Andy Slavitt's Hearing
"SBMs"
Before
Committee on Energy & Commerce, Subcommittee on Oversight & Investigations

December 8, 2015

Attachment - Additional Questions for the Record

The Honorable Tim Murphy

1. **Mr. Slavitt, I'm concerned about CMS' ability to keep adequate track of Federal loan funds. As I requested during the hearing, please provide the subcommittee with CMS's conclusions regarding OIG's findings that funds were misspent by the Washington State exchange. How much was misspent, according to CMS? How does CMS's conclusion differ from OIG's?**

Answer: Section 1311 of the Affordable Care Act provided for grants to states, not loans, for the planning and establishment of Exchanges. In April 2015, the OIG sent a memo to CMS stating that some SBMs, specifically Washington, were at risk of using establishment funds to support operations. In this memo, OIG recommended CMS to develop and publish clear guidance on operational costs in order to minimize marketplaces' improper use of establishment funding for operational expenses after January 1, 2015. CMS followed OIG's recommendation and issued clarifying guidance, detailing which activities are considered allowable establishment activities.[1]

In addition, CMS conducted a line-by-line review of Washington's budget and determined all costs to be for allowable purposes.

2. **In response to OIG conclusions regarding funds misspent by state exchanges, what plans have you put in place to recover Federal loan dollars? Have you changed CMS processes after the OIG alert to better find misuse of federal dollars by state exchanges? Please explain.**

Answer: Section 1311 of the Affordable Care Act provided for grants to states, not loans, for the planning and establishment of Exchanges. In June 2015, consistent with the recommendation of the HHS Office of the Inspector General (OIG), CMS issued additional guidance on the difference between operational and establishment costs, including specific examples for states to consider.[2] In addition, CMS provides SBMs with technical assistance to clarify the difference between operational and establishment costs, including through webinars and phone conferences tailored to individual states. CMS also continues to monitor SBM use of establishment grant funds and take appropriate action, as OIG recommended, if any SBM uses grant funds for unallowable costs or for activities that are not authorized according to the terms of the grant. SBMs are required to provide budgets and justifications to spend grant awards, which CMS carefully reviews. CMS also conducts ongoing oversight though regular monitoring calls and site visits, SBM grant budget and performance reports, and by requiring SBMs to conduct annual financial audits. When misuse of 1311 funding is identified through these review and oversight activities, CMS takes appropriate action to recoup

[1] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf
[2] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf

funds that have been misspent.

3. **During the hearing, you mentioned that CMS has produced a variety of visual representations of the state exchange program. Please provide the subcommittee with any charts relevant to state exchange financial sustainability.**

Answer:

State	Sustainability Plan for 2016 (based on budget information reported by the SBMs)
CA	$13.95 Per Member Per Month (PMPM) on individual QHPs, $18.60 PMPM on SHOP QHPs, and $0.83 PMPM on dental plans.
CO	3.5% user fee on plans sold through the Marketplace, $1.80 PMPM marketwide assessment, premium tax credit donation by issuers, and private foundation grants.
CT	1.65% marketwide assessment on all health insurance carriers.
DC	1% marketwide assessment on all health insurance carriers.
HI	$2 million state appropriation for FY2016 and 3.5% user fee on plans sold through the Marketplace
ID	1.9% user fee on plans sold through the Marketplace.
KY	1% PMPM marketwide assessment on all health insurance premiums and a stop-loss assessment
MA	Issuer assessment on all plans sold through Marketplace: 3% of premium for ConnectorCare (0-300% federal poverty level [FPL]) and stand-alone dental, 2.5% of premium for APTC only plans, subsidized non-group members, and small group members; and a state appropriation.
MD	State budget.
MN	3.5% PMPM on plans sold through the Marketplace.
NM	Marketwide assessment on all major carriers (% varies based on their market share) and a special carrier reserve assessment.
NV	3.15% PMPM on plans sold through the Marketplace.
NY	State budget.
OR	Issuer assessment on plans sold through the Marketplace: $9.66 PMPM on QHPs and $0.97 on QDPs.
RI	Marketwide premium assessment: average 2.86% on individual and 0.59% on small-business group plans; $2.6 million state appropriation in FY2016.
VT	State budget.
WA	State budget (sources are: $7.46 PMPM on QHPs sold on the Marketplace and a 2% PMPM marketwide assessment that is generated specifically by plans sold through the Marketplace.)

The Honorable David McKinley

1. **Mr. Slavitt, during the hearing, you expressed that you were sure some employees had lost their jobs during the failure of state exchanges. Please provide the subcommittee with all available names of those who have been held accountable for misallocated funds in the state exchange system.**

Answer: Many State Based Marketplaces have made leadership and staff changes, which have been widely reported. For example, officials have left positions in Oregon[3], Massachusetts[4], Minnesota[5], Hawaii[6], and Maryland.[7]

The Honorable Marsha Blackburn

1. **Mr. Slavitt, during the hearing, you told me that you have access to a full accounting of all Federal outlays to state exchanges, totaling $4.5 billion. Please provide the subcommittee with these figures, including details on misallocated funds that are yet to be recovered.**

Answer: CMS has provided the Subcommittee staff with an accounting of 1311 Funding Grants obligations and deobligations. As of November 30, 2015, approximately $319 million in grant funding awarded has been deobligated and returned to the federal government. This does not include the $32.5 million that Maryland has agreed to return to the federal government due to their legal settlement with their contractor. CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs. CMS has identified unallowable costs from Arkansas, Minnesota, Oregon and Washington and we are working with states to recover this funding.

