this information, however, must necessarily be collected from the state Medicaid agencies. The accuracy, comparability, and timeliness of the information available to CMS from state agencies is, in turn, heavily dependent upon reliable state management information systems. Enhanced Medicaid matching rates are available to states for the costs of developing (90 percent) and operating (75 percent) Medicaid Management Information (MMIS) systems that meet six specific federal statutory requirements, each of which requires the application of specifications developed by CMS and other federal agencies. These include requirements that the MMIS be (1) “adequate to provide efficient, economical, and effective administration” of the state Medicaid plan, (2) capable of providing “accurate and timely “ data, and (3) able to provide for electronic transmission of claims data consistent with the Medicaid Statistical Information System (MSIS) in a format specified by CMS.<sup>70</sup>

### III. STATE ADMINISTRATIVE FUNCTIONS

From an administrative perspective, Medicaid is a health insurance program: it purchases a broad range of acute and long-term care services on behalf of eligible low-income individuals. Like any other health insurer, the state Medicaid agency faces nine generic administrative tasks. (1) It must inform individuals who are potentially eligible and enroll those who are eligible. (2) It must determine what benefits it will cover in what settings. (3) It must determine how much it will pay for the benefits it covers and whether it will buy those services from fee-for-service providers and/or managed care plans. (4) It must establish standards for the providers and managed care plans from which it will purchase covered benefits and enroll (or contract with) those which meet the standards. (5) It must process and pay claims from fee-for-service providers and make capitation payments to managed care plans. (6) It must monitor the quality of the services it purchases to ensure that beneficiaries are protected from, and that federal taxpayers are not subsidizing, substandard care. (7) It must ensure that state and federal health care funds are not spent improperly or diverted by fraudulent providers. (8) It must have in place a process for resolving grievances by applicants, beneficiaries, and providers. (9) It must collect and report information necessary for effective administration and program accountability.

In each case, these administrative tasks are the primary responsibility of the states. In carrying out these tasks, the state agencies and their contractors must work within federal requirements. In some instances, such as nursing home quality standards, the federal requirements are prescriptive; in most cases, however, they are quite broad, allowing considerable discretion to state Medicaid agencies. There are relatively few specific, empirical federal performance standards to which state Medicaid agencies must adhere. The most prominent of these, under the rubric of “quality control,” sets a threshold for spending resulting from erroneous eligibility determinations. The following discussion provides an overview of the basic federal-state arrangements in each of these functional areas, as framed by the statutory state plan requirements.

Within most of these functional areas, there is an important distinction between fee-for-service and managed care. Historically, state Medicaid agencies purchased almost all of their covered services on a fee-for-service basis. During the 1990s, however, there was a dramatic increase in the number of Medicaid beneficiaries enrolled in managed care plans and, correspondingly, in the amount of Medicaid funds

flowing to these plans in the form of monthly capitation payments. By 1999, nearly 56 percent of all Medicaid beneficiaries were enrolled in some form of managed care; in 14 states, managed care enrollment exceeded 75 percent.<sup>71</sup> In FY 2000, \$14.7 billion in federal matching payments, or 12.5 percent of all federal Medicaid spending that year, flowed to managed care plans.<sup>72</sup>

Medicaid managed care takes two forms: primary care case management (PCCM) and managed care organizations (MCOs). Under the PCCM approach, providers are paid on a fee-for-service basis; beneficiaries are assigned to a physician case manager who is paid a monthly fee to manage the use of specialty and hospital care but who does not assume financial risk. Under the MCO approach, beneficiaries are enrolled in an MCO that receives a monthly capitation payment from the state Medicaid agency in exchange for assuming responsibility for the provision of hospital and other covered services. About four out of every five Medicaid beneficiaries enrolled in managed care arrangements in 1999 were enrolled in MCOs; the rest were enrolled in PCCMs.<sup>73</sup>

The administrative demands of the PCCM approach upon state Medicaid agencies differ from those of an MCO approach. Under the PCCM approach, state agencies must focus on ensuring the participation of physician case managers, administering the assignment of beneficiaries to case managers, and monitoring the use of services by enrollees and the quality of care received. The MCO approach poses additional challenges. As Verdier and Young have noted, “Risk-based managed care purchasing requires state Medicaid agencies to do business in ways that differ in major respects from the manner in which they have operated in traditional Medicaid fee-for-service programs. ... State Medicaid managed care programs are businesses that are purchasing hundreds of millions (often billions) of dollars worth of health care services each year on behalf of some of the nation’s most vulnerable citizens.”<sup>74</sup> The purchase of covered services from MCOs on a risk basis creates new administrative responsibilities for state Medicaid agencies, including development of requests for proposal (RFPs) and contracts, actuarial rate-setting, educating and enrolling beneficiaries, developing new data systems, monitoring MCO solvency, and arranging for independent external quality reviews.<sup>75</sup>

## Beneficiary Outreach and Enrollment

There are few federal requirements that state Medicaid programs must follow with respect to outreach and enrollment. First, states are required to ensure that all

individuals who want to apply for Medicaid coverage have the opportunity to do so; states must furnish Medicaid coverage to applicants who are eligible with “reasonable promptness.”<sup>76</sup> CMS has interpreted this requirement to mean that a state has 45 days from the date of application to make a decision on an application and mail a notice of its decision to the applicant (90 days in the case of individuals applying on the basis of disability), except in “unusual circumstances.”<sup>77</sup> Second, a state Medicaid agency may not delegate the responsibility for making final eligibility determinations to private contractors,<sup>78</sup> but it may delegate this task to state or local welfare agency personnel.<sup>79</sup> Third, as discussed below, states must limit their errors in making determinations that individuals are eligible for Medicaid so that not more than three percent of their spending is attributable to individuals who are erroneously enrolled. Fourth, states must allow pregnant women and children to apply for Medicaid at locations other than welfare offices, such as provider sites serving large numbers of low-income uninsured patients (e.g., disproportionate share hospitals (DSH) and federally-qualified health centers (FQHCs)), and must use application forms other than those used for cash assistance.<sup>80</sup> Finally, a state must provide “safeguards” to ensure that eligibility for coverage will be determined “in a manner consistent with simplicity of administration and the best interests of recipients.”<sup>81</sup> CMS has not provided any regulatory guidance on how states should operationalize this state plan requirement.<sup>82</sup>

Federal Medicaid law imposes no other specific requirements on states relating to outreach and enrollment. States are not required to conduct outreach efforts to identify potentially eligible individuals, inform them of the program, or assist them in applying for coverage; they are not required to use a standard “streamlined” application form, and they are not required to use consumer-friendly enrollment procedures, such as mail-in applications. States may, however, adopt such policies and receive federal matching funds at the general administrative rate of 50 percent for the costs of such activities, and many states do so. For example, a survey conducted in the summer of 2000 found that 35 states were marketing Medicaid and their State Children’s Health Insurance Programs (SCHIP) jointly to uninsured children and families, and seven states were marketing their Medicaid and SCHIP programs separately. Only six of the 48 reporting states (Colorado, Iowa, Montana, New Jersey, Utah, and Virginia) were marketing their SCHIP programs but not their Medicaid programs.<sup>83</sup> Similarly, a July 2000 survey of state enrollment procedures found that 39 states and the District of Columbia had eliminated the requirement for a face-to-face interview for children.<sup>84</sup>

Other than the 45- or 90-day standard for processing applications for Medicaid eligibility, the only concrete performance standard to which states are subject with respect to outreach or enrollment has to do with erroneous eligibility determinations. Under the so-called “Quality Control” standard, states must keep their “erroneous excess payments” at three percent of total Medicaid benefits payments or less.<sup>85</sup> For this purpose, an erroneous payment is a payment made on behalf of an ineligible individual. The three percent standard is enforced with a prohibition on the payment of federal matching funds for erroneous state payments above the standard. The Secretary may waive this penalty if the state made a “good faith effort” to achieve the three percent rate. No federal matching funds have been withheld from any state for a violation of this performance standard during the past two decades.

Two points should be noted regarding Medicaid eligibility errors. First, each state is held to accuracy against its own eligibility rules. Thus, states that have streamlined their eligibility criteria—for example, by eliminating resource tests—have fewer occasions to commit error. Second, under the current “Quality Control” methodology, there is no comparable performance standard for erroneous denials or terminations of Medicaid coverage to individuals who are in fact eligible. CMS has, however, encouraged states to use their Medicaid Eligibility Quality Control (MEQC) programs to target closed cases to determine if beneficiaries were improperly terminated because of a termination of Temporary Assistance for Needy Family (TANF) benefits.<sup>86</sup>

In states that purchase covered services through managed care, enrollment in Medicaid is not the state’s only administrative task. Individuals enrolled in Medicaid must also enroll (or be enrolled) in an MCO or PCCM programs. In most instances, Medicaid beneficiaries who elect to (or are required to) enroll in managed care are given a choice of at least two plans. This poses additional administrative responsibilities for states, including informing beneficiaries of their choices, enrolling them in the MCO or PCCM of their choice, and processing disenrollments for cause.<sup>87</sup> In 2000, 33 states reported that they contracted out one or more of these functions to private entities known as enrollment brokers.<sup>88</sup>

## Defining Scope of Covered Benefits

Federal Medicaid law imposes certain requirements on states with respect to their Medicaid benefits packages. These requirements, which are discussed in some detail in the Benefits Chapter,<sup>89</sup> stipulate certain types of services that a state must cover (e.g., physician, hospital,

laboratory, and nursing facility services) and certain types that a state may cover with federal matching funds (e.g., prescription drug, clinic, preventive, and case management services). Within each type of benefit, states have flexibility to impose limitations (e.g., 20 inpatient hospital days per year), so long as the benefit’s resulting amount, duration, or scope is, in the judgment of the Secretary, “sufficient ... to reasonably achieve its purpose.”<sup>90</sup> The type and scope of each service that a state offers to Medicaid beneficiaries must be specified in its state Medicaid plan. Any additions to, deletions from, or modifications of this benefits package must be done through the submission of an amendment to the state Medicaid plan and its approval by CMS.<sup>91</sup> As of July 2000, the state Medicaid agency in all but four states determined Medicaid scope of benefits policy.<sup>92</sup>

**Fee-for-service.** When purchasing covered benefits on a fee-for-service basis, states must be able to receive and process claims for payment from providers. A state’s claims processing system must be able to verify that the provider submitting the claim participates in the program; that the beneficiary to whom the service was rendered is enrolled in the program; and that the service is covered under the state Medicaid plan. The system must also be capable of issuing payments to the provider for covered services and maintaining information about the transaction for record-keeping and audit purposes. Some states administer this claims processing function within their Medicaid agencies; others contract out this function to fiscal agents.

