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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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MEMORANDUM

October 21, 2015

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations"

On Friday, October 23, 2015, at 9:00 a.m. in Room 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing titled "Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations." The hearing will focus on two newly released GAO reports examining the Center for Medicare & Medicaid Services (CMS) oversight of Medicaid and exchange eligibility determinations. The majority has indicated that the hearing will also focus on preliminary results of work conducted by GAO's Forensic Audits and Investigative Services division on enrollment controls in the state and federal marketplaces. The materials, pertaining to enrollment controls had not been furnished to the minority staff at the time this memo was issued.

I. BACKGROUND

The Affordable Care Act (ACA) is improving access to affordable, high quality health insurance coverage, as well as transforming the nation's healthcare delivery system.

- Nearly 9.9 million consumers had effectuated enrollments in the state and federally facilitated exchanges as of June 30, 2015.[1]

- Of those 9.9 million consumers, about 84 percent, or more than 8.3 million consumers, were receiving an advanced premium tax credit (APTC) to make their

[1] Centers for Medicare & Medicaid Services (CMS), June 30, 2015 Effectuated Enrollment Snapshot (Sept. 8, 2015) (online at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html).

premiums more affordable. The average APTC for qualifying enrollees was $270 per month.[2]

- Medicaid enrollment has increased by 13.2 million individuals since October 2013, when the initial Marketplace open enrollment period began.[3]

- Since passage of the law more than five years ago, an estimated 17.6 million uninsured people have gained health coverage through the ACA's various coverage provisions.[4]

- According to newly-released data from the U.S. Census Bureau, the uninsured rate fell from 13.3 percent to 10.4 percent from 2013 to 2014, representing the largest single-year reduction in the uninsured rate since 1987.[5]

- In 2014, hospital uncompensated care costs were $7.4 billion lower than 2013 levels as a result of exchange coverage and Medicaid expansion.[6]

- The ACA has also improved health care delivery systems: hospital readmissions are down, and indicators of patient safety, such as hospital-acquired conditions, have improved significantly.[7]

A. Medicaid Expansion Population and Enhanced Federal Assistance

Historically, Medicaid eligibility has been limited generally to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. Under the ACA, however, states have the option to extend Medicaid coverage to most nonelderly, low-income individuals making up to 133 percent of the federal poverty level

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[2] *Id.*

[3] Department of Health and Human Services (HHS), *Medicaid & CHIP: July 2015 Monthly Applications, Eligibility Determinations and Enrollment Report* (Sept. 28, 2015) (online at http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/july-2015-enrollment-report.pdf).

[4] HHS, Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage and the Affordable Care Act* (Sept. 22, 2015) (online at http://aspe.hhs.gov/basic-report/health-insurance-coverage-and-affordable-care-act-september-2015).

[5] Center on Budget and Policy Priorities, *Census Data Show Historic Coverage Gains in 2014* (Sept. 18, 2015) (online at www.cbpp.org/research/health/census-data-show-historic-coverage-gains-in-2014).

[6] HHS, *Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act* (Mar. 23, 2015) (online at http://aspe.hhs.gov/sites/default/files/pdf/83961/ib_UncompensatedCare.pdf).

[7] HHS, *The Affordable Care Act is Working* (June 24, 2015) (online at http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-is-working/index.html).

(FPL).

Thirty states, at present, have opted to expand Medicaid.[8] The ACA provides enhanced federal Medicaid matching rates for the individuals who receive Medicaid coverage through the ACA Medicaid expansion.

B. ACA Medicaid Enrollment and Eligibility Determinations

The ACA created a streamlined approach to determine eligibility for Medicaid and the Children's Health Insurance Program (CHIP) or for APTC and cost-sharing subsidies (CSRs) for coverage through the exchanges. The ACA approach was designed to ensure that individuals could qualify for an appropriate programs without gaps in, or duplication of, coverage. This approach facilitates portability of coverage among health insurance programs in cases where an individual's income grows or shrinks, thereby causing a particular beneficiary to either lose eligibility for one form of coverage and to gain eligibility for another. The ACA's "no wrong door" policy means that individuals can apply for health insurance coverage through the exchanges or through a state Medicaid or CHIP agency in their state and receive an eligibility determination for the health insurance program for which they are eligible.

