Vikki Wachino's Hearing
"Medicaid at 50"
Before
E&C Health Subcommittee

July 8, 2015

Attachment 1—Additional Questions for the Record

The Honorable Representative Pitts

1. **As we discussed at the hearing, the federal statute on 1115 waivers is brief and does not include requirements for consistency related to the Secretary's review and approval of demonstration projects. Similarly, the agency does not have regulations requiring consistency in demonstration reviews or approvals. Please provide *specific details* regarding how the agency ensures that it is being consistent and equitable in its review and approval of state demonstration projects.**

Answer: While every section 1115 demonstration project is unique in addressing state-specific concerns, CMS is committed to a consistent and equitable review and approval process for section 1115 demonstration projects. Since 2009, we have approved new demonstrations in 21 states[1] and approved 56 renewal actions. We work to apply the same four criteria, which we recently posted on Medicaid.gov, to all states seeking approval for section 1115 demonstration projects. When reviewing a state's request, we determine whether the demonstration will:

1. Increase and strengthen overall coverage of low-income individuals in the state;
2. Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. Improve health outcomes for Medicaid and other low-income populations in the state; or
4. Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

We supplement these criteria by issuing additional guidance on specific policy areas based on states' interest in using section 1115 authority to test new policy approaches in those areas. For example, when a number of states were proposing or proposed to provide long-term services and supports (LTSS) through managed care, CMS issued specific guidance in May 2013 that set forth ten key elements of a managed long term services and supports program under section 1915(b) or 1115(a) demonstration authority.[2] The elements focused on adequate planning, stakeholder engagement, the provision of home- and community-based services (HCBS) in integrated settings, alignment of payment structures and goals, support for beneficiaries, person-centered planning, comprehensive service packages, qualified providers,

[1] VA, RI, IN, NH, MT, NV, NM, MO, PA, LA, MN, NJ, AZ, DC, GA, IA, TX, MI, KS, WI, and AR.
[2] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-21-2013.pdf

participant safeguards, and quality. Reviewing proposals against this guidance facilitates consistent and equitable review and approval of state demonstration projects.

Similarly, in March 2013, we issued guidance regarding demonstrations seeking to provide premium assistance using Qualified Health Plans (QHPs) offered in the Marketplace.[3] This guidance states that HHS will only consider proposals that: (1) provide beneficiaries with a choice of at least two qualified health plans; (2) provide any necessary wrap-around benefits and cost sharing; and (3) are limited to individuals whose benefits are closely aligned with the benefits available on the Marketplace. CMS has applied these requirements consistently to all three QHP premium assistance demonstrations (Arkansas, Iowa, and New Hampshire).

It is not always possible to develop guidance in advance to address every possible element of a demonstration. Sometimes guidance is developed after CMS has developed experience with an issue. In that instance, CMS generally only applies the guidance to existing demonstration projects upon renewal, or may permit a longer transition period for the state to adapt its demonstration.

CMS also seeks to review each section 1115 demonstration proposal against the transparency requirements published in regulations on February 27, 2012. For example, every section 1115 demonstration proposal must contain the following:

- i) a comprehensive program description of the demonstration, including the goals and objectives to be implemented under the demonstration;
- ii) a description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing required of individuals who will be impacted by the demonstration;
- iii) an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data;
- iv) current enrollment data and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration;
- v) other program features that the demonstration would modify in the state's Medicaid program or its Children's Health Insurance Program (CHIP);
- vi) the specific waiver and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- vii) the research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses, and if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators; and
- viii) written documentation of the state's compliance with the public notice requirements.

All section 1115 demonstration proposals must meet these requirements for CMS to review the proposal. CMS has posted a section 1115 demonstration template on Medicaid.gov so that all

[3] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

states can provide their application information in a standardized way, which also promotes consistency.[4]

Finally, CMS includes standard terms and conditions in each demonstration project we approve. Specifically, every demonstration approval includes standard program and financial requirements, including standard requirements related to monitoring the demonstration's budget neutrality. In addition, we apply the same reporting and evaluation procedural requirements to all states. For example, each state is required to submit a draft evaluation design, interim evaluation reports, final evaluation design, and final evaluation reports. The nature of the reporting and evaluation, of course will depend on the nature of the demonstration, and the research hypotheses that the demonstration is testing.

CMS is committed to enhancing transparency in section 1115 demonstrations. In our regulations at 42 CFR 431.400-431.428, we have established a process for ensuring public input into the development and approval of new section 1115 demonstrations as well as extensions of existing demonstrations. The regulations set standards for making information about Medicaid and CHIP demonstration applications and approved demonstration projects publicly available at the state and Federal levels. In addition, we post on Medicaid.gov all pending applications, all approved applications and related documents, and all documents that are part of the administrative record for each demonstration for each state.

2. **Under states' expansion of Medicaid under PPACA, the federal government is paying 100% of cost for the expansion population until 2016. What specific actions is CMS taking to ensure that states are correctly determining eligibility for those for whom the 100% federal match is being claimed?**

Answer: In 2012, CMS issued regulations at 42 CFR 435.940-435.960 to implement the Affordable Care Act provisions establishing a modernized, data-driven approach to verify financial and non-financial information for Medicaid and CHIP eligibility determinations. Since January 2014, when the Medicaid expansion populations became eligible for the 100-percent Federal match, states have increasingly been using available electronic data sources to confirm information included on the enrollment application, verify eligibility, and promote program integrity. CMS has been working actively with states since these regulations were issued.

CMS issued regulations at 42 CFR 433, Subpart E, governing the requirements and procedures necessary to support claims for enhanced matching for the Medicaid expansion population. To simplify administration and reduce the burden on beneficiaries, those regulations provide for using individual income-based determinations as part of a "threshold methodology." Adjustment is then made for relevant factors other than income that were applied as of the reference date of December 1, 2009. CMS reviewed and approved each state's application of the threshold methodology, including any adjustments. To ensure that states are accurately claiming for individuals eligible for the enhanced match, CMS reviews enrollment and expenditure data reported by states through the Medicaid Budget and Expenditure System (MBES).

[4] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/application.html

Beginning January 1, 2014, states started reporting quarterly Medicaid enrollment data as part of their Medicaid-expenditure reporting through MBES. The enrollment information is a state-reported count of unduplicated individuals enrolled in the state's Medicaid program at any time during each month in the quarterly reporting period. The enrollment data identifies the total number of Medicaid enrollees and, for states that have expanded Medicaid, provides specific counts for the number of individuals enrolled in the new adult eligibility group.

When states submit their quarterly Medicaid enrollment reports through MBES, state officials certify to the accuracy of the data. CMS also conducts a review to assess whether the data are reasonable. The review consists of comparing the state-reported data to other readily available information, including state-reported performance indicators and expenditures, and follow-up with the state as needed. MBES provides preliminary reporting of this enrollment data. Data collected through the forthcoming Transformed Medicaid Statistical Information System (T-MSIS), which will use the same definitions as the MBES report, will undergo a more thorough quality review and will serve as the authoritative enrollment data.

CMS oversees state enrollment of Medicaid beneficiaries and reporting of expenditures by requiring states to conduct multiple reviews to assess the accuracy of states' Medicaid eligibility determinations and payment rates. CMS has also implemented a pilot eligibility review to assess states' determination of Medicaid eligibility and eligibility groups. Under this pilot, states must report on the accuracy of determinations for a selected sample of applications and develop a corrective action plan for any errors found in the eligibility determination process. CMS reviews these reports every six months.

CMS has provided significant training and guidance to ensure that states have mechanisms and systems in place to track and report new adult group expenditures appropriately. Additionally, CMS has placed special emphasis on ensuring that Federal financial participation paid to states for the new adult group is accurate, including conducting enhanced quarterly reviews of new adult group expenditures to ensure that the expenditures are claimed at the appropriate Federal matching rate. CMS has the authority to defer questionable expenditures or disallow improper expenditures as a result of its oversight activities.

CMS performs various financial management oversight activities to help make sure expenditures reported by states are allowable under Federal requirements. This oversight includes a structured process through the use of standardized and comprehensive review guides, protocols, and training. CMS recently updated the CMS-64 Review Guide to include additional steps to provide increased scrutiny on state claiming for individuals in the new adult group and provided a series of national training to states and CMS financial staff for the proper reporting and review of these expenditures claimed at the increased Federal financial participation. CMS also performs financial management reviews of specific or focused areas of state financial compliance with the Medicaid program. These reviews are similar to audits of state compliance with Federal statutes and regulations. In FY 2016, CMS has several financial management reviews planned in states that have expanded Medicaid to help ensure expenditures are properly claimed.

3. Has CMS determined an eligibility error rate for the newly-eligible expansion population?

a. **If so, what is the eligibility error rate for this population and how does the error rate vary for those determined Medicaid eligible through the Federally-Facilitated exchanges versus those whom states determine eligibility?**
b. **If not, a year and a half into expansion, why hasn't CMS determined an eligibility error rate for the expansion population and when will such analysis be conducted?**

Answer to a&b: Reducing improper payments is a high priority for CMS, and we continuously strive to reduce improper payments in Medicaid.

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP and produces state and national error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Federal fiscal year under review. PERM uses a 17-state rotational approach to measure improper payments in Medicaid and CHIP for the 50 states and the District of Columbia over a three-year period. As a result, each state is measured once every three years.

It is important to note that the error rate is not a "fraud rate," but simply a measurement of payments that did not meet statutory, regulatory, or administrative requirements. The error rate includes any payment to an ineligible beneficiary, any duplicate payment, any payment for services not received, or any payment incorrectly denied. It also includes payments for services that contain insufficient documentation to determine payment accuracy.

The Affordable Care Act's changes to Medicaid and CHIP eligibility required a redesign of many Medicaid business operations, systems, and interaction with other state and Federal partners, including an update to PERM eligibility review methodologies. In order to allow time for that update to occur, and to inform the development of new regulations and methodologies, CMS established a 50-state pilot program strategy with rapid feedback for improvement (known as the Medicaid and CHIP Eligibility Review Pilots), in place of the PERM and the Medicaid Eligibility Quality Control (MEQC) eligibility reviews for Fiscal Years (FYs) 2014-2017.[5] All states are required to participate in the Medicaid and CHIP Eligibility Review Pilots to provide more targeted, detailed information on the accuracy of eligibility determinations and provide states and CMS with critical feedback during initial implementation.

The eligibility review pilots provide a testing ground for different approaches and methodologies when reviewing for improper payments. The results from these pilots will help inform CMS rulemaking to prepare for the resumption of the full PERM eligibility measurement component which will result in initial results reported in the FY 2019 Agency Financial Report (AFR) and will include eligibility error associated with the newly eligible population.

Because of the Affordable Care Act's changes, states are required to participate in the Pilot measurement every year over the four year-period instead of potentially being reviewed only once during this period under PERM. The pilots are designed to measure: (1) state-by-state

[5] Under the Medicaid Eligibility Quality Control program, states must annually demonstrate the accuracy of their Medicaid eligibility determination process.

programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) strengths and weaknesses in operations and systems leading to errors; and (3) the effectiveness of corrections and improvements in reducing or eliminating those errors.

To maintain transparency regarding the accuracy of Medicaid and CHIP enrollment, CMS will include an overall analysis of the Medicaid and CHIP Eligibility Review Pilot results in the AFRs for FYs 2015-2018. In addition to posting the overall analysis on our website, CMS will also continue to post the Medicaid and CHIP improper payment reports to the CMS PERM website.[6]

4. One problem that has been cited related to CMS's assessment of budget neutrality of waivers is the use of "hypothetical costs." For example, CMS allowed one state to assume it would pay significantly higher payment amounts to providers than in place at the time of its waiver application, resulting in an approved spending limit that was nearly $800 million higher than if actual payment rates were used.

a. How does CMS justify the use of such hypothetical costs?

Answer: Our policy is that demonstrations must be budget neutral—demonstrations must not cost the Federal Government more than what would have been spent absent the demonstration. Moreover, budget-neutrality calculations necessarily involve projecting what would have happened in the future. In developing the budget-neutrality expenditure limit, CMS reviews the most reliable data available. In order to develop an expenditure limit for the newly-eligible adult group, a population that most states did not have experience in covering, we worked with multiple states and requested that they submit the best historical data possible. In the instance indicated above, the state sought to cover the new Medicaid eligibility group with a new benefit package, and since historical Medicaid spending was not available for either the new eligibility group or the traditional Medicaid benefit package, the state incorporated commercial market prices into its projections.

b. Given CMS's stated interest in being a good steward of taxpayer dollars, does CMS support having OACT actuaries review the use of hypothetical costs when the agency believes the approval of hypothetical costs may be warranted?

Answer: CMS takes a number of steps to ensure the integrity of our review and approval of section 1115 demonstrations complies with our budget-neutrality policy, including working closely with other Federal partners. In computing budget neutrality, CMS applies a cost trend that generally is based on the "lower of" the state's historical trend rate or the most recent President's Budget's Medicaid estimates for the associated demonstration period. The Medicaid estimates in the President's Budget are produced by the Office of the Actuary (OACT) each fiscal year. CMS has applied this cost trend for the new adult group in all expansion states' budget-neutrality calculations.

[6] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/PERMErrorRateFindingsandReport.html

c. **If CMS is going to approve the use of hypothetical costs in setting state spending limits, in the interest of transparency, will CMS be candid about this fact in the future?**

Answer: Each section 1115 demonstration approved by CMS includes a Special Term and Condition (STC) describing the methodology for determining the demonstration's budget-neutrality agreement. Demonstration terms and conditions are publicly available on Medicaid.gov. These terms include the elements of the "without waiver" budget analysis. For example, each set of STCs contains a table that shows the agreed-upon per-member per-month costs and trend rate that is used in establishing the budget-neutrality limit for hypothetical populations. More broadly, we have taken a number of steps to enhance transparency with respect to section 1115 demonstrations, including for our process for determining budget neutrality. CMS released a section 1115 template for states to use, which includes instructions and an accompanying budget worksheet that provides guidance on some of the most commonly-used data elements for demonstrating budget neutrality, including proposals for hypothetical costs. This guidance is part of the Agency's broader efforts to increase transparency in the review and approval of section 1115 demonstrations.

5. **How does CMS ensure that drugs are appropriately classified and that manufacturer drug rebates are paid at the appropriately level?**

   a. **It is my understanding that concerns have been raised to CMS that the manufacturer of EpiPen, epinephrine auto-injectors indicated for emergency treatment of anaphylaxis, inappropriately classifies their products as generic drugs for purposes of the Medicaid drug rebate, resulting in significantly lower Medicaid rebate obligations and potentially reduced patient access to other epinephrine auto-injectors subjected to higher brand drug rebates. Has CMS looked into these concerns? If so, what is the status of CMS's review and what, if any, actions has CMS taken or do you plan to take?**

Answer: Under section 1927 of the Social Security Act ("the Act"), drug manufacturers classify their drugs as either single-source drugs, innovator multiple-source drugs (both of which generally align with brand-name drugs), or non-innovator multiple-source drugs (which generally align with generic drugs) and report Average Manufacturer Price (AMP) and Best Price the information to the Secretary for use in determining the manufacturer's rebate obligations. It is the manufacturers' responsibility to ensure that the information about its drug products is reported accurately to the Medicaid Drug Rebate program. If CMS identifies any misreporting in the product data reported by the manufacturer, CMS contacts the manufacturer to provide further guidance on how we recommend they correct the information being reported. If the manufacturer does not correct the issue in its reporting, CMS can, along with the Department of Justice (DOJ) and/or the Department of Health and Human Services (HHS) Office of Inspector General (OIG), take further action. As specified under section 1927(b)(3)(C)(ii) of the Act, a manufacturer that knowingly provides false information is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information, in addition to other penalties prescribed by law. Regarding the EpiPen specifically, CMS is currently looking into the issue.

6. **The President's budget proposal calls for excluding authorized generics from the calculation of average manufacturer price. Can you please explain the intent behind this proposal?**

Answer: The purpose of this proposal is to improve the efficiency and economy of the Medicaid program by lowering the cost of brand name drugs to states and the Federal Government. A manufacturer holding the approved new drug application of an authorized generic must report the AMP of these drugs when they are sold to a wholesaler. In some instances, a manufacturer produces both the brand-name drug and the authorized generic and then sells the authorized generic to a secondary manufacturer for retail distribution. This sale price, known as a transfer price, can be very low and not representative of the actual price of the drug to retail community pharmacies. When manufacturers include the authorized generic transfer price in the brand name drug's AMP, it results in a lower brand-name drug AMP, thereby reducing the manufacturer's rebates on its brand name drugs.

a. **How would implementation of this policy affect states?**

Answer: CMS believes this policy would increase AMPs for affected brand name drugs, which would result in higher rebates for states.

b. **What impact do you anticipate this policy will have on Medicaid reimbursement to pharmacies?**

Answer: The effect of this policy on pharmacies would be limited. States reimburse pharmacies for covered outpatient drugs under the Medicaid program at a level that represents the pharmacy's estimated acquisition cost (EAC) of the drug. States have flexibility to determine EAC, subject to CMS approval through a Medicaid state plan amendment (SPA). An aggregate Federal upper payment limit applies to certain generic drugs for which the Food and Drug Administration (FDA) has rated three or more products pharmaceutically and therapeutically equivalent. The limit is at least 175 percent of the weighted AMP. To the extent that this policy increases the AMP on affected brand name drugs, it could cause the upper payment limit to increase.

7. **CMS has asserted that Medicaid is a cost-effective program that costs less per beneficiary than private insurance. However, recent data from the Health Care Cost Institute (HCCI) indicates that Medicaid per capita spending for children is actually higher than spending under employer sponsored insurance (ESI). Specifically, HCCI found that ESI spending per child was $2,574 in 2013.[1] A June 2014 GAO report, which used 2008 data, found that the national average Medicaid per enrollee spending for children was $2,973—$500 higher than ESI.[2] With medical inflation, an analysis of 2013 Medicaid data would likely show an even higher differential between Medicaid and ESI spending. Given this data, can CMS offer more fiscal or economic data to back up its claim that Medicaid is a cost-efficient program?**

Answer: The 2014 Medicaid actuarial report shows that per-enrollee spending on children in 2013 was $2,807, which is slightly lower than the 2008 figure ($2,973) the question cites. Additionally, Medicaid enrollment is characterized by a higher proportion of children in

poverty and in high-risk segments of the population, including those with special health care needs – two factors that are associated with higher expenditures. The Health Care Cost Institute report cited notes that the effect of individual or population health status, such as the existence of chronic conditions, was not taken into account in their analysis. Comparisons that do adjust for health status, as they should since the Medicaid population is skewed towards a high need/high cost population, find that Medicaid costs less per enrollee than private insurance, both for children and for adults.[7] Lastly, if enrolled in Medicaid, beneficiaries are able to access preventive care and retain a usual source of care for the treatment of chronic conditions, leading to improved health outcomes and overall cost savings compared to individuals who remain uninsured.

8. **Federal Medicaid statute does not explicitly cover women's access to Certified Professional Midwives (CPMs), though at least a dozen states have opted to recognize and reimburse CPMs in their respective Medicaid programs.**

    a. **To what extent does CMS have data on states' use of midwifery-led maternity care in their respective Medicaid programs?**

Answer: Under existing CMS policy, services provided by nurse midwives who are registered professional nurses are covered as a mandatory Federal benefit. In addition, services provided by certified professional midwives (CPMs), who often are not registered nurses, may be covered as "Other Licensed Professionals." In addition, states that license or approve freestanding birth centers are required to include coverage for providers administering prenatal labor and delivery or postpartum care in such centers; this can include CPMs. While we recognize that there is variation among state Medicaid programs with respect to CPMs, we do not track states' use of CPMs or other midwifery-led maternity care. CMS' Strong Start Initiative for Mothers and Newborn is, however, testing the delivery of evidence-based enhanced prenatal care to decrease prematurity. One of the approaches being tested is care delivered at Birth Centers, where care is typically delivered by midwives. Another approach that is being tested is "centering" or group-based care delivery, a model of prenatal care developed by nurse midwives. Preliminary findings show that women enrolled in this program have lower than average Cesarean section rates, higher rates of breastfeeding, and in some cases lower rates of preterm deliveries than the nation as a whole.[8]

    b. **Has CMS examined the extent to which Medicaid coverage of CPM services could address maternity workforce shortages—especially in rural areas?**

Answer: We have not examined this.