The Honorable Michael C. Burgess, M.D.

1. **Mr. Slavitt, during the hearing, we discussed the implementation of Sec. 1311-H of the Affordable Care Act, as it pertained to provider quality. Has CMS ever excluded a provider from accessing state exchanges based on quality? If yes, please explain the nature of each exclusion.**

Answer: Providers contract with individual insurance issuers, which are regulated by state Departments of Insurance. CMS reviews and approved the Qualified Health Plans (QHPs) offered by those issuers.

CMS has been phasing in implementation of Section 1311(h), which requires qualified health plans (QHPs) to only contract with hospitals with greater than 50 beds that use patient safety evaluation systems (PSES) and implement comprehensive hospital discharge programs. It also requires QHPs to contract with health care providers who implement health care quality improvement mechanisms.

[3] http://www.oregonlive.com/health/index.ssf/2014/03/kitzhaber_cleans_house_announc.html
[4] http://boston.cbslocal.com/2015/02/25/gov-baker-calls-for-resignation-of-gruber-at-health-connector/
[5] http://www.twincities.com/2013/12/16/under-fire-mnsures-executive-director-abruptly-resigns/
[6] http://www.bizjournals.com/pacific/news/2016/01/13/hawaii-health-connector-board-members-resign.html
[7] http://www.bizjournals.com/baltimore/news/2013/12/06/maryland-health-exchange-head-rebecca.html

In the Notice of Benefit and Payment Parameters for 2015[8], which we finalized after offering an opportunity for public comment, we established that for the initial two years beginning January 1, 2015, we would draw on Medicare standards and require that QHP issuer-contracted hospitals are:

- Medicare-certified or are Medicaid-only hospitals, and
- Are subject to Medicare Hospital Conditions of Participation (CoP) standards for a quality assessment and performance improvement program (QAPI) and for discharge planning.

In the Proposed Notice of Benefit and Payment Parameters for 2017[9], which we have released for public comment, we propose to strengthen standards and align with current, effective patient safety interventions. We propose requiring QHPs to:

- Verify that their contracted hospitals, with more than 50 beds, have current agreements with Patient Safety Organizations (PSO); or
- Provide reasonable exceptions to the PSO requirement, including allowing QHPs to contract with hospitals that implement evidence-based initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events.

CMS looks forward to reviewing comments received on the proposed notice.

The Honorable Bill Flores

1. Mr. Slavitt, what is the remaining balance on each state exchange's Federal loan?

Answer: Section 1311 of the Affordable Care Act provided for grants, not loans, to states for the planning and establishment of Exchanges. All funds for the establishment of SBMs have been allocated following HHS Grants Policy and applicable Federal statutes and regulation. States applied for funding through a competitive grant opportunity, and were required to meet the criteria established in the Funding Opportunity Announcement.[10]

CMS has provided the Subcommittee staff with an accounting of 1311 Funding Grants obligations and deobligations. As of November 30, 2015, approximately $319 million of grant funding awarded has been deobligated and returned to the federal government. This does not include the $32.5 million that Maryland has agreed to return to the federal government due to their legal settlement with their contractor. CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs.

The Honorable Markwayne Mullin

1. Mr. Slavitt, during the hearing, we discussed the math behind calculating state

[8] https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015

[9] https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017

[10] https://www.cms.gov/cciio/resources/Funding-Opportunities/index.html#Health Insurance Marketplaces

exchanges' provider user fees. Please provide the subcommittee with a detailed description of the calculations CMS employed in arriving at the established user fees.

Answer: In the Proposed Notice of Benefit and Payment Parameters for 2017[11], which we released for public comment, CMS proposed to charge issuers offering QHPs through an SBM-FP a user fee rate of 3.0 percent of the monthly premium charged by the issuer for each policy under a plan offered through an SBM-FP. This fee will recover funding to support FFM operations incurred by the Federal government associated with providing the services that SBM-FPs have elected to leverage. CMS also stated that, for the 2017 benefit year, we would consider reducing the user fee rate by one half or one third (that is, to 1.5 or 2.0 percent) for the issuers in SBM-FPs, to provide these States additional time to integrate this user fee rate.

The proposed user fee rate was calculated based on the proportion of FFM costs that are associated with the FFM information technology infrastructure, the consumer call center, and eligibility and enrollment services, and allocating a share of those costs to issuers in the relevant SBM-FPs. A significant portion of expenditures for FFM services are associated with the information technology, call center infrastructure, and personnel who conduct eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs as defined at section 1413(e) of the Affordable Care Act, and who perform the functions set forth in §155.400 to facilitate enrollment in QHPs. We intend to review the costs incurred to provide these special benefits each year, and revise the user fee rate for issuers in SBE-FPs accordingly in the annual HHS Notice of Benefit and Payment Parameters. Additional guidance on user fee collection processes will be provided in the future.

[11] https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017