Congress of the United States
Washington, DC 20515

December 19, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Dear Acting Administrator Slavitt:

Today, Medicaid is the world's largest health insurance program, currently covering about 82 million Americans at some point this year. The Medicaid program today accounts for more than 15 percent of all health care spending in the United States and plays an increasingly large role in our nation's health care system. Representing roughly one in every four dollars in a state's average budget, Medicaid, along with the Children's Health Insurance Program (CHIP), will pay for roughly half of all births in the United States this year.

As Chairmen of authorizing committees in Congress charged with overseeing the Medicaid program, we write to better understand the Centers for Medicare and Medicaid Services' (CMS) policies and procedures regarding states' Medicaid expansion. With millions of Americans enrolled in the program, inconsistencies in CMS's approach to expansion populations and expenditures can shift billions of dollars to states and taxpayers. Therefore, it is crucial that CMS ensure lawmakers both in Congress and state capitals have a clear understanding from CMS regarding its role in overseeing the program.

Under current law, the optional Medicaid expansion included in the Patient Protection and Affordable Care Act (PPACA) allows states to expand Medicaid eligibility to individuals under the age of 65 with income up to 138 percent of the federal poverty level (FPL).[1] Through November 2015, an additional 14.1 million individuals have gained Medicaid or CHIP coverage.[2] PPACA provided enhanced federal funding for the expansion population, with the federal government covering 100 percent of the expenditures for the expansion population through 2016, 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019. Under current law, the Federal Medical Assistance Percentage (FMAP) for the expansion population is set at 90 percent in 2020 and thereafter.

---

[1] As a result of the Supreme Court's 2012 NFIB vs. Sebelius ruling, PPACA's Medicaid expansion is entirely optional for states.
[2] There is no comprehensive, authoritative source detailing what portion of enrolled individuals may have previously had some form of private commercial coverage or employer coverage that was disrupted as a result of PPACA.

This year, total federal-state Medicaid outlays are expected to be about $545 billion. Next year, enrollment and program expenditures are anticipated to increase and states will have to begin chipping in for the cost of Medicaid expansion. At the same time, states will be facing reductions in Medicaid disproportionate share hospital payments mandated by PPACA. Therefore, to protect Medicaid dollars and help provide certainty to the Congress and to state Medicaid programs, below we outline a number of questions related to CMS's approach to the Medicaid expansion.

Ensuring the Integrity of Federal Expenditures for Medicaid Expansion Enrollees

1) In response to questions from the Committee on Energy and Commerce earlier this year, Secretary Burwell noted that "the accuracy of Medicaid eligibility decisions is a high priority and CMS has implemented a number of strategies to ensure program integrity. Pursuant to CMS regulations, states have implemented strategies to electronically verify a number of factors of eligibility, including income, citizenship, and eligible immigration status."[3]

   However, audit work by the Government Accountability Office (GAO) found that in some of the cases tested, fictitious applicants were able to enroll in Medicaid and the federal Marketplace and selected state marketplaces.

   Since Medicaid coverage is often provided at little to no cost to the individual, there is a financial incentive for individuals to obtain Medicaid coverage for expensive health services for which they may not otherwise choose to obtain should they be responsible for paying for a portion of the expense (such as through deductibles, copays, or coinsurance). Ineligible individuals enrolling and receiving services in Medicaid would also been an inappropriate use of Medicaid funds.

   a. What *specific, concrete* steps has CMS taken to prevent ineligible individuals to enroll in Medicaid coverage? Please describe steps taken with respect to both states relying on the federally-facilitated exchanges and states operating their own state-based exchanges.

   b. How does HHS know that these steps are sufficiently protecting taxpayer dollars? For example, is CMS aware of any independent testing of the integrity of its own eligibility determinations and eligibility checks? Are these processes reviewed by a contractor or independent third party?

2) The CMS Office of the Actuary's (OACT) *2015 Actuarial Report on the Financial Outlook for Medicaid*, mentions states use of risk-sharing arrangements for the expansion population. It is important for Congress to understand these risk-sharing arrangements since the full federal funding of the expansion population means that states have no incentive to be cost conscious consumers.

   a. How many and which states have risk sharing arrangements for the expansion population?