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[7]See Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope and Dean Resnick, The Urban Institute *What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults* May 03, 2013 available at http://www.urban.org/research/publication/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and

[8] See Centers for Medicare & Medicaid Services. Strong Start for Mothers and Newborns Evaluation: Year 1 Annual Report. http://innovation.cms.gov/Files/reports/strongstart-enhancedprenatal-yr1evalrpt.pdf

c. **With roughly half of all births in the nation currently being financed by Medicaid, has CMS examined the possible cost-savings to Medicaid stemming from further encouraging midwifery-led care?**

Answer: We have not examined cost savings to Medicaid from encouraging midwifery-led care. Evaluation of the Strong Start for Mothers and Newborns Initiative described above will include an assessment of the impact of models of care on Medicaid and CHIP costs for women and infants, from pregnancy through the first year of life. The models of care will include care delivered at Birth Centers, where care is typically delivered by midwives, and "centering" or group-based care delivery, a model of prenatal care developed by nurse midwives. We will have data on cost-savings on models of care that include midwifery, but will not have data specifically on cost savings related to midwifery.

9. **Some states – at least Oregon and New York – cover the cost of sex-change operations in their Medicaid program. Does CMS provide federal matching for these services?**

Answer: CMS provides Federal matching of state expenditures for covered Medicaid services furnished to eligible individuals under an approved state plan. Individual states have considerable flexibility to define eligibility, benefits and payment under their individual state Medicaid programs within a broad Federal framework. While there is no separate benefit category for gender-reassignment services (which may include sex change operations), such services may be included under several Medicaid benefit categories.

10. **A recent GAO report indicated that CMS has four "general criteria" against which it reviews section 1115 demonstrations to determine whether Medicaid program objectives are met. CMS has said it is currently evaluating the possibility of publicly disseminating these criteria. While I think CMS needs a more formal process eventually, why won't CMS just put these criteria on its website and notify states and other stakeholders?**

Answer: We appreciate the work of the Government Accountability Office (GAO) on this issue. As we confirmed to GAO, and as we noted in response to question 1, above, we review all section 1115 demonstration requests against four criteria to determine if they promote the objectives of the Medicaid program. We have published these criteria on the section 1115 demonstrations webpage on Medicaid.gov. We have also disseminated this information to members of our Medicaid demonstration list serve, which includes state Medicaid agencies and other stakeholders.

11. **Please provide an update on CMS's actions to recoup Medicaid overpayments made by New York from developmental centers. From what I understand, last year, Penny Thompson of CMS said the agency was disallowing close to $1.3 billion for 2010 and that they were going to look at two other years as well. I forget if it was 2009 and 2011 or 2011 and 2012. It is my understanding CMS sent the State a letter outlining the reasons for the disallowance and why they disagreed with the state's claim that CMS had previously approved these rates. Certainly, it is common sense that these payment rates were well in excess of cost. Please provide the Committee with an update on the**

$1.3 billion disallowance as well as New York's appeal, as well as pending or completed CMS actions on the other two years as well.

Answer: On March 20, 2015, the state of New York and CMS entered into a settlement agreement to resolve all disputed issues over payments made to these state-run facilities. Under the agreement, the state has agreed to reimburse $1.95 billion to CMS. This payment amount is substantial and covers the disallowance issued for State Fiscal Year (SFY) 2011 and anticipated potential additional disallowances for SFYs 2012 and 2013. The settlement also resolves rate issues involving state providers of HCBS over the same periods. CMS and the state wished to reach a resolution in order to focus on the ongoing process of transforming the Medicaid program in New York, rather than engaging in lengthy and protracted litigation.

In addition, effective April 1, 2013, CMS approved a new Medicaid SPA revising the methodology for determining payment rates for state-operated intermediate-care facilities to ensure that such rates would be computed based on costs reported by the state on a Consolidated Fiscal Report, in accordance with applicable accounting principles, and that the costs of closed facilities would be removed from the computation of payment rates. In addition, CMS approved a waiver amendment for HCBS, also effective April 1, 2013, which contains a revised payment methodology that CMS believes resolves these issues of inconsistent and undefined rate methodologies. Also starting in 2013, CMS has required all states to submit their upper-payment-limit demonstrations for annual review, rather than reviewing them solely when states request to amend them.

12. **CMS took years to develop the proposed managed care regulation, but states have just 2 months – the same time allotted other stakeholders—to review and comment on the proposed reg. Given that states are partners in the funding and administration of the Medicaid program, in the spirit of ensuring they are equal partners, would CMS support modifying (if necessary) the Administrative Procedures Act explicitly and only for the purpose of ensuring that CMS staff could have more open and candid conversations with state staff during the development of such a regulation –including before the public comment period, during the public comment period, and after the public comment period?**

Answer: We agree that states are key partners and resources in developing new and revised regulations and guidance. CMS routinely works with, and speaks with, state Medicaid program staff and their national associations, such as the National Association of Medicaid Directors (NAMD), regarding the range of issues facing the Medicaid program. We encourage states to respond on guidance and policy through the State Operations and Technical Assistance process. This ongoing work and collaboration helps to inform CMS's development of regulations, including the recently-proposed managed care regulations.

With respect to the development of the managed-care NPRM, CMS hosted four conversations with NAMD's managed-care board and an additional conversation with NAMD's leadership to inform CMS policy development and identify key operational considerations and areas of state variation. The topics discussed during those meetings were further addressed in four letters from NAMD that were similarly taken into account during the policy-development phase. In addition, after the NPRM was published in the Federal Register on June 1st, CMS conducted extensive

and significant outreach to the general public and stakeholders by hosting informational webinars to describe the provisions of the proposed rule and to facilitate timely and meaningful public input into the rulemaking. Beginning immediately after the release of the NPRM, CMS hosted 15 webinars on specific proposals in the rule. These webinars were well-attended by states, tribes, health plans, advocates, and other stakeholders. Eight webinars were for states only and averaged over 400 participants each, and the remaining seven webinars were held for all other stakeholders and averaged approximately 300 participants. Additionally, CMS engages states and state organizations such as NAMD, managed-care trade organizations, and other stakeholders in discussions on an ongoing basis. These discussions have included soliciting feedback on the NPRM. Over 876 comments were received in the response period, including 41 comments from states and 13 comments from organizations representing states. We are continuing to review the comments we received on the NPRM, including those from states.

13. **Has CMS been made aware of federal regulatory hurdles facing state Medicaid program in reimbursing specialty facilities that offer inpatient treatment of infants diagnosed with neonatal abstinence syndrome; facilities that may offer specialized treatment at a lower cost than alternative sites, such as hospital neonatal intensive care units or nursing facilities?**

Answer: CMS is not aware of any Federal regulatory barriers that prevent states from covering or setting appropriate payment rates for Medicaid services to infants diagnosed with neonatal abstinence syndrome. We are also unaware of prohibitions on covering or setting appropriate payment rates for qualified and enrolled providers that offer treatment at lower-cost alternative sites. To receive direct payments for covered inpatient care and associated costs, a facility must meet the requirement for participation as an inpatient facility under the Medicaid program, be enrolled as a Medicaid provider, and be licensed under state law. If a state wishes to provide coverage for specialty facilities that are not qualified to participate in the Medicaid program as a provider, states could pay for the covered professional services provided to beneficiaries within these settings without seeking a demonstration. CMS would need to work individually with a given state in order to understand the issues with respect to particular inpatient-facility settings.

14. **Does CMS have a process for allowing state Medicaid programs to reimburse innovative facilities, such as facilities focused on treatment for neonatal abstinence syndrome, which do not fit within the defined set of providers for which there are existing federal Medicare or Medicaid standards?**

    a. **If so, please describe the process CMS has in place?**
    b. **If not, what options exist for states interested in providing Medicaid coverage for care at such facilities?**

Answer to a&b: Federal Medicaid matching funds are available only for state payments for covered services furnished by inpatient facilities that fall within a Federally-recognized benefit category and meet Medicaid statutory and regulatory standards. However, even if the facility is not qualified to participate in the Medicaid program as a provider, CMS can match state Medicaid payments for the covered professional services provided to beneficiaries within these settings. CMS would need to work individually with a given state in order to understand

whether particular services, qualified providers, and payment methodologies meet the Federal requirements applicable to all covered services.

15. The Morning Consult recently ran a story on a CRS report which clarifies that current law may give CMS discretion to decide not to apply a matching requirement for the use of the Part D enhanced allotment approved to Territories in lieu of the Part D Low Income Subsidy (LIS). This would allow the Commonwealth of Puerto Rico to draw down funds to support their program for vulnerable dual eligible beneficiaries on the island. Has CMS considered allowing the use of these funds without matching for FY15 and going forward?

Answer: CMS does not believe we have flexibility under the statute to not apply state matching requirements for the Part D enhanced allotment program. Under the Medicaid program, the Secretary's general authority to pay states is limited to payment of the Federal matching share of eligible state expenditures. The Congress has made it explicit when it wishes to provide a higher Federal matching rate, including when it intends to provide 100-percent Federal match.

16. Researchers have estimated that fluctuations in income or changes in family situations could lead to significant number of individuals shifting back and forth between Medicaid coverage and subsidized coverage through the exchange. Given the known limitations of Medicaid data and the demonstrated shortcomings of your website—Healthcare.gov, what is CMS doing to ensure continuity of care for individuals, while at the same time ensuring that the federal government is not paying for duplicative coverage in Medicaid and the exchange?

Answer: CMS is committed to ensuring that individuals and families who are eligible for coverage, whether through Medicaid or through the Marketplace, can access that coverage with minimal burden. Due to changes in income and other circumstances, individuals will transition from one form of health coverage to another. Federal regulations at 42 CFR 435.1200 require coordination between Medicaid and the Marketplace to ensure smooth transitions and continuity of coverage for individuals making these transitions. For example, when an individual is determined no longer eligible for Medicaid, the agency is required to assess potential eligibility for other insurance affordability programs, and transfer the individual's account to the Marketplace in a timely manner. Individuals who lose minimum essential coverage, such as when they are determined no longer eligible for Medicaid, are entitled to a Special Enrollment Period on the Marketplace, so they are able to enroll in coverage with minimal gaps.

Since January 2014, when an individual applies for coverage through Healthcare.gov, the Federally-Facilitated Marketplace (FFM) queries states' current Medicaid/CHIP enrollment in real-time in all but five FFM states (which currently lack the necessary system capacity but will all have the technical-service functioning in 2016) to determine whether the individual already is enrolled. This tool, used prior to granting Federal financial assistance, along with questions on the application regarding access to other sources of health coverage, help avoid duplicate enrollment.

In order to move toward a process that checks eligibility for Federal financial assistance against Medicaid/CHIP enrollment, CMS is implementing additional functionality, including

implementing a data-matching effort to compare the list of individuals enrolled in a Qualified Health Plan and receiving Federal financial assistance with those currently enrolled with minimum essential coverage.

In addition, the Affordable Care Act gives states the option of creating a Basic Health Program, a health-benefits coverage program for low-income residents who otherwise would be eligible to purchase coverage through the Health Insurance Marketplace. The Basic Health Program gives states the ability to provide affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels.

17. Since section 1115 demonstration programs are intended to be experimental or pilot projects to test new ways of providing services, it is my understanding that each demonstration is to be evaluated. Does CMS conduct its own evaluations or analysis of demonstration projects?

- **a. If so, please describe the evaluations conducted by CMS and what CMS has learned from demonstration programs that could be applied on a larger scale to enhance Medicaid program efficiency, reduce program costs, and improve quality? Please also explain how long it takes after the completion of a demonstration program to complete an evaluation, as well as how members of the public may access the evaluation.**
- **b. If not, how does CMS ensure that the demonstration projects are meeting their stated goals?**

Answer to a&b: Section 1115 demonstration authority provides states with flexibility to design and test policies that promote the objectives of the Medicaid program. These demonstrations can introduce new and innovative approaches to Medicaid, which can influence policy-making at the state and Federal levels. CMS has been placing increased emphasis on the need for robust evaluations that are performed using a transparent process. The discussion in this response reflects our current procedures for evaluations. Given the potential impact that demonstration projects can have, states are required to describe, as part of the application process, the research hypotheses that the demonstration will test and the general framework for how the state will evaluate the demonstration.

Every approved section 1115 demonstration includes an STC requiring the state to submit an evaluation-design plan for CMS approval. Once the design is approved, the state must contract with an independent entity to conduct the evaluation in accordance with the terms of the approved design plan. States publish to the state's public website the draft demonstration-evaluation design within 30 days of CMS approval as part of our transparency regulation. CMS posts on our website, or provides a link to the state's public website, all evaluation materials, including research and data collection, for purposes of sharing findings with the public within 30 days of receipt of materials. CMS receives updates on the evaluation through our standard monitoring and evaluation requirements that are specified in a demonstration's approved terms and conditions, including but not limited to quarterly and annual reporting, as well as the interim and final evaluation reports.

While final evaluation reports are required once the demonstration has ended, interim evaluation reports are required as part of a state's request to extend its demonstration. Including the interim evaluation report in its extension request enables CMS to review the demonstration's progress during the review and approval process. A draft version of the final evaluation is usually due to CMS 120 days after the demonstration ends. After CMS's review and acceptance, the public is able to access the evaluation reports on Medicaid.gov. State evaluations must be published on the state's public website within 30 days of submission to CMS.

In addition to the evaluations required under the states' approved terms and conditions, CMS has recently engaged a Federal evaluator for a subset of section 1115 demonstrations. The evaluation design is posted for public access on Medicaid.gov. The evaluation design focuses on four demonstration types: Delivery System Reform Incentive Payments (DSRIP); Managed Long-Term Support Services (MLTSS); Premium Assistance; and Beneficiary Engagement demonstrations, including premiums and incentives for healthy behaviors. In these four priority areas, the Federal evaluator is looking broadly at demonstration performance as well as providing in-depth reports on specific demonstration impacts and outcomes. CMS, states and other stakeholders will use the evaluation products to inform policy decisions and renewals of demonstrations. Reports and findings from the Federal evaluation will be posted to Medicaid.gov.

The Honorable Representative Guthrie

1. **In your written statement, you described numerous CMS initiatives aimed at innovation and achieving better health outcomes at a lower cost. I was pleased to learn at the hearing that CMS does have plans to assess or evaluate these initiatives. Could you please provide a detailed description of the assessments or evaluations CMS has undertaken for the initiatives discussed in your statement and note when each evaluation is scheduled to be completed? Please also include information on whether CMS employees or a contractor are conducting the review.**

Answer: Evaluations are an important part of CMS's initiatives that are aimed at innovation and improvements in health outcomes at a lower cost. Robust evaluations help CMS and states understand the effect of these new and innovative approaches to delivering and paying for care.

Pursuant to the Affordable Care Act, CMS used a contractor for the interim evaluation of the Medicaid Health Home program and released an interim Report to Congress describing the results.[9] The Interim Report describes the commonalities and differences among the health home programs in each of the states that have chosen to implement the program. This report also describes the processes by which states arrived at the decision to pursue a health home state plan amendment and how states built upon initiatives and infrastructure that pre-dated the health home programs. From this information, the report describes challenges and best practices identified by the states in the design and implementation process. Preliminary anecdotal evidence suggests that the health home programs have had a positive impact on the quality of care health home enrollees receive. States are seeing preliminary successes with patient empowerment, improved care coordination, integration of primary and behavioral health services, care transitions and access to health care and other community-based services. As required by section 2703 of the Affordable Care Act, a more in-depth analysis will be included in an independent Report to Congress on the effect of the home health-home option on hospital admissions, emergency room visits, admissions to skilled nursing facilities, and costs over time. The Assistant Secretary for Planning and Evaluation (ASPE) is responsible for the independent evaluation of health homes and the Report to Congress. ASPE is using a contractor to complete this evaluation and report. CMS is also collaborating with ASPE on its evaluation of the Balancing Incentive Program, and has issued an initial report.[10] This initial report is on the baseline status of the 21 Balancing Incentives Program participating states, and is the first deliverable in an evaluation that focuses primarily on the actions states took to attain the required program goals and the challenges they faced.

Ten grants were awarded under the Children's Health Insurance Program Reauthorization Act Quality Demonstration Grant Program to identify replicable strategies for improving the quality of health care for children enrolled in Medicaid and CHIP. Approximately $100 million was awarded over five years to a total of 18 state Medicaid and CHIP programs. As a group, the 18 demonstration states implemented 52 projects in five categories:

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[9] The report is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/downloads/medicaid-health-home-state-plan-option.pdf

[10] The initial report is available at http://aspe.hhs.gov/basic-report/descriptive-overview-and-summary-balancing-incentive-program-participating-states-baseline

- Using quality measures to improve child health care;
- Applying health information technology for quality improvement;
- Implementing provider-based delivery models;
- Investigating a model format for pediatric electronic health records (EHRs); and,
- Assessing the utility of other innovative approaches to enhance quality.

CMS, in collaboration with the Agency for Healthcare Research & Quality, has conducted an evaluation of this grant initiative using a contractor to assess best practices and replicable strategies for improving children's health care quality. Results of analyses are summarized in Evaluation Highlight Summaries, reports, journal articles and national presentations.[11]

The Adult Medicaid Quality Grant is a two-year grant program, funded in December 2012, and designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set). CMS selected 26 states to participate in this grant program and grantees were eligible to receive up to one million dollars for each 12-month budget period. CMS has contracted to complete an assessment of the grant program to help the CMS and other Medicaid stakeholders gain a deeper understanding of the feasibility of implementing the core measures. The assessment goals include: (1) identifying effective strategies grantees have implemented that have resulted in successful collection, reporting, analysis, and use of the measures; (2) assessing the strengths and weaknesses of the grant program; and (3) disseminating information about the grant program to CMS, state and Federal Medicaid agencies, and other key stakeholders. The final assessment is scheduled for completion in 2016.

In March 2014, the Centers for Medicare & Medicaid Services (CMS) awarded Testing Experience and Functional Tools (TEFT) planning grants to nine states to test quality-measurement tools and demonstrate e-health in Medicaid community-based long-term services and supports (CB-LTSS). The grant program is designed to field test an experience of care survey and a set of functional assessment items, demonstrate personal health records, and create a standard electronic LTSS record. With the total grant program nearing $42 million, this is the first time CMS is promoting the use of health information technology (HIT) in CB-LTSS systems. TEFT will provide national measures and valuable feedback on how health information technology can be implemented in this component of the Medicaid system. Evaluation of this effort utilizing contractor support will result in real time reports that will help with implementation of the grant program and annual evaluations that will conclude in 2018.

Several other important delivery system reform initiatives are being conducted in partnership with the CMS Innovation Center. As required by statute, the Innovation Center conducts an evaluation of each new payment and service delivery model being tested. The statute specifies that measures in each evaluation must include an analysis of the quality of care provided under the model (including the measurement of patient-level outcomes and patient-centeredness criteria) as well as changes in spending. In addition to the rigorous evaluation of the effect of each model, the Innovation Center provides frequent feedback to providers who participate in

[11] These documents are available at http://www.ahrq.gov/policymakers/chipra/demoeval/index.html. A final summary on key lessons learned is available at http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/finalsummary/index.html.

each model to support continuous quality improvement, with the understanding that learning and adaptation are essential to enable providers and health systems to achieve the greatest efficiencies and improvements possible in each new payment model.

Evaluations have been conducted on the Strong Start for Mothers and Newborns initiative and the State Innovation Models (SIM) Initiative. The Strong Start for Mothers and Newborns Initiative aims to improve maternal and infant health outcomes for Medicaid and CHIP covered pregnancies. Strong Start cooperative agreement funding was awarded in February of 2013 to support service delivery to 27 awardees and provider sites across 30 states, the District of Columbia, and Puerto Rico for four years. CMS contracted to conduct an independent five-year study of Strong Start to evaluate the implementation and impact of Strong Start on health care delivery, health outcomes and cost of care. The evaluation approach of Strong Start is a mixed methods research design, which includes participant level information and a quantitative analysis of the impacts of Strong Start on birth outcomes and costs of care. The final evaluation is scheduled for completion in 2018.