The ACA also required the establishment in all states of a coordinated eligibility and enrollment process for Medicaid and the exchanges. Exchanges and state Medicaid agencies must enter into agreements with one another to ensure prompt eligibility determinations and enrollment of individuals in the appropriate programs regardless of where these individuals might apply. In 12 states, the state-based marketplace (SBM) operates a single, integrated system that makes eligibility determinations for both Medicaid and Marketplace coverage.[9]

For states using the federally-facilitated marketplace (FFM), CMS first determines whether an applicant is eligible for Medicaid or exchange coverage. There are two types of states: *determination states*, where the FFM actually determines Medicaid eligibility, and *assessment states*, where the FFM transfers cases it assesses as being potentially eligible for Medicaid to the state Medicaid agency for a final determination. In the ten (10) *determination states*, the FFM transfers the case to the Medicaid agency to enroll the individual in coverage. In the *assessment states*, the Medicaid agency must make a determination of eligibility once the case is transferred. Likewise, the state Medicaid agency is responsible for transferring accounts

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[8] *See* Center on Budget and Policy Priorities, *Health Reform's Medicaid Expansion* (online at www.cbpp.org/health-reforms-medicaid-expansion for more information on individual state expansions).

[9] Kaiser Family Foundation, *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015* (Jan. 20, 2015) (online at http://kff.org/health-reform/report/modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015/).

of individuals deemed ineligible for Medicaid to the FFM for a determination of eligibility to enroll in subsidized exchange coverage.[10]

C. Exchange Enrollment and Eligibility Determinations

In some SBMs and the FFM, the first step to enrolling in exchange coverage is to complete identity proofing (ID proofing). Once the individual has successfully completed ID proofing, he or she can continue filling out the application for coverage online. An applicant must 1) be a citizen of the United States, be a national of the United States, or be lawfully present in the United States; 2) not be incarcerated; and 3) meet applicable residency standards. To be eligible for APTC/CSR, an applicant must meet additional requirements related to household income, not be eligible for other minimum essential coverage, and provide self-attested information on family size.[11] Additionally, individuals covered through the SBMs, FFM, and Medicaid are subject to annual eligibility redeterminations to ensure ongoing eligibility.

During the time period from April 1, 2015 to June 30, 2015, enrollment in coverage through the FFM was terminated for about 306,000 consumers with citizenship or immigration status data matching issues who failed to produce sufficient documentation of their citizenship or immigration status. In addition, during the same time period, about 734,000 households with annual household income inconsistencies had their APTC and/or CSRs for 2015 coverage adjusted. Overall, as of June 30, 2015, the FFM has ended 2015 coverage for approximately 423,000 consumers with 2015 coverage who failed to produce sufficient documentation on their citizenship or immigration status and has adjusted APTC and/or CSRs for about 967,000 households.[12]

II. GAO REPORTS

A. Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds

GAO examined CMS efforts to ensure states are accurately verifying eligibility for Medicaid, and that expenditures for Medicaid enrollees in different eligibility groups are appropriately matched with the right FMAP. GAO found a gap in CMS's efforts to review Medicaid eligibility determinations in those states that have delegated authority to the federal government to make Medicaid eligibility determinations through the FFM. In addition, GAO made recommendations to improve CMS's reviews of states' Medicaid expenditures in order to

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[10] Government Accountability Office (GAO), *Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage* (October 2015) (GAO-15-728).

[11] HHS, *Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data* (June 2014) (OEI-01-14-00180) (online at http://oig.hhs.gov/oei/reports/oei-01-14-00180.pdf).

[12] *Id.*

identify expenditures that are erroneous due to incorrect eligibility determinations. CMS concurred with all of GAO's recommendations.

B. Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage

To conduct this study, GAO reviewed information from CMS regarding FFM-related policies and procedures, as well as information from four states that use the FFM - Arizona, Iowa, Texas, and Utah. In addition, GAO reviewed information from four SBMs - Colorado, Kentucky, New York, and Washington. GAO found that CMS's policies and procedures do not sufficiently minimize the potential for coverage gaps and duplicate coverage for individuals transitioning between Medicaid and exchange coverage in FFM states. Although CMS has implemented policies and procedures to reduce the potential for coverage gaps and duplicate coverage, GAO identified weaknesses in these policies and procedures and made recommendations to improve controls for FFM states. CMS concurred with all of GAO's recommendations.[13]

III. WITNESSES

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Forensic Audits and Investigative Services
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Carolyn Yocom
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[13] GAO, *Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage* (October 2015) (GAO-15-728).