U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

July 6, 2015

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing: "Medicaid at 50: Strengthening and Sustaining the Program."

I. INTRODUCTION

On Wednesday, July 8, at 10:15 a.m. in 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, "Medicaid at 50: Strengthening and Sustaining the Program."

II. WITNESSES

- Vikki Wachino, Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) and Director, Center for Medicaid and CHIP Services, CMS;
- Carolyn Yocom, Director, Health Care, Government Accountability Office (GAO);
    - accompanied by Katherine Iritani, Director, Health Care, GAO; and
- Anne Schwartz, Executive Director, Medicaid and CHIP Payment and Access Commission (MACPAC).

III. BACKGROUND

Medicaid Overview

Created in 1965 as a joint federal-state program to finance health care coverage to serve low-income Americans and the indigent, Medicaid turns 50 years-old this year. Today, Medicaid is the world's largest health insurance program. Medicaid currently covers more than 71 million Americans—more than Medicare—and up to 83 million may be covered at any one point in a given year.[1] The Federal government currently spends more general tax revenue on Medicaid than it does on Medicare. During Fiscal Year 2016, the federal share of Medicaid outlays is expected to be approximately $344.4 billion.

[1] http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf and http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf

Today, Medicaid 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.[2] Representing roughly one in every four dollars in a state's average budget, Medicaid accounts for nearly half of national spending on long-term services and supports, and roughly a quarter of all mental health and substance abuse treatment spending. At the same time, Medicaid, along with the Children's Health Insurance Program (CHIP), pays for roughly half of all births in the United States each year.[3]

The federal government establishes specific parameters and minimum requirements for the program, while states administer their own Medicaid programs, thus effectively creating 56 different Medicaid programs—one for each state, territory, and the District of Columbia. Importantly, there are key waiver authorities that allow states, with CMS approval, to operate all or parts of their Medicaid program outside of statutory requirements:

- *Section 1115 Research & Demonstration Projects.* States may apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- *Section 1915(b) Managed Care Waivers*. States may apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- *Section 1915(c) Home and Community-Based Services Waivers*. States may apply for waivers to provide long-term services and supports in home and community settings rather than institutional settings.

For purposes of brevity, given the complexity and scope of the program, some generalizations are necessary about Medicaid's eligible populations, benefits, and financing.

- *Eligibility.* Eligibility for Medicaid is determined by both federal and state law, whereby states set eligibility criteria within federal minimum standards. Individuals must meet both categorical eligibility and financial criteria. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. Medicaid statute also requires beneficiaries to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

- *Benefits*. Federal law outlines minimum benefit packages for most populations in state Medicaid programs, as well as alternative benefit plans (ABP) and special benefits or special rules regarding certain benefits for targeted populations. Because of the breadth of the populations that Medicaid covers, Medicaid offers some benefits that are not typically covered by insurance plans—like nursing facility care, home and personal care, and early and periodic screening, diagnosis, and treatment [EPSDT] services.[4] Medicaid also covers the premiums and cost-sharing for roughly 9 million seniors who are enrolled in both Medicare

[2] https://www.macpac.gov/wp-content/uploads/2015/01/Table-16.-National-Health-Expenditures-by-Type-and-Payer-2012.pdf
[3] http://www.crs.gov/pdfloader/R43357
[4] http://www.crs.gov/pdfloader/R43357

and Medicaid. Additionally, states may receive federal dollars for additional, optional benefits and services which a state provides.

- *Financing*. Under the program, states claim federal matching funds for Medicaid expenditures from CMS, which oversees the program at the federal level. CMS matches state expenditures on medical assistance based on the federal medical assistance percentage (FMAP), which is set by a statutory formula and can be no lower than 50 percent. The FMAP is generally calculated annually and varies by state according to each state's per capita income relative to the U.S. per capita income.[5] The formula provides higher FMAP rates, or federal reimbursement rates, to states with lower per capita incomes and lower FMAP rates to states with higher per capita incomes.

  While the federal government provides general guidelines for states regarding allowable funding sources for the non-federal/state share of Medicaid expenditures, there is significant variation among states in the funding sources they use to finance their Medicaid program. States may use state general funds as well as provider taxes, local government funds, etc. to finance the state share of Medicaid (up 60 percent of state shares may come from local government funding).[6]

Key Changes in Recent Years

The last two decades have seen marked changes in the footprint of the Medicaid program, with enrollment and expenditures increasingly rather dramatically since the early 1990s.[7] However, some of the most sweeping changes to the program have occurred in recent years.