A team from RTI International, The Urban Institute, and the National Academy for State Health Policy was awarded a contract to evaluate the SIM Initiative, including the planning process and resulting plans of the Model Design and Pre-Test states.

The Medicaid Innovation Accelerator Program (IAP), launched July 2014, is designed to support state Medicaid agencies' ongoing health care delivery-reform efforts in key program priority areas by providing targeted, technical programmatic support. CMS began working with states on the first program area, reducing substance-use disorders, in January, and will confirm selected states for its second program area, improving care for Medicaid beneficiaries with complex care needs and high costs, at the end of September. Additional program areas, community integration-long-term services and supports and physical/mental health integration, will launch later this year. Beginning late fall 2015, CMS' Innovation Center will lead a contracted evaluation of IAP. This evaluation will provide an assessment of CMS' and states' experiences with developing and using IAP resources and early effects of these resources on states' health care delivery-reform efforts.

Every approved section 1115 demonstration includes an STC requiring the state to submit an evaluation-design plan for CMS approval. Once the design is approved, the state must contract with an independent entity to conduct the evaluation in accordance with the terms of the approved design plan. States publish to the state's public website the draft demonstration evaluation design within 30 days of CMS approval as part of our transparency regulation. CMS posts on its website, or provides a link to the state's public website, all evaluation materials, including research and data collection, for purposes of sharing findings with the public within 30 days of receipt of materials. CMS receives updates on the evaluation through our standard monitoring and evaluation requirements that are specified in a demonstration's approved terms and conditions, including but not limited to quarterly and annual reporting as well as the interim and final evaluation reports.

While final evaluation reports are required once the demonstration has ended, interim evaluation reports are required as part of a state's request to extend its demonstration. Including the interim evaluation report in its extension request enables CMS to review the demonstration's progress

during the review and approval process. A draft version of the final evaluation is usually due to CMS 120 days after the demonstration ends. After CMS's review and acceptance, the public is able to access the evaluation reports on Medicaid.gov. State evaluations must be published on the state's public website within 30 days of submission to CMS.

In addition to the evaluations required under the states' approved terms and conditions, CMS has recently engaged a Federal evaluator for a subset of section 1115 demonstrations. The evaluation design is posted for public access on Medicaid.gov. The evaluation design focuses on four demonstration types: DSRIPs; MLTSS; Premium Assistance; and Beneficiary Engagement demonstrations, including premiums and incentives for healthy behaviors. In these four priority areas, the Federal evaluator is looking broadly at demonstration performance as well as providing in-depth reports on specific demonstration impacts and outcomes. CMS, states, and other stakeholders will use the evaluation products to inform policy decisions and renewals of demonstrations. Reports and findings from the Federal evaluation will be posted to Medicaid.gov.

2. **GAO has raised concerns that the four "general criteria" that CMS indicates that it used to review section 1115 demonstrations to determine whether Medicaid program objectives are being met are not sufficiently specific to allow a clear understanding of what you consider approvable for Medicaid purposes. For example, GAO points out that the criteria relate to serving low-income populations, but CMS has not defined what it means by low-income. Is it accurate to say that CMS generally defines low-income for purposes of Medicaid demonstrations as individuals with annual income at or below 250% FPL?**

Answer: As indicated in our response to Chairman Pitts' first question above, we apply four criteria to all state demonstration proposals in order to promote consistency and equity in the review and approval of state requests. While the criteria reference "low-income individuals" and "low-income populations," we do not apply a standard Federal definition of "low-income." Instead, we look to the demographics specific to each state. While most of our demonstration approvals do not include individuals above 250 percent of the Federal poverty level (FPL), in some cases, we have approved state requests for demonstrations involving populations at higher income levels when we determine the program furthers the objectives of title XIX in that state. For example, approving a program that serves individuals with income above 250 percent FPL can still further the objectives of title XIX, if the program helps keep individuals healthy, especially those who may be at risk of developing a medical condition that could cause them to lose income, which may cause the individuals to become Medicaid eligible. A good example is to look at a program that provides home-care services to a population that is not yet Medicaid eligible. By providing these types of HCBS, the individual can remain safely in his/her home and receive care rather than receiving similar services in an institution.

3. **At the hearing, you noted that CMS has taken some actions to improve the integrity of Medicaid Personal Care Services, an area where the OIG has found significant and persistent compliance, payment, and fraud vulnerabilities. Please provide specific details on the actions taken and how they address the concerns raised by the OIG.**

Answer: CMS appreciates the work of HHS OIG, and we take its recommendations seriously. CMS is committed to working with states to ensure that all personal care services provided to beneficiaries meet all program requirements. CMS has taken a number of steps to improve program systems and personal-care-service data by providing technical assistance to states and modernizing Federal databases.

To address an HHS OIG recommendation to reduce erroneous Medicaid payments for personal care services provided during institutional stays, CMS has greatly improved state access to Medicare data, and provided states technical assistance on reviewing Medicare and Medicaid data analysis. CMS has also been offering states technical assistance on fraud detection and will continue to do so as new algorithms are developed based on new T-MSIS data.

HHS OIG also recommended that CMS work with states to ensure that agencies and attendants are aware of attendant qualification and documentation requirements and that Medicaid claims for personal care services provided by attendants with undocumented qualifications are not paid, and CMS began reviews of section 1915(c) waivers to ensure state compliance with their own provider qualifications. Improved data from T-MSIS will help states and CMS identify data accuracy issues and state trends far more easily.

CMS has also conducted a roundtable that brought together providers, consumers, HHS OIG investigators and representatives from various areas of CMS to help better understand the issues surrounding PCS in order to balance the self-direction flexibilities inherent in PCS with the need to reduce fraud, waste, and abuse.

Finally, to address personal care services delivered through section 1915(c) HCBS waivers, CMS released guidance to states that emphasized the areas of provider qualifications, unusual incident reporting for exploitation (of funds), service plan requirements for monitoring of duration, scope and amount of services and fiscal integrity. Also, in January 2014, CMS published a Final Rule pertaining to section 1915 HCBS that includes a provision which prohibits the provision of unnecessary or inappropriate services and supports.

In November 2012, HHS OIG issued "Medicaid—Personal Care Services Portfolio—Trends, Vulnerabilities, and Recommendations for Improvement (OIG 12-12-01. 2012), which recommended that CMS:

(1) Establish minimum Federal attendant qualification standards applicable for all personal care services reimbursed by Medicaid;
(2) Require states to either enroll all personal-care service attendants as providers or require all such attendants to register with their state Medicaid agencies and assign each attendant a unique identifier;
(3) Require that personal-care service claims include the specific date(s) when services were performed and the identity of the rendering attendants;
(4) Issue operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants;
(5) Issue guidance to states regarding adequate prepayment controls, consider whether additional controls are needed to ensure that personal care services are allowable and are actually provided; and,

(6) Provide states with data suitable for identifying overpayments for personal-care service claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.

States may offer personal care services as an optional state plan benefit under 42 CFR 440.167, as a home- and community-based waiver service under 42 CFR 440.180(b)(4), or as a state plan home- and community-based service under 42 CFR 440.182(c)(4). In January 2014, CMS issued a detailed Technical Guide for the review of home- and community-based waivers, including those covering personal care services, which addresses a number of HHS OIG recommendations including (1), (2), (4), (5), and (6) above.[12] CMS applies this Guide in reviewing applications for new and renewing 1915(c) waivers. The Guide addresses HHS OIG recommendations (4) and (5) above relating to operational guidance for beneficiary assessments, plans of care, supervision of attendants, and adequate pre-payment controls.

The Guide addresses attendant qualifications (HHS OIG recommendations (1) and (2) above) by applying the following review criteria: (1) the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards identified and described by the state prior to their furnishing waiver services; (2) the state monitors non-licensed/non-certified providers to assure adherence to waiver requirements; and (3) the state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver (Appendix C-2 Quality Improvement; Qualified Providers, p. 115).

The Guide addresses claims documentation, payment accuracy, and overpayments (HHS OIG recommendations (4), (5), and (6) above) by requiring that adequate records and information be maintained to support financial accountability. Specifically, states must maintain records and additional documentation sufficient to ensure that there is an audit trail documenting payments made to providers for waiver services. The audit trail must begin at the point of service to the participant (and, thereby, include sufficient documentation that the service was actually rendered on the date shown on the provider billing) and continue through to the claim for Federal payment (Appendix I-2, Rates, Billing, and Claims, p. 256).

The recommendation that personal care services be billed by date of service and with specific identifiers can be a very difficult and expensive undertaking, and CMS believes it is critical that the provider agencies and financial management entities maintain a detailed paper trail to back up claims. Claim forms are not currently set up to include individual personal-care service provider detail, and per-line electronic claim filing fees can be exorbitantly high for the small agencies if they are having to submit daily claims for each worker for each beneficiary (as compared to one claim per month per beneficiary). There currently is no authority to require such invoicing practices.

4. Considering the widespread nature of fraud in Personal Care Services and the documented cost savings published on Medicaid programs using Electronic Visit

[12] See "Application for a Section 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide, and Review Criteria (January 2015)," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf.

Verification, do you see value in states having in place technology that validates homecare visits?

Answer: Although CMS has oversight responsibility, states administer Medicaid and have the frontline responsibility to ensure that Federal and state Medicaid funds are properly spent – that is, that funds are used to pay for covered Medicaid services furnished by qualified providers to eligible beneficiaries. This basic program-integrity principle applies to home health visits and personal care services just as it does to all other covered services. States have discretion in how they carry out their program integrity responsibilities. If a state determines that a technology helps ensure that Medicaid funds are properly spent, then a state may deploy that technology.

5. **Given the wealth of documentation supporting the benefits of members receiving care in their homes, do you see any reason CMS should not require states to require providers who are providing Personal Care Services to have in place visit verification technology for Medicaid homecare services?**

Answer: While CMS supports state proposals to use Electronic Visit Verification, we do not generally require states to use certain approvable technologies.

6. **Would it be beneficial to have consistent national data on date, time, location, member and caregiver for Medicaid homecare services?**

Answer: CMS values national data on Medicaid personal care services and other Medicaid long-term care services. On June 30, 2015, CMS posted national expenditure data for FY 2013, including spending on personal care services by state.[13] CMS also is in the process of standing up T-MSIS, which modernizes and enhances the way states will submit operational data about beneficiaries, providers, claims, and encounters involving all Medicaid-covered services, including personal care services. We would want beneficiaries to have maximum access to these services in their homes and communities, so would want systems to track such use to have the flexibility to be used in varied locations.

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[13] See Tables L and V of "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending," available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

The Honorable Representative Whitfield

Medicaid turns 50 years old this year, and more than 71 million Americans currently depend on it to cover a wide range of health care services and benefits. From what I understand, Medicaid currently covers more lives and spends more general tax revenue than Medicare, which is expected to be approximately $344.4 billion for fiscal year 2016. These figures create a great deal of concern for me, and I believe many of my constituents in Kentucky want to understand what CMS is doing to ensure the Medicaid program will remain a viable option for those that need it most.

The GAO report raised concerns that CMS authorized federal matching funds for state programs that provide:

- **loan repayment to recent medical school graduates**
- **grants to councils on aging**
- **veteran's benefits**

Yet, other federal agencies already provide funding for these causes. This raises serious concerns that demonstrations are duplicating potentially billions of dollars in federal funding. It is my understanding that CMS does not current take ANY steps to ensure that the funding of state based programs does not result in overlap or duplication of federal funding.

1. Is that correct?

Answer: When CMS approves Federal matching for the costs of state-funded programs, we require states to subtract out any other Federal funding from their state-funded program costs. We also require states to subtract out any current maintenance-of-effort dollars for other Federal grants. In addition, members of the Federal Review Team comprised of other federal agencies also assist in identifying whether there are similar existing federal programs that fund similar programs.

According to OMB, the Medicaid program has the third highest amount of improper payments – over $17 billion a year. While the improper payment rate in Medicaid had been declining, this past year, the rate increased by nearly 1 percent, from 5.8 to 6.7 percent. This is especially troubling given that it comes at a time when the program is expanding greatly.

2. What explains the increase in the error rate and what is CMS doing to reverse the trend and reduce improper payments in the program?

Answer: The PERM program measures improper payments in Medicaid and CHIP, and produces state and national error rates for each program. The error rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the Federal fiscal year under review. It is important to note the error rate is not a "fraud rate," but simply a measurement of payments made that did not meet statutory, regulatory, or administrative

requirements. The error rate includes any payment to an ineligible beneficiary, any duplicate payment, any payment for services not received, or any payment incorrectly denied.

The primary reason for the 2014 Medicaid improper payment rate increase was errors identified relating to state claims-processing systems not being fully compliant with new requirements. In particular, all referring or ordering providers providing services under a state plan or waiver must now be enrolled in Medicaid. States are required to screen providers under a risk-based screening process prior to enrollment, and the attending provider National Provider Identifier (NPI) must be included on all electronically-filed institutional claims. If the non-compliance errors related to these new requirements were removed from the measurement, the 2014 Medicaid improper payment rate would have decreased from 2013, meaning that improvement was made in every other aspect of the program. While these requirements will strengthen the integrity of the program, they require systems changes that many states had not fully implemented during the period of measurement for this report.

To help address the improper payment rate, CMS identifies and classifies types of errors and shares this information with each state. States then analyze the findings to identify why the errors occur, which is a necessary precursor to developing and implementing effective corrective actions. CMS works closely with states following each measurement cycle to develop state-specific corrective action plans. States, in close coordination with CMS, are responsible for implementing, monitoring, and evaluating the effectiveness of these plans.

The Honorable Representative Shimkus

1. **CMS requires states to have actuaries certify their payment rates under Medicaid managed care. However, while CMS has actuaries in house, it is my understanding that the agency does not currently require actuarial certification of the budget neutrality of 1115 demonstrations. As a steward of American taxpayer dollars, why has the agency not utilized the expertise of its actuaries and required them to attest to the budget neutrality of waivers prior to their approval?**

Answer: CMS takes a number of steps to ensure the integrity of our review and approval of section 1115 demonstrations complies with our budget-neutrality, including working closely with other Federal partners to ensure that all demonstrations comply with our budget-neutrality policy, which establishes Federal funding limits that align with the President's Budget's Medicaid estimates for the associated demonstration period. The Medicaid estimates in the President's Budget are produced by the Office of the Actuary (OACT) each fiscal year.

2. **When asked about administration proposals to address the fiscal sustainability of Medicaid, you noted the President's budget proposals related to Medicaid payments for durable medical equipment and drugs. I am pleased to say that the Committee's 21st Century Cures bill that passed the House on July 10th includes at least two provisions from the President's budget in these two areas. What other specific recommendations or concrete policy ideas does CMS have to address the unsustainable trajectory of Medicaid spending so that we can preserve the program for the nation's most vulnerable?**

Answer: The President's FY 2016 Budget includes a package of legislative proposals to improve benefits and facilitate coverage for Medicaid beneficiaries while also strengthening cost-effectiveness and safeguarding the program against fraud, waste, and abuse. These include proposals that will strengthen the cost-effectiveness of Medicaid by making changes to Medicaid drug policy, such as: by clarifying the Medicaid definition of brand drugs, applying inflation-associated penalties to Medicaid rebates for generic drugs, correcting the Medicaid rebate formula for new drug formulations, excluding brand and authorized generic drug prices from the Medicaid Federal upper payment limits, targeting policies to lower drug costs in Medicaid, and promoting program integrity for Medicaid drug coverage. We estimate that, over the 10-year period of FYs 2016–2025, our proposals to limit Medicaid drug costs and strengthen the Medicaid drug rebate program would reduce Federal Medicaid spending by $6.3 billion. The President's FY 2016 Budget also includes proposals that together would both save the Federal Government over one billion dollars over 10 years and strengthen efforts to fight fraud, waste, and abuse in the Medicaid program.

3. **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. 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. CBO has warned repeatedly that the continued growth of our entitlements, including Medicaid, is the single largest structural driver of our debt and deficits.**

a. **During your testimony, you suggested that CMS's response to the longer-term threat of the ballooning Medicaid spending was outlined in the President's Budget. The President's budget proposes Medicaid policies that, all combined, would *cost,* $27.8 billion over a decade. See: https://www.cbo.gov/sites/default/files/cbofiles/attachments/50013-HealthPolicy.pdf Just adding up the policies that would reduce federal spending yields a $16 billion reduction over 10 years to Medicaid spending. That amount is 0.303% of the $5.27 trillion federal Medicaid spending projected over the coming decade (according to CBO's March 2015 baseline). Does CMS really believe these proposals can be characterized as taking a meaningful step towards the sustainability of the program?**

Answer: The President's FY 2016 Budget includes a robust health-savings package estimated to save approximately $400 billion over 10 years. As part of this package, the Budget includes a number of Medicaid proposals, including investments to improve benefits and facilitate coverage for Medicaid beneficiaries while also strengthening the cost-effectiveness of Medicaid.

b. **If more needs to be done, what other proposals does the Administration have to protect current and future beneficiaries who depend on Medicaid?**

Answer: CMS is actively working to address factors that increase costs in Medicaid and throughout the health care system by improving the delivery of care to ensure quality and value and promote community integration for people who use long term services and supports. CMS is engaged in a variety of initiatives to work with states, providers, and other stakeholders to help spur innovation and change and improve delivery of care in Medicaid.

Our efforts include:

- Collaborating with states in key areas to improve the quality of care through payment and delivery system reforms;
- Working with innovator states to advance state-specific reforms;
- Providing states with tools and guidance developed to meet the needs of Medicaid beneficiaries through new models of care; and
- Working to measure and improve quality across states, in coordination with similar efforts under way in Medicare and in the private market.

CMS is also working with various states on new payment models. The CMS Innovation Center created the SIM initiative for states that are prepared for or committed to planning, designing, testing, and supporting evaluation of new payment and service delivery models in the context of larger health system transformation. The SIM is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and CHIP beneficiaries.

The Honorable Representative Burgess

1. **On Monday July 6, OIG released a report, "Not all States Reported Medicaid Managed Care Encounter Data as Required," examining State reporting of encounter data into the national Medicaid database, which is essential to proper oversight of the Medicaid program. The report showed that only 12 states reported all encounter data in 2011. This is not the first time OIG has raised concerns over CMS enforcement of data reporting. In response to a 2009 report, CMS stated that it would increase efforts to enforce Federal requirements regarding encounter data; however OIG found that CMS is still not enforcing requirements. Does CMS have plans to increase monitoring of encounter data and provide further guidance to the States to address these issues?**

Answer: We agree with HHS OIG that accurate, complete, and timely managed care encounter data are essential to proper oversight of the Medicaid program. We are taking a number of steps – through rulemaking, through sub-regulatory guidance, and through technical assistance to states – to ensure that these data are available to state Medicaid agencies and to CMS.

As you know, sections 6402(c) and 6504(b) of the Affordable Care Act amended the Medicaid statute under title XIX of the Act (by, respectively, adding section 1903(i)(25) and amending section 1903(m)(2)(A)(xi)) to add provisions relating to routine reporting of encounter data as a condition for receiving Federal Medicaid matching payments. Section 1903(i)(25) of the Act requires reporting of enrollee encounter data to a state's Medicaid Statistical Information System (MSIS) in a timely manner. Section 1903(m)(2)(A)(xi) of the Act requires contracts with managed care organizations to include requirements for the organizations to submit encounter data to state Medicaid agencies at a frequency and level of detail to be specified by the Secretary, in order for the state's capitation payments under the contracts to be eligible for Federal financial participation.