[3] http://docs.house.gov/meetings/IF/IF14/20160224/104521/HHRG-114-IF14-Wstate-BurwellS-20160224-SD002.pdf

b. What arrangements do states who have expanded Medicaid have and how do these arrangements compare to those in place for non-expansion populations?

c. How many of those arrangements include provisions for Medicaid managed care organizations (MCOs) to return excess payments to the government?

d. When do states have to report the results of such arrangements to CMS and when are such payments due to the government?

e. How many states, if any, have returned excess payments as a result of risk-sharing arrangements for expansion populations to the federal government and how much money, to date, has been returned to federal taxpayers?

f. If states have risk sharing arrangements for non-expansion populations, does CMS require such arrangements for the expansion populations and do the arrangements have to be the same (i.e. if states require MCO's to return excess funds for non-expansion populations -where states have skin in the game - do they also have to for expansion populations and at the same rate)?

g. If risk-sharing arrangements are for the contract as a whole (and not by population), how does CMS ensure the federal government gets its fair share of any refund given the different federal matching rates for expansion and non-expansion populations?

3) We are unclear if CMS is taking sufficiently robust, timely, and targeted measures to ensure that states that have expanded Medicaid are accurately classifying individuals enrolled—and thus claiming the correct corresponding FMAP.

a. Please describe CMS's current policy directives to states regarding individuals whose Medicaid eligibility pathway may change during the course of their time enrolled in the program, or who may have multiple pathways for eligibility.

i. Consider the illustrative case of a pregnant woman with income below 133% of FPL in a state that has expanded Medicaid, or a disabled man with income below 133% of FPL in a state that has expanded Medicaid. Are the man and woman qualified under the traditional Medicaid pathways (pregnant and disabled) and therefore the state is eligible for the traditional FMAP, or is the state authorized to classify these individuals as expansion enrollees and thus, eligible to claim the enhanced FMAP for the expansion population for these individuals? Please share any of CMS's current written policy directions to states on this issue.

ii. Now consider a woman who is enrolled in Medicaid as an expansion enrollee and then becomes pregnant. Would the woman stay as an expansion enrollee until her next eligibility redetermination? At what point should the state reclassify her as a result of the pregnancy and thus only be able to claim expenditures under the traditional FMAP?

b. What processes or procedures does CMS have in place to ensure that states are appropriately classifying (or reclassifying) individuals, such as those in the examples above, and claiming the correct federal matching rate? For example, how would CMS ever know if a state kept the pregnant woman in the expansion population, thus claiming a higher federal matching rate?

Working with States

1) Some states have raised questions about the transition down from the 100% FMAP for the Medicaid expansion enrollees. What, if any, steps is CMS taking to communicate with state any system or process changes related to the reduced FMAP?

2) Some states have raised questions about the security of data CMS requests from states related to the Medicaid expansion.[4] Please explain what contractual obligations and data security protocols are in place between CMS and its data vendors, related to data security.

3) Secretary Burwell has suggested that CMS reviews Medicaid 1115 demonstration waiver requests for covering the Medicaid expansion population in light of federal aims to strengthen coverage and increase access to health care.[5] The Social Security Act gives wide latitude to the Secretary of Health and Human Services to waive provisions of federal statute, "which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid in a state.[6] However, since Medicaid objectives are not specified in federal statute and CMS only has general criteria listed on its website which can be interpreted in a wide variety of ways,[7] we believe lawmakers and state Medicaid programs deserve a more detailed understanding of CMS's approval criteria for 1115 demonstration waivers related to expansion. Therefore:

   a. What is CMS's comparison point for the program aim of "increase and strengthen overall coverage of low-income individuals in the state"—is the benchmark the program as it exists today in a state (i.e. with expansion) or the program if there was no expansion?

   b. If it is only the former, doesn't that create an uneven playing field for states and does that mean a state has to terminate expansion in order to get a waiver to do expansion differently?