Patient Protection and Affordable Care Act. PPACA made a number of modifications to Medicaid that, taken together, represent the most significant expansion and changes to the program since its creation in 1965.

Historically, Medicaid eligibility was largely limited to low-income children, pregnant women, parents of dependent children, elderly individuals, and individuals with disabilities. However, PPACA included a Medicaid expansion, which (subsequent to the Supreme Court's ruling in *NFIB vs. Sebelius*), allowed states to expand Medicaid eligibility to individuals under the age of 65 with income up to 133 percent of the federal poverty level (FPL) (effectively 138 percent FPL). PPACA also provided enhanced federal funding for coverage of this new expansion population, with the federal government covering 100 percent of the costs through 2016. The FMAP gradually diminishes to 90 percent by 2020.

In addition to the Medicaid expansion, as the Congressional Research Service summarized, PPACA:

- expanded eligibility for children ages 6 to 18 and former foster care children;

[5] States' FMAPs: https://www.macpac.gov/wp-content/uploads/2015/01/Federal-Medical-Assistance-Percentages-FMAPs-and-Enhanced-FMAPs-E-FMAPs-by-State-FY-2012–FY-2016.pdf
[6] http://www.crs.gov/pdfloader/R43357
[7] https://www.macpac.gov/wp-content/uploads/2015/01/Figure-1.-Medicaid-Enrollment-and-Spending-FY-1966-FY-2013.pdf

- transitioned to calculating income using a modified adjusted gross income (MAGI) methodology for most non-elderly beneficiaries;
- required ABP coverage for certain Medicaid beneficiaries;
- modified program integrity activities; and
- provided CMS with expansion demonstration authority for dual eligibles.

Managed Care. With the growing cost and complexity of the program, states have increasingly turned to managed care plans as a tool to help manage their Medicaid programs. Today, roughly three-fourths of all Medicaid beneficiaries are enrolled in some type of managed care plan.[8] As MACPAC explains, "compared with fee for service, managed care can allow for greater accountability for outcomes and can better support systematic efforts to measure, report, and monitor performance, access, and quality" and "may provide an opportunity for improved care management and care coordination."[9] CMS notes that an increasing number of states are using Managed Long Term Services and Supports (MLTSS) "as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality and increasing efficiency."[10]

On May 26, 2015, CMS published the Medicaid and CHIP Managed Care Notice of Proposed Rulemaking (CMS 2390-P), which proposes to modernize Medicaid and CHIP managed care regulations.[11] This proposed rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade.

Home and Community-Based Services. With LTSS accounting for over a quarter of Medicaid expenditures and expected to increase in coming years with the aging of the baby boom population, states are increasingly turning to home and community-based services (HCBS) to provide care. Last year, CMS finalized a rule related to several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS.

Evolving Challenges Facing the Program.

As Medicaid turns 50 this year, the program faces a rapidly evolving policy landscape—which presents both challenges and opportunities. For Medicaid to be strengthened and sustained as a vital safety net to provide needed care for our nation's most vulnerable patients for coming decades, Congress and CMS will undoubtedly be forced to make changes to the program in the years ahead. As GAO has noted, "the effects of unprecedented changes recently made to the Medicaid program will continue to emerge in the coming years and are likely to exacerbate the challenges and shortcomings that already exist in federal oversight and management of the

[8] http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/2011-medicaid-mc-enrollment-report.pdf
[9] https://www.macpac.gov/subtopic/managed-care/
[10] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html
[11] https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

program."[12] There are a number of challenges which may merit Congressional or administrative review and action.

Long-Term Services and Supports. The Medicaid program allows for the coverage of LTSS through several possible state delivery models and over a continuum of settings, including institutional care and HCBS. This part of the Medicaid program has seen renewed focus in recent years, with the termination of the CLASS Act (created in PPACA) and Congress's creation of the Commission on Long-Term Care.[13] With the aging of the Baby Boomers, LTSS will continue to represent an important benefit for millions of Americans—as well as being a significant driver of overall spending growth.