On June 1, 2015, CMS published an NPRM in the Federal Register, "Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability," CMS-2390-P. Among other changes, this rule proposes to implement the Affordable Care Act requirements in proposed sections 42 CFR 438.2, 438.242, and 438.818. We explain these proposals in detail at 80 *Fed. Reg.* 31166-31167 (June 1, 2015). We currently are considering comments on the NPRM and anticipate issuing the Final Rule in 2016.

We have also issued sub-regulatory guidance to states regarding the collection of encounter data. In August 2013, we released SMDL #13-004, providing guidance to states on the T-MSIS.[14] As we stated in the preamble to the NPRM, we intend to review whether managed care entities provide timely and accurate encounter data to facilitate the transition to T-MSIS.

Finally, CMS provides direct technical assistance to state Medicaid agencies in developing, enhancing, implementing, and evaluating managed care programs. One of the focus areas for assistance is the collection, validation and analysis of encounter data. In November 2013, CMS posted a Managed Care Encounter Data Toolkit, a practical guide to collecting, validating, and

[14] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf.

reporting Medicaid managed care encounter data.[15] The Toolkit is designed as a step-by-step guide for state Medicaid staff responsible for managing the daily operations involved in encounter data, as well as for senior managers and policymakers who oversee this function.

2. My home state of Texas has an 1115 Medicaid waiver that is making a positive transformation in care delivery. However, this waiver expires in 2016 and renewal discussions are currently underway. In the past, CMS has not had criteria by which it was making approval determinations. However, a recent GAO report indicated that CMS has established four "general criteria" against which it reviews section 1115 demonstrations to determine whether Medicaid program objectives are met. Where are these criteria documented and how has CMS communicated these criteria to states and other stakeholders?

Answer: As indicated in response to Chairman Pitts' Question #1, the four general criteria we apply to all state proposals for section 1115 demonstrations are whether the demonstration will:

1. Increase and strengthen overall coverage of low-income individuals in the state;
2. Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. Improve health outcomes for Medicaid and other low-income populations in the state; or
4. Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.[16]

3. Medicaid pays for more than 60 percent of national spending on long-term services, accounting for 28.1 percent of Medicaid expenditures in 2013. One of the most promising initiatives is transitioning away from institutional care towards home-health and community based services. In your testimony, you mentioned the Community First Choice program as a way to encourage states to provide home and community based care. However, only 5 states are currently participating. Could you discuss any reasons or obstacles that states are finding as they try to transition to community-based care?

Answer: As you know, the Affordable Care Act provided states additional options for increasing access to HCBS in the Medicaid program. One of these is the Community First Choice (CFC) Option authorized by section 2401 of the Affordable Care Act. Others include the Affordable Care Act's removal (under section 2402) of certain barriers to the provision of HCBS under a state Medicaid plan option first authorized in 2005, and the extension by section 2403 of the Money follows the Person Rebalancing Demonstration.

CMS and state Medicaid programs, working in partnership with consumers and advocates, providers and other stakeholders, are using these Affordable Care Act options to make real progress towards creating a sustainable, person-driven, long-term support system in which

[15] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf.
[16] These criteria are posted at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html.

people with disabilities and chronic conditions have choice, control and access to a full array of quality services in their homes and communities. CMS is pleased that five states have taken up the CFC option, 16 states have taken up the section 1915(i) HCBS state plan option, and 43 states and the District of Columbia participated in the Money Follows the Person Rebalancing Demonstration.

Although some states describe competing priorities and resource constraints, including financial implications for state dollars given the broad reach of the program across disability populations, as reasons for not moving forward with CFC, states are generally making strong progress toward transitioning to home and community-based care. In fact, spending on home and community-based services accounted for a majority (51.3 percent) of Medicaid expenditures for long-term services and supports expenditures in FY 2013, the first time in the history of the Medicaid program that non-institutional long-term care spending exceeded spending on institutional long-term care.[17] CMS is encouraged by these developments and looks forward to continuing to work with states and stakeholders to expand access to services that help beneficiaries maintain their independence in the community.

Evaluations of the Balancing Incentive Program and the Money Follows the Person program are providing valuable information about the challenges that states face in seeking to re-orient their Medicaid-funded long-term services and support away from institutional care toward greater reliance on home and community-based services and the strategies that states have successfully employed to reach their goals. CMS shares this information with participating states via periodic conference calls and makes it publicly available on contractors' technical assistance websites and by posting evaluation reports on the CMS website as they are completed.

4. **Over the next 10 years, the federal government is expected to spend over 4.6 trillion on the Medicaid program. The majority of the Medicaid program is run through managed care to provide services for Medicaid beneficiaries. While this transition to managed care has the potential to produce high quality care, it has been documented that CMS is not engaging in federally required oversight needed to confirm that states are properly monitoring where taxpayer dollars are being spent. In particular, GAO raised the issue of flawed Medicaid managed care rate-setting methodology in 2010. What has been done to assure that rate-setting methodology is being appropriately set and is actuarially sound?**

Answer: We appreciate the work of GAO on this issue, and have used its findings to help strengthen our policies in this area. CMS and states share the goal of developing managed care rates that accurately reflect the costs and risks of furnishing covered services to Medicaid beneficiaries enrolled in managed care plans. We take our responsibility to ensure the actuarial soundness of capitation rates paid to managed care organizations seriously.

To assist states in setting actuarially-sound rates, CMS released Managed Care Rate Development Consultation Guides in September 2013 and September 2014; most recently, in

[17] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

June 2015, we released a Draft Rate Development Guide for the 2016 rate-setting process.[18] These guides specify the information CMS expects states to provide when developing rate certifications. They were developed in consultation with OACT, states, and actuaries experienced with setting managed care capitation rates. OACT initially was engaged in the CMS rate-review process beginning with the 2014 Medicaid expansion rate certifications. Since that time, OACT has broadened its engagement to include all Medicaid managed-care programs.

In the NPRM (CMS-2390-P) discussed in the answer to your first question above, we propose to strengthen and improve the standards for the development of actuarially sound capitation rates by states and their actuaries. More specifically, we propose to define actuarially-sound capitation rates as rates that are projected to provide for all reasonable, appropriate, and attainable costs under the terms of the risk contract between the managed care organization and the state, for the period and population covered under the contract. We also propose to revise the rate-setting framework. An extensive discussion of our proposal is set forth at 80 *Fed. Reg*. 31118-31126 (June 1, 2015). Our goal is to reach the appropriate balance of regulation and transparency that accommodates the Federal interests as payer and regulator, the state interests as payer and contracting entity, the actuary's interest in preserving professional judgment and autonomy, and the overarching programmatic goals of promoting beneficiary access to quality care, efficient expenditure of funds, and innovation in the delivery of care. We currently are considering comments received on the NPRM and anticipate issuing a Final Rule in 2016.

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[18] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/draft-2016-managed-care-rate-guidance.pdf.

__**The Honorable Representative Blackburn**__

1. **The Medicaid managed care proposed rules that CMS issued in May call for states to provide at least 14 calendar days of fee-for-service coverage for enrollees to make a managed care plan selection. While we, of course, want enrollees to actively participate in the process and make informed selections, how does CMS envision this requirement working in states such as mine whose entire program operates under managed care?**

    a. **Couldn't this waiting period lead to unnecessary delays and disruptions in continuity of care for Medicaid beneficiaries?**
    b. **Why does CMS feel it is important to have this 14 day waiting period as opposed to the current policy in which beneficiaries may disenroll from their assigned Medicaid health plan without cause within the first 90 days of being enrolled in the plan?**

Answer to a&b: In the NPRM published in the Federal Register on June 1, 2015, CMS-2390-P, we propose an enrollment standard applicable to both voluntary and mandatory managed care programs that all states must provide a period of time of at least 14 calendar days of FFS coverage for potential enrollees to make an active choice of their managed care plan (42 CFR 438.54(c)(2) and (d)(2)).

As we stated in the preamble to the NPRM at *80 Fed. Reg. 31133-31134*, we believe this minimum time period is important since, similar to enrollees in a commercial insurance product, Medicaid enrollees can be "locked in" to their selected health plan for up to a year. Given the sensitive nature of the transition from FFS to managed care, or from one managed care system to another, and given the often complex medical, physical, and/or cognitive needs of Medicaid beneficiaries, we proposed that states provide coverage during the selection period based on a belief that enrollment processes should be structured to ensure that the beneficiary has an opportunity to make an informed choice of managed care plan and that state processes support a seamless transition for an enrollee to managed care.

We recognize that providing a minimum active choice period would be a change in process for some states, and we requested comment on the impact of this new standard on managed care program costs and operations. We are in the process of reviewing comments received on the NPRM and anticipate issuing a Final Rule in 2016.

2. **As we discussed at the hearing, Obamacare explicitly requires that states suspend the billing privileges of most providers who have been terminated or revoked by another state or Medicare. However, more than 5 years after enactment banned providers are still receiving Medicaid payments. At the hearing you indicated that CMS has taken steps to ensure that prohibited providers are excluded from Medicaid. Please provide details on the *specific steps* that CMS has taken to ensure that prohibited providers are not receiving federal Medicaid dollars?**

Answer: We share your interest in ensuring the most effective and efficient use of taxpayer dollars in the Medicaid program. States and the Federal Government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application

and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and state dollars.

Section 6501 of the Affordable Care Act amends section 1902(a)(39) of the Act to require state Medicaid agencies to terminate the participation of any provider that has been terminated by Medicare, another state Medicaid program, or CHIP. CMS has implemented this requirement through regulations, sub-regulatory guidance, and systems of sharing information with states.

CMS issued implementing regulations in February 2011, 42 CFR 455.416(c). We define "termination" at 42 CFR 455.101 as occurring when a state Medicaid program or CHIP has taken an action, or CMS has taken action in Medicare, to revoke a provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. The requirement to terminate under section 6501 of the Affordable Care Act only applies in cases where providers have been terminated or had their billing privileges revoked "for cause," which includes fraud, integrity, or quality (42 CFR 455.101).

CMS clarified in Informational Bulletins issued in May 2011 and January 2012, that "for cause" terminations do not include terminations for reasons such as a provider's failure to submit claims due to inactivity or who allow their medical license to expire due to relocation to another state. We also provided a list of examples of conduct that would constitute "for cause" terminations, including terminations resulting from adverse licensure actions, fraudulent conduct, abuse of billing privileges, and falsification of billing records.[19]

States are required to report their data on terminations to CMS. States can use this information to terminate enrollment of providers who are terminated by other programs, and CMS uses the state data in connection with its discretionary authority to revoke providers' Medicare billing privileges if they have been terminated for cause by another program. In November 2013, CMS developed and launched a new delivery, storage, and reporting process for information about Medicaid terminations. The Tibco MFT Server enables for state-to-state sharing of information on terminated providers. It allows states to view Medicare "for cause" revocations data on providers populated from the Medicare provider enrollment database, to browse previous Medicaid and CHIP Statistical Information System data on terminated Medicaid providers, and to view new "for cause" Medicaid terminations and download accompanying provider letters. Between December 2012 and June 2015, 35 states submitted a total of 2050 Medicaid terminations to the Tibco MFT server.

a. **What, if any, steps has CMS taken steps to recoup federal dollars paid to prohibited providers by state Medicaid programs and how much has CMS recouped?**
b. **If CMS has not attempted to recoup federal Medicaid dollar paid to prohibited providers, please explain why CMS has not taken action and identify any barriers to collection?**

Answer to a&b: A payment by a state Medicaid agency to a provider that has been excluded from participation in Federal health care programs by either HHS OIG or pursuant to state authority would constitute an overpayment to that provider. Due to the nature of the state-

[19] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-20-12.pdf.

administered Medicaid program, CMS does not directly recoup the Federal share of overpayments from providers. Instead, states themselves are required to return to CMS the Federal share of any overpayment. Section 1903(d)(2) of the Act (as amended by section 6506 of the Affordable Care Act) provides states up to one year from the date of discovery of an overpayment (subject also to limited exceptions in cases of fraud and abuse and bankruptcy) to recover, or to attempt to recover, an overpayment before refunding the Federal share of the overpayment through an adjustment to the quarterly expenditure report. Importantly, states are required (subject to limited exception) to refund the Federal share of an overpayment irrespective of whether they collect anything from the providers.

3. **Does CMS disagree that federal Medicaid dollars should only be reserved for individuals that are determined to be actually eligible for Medicaid? Would CMS work with the Committee to make a statutory change to ensure that satisfactory proof of applicants' citizenship or status as eligible legal permanent residents has been provided before applicants are enrolled and receive Medicaid benefits?**

Answer: CMS agrees that Federal Medicaid dollars should be expended on behalf of individuals who are eligible for Medicaid (as well as program administration and other statutorily authorized purposes). Both CMS and state Medicaid agencies work to ensure the integrity and accuracy of the Medicaid eligibility determination process. The availability of electronic data sources to verify financial and non-financial information included on the application (including citizenship and immigration status) has streamlined the process and helped to ensure more timely and accurate determinations, while minimizing the burden on consumers.

Section 1902(a)(46)(B) of the Act requires that state Medicaid agencies verify the status of individuals declaring to be citizens or nationals of the United States using the procedures set forth under either section 1902(ee) or section 1903(x) of the Act. In either case, the state must give applicants a "reasonable opportunity" to provide proof of their citizenship if the state Medicaid agency is unable to promptly verify their status. During this period (referred to as the "reasonable opportunity period"), states are required under the statute to provide Medicaid benefits to those individuals who are determined otherwise eligible for Medicaid. Under section 1902(ee) of the Act, the reasonable opportunity period is defined as 90 days (see sections 1902(ee)(1), 1903(x)(4) of the Act, 42 CFR 435.911(c) and 435.407(k)).

Similarly, section 1902(a)(46)(A) of the Act requires state Medicaid agencies to have in place a system of income and eligibility verification that meets the requirements of section 1137 of the Act. Under section 1137(d)(4)(A) of the Act, states also must provide benefits during a reasonable opportunity period to applicants who have attested, under penalty of perjury, to being in a satisfactory immigration status, but whose status cannot be immediately verified with DHS, provided that the individual otherwise meets the eligibility requirements for coverage. This period provides the individual with time to produce additional documentation of satisfactory immigration status and the agency time to complete the eligibility verification process with DHS.

Citizenship status for most citizens can be quickly verified through a data match with SSA, and immigration status for most non-citizens can be quickly verified through a data match with DHS. However, for a minority of applicants, the process is more time consuming. We believe that the current statutory framework strikes the appropriate balance between providing needed Medicaid

coverage to eligible individuals and ensuring that those individuals are in fact eligible. CMS always is open to working with the Committee to address identified vulnerabilities in the integrity of the programs it oversees.

The Honorable Representative Lance

1. **Some States have been operating under an 1115 waiver for decades. Some, including witnesses we heard from two weeks ago, have suggested that Congress create a "path to permanency" for states that have been operating under an 1115 waiver for decades. This would seem to save a great deal of state and federal resources. Does CMS support this idea, and if so, would you work with the Committee on a legislative proposal to codify this aim?**

Answer: While we are continuing to look for ways to streamline the process for reviewing proposals from states to extend established section 1115 demonstrations that reauthorize longstanding policies currently authorized under section 1115 authority that have demonstrated positive program outcomes, it is important to preserve the review and approval process. As you may know, these demonstration projects test policies not otherwise permitted under Medicaid by waiving certain provisions of Medicaid law. In addition to testing alternative policies, demonstration projects must also show how they "assist in promoting the objectives" of the Medicaid program as well as demonstrate that they are budget neutral to the Federal Government.

Proposals for demonstration projects often have a major impact on beneficiaries, altering benefits, imposing premiums, and changing delivery system for long-term services and supports or the way that coverage is delivered. The review process is designed to assess the impact of these proposals on states, beneficiaries, and the Federal Government.

2. **As the Medicaid program continues to move toward providing care in a Home and Community Based setting rather than in nursing facilities, what steps is CMS taking to ensure that beneficiaries are receiving care from qualified providers in their homes? As I understand it, currently there are no Federal rules that require a simply background check for providers going into beneficiary homes. What is CMS doing to protect Medicaid beneficiaries?**

Answer: CMS is committed to working with states to ensure Medicaid beneficiaries receive safe and effective care. As you know, the Affordable Care Act established a nationwide program for national and state background checks on prospective direct patient access employees of long-term care facilities and providers. The purpose of the program is to identify efficient, effective, and economical procedures for conducting background checks. CMS has awarded grants to 26 states to design comprehensive national background check programs for direct patient access employees.

In addition, states are required to identify the specific requirements for each provider of a service in their 1915(c) home and community-based waiver and 1915(i) state plan submissions. The state must affirmatively declare whether or not they are requiring criminal background checks and/or screening through a state-maintained abuse registry. Regular monitoring and reporting on compliance with the established qualifications are required in the state's continuous quality improvement system.

As we indicated in our response to Mr. Guthrie above, in January 2014, CMS issued a detailed Technical Guide for the review of home- and community-based waivers.[20] CMS applies this Guide in reviewing applications for new and renewing 1915(c) waivers used by states to cover HCBS services for low-income elderly individuals or those with disabilities who in the absence of HCBS services would need an institutional level of care.

The Guide addresses attendant qualifications by applying the following review criteria: (1) the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services; (2) the state monitors non-licensed/non-certified providers to assure adherence to waiver requirements; and (3) the state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver (Appendix C-2 Quality Improvement; Qualified Providers, p. 115).

Additionally, each section 1915(c) waiver must have performance indicators for each of the statutory assurances.[21] Two years prior to each section 1915(c) waiver renewal, the state submits a report that describes the outcomes of their identified performance measures. States are also required on an annual basis to submit a waiver report (the CMS-372) that identifies any health and safety issues identified in the waiver reporting year as well as utilization and spending.

[20] "Application for a Section 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide, and Review Criteria (January 2015)," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf.

[21] Administrative Authority is retained by the Medicaid Agency, at least annually an assessment and person-centered plan of care are developed, each individual is assessed to meet the institutional level of care, health and welfare of beneficiaries is monitored and issues remediated.

The Honorable Representative Griffith

1. **CBO has indicated that the ACA's Medicaid expansion would, on balance, reduce incentives to work and that work would increase available resources for Americans. In fact, CBO has said that, on net, ACA will reduce the workforce by about 2 million jobs. Several states have proposed including job training or work requirements as part of state demonstration waivers. However, to date, CMS has refused to allow states to test such ideas. Is there anything in the section 1115 statute that would prevent CMS from approving work related requirements?**

    a. **Since demonstration waivers are intended to test new ideas and increasing incentives to work is good for Americans, why is CMS so reticent to allow states to innovate in this area?**

Answer: We are committed to working with states interested in pursuing new and innovative policy approaches in their Medicaid program. We do consider encouraging work an important state objective, and to that end have worked with states to develop approaches that encourage work and job training participation. However, the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work or receive job training because that is not an objective of Title XIX.

   b. **What assurances or parameters would make such ideas palatable for CMS?**

Answer: Section 1115 of the Act authorizes the Secretary to waive provisions of section 1902 of the Act to enable states to conduct demonstrations that would, in her judgment, be likely to assist in promoting the objectives of Title XIX. The Secretary has used this authority extensively to enable states to conduct demonstrations that promote the objectives of the Medicaid program. Since 2009, we have approved new demonstrations in 21 states[22] and approved 56 renewal actions. However, as noted in response to the first part of your question, the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work or receive job training because that is not an objective of Title XIX.

The Secretary has approved a number of demonstrations in which states will also promote employment through state programs operated outside of the demonstration. For example, in coordination with its 1115 demonstration, Indiana will seek to encourage employment through a state-funded incentive program that will be administered separate from the Medicaid program. Participation in this program is voluntary and will not impact coverage or benefits for individuals.

[22] VA, RI, IN, NH, MT, NV, NM, MO, PA, LA, MN, NJ, AZ, DC, GA, IA, TX, MI, KS, WI, and AR

The Honorable Representative Bilirakis

1. **You indicated that once the proposed rule for Medicaid and CHIP managed care was finalized, CMS will have "pretty lengthy implementation schedules and a very substantial public input process." Will CMS have such implementation schedules and this public input process for the quality measures and the quality rating system sections specifically or for the entire rule?**

Answer: As we explained in the preamble to the NPRM at *80 Fed. Reg. 31148-31158*, we are proposing to strengthen quality measurement and improvement efforts in managed care by focusing on three principles: (1) improving transparency to increase both state and health plan accountability for the quality of care provided to Medicaid beneficiaries; (2) aligning, where appropriate, quality standards for Medicaid managed care with that of Medicare Advantage and the Marketplace; and, (3) consumer and stakeholder engagement, especially in designing an approach to measuring quality for Medicaid managed care.