Per Capita Spending for Individuals Enrolled in Medicaid Expansions

1) According to the CMS Office of the Actuary's (OACT) *2015 Actuarial Report on the Financial Outlook for Medicaid*, states paid about 49% more per enrollee ($6,366) in fiscal year 2015 than the agency predicted ($4,281) in the 2014 report.[8] OACT believes that about 9% of the 2015 payments will be returned to the government through medical loss ratio

[4] http://www.modernhealthcare.com/article/20160620/NEWS/160629999
[5] http://www.courier-journal.com/story/news/politics/2016/07/26/feds-advocates-question-bevin-health-changes/87536054/
[6] Section 1115 of Title XI of the Social Security Act.
[7] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html
[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf

(MLR) and risk corridor contract provisions. Even if this amount is returned to the federal government, the Medicaid expansion is proving costlier than was estimated just a year ago. While it is inherently difficult to predict future expenditures for new programs with a high degree of certainty, this is a notable increase in anticipated spending.

a. One potential cause for the higher than expected expenditures is that, because of the 100% FMAP for the expansion population, states set higher capitation rates for the expansion population—much higher than the amounts for previously eligible Medicaid adult enrollees. Do you believe this is a reason for the higher expenditures and has CMS compared states capitation rates for the expansion population with rates for previously eligible adults?

b. To help Congress and states understand more about the expenditures for the expansion population, please provide the spending per newly eligible enrollee by state for both fiscal years 2014 and 2015.

c. Under CMS's newly-finalized Medicaid managed care regulation, CMS will be taking a more active role in reviewing states' managed care rate setting process. Please describe how CMS will monitor state capitated payment rates for the newly eligible population; what the process involves and how, if at all, it differs from CMS's review of rates for non-expansion populations; and how the process differs from that used previously by CMS to review state capitated payment rates.

d. How did the MLR/risk corridor provisions affect final 2014 federal spending? And 2015? By state, please provide the amounts returned to or paid extra through these provisions.

The Role of Medicaid Expansion and Other Federal Programs

1) The GAO has determined that because "CMS has excluded from review federal Medicaid eligibility determinations in the states that have delegated authority to the federal government to make Medicaid eligibility determinations through the federally facilitated exchange" (FFE), this "creates a gap in efforts to ensure that only eligible individuals are enrolled into Medicaid and that state expenditures are correctly matched by the federal government."[9] GAO also found that "CMS reviews of states' expenditures do not use information obtained from the reviews of state eligibility determination errors to better target its review of Medicaid expenditures for the different eligibility groups."

a. Does CMS now review the accuracy of federal Medicaid eligibility determinations in the states that have delegated authority to the federal government to make Medicaid eligibility determinations through the FFE? If so, please describe the results of any reviews of federal Medicaid eligibility determinations.

[9] http://docs.house.gov/meetings/IF/IF14/20160224/104521/HHRG-114-IF14-Wstate-BurwellS-20160224-SD002.pdf

b. Please describe how CMS uses information obtained from the reviews of state eligibility determination errors to better target its review of Medicaid expenditures for the different eligibility groups.

2) In February of this year, Secretary Burwell explained that "the Marketplace checked whether enrollees were dually enrolled in Marketplace coverage with APTC and Medicaid or CHIP prior to Open Enrollment for 2016. Consumers who were identified as dually enrolled were notified that they should end their Marketplace coverage with APTC. In spring 2016, we will check again whether Marketplace enrollees with APTC are also enrolled in Medicaid or CHIP. Notices will be sent in May to consumers who were enrolled in both."

a. How many notices were sent to consumers enrolled in both Exchange coverage and Medicaid or CHIP, and under what schedule were these notices sent? For example, a *New York Times* story on August 19, 2016 noted that "in the last few days, consumers around the country have received letters warning" of dual enrollment in the Exchange and Medicaid/CHIP programs.[10] As the article rightly concludes, "the federal government may be paying twice for the same person if the person is in both Medicaid and a subsidized insurance policy bought through the marketplace."

b. How many consumers were disenrolled from Medicaid or Exchange coverage respectively as a result of these notifications?

c. What is the federal savings attributable to this notification-and-disenrollment process?

3) It has been interesting to watch Louisiana's recent Medicaid expansion unfold, since many now-Medicaid eligible consumers already were enrolled in Exchange coverage. In fact, according to one article, "The state says people who bought individual policies through the federal marketplace but now qualify for Medicaid under the state expansion can keep their Obamacare plans if they prefer them over Medicaid. They just have to keep paying their share of the premiums."[11]

a. Is this statement from the state accurate? If so:

i. Since individuals who are eligible for Medicaid are not eligible to receive subsidized health care coverage on the exchange, what is the statutory basis for allowing these individuals to continue their individual policies through the federal marketplace?

ii. Will these individuals' subsidies be continued despite their eligibility for Medicaid? If so, what authority does CMS have to continue these subsidies?

