



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

January 30, 2017

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing: “Strengthening Medicaid and Prioritizing the Most Vulnerable”

I. INTRODUCTION

On Wednesday, February 1, 2017, at 10:00 a.m. in 2123 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, “Strengthening Medicaid and Prioritizing the Most Vulnerable.”

II. WITNESSES

- Avik Roy, President, The Foundation for Research on Equal Opportunity;
- John McCarthy, former Director, Ohio Department of Medicaid, and former Deputy Director, District of Columbia Department of Health Care Finance;
- Judith Solomon, Vice President for Health Policy, The Center on Budget and Policy Priorities.

III. BACKGROUND

Medicaid Program Trend

The Medicaid program is a critical safety net for some of our nation’s most vulnerable patients, as the program provides health care for children, pregnant mothers, elderly individuals, blind individuals, and individuals with disabilities. Created in 1965 to finance health care coverage to serve low-income Americans, Medicaid is now the world’s largest health insurance program. Medicaid currently covers approximately 72 million Americans—more than Medicare — and up to 98 million may be covered at any one point in a given year.¹

Medicaid is jointly funded by Federal and State governments. According to the Congressional Budget Office, Federal Medicaid outlays are expected to increase dramatically over the coming decade, from \$368 billion in 2016 to \$650 billion in 2027.² According to National Health Expenditure projections, *total* Medicaid outlays will climb to approximately \$1

¹ <https://www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf>

² <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-outlook.pdf>

trillion *each year* by the end of a decade.³ Just this year, overall Medicaid spending is projected to be greater than what we spend on national defense.⁴

Under the Patient Protection and Affordable Care Act (PPACA), States may expand Medicaid eligibility to people under the age of 65 with income up to 138 percent of the federal poverty level (FPL).⁵ The law provided enhanced federal funding for coverage of this new expansion population, in the form of a higher Federal Medical Assistance Percentage (FMAP).⁶ Specifically, the federal government covered 100 percent of the costs for the expansion population through 2016—a 100 percent FMAP. In 2017, the FMAP for this population is 95 percent, and the FMAP gradually diminishes to 90 percent by 2020. Thus, under PPACA, the federal government covers a higher percentage of the cost of care for able-bodied adults above poverty compared to the disabled, elderly, or children below poverty. In some cases, this may create an incentive for States that face budgetary pressures to use policy tools to reduce benefits, services, or eligibility for the traditional, vulnerable Medicaid populations served by their programs.

Today, Medicaid is one of the fastest growing spending items for States, and accounted for more than 28 percent of state spending in fiscal year 2015, according to the National Association of State Budget Officers.⁷ This portion of state budgets devoted to Medicaid has grown over time, and has accelerated in recent years.⁸ Notably, irrespective of whether or not a state chose to expand Medicaid under PPACA, all States are experiencing greater Medicaid program outlays due to the effects of the individual mandate and penalties. A recent estimate by the Congressional Budget Office (CBO) attributed \$281 billion in federal Medicaid outlays over a decade to the effect of the individual mandate tax penalty in PPACA, because the mandate has effectively forced many individuals who were previously eligible (but not previously enrolled) to enroll in Medicaid.⁹

With the Medicaid program facing increased demands and with federal outlays continuing to climb, the Committee is exploring a range of additional policies that could help further the goals of empowering States, improving access, prioritizing vulnerable patients, improving health outcomes, modernizing outdated and inefficient rules, increasing efficiency, and putting federal Medicaid spending on a more sustainable path. In addition to Medicaid-related legislation introduced by Committees members and Medicaid policies outlined in A

³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

⁴ <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-outlook.pdf> The defense total includes spending on Overseas Contingency Operations. For total Medicaid spending see:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

⁵ *National Federation of Independent Business ET AL. V. Sebelius, Secretary of Health and Human Services*, ET AL. Supreme Court of the United States, June 28, 2012.

⁶ The expansion population is non-elderly, non-disabled, childless adults, many of whom may be able-bodied.

⁷ [https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20\(Fiscal%202014-2016\)%20-%20S.pdf](https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202014-2016)%20-%20S.pdf)

⁸ See slide 28, <https://energycommerce.house.gov/news-center/blog-posts/ec-shares-handy-medicaid-overview-tool>

⁹ <https://www.cbo.gov/budget-options/2016/52232>

Better Way, the Committee is examining a number of ideas proposed by Governors and States that could achieve these goals.¹⁰ As the National Association of Medicaid Directors recently explained, “there are meaningful opportunities for federal policymakers to support states in working towards . . . shared goals, including by making targeted reforms to antiquated federal statute and regulations. Too many of the federal policies in place today are legacies from the last century. They do not reflect the current realities for running a Medicaid program nor do they align with the vision for Medicaid and the broader health care system.”¹¹

Medicaid Home and Community Based Services

Long-term services and supports (LTSS),¹² refers to a broad range of services and supports that are needed by individuals over an extended period of time. LTSS may include some health care services, but also non-health care services. The need for LTSS is generally measured by limitations in an individual’s ability to perform daily personal care activities (i.e., eating, bathing, dressing, and walking), or activities that allow individuals to live independently in the community (i.e., shopping, housework, and meal preparation).¹³ The probability of needing LTSS increases with age. However, younger persons with disabilities may also find themselves in need of medical and supportive care offered through LTSS, which can allow them to live longer, more productive lives.