Currently, 42 CFR 438.240(a)(2) allows CMS, in consultation with states and other stakeholders, the option to specify performance measures and topics for performance improvement projects to be required by states in their contracts with MCOs and PIHPs. Proposed 42 CFR 438.330(a)(2) would add ''through a public notice and comment process'' to clarify the manner in which CMS would consult with states and other stakeholders to specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion alongside state-specified measures and topics in state contracts with their Medicaid managed care plans. We proposed this would be accomplished after notice and public comment to ensure that states, beneficiaries, and other stakeholders have the opportunity to provide input during the measure selection process.

Proposed 42 CFR 438.334 would require states to establish a quality rating system for Medicaid managed care plans. A quality rating system will provide information that will enable beneficiaries to consider quality when choosing a Medicaid health plan and enable state Medicaid agencies to formulate quality improvement goals and objectives and conduct quality oversight of health plans. We proposed that the state's quality rating system would measure and report on performance data collected from each MCO, PIHP, and PAHP on a standardized set of measures that will be determined by CMS, and that each state would apply a methodology, also established by CMS, to the performance measures to determine the quality rating or ratings of each MCO, PIHP, and PAHP. To ensure that states and other stakeholders have ample opportunity to comment and offer feedback during the development of the proposed Medicaid quality rating system, we would utilize a robust public engagement process, similar to that used by CCIIO in the development of the QHP quality rating system. This may include a series of listening sessions or town halls, the release of a request for information, and/or a series of notice and comment periods. In recognition of the need for state flexibility, we proposed that, contingent on CMS approval, states may elect to use an alternative or preexisting quality rating system. This would allow states that have already invested in the development and implementation of their own quality rating system the option of either adopting or modifying the preexisting system. Our intention is that the Medicaid managed care quality rating system standards would be refined over a period of three to five years prior to implementation. We are

in the process of reviewing comments received on the NPRM and anticipate issuing a Final Rule in 2016.

2. If the latter, should the proposed rule be finalized, for those sections of the proposed rule where a date is not given by which implementation would need to be completed, will CMS provide any guidance on the rollout and expectations of when such sections would need to be in place and when respective parties and stakeholders are expected to be operational and in compliance?

Answer: As stated in the previous response, we are proposing an extended implementation schedule and robust public engagement process of three to five years for the quality rating system. We will provide guidance on operations and compliance for major provisions of the Final Rule.

The Honorable Representative Long

1. **In your statement you discuss the streamlined and coordinated application process for Medicaid, CHIP and qualified health plans through the Exchange. However, GAO has found that poor oversight and insufficient eligibility verification related to Healthcare.gov provided opportunities for ineligible individuals, such as unlawfully present immigrants, to enroll in subsidized health insurance. What has CMS done to ensure that the same failures to properly determine eligibility for qualified health plans have not been imported into Medicaid?**

Answer: As we indicated in our response to Representative Blackburn's question #3 above, CMS agrees that Federal Medicaid dollars should not be expended on behalf of individuals who are not eligible for Medicaid. Both CMS and state Medicaid agencies work to ensure the integrity and accuracy of the Medicaid eligibility determination process. More specifically, state Medicaid agencies are responsible for the day-to-day administration of the Medicaid program, including the processing of Medicaid eligibility applications. Where states have delegated the authority to make Medicaid determinations to other permitted entities, including Exchanges, the state must ensure that the delegated entity complies with all relevant Federal and State law, regulations and policies. CMS is responsible for ensuring that state Medicaid agencies comply with statutory requirements relating to eligibility, including those at section 1902(a)(46) of the Social Security Act, which sets forth requirements for verification of citizenship, and section 1137 of the Social Security Act, which requires verification of satisfactory immigration status. The availability of electronic data sources to verify financial and non-financial information provided by applicants (including citizenship and immigration status) has streamlined the process and helped to ensure more timely and accurate determinations, while minimizing the burden on consumers.

2. **The Medicaid managed care proposed rule adds a number of new administrative requirements for plans, including MLR reporting requirements and the submission of data and documentation relating to the entity's compliance with new program requirements. Does the agency expect these new administrative requirements will affect plan MLRs? If so, are there mechanisms in place to ensure the new MLR requirement is consistent with these new plan responsibilities?**

Answer: As you know, we have proposed that capitation rates for Medicaid managed care plans must be set such that the plans would achieve an MLR of at least 85 percent, but not exceed a reasonable maximum threshold that would account for reasonable administrative costs. In the preamble to the NPRM at *80 Fed. Reg. 31107-31113*, we explained that if capitation rates do not account for reasonable administrative costs, the result could be poor client and provider experiences. The comment period on the proposed rule ends on July 27, 2015. We are in the process of reviewing comments received on the NPRM and anticipate issuing a Final Rule in 2016. The Final Rule will address all comments received, including comments relating to the proposed provisions that include an MLR.

The Honorable Representative Ellmers

1. **I'm concerned that lack of access to appropriate care often times leads to more significant costs to beneficiaries and the program, especially those with chronic conditions such as diabetes. Have you examined the impact of access to care on cost, care needs and mortality?**

Answer: We have not sponsored studies specifically on cost, care needs or mortality impacts as a result of Medicaid access to care; however, we agree that assuring access to care for Medicaid beneficiaries is crucial to manage the costs of individuals with chronic conditions. To help improve access to quality care for individuals with chronic conditions, Medicaid issued guidance in 2010 on a "State Option to Provide Health Homes for Enrollees with Chronic Conditions."[23] This state option, required by section 2703 of the Affordable Care Act, provides states with an opportunity to address and receive additional Federal support for the enhanced integration and coordination of care for individuals with chronic conditions, and thus reduce their chances of premature mortality. Currently, 19 states and the District of Columbia have elected this option. In addition, CMS has released several pieces of sub-regulatory guidance in the form of Informational Bulletins that clarifies Federal expectations and provides best practices on the delivery of services for conditions such as Autism Spectrum Disorders and Mental Health and Substance Use Disorders. All of these documents are available on the Medicaid.gov website.

It is also important to note that recent studies have shown that Medicaid beneficiaries and individuals with private insurance generally have comparable access to services. In its own testimony, GAO highlighted that according to national survey data, access to medical care reported by Medicaid enrollees is generally comparable to that of individuals with private health insurance, with few (less than four percent) reporting difficulty obtaining necessary medical care in 2008 and 2009.

Medicaid beneficiaries and the privately insured have comparable access to preventive and primary care. The small percentage reporting that children delayed or went without care is the same between Medicaid and privately insured children.[24] In addition, children are similarly likely to have had a primary care visit in the past year whether they are publicly or privately insured.[25] Similar results were found in a study analyzing data from the 2012 National Health Interview Survey.

Numerous studies also have shown that adults in Medicaid were less likely to report unmet needs for medical care, prescription drugs, and mental health care, compared with privately insured

[23] More information on health homes is available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10024.pdf
[24] *Health, United States, 2012*, National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, May 2013.
[25] *2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP*, U.S. Department of Health and Human Services, December 2012.
[26] http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/
[27] http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

adults. These results are largely consistent with findings from other studies comparing Medicaid and privately insured adults' access and utilization.[26]

2. **Have you examined the published evidence of Medicaid patient access barriers to podiatrists and the experience of state Medicaid programs that have ensured access to podiatrists?**

Answer: Podiatry is an optional Medicaid state plan benefit. While we have not specifically examined access barriers to podiatry services, overall access to care in the Medicaid program is an important priority for CMS. CMS issued an NPRM on May 6, 2011, that proposes new processes for states to document access to care in the Medicaid program. The rule would require states to review and monitor program data that indicates sufficient access as well as solicit feedback on access concerns from beneficiaries and other stakeholders. CMS is working to finalize this NPRM.

3. **A recent GAO report notes that CMS authorized federal Medicaid funding in five states for more than 150 state programs. As I noted at the hearing, based on their names, many of these programs appear to be for very worthwhile causes. However, it is difficult to see how some of these state funded programs promote Medicaid programs objectives. In order for us to understand why CMS thought authorizing federal Medicaid funding was appropriate, please provide the following information for <u>each</u> of the programs listed below:**

    - **The program's target population**
    - **Whether the program is focused on individuals with a certain level of income and if so, the income level of the program's recipients**
    - **How CMS believes the program promote Medicaid objectives**

<u>List of selected state programs funded by CMS under demonstration programs</u>

State	Programs
California	Acquired Immunodeficiency virus (AIDS) Drug Assistance Program
California	Department of developmental services
California	Song Brown healthcare workforce training program
California	Steven M. Thompson physician corps loan repayment program
Massachusetts	Department of Corrections - DPH/Shattuck Hospital Services
Massachusetts	Department of Public Health – Sexual assault nurse examiners program
Massachusetts	Public Health Programs for Prostate Health Awareness
Massachusetts	Public Health Programs for Multiple Sclerosis

[26] Long S et al., "How Well Does Medicaid Work in Improving Access to Care?" *Health Services Research* 40(1), February 2005. Coughlin T et al., "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs* 24(4), July/August 2005. Coughlin T et al., "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults," *Kaiser Commission on Medicaid and the Uninsured*, May 2013.

Massachusetts	**Public Health Programs for Stroke Education and Public Awareness**
Massachusetts	**Public Health Programs for Ovarian Cancer Screening, Education, and Prevention**
Massachusetts	**Public Health Programs for Diabetes Screening and Outreach**
Massachusetts	**Public Health Programs for Breast Cancer Prevention**
Massachusetts	**Public Health Programs for Universal Immunization**
Massachusetts	**Executive Office of Elder Affairs - Grants to Councils on Aging**
Massachusetts	**Center for Health Information and Finance – Fisherman's partnership**
Massachusetts	**Turning 22 (various programs with the Commission for the Blind and the Rehabilitation Commission)**
Massachusetts	**Department of Veterans' Services – Veterans' benefits**
New York	**Health Care Reform Act: Tobacco Use Prevention and Control**
New York	**Health Care Reform Act: Health workforce retraining**
New York	**Health Care Reform Act: Recruitment and Retention of Health Care Workers**
New York	**Health Care Reform Act: Telemedicine Demonstration**
New York	**Health Care Reform Act: Pay for Performance Initiatives**
New York	**Office of Aging: Community services for the elderly**
New York	**Office of Children and Family Services: Committees on special education direct care programs**
New York	**Childhood Lead Poisoning Primary Prevention**
New York	**Healthy Neighborhoods Program**
New York	**Newborn Screening Programs**
New York	**Office of Mental Health: Residential (Non-Treatment)**
New York	**Office of People with Developmental Disabilities Services: Day training**
New York	**Office of People with Developmental Disabilities Services: Pre-vocational services**
New York	**Office of People with Developmental Disabilities Services: Jervis clinic**
New York	**Office of Temporary and Disability Assistance: Homeless health services**
Oregon	**Addictions and Mental Health Program Group: Special projects**
Oregon	**Addictions and Mental Health Program Group: Community crisis**
Oregon	**Addictions and Mental Health Program Group: Homeless**
Oregon	**Children, Adults and Families Program Group: Community Based Domestic Violence**
Oregon	**Children, Adults and Families Program Group: Foster care prevention**
Oregon	**Children, Adults and Families Program Group: Project for parenting**
Oregon	**Public Health Division Program Group: Licensing fees**
Oregon	**Public Health Division Program Group: Newborn screening (used for match for the maternal and child health block grant)**

Oregon	Office of Private Health Partnerships: Oregon medical insurance pool
Vermont	State-Funded Marketplace Subsidies Program

Answer: The table below provides further details on programs identified as eligible for Federal match as authorized by the state's approved section 1115 demonstration, and notes the target population and how they promote Medicaid objectives.

State	Program Name	Program population and how the authorized program furthers Medicaid objectives
CA	AIDS Drug Assistance Program	Provides prescription drug coverage for uninsured and under-insured individuals who are HIV positive, to ensure that they have access to medication. This program provides crucial access to services to improve health outcomes for Medicaid and low-income individuals.
CA	Department of Developmental Services	Ensures individuals with disabilities receive the services and supports needed to live independent and productive lives. Program serves individuals with intellectual disabilities, cerebral palsy, epilepsy, autism and related conditions. This program provides access to critical services which can improve health outcomes for Medicaid and low-income individuals.
CA	Song Brown HealthCare Workforce Training Program	Trains and educates residents and students by providing clinical training in Areas of Unmet Need. This program strengthens providers and provider networks available to serve Medicaid and low-income populations while increasing the quality of care for Medicaid.
CA	Steven M. Thompson Physician Corp Loan Repayment Program	Awards a loan repayment to recent graduates in exchange for a three-year commitment to practice direct patient care in a medically underserved area. This program increases access to and strengthens providers and provider networks available to serve Medicaid and low-income individuals.
MA	DOC Department of Corrections - DPH/Shattuck Hospital Services	Provides hospital services at DPH Shattuck hospital for inmates of DOC facilities to increase the quality of care for Medicaid and improve health outcomes for Medicaid and low-income individuals.
MA	Sexual Assault Nurse Examiner Program	Through specially-trained nurses or physicians, collects forensic evidence and provides comprehensive care to survivors of sexual assault ages 12 and over in designated hospital emergency departments and urgent care centers. Providing these services can improve health outcomes for Medicaid and low-income individuals.

MA	DPH Prostate Cancer Prevention - Screening component	Provides education and outreach to men and their families, and opportunities for prostate cancer screenings. This program can improve quality of care and health outcomes for Medicaid and low-income individuals.
MA	DPH Multiple Sclerosis	Provides service coordination for individualized, flexible assistance to individuals with multiple sclerosis and their families on a state-wide basis. This program provides access to services that can improve outcomes for Medicaid and low-income individuals.
MA	DPH Stroke Education and Public Awareness	Provides stroke treatment and an ongoing stroke prevention program. This program can improve health outcomes for Medicaid and low-income individuals.
MA	DPH Ovarian Cancer Screening, Education, and Prevention	Provides ovarian cancer screenings, education, and prevention activities resulting in increased quality of care and better health outcomes for Medicaid and low-income individuals.
MA	DPH Diabetes Screening and Outreach	Provides screening and outreach activities related to diabetes, resulting in better health outcomes for Medicaid and low-income individuals.
MA	DPH Breast Cancer Prevention	Provides direct clinical services including: breast cancer screenings, exams, and follow-up diagnostic tests and procedures, leading to better health outcomes for Medicaid and low-income individuals.
MA	DPH Universal Immunization Program	Significantly reduces the incidence of vaccine preventable diseases by achieving and maintaining immunization rates of over 90 percent in two-year-old children throughout the Commonwealth. This program can improve health outcomes for Medicaid and low-income children.
MA	ELD Grants to Councils on Aging	Provides grant funding to cities and towns to provide critical services to elderly adults so they may remain independent, productive and in the community. These services increase access to providers for low-income seniors and strengthens their overall coverage while helping these individuals remain in their own communities.
MA	HCF Fisherman's Partnership	Since July 2011, assists fishing families with completing health insurance applications and connecting families with professional counseling services, as needed. Through June 2011, the program offered these individuals the opportunity to purchase health insurance at a reduced rate, strengthening health care coverage for previously-uninsured or chronically under-insured individuals.
MA	"Turning 22"	Provides a planning process and services for young adults with severe disabilities as they leave special education and transition into the adult service system. These programs can strengthen

		health outcomes for Medicaid and low-income individuals.
MA	VET Veterans' Benefits	Provides a percent reimbursement for the medical costs and health insurance (and Medicare Part B) premiums of qualifying veterans, as submitted by local veterans' agencies. Qualifying veterans, and some qualifying dependents of veterans, are eligible if their income is at or below 200 percent of the FPL. By assisting these individuals with medical costs, this program provides increased access and improved outcomes for Medicaid and low-income individuals.
NY	Health Care Reform Act: Tobacco Use Prevention and Control	Implements a policy-driven, population and evidence-based approach designed to prevent youth from smoking and motivate adult smokers to quit. Preventing tobacco use can improve health outcomes for Medicaid and low-income individuals, which are disproportionately impacted by tobacco use.
NY	Health Care Reform Act: Health Workforce Retraining	Trains health care workers for positions and occupations with shortages of health care workers and provide employment for health care workers who need new jobs and/or new skills because of changes in the health care delivery system. This program can strengthen providers and provider networks available to Medicaid and low-income individuals.
NY	Health Care Reform Act: Recruitment and Retention of Health Care Workers	Promotes health care worker recruitment and retention in hospitals, nursing homes and clinics, and among certain home care providers. This program can increase access to stabilize, and strengthen, providers and provider networks available to Medicaid and low-income individuals.
NY	Health Care Reform Act: Telemedicine Demonstration (expired)	Generated additional knowledge and experience on, and collected information relating to, the use of telemedicine technologies in the home care setting. Providing telemedicine can improve health outcomes for Medicaid and low-income individuals and increase efficiency and quality of care. This authority expired on March 31, 2014.
NY	Health Care Reform Act: Pay for Performance Initiatives (expired)	Assisted the state to fund up to five regional demonstrations in the Fall of 2006 to transform the service delivery networks. The demonstrations involved collaboration between multiple insurers and providers as they work towards developing physician incentive programs designed to promote patient safety and quality of care, which can improve Medicaid health outcomes. This authority expired on March 31, 2014.
NY	State Office on Aging: Community Services for the Elderly	Provides a broad range of community-based supportive services to allow frail, elderly individuals to maintain their independence and remain in the community, thus avoiding the need for institutional care. These services can improve health outcomes for Medicaid and low-income seniors by helping these individuals to remain in the community.

NY	Office of Children and Family Services: Committees on Special Education direct care programs	Serve as the primary placing system for providing special education services for children with educational disabilities. Providing access to these critical services can improve outcomes for Medicaid and low-income individuals.
NY	Childhood Lead Poisoning Primary Prevention	Increases the availability and number of housing units that are free of lead-based paint hazards in targeted communities identified with high incidence of childhood lead poisoning, in an effort to eliminate such poisoning in the state. Preventing lead poisoning can improve health outcomes for Medicaid and low-income children, who are disproportionately impacted by lead poisoning.
NY	Healthy Neighborhoods Program	Seeks to reduce the burden of housing related illnesses and injury through a holistic, healthy homes approach. The program provides assessments and interventions for asthma, tobacco cessation, indoor air quality, lead, fire safety, and other environmental health hazards in selected communities throughout New York State. This program can lead to better health outcomes for Medicaid and low-income individuals by assessing homes for environmental health and safety issues.
NY	Newborn Screening Programs	Performs more than 11 million screens annually for more than 40 congenital disorders and exposure to HIV. This program can improve health outcomes for Medicaid and low-income individuals by testing approximately quarter of a million babies born each year in New York State.
NY	Office of Mental Health: Residential (Non-Treatment)	Serve adults and/or children diagnosed with a Serious and Mental Illness or Serious Emotional Disturbance. Providing these supports can improve health outcomes for Medicaid and low-income individuals with disabilities.
NY	Office for People with Developmental Disabilities: Day Training	Provides services to individuals with disabilities that offer "wrap around" sheltered workshops or provide recreational service options for individuals who are interested in a less active environment than is available at the workshop. These services can improve health outcomes for Medicaid and low-income individuals.
NY	Office for People with Developmental Disabilities: George A. Jervis Clinic	Serves individuals with developmental disabilities and their families as a specialized diagnostic and research center. The neurological, psychiatric behavioral, and genetic services offered at the clinic include evaluation for autism, developmental disabilities, cerebral palsy, seizure disorders, dementia, speech and behavioral abnormalities. These services can improve health outcomes for Medicaid and low-income individuals.