A state is not required to pay every claim submitted by a participating provider for a service set forth in its state Medicaid plan that is delivered to an eligible beneficiary. State Medicaid agencies are expressly authorized to place “appropriate” limits on a service through the use of “medical necessity” criteria or “utilization control procedures.”<sup>93</sup> With one exception, there is no federal statutory or regulatory definition of “medical necessity;”<sup>94</sup> states have broad discretion in denying payment on the basis of their own “medical necessity” standards.<sup>95</sup>

Similarly, there is generally no federal specification of the type of utilization control procedure a state may adopt. States have substantial flexibility to impose prior authorization requirements, to conduct retrospective utilization review, or to undertake other procedures designed to reduce unnecessary provision of services by fee-for-service providers. As of 2000, Medicaid agencies in 13 states operated programs to manage the care of beneficiaries with specific conditions who receive services on a fee-for-service basis (or through PCCMs). These “disease management” programs most commonly

focused on individuals with diabetes, asthma, or HIV/AIDS.<sup>96</sup>

One significant exception to this general flexibility is with respect to prescription drugs: Congress has required that each state have in place a drug use review (DUR) program involving both prospective and retrospective review in order to ensure that prescriptions are appropriate, medically necessary, and “not likely to result in adverse medical results.”<sup>97</sup> In addition, if a state elects to impose prior authorization controls on prescription drugs, it must comply with certain statutory requirements, including 24-hour response time.<sup>98</sup> A 2000 survey of state Medicaid programs found that 36 of the 43 responding states subjected one or more prescription drugs to prior authorization.<sup>99</sup>

In some cases, states have sought to place individuals with mental illness or mental retardation in nursing facilities primarily in order to qualify the costs of their care for federal Medicaid matching funds. This has led to the evolution of a more prescriptive federal regulatory approach designed to deter the placement of such individuals in nursing facilities not appropriate to their needs. Under the federal Preadmission Screening and Annual Resident Review (PASARR) requirement, each state is required to have in effect a preadmission screening program to ensure that individuals with mental illness or mental retardation are not admitted to a nursing facility unless they are determined, prior to admission, to require the level of services provided by a nursing facility (rather than a psychiatric hospital or other specialized facility).<sup>100</sup>

**Managed care.** State Medicaid agencies have a great deal of flexibility in determining which of the services covered under their state Medicaid plans they will purchase from MCOs on a risk basis, and which they will “carve out” from their contracts with the MCOs, either buying from fee-for-service providers or from behavioral health organizations (BHOs) on a risk basis.<sup>101</sup> However, the benefits that the state Medicaid agency elects to purchase from an MCO must be specified in the contract between the state agency and the MCO.<sup>102</sup> Because the purchase of services from an MCO by definition includes the purchase of its utilization management procedures, there is no need for a state Medicaid agency to extend its fee-for-service utilization control procedures to the MCO. In states that purchase services through PCCMs, utilization controls commonly take the form of case management services obtained from the PCCM in

exchange for a small monthly fee on behalf of each enrolled beneficiary.

## Setting Provider and Plan Rates

States have broad flexibility to decide not only whether to buy covered services on a fee-for-service or managed care basis, but also what rates they will pay providers or plans. A state’s reimbursement policies, whether fee-for-service or risk-based, must be set forth in its state Medicaid plan, and changes in those policies must be reflected in state plan amendments.

**Fee-for-service.** Federal regulations impose ceilings, in the form of upper payment limits (UPLs), on the amounts that state Medicaid programs can pay in the aggregate for certain institutional services (inpatient hospital, nursing facility, and intermediate care facility for the mentally retarded (ICF/MR) services) and for outpatient hospital and clinic services.<sup>103</sup> But, with the repeal of the “Boren” amendment in 1997, there are no longer any federal floors on payment rates to these institutional providers. (States are required to make a payment adjustment in the case of hospitals serving a “disproportionate share” of Medicaid and low-income patients, but they have broad discretion within federal caps in establishing these DSH payment amounts to individual facilities.)<sup>104</sup> Similarly, there are no federal floors on payment rates to physicians and other individual practitioners; these state payments are constrained only by the highly elastic requirement that they be “sufficient” to ensure access to such services equal to that enjoyed by other populations in the area. Only two groups of fee-for-service providers are protected by payment floors: federally-qualified health centers (FQHCs), which must be paid using cost-related prospective rates, and hospices, which must be paid at Medicare rates.<sup>105</sup>

Federal law requires states to meet certain “public process” requirements in setting Medicaid payment rates for hospital, nursing facility, and ICF/MR services.<sup>106</sup> These requirements include publishing of proposed rates and methodologies, opportunity for review by providers and beneficiaries, and publication of final rates. States may (but are not required to) comply with these requirements by holding a public hearing.<sup>107</sup> There are no comparable federal procedural requirements with respect to practitioners, clinics, or other fee-for-service providers. As of July 2000, in all but ten states (Alaska, Florida, Massachusetts, New Hampshire, New Jersey, New Mexico, Oregon, Tennessee, Texas, West Virginia), the functions of fee-for-service rate setting and reimbursement policy development are performed exclusively by state Medicaid agencies.<sup>108</sup>

**Managed care.** While there are no federal “public process” requirements with respect to the development of capitation rates for Medicaid MCOs, the federal Medicaid statute does require that MCOs be paid on an “actuarially sound basis.”<sup>109</sup> CMS has not yet clarified the content of this standard by regulation or guidance, leaving states with considerable discretion in setting rates (subject to the fee-for-service upper payment limit, which CMS has specified in regulation).<sup>110</sup> State procedures for establishing capitation rates vary widely, from establishment of rates by the state agency to competitive bidding to negotiation between state agencies and MCOs.<sup>111</sup> The actuarial methods used by state Medicaid agencies vary as well. In 2000, over three fourths of the states (36) with managed care programs reported contracting out to private entities some or all of the task of making the actuarial calculations involved in setting MCO capitation rates.<sup>112</sup> In the case of states that use the PCCM approach, providers are usually paid a small monthly fee for managing the use of services by beneficiaries.

### Enrolling Providers and Plans

As a general rule, state Medicaid plans must allow beneficiaries to obtain covered services from any provider or managed care plan that chooses to serve Medicaid patients, has not been excluded from Medicaid for fraud, and is “qualified to perform the service or services required”.<sup>113</sup> State Medicaid agencies make the determination as to whether a provider or plan is “qualified” to participate in Medicaid, subject in the case of some provider types (e.g., nursing facilities) to detailed federal criteria. The federal requirements for provider enrollment in Medicaid are minimal: if the state requires licensure, the provider must be licensed, and there must be a written agreement between the provider and the state Medicaid agency under which the provider agrees to maintain specified records; disclose certain ownership information; and give federal or state auditors access to books and records.<sup>114</sup> A 2000 GAO report noted that “States have considerable latitude in how they structure their provider enrollment processes. While some states have begun to strengthen these processes, few have taken comprehensive measures to prevent problem providers from entering Medicaid.”<sup>115</sup>

### Payment of Providers and Plans

States have the responsibility for making payments (at the rates they have established) to participating providers and plans (that they have enrolled) for furnishing covered services (that they have specified) to beneficiaries. In

carrying out this function, states (and their fiscal agents, if any) are subject to four basic federal requirements. First, they must have in place procedures for “prepayment and postpayment claims review” to ensure the “proper and efficient” payment of claims.<sup>116</sup> Second, in the case of claims for payment submitted by physicians and other practitioners (but not hospitals or other institutions), the state must pay 90 percent of the “clean” claims within 30 days of receipt, and 99 percent within 90 days.<sup>117</sup> Third, in the case of capitation payments to an MCO under a contract for more than \$1 million per year, the state must obtain “prior approval” of the contract from CMS.<sup>118</sup> Finally, states must identify third parties, such as the Medicare program, private health insurers, automobile liability insurers, state workers’ compensation programs, or noncustodial parents with medical support obligations that are liable for the costs of treating a Medicaid beneficiary and ensure that these third parties pay these costs, in most cases before Medicaid pays.<sup>119</sup>

### Monitoring Service Quality

In general, state Medicaid programs have broad flexibility in monitoring the quality of services provided to program beneficiaries on a fee-for-service basis. State health agencies are responsible for “establishing and maintaining health standards for public or private institutions” participating in Medicaid.<sup>120</sup> Each state’s Medicaid plan must include a description of “standards and methods the State will use to assure that medical or remedial care and services provided to [beneficiaries] are of high quality.”<sup>121</sup> The promulgation of such “standards,” and the “methods” for monitoring and enforcing such standards, are left to the discretion of each state, with two notable exceptions: nursing facility services and laboratory services.

In the case of nursing facilities, 1987 amendments to federal Medicaid law overhauled the system for monitoring the quality of nursing facilities participating in the program by placing more authority at the federal level and imposing more accountability on state survey agencies. In particular, state survey agencies must conduct, on an annual basis, unannounced standard surveys of each nursing facility participating in Medicaid. If a facility is found to have provided care of substandard quality, the survey agency must conduct an extensive survey within two weeks and, if warranted, take enforcement action. In conducting these surveys, state agencies must use a protocol developed by CMS.<sup>122</sup> A study of state agency survey and enforcement actions in 1999 found considerable variation among states in regulatory activity.<sup>123</sup> In the case of laboratory services, state Medicaid programs may only make payment for

services that are provided by laboratories that meet federal standards for accuracy and reliability and are subject to monitoring by CMS.<sup>124</sup>

With respect to managed care, states are required to develop and implement a “quality assessment and improvement strategy” that includes procedures for monitoring and evaluating the quality and appropriateness of care and services.<sup>125</sup> Each state’s “strategy” must be consistent with standards established by the Secretary.<sup>126</sup> State Medicaid agencies must also ensure that, with respect to each Medicaid MCO with which they contract on a risk basis, an external quality review organization (EQRO) conducts an annual independent review of the quality and accessibility of Medicaid services covered under the contract.<sup>127</sup> (States may exempt Medicaid MCOs that are also Medicare + Choice contractors.) In conducting these independent external reviews, the EQROs are to use a protocol developed by a private national quality review organization under contract with the Secretary. In letting this contract, the Secretary is expressly required to act “in coordination with the National Governors’ Association.”<sup>128</sup> A 2000 survey by the National Academy for State Health Policy found that the most common EQRO activity was medical record review, but that 25 states also contracted with EQROs to validate performance measures.<sup>129</sup> The same survey also found that seven of the states purchasing services through PCCM programs contracted with administrative service organizations (ASOs) to conduct quality improvement activities.<sup>130</sup>

## Ensuring Program Integrity

Because they control the disbursement of Medicaid funds on a day-to-day basis, states have the primary responsibility for minimizing the amount of improper payments made, either due to inadvertent error or to fraud. As noted by GAO, the amount of improper payments in Medicaid is not known: CMS does not have a national estimate, state Medicaid agencies are not required to measure the accuracy of their payments, and few states do so.<sup>131</sup>

The adequacy of a state’s provider enrollment procedures and claims processing systems determines, in large measure, the risk of improper payments in fee-for-service Medicaid. For example, an investigation of pharmacy and durable medical equipment suppliers in California has identified payments to fraudulent providers that could exceed \$250 million. In the view of GAO, “[a]dministrative weaknesses in the California Medicaid program made these activities easier to accomplish. For example, the program was issuing new billing numbers to

individuals with demonstrated histories of current or past questionable billing practices. The program allowed providers to have multiple numbers, and applicants did not have to disclose past involvement in the program or any ongoing audits. As a result, in some cases, individuals who had past questionable billings applied for a new provider number and were reinstated with full billing privileges.”<sup>132</sup> To the extent that these improper payments are not recovered, they will be unavailable for the purchase of needed services for program beneficiaries.