Federal Financial Sustainability. According to CBO, the Federal share of Medicaid outlays are expected roughly to double over the coming decade, increasing from $270 billion in 2014, to more than $529 billion in 2024.[14] Medicaid spending already consumes roughly one in four State dollars. Based on current trends, by 2025, *each year* Medicaid will cost Federal and State taxpayers more than $1 trillion and will cover more than 98 million Americans at some point that year.[15] CBO has warned repeatedly that the continued growth of our entitlements, including Medicaid, is the single largest structural driver of our debt and deficits. Specifically, CBO warned that "[t]he long-term outlook for the federal budget has worsened dramatically over the past several years, in the wake of the 2007–2009 recession and slow recovery."[16] Unless Congress changes course, according to CBO data, by 2030 the entire federal budget will be spent on debt payments, Social Security, and our health care entitlements.[17]

State Financing. Because states finance *no more than half* of the total cost of their Medicaid programs, states may have mixed incentives with regard to overseeing the financial growth of the program. This dynamic is particularly exacerbated due to a number of funding sources states have used, including some financing mechanisms designed to maximize the amount of federal Medicaid funds coming to the state. For example, in 2014, GAO found that "states financed 26 percent, or over $46 billion, of the nonfederal share of Medicaid expenditures with funds from health care providers and local governments in state fiscal year 2012."[18] Although such financing arrangements are allowed under certain conditions, GAO noted such arrangements "can also result in shifting costs to the federal government with limited benefits to providers and beneficiaries." The Inspector General's Office at HHS noted a similar concern, saying, such state policies distort the federal-state partnership, "causing the Federal Government to pay more than its share of Medicaid expenditures," while not yielding "any increase in benefit to beneficiaries… at the expense of the Federal Government and, ultimately, Federal

[12] http://www.gao.gov/highrisk/medicaid_program/why_did_study#t=1
[13] http://ltccommission.org/
[14] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf
[15] Spending estimates based on projections of National Health Expenditure data from CMS, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html. Medicaid spending for 2024 and 2025 was further estimated assuming an annual rate of growth of 6.5 percent. Enrollment projection from CBO's Medicaid baseline, https://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf
[16] http://www.cbo.gov/publication/50250
[17] Check stat with Budget tables
[18] http://www.gao.gov/products/GAO-14-627

taxpayers."[19] The President's *National Commission on Fiscal Responsibility and Reform* recommended that Congress reduce and eventually phase out state's ability to use provider taxes to fund Medicaid.[20] Other state financing schemes include intergovernmental transfers and payment policies like DSH or other supplemental payments that effectively draw down federal funds without expending a proportional amount of state general funds.

Medicaid Expansion. Adding to the significant uptick in annual Medicaid outlays is the categorical expansion of Medicaid to childless adults under PPACA. CBO has estimated the Medicaid and CHIP coverage provisions under PPACA will cost taxpayers roughly $800 billion over the 2015-2024 period.[21] PPACA included "newly eligible" FMAP rates for childless adults that were notably higher than any other FMAP. Under the "newly eligible" FMAP rate, from 2014 through 2016, states receive a 100% FMAP rate for the cost of individuals who are "newly eligible" for Medicaid due to the ACA expansion. This "newly eligible" FMAP rate phases down to 95 percent in 2017 and following years so that by 2020 it is 90 percent where it remains thereafter under current law. While the enhanced FMAP for this population may cost less per enrollee than traditional Medicaid populations, some have raised questions regarding the appropriateness of the federal government covering a higher percentage of the cost of care for adults above poverty compared to disabled, elderly, or children below poverty. Additionally, the states who have expanded coverage under PPACA through a five-year 1115 demonstration waiver may face administrative or financial hurdles in renewing those waivers in their current form.

