U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 3, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This letter responds to your request that we address questions submitted for the record related to the October 23, 2015, hearing entitled *Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations*. GAO's responses to these questions are enclosed and are based on previous work related to the areas addressed.

If you have any questions about these responses our need additional information, please contact Carolyn L. Yocom at yocomc@gao.gov or call (202) 512-7114.

Sincerely yours,

Carolyn L. Yocom
Director, Health Care

Enclosure

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

Post-Hearing Questions for the Record
Submitted to Carolyn Yocom, Director, Health Care
U.S. Government Accountability Office,
From the Honorable Joseph R. Pitts

"Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations"

October 23, 2015

The Honorable Representative Joseph R. Pitts

1. **Given the 100 percent federal funding for the newly eligible Medicaid beneficiaries, states obviously have a financial incentive to increase the proportion of applicants and expenditures for that population. Your report indicates that CMS officials said that their expenditure reviews are primarily intended to ensure that states are correctly grouping expenditures for the different eligibility groups as initially determined, not whether the determination is correct.**
    a. **What exactly does that mean and what is CMS checking versus not checking as part of these reviews?**

What this means is that there is a disconnect between the determination of eligibility and the determination as to whether the appropriate matching rate has been used in reimbursing states for Medicaid claims. As part of its oversight responsibilities, CMS reviews state-reported expenditures on a quarterly basis. CMS has modified this review process to include an examination of expenditures for different groups of enrollees, since the federal share varies by eligibility group. Specifically, CMS staff must select a sample of different types of enrollees—including at least 25 PPACA-expansion eligible enrollees, 10 state-expansion eligible enrollees (where applicable), and 5 traditionally eligible enrollees—and examine their expenditures to ensure that they were categorized as expenditures for the correct eligibility type. CMS accepts the initial eligibility determination as correct for the purposes of the expenditure review, and checks to ensure that states are correctly grouping expenditures for the different eligibility groups. However, there is a disconnect because CMS does not use this review to assess the accuracy of the initial eligibility determination. Instead, the agency relies on pilot eligibility reviews, conducted by the states and CMS contractors, to assess initial eligibility determinations. Although the purposes of the CMS-64 expenditure review are distinct from the eligibility review, the information gained from the pilot eligibility reviews on state eligibility determination errors could be useful in identifying potentially erroneous expenditures that require further review by CMS. Consequently, we recommended that CMS use the information obtained from eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately.

    b. **What, if any, safeguards has CMS instituted to ensure that federal taxpayers are not paying more than their share of states' Medicaid programs?**

CMS has implemented interim efforts—pilot eligibility reviews and the eligibility support contractor program—to assess the accuracy of state Medicaid eligibility determinations; however, as we reported, these efforts generally do not assess the accuracy of federal Medicaid eligibility determinations. As we reported in October 2015, for the states in which

the federal government performs eligibility determinations, there is a gap in assuring that the determinations are accurate. We recommended that CMS take action to improve the effectiveness of its oversight of eligibility determinations and increase assurances that states' expenditures are appropriately matched.

2. **Your reports contain several recommendations for CMS. What actions has CMS indicated that it would take in response to GAO's recommendations? Do you think these actions are sufficient to address the concerns raised?**

Across these two reports, we made five recommendations. While CMS generally concurred with our recommendations, it is too soon to determine whether the actions it has taken or plans to take will be sufficient to address the concerns raised. We will monitor CMS's efforts to address these recommendations.

We made two recommendations to improve the effectiveness of CMS' oversight of eligibility determinations and increase assurances that states receive an appropriate amount of federal matching funds.

- In written comments to our October 2015 report, HHS concurred with our first recommendation that CMS conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary. HHS noted that federal eligibility determinations in two states were being reviewed by the eligibility support contractor, and stated that federal determinations would be examined under the Payment Error Rate Measurement (PERM) program, used to measure improper payments in Medicaid. However, the eligibility component of the PERM will not resume until 2018, and in the interim, without a systematic assessment of federal eligibility determinations we remain concerned that CMS lacks a mechanism to identify and correct federal eligibility determination errors and associated payments. Given the program benefits and dollars involved, we urged CMS to look for an opportunity to identify erroneous federal eligibility determinations and implement corrective actions as soon as possible.
- With regard to our second recommendation—to use the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately—HHS agreed with the concept of our recommendation, but noted that eligibility and expenditure reviews are two distinct, but complementary oversight processes, with different timeframes. We continue to believe that using the information obtained from state and federal eligibility review to inform the agency's review of expenditures for different eligibility groups will help ensure that expenditures are reported correctly and matched appropriately.

We also recommended that CMS take three actions to better minimize the risk of coverage gaps and duplicate coverage for individuals transitioning between Medicaid and the exchange in FFE states.

- With regard to our first recommendation—monitoring the timeliness of account transfers from state Medicaid programs to CMS and identifying alternative procedures as necessary—HHS commented in September 2015 that HHS monitors and reviews account transfers on a weekly basis and resolves any concerns about transfer frequency with the states. However, we do not believe these actions are

sufficient to address the recommendation, as knowing the frequency of account transfers may not provide enough information without HHS also having information on the timeliness of transfers—that is, the amount of time it takes the state to transfer an individual's account to CMS after determining that the individual is no longer eligible for Medicaid.