States are required to operate a Medicaid fraud and abuse control unit (MFCU) that is “separate and distinct from” the state Medicaid agency unless the state demonstrates that there is “minimal fraud” in its Medicaid program and that beneficiaries will be protected from abuse and neglect.<sup>133</sup> As of 2001, all states but Idaho, Nebraska, and North Dakota had a MFCU; in most cases, these units are located in the state Attorney General’s office.<sup>134</sup> The fraud control units have two basic duties: investigating and prosecuting violations of state fraud and abuse laws (both criminal and civil), and investigating and prosecuting cases of patient abuse and neglect in nursing facilities and other institutions receiving Medicaid funds.<sup>135</sup> Their performance is overseen by the OIG, which as discussed above is responsible for enforcement of federal civil fraud and abuse laws. The fraud control units have statutory access to information on “probable fraud and abuse” generated by a state’s Medicaid management information system (MMIS, described below),<sup>136</sup> as well as to the results of state surveys of nursing facilities.<sup>137</sup>

## Processing Appeals

In any health insurance program there will be disputes among patients, providers, and payors over whether particular services meet the standards for payment. In the means-tested Medicaid program, these coverage disputes are augmented by disputes arising in connection with the determination and redetermination of eligibility. Because Medicaid is an entitlement to individuals as well as to states, state Medicaid agencies are subject to constitutional and statutory “due process” requirements regarding denials of eligibility or coverage. In particular, state Medicaid agencies are required to grant an opportunity for a “fair hearing” to each individual (applicant or beneficiary) whose claim for Medicaid benefits is denied or is not acted upon with “reasonable promptness.”<sup>138</sup> The “fair hearing” entitlement includes the right to written notice of the opportunity to request a fair hearing, the right to a hearing before an impartial decision-maker, and the right to the continuation of benefits pending the hearing decision.<sup>139</sup> The “fair

hearing” protections apply to all Medicaid beneficiaries, including those who are enrolled in MCOs and seek to challenge denials or delays of covered services.<sup>140</sup> Beneficiaries who are residents of nursing facilities also have a right to a hearing in the event of an involuntary transfer or discharge.<sup>141</sup>

The federal Medicaid statute also provides procedural safeguards for certain types of providers and for managed care plans. Intermediate care facilities for the mentally retarded (ICFs/MR) that CMS seeks to terminate for noncompliance with program requirements are entitled to a federal administrative hearing and judicial review by the federal courts.<sup>142</sup> There are no statutory safeguards for other classes of providers, although they may have the benefit of procedural protections under state law. With respect to managed care plans, states may not terminate the contract of a plan, regardless of the grounds for the termination, unless the MCO or PCCM is provided a hearing prior to termination. The state may, however, notify beneficiaries enrolled with the plan that a termination proceeding is underway and permit them to disenroll immediately without cause.<sup>143</sup> The federal fraud and abuse laws that apply to Medicaid contain procedural protections that do not distinguish among types of providers.<sup>144</sup>

### Collection and Reporting of Information

State Medicaid agencies enjoy somewhat less flexibility with respect to collection and reporting of information than they do in other functional areas. As discussed above, states, as a general matter, are required to use “methods of administration” as the Secretary finds “necessary for the proper and efficient” administration of their Medicaid program.<sup>145</sup> Among these “methods” is an MMIS that meets federal requirements, including “performance standards” specified by CMS. Each state’s MMIS must be compatible with those used by Medicare intermediaries and carriers so that the two programs can exchange enrollment and claims data relating to those beneficiaries and providers enrolled in both programs.<sup>146</sup> Each state’s system must also be capable of transmitting data on Medicaid beneficiaries and paid claims electronically in a format consistent with the Medicaid Statistical Information System (MSIS).<sup>147</sup> In addition, a state’s MMIS must comply with the HIPAA “administrative simplification” provisions implementing national standards for electronic transactions relating to claims payment.<sup>148</sup> Finally, each state’s MMIS must be capable of exchanging data regarding providers sanctioned for fraud or abuse with Medicare and with other state Medicaid programs, and of providing information on probable fraud

and abuse to the state’s Medicaid fraud control unit.<sup>149</sup> States may contract out these MMIS responsibilities to the private sector, and, as of July 2000, nearly three fifths of the states had opted to do so.<sup>150</sup>

State Medicaid programs are also required to “make reports, in such form and containing such information, as the Secretary may from time to time require.”<sup>151</sup> These reports include quarterly projected expenditures (Form HCFA-37),<sup>152</sup> quarterly actual expenditure data (Form HCFA-64),<sup>153</sup> annual enrollment data (Form HCFA-2082),<sup>154</sup> and annual information relating to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children (Form HCFA-416).<sup>155</sup> In addition, state MMIS must submit data on Medicaid beneficiaries and paid claims electronically in a format consistent with the MSIS.<sup>156</sup> As discussed in the Issues section below, several of these reporting instruments, and the data that they yield for CMS, have been criticized as inaccurate and incomplete. In addition to the broad grant of authority to the Secretary to require reporting, the Medicaid statute imposes specific reporting requirements on state Medicaid agencies with respect to EPSDT participation,<sup>157</sup> DSH hospitals,<sup>158</sup> and the operation of the drug rebate program.<sup>159</sup> Implementation of these targeted reporting requirements has been uneven.<sup>160</sup>

Finally, state Medicaid programs have reporting responsibilities to national databanks relating to quality of care and fraud and abuse. In both cases, the state Medicaid agencies are required to ensure that other state agencies supply the specified information. Thus, states must have in place a system for reporting to the National Practitioner Data Bank regarding adverse actions taken by state licensing authorities against practitioners or institutional providers, whether or not these providers participate in Medicaid.<sup>161</sup> Similarly, state Medicaid Fraud Control Units and state licensure authorities must report any final adverse action taken against a practitioner, supplier, or institutional provider to the National Health Care Fraud and Abuse Data Collection Program.<sup>162</sup>

## IV. SPENDING ON MEDICAID ADMINISTRATION

The federal government matches state spending on allowable Medicaid administrative costs. Unlike federal matching funds for state payments to DSH hospitals, which are subject to annual state-specific caps, federal matching payments for administrative costs are open-ended. And, unlike the matching rates for the costs of covered services (or payments to DSH hospitals), which vary from state to state depending on per capita income,

the matching rates for administrative costs are uniform across all states. They do, however, vary by function.<sup>163</sup>

Most types of allowable administrative costs incurred by state Medicaid programs are matched at 50 percent. State expenditures for certain administrative functions are matched at 75 percent:

- compensation or training of physicians, nurses, and other skilled professional medical personnel used by the state Medicaid agency (or other state or local agencies) to administer the program;
- operation of a Medicaid management information system (MMIS);
- surveys and certification of nursing facilities;
- performance of medical and utilization review or quality assurance by a Quality Improvement Organization (QIO, formerly called a Peer Review Organization) or External Quality Review Organization (EQRO);
- operation of state Medicaid fraud control units (MFCUs).

In the case of MMIS systems and MFCUs, the federal government matches 90 percent of start-up expenses. The federal government pays 100 percent of the costs incurred by states in verifying the immigration status of applicants and beneficiaries.

In total, the states spent \$6.6 billion (federal and state funds combined) on program administration in FY 1997, representing \$163 per enrollee and 3.9% of total Medicaid spending.<sup>164</sup> Table 4-1, which presents estimates of the amount each state spent in 1997 on administration of its Medicaid program, shows that significant variation exists among the states in administrative spending. Spending per enrollee in FY 1997 ranged from a high of \$443 in Alaska to \$46 in Tennessee. There was also wide variation in the percentage of total Medicaid spending attributable to administrative costs, ranging from 9.3% in Oklahoma to 1.7% in New Jersey. To some degree, this variation is consistent with the differing ways in which states spend their state and federal administrative funds. For example, some states have been more aggressive than others in claiming federal administrative matching funds in connection with the provision of school-based health services; a GAO study of school-based administrative claims in 17 states in 1999 found that these claims ranged from 47 percent of total Medicaid administrative spending in Michigan to less than 0.02 percent of total Medicaid administrative spending in California.<sup>165</sup>

However, some of this state-to-state variation may also be explained by the data that underlies these estimates.

These data, which are taken from state reports to CMS, are subject to a number of caveats. States differ in how they classify different costs that they report to CMS. For example, some states would classify certain case management activities as services, but other states may treat them as administrative costs. These different classifications could have a significant impact on a state's estimates of its administrative costs. In addition, CMS may make adjustments to states' costs after the end of the fiscal year. The CMS adjustments, which are not reflected in the data underlying the estimates in Table 1, could change the total amounts states spend on administration significantly. These caveats should lead to caution about drawing broad inferences about administrative spending in particular states from these estimates. (For a discussion of how these amounts were derived, see Exhibit B: *Estimating Medicaid Administrative Spending*, p. 153.)