NY	Office for People with Developmental Disabilities: Pre-vocational Services	Provides prevocational services individuals with disabilities to help prepare them for paid employment. Prevocational services teach such concepts as following directions, attending to task, task completion, problem solving, and safety. These services can lead to better outcomes for Medicaid and low-income individuals with disabilities.
NY	Homeless Health Services	Provides shelter, constructing supportive housing, and offering essential services to stabilize housing situations and increase levels of self-sufficiency. This program's continuum of services improves health outcomes for Medicaid and low-income individuals.
OR	Mental Health Special Projects	Provides critical supports such as counseling and crisis support to individuals with a mental health condition to enable these individual to remain in the community and provides access to supported employment. These services can improve health outcomes for Medicaid and low-income individuals.
OR	Community Crisis	Provides immediate mental health crisis intervention (24/7) and assessment; triage and intervention services (psychological treatment services and crisis counseling services) delivered to individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. These services can improve health outcomes for Medicaid and low-income individuals.
OR	Homeless (MH and Alcohol and Drug)	Provides critical mental health services such as outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, and case management services to homeless individuals. These services can improve health outcomes for Medicaid and low-income homeless individuals.
OR	Community Based Domestic Violence	Provides contracted services for Domestic Violence Advocates to provide support and treatment services to individuals who are victims of domestic violence. These services can improve health outcomes for Medicaid and low-income homeless individuals.
OR	Foster Care Prevention	Provides therapeutic supports, in-home case management, and counseling services to families with children at risk of out-of-home placement. The services provided by through this program can improve health outcomes for Medicaid and low-income individuals.
OR	IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)	Provides additional supports in the form of peer mentoring or relationship based visitation for parents and children served by Child Welfare. These supports can improve health outcomes for Medicaid and low-income individuals.
OR	Licensing Fee	Regulates, inspects, licenses and provides certification and approval for the following entities and individuals: Ambulatory Surgical Centers, Birthing Centers, Dialysis Facilities,

		Hemodialysis Technicians, Home Health Agencies, Hospice Agencies, Hospitals, In-Home Care Agencies, Special Inpatient Care Facilities, Trauma Hospital designations. This program strengthens provider networks available to Medicaid and low-income individuals by ensuring these individuals are able to access safe, high-quality care, resulting in improved health outcomes for Medicaid and low-income individuals.
OR	PHD Laboratory Northwest Regional Newborn screening Program	Screens all newborn infants to prevent intellectual disabilities and premature death in children through early detection and treatment of congenital disorders. Through early detection and treatment of congenital disorders, this program can improve health outcomes of Medicaid and low-income individuals.
OR	Oregon Medical Insurance Pool (expired)	Served as the high-risk health insurance pool as established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. This program increased access and strengthened health care coverage for low-income individuals in the state. This program expired June 30, 2014.
VT	State-Funded Marketplace Subsidies Program	Effective January 1, 2014, expenditures for state-funded subsidy programs that provide assistance to certain individuals who purchase health insurance through the Marketplace. This program increases and strengthens health care coverage for low-income individuals in the state. This program provides subsidies for individuals with income up to 300 percent of the FPL. Prior to 2014, Vermont provided premium subsidies for individuals with income up to 300 percent of the FPL under its Global Commitment to Health demonstration.

The Honorable Representative Brooks

1. **If another state wants to replicate the Indiana HIP 2.0 model – or any other wavier program that has been approved for in another state – is there an expedited process for states wanting to replicate previously approved waiver programs or will they have to start from ground zero? Is CMS examining ways in which these types of waiver requests can be expedited?**

    a. **Are the waivers that Indiana received available to other states? If not, why is this not the case?**

Answer: As described in our response to Representative Pitts' first question, when several states express interest in a specific policy area, CMS will often issue guidance to states related to the use of section 1115 authority to test new approaches in that particular policy area. Examples of this include the guidance we released regarding managed long term services and supports demonstrations, as well as the guidance regarding QHP premium assistance demonstrations.

It is also important to recognize, however, that successful innovations in one state may not entirely transfer to another state, given the unique characteristics of state populations, delivery systems, and existing state Medicaid programs. In some cases where new approaches are being tested, such as in Indiana's HIP 2.0 approved earlier in 2015, it is also important to evaluate the impact of the new approaches being tested in section 1115 demonstrations before approving similar policies in other states. CMS is committed to working directly with states that are interested in pursuing innovations that are working in other states and considering how results of state-based demonstrations can influence broader Medicaid policy, while still ensuring key beneficiary protections and meeting the objectives of the Medicaid program.

In addition, CMS has taken steps to streamline the application process for section 1115 demonstrations and enhance transparency of the review process. For example, CMS developed a section 1115 demonstration application template, for states to use at their option, to simplify the application process.

Finally, in a Final Rule published on February 27, 2012, CMS standardized the section 1115 demonstration application process and established a process for ensuring public input into the development and approval of demonstrations. The final rule helps to ensure public input and that the development and review of demonstration applications will proceed in a timely and responsive manner.

2. **It is my understanding that unlike state plan amendments and waivers under Section 1915, CMS has no set period of time for reviewing and responding to 1115 demonstration requests. Analysis has shown that the average time between application submission and approval for a new Medicaid waiver was 337 days (and that does not account negotiations between States and CMS prior to the official submission of the waiver application). For example, the Medicaid expansion in Indiana, often referred to as "Healthy Indiana Plan 2.0," took two years from the beginning of negotiations until the waiver was granted. That is half of a Governor's term in office. Would CMS**

oppose any effort to put parameters around the process to provide some certainty for states?

a. **If yes – So you don't think it's fair that CMS be held accountable to some timeframe for review?**
b. **If no – Great. Would you commit to working with this Committee on legislative proposals to do that?**

Answer to a&b: Since 2012, the average time between application submission and approval for a new section 1115 demonstration has been less than six months. This does not include the time prior to an application, when the state may be seeking technical assistance from CMS to develop its proposal. CMS makes every effort to respond to states in a timely manner and has taken steps to streamline the review and approval process. We have designed a section 1115 demonstration application template that is available for states to use at their option to help ensure, among other things, that they are providing CMS with the information needed to review a section 1115 demonstration application in accordance with Federal regulation.

That being said, each state's application is unique and the complexity and goals of the request will dictate the length of time needed for review. At times, states add to and revise their initial requests, which can also lengthen the time that it takes to approve a demonstration. Given that beneficiary experience, payment to providers and Federal dollars are at stake, we want to ensure that we are being thorough in our review.

The Honorable Representative Collins

1. **The Medicaid program is already on OMB's list of high error programs and thus I would hope that CMS would be diligently working to reduce improper payments in the program. Thus, you could understand why I was dismayed to learn that CMS actually revised its target error rate upward from 5.6 percent for 2014 to 6.7 percent for 2015.**

    a. **Can you explain why CMS would set a lower bar for itself and raise the Medicaid improper payment rate target?**
    b. **How does CMS determine its target rate?**

Answer to a&b: CMS reviews states in cycles such that one third of the states are measured each year. The Medicaid improper payment rate is a rolling rate that includes findings from the most recent three cycle measurements so that all 50 states and the District of Columbia are captured in one rate. Each time a group of 17 states is measured, the previous findings for that group of states are dropped from the calculation and the newest findings are added. Therefore, the only factor that determines an increase or decrease in the national improper payment rate from year to year is whether or not the improper payment rates for one cycle of states increased or decreased from the last time they were measured.

The primary reason for the 2014 Medicaid improper payment rate increase was errors identified relating to state claims-processing systems not being fully compliant with new requirements. If the non-compliance errors related to these new requirements were removed from the measurement, the 2014 Medicaid improper payment rate would have decreased from 2013, meaning that improvement was made in every other aspect of the program. While these requirements will ultimately strengthen the integrity of the program, they require systems and process changes that, at the time of the error measurement, many states had not fully implemented.

When the 2014 improper payment rate was calculated and reported in November 2014, it was clear that states under review for 2015 and 2016 would have the same errors relating to non-compliance with new requirements as states work to implement them. In 2015, CMS will report on the review of claims paid October 1, 2013, through September 30, 2014, so any corrective actions taken more recently will not have an impact on the 2015 improper payment rate.

Setting the 2015 target equal to the 2014 improper payment rate was aggressive yet still realistic. CMS anticipated that the rates in the 2015 cycle of states would be impacted by errors relating to non-compliance with new provider screening and enrollment requirements because these were not a factor the last time this cycle of states was measured. We do expect to see improvement related to other issues, such as insufficient documentation errors and provider billing errors, because states received information on these topics and have worked to minimize these errors since the last time they were measured.

c. **Does raising it conflict with any of CMS' internal control practices?**

Answer: Internal control practices are followed when setting improper payment rate targets. Improper payment rate targets follow the same clearance process as the HHS AFR,

which is reviewed and cleared by CMS, HHS, and the Office of Management and Budget (OMB). The 2015 Medicaid improper payment rate target was reviewed and cleared by CMS, HHS, and OMB.

d. Who ultimately approves Medicaid's improper payment rate target? Do you?

Answer: Per OMB Circular A-123 Appendix C, reduction targets must be approved by CMS, HHS, and OMB as part of the review and clearance of the HHS AFR.

e. What is your role in determining the Medicaid improper payment rate target?

Answer: Each year CMS, in conjunction with HHS, proposes improper payment targets that are approved by CMS, HHS, and OMB and published in the HHS AFR.

The CMS managed care proposed rule includes additional minimum elements that Medicaid managed care plans must include in their provider directories, including whether providers are accepting new patients, and requires states to update their electronic directories within 3 business days of receiving updated provider information. To what extent are states that provide services under Medicaid fee-for-service required to provide similar information on available providers to Medicaid beneficiaries?

f. Earlier this month, Matt Salo, Executive Director of the National Association of the Medicaid Directors, said before this Committee that fee-for-service too often effectively meant "fend for self." What could be done to improve the information available to Medicaid beneficiaries served under fee-for-service to help them find providers?

Answer: CMS works closely with stakeholders at the local, state, and national level, including NAMD, to help ensure that state Medicaid programs provide beneficiaries with the care they need in a timely manner. CMS will continue to work with states and with NAMD to determine the most effective ways to provide information about care delivery to beneficiaries served under a fee-for-service delivery system.

CMS is also working to improve the information and approaches that states rely on to document access to care in their programs. On May 6, 2011, CMS issued the NPRM "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services" (76 FR 26342). The NPRM, for the first time, proposed a specific process through which states would document that their payment FFS rates provide access to care consistent with the requirements of the Act. Through a transparent process, all states would rely on data and information from beneficiaries, providers and other stakeholders to ensure access to care is available to Medicaid beneficiaries to the extent that care and services are available to the general population in a geographic area. The NPRM, which applies to services that states cover through the Medicaid state plan, is scheduled to be finalized later in 2015.

Finally, CMS has made changes to the Medicaid.gov and Insure Kids Now websites to help provide more program information and resources to individuals and parents. Specifically, Medicaid.gov now includes a new "Outreach Tools" web page, which highlights a section and

dedicated link to "Helping Connect Enrollees to Care." the Insure Kids Now website includes a "Find a Dentist" tool as part of a search tool available to consumers looking for information on health insurance programs and dental providers within a state.[27]

2. **HHS OIG has a long standing recommendation that Medicaid payments to public providers should be limited to the cost of providing those services. But OIG and GAO have continued to identify examples where States make Medicaid payments to certain health care providers for services that far exceed the cost of providing those services. Often these involve financing mechanisms to obtain Federal Medicaid funds without committing the States' shares of required matching funds or, by other means, artificially inflating the Federal share.**

    a. **Why does CMS allow state Medicaid programs to pay state and local government facilities providing Medicaid services at rates well above the cost of providing those services?**
    b. **What actions has CMS taken to ensure that Medicaid providers are paid appropriately for the services they provide, while at the same time ensuring that costs of providing care aren't inappropriately shifted to the Federal Government?**

Answer to a&b: States establish their own Medicaid provider payment rates within broad Federal guidelines, and base the rates on many factors, including, but not limited to, the underlying costs of providing the services, and payment rates by Medicare or commercial payers in the local community. CMS oversees and reviews state payment policies for consistency with statute and Federal regulations. CMS also sets the outer bound for how much states can pay providers in certain fee-for services arrangements. The Medicaid Upper Payment Limit requirements provide that payments, in the aggregate, for inpatient hospital, outpatient hospital, clinic, nursing facility, and other services are not allowed to exceed an estimate of what Medicare would have paid for the same services. In addition, CMS carefully oversees and evaluates state funding sources for the non-Federal share of the state Medicaid program in order to enforce the statutory balance between the state and Federal share of Medicaid funding. CMS has recently issued additional guidance in this area, including a May 2014 State Medicaid Director Letter #14-004, which provided clarifying guidance to states concerning Federal statute and regulations related to the allowable and unallowable use of provider-related donations as the non-Federal share of Medicaid payments and also addressed the use of certain types of public-private arrangements, such as Low-Income and Needy Care Collaboration Agreements, Collaborative Endeavor Agreements, and Public-Private Partnerships.

[27] http://www.insurekidsnow.gov/state/

The Honorable Representative Matsui

1. **Can you comment on the ability of states to use waivers to make new and innovative changes to their Medicaid program? Please include any comments you have on California's success.**

Answer: Section 1115 demonstration authority enables the Secretary to provide states with additional flexibility to design and test new and innovative policies that promote the objectives of the Medicaid program. As explained in the answer to Chairman Pitts' question #1, we apply the same four criteria, which are posted on Medicaid.gov, to all states, focusing on meeting Medicaid's objectives and improving the health of vulnerable, low-income individuals. Through its demonstration, California established the first DSRIP program, as a way to use supplemental provider payments to provide incentives to public hospitals to improve quality of care and population health. The concept of DSRIP has been expanded and further refined by other states and CMS, and has the potential to strengthen delivery system reform efforts in several states. The DSRIP and coverage expansion components of California's demonstration also helped prepare the state's health care system for the broad expansion of Medicaid coverage in 2014. CMS continues to be willing to work with California and with all states on demonstration requests that further the objectives of the Medicaid program.

2. **How is the Medicaid program, especially through waivers and demonstration projects, making a difference in the mental health system?**

Answer: In April, we released an NPRM proposing to apply certain provisions of the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid and CHIP. The NPRM ensures that all beneficiaries who receive services through managed care organizations or under alternative benefit plans have access to mental health and substance use disorder benefits regardless of whether services are provided through the managed care organization or another service delivery system. We are continuing to work on the Final Rule. We plan to provide technical assistance to states to help with the implementation of the Final Rule and to improve quality control with respect to the requirements of mental health parity. Finally, we plan to analyze the impact of the requirements of parity on Medicaid and CHIP coverage for behavioral health conditions, access to treatment, service delivery, and health outcomes.

CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014, designed to support state Medicaid agencies' ongoing health care delivery reform efforts in key program priority areas by providing targeted, technical programmatic support. Based on our work with states and stakeholders, CMS identified reducing substance-use disorders as an area of focus for IAP efforts, as well as physical and behavioral health integration, community integration-long-term services and supports, and Medicaid beneficiaries with complex care needs and high cost. We are working intensively right now with seven states via a high intensity learning to improve the care and outcomes for Medicaid beneficiaries with substance-use disorders, by leveraging IAP resources to introduce policy and infrastructure changes that better identify individuals with an substance-use disorder, expand coverage for effective substance-use disorder treatment, and enhance substance-use disorder practices delivered to beneficiaries.

The Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with CMS and ASPE, intends to award a total of $25 million in planning grants to up to 25 states to support their efforts to improve behavioral health services under the Medicaid program by providing community-based mental health and substance-use-disorder treatment.

Authorized under section 223 of the Protecting Access to Medicare Act of 2014, the planning grants are part of a comprehensive effort to integrate behavioral health with physical health care, utilize evidence-based practices on a more consistent basis, and improve access to high quality care. The planning grants will be used to support states to certify community behavioral health clinics, solicit input from stakeholders, establish prospective payment systems for demonstration reimbursable services, and prepare an application to participate in the demonstration program.

CMS, in conjunction with SAMHSA and ASPE, will provide intensive technical assistance to states throughout the one-year planning phase of the demonstration. When the planning grant phase ends, up to eight states will be selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics. CMS, in consultation with ASPE and SAMHSA, developed an innovative prospective payment system rate methodology that will be used to pay these clinics for demonstration services.

3. **Under your leadership, CMS recently released the first major proposed update to Medicaid and CHIP managed care rules since 2003. One of the provisions of the proposed rule would provide flexibility for Medicaid managed care on the so-called IMD exclusion, which prevents Medicaid from paying for inpatient mental health services in facilities with more than 16 beds. Can you please elaborate on that policy and how it is intended to strike the right balance between ability to provide inpatient services and emphasis on community-based care?**

Answer: Medicaid is the largest payer for mental health services in the United States, comprising 27 percent of all mental health expenditures. CMS recognizes that different treatment settings can offer unique benefits to individuals with mental illness or substance-use disorder and has several initiatives to help states implement innovative models to deliver care to these individuals, including the Medicaid Emergency Psychiatric Demonstration Program, and Health Homes for Enrollees with Chronic Conditions. In addition, over the past three years, CMS has developed and disseminated informational bulletins that provide information on community-based evidence-based practices for mental health and substance use disorders.

Additionally, as you noted, the recently-released proposed rule on Medicaid managed care proposes that managed care plans may receive a capitation payment from the state for enrollees who have a short term stay of no more than 15 days per month in an institution for mental disease (IMD) so long as the facility is an inpatient hospital facility or a sub-acute facility providing short term crisis residential services. We specifically included short term crisis residential services to offer a community based alternative to individuals needing inpatient hospitalization. The proposal recognizes that managed care plans have some flexibility to provide access to covered services while ensuring that use of an alternate appropriate setting does not endanger beneficiaries' overall entitlement to Medicaid benefits for the entire month during which a short term stay occurs; CMS is sensitive to ensuring compliance with IMD

exclusion in section 1905 of the Act. We are in the process of reviewing comments received on the NPRM and anticipate issuing a Final Rule in 2016.

4. **CMS has been taking a closer look at mental health and behavioral health integration. For example, both are prioritized in the new Medicaid Innovation Accelerator Program. What type of work will CMS undertake to plan the agency's approach in this area, such as integrating behavioral health in managed care? Are you seeing promising state innovations in behavioral health on the ground now (especially in California)?**

Answer: Through the Medicaid IAP, we are working actively right now with seven states to improve the care and outcomes for Medicaid beneficiaries with substance-use disorders, by leveraging IAP resources to introduce policy and infrastructure changes that better identify individuals with a substance-use disorder, expand coverage for effective substance-use disorder treatment, and enhance substance-use disorder practices delivered to beneficiaries. In addition to substance use disorders, we are also planning to offer states program support through an IAP track related to physical-mental health integration. In December 2015, CMS will hold an information session for states interested in learning about the type of IAP program support available related to physical-mental health integration. Through this IAP opportunity, it is anticipated that selected states will improve their capacity for data analytics and quality measurement, and develop and/or operationalize approaches to payment and contracting for physical and mental health integration.

5. **Can you provide any examples of how telehealth is improving access to care in the Medicaid program? I know that California has been working on tele-dentistry projects and that Blue Cross of California's rural-urban telemedicine demonstration has shown some success.**

Answer: For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (*e.g.,* face-to-face consultations or examinations between provider and patient) that states can choose to cover under Medicaid. This definition is modeled on Medicare's definition of telehealth services (42 CFR 410.78).

Through the Health Care Innovation Awards, California is working with partners from Montana, Washington, and Wyoming to provide a Patient Centered Medical Home Program with mental health and substance use disorder services in areas where geography and lack of psychiatrists and psychologists complicate access. This model will offer videoconferencing between local patients and HealthLinkNow psychiatrists; instant messaging, email, and telephone calls via HealthLinkNow between providers and patients; and a HealthLinkNow IT platform that allows billing, e-prescribing, and practice management. The program will improve access to psychiatric consultations, therapy, and long-term mental health case management. We anticipate lower costs through reduced hospital admissions and emergency room visits. Over a three-year period, HealthLinkNow will hire 24 health care providers, including both psychiatrists and therapists.

