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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

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July 28, 2015

Ms. Victoria Wachino
Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Wachino:

Thank you for appearing before the Subcommittee on Health on July 8, 2015, to testify at the hearing entitled "Medicaid at 50: Strengthening and Sustaining the Program."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on August 11, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — 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.

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?

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?

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?

    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?

    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?

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?

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?

    a. How would implementation of this policy affect states?

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

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?

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?

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

    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?

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?

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

[1] See http://www.healthcostinstitute.org/files/KidsReport2013_Final.pdf
[2] See http://www.gao.gov/assets/670/664115.pdf

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?

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.

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?

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?

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?

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?

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?

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?

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.

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?

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.

4. Considering the widespread nature of fraud in Personal Care Services and the documented cost savings published on Medicaid programs using Electronic Visit Verification, do you see value in states having in place technology that validates homecare visits?

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?

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

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?

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?

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?

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?

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?

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

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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

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?

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?

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?

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?

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?

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?

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 each 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

List of selected state programs funded by CMS under demonstration programs

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
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

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?

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?

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?

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

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

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

2. 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?

    a. 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?

3. 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?

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.

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

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?

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)?

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.

The Honorable Representative Lujan

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

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?

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?

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?

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?

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?

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?

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?

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.

9. 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?

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

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

11. 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.

12. 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?

13. 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?

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

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

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

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

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

18. 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?

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

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

21. 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?

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.

22. 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?

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

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

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

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

27. 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?

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.

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

29. 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?

30. 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.

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

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.

32. 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?

33. 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?

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.

34. 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?

35. 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?

36. 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