Finally, these estimates do not include the administrative costs incurred by Medicaid managed care plans. In some states, administrative outlays are folded into capitation payments to MCOs. These outlays reflect the costs attributable to activities such as utilization review, quality improvement, and data collection and reporting. Although these amounts are not included in the data states report to CMS, one study has reported that HMOs participating in Medicaid had administrative cost ratios of over fourteen percent in 1998. The same study found that HMOs that did not participate in Medicaid had administrative cost ratios of just under 16 percent for that same year.<sup>166</sup>

A number of observers, including some former state Medicaid directors, have questioned whether Medicaid administrative spending is adequate to the tasks described in Section III. For example, the GAO has noted that "[e]fforts by state Medicaid programs to address improper payments are modestly and unevenly funded. Half of the states spend no more than one tenth of one percent of program expenditures on activities to safeguard program payments. Few secure all available federal funds earmarked for antifraud efforts because states would have to increase their own spending to do so."<sup>167</sup>

A similar point is made on the managed care side of the program. The increase in state contracting with MCOs on a risk basis, it is argued, creates the need for more, not fewer, administrative resources: "... the movement by Medicaid officials to contract with large managed care companies does not, as many originally thought, mean that the staffs of state governments can easily be streamlined. To the contrary, the effective management of managed care puts pressures on state agencies to hire additional personnel. Failure to do so seriously threatens the access of Medicaid enrollees to health care of adequate quality. Whether state agencies will be able to


**TABLE 4-1: STATE MEDICAID ADMINISTRATION SPENDING, 1997**

	Enrollees (in thousands)	Spending (in thousands)	Spending Per Enrollee	Spending as % of Total Medicaid Spending
<b>United States</b>	<b>40,570</b>	<b>\$6,618,429</b>	<b>\$163</b>	<b>3.9%</b>
Alabama	633	\$49,251	\$78	2.2%
Alaska	83	\$36,786	\$443	9.2%
Arizona	671	\$104,418	\$156	5.7%
Arkansas	394	\$74,149	\$188	5.3%
California	6,387	\$824,836	\$129	4.5%
Colorado	352	\$63,475	\$180	4.0%
Connecticut	398	\$65,799	\$165	2.2%
Delaware	103	\$27,261	\$266	6.2%
District of Columbia	139	\$31,834	\$229	3.8%
Florida	2,086	\$215,707	\$103	3.2%
Georgia	1,238	\$170,513	\$138	4.5%
Hawaii*	206	\$31,812	\$154	4.8%
Idaho	121	\$42,861	\$354	9.2%
Illinois	1,868	\$347,609	\$186	5.1%
Indiana	601	\$77,897	\$130	3.0%
Iowa	321	\$72,604	\$226	5.4%
Kansas	261	\$52,538	\$201	4.9%
Kentucky	667	\$67,100	\$101	2.5%
Louisiana	761	\$90,950	\$120	2.9%
Maine	189	\$42,402	\$224	3.7%
Maryland*	582	\$183,876	\$316	6.4%
Massachusetts	810	\$130,019	\$161	2.4%
Michigan	1,366	\$497,271	\$364	8.3%
Minnesota	590	\$183,749	\$311	6.3%
Mississippi	544	\$40,677	\$75	2.3%
Missouri	775	\$107,074	\$138	3.3%
Montana	95	\$18,859	\$199	4.6%
Nebraska	199	\$38,089	\$191	4.9%
Nevada	128	\$29,265	\$228	5.6%
New Hampshire	102	\$33,776	\$331	4.4%
New Jersey	859	\$95,609	\$111	1.7%
New Mexico	341	\$51,863	\$152	5.2%
New York	3,229	\$574,265	\$178	2.3%
North Carolina	1,203	\$149,332	\$124	3.2%
North Dakota	64	\$15,645	\$243	4.5%
Ohio	1,491	\$158,060	\$106	2.4%
Oklahoma	432	\$123,309	\$286	9.3%
Oregon	554	\$117,847	\$213	7.1%
Pennsylvania	1,725	\$302,091	\$175	3.6%
Rhode Island	148	\$33,768	\$228	3.5%
South Carolina	587	\$88,215	\$150	3.9%
South Dakota	84	\$12,067	\$144	3.5%
Tennessee	1,433	\$65,470	\$46	1.9%
Texas	2,805	\$469,547	\$167	4.7%
Utah	179	\$48,842	\$272	7.2%
Vermont	125	\$28,116	\$224	7.1%
Virginia	714	\$102,592	\$144	4.3%
Washington	908	\$259,858	\$286	7.5%
West Virginia	391	\$45,357	\$116	3.7%
Wisconsin	576	\$112,494	\$195	4.2%
Wyoming	53	\$11,623	\$220	5.6%

Source of Enrollee Data: Urban Institute estimates based on data from HCFA-2082 reports.

Source of Administrative Spending Data: HCFA-64 Report for FY 1997. Does not include the U.S. Territories. Figures may not sum to totals due to rounding.

\*Denotes states where significant numbers of enrollees were either missing or categorized as “unknown” in the original data released from CMS. The estimates shown rely heavily on supplemental data sources.

build and sustain adequate staffs to deal with managed care in an era dominated by the dogma of downsizing remains an open question.”<sup>168</sup>

As noted above, federal matching funds are available to states on an open-ended basis at rates ranging from 50 to 90 percent for the costs of additional staffing and upgraded information systems. However, there is no federal minimum requirement for state spending on, or staffing of, the administration of their Medicaid programs. It is an open question as to whether, under current matching arrangements, state legislators who face competing budgetary and political priorities will appropriate the state funds necessary to enable state Medicaid administrators (with federal matching dollars) to acquire and maintain the personnel and information systems essential to effective operation of their programs. State legislators have traditionally expected low administrative costs in all their programs, including Medicaid, and they are often reluctant to authorize an increase in the numbers of state personnel or in salary levels. This in turn can make it difficult for state Medicaid agencies to compete with health care providers, managed care plans, or health care consulting firms for skilled employees. As Sparer and Brown noted in their 1992 study of the challenges facing Medicaid managers in four states (California, Michigan, Minnesota, New York): “[s]taff cutbacks and the inflexibility of civil service rules contribute to a crisis atmosphere that dominates many Medicaid agencies. ... Medicaid managers tend to grope along from crisis to crisis without the time or the staff for long-term research and planning.”<sup>169</sup>

## V. ISSUES IN MEDICAID ADMINISTRATION

The Medicaid program poses a broad array of administrative challenges for the states and the federal government. From a technical standpoint, administrative issues are often among the most difficult to resolve. Their arcane nature creates problems for state agency officials in explaining them to state legislators and obtaining the political and fiscal support necessary to their resolution. Yet even though administrative issues are often less visible to policymakers, beneficiaries, and the public at large than broad policy disputes like coverage for abortions, they are crucial to the successful implementation of Medicaid at both the state and national level.

The past few years have been particularly challenging for Medicaid program administrators. Congress has legislated a number of major policy changes with enormous administrative implications for the states and

CMS, including the repeal of the AFDC program in 1996 and concomitant delinking of cash assistance and Medicaid eligibility; the enactment that same year of new restrictions on Medicaid eligibility for legal immigrants; the enactment, also in 1996, of the HIPAA “administrative simplification” provisions; the enactment in 1997 of SCHIP; the revision of federal policies governing Medicaid managed care contracting, also in 1997; and the imperative of achieving Y2K compliance by the end of 1999. In addition, significant tension emerged among CMS, the Congress, and the states regarding the appropriateness of state claims for billions of federal matching funds in connection with school-based services and upper payment limits (UPLs). This section discusses two of the many administrative challenges facing state Medicaid agencies: the delinking of cash assistance and Medicaid eligibility and the lack of accurate program data.

### Delinking Cash Assistance and Medicaid

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P.L. 104-193, replaced the Aid to Families with Dependent Children (AFDC) entitlement program with a block grant, the Temporary Assistance to Needy Families (TANF) program. Prior to this law, parents and children in families receiving cash assistance under AFDC were automatically eligible for Medicaid. The 1996 law broke this linkage between receipt of cash assistance and eligibility for Medicaid. Individuals receiving cash or other assistance under a state’s TANF program are not automatically eligible for Medicaid. Instead, these parents and their children may be eligible for Medicaid under one or more other eligibility pathways, including the “section 1931” pathway for families with children established by the same 1996 law.<sup>170</sup>

Thus, a family that does not qualify for cash assistance under TANF may still qualify for Medicaid coverage. Similarly, a family that loses cash assistance under a state’s TANF program is not automatically disqualified from Medicaid. In each case, the state Medicaid agency has a legal obligation to determine whether each parent and child in the family qualifies for Medicaid under one of the eligibility pathways under the state’s Medicaid program. The policy logic behind implementation of TANF—to increase workforce participation and reduce long-term dependence on cash assistance—was not intended to result in an increase in the number of low-income families without Medicaid or other health insurance coverage. To help avoid this result, Congress made available \$500 million at enhanced federal

matching rates of up to 90 percent to assist states with the administrative costs associated with delinking.<sup>171</sup>

Yet that is what occurred during the first few years of delinking in many states. A recent study of enrollment of families, children, and pregnant women in 43 states found that monthly enrollment declined from 18.7 million in June of 1997 to 17.9 million in June of 1998.<sup>172</sup> A number of analyses have determined that one of the factors driving this decline was the loss of Medicaid by families leaving welfare due not to ineligibility for Medicaid but to welfare policies and procedures.<sup>173</sup> Recently, Medicaid enrollment by families and children has increased, rebounding to 18.8 million by December of 1999 in those same 43 states.<sup>174</sup> In April 2000, CMS notified state Medicaid directors of their obligations to correct any problems in their eligibility determination systems and to identify and reinstate families whose Medicaid coverage has been improperly terminated upon loss of cash assistance eligibility.<sup>175</sup> A number of states have taken steps to reinstate individuals improperly terminated, including Maryland (62,000), Pennsylvania (32,000), and Washington (29,600).<sup>176</sup>

The issues that have arisen around implementation of the new Medicaid and welfare eligibility rules have received significant attention.<sup>177</sup> But these issues are only the most recent examples of the problems faced by low-income families and program administrators alike in navigating the Medicaid program. Complex eligibility rules, the products of decades of federal and state legislation and court decisions, create confusion on the part of applicants and enrollees, as well as the social services staff responsible for administering Medicaid eligibility. Official notices conveying eligibility information to enrollees are often written in complicated, legalistic language. Automated eligibility systems, which generally remain the province of state welfare agencies, not state Medicaid programs, can promote proper eligibility determinations. However, if these systems are not correctly adjusted to reflect changes in Medicaid (or welfare) law, they may lead to erroneous terminations of Medicaid coverage.<sup>178</sup> In short, the successful enrollment of eligible individuals in Medicaid requires effective administrative systems and procedures.