The Honorable Representative Lujan

1. **At the moment, are you confident that New Mexicans enrolled in Medicaid have adequate access to behavioral health services?**

Answer: We share your concern about the need for adequate access to behavioral health services in New Mexico. While we are confident that the state has made progress in addressing this issue, we do not have sufficient reliable data on which to evaluate whether Medicaid beneficiaries in the state have adequate access to behavioral health services.

CMS has reviewed several sources of data from the state and it is difficult for us to make an informed assessment of access to behavioral health services using this data. Historic data reporting does not provide a good baseline for comparisons with more current data. The historic data have limitations including the completeness of the data, the ability to analyze trends over time, and the ability to identify which geographic areas and populations may be experiencing decreases in utilization and therefore would indicate potential access issues.

For these reasons, CMS has been working with New Mexico to develop a stronger data approach. The state Behavioral Health Collaborative is currently submitting quarterly reports that include data on utilization of behavioral health services by Medicaid beneficiaries and by the uninsured. At our request, the state has engaged its External Quality Review Organization (EQRO) to undertake an independent validation of this data. Once the EQRO has completed its analysis, we will be in a better position to draw evidence-based conclusions about the adequacy of access to behavioral health services by Medicaid beneficiaries in New Mexico.

This past summer, the Human Services Department (HSD) embarked on a strategic planning process that will develop and implement recommendations to improve access to behavioral health services by Medicaid beneficiaries and the uninsured. In the course of this process, the state is looking at current barriers to the availability of behavioral health providers and is examining payment strategies to provide incentives for providers to serve these populations. The behavioral health strategic plan is expected to be completed by December 2015 and reviewed by the Behavioral Health Collaborative of state agencies (mental health, corrections, child welfare, etc.) in January 2016 prior to implementation.

2. **When CMS has serious concerns about access to key health services in a state, how do you work with the state to address those concerns? And specifically, what steps are you taking in New Mexico?**

Answer: As you know, we have worked closely with the state over the past several years and encouraged them to develop strategies to enhance behavioral health services and providers in the state. Specifically, we have worked with the state to improve its stakeholder communications and access to information regarding services to beneficiaries with behavioral health needs through the Independent Consumer Support System. We meet bi-weekly with the state to discuss many aspects of Centennial Care, and in particular, the ongoing efforts to increase access to behavioral health services.

We believe these meetings helped the state and MCOs reduce the number of abrupt transitions experienced by beneficiaries, such as those experienced in 2013. For example, in these meetings the state has provided us with information regarding providers who are at risk for leaving the network thereby affecting network adequacy, and the steps it was taking to mitigate these risks. When the state identified three at-risk providers, we set up additional meetings with the state to assist with planning for the transitions of beneficiaries who receive care from these providers. By closely working with the three affected providers, the state was able to arrange for a longer transition period (in some instances up to five months) to the new providers. In addition, the state provided technical assistance to a provider to strengthen their operations which allowed them to continue to render services to beneficiaries in their service area.

3. **Ms. Wachino, I know that we both agree that CMS has a responsibility to ensure access to care in Medicaid. I believe you've asked the state for a transition plan. Has the state delivered?**

Answer: In December 2013, CMS asked the state for a network development plan that addresses network deficiencies. The state has recently submitted a concept paper to CMS, which is currently under review, which provides information on actions the state is proposing to improve access to services. Specifically, the network development concept paper lays out needed changes in three main areas: regulatory and procedural processes, financial (i.e., payment reforms) and workforce. We are currently reviewing the paper with the state and discussing implementation plans and timeframes.

4. **Finally, what additional enforcement tools do you have when there is concern that states are not meeting their end of the bargain on ensuring equal access?**

Answer: CMS has the authority to require states to collect and analyze utilization data that enables both the state and CMS to assess the extent to which covered services are accessible to Medicaid beneficiaries. As noted above in our response to question 1, CMS has asked for, and New Mexico has agreed to, an independent analysis of behavioral health utilization data in order to determine whether Medicaid beneficiaries face access barriers, and if so, whether those barriers include inadequate provider participation.

CMS regulations at 42 CFR 447.204 require that a state Medicaid agency's payments to providers be "sufficient to enlist enough providers so that services…are available to beneficiaries at least to the extent that those services are available to the general population." Noncompliance with this state Medicaid plan requirement, like noncompliance with any state Medicaid plan requirement, can ultimately result in the loss of Federal Medicaid matching payments until the noncompliance is cured. CMS released a proposed rule in 2011 that proposed to strengthen states' and CMS' approach to ensuring access, which CMS is working to finalize.

Under 42 CFR 430.35(a), if CMS finds that a state fails to comply substantially with a state plan requirement, CMS can withhold Federal matching funds from the state until CMS is satisfied that the state is, and will continue to be, in compliance. Any withholding of Federal matching funds cannot occur until the state has been given notice and opportunity for a hearing. A state also has the right under 42 CFR 430.38 to judicial review of any withholding of Federal funds.

Before withholding Federal funds from a state, CMS makes every effort to work with the state to bring it into compliance. These efforts include notifying the state of the nature and scope of its noncompliance, clarifying for the state what specific steps it needs to take in order to bring itself back into compliance, providing any needed technical assistance, and matching the administrative and benefits costs incurred by the state in returning to and remaining in compliance.

Director Wachino, following the New Mexico delegation's April 2015 meeting with Secretary Burwell, our offices submitted follow up questions on May 20th. Unfortunately, our offices have not yet received answers to these questions:

We know that as a result of the September 2013 visit to New Mexico, CMS issued findings to the state which included areas needing improvement, and a return visit was made in August 2014.

5. **In your estimation, how satisfactorily have your recommendations been implemented?**

Answer: In a December 2013 letter to the state, CMS asked the state to finalize an outstanding memoranda of understanding with providers and schools, and to submit the following:

- A network development plan that addresses network deficiencies;
- A communications plan;
- Documentation ensuring that each Core Service Agency in the state was part of all four MCOs' behavioral health provider network; and,
- Monthly updates on the number of beneficiaries receiving behavioral health services.

Since then, the state has:

- Documented that it has finalized its outstanding memoranda of understanding;
- Documented that each Core Service Agency is in the MCOs' provider networks;
- Developed a strategy to improve communications with stakeholders and providers, including: initial discussion regarding billing and other implementation issues (August and September 2014), holding regularly scheduled town hall meetings which occurred from February through April of 2015, and offering to schedule additional meetings on an as-needed basis to discuss ongoing implementation issues;
- Developed, and is in the process of implementing, a strategic planning process to improve behavioral health services to Medicaid beneficiaries. This strategic planning process includes several workgroups that include state staff, MCOs and stakeholders. The strategic plan is scheduled to be completed by December of 2015 and implemented early 2016;
- Requested that it provide service utilization information to us on a quarterly basis rather than a monthly basis, which CMS has agreed to. This information provides information on the number of individuals served and expenditures on services for inpatient, residential, outpatient and recovery services. The state has provided this information quarterly to CMS since January 2015; and,
- Submitted a concept paper in July 2015 outlining an approach to improving network adequacy which was used to develop the strategic plan described above.

In a January 2015 letter to the state, we outlined several follow-up actions identified during CMS' 2014 site visit. The state has:

- Hosted periodic (quarterly) meetings with the leaders from the behavioral health community to improve communication;
- Provided beneficiaries with behavioral health needs information through the Independent Consumer Support System; and,
- Worked closely with the MCOs and providers to resolve billing issues.

In addition to the above, in March, we requested that the state hold periodic high-level discussions with stakeholders, including scheduling local town hall meetings with communities that were to be affected by yet another transition earlier this year. Based on our conversations with both the state and with the stakeholders that participated in the 2014 site visit, stakeholders have indicated that the state's communication strategy is improving the communication between them and the state. Specifically, and as noted above, the state has implemented a meetings-based communication strategy, which outlines various meetings the state has established, including future meetings it intends to convene to discuss issues as implementation moves forward.

In CMS's assessment, the state has made efforts to respond to our 2013-2015 recommendations, but the extent of the progress the state has made toward addressing the concerns that underlie them is mixed. The state has improved stakeholder communications and has improved access to information regarding services to beneficiaries with behavioral health needs through the Independent Consumer Support System. In terms of the data, it is difficult to make an assessment given the challenges of historic data reporting which fails to provide a good baseline for comparisons with more current data. The state did not respond in a timely manner to our request for a comprehensive network development plan. The pace of that effort, which CMS considers to be essential to addressing issues of access to behavioral health services in the state over the long term, should be accelerated. CMS is completing its review of the concept paper that the state submitted in July and would like the state to complete and implement that plan quickly.

In addition, data reporting and interpreting available data continue to be a challenge. CMS is currently reliant on state-submitted data. The data has significant limitations including the completeness of the data, the ability to analyze trends over time, and the ability to identify which geographic areas and populations may be experiencing a decrease in utilization and, therefore, would indicate potential access issues. CMS is discussing additional data reporting with the state.

6. **Has communication sufficiently improved? Has meaningful quarterly stakeholder meetings continued to occur? And has the Independent Consumer Support System been available to all Medicaid beneficiaries with behavioral health needs?**

Answer: Communication with stakeholders over the past year has improved. The state has held bi-weekly meetings with the Core Service Agencies and the MCOs regarding billing and to obtain input into the New Mexico Behavioral Health Strategic Plan. The state is also holding monthly meetings with the New Mexico Behavioral Health Provider Association, the Behavioral Health Planning Council and its 4 sub-committees, and the Behavioral Health Collaborative

Alliance. The state will set up a monthly meeting with the behavioral health professional associations.

Some of the stakeholder meetings have been more targeted, including in-person meetings with stakeholders in the areas that remain most affected by the 2013 provider transitions. In addition, the state has made changes to the Independent Consumer Support System to make information specific to behavioral health available to all Medicaid beneficiaries. This has included changes to the ICSS website and the dissemination of information regarding the New Mexico Crisis and Access Line which connects consumers and families to the appropriate behavioral health providers in their service area. In addition, the state is in the process of implementing the New Mexico Behavioral Health Network of Care web portal that will provide a statewide resource directory for behavioral health services, a comprehensive peer-reviewed behavioral health resource library, and a password protected consumer web page for the storage of personal health information.

The April 2014 CMS letter to NMHSD expressed concern regarding network inadequacy in certain geographic regions of the state.

7. **How are you monitoring the state's transition plan to address this beyond just receiving reports from the state?**

Answer: We held bi-weekly meetings with the state to review the steps taken to ensure the availability of behavioral health services in certain areas of the state that were affected by an additional transition in early 2015. This included monitoring of the stability of an existing New Mexico provider (Tri County Social Services in Taos) as well as ensuring a smooth transition of beneficiaries from La Frontera and Turquoise Health and Wellness to existing New Mexico providers. Specifically, the state, the MCOs and the incoming providers have taken action to:

- Inform beneficiaries of the change;
- Offer assistance during the transition (care managers at the MCOs, case managers at the new providers and the New Mexico Crisis and Access Line); and,
- Meet with the stakeholders in the affected areas to discuss the transition and address their concerns.

8. **Last June, you told us that you were closely following network adequacy planning. Does CMS expect any other corrective actions now that two Arizona agencies have already pulled out?**

Answer: We continue to closely follow the state's network adequacy planning to ensure beneficiary access to behavioral health services. Specifically, we met with the state on a bi-weekly basis to discuss many aspects of Centennial Care, and in particular, the ongoing efforts to increase access to behavioral health services. In these meetings, the state provided us with information regarding providers who are at risk for leaving the network thereby affecting network adequacy, and the steps it was taking to mitigate these risks. For example, when the state identified three at-risk providers, we set up additional meetings with the state to assist with planning for the transitions of these providers. We believe these meetings helped the state and MCOs reduce the number of abrupt transitions experienced by beneficiaries, such as those in 2013, by closely working with the three affected providers to provide a longer transition

period (in some instances up to five months) to new providers for beneficiaries. In addition, the state provided technical assistance to a provider to strengthen their operations which allowed them to continue to render services to beneficiaries in their service area.

In addition to the bi-weekly meetings described above and the quarterly data and behavioral health collaborative report CMS receives from the state, we continue to meet with the stakeholder community to obtain their feedback on the state's efforts to improve network adequacy. For example, in March 2015, six months after CMS's 2014 site visit, CMS staff convened several follow-up phone calls with the same group of stakeholders that participated in the site visit to see how implementation was going and to hear about any concerns that the stakeholders may have. These conversations, in addition to those CMS had with the state, allow CMS to follow the state's progress in improving network adequacy.

9. **We understand that CMS is working with HSD on a transition plan in the wake of two Arizona providers pulling out of the state. We would appreciate your providing that plan to our offices.**

Answer: Since December 2013, we have requested that the state develop a network development plan to strengthen the availability of the behavioral health services to Medicaid beneficiaries. We did not request a specific transition plan for the two providers but tracked the progress and the specific steps the state and the plans were undertaking to transition beneficiaries from the two existing providers to new providers.

As indicated in the response to question 1 above, the state has recently submitted a concept paper to CMS, which is currently under review, which provides information on actions the state is proposing to improve access to services. Specifically, the network development concept paper lays out needed changes in three main areas: regulatory and procedural processes, financial (*i.e.,* payment reforms) and workforce. We are currently reviewing the paper with the state and discussing implementation plans and timeframes.

We have asked the state to share the concept paper with the delegation.

10. **In the event that CMS determines that access to behavioral health services is insufficient for particular segments of the population, what are the potential applications of 1915(b) waivers to create geographic incentives for providers to increase or expand services for such regions within New Mexico?**

Answer: New Mexico operates its managed care program under section 1115 authority, not section 1915(b) authority; therefore, we do not anticipate the state submitting any section 1915(b) waiver applications to ensure access to behavioral health services. Section 1115 provides flexibility to allow for the implementation and testing of innovative approaches for ensuring access to care, including those that address localized access issues. For instance, we have been working with the state to include new services such as crisis residential services to divert individuals as appropriate from inpatient psychiatric services. CMS is ready to work with New Mexico to address behavioral health access issues that may be encountered. We have offered technical assistance to the state as they develop and implement their strategic plan for behavioral health services. We also offered the state technical assistance regarding their

application for the Certified Community Behavioral Health Center demonstration. Additionally, CMS has provided technical assistance to the state on the coverage of behavioral health services for children under the under section 1905(a) rehabilitative services benefit category. To date, based on CMS comments, the state is working on revising their state plan to come into compliance with Federal requirements.

As you know, two of the Arizona providers HSD brought into New Mexico are already leaving the state due to financial difficulties.

11. **Did you have any sense that these two providers were in financial trouble and would be pulling out of New Mexico?**

Answer: The state provided us with information immediately after being notified by the three providers (including the two Arizona providers) regarding their intentions to leave the network. As discussed in an earlier response, we worked closely with the state to minimize disruption by securing longer transition periods.

12. **Do you have information about the financial health of the remaining Arizona providers? Are you currently collecting any related data? Does CMS has concerns with any of the remaining providers? We appreciate your keeping us informed if and when you do.**

Answer: It is our understanding that MCOs have been assessing the readiness, including operational readiness, of many of the larger New Mexico behavioral health providers. Specifically, we understand the MCOs have engaged Parker Dennison and Associates to do a survey of the revenues and expenditures of these agencies to assess their fiscal stability.

13. **Would you agree that CMS already has the statutory authority to require State compliance regarding continuity of care, network adequacy, and transition planning? Are there additional authorities that you believe would be helpful?**

Answer: The Medicaid managed care regulation at 42 CFR 438.206 requires states to make all state plan covered services available to beneficiaries. If a contracted MCO is unable to provide these services within its network, they must be covered by an out of network provider. The managed care regulations do not currently require states to complete transition planning, although the state does have the responsibility to assure beneficiaries receive the treatment they require as needed. States do have the option to require transition planning as part of their contracts with MCOs. CMS is in the process of strengthening its authorities to oversee states' efforts to ensure that individuals receiving benefits through MCOs maintain access. Specifically, we published an NPRM in the Federal Register on June 1, 2014, that proposed, among other things, to strengthen managed care transition services, continuity of care and network adequacy standards. CMS is in the process of finalizing this NPRM.

14. **What possible sources of emergency funding from HRSA, SAMSHA or other agencies are available to bridge the chasm of behavioral health services, especially in the more rural areas of the state?**

Answer: CMS understands that the Health Resources and Services Administration (HRSA) is looking at ways to support the four health centers (Hidalgo Medical Services/Lordsburg, NM, La Casa de Buena Salud/Portales, NM, La Clinica de Familia/Las Cruces, NM and Presbyterian Medical Services/Santa Fe, NM) who are stepping in to fill this service gap and provide mental health services in southern New Mexico.

These four health centers have been assessing the capacity to meet the increased demand for mental health services. HRSA anticipates that several health centers will open up new service-delivery sites to provide mental health services and address this gap. As health centers add new sites to their program scope through the submission of Change In Scope (CIS) requests, HRSA is prepared to expedite any such CIS requests to address this service gap.

The New Mexico Primary Care Association (PCA) is also engaged in providing support to these health centers and is in regular communication with state officials to address issues faced by the health centers. The PCA is working with the state on an effort to expedite the state Mental Health licensing approval process including the determination of whether each health center's current mental health service scope will satisfy state requirements for the Community Mental Health Agency license.

SAMHSA provides specific technical assistance to providers, counties, tribes, and states to improve access to behavioral health services, to use technologies, and to train existing health providers in mental and substance use skills and interventions. In addition, SAMHSA works with other Agencies, including HRSA, the Indian Health Service, and the Administration for Children and Families on behavioral health issues.

Another issue that I'd like to touch on is data integrity. New Mexico expanded Medicaid and implemented a new Centennial Care program on January 1, 2014 that is administered by four managed care organizations (MCOs). A recent report to the New Mexico State Legislature Finance Committee stated "the amount and quality of utilization data collected by Human Service Department has deteriorated leaving the question of whether enrollees are receiving more or less care under Centennial Care. It is unknown if the current system under Centennial Care is adequate or cost-effective compared to previous years…It is unclear whether most pre-existing behavioral health cohorts are being served at higher or lower levels under Centennial Care."

The report also says that "Spending and number of children served in several key service categories decreased following suspension of Medicaid payments to 15 New Mexico behavioral health providers, and have not recovered under Centennial Care. Although most other program areas do not have comparable utilization data pre-Centennial Care to Centennial Care, some behavioral health service data can be compared due to the existence of similar reporting pre-Centennial Care to Centennial Care on an age group level. Data available for comparison is limited to recipients under 18 years of age."

Again, I want to understand what's happening in my home state so that we can ensure our most vulnerable citizens are protected. But this report troubles me. Without meaningful data, it is impossible to hold policymakers accountable.

15. Ms. Wachino, what is CMS doing to ensure that the data collected by states is meaningful?

Answer: As you know, for capitated managed care programs, encounter data are detailed information regarding the services provided to individual beneficiaries, the equivalent of claims data for fee-for-service arrangements. The Affordable Care Act amended Medicaid authority under title XIX of the Social Security Act with respect to the transparency and availability of managed care encounter data. Specifically, these changes require the submission of encounter data, and CMS is committed to ensuring states report accurate and timely Medicaid encounter data. Medicaid managed care programs deliver health services through contracted arrangements between state Medicaid agencies and managed care entities. In the meantime, CMS will continue to work with states to improve the quality of Medicaid and CHIP data, which is analyzed for completeness and accuracy as states submit to CMS. In addition, CMS issued an NPRM that would impose requirements on states regarding validating the accuracy and completeness of their managed-care data as submitted to them by their Medicaid Managed Care Organizations and also as submitted to CMS via T-MSIS.