Program Vulnerabilities. The Medicaid program was designated by GAO as a high risk program more than a decade ago due to "its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight." While the shared federal-state nature of the program leads to significant variability, nationally, Medicaid is a program facing significant program integrity challenges. The federal error rate for Medicaid payments is high – and was recently adjusted upwards.[22] Additionally, due to a number of factors, many state Medicaid programs suffer from significant waste, fraud, and abuse, due to failures in state and federal oversight and enforcement actions. For example, a recent GAO report found thousands of beneficiaries had payments made on their behalf concurrently by two or more state Medicaid programs, while hundreds of deceased beneficiaries received millions of dollars in Medicaid benefits subsequent to the beneficiary's death.[23] Unfortunately, such lapses can also negatively impact patient safety. GAO found dozens of providers who were excluded from federal health-care programs, including Medicaid, for a variety of reasons that include patient abuse or neglect, fraud, theft, bribery, or tax evasion were still being paid by the program. The Inspector General's office at HHS has found repeated cases of fraud, abuse, or neglect in Medicaid personal care services – services owed to some of the nation's most vulnerable patients.[24]

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[19] http://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp

[20] https://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf, page 39

[21] http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

[22] https://paymentaccuracy.gov/tracked/medicaid-2014#learnmore and http://energycommerce.house.gov/press-release/committee-leaders-question-administration%E2%80%99s-decision-ease-fraud-reduction-targets

[23] http://www.gao.gov/assets/680/670208.pdf

[24] https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

Quality and Access to Care. Timely access to the right care provided by the right provider in the right setting is often a concern because of the needs and vulnerability of the individuals covered by Medicaid, including children, the elderly, and the disabled. Nationally, only a portion of primary health care providers accept Medicaid beneficiaries—often with even fewer specialists accepting such patients.[25] GAO noted that while national survey data have suggested that access reported by Medicaid beneficiaries is adequate, results for individual beneficiaries may vary greatly by location, provider relationships, and a number of other factors. Moreover, GAO has found that Medicaid beneficiaries do face particular challenges in accessing certain types of care.[26] Some research has suggested that, at least in some studies, Medicaid beneficiaries have not experienced notably better health outcomes than individuals with no health coverage – raising additional questions about the quality and timeliness of access for Medicaid patients.[27] Given the growing role of Medicaid in our health system, it will be critical in the future to continue to evaluate the quality of care and access to care that vulnerable Medicaid patients receive.

Growth of 1115 Waivers. Section 1115 of the Social Security Act (Act) authorizes the Secretary of HHS to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.[28] In recent years, 1115 demonstrations have been used by some states to expand Medicaid under PPACA.[29] Section 1115 demonstrations also have been used by six states to implement Delivery System Reform Incentive Payment (DSRIP) programs, which provide Medicaid funds for states to make supplemental payments that would not otherwise be permitted under federal managed care rules and as tools for investing in provider-led efforts intended to improve health care quality and access.[30] Section 1115 demonstrations account for a significant and growing proportion of federal Medicaid expenditures. GAO has noted that in fiscal year 2014, section 1115 demonstrations accounted for close to *one-third* of total Medicaid expenditures.[31] Yet, GAO found that in fiscal year 2011, "$57.5 billion in federal funds, or about one-fifth of the $260 billion in federal Medicaid expenditures, were for services, coverage initiatives, and delivery system redesigns provided under section 1115 demonstrations in 40 states."[32] Recent Congressional oversight has raised serious concerns over the Administration's process for approving 1115 demonstrations, including the approval criteria used, the timeframe for review, adherence to budget neutrality concerns, and other issues.[33]

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[25] https://www.macpac.gov/wp-content/uploads/2015/01/Table-23.-Provider-Availability-Measures-of-Access-to-Care-for-Medicaid-CHIP-Beneficiaries-2012.pdf
[26] http://www.gao.gov/highrisk/medicaid_program/why_did_study#t=1
[27] http://www.nejm.org/doi/full/10.1056/NEJMp1108222
[28] http://www.ssa.gov/OP_Home/ssact/title11/1115.htm. Note: While the statute gives this authority to the Secretary of HHS, most of the oversight of Medicaid demonstrations is delegated to the Administrator of the Centers for Medicare and Medicaid Services (CMS).
[29] http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers
[30] In its June 2015 report, MACPAC indicated that clear and consistent federal guidance about DSRIP program design, policies, and goals is needed.
[31] http://www.gao.gov/assets/670/669582.pdf
[32] GAO report GAO-13-384, page 2.
[33] http://energycommerce.house.gov/press-release/subhealth-continues-efforts-protect-most-vulnerable

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Josh Trent or Michelle Rosenberg of the Committee staff at (202) 225-2927.