### Shortcomings in Medicaid Program and Policy Data

A long-standing issue in Medicaid administration is the lack of accurate, timely, and reliable Medicaid policy and program data at the national level. Although the Secretary of HHS does not administer Medicaid on a day-to-day basis, he is accountable to the Congress

(representing both program beneficiaries and federal taxpayers) for the expenditure of more than \$130 billion in federal matching funds annually. At a minimum, Congress needs to know the extent to which federal Medicaid funds are being spent properly—that is, not being lost to inadvertent error or fraud. And, for federal budgeting purposes, Congress and its support agencies like CBO need to understand Medicaid spending trends as they evolve. Satisfactory answers to these basic inquiries require accurate and current data on Medicaid enrollment and expenditures from all participating states. As of this writing, this information is not readily available from the Department, either to the Congress (or its information-gathering agencies, CBO and GAO) or to the public. The electronic submission of enrollee encounter data through the MSIS will help address this situation, but implementation of this Balanced Budget Act of 1997 requirement, as of 2001, is still in process.<sup>179</sup>

There are numerous examples of Medicaid data shortcomings. One has to do with basic enrollment data—i.e., how many Americans are served by Medicaid in each state? Those looking for this information will find that, as of April 2002, the CMS website contains data only through the fiscal year ending September 30, 1998.<sup>180</sup> This information is not timely to fully assess the effects of the 1996 welfare law on Medicaid enrollment of families and children. In order to obtain more timely information, the Kaiser Commission on Medicaid and the Uninsured funded a survey of the states to obtain monthly enrollment data broken down by broad Medicaid population groups (e.g., families, children, pregnant women, aged, and disabled).<sup>181</sup> The Kaiser Commission is not alone in its approach to obtaining Medicaid policy data: in a study of the effect of welfare reform on Medicaid enrollment, the GAO identified enough problems with CMS data that it decided to undertake its own survey of the states.<sup>182</sup>

CMS does collect enrollment (and expenditure) data from the states. However, as one former state Medicaid director observes, the federal reporting forms are of limited value from the state perspective: “States keep data for their own purposes that is different from what they report to CMS, because the CMS reports are not viewed as being particularly useful.”<sup>183</sup> It is not surprising then that researchers have long noted the problems with the resulting data:

“Expenditure data on HCFA-64 reports are considered to be more reflective of true Medicaid spending than expenditure data from HCFA-2082 reports, but the HCFA-64 reports lack enrollment data and report only aggregate spending by state and type of medical

service. ... Historically, HCFA-2082 reports have been problematic data sources, although data quality has vastly improved in recent years. Still, these data often contain errors. Common errors include missing, zero, or negative expenditures for some services or eligibility groups; extreme shifts in expenditures for enrollment patterns across years; and inconsistencies between enrollment and expenditure levels.”<sup>184</sup>

Obviously, the ability of CMS or the Congress to obtain reliable and comparable enrollment and expenditure data from each state depends in large measure on the capacity of each state to collect and report the needed information in a standard format. That state capacity, in turn, depends upon an adequate MMIS. As more than one observer has noted, however, the federal government’s efforts over the past 30 years to improve state management information systems has been a constant irritant in federal-state relations:

“As a consequence of [Congressional efforts beginning in 1972 to obtain improvements in state Medicaid Management Information (MMIS) Systems], states came to submit more valid, reliable, and comparable data to HCFA concerning expenditures and services provided to different clusters of beneficiaries. Nonetheless, complaints persist about the adequacy of HCFA efforts to gain comparable data about state programs. HCFA frequently finds statistical discrepancies and errors in the annual reports of the states. Noting this problem, GAO has criticized HCFA for being too deferential to the states in tolerating these errors. It has urged HCFA to demand more rigorously documented justifications from the many states that apply for federal funds to enhance their information systems and has chided HCFA for being weak in post-implementation reviews of these state enhancements. But if various players have pushed HCFA to be more assertive about MMIS, many states have found HCFA requirements to be onerous. The rise of managed care as a major vehicle for serving Medicaid beneficiaries—with its promise of capitated payment rather than the fee-for-service that MMIS emphasizes—has fueled discontent. As a top Medicaid administrator from the state of Wisconsin put it, ‘We have this awful MMIS that we’re forced to operate that does us no good’.”<sup>185</sup>

Managed care offers another example of the shortcomings in program and policy data at the national level. As noted above, more than half of all Medicaid beneficiaries nationally are enrolled in some form of Medicaid managed care, and about 15 percent of all Medicaid spending nationally flows to Medicaid

managed care organizations (MCOs) or primary care case management (PCCM) plans. Yet CMS can only supply information on the number of Medicaid beneficiaries enrolled in managed care in each state, broken down by type of plan.<sup>186</sup> Those wanting to know, for example, how many individuals with disabilities are enrolled in Medicaid managed care arrangements would have to look to other sources or, in the absence of such sources, conduct their own survey comparable to that sponsored by the Kaiser Commission.<sup>187</sup> Those wanting to know what MCOs participate in Medicaid, and whether those MCOs primarily serve Medicaid beneficiaries, would either have to access other databases or conduct their own survey.<sup>188</sup> Finally, those wanting to know what capitation rates, on average, states and the federal government paid to Medicaid MCOs for specified groups of beneficiaries would also have to conduct their own survey.<sup>189</sup>

Equally problematic is the impact of managed care information shortfalls on Medicaid expenditure data. As Urban Institute researchers have noted:

“Recent growth of capitated payments under Medicaid managed care makes it increasingly challenging to understand individual state Medicaid programs, or to prepare multi-state comparison tables. ... In the past, states primarily reported expenditures by type of service for adults, children, disabled, and elderly beneficiaries. For example, spending was presented as inpatient hospital, physician services, and outpatient services for each beneficiary group. Under managed care arrangements, states tend to report only total payments to managed care organizations. Little information is gathered on either HCFA-2082 or HCFA-64 reports as to how and for whom these dollars are spent.”<sup>190</sup>

Under current reporting conventions, if enrollment in risk-based Medicaid managed care grows, CMS will have correspondingly less claims-based data on use of acute care services by Medicaid beneficiaries and more capitated amounts that are not broken down by type of service. In addition, because managed care enrollment data is not broken down by type of beneficiary (e.g., children, pregnant women, individuals with disabilities, elderly), the calculation of average per beneficiary expenditures on either a national or state-by-state basis becomes more and more speculative.

Another example of problematic program data relates to the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to which the 18 million children enrolled in Medicaid are entitled. In 1989,

Congress directed the Secretary of HHS to set state-specific annual goals for participation of enrolled children in EPSDT<sup>191</sup> and required that states report annually on their progress in achieving such goals.<sup>192</sup> The Secretary set the goal at 80 percent (to be achieved by 1995) and issued a reporting form (HCFA-416) that captures, among other things, the number of children (by age group) who received EPSDT health screens and were referred for corrective treatment. Over a decade later, a GAO report concluded:

“HCFA’s efforts to assemble reliable information about EPSDT participation in each state have so far been unsuccessful. State-reported data, upon which HCFA depends, are often not timely or accurate. For example, states were required to submit their fiscal year 1999 [HCFA-416] reports by April 1, 2000. As of January 2001, 15 states had not submitted their 1999 reports and another 15 states’ reports had been returned by HCFA because they were deficient. HCFA and state officials acknowledge long-standing difficulties that states face in their efforts to collect complete and reliable data, which are used as the basis for EPSDT reports. These difficulties continue despite HCFA’s attempts to improve the reliability of state EPSDT reports by revising the report format and guidance.”<sup>193</sup>

The shortcomings in CMS’s program and policy database—of which enrollment and managed care data are only two examples—make it difficult for the agency to meet its performance goals. Under the 1993 Government Performance and Results Act (GPRA), CMS, like other federal agencies, must develop short-term performance goals and report annually on its progress in achieving these goals. CMS has a total of 39 performance goals for FY 2001. Of these, 18 relate to the Medicare program; four relate to quality of care among Medicare beneficiaries and other populations; three relate to the quality of care in Medicare- and Medicaid-funded nursing facilities; six relate to Medicaid; one relates to SCHIP; and the remainder concern miscellaneous issues. One of the performance goals is SCHIP1-02: “Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid.” CMS’s 2000 Annual Performance Report states that in FY 1999, 1.98 million were served by SCHIP; for the same fiscal year, the Report states that 20 million children were served by Medicaid with a notation that this figure (unlike the SCHIP number) is an estimate “based on incomplete data submitted by the States.”<sup>194</sup> CMS reports that it achieved its GPRA target for FY 2000 (a 1 million yearly increase in the number of children served by both programs) on the basis of the SCHIP data.

The lack of timely, reliable program data also complicates CMS’s efforts to measure performance vis-à-vis its own Medicaid performance goals (Exhibit C, p. 155). Consider Performance Goal MMAI-02: “Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized.” Although Medicaid has covered immunizations for children as an element of the mandatory EPSDT benefit since 1967, no data is available to CMS on immunization rates among two-year old Medicaid beneficiaries, whether in fee-for-service or in managed care. Instead, for purposes of measuring performance, the states have been divided into three groups: the first group will not report until FY 2001, the second until FY 2002, and the third until FY 2003. The Annual Performance Report notes: “Due to the various data collection and reporting methodologies likely to be used by individual States, immunization coverage levels will not be directly comparable across States. However, each State will measure its own progress, using a consistent methodology.”<sup>195</sup> In contrast, in order to measure its performance in relation to the goal of increasing the percentage of Medicare beneficiaries 65 and older who receive an annual vaccination for influenza, CMS will use as its primary data source the Medicare Current Beneficiary Survey (MCBS), an ongoing survey of a representative national sample of the Medicare population.<sup>196</sup>

The availability of timely, accurate program data would assist not only CMS, but also the states. Standardized program data, reported on a state-by-state basis, would enable state Medicaid administrators to compare their expenditures against those of neighboring states and against national averages. The posting of this information on the Web would also enable federal and state policymakers, the media, and the public to better understand the administration of the program, to identify problems, and to develop policies for improvement.<sup>197</sup>

## VI. CONCLUSION

For both states and the federal government, Medicaid is a challenging program to administer. Medicaid bears all of the administrative responsibilities of a traditional insurer, which range from determining the scope of benefits it offers to processing claims to monitoring the quality of services it purchases. In addition, Medicaid pays for a much broader array of benefits than private insurers or Medicare and must make income and resource eligibility determinations that those payors do not. Finally, states and the federal government must carry out these responsibilities in an environment of rapid change in the health care marketplace and ever-increasing fiscal stakes.



# EXHIBIT A: STATE MEDICAID PLAN ADMINISTRATIVE REQUIREMENTS



## STATE MEDICAID PLAN ADMINISTRATIVE REQUIREMENTS, 2001

Requirement	Statute	Regulation
Fair hearings	§1902(a)(3) of the Social Security Act	42 CFR 431.200—431.250
Methods of administration	§1902(a)(4)(A)	42 CFR 431.15
Conflicts of interest	§1902(a)(4)(D)	
Single State Agency	§1902(a)(5)	42 CFR 431.10
Reporting	§1902(a)(6)	42 CFR 431.16
Confidentiality	§1902(a)(7)	42 CFR 431.303—431.307
Promptness of eligibility determinations	§1902(a)(8)	42 CFR 435.930
Standards for institutions	§1902(a)(9)	
Arrangements with State Maternal and Child Health Agency	§1902(a)(11)	42 CFR 431.615
Estate recoveries	§1902(a)(18)	
Simplicity of Administration	§1902(a)(19)	42 CFR 435.902
Recovery of third party liability (TPL)	§1902(a)(25)	42 CFR 433.135—433.154
Survey and Certification of Nursing Facilities	§1902(a)(28)(D)(ii)	42 CFR 488.300—488.335
External Quality Review of MCOs	§1902(a)(30)	
Claims Payment Procedures	§1902(a)(37)	
Exclusion of Fraudulent Providers	§1902(a)(39), (41)	
EPSDT outreach and reporting	§1902(a)(43)	42 CFR 441.56
Income and eligibility verification	§1902(a)(46)	42 CFR 435.940—435.965
Outstationing eligibility workers	§1902(a)(55)	42 CFR 435.904
Advance Directives	§1902(a)(58)	42 CFR 431.20
Listing of physician unique identifiers	§1902(a)(59)	
Fraud and abuse control unit	§1902(a)(61)	42 CFR 455.12—455.23
Mechanism for reports of waste, fraud, and abuse	§1902(a)(64)	

ELIGIBILITY

BENEFITS

FINANCING

ADMINISTRATION

GLOSSARY

APPENDICES





## EXHIBIT B:

# ESTIMATING MEDICAID ADMINISTRATIVE SPENDING

THE HCFA-64 REPORT FOR FY 1997 is the primary source for the estimates of state and federal Medicaid administrative costs in Section IV of this chapter. This report, which the states submit to CMS on a quarterly basis, is an accounting statement of actual expenditures for which the states claim federal Medicaid matching payments. Using these quarterly reports, CMS develops an annual report of state Medicaid spending, which it makes available on its website at [www.hcfa.gov/medicaid/m64.htm](http://www.hcfa.gov/medicaid/m64.htm). The HCFA-64 reports Medicaid spending for each fiscal year. However, after the end of the fiscal year, CMS may make significant adjustments to a state's costs, and these adjustments are not reflected on the HCFA-64.