- With regard to our two other recommendations—including establishing a schedule for regular checks for duplicate coverage and developing a plan to routinely monitor the effectiveness of the checks and other planned procedures to prevent and detect duplicate coverage—HHS stated in September 2015 that its first check was underway in August 2015. HHS said that it will analyze the rate of duplicate coverage identified and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of future checks. HHS also stated that it will monitor the rate of duplicate coverage identified in its checks and that it is working to implement additional internal controls to reduce duplicate coverage. We believe that these actions could be sufficient to address the recommendations—depending on how frequently the checks are performed and whether CMS's plan for monitoring the results of the checks incorporates target levels of duplicate coverage the agency deems acceptable. The less frequently the checks are conducted, the longer duplicate coverage could last, and without such targets, it will be difficult for CMS to provide reasonable assurance that its procedures are sufficient or whether additional steps are needed.

3. **Some may argue that any duplicate payments will be resolved through the tax reconciliation process because individuals that receive a subsidy are required to file income tax returns. To what extent has the tax reconciliation process helped to address duplicate federal payments resulting from dual coverage? For example, how would the tax reconciliation process interact with enrollees who do not file taxes?**

   The IRS's process for reconciling the amount of the APTC individuals may owe has the potential to reduce the financial implications of any duplicate federal payments, but challenges exist. Although we have not assessed the extent to which this process helped to address any duplicate payments resulting from duplicate coverage in tax year 2014, we reported in October that, according to IRS officials, IRS will generally not have the information necessary to identify duplicate coverage until the tax filing season for tax year 2015, when states are required to report Medicaid enrollment data to IRS. Further, once IRS begins receiving the data, its ability to identify the need for repayment due to duplicate coverage will depend on the quality of the data and IRS's available resources. For example, we reported in July 2015 that the IRS experienced challenges related to the APTC reconciliation process for tax year 2014, including that incomplete and delayed data from the exchanges limited IRS's ability to match taxpayer claims for the APTC with exchange data at the time of return filing.[1] Among other recommendations, we recommended that IRS assess whether exchange data delays are an ongoing problem, assess the reliability of the data for IRS matching, and work with CMS to get complete data.

[1]See GAO, *Patient Protection and Affordable Care Act: IRS Needs to Strengthen Oversight of Tax Provisions for Individuals*, GAO-15-540 (Washington, D.C.: July 29, 2015).

4. **In your testimony, you mentioned some actions CMS was taking to identify consumers who are dually enrolled in Medicaid and marketplace coverage. The Congressional Budget Office has estimated that Exchange subsidies and related spending—as well as the increased Medicaid and CHIP outlays under the law—cost federal taxpayers $77 billion in 2015. Next year, CBO notes the total cost for Exchange and Medicaid related spending due to the law will jump to $116 billion dollars. Given the financial implications of duplicate coverage for both the beneficiary and the American taxpayers, what is CMS doing to <u>prevent</u> such duplication from occurring in the first place?**

   We reported that CMS has a number of policies and procedures that may help prevent duplicate coverage in FFE states. For example, when individuals in FFE states are determined potentially eligible for subsidized exchange coverage, CMS conducts automated checks of state IT systems to determine if individuals already have Medicaid coverage.[2] In addition to these checks, CMS has guidance on the FFE website that outlines the steps individuals must take when they have subsidized exchange coverage and are later determined eligible for Medicaid, including that they are responsible for ending subsidized exchange coverage. CMS also notifies individuals in FFE states of this responsibility when they are enrolling in exchange coverage as well as when they are determined eligible or potentially eligible for Medicaid. However, we also reported weaknesses in CMS's controls to prevent duplicate coverage, including limitations in CMS's check for Medicaid coverage in FFE states, and that CMS does not have procedures to automatically terminate exchange subsidies when individuals are determined eligible for Medicaid. Because CMS's planned steps to address the risk of duplicate coverage in FFE states focus on steps to identify and resolve rather than prevent duplicate coverage, we recommended that CMS develop a plan to monitor the effectiveness of procedures to prevent and detect duplicate coverage and take additional actions as appropriate.

5. **Your report seems to indicate that CMS has been changing the guidance and parameters of the pilot eligibility reviews. What implications does changing the instructions midstream have for the usefulness of the results?**

   We reported that states had completed the initial round of pilot eligibility reviews, which showed wide variation in both the design and the results among the states—reflecting, in part, the latitude they were given in designing their review methodology. For subsequent rounds, CMS revised its guidance to standardize state reporting of results. For example, CMS updated instructions for the second round to include standard definitions for errors and deficiencies, and to require the inclusion of eligibility redeterminations in the review, and plans to further refine the instructions for future rounds. Based on these updated instructions, the results of the future rounds of pilot eligibility reviews may result in more comparable information across states.

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[2]For this check to work, states' Medicaid IT systems must respond to electronic inquiries from the FFE on applicants' current Medicaid coverage. According to CMS officials, six states—Alaska, Kansas, New Jersey, Tennessee, Oregon, and Wyoming—were unable to perform this check as of July 2015. This check supplements the question in the application asking the applicant to attest to whether they have minimum essential coverage, including Medicaid.