In addition to updating our regulations to comply with Affordable Care Act's encounter data requirements, CMS is in the process of transforming the way in which it collects state Medicaid and CHIP claims and eligibility data with the goal of improving the completeness and timeliness of such data. To accomplish this goal, CMS has built a new data collection system: T-MSIS, which supports monthly data submissions rather than the prior schedule of quarterly data submissions to CMS' existing data collection system, MSIS. In order to reduce incomplete data, the Federal IT platform has front-end data validation and a robust rules engine to monitor and improve data quality. With this improved Federal IT infrastructure, the T-MSIS system will also have more data as compared to MSIS. T-MSIS includes over 400 additional data elements and three new state files: a managed care plan file; a provider file; and a third party liability file. The additional files and data elements will allow CMS to conduct more thorough and timely analysis. CMS is working closely with states to implement T-MSIS with states on a rolling basis with the goal of having most states submitting data by the end of 2016.

This state requirement for validation of their managed care data will help improve the quality and completeness of the encounter data that states send to CMS which has been a historic problem. CMS is also revising some monitoring requirements, including data reporting, for section 1115 demonstrations.

16. What tools do you have in place to support states that are struggling to collect meaningful data?

Answer: CMS provides enhanced funding (90 percent Federal match) for states IT systems, including both eligibility and enrollment systems and claims payment systems and a 75 percent match for operational costs. As previously noted, CMS's Medicaid and CHIP Managed Care NPRM did propose requirements for states regarding the quality of their managed care data.

In addition to the Federal systems funding, the T-MSIS system CMS built provides state Medicaid agencies with real-time feedback on their monthly data submissions, highlighting missing data or data anomalies. CMS then works with the states on a data improvement plan to

improve the overall data quality, whether technical or due to issues at the data sources; e.g., managed care plans. By virtue of CMS establishing a uniform, national T-MSIS data dictionary, states can now work more effectively with each other to address data issues involving multi-state plans or shared system vendors. CMS also provides direct technical assistance to assist state Medicaid agencies in developing, enhancing, implementing, and evaluating managed care programs. One of the focus areas for assistance is the collection, validation and analysis of data. Additionally, CMS has created a Managed Care Encounter Data Toolkit, which provides a practical guide to collecting, validating, and reporting Medicaid managed care encounter data.[28] It is designed as a step-by-step guide for state Medicaid staff responsible for managing the daily operations involved in encounter data, as well as for senior managers and policymakers who oversee this function.

17. Please explain the difference between a credible allegation of fraud and billing errors.

Answer: Within the Medicaid program, 42 CFR 455.2 defines a credible allegation of fraud:

A credible allegation of fraud may be an allegation, which has been verified by the state, from any source, including but not limited to the following:

(1) Fraud hotline complaints;
(2) Claims data mining; and,
(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Fraud is defined to mean "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law."

Abuse is defined to mean provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Billing errors are not defined in this section. A provider could err in its billing either unintentionally or intentionally. Errors in billing may be evaluated by a State Medicaid agency to determine whether it falls within the scope of fraud or abuse.

18. Do initial findings of overbilling, missing billing documentation or other compliance issues inherently constitute a credible allegation of fraud?

Answer: Irrespective of the circumstances, absent pending investigations of credible allegations of fraud, payment suspensions would not be triggered under 42 CFR 455.23, although that does

[28] The toolkit can be found at http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf.

not preclude the possibility that a State may exercise its own broader suspension authority in other circumstances.

19. Does anything in 42 C.F.R. 455.23 trigger payment suspensions when an audit identifies potential billing errors not related to allegations of fraud?

Answer: As discussed above, absent pending investigations of credible allegations of fraud, payment suspensions would not be triggered under 42 CFR 455.23. Under 42 CFR 455.23, a state Medicaid agency must suspend all payments to a Medicaid provider after the agency determines there is credible allegation of fraud, for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

20. Is there anything in this regulation that precludes a state from exercising its own broader suspension authority to address overbilling issues?

Answer: No. Under 42 CFR 455.23, a state Medicaid agency must suspend payment when it finds a credible allegation of fraud, unless it finds good cause not to do so. A state Medicaid agency, at its discretion, may choose to suspend payments based on other types of overbilling.

21. Does this regulation require a state to commence payment suspensions solely on the basis of billing errors or non-fraudulent compliance issues?

Answer: No, a state Medicaid agency is not required to suspend payments based on billing errors where those billing errors do not constitute credible allegations of fraud, nor is a state required to suspend payments based on non-fraudulent compliance issues. However, states are not precluded from using payment suspension at their discretion for overpayments that are not related to fraud.

22. In other words, would it be accurate to say that while a state may suspend provider Medicaid provider payments—pursuant to applicable state laws—it would have no basis or justification for doing so under 42 CFR 455.23 absent a credible allegation of fraud?

Answer: Yes, while a state may suspend provider Medicaid provider payments—pursuant to applicable state laws—the basis for doing so under 42 CFR 455.23 is a credible allegation of fraud.

The purpose of Federal oversight is to ensure that States have effective processes in place to determine whether allegations of fraud are credible. 1 A credible allegation may originate from any source but must be independently verified by the state via a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.2 However, a state Medicaid agency can only refer a case to an MFCU after a preliminary investigation has been conducted.

23. What steps, if any, does CMS take to ensure that a State Medicaid Agency is implementing a process that reviews all allegations facts, and evidence carefully and

acts judiciously on a case-by-case basis when contemplating a payment suspension, mindful of the impact that payment suspension may have upon a provider?

Answer: State Medicaid agencies must annually report summary information regarding payment suspensions to CMS under 42 CFR 455.23; however, Federal regulations do not provide for CMS to be involved in a state Medicaid agency's payment suspension process. In the Final Rule published February 2, 2011, we recognize states may have different considerations in determining what may be a "credible allegation of fraud." Accordingly, we believe states should have the flexibility to determine what constitutes a "credible allegation of fraud" within the bounds set forth in the definition of credible allegation of fraud found at 42 CFR 455.2. Under 42 CFR 455.13, the Medicaid agency must have methods and criteria for identifying suspected fraud cases, and methods for investigating these cases that do not infringe on the legal rights of persons involved and afford due process of law. Under 42 CFR 455.15 and 455.21, the state Medicaid agency must refer all cases of suspected fraud to the State Medicaid fraud control unit (MFCU) and/or to the appropriate law enforcement agency. Additionally, under 455.23(d) state Medicaid agencies are required to refer any investigation which leads to the initiation of a payment suspension to the state MFCU or appropriate law enforcement agency. For FY 2016 CMS' State Program Integrity Reviews are focus reviews of program integrity in states' managed care programs and included an assessment of payment suspensions limited to managed care only. A state Medicaid agency must implement payment suspensions under Federal regulation 42 CFR 455.23(b), requiring written notification to a provider issued within specified time frames. Under this same regulation, a provider under payment suspension has an opportunity to provide written evidence for consideration and must be notified of applicable state administrative appeals process and state laws.

24. At what point does CMS actually ensure compliance with the required preliminary investigation?

Answer: State Medicaid agencies must annually report payment suspensions to CMS under 42 CFR 455.17; however, Federal regulations do not provide for CMS to be involved in a state Medicaid agency's payment suspension process.

25. What safeguards are in place to protect providers from payment suspensions based on allegations, facts or evidence not independently verified by a preliminary investigation?

Answer: Under 42 CFR 455.2, a credible allegation of fraud is one that has been verified by the state. Under 42 CFR 455.13, a state Medicaid agency must have methods and criteria for identifying suspected fraud cases and methods for investigating these cases that do not infringe on the legal rights of persons involved and afford due process of law.

26. Is there any statutory prohibition that precludes CMS from requesting a state to verify its compliance with the preliminary investigation requirement?

Answer: We are not aware of any such statutory prohibition.

27. If not, why has CMS not acted in circumstances where it has been informed of irregularities surrounding a state's process for payment suspensions?

Answer: CMS acts when informed of noncompliance with Federal regulations. CMS investigates such allegations to determine whether agencies over which CMS has oversight are properly applying regulations and acts to ensure that any deficiencies are corrected. CMS not only acts when allegations of irregularities are received, but undertakes proactive reviews to identify and correct vulnerabilities before problems emerge. CMS conducts State Program Integrity Reviews to assess compliance with federal program integrity regulations as well as many other aspects regarding the effectiveness of the state's program integrity operations. Where deficiencies are identified, CMS makes recommendations to correct non-compliance issues, requires states to develop corrective action plans to address CMS recommendations, and provides guidance to help states use payment suspensions more effectively (*i.e.,* CMS' Medicaid Payment Suspension Toolkit).

28. What sort of oversight, or corrective actions does CMS take once it is presented with evidence casting doubt on whether a State Medicaid agency conducted a preliminary investigation prior to suspending payments?

Answer: We want to foster effective and efficient state program integrity efforts with respect to which payment suspension is an integral component, but we do not want to create a system so procedurally onerous that it overwhelms a state's ability to substantively perform this critical work. Nevertheless, we will thoroughly investigate and act by, among other things, working with the state to develop a compliance plan to make sure there is a process in place and utilized for suspending payments. CMS also has the authority to defer and/or disallow Federal financial participation in accordance with 42 CFR 430.40 and 430.42, if program integrity reviews or other methods of ensuring state compliance with Medicaid program requirements reveal a state is failing to suspend payments (or inappropriately applying a good cause exception) where pending investigations of credible allegations of fraud do exist. A state may not claim (on its Form CMS–64) Federal financial participation for payments that are suspended. Any state that does not suspend payments, or that suspends payments but continues to claim Federal financial participation with respect to what would have been paid had no suspension been in place, puts that Federal financial participation at risk. In such cases, we may pursue a deferral and/or disallowance to reclaim the Federal portion of such payment.

The ACA lowered—but did not abolish—the evidentiary standard State Medicaid Agencies must meet to commence payment suspensions against potentially fraudulent providers.4 Recognizing that the process for determining what constitutes a credible allegation of fraud varied among States, CMS established a minimal level of due diligence each state must conduct in making such determinations. According to CMS' commentary to the final rule, this standard of review requires State Medicaid Agencies to review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis when contemplating a payment suspension, *mindful of the impact that payment suspension may have upon a provider*.

4 Pub. L. No. 111-148 §6402(h)(2).
5 76 Fed. Reg. 5932
6 76 Fed. Reg. 5967; *see also* Medicaid Payment Suspension Toolkit.

In promulgating the regulations, CMS granted State Medicaid Agencies wide latitude to determine what constitutes a credible allegation of fraud. CMS indicated that it did not want to *limit* a State's due diligence process or preliminary investigations with respect to its assessment of credibility.6 However, this standard was not explicitly reflected in the final regulatory language as constituting a baseline standard of review, which, as codified, stated that allegations are considered to be credible when they have indicia of reliability and a State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

7 42 CFR 455.2
8 CMS Medicaid Payment Suspension Toolkit
9 76 Fed. Reg. at 5862, 5932

Most recently, the Medicaid Payment Suspension Toolkit noted that a State "can conduct whatever due diligence it deems necessary."8 This contradictory CMS guidance seems to result in two seemingly conflicting policies: CMS created a minimal level of scrutiny state must apply in determining the credibility of fraud allegations while at the same time seemingly indicating that it would not reviewing a state's due diligence or preliminary investigation process.

29. **Does this mean States have carte blanche to suspend payments regardless of the underlying allegations credibility?**

Answer: Medicaid payment suspensions based on 42 CFR 455.23 must meet the criteria for payment suspension at 455.23(a)(1). The state Medicaid agency must provide due process to the provider as described within the regulation. Neither the Affordable Care Act nor the regulatory provision at 455.23 address payment suspensions based on allegations of waste or abuse. States are not required to suspend payments in cases of "allegations" of waste or abuse. However, a state, in its discretion, may decide to voluntarily suspend payments in situations involving waste or abuse. The term "abuse" is defined under 455.2.

30. **If not, please clarify the circumstances in which CMS would deem a State Medicaid Agency to have suspended provider payments based on non-credible allegations?**

Answer: Neither the Affordable Care Act nor the regulatory provision at 455.23 address payment suspensions based on allegations of waste or abuse. States are not required to suspend payments in cases of "allegations" of waste or abuse. However, a state, in its discretion, may decide to voluntarily suspend payments in situations involving waste or abuse. The term "abuse" is defined under 455.2.

31. **State Medicaid Agencies may suspend payments with an appropriate level of earnestness and vigor, as they should. However, while a Medicaid Agency may strike hard blows, it may not strike foul ones.**

32. **Do Medicaid Agencies have a duty to safeguard both the integrity of the Medicaid program and the interests of public access to services?**

Answer: State Medicaid programs and CMS share responsibility for ensuring that state and Federal dollars are used to deliver cost-effective health care services to eligible individuals and are not diverted into fraud, waste, or abuse.

In its commentary to the final rule, CMS structured 42 CFR 455.23 around a general presumption that State Medicaid Agencies would act honestly and fairly in determining the existence of credible allegations of fraud. Specifically, CMS indicated that it was unaware of any circumstances where a State Medicaid Agency had *misused* its payment suspension authority against providers. 9 Furthermore, it requested States to be *mindful* of the impact such suspensions may have upon providers. Taken together, these comments assert that a State has as much responsibility to refrain from using improper methods to produce wrongful suspensions as it does to use legitimate means to bring about justified suspensions. Thus, CMS implicitly set forth a standard of good faith that State Medicaid Agencies must meet in suspending provider payments based on credible allegations of fraud.

33. **While the decision to suspend payments does not depend on the ultimate innocence or guilt of an accused provider, do you agree that it must be based on the honest and reasonable belief of a state Medicaid Agency that a credible allegation of fraud exists?**

Answer: Yes. Under 42 CFR 455.2, the term "credible allegation of fraud" is defined as an allegation that has been verified by the state.

34. **Is the reliability of a State Medicaid Agency's source of information relevant to the reasonableness of its belief regarding the credibility of an allegation?**

Answer: Yes. Under 42 CFR 455.2, the term "credible allegation of fraud" is defined as an allegation that has been verified by the state. The requirements to apply methods and conduct a preliminary and full investigation are described under 42 CFR 455.13, 455.14, and 455.15, respectively.

In July, 2015, OIG Report released report number OEI-07-13-00120 (July 2015), entitled "Not All States Reported Medicaid Managed Care Encounter Data as Required" regarding reporting of MSIS claims files for the third quarter of FY 11 (January 2012). Page ten of this report indicated that New Mexico submitted encounter data with a plan ID that OIG "could not use to determine the extent to which at least once encounter was reported for all managed care companies." According to OIG, without accurate values for plan IDs, "it is not possible to determine whether encounter data are present in a given MSIS claims file for all managed care entities." On page 19, OIG states that it could not determine the status of New Mexico's reported encounter data because of "blank, invalid or dummy" plan IDs.

35. **Was this error in New Mexico's submission ever corrected? If not, what action did CMS take to ensure that New Mexico was correctly submitting complete encounter data?**

Answer: CMS has been working with New Mexico on its MSIS data submission, including the submission of health plan IDs numbers. New Mexico began providing the managed care plan IDs for the inpatient claims, long term care claims, and other claim files in the last quarter of FY 2013. Beginning with the first quarter of FY 2014, New Mexico began providing the managed care plan IDs on prescription drug encounters in the "RX "file. These improvements will carry over to New Mexico's T-MSIS data submissions.

36. Did New Mexico correctly submit complete encounter data for the 4th Q of FY 2011, and each quarter of FY 2012, FY 2013 and FY 2014?

Answer: No. The state has some missing encounter data in its historic MSIS files. New Mexico has indicated to CMS the state will submit the available encounter data once it has successfully transitioned to T-MSIS.

37. Please provide any correspondence between CMS and New Mexico regarding the submission of the state's encounter data to MSIS for FY 2011 through FY 2014.

Answer: We will work to provide the information requested to your staff.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Representative Bilirakis

1. **Ms. Wachino, you probably know about Puerto Rico's financial challengers, which are rather severe, I am sure you will agree. A recent morning consult story highlighted the contrast in treatment that Puerto Rico receives under Federal health care programs. For example, Puerto Rico has a rather low spending cap on its program. Are you monitoring the rate at which Puerto Rico is spending its Medicaid funds, and do you worry it will exhaust those funds well before 2019? In your estimation, will they exhaust the funds before 2019?**

Answer: We are acutely aware of the differences between the way Medicaid funding works for Puerto Rico (and the other Territories) compared to states. Each territory, including Puerto Rico, is provided funding that is capped under section 1108 of the Act to serve its Medicaid population. The territories submit claims and receive the Federal match for those claims, but Federal matching funds cannot exceed their territorial cap. In contrast, funds received by the 50 states and DC are not capped. Moreover, the Federal medical assistance percentage (FMAP) rate for Puerto Rico (and the other territories) does not follow the same formula used for the states, but is fixed by statute. There has been an increase in the FMAP through the Affordable Care Act. Beginning in the fourth quarter of FY 2011, the Affordable Care Act increased the FMAP for territories from 50 percent to 55 percent. From January 1, 2014, to December 31, 2015, there is a temporary 2.2 percent FMAP increase for all Medicaid enrollees, bringing the FMAP to 57.2 percent. In addition, territories that are considered expansion states, such as Puerto Rico receive an enhanced FMAP for non-pregnant childless adults in the expansion population (VIII group), which ranges from 78.60 percent to 90 percent during 2014-2020 and beyond. Puerto Rico expanded coverage to an additional 300,000 people. Also, for the period of July 1, 2011, through December 31, 2019, the Affordable Care Act provided for the availability of an additional $6.4 billion in Medicaid funding to Puerto Rico. I am aware of the concerns about access to health care services in Puerto Rico as well as how quickly Puerto Rico will exhaust its Affordable Care Act funding, which we estimate could be exhausted by the end of FY 2017. We monitor Puerto Rico's spending very closely and will continue to work with Puerto Rico to monitor expenditures. HHS has established a Task Force to investigate these issues. However, the spending cap imposed upon Puerto Rico (and the other Territories) is a statutory provision. We understand that the Congress is also aware of Puerto Rico's funding limitations. HHS, including CMS, is analyzing options to help Puerto Rico address its health care financing challenges, and I will keep you and your staff apprised of those efforts as they develop.

<u>The Honorable Representative Cardenas</u>

1. **Ms. Wachino, with over 25 million low income Americans nationwide who are unable to see a primary care physician, I believe telemedicine could provide an incredibly effective way to improve the health care system for everyone. Could you expand on the particular benefits for using telemedicine with dual eligibles who are unable to visit their doctor due to illness or immobility? And not just in rural areas, but also in higher populated areas as well.**

Answer: Today, there are over 10 million Americans enrolled in both the Medicare and Medicaid programs, commonly known as "dual eligible" beneficiaries. The Medicare-Medicaid Financial Alignment Initiative is designed to better align the financial incentives of the two programs to provide these dual eligible beneficiaries with improved health outcomes and a better care experience.

The Financial Alignment Initiative created two model types: capitated and managed fee-for-service. In the capitated model, a state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. In the managed fee-for-service model, a state and CMS enter into an agreement by which the state is eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. Implementation of each demonstration is a collaborative effort between CMS and the state, and CMS has made several resources available to assist states with implementation activities. To date, new demonstrations are underway in 12 states, with approximately 400,000 dually-eligible beneficiaries participating in the financial-alignment models.

Virginia is partnering with CMS to test a capitated payment model through the Initiative, and is authorizing participating health plans to cover telehealth services consistent with Virginia's current Medicaid requirements. This includes allowing telehealth coverage for Medicare-Medicaid enrollees in both urban and rural areas and for services such as remote patient monitoring and specialty consultative services.

In addition, CMS is supporting enhanced care & coordination providers (ECCPs) that are partnering with nursing facilities to implement evidence-based interventions aimed at reducing avoidable hospitalizations for Medicare-Medicaid enrollees who are long stay nursing facility residents. The University of Pittsburgh Medical Center (UPMC), one of the organizations serving as an ECCP in the initiative, is utilizing telemedicine to provide nurse practitioner coverage after hours. This is done through multiple functionalities, including video-chat, high-resolution cameras, and e-stethoscope, EKG, and otoscope.

CMS is looking forward to reviewing the results of these demonstrations and will continue to work with states like Virginia and providers like UPMC to inform future efforts to alleviate the fragmentation and improve coordination of services for dually-eligible beneficiaries, enhance quality of care, and reduce costs for states and the Federal Government.