States report to CMS their "total computable" spending, which forms the basis of federal payments to the states. ("Total computable" refers to a state's expenditures before application of the federal Medicaid matching rate to determine the federal share.) They break down the amounts they spend into different categories, including administration. States break administrative spending down into three categories: "mechanized systems" (Medicaid Management Information Systems, or MMIS); drug claims systems; and "miscellaneous" expenditures. The miscellaneous category includes spending on immigration status verification systems, family planning, Quality Improvement Organizations (formerly called "Peer Review Organizations"), skilled professional medical personnel, preadmission screening, and resident review. Because funds spent on family planning services are not administrative costs, we excluded these amounts from our estimates of administrative costs.

The HCFA-64 report does not include information on two important components of state administrative spending: survey and certification of nursing and other facilities and fraud and abuse control units. State spending on these programs is reported separately to CMS and OIG. CMS staff provided us with FY 1997 estimates of total federal dollars spent by states on survey and certification activities and on the operation of state Medicaid Fraud Control Units (MFCUs).<sup>198</sup> Using these federal amounts, we calculated the 25 percent state share of spending for these programs. (Note that MFCU spending was not available for the District of Columbia, Nebraska, or Idaho, so total administrative spending for those states does not include fraud and abuse control unit costs). The state and federal spending on survey and certification and fraud and abuse control units was added to our calculations from the HCFA-64 data to arrive at a more complete estimate of overall administrative spending.

For the purposes of this analysis, we broke down spending into four categories: "MMIS", "Survey and Certification," "Fraud and Abuse" and "General Administration." "General Administration" includes amounts reported in the HCFA-64 report for drug claims systems and the items CMS includes in its

"miscellaneous" category, minus amounts spent on family planning.

To develop state-by-state estimates of the average administrative spending per Medicaid enrollee, we divided the estimate of administrative spending for each state by the number of enrollees in that state in 1997, as estimated by The Urban Institute based on data from HCFA-2082 reports. In its analysis, the Urban Institute defined "enrollees" as people who sign up for Medicaid for any length of time in a given fiscal year. All estimates of administrative spending in this section exclude spending in the U.S. territories.

In Section I of this chapter, we compared the percentage of total funding that was devoted to administration for Medicare, Medicaid, and private insurance. To ensure that we treated these types of insurers in a consistent manner, we used data from CMS's National Health Expenditures 2000 to estimate the proportion of total expenditures that spent on administration. The National Health Care Expenditures estimates indicate that in 1997 \$7.9 billion of Medicaid's \$159.6 billion in total expenditures were spent on administration. These estimates, like the ones presented in Section IV of this chapter that estimate FY 1997 Medicaid administrative spending at \$6.6 billion, are based on HCFA-64 data, but

are calculated on a calendar year basis rather than a fiscal year basis. The National Health Care Expenditure data seem consistent with the Congressional Budget Office (CBO) estimates that in FY 2001 the federal government will spend \$6.9 billion on administrative costs, or 5.3 percent of the projected federal Medicaid outlays of \$129.5 billion (*April 2001 Baseline Medicaid and State Children's Health Insurance Program*, Congressional Budget Office, April 18, 2001). CBO estimates were not available for FY 1997.



# EXHIBIT C: CMS MEDICAID PERFORMANCE GOALS, FY 2002

## Medicaid Performance Goal

MA1-02: Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance.

MMA2-02: Increase the percentage of Medicaid two-year-old children who are fully immunized.

MMA3-02: Provide to states linked Medicare and Medicaid data files for dually eligible beneficiaries.

MMA4-02: Assist states in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.

MMA5-02: Increase the percentage of Medicaid-enrolled children who have received dental services by working with states to improve dental access

MMA6-02: Increase the percentage of Medicaid-enrolled children screened for lead poisoning.

SCHIP1-02: Decrease the number of uninsured children by working with states to implement SCHIP and by enrolling children in Medicaid.

## FY 2002 Target

Establish and meet an enrollment target for FY 2002.

Measure state-specific immunization rates (Groups I and II) and establish state-specific baselines and targets (Group III)

56 states/territories

Assess pilot studies to determine FY 2003 target

To be determined

To be determined

+ 1 million over FY 2001

SOURCE: DHHS, Health Care Financing Administration FY 2002 Annual Performance Plan & Report (October 2000)

- 1 CBO's April 2001 Baseline for Medicaid and the State Children's Health Insurance Program does not contain an estimate of the amount of state spending on Medicaid. The \$98 billion figure in the text assumes that nominal federal Medicaid matching rates (57 percent on average) reflect actual federal-state spending distributions, an assumption CBO does not make. "CBOs Baseline Projections of Mandatory Spending," *An Analysis of the President's Budgetary Proposals for Fiscal Year 2002*, Congressional Budget Office, May 2001, Table 10. Accessed on [www.cbo.gov](http://www.cbo.gov) on April 10, 2002.
- 2 In 1999, the Philadelphia Health Department was recognized as a winner of a prestigious "Innovation in American Government" award for its efforts to coordinate behavioral health services for Medicaid enrollees, and, in 1997, the State of Arkansas won this award for its technologically advanced Medicaid managed care program under ConnectCare. Accessed on [www.excelgov.org/innovations/innovations.htm](http://www.excelgov.org/innovations/innovations.htm) on April 10, 2002.
- 3 Perry, M., and Kannel, S., Lake Snell Perry & Associates; Valdez, R. B., UCLA School of Public Health; Chang, C., *Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, January 2000.
- 4 Holahan, J., Rangarajan, S. and Schirmer, M., 1999. "Medicaid Managed Care Payment Rates in 1998." *Health Affairs*, May/June, Vol. 18(3), pp. 217–227.
- 5 Information regarding other major aspects of the Medicaid program are discussed in Chapter 1: Medicaid Eligibility, Chapter 2: Medicaid Benefits, and Chapter 3: Medicaid Financing.
- 6 For state-by-state data on Medicaid enrollment, eligibility, spending, managed care, section 1115 waivers, and other topics, see [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org). Accessed on April 10, 2002.
- 7 For a summary of state Medicaid agency and CMS administrative responsibilities under federal law, and court cases interpreting those responsibilities, see Perkins, J., Melden, M., and Regan, M., *An Advocate's Guide to the Medicaid Program*, National Health Law Program, June 2001, 2.3-2.17, Accessed on [www.healthlaw.org](http://www.healthlaw.org) on April 10, 2002.
- 8 For an introduction to Medicaid, see *Medicaid: A Primer*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2001.
- 9 Tallon, J., and Brown, L., "Who Gets What? Devolution of Eligibility and Benefits in Medicaid," Thompson, F., and Dilulio, J. (eds), *Medicaid and Devolution: A View from the States*, Brookings Institution Press, 1998, p. 255.
- 10 "Organizing Medicaid Responsibilities: A Look at Current State Agency Structure," *Washington Memo*, American Public Human Services Association, July–September 2000, Table 1.
- 11 This estimate of the proportion of Medicaid funds spent on administration differs from the estimate made in Section IV of this chapter. Reasons for this difference are laid out in *Exhibit B, Estimating Medicaid Administrative Spending*, p. 154.
- 12 Davidson, S. and Somers, S. (eds.), *Remaking Medicaid: Managed Care for the Public Good*, 1998.
- 13 *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services*, General Accounting Office, Testimony before the Committee on Finance, U.S. Senate, Hearing on Medicaid Coverage of School-Based Services, June 17, 1999; *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit*, Testimony before the Committee on Finance, U.S. Senate, April 5, 2000.
- 14 Schwalberg, R. et al., *Health Systems Research, Making Child Health Coverage a Reality: Lessons from Case Studies of Medicaid and CHIP Outreach and Enrollment Strategies*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 1999, p. 18.
- 15 Maloy, K., and Happoldt, I., *Promise Fulfilled or Missed Opportunities? California Counties, Welfare Reform, and Medi-Cal*, Medi-Cal Policy Institute, April 2001, p. 23. Accessed on [www.medi-cal.org/publications/reports.cfm](http://www.medi-cal.org/publications/reports.cfm) on April 10, 2002.