[10] http://www.nytimes.com/2016/08/20/us/politics/affordable-care-act-medicaid-duplicate.html?_r=0
[11] Griggs, Ted. "Uncertainty surrounds whether newly Medicaid-eligible in Louisiana can keep their Obamacare plans if prefer them," *The Advocate*, July 3, 2016. Baton Rouge, Louisiana. http://www.theadvocate.com/baton_rouge/news/business/article_77c9e2b6-3e22-11e6-8a7f-b33542bd39e1.html?sr_source=lift_amplify

iii. If these individuals who are Medicaid eligible are allowed to choose to remain in subsidized exchange coverage, why aren't other individuals who would prefer private coverage from the marketplace afforded the same choice?

iv. Why is it acceptable for these individuals to pay a premium in the exchange, yet CMS will not allow states to charge the exact same individual a premium if they are enrolled in Medicaid?

b. Since individuals who are eligible for Medicaid are not eligible to receive subsidized health care coverage on the exchange, when do Louisiana residents, who are now eligible for Medicaid under the state's Medicaid expansion, but were receiving subsidized exchange coverage, have to switch to Medicaid coverage? When do these individuals federal subsidies end?

i. If the switch to Medicaid does not occur as soon as Medicaid eligibility is established, what action will CMS take to ensure that federal taxpayers are not paying more than necessary to subsidize the cost of individuals eligible for Medicaid, but still getting subsidized coverage on the exchange?

ii. What action is the state and CMS taking to identify individuals receiving coverage on the exchange who may now be eligible for Medicaid?

c. How, if at all, will this process be different next year when states are responsible for paying a portion of the costs of Medicaid coverage for expansion enrollees? If a state were to implement Medicaid expansion in the middle of the year, what actions would CMS take, or require the state to take, to ensure that individuals who become eligible for Medicaid are not receiving federally subsidized exchange coverage?

4) In February 2016, CMS announced a change in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.[12] This directive re-interpreted the scope of services that can be considered to be "received through" an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). The scope of service change also applied to transportation that is covered as a service under the state Medicaid plan. This is a notable change to the Medicaid program and may have interactions with state decisions related to expansion. Therefore, in the interest of helping Congress and states understand CMS's approach, please explain the following:

a. Because this directive changes the types of services eligible for the 100 % FMAP under current law, what types of federal costs/state savings does CMS estimate this policy change may generate?

[12] https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

b. Given that CMS modified payment policy based on existing federal statute and regulation, please explain why CMS declined to pursue this policy change through the regulatory process, rather than just sending a State Health Official/State Medicaid Director letter?

c. How many individuals enrolled in Medicaid or IHS does CMS estimate will be impacted by this policy change?

d. What number of states does CMS estimate will be impacted by policy change and how does CMS think this policy change will impact states' Medicaid expansion programs or related-decisions?

Research Questions Regarding the Medicaid Expansion

1) In answering questions submitted for the record related to Secretary Burwell's testimony before the Committee on Energy and Commerce, it was stated that "research shows Medicaid expansion does not "crowd out" private coverage."[13] However, other recent research demonstrates just the opposite. So Congress can have a full understanding of research informing HHS, please list all research to which Secretary was referring and note whether or not the individuals conducting the studies, or the studies themselves, were funded in whole or in part by the Department of Health and Human Services (HHS).

2) For 2015, how does the federal cost of exchange subsidies for individuals who would be eligible for Medicaid expansion (at or below 133% FPL) compare to the average per capita expenditures for the cost of covering these individuals on Medicaid? Please provide a state-by-state breakdown.

We respectfully request your response within 30 days of the receipt of this letter. Thank you for your personal attention to this important issue. If you have any questions regarding this request, please contact Josh Trent with the Energy and Commerce Majority staff at (202) 225-2927.

Sincerely,

Orrin G. Hatch
Chairman
Committee on Finance
U.S. Senate

Joseph R. Pitts
Chairman
Subcommittee on Health
U.S. House of Representatives

[13] http://docs.house.gov/meetings/IF/IF14/20160224/104521/HHRG-114-IF14-Wstate-BurwellS-20160224-SD002.pdf

Tim Murphy
Chairman
Subcommittee on Oversight
and Investigations
U.S. House of Representatives