- 16 Accessed on [www.hcfa.gov/medicaid/stateplan/default.asp](http://www.hcfa.gov/medicaid/stateplan/default.asp) on April 10, 2002.
- 17 The requirements for “state plans for medical assistance” are set forth at section 1902(a)(1)-(14), (16)-(46), (48)-(65) of the Social Security Act, 42 U.S.C. 1396a(a)(1)-(14), (16)-(46), (48)-(65).
- 18 As originally enacted, the requirements for state Medicaid plans were set forth in section 1902(a)(1)—(22) of the Social Security Act, 42 U.S.C. 1396a(a)(1)(22). Section 121(a) of P.L. 89-97, July 30, 1965.
- 19 Section 1902(a)(4) of the Social Security Act, 42 U.S.C. 1396(a)(4).
- 20 42 C.F.R. 431.15, issued in 1979, provides, in its entirety, “A state plan must provide for methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the plan.”
- 21 Section 1902(a)(5) of the Social Security Act, 42 U.S.C. 1396a(a)(5).
- 22 42 C.F.R. 431.10(e).
- 23 “Organizing Medicaid Responsibilities: A Look at Current State Agency Structure,” *Washington Memo*, American Public Human Services Association, July–September 2000, Table 3.
- 24 42 C.F.R. 431.12.
- 25 Section 1927 of the Social Security Act, 42 U.S.C. 1396r-8. See also Bruen, B., *The Urban Institute, Medicaid and Prescription Drugs: An Overview*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2000. Accessed on [www.kff.org](http://www.kff.org) on April 10, 2002.
- 26 Section 1173(a)(1) of the Social Security Act, 42 U.S.C. 1320d-2(a), implemented at 45 C.F.R. 160.101 et seq.
- 27 Section 1903(d) of the Social Security Act, 42 U.S.C. 1396b(d).
- 28 DAB decisions may be found at [www.hhs.gov/dab/](http://www.hhs.gov/dab/), accessed on April 10, 2002.
- 29 See Chapter 3, Medicaid Financing, pp. 96-97.
- 30 See *Medicaid in Schools: Improper Payments Demand Improvements in CMS Oversight*, General Accounting Office, April 5, 2000, (GAO/HEHS/OSI-00-69); *Medicaid: State Financing Schemes Again Drive Up Federal Payments*, Testimony before the Committee on Finance, General Accounting Office, September 6, 2000, (GAO/T-HEHS-00-193).
- 31 Section 1903(a) of the Social Security Act, 42 U.S.C. 1396b(a).
- 32 For a summary of the three basic waiver authorities—section 1115 demonstration waivers, section 1915(b) freedom-of-choice waivers, and section 1915(c) home- and community-based services waivers, see Chapter 3, Medicaid Financing.
- 33 For a description of the section 1115 waiver application and approval process see Lambrew, J., *Section 1115 Waivers in Medicaid and the State Children’s Health Insurance Program: An Overview*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, at pp. 13–19, July 2001. Accessed on [www.kff.org](http://www.kff.org) on April 10, 2002.
- 34 42 C.F.R. Parts 430–456.
- 35 Accessed on [www.hcfa.gov/pubforms/45\\_smm/pub45toc.htm](http://www.hcfa.gov/pubforms/45_smm/pub45toc.htm) on April 10, 2002.
- 36 Accessed on [www.hcfa.gov/medicaid/smdhmpg.htm](http://www.hcfa.gov/medicaid/smdhmpg.htm) on April 10, 2002.
- 37 Technical Assistance Guide On Medicaid and School Health, Health Care Financing Administration, August 1997. Accessed on [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm) on April 10, 2002.
- 38 Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, Health Care Financing Administration, October 2000.
- 39 Enrolling and Retaining Low-Income Families and Children in Health Care Coverage, Health Care Financing Administration, 2001, Accessed on [www.hcfa.gov/init/outreach/progress.pdf](http://www.hcfa.gov/init/outreach/progress.pdf) on April 10, 2002.
- 40 Section 1102(a) of the Social Security Act, 42 U.S.C. 1302(a).
- 41 See section 1919(f)(7)(A) of the Social Security Act, 42 U.S.C. 1396r(f)(7)(A), directing the Secretary to issue regulations defining the costs which nursing facilities may charge to the personal funds of Medicaid-eligible residents.
- 42 See Chapter 3 Medicaid Financing, pp 111-115.

- 43 Section 1902(a)(19) of the Social Security Act, 42 U.S.C. 1396a(a)(19).
- 44 Section 1902(a)(3) of the Social Security Act, 42 U.S.C. 1396a(a)(3).
- 45 Section 1904(2) of the Social Security Act, 42 U.S.C. 1396c(2).
- 46 *April 2001 Baseline Medicaid and State Children's Health Insurance Program*, Congressional Budget Office, April 18, 2001.
- 47 Not all states require licensure for all classes of providers participating in Medicaid. For those classes for which a state does not require licensure, the state Medicaid agency generally establishes and applies its own standards.
- 48 For similar reasons, the Secretary also was given statutory authority to decertify intermediate care facilities for the mentally retarded (ICFs/MR), including those operated by a state, that do not provide "active treatment" to their residents or otherwise meet the requirements of participation in the program. Section 1910(b) of the Social Security Act, 42 U.S.C. 1396l(b).
- 49 Section 1919(g)(2)(C) of the Social Security Act, 42 U.S.C. 1396r(g)(2)(C).
- 50 Section 1919(g)(3) of the Social Security Act, 42 U.S.C. 1396r(g)(3).
- 51 Section 1919(h)(3) of the Social Security Act, 42 U.S.C. 1396r(h)(3).
- 52 Section 1919(g)(3)(C) of the Social Security Act, 42 U.S.C. 1396r(g)(3)(C).
- 53 See *California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations*, General Accounting Office, July 28, 1998, (GAO/T-HEHS-98-219); *Nursing Homes: Enhanced CMS Oversight of State Programs Would Better Ensure Quality*, General Accounting Office, November 4, 1999, (GAO/HEHS-00-6); *Nursing Homes: Sustained Efforts are Essential to Realize Potential of the Quality Initiatives*, General Accounting Office, September 2000, (GAO/HEHS-00-197).
- 54 *Report to Congress: Interim Report on Nursing Home Quality of Care and Implementation of The Nursing Home Initiative*, CMS, Fall 2000.
- 55 *Abuse of Residents Is a Major Problem in U.S. Nursing Homes*, House Committee on Government Reform, Minority Staff Special Investigations Division, July 2001. Accessed on [www.house.gov/reform/min/inves\\_nursing/index.htm](http://www.house.gov/reform/min/inves_nursing/index.htm) on April 10, 2002.
- 56 Nursing Home Compare, accessed on [www.medicare.gov/nhcompare/home.asp](http://www.medicare.gov/nhcompare/home.asp) on April 10, 2002.
- 57 The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, *Nursing Home Staffing Standards*, forthcoming 2001.
- 58 *State Efforts to Control Improper Payments Vary*, General Accounting Office, June 2001, (GAO-01-662), p. 14.
- 59 Ibid. at p. 4.
- 60 *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments* (A-17-00-02000), Office of Inspector General, March 6, 2000. Accessed on [oig.hhs.gov/oas/reports/afima/a0002000.pdf](http://oig.hhs.gov/oas/reports/afima/a0002000.pdf) on April 10, 2002.
- 61 *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 2000*, OIG, February 2001, (A-17-00-02001), CMS Financial Report, Fiscal Year 2000, OIG, February 2001, at p. 132. A CMS description of its program integrity efforts appears at Appendix III of GAO, *State Efforts to Control Improper Payments Vary*, General Accounting Office, June 2001, (GAO-01-662), pp. 67–68.
- 62 These activities are funded through the Health Care Fraud and Abuse Control Program established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), *Annual Report of the Departments of Health and Human Services and Justice: Health Care Fraud and Abuse Control Program FY 1999*, January 2000. Accessed on [www.hhs.gov/oig/](http://www.hhs.gov/oig/) on April 10, 2002.
- 63 Section 1903(q) of the Social Security Act, 42 U.S.C. 1396b(q).
- 64 CMS's "National Medicaid Fraud and Abuse Initiative" is summarized at Table 3 of GAO, *State Efforts to Control Improper Payments Vary*, General Accounting Office, June 2001, (GAO-01-662), pp. 25–26. See also [www.hcfa.gov/medicaid/fraud/](http://www.hcfa.gov/medicaid/fraud/), accessed on April 10, 2002.
- 65 42 U.S.C. 2000d, 45 C.F.R. 80.1 et seq.

- 66 42 U.S.C. 12101 et seq., 28 C.F.R. Parts 35 and 36.
- 67 *Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency*, OCR, August 30, 2000. Accessed on [www.hhs.gov/ocr/lep/guide.html](http://www.hhs.gov/ocr/lep/guide.html) on April 10, 2002; Perkins, Jane, et al., National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, January 1998, The Henry J. Kaiser Family Foundation.
- 68 119 S. Ct. 2187, 1999; *The Olmstead Decision: Implications for Medicaid*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2000. CMS has issued five letters to State Medicaid Directors on *Olmstead* implementation; they can be accessed on [www.hcfa.gov/medicaid/olmstead/smdltrs.htm](http://www.hcfa.gov/medicaid/olmstead/smdltrs.htm), April 10, 2002.
- 69 See further discussion on Appropriations Justifications, p. 150.
- 70 Section 1902(r)(1) of the Social Security Act, 42 U.S.C. 1396b(r)(1).
- 71 “Medicaid Facts: Medicaid and Managed Care,” The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2001.
- 72 *April 2001 Baseline Medicaid and State Children’s Health Insurance Program*, Congressional Budget Office, April 18, 2001.
- 73 *Medicaid Facts: Medicaid and Managed Care*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2001.
- 74 Verdier, J. and Young, C., *Medicaid Managed Care Purchasing: What Works and What Doesn’t*, Center for Health Care Strategies, July 2000. Accessed on [www.chcs.org/publications/purchasing.html](http://www.chcs.org/publications/purchasing.html) on April 10, 2002.
- 75 Verdier, J., *Restructuring Medicaid Offices to Deal with Managed Care*, Center for Health Care Strategies. Accessed on [www.chcs.org/publications/purchasing.html](http://www.chcs.org/publications/purchasing.html) on April 10, 2002.
- 76 Section 1902(a)(8) of the Social Security Act, 42 U.S.C. 1396a(a)(8).
- 77 42 C.F.R. 435.911(a).
- 78 Section 1902(a)(5) of the Social Security Act, 42 U.S.C. 1396a(a)(5). States may delegate eligibility determinations to local welfare agencies, as California and New York have done.
- 79 42 C.F.R. 431.10(c).
- 80 Section 1902(a)(55) of the Social Security Act, 42 U.S.C. 1396a(a)(55).
- 81 Section 1902(a)(19) of the Social Security Act, 42 U.S.C. 1396a(a)(19).
- 82 42 C.F.R. 435.902, issued in 1979, provides in its entirety: “The agency’s policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient.”
- 83 Perry, M., Smith, V., Smith, C., and Chang, C., *Marketing Medicaid and CHIP: A Study of State Advertising Campaigns*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2000, Table 1.
- 84 Ross, D.C., and Cox, L., Center on Budget and Policy Priorities, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2000, Table 2.
- 85 Section 1903(u) of the Social Security Act, 42 U.S.C. 1396b(u).
- 86 CMS, Letter to State Medicaid Directors, September 12, 2000. Accessed on [www.hcfa.gov/medicaid/letters/smdltrs.htm](http://www.hcfa.gov/medicaid/letters/smdltrs.htm) on April 10, 2002.
- 87 See *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*, General Accounting Office, May 1997, (GAO/HEHS-97-86).
- 88 Kaye, N., *Medicaid Managed Care: A Guide for States, Fifth Edition*, National Academy for State Health Policy, May 2001, Table 80, p. 128.
- 89 See Chapter 2, Medicaid Benefits, pp. 55-63.
- 90 42 C.F.R. 440.230(b).
- 91 42 C.F.R. 430.12(c).
- 92 American Public Human Services Association, *op. cit.*, Table 3. In New Hampshire, New Mexico,

- Oregon, and Texas this function is shared by the state Medicaid agency with other state agencies.
- 93 42 C.F.R. 440.230(d).
- 94 The only exception is the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under 21 benefit, which specifies that diagnostic and treatment services must be provided when necessary “to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services ... .”
- 95 See Chapter 2, Medicaid Benefits, pp. 60-61.
- 96 Kaye, N., *Medicaid Managed Care: A Guide for States, Fifth Edition*, National Academy for State Health Policy, May 2001, Table 16, p. 43.
- 97 Section 1927(d)(5) of the Social Security Act, 42 U.S.C. 1396r-8(d)(5). For a description of state DUR programs, see Schwalberg et al., *Health Systems Research, Medicaid Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, August, 2001.
- 98 Section 1927(g) of the Social Security Act, 42 U.S.C. 1396r-8(g).
- 99 Schwalberg, R. et al., Health Systems Research, *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 2001, Table II-3.
- 100 Section 1919(e)(7) of the Social Security Act, 42 U.S.C. 1396r(e)(7).
- 101 Rosenbaum, S. et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Ed.*, George Washington Center for Health Services Research and Policy, June 1999, Vol. 1, pp. 4–17; Rosenbaum S. et al., *Negotiating the New Health System Special Report: Mental Illness and Addiction Disorder Treatment and Prevention*, George Washington Center for Health Services Research and Policy, March 1998, pp. 19–20.
- 102 Section 1932(b)(1) of the Social Security Act, 42 U.S.C. 1396u-2(b)(1).
- 103 See Chapter 3, Medicaid Financing, pp. 111-115.
- 104 For a discussion of the federal rules relating to DSH hospital payments, see Chapter 3, Medicaid Financing.
- 105 For a discussion of the federal rules governing reimbursement to FQHCs, hospices, and other providers, see Chapter 3, Medicaid Financing.
- 106 Section 1902(a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(A).
- 107 CMS Letter to State Medicaid Directors, December 10, 1997, Enclosure 2. Accessed on [www.hcfa.gov/medicaid/letters/smdltrs.htm](http://www.hcfa.gov/medicaid/letters/smdltrs.htm) on April 10, 2002.
- 108 American Public Human Services Association, *op cit.*, Table 3.
- 109 Section 1903(m)(2)(A)(iii) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A)(iii).
- 110 Under current regulations, capitation payments to individual MCOs are subject to an upper payment limit that prohibits a state Medicaid program from paying more to an MCO than what the state would spend on covered services for the enrolled population on a fee-for-service basis 42 C.F.R. 447.361. CMS has proposed repealing this UPL, 66 *Fed. Reg.* 6228 (January 19, 2001), effective August 16, 2002, 66 *Fed. Reg.* 43090, (August 17, 2001).
- 111 Schwalberg, R., Health Systems Research, *The Development of Capitation Rates under Medicaid Managed Care Programs: A Pilot Study*, The Henry J. Kaiser Family Foundation, November 1997, pp. iv–viii.
- 112 Kaye, N., *Medicaid Managed Care: A Guide for States, Fifth Edition*, National Academy for State Health Policy, May 2001, Table 80, p. 128.
- 113 Section 1915(a)(23) of the Social Security Act, 42 U.S.C. 1396a(a)(23).
- 114 42 CFR 431.107. In the case of states operating section 1915(b) waivers, PCCMs are subject to additional requirements relating to accessibility.
- 115 *Medicaid: CMS and States Could Work Together to Better Ensure the Integrity of Providers*, General Accounting Office, July 18, 2000, GAO/T-HEHS-00-159, p. 9.
- 116 Section 1902(a)(37)(B) of the Social Security Act, 42 U.S.C. 1396a(a)(37)(B).

- 117 Section 1902(a)(37)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(37)(A).
- 118 Section 1903(m)(2)(A)(iii) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A)(iii).
- 119 Section 1902(a)(25) of the Social Security Act, 42 U.S.C. 1396a(a)(25). State-by-state information on Third Party Liability (“TPL”) collections appears at [www.hcfa.gov](http://www.hcfa.gov).
- 120 Section 1902(a)(9)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(9)(A).
- 121 Section 1902(a)(22)(D) of the Social Security Act, 42 U.S.C. 1396a(a)(22)(D).
- 122 Section 1919(g)(2) of the Social Security Act, 42 U.S.C. 1396r(g)(2). CMS must conduct “verification” surveys (using the same national protocol) to ensure that the monitoring efforts of state agencies are adequate.
- 123 The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, “Nursing Home Staffing Standards,” forthcoming 2002.
- 124 Section 1902(a)(9)(C) of the Social Security Act, 42 U.S.C. 1396a(a)(9)(C). Accessed on [www.hcfa.gov/medicaid/clia/cliahome.htm](http://www.hcfa.gov/medicaid/clia/cliahome.htm) on April 10, 2002.
- 125 Section 1932(c)(1) of the Social Security Act, 42 U.S.C. 1396u-2(c)(1).
- 126 CMS published final regulations relating to state strategies for assessing and improving the quality of managed care, 42 C.F.R. 438.200-438.204, 66 *Fed. Reg.* 6413-6414 (January 19, 2001) and delayed their effective date until August 16, 2002, 66 *Fed. Reg.* 43090 (August 17, 2001).
- 127 Section 1932(c)(2) of the Social Security Act, 42 U.S.C. 1396u-2(c)(2).
- 128 Section 1932(c)(2)(A)(iii) of the Social Security Act, 42 U.S.C. 1396u-2(c)(2)(A)(iii).
- 129 Kaye, N., *Medicaid Managed Care: A Guide for States, Fifth Edition*, National Academy for State Health Policy, May 2001, Table 74. Sixteen of the 29 states with PCCM programs also reported using EQROs to monitor quality, Table 76.
- 130 Kaye, N., *op cit.*, p. 124.
- 131 *Medicaid: State Efforts to Control Improper Payments Vary*, General Accounting Office, June 2001, (GAO-01-662), p. 4.
- 132 *Medicaid: State Efforts to Control Improper Payments Vary*, General Accounting Office, June 2001, (GAO-01-662), pp. 10–11.
- 133 Section 1902(a)(61) of the Social Security Act, 42 U.S.C. 1396a(a)(61).
- 134 *Medicaid: State Efforts to Control Improper Payments Vary*, General Accounting Office, June 2001 (GAO-01-662), p. 7. See also [www.naag.org](http://www.naag.org), accessed on April 10, 2002.
- 135 Section 1902(q)(3), (4) of the Social Security Act, 42 U.S.C. 1396b(q)(3), (4).
- 136 Section 1903(r)(2)(B) of the Social Security Act, 42 U.S.C. 1396b(r)(2)(B).
- 137 Section 1919(g)(5)(D) of the Social Security Act, 42 U.S.C. 1396r(g)(5)(D).
- 138 *Goldberg v. Kelly*, 397 U.S. 254 (1970); section 1902(a)(3) of the Social Security Act, 42 U.S.C. 1396a(a)(3).
- 139 42 C.F.R. 431.200—431.250.
- 140 *Daniels v. Wadley*, 926 F. Supp. 1305 (M.D. Tenn. 1996), vacated on other grounds sub nom. *Daniels v. Menke*, 1998 U.S. App. LEXIS 7973 (6th Cir. 1998). For a summary of state “fair hearing” procedures as applied to Medicaid MCO enrollees, see Rawlings-Sekunda, J., National Academy for State Health Policy, *Addressing Complaints and Grievances in Medicaid Managed Care*, January 1999, Appendix B.
- 141 Section 1919(e)(3) of the Social Security Act, 42 U.S.C. 1396r(e)(3).
- 142 Section 1910(b)(2) of the Social Security Act, 42 U.S.C. 1396l(b)(2).
- 143 Section 1932(e)(4) of the Social Security Act, 42 U.S.C. 1396u-2(e)(4).
- 144 See, e.g., section 1128A(c), (e), (f), and (g) of the Social Security Act (relating to procedures for imposition of civil money penalties).
- 145 Section 1902(a)(4)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(4)(A).

- 146 Section 1903(r)(1)(B) of the Social Security Act, 42 U.S.C. 1396b(r)(1)(B).
- 147 Section 1903(r)(1)(F) of the Social Security Act, 42 U.S.C. 1396b(r)(1)(F).
- 148 Section 1903(r)(1)(D) of the Social Security Act, 42 U.S.C. 1396b(r)(1)(D). Under the HIPAA “Administrative Simplification” provisions, the Medicaid program is treated as a “health plan” that is required to comply with standards adopted by the Secretary of HHS for electronic exchange of information relating to health claims, enrollment and eligibility. Section 1172(a)(1) of the Social Security Act, 42 U.S.C.1320d-1(a)(1). State Medicaid programs and other health plans must comply with these standards by no later than October 16, 2003 under terms of the 1-year extension granted by the Administrative Simplification Act, P.L. 107-105. (December 27, 2001).
- 149 Section 1903(r)(1)(B), (2)(B) of the Social Security Act, 42 U.S.C. 1396b(r)(1)(B), (2)(B).
- 150 American Public Human Services Association, *op. cit.*, Table 3.
- 151 Section 1902(a)(6) of the Social Security Act, 42 U.S.C. 1396a(a)(6).
- 152 See [www.hcfa.gov/medicaid/ofs-37.htm](http://www.hcfa.gov/medicaid/ofs-37.htm), accessed on April 10, 2002.
- 153 See [www.hcfa.gov/medicaid/ofs-64.htm](http://www.hcfa.gov/medicaid/ofs-64.htm), accessed on April 10, 2002.
- 154 See [www.hcfa.gov/medicaid/msis/mstats.htm](http://www.hcfa.gov/medicaid/msis/mstats.htm), accessed on April 10, 2002.
- 155 See [www.hcfa.gov/medicaid/416inst.htm](http://www.hcfa.gov/medicaid/416inst.htm), accessed on April 10, 2002.
- 156 This requirement is effective for claims filed on or after January 1, 1999. Section 1903(r)(1)(F) of the Social Security Act, 42 U.S.C. 1396b(r)(1)(F).
- 157 Section 1905(r) of the Social Security Act, 42 U.S.C. 1396d(r) (relating to annual participation goals).
- 158 Section 1923(a)(2)(D) of the Social Security Act, 42 U.S.C. 1396-4(2)(2)(D)
- 159 Section 1927(i) of the Social Security Act, 42 U.S.C. 1396r-8(i).
- 160 See Guyer, J., Center on Budget and Policy Priorities, et al., *Untangling DSH: A Guide for Community Groups to Using the Medicaid DSH Program to Promote Access to Care*, The Access Project, 2000, pp. 37–39. Accessed on [www.accessproject.org](http://www.accessproject.org) on April 10, 2002.
- 161 Sections 1902(a)(49) and 1921 of the Social Security Act, 42 U.S.C. 1396a(a)(49) and 1396r-2.
- 162 Section 1128E(b)(1) of the Social Security Act, 42 U.S.C. 1320a-7e(b)(1); 45 CFR Part 61.
- 163 Section 1903(a)(2)-(7) of the Social Security Act, 42 U.S.C. 1396b(a)(2)-(7).
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