Medicaid plays a key role in covering LTSS for aged and disabled individuals. The Congressional Research Service notes, “as the largest single payer of LTSS in the United States, federal and state Medicaid spending accounted for \$142.1 billion or 42.1% of all LTSS expenditures in 2014 (\$337.3 billion). LTSS are also a substantial portion of spending within the Medicaid program relative to the population served, accounting for one-third (31.9%) of all Medicaid spending in 2014.”¹⁴

Medicaid funds LTSS for eligible beneficiaries in both institutional and home and community-based settings. States are required to offer certain Medicaid institutional services. However, the majority of home and community-based service (HCBS) offerings are optional for States.

In general, Medicaid law provides states with two extensive authorities to provide HCBS by either: (1) covering certain HCBS as a benefit under the Medicaid state plan, or; (2) covering the services through a waiver program which permits states to disregard certain Medicaid requirements in the provision of these services, subject to approval.

The most common waiver authority States use to provide HCBS is the Section 1915(c) waiver authority, which refers to the provision of the federal Medicaid statute in which it is authorized. Individuals served by these waiver programs live in a home or community-based

¹⁰ <http://abetterway.speaker.gov/assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf>

¹¹ http://medicaiddirectors.org/wp-content/uploads/2016/12/NAMD-Legislative-Top-Issues-for-2017_FINAL.pdf

¹² LTSS is often referred to outside of the Medicaid program simply as “long term care.”

¹³ Often referred to as activities of daily living and instrumental activities of daily living.

¹⁴ Congressional Research Service, “Medicaid Coverage of Long-Term Services and Supports,” January 14, 2016, Kirsten Colello, Report R43328.

setting, but require an institutional level of care.¹⁵ HCBS waivers allow States to cover services that exceed the core medical benefits that have been the traditional focus of the Medicaid program—including a variety of non-medical and supportive services that allow individuals to live independently in their communities. These services include case management, homemaker/home health aide, personal care, adult day health, habilitation, rehabilitation, and respite care, but HCBS waivers may not cover room and board in a community-based setting, such as an assisted living facility. Eligible HCBS waiver participants must meet certain financial requirements (including income and asset requirements) and state-defined level-of-care criteria that demonstrate the need for LTSS.

States may target HCBS waivers to a specific population, such as individuals under age 65 with physical disabilities, individuals with intellectual or developmental disabilities, individuals ages 65 and older, or individuals with mental illness. As a result, states often have more than one approved HCBS waiver. According to the Centers for Medicare and Medicaid Services, nearly all States and DC offer services through HCBS waivers. States can operate as many HCBS waivers as they want — currently, more than 300 HCBS waiver programs are active nationwide.¹⁶ Expenditures under HCBS waivers are matched at the state’s regular FMAP rate. For FY2013, Medicaid expenditures for Section 1915(c) HCBS waivers were \$41.1 billion.¹⁷

Section 1915(c) HCBS waivers must meet a “cost-neutrality” test where average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred absent the waiver. As the Congressional Research Service reported, “a majority of states with Section 1915(c) waivers (88%) use cost-containment strategies in addition to the federally mandated cost neutrality requirement, such as fixed expenditure caps either applied to individual participants or in aggregate, as well as service limitations, and geographic limits.”¹⁸

Under the HCBS waiver authority, States may limit the number of individuals served in a waiver program by limiting the number of individuals participating in the waiver, a cost-containment strategy utilized by many States. Because state Medicaid programs often have greater demand for HCBS than the number of available waiver “slots” for a given program, many States maintain waiting lists when their program slots are filled.¹⁹ There are no statutory or regulatory provisions related to waiting lists for Medicaid HCBS waiver programs, and CMS does not collect this information from States.

According to survey data from the Kaiser Family Foundation, in 2015, 35 States reported waiver waiting lists, while 12 States and DC reported not having lists. The Kaiser Family

¹⁵ Some states also use 1115 waiver authority.

¹⁶ <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html>, accessed week of 01/27/17

¹⁷ Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports in FY2014*, Truven Health Analytics, April 15, 2016.

¹⁸ Some states also use 1115 waiver authority.

¹⁹ Waiting lists may also be referred to as interest lists, planning lists, or registries. Waiting lists can also occur in cases in which a State legislatures may not fully fund the maximum number of waiver slots under the CMS approved waiver program for that State.

Foundation found “in 2015, there were 640,841 individuals on waiver waiting lists across 133 Section 1915(c) waivers. Section 1915(c) waivers for people with I/DD (Intellectual/ Developmental Disabilities) had the greatest number of individuals on waiting lists (428,151 individuals, or 67% of total waiting list enrollment) followed by waivers serving people who are aged and aged or disabled (145,424 individuals, or 23% of total waiting list enrollment).”²⁰ With Medicaid outlays projected to outpace economic growth, the growth in Medicaid likely means that, despite State efforts, the waiting list for Medicaid services may continue to grow over time.²¹ While capping enrollment of HCBS waivers is a cost-containment tool for some states, increased Medicaid program demands and spending under PPACA may exacerbate State waiting lists for patients, putting care for some of the most vulnerable Americans at risk. .

At this hearing, the Subcommittee will discuss draft legislation which would modify provisions in current law that effectively force States to spend money on individuals who may not be the most vulnerable compared to other populations served or potentially served by Medicaid. The goal of the legislation is to strengthen the Medicaid program and protect the most vulnerable Medicaid beneficiaries by better targeting Medicaid dollars to help patients. As envisioned, the legislation would reduce federal and state outlays, decrease the deficit, and set aside a portion of the savings to help States reduce the size of their HCBS waiting lists, thus protecting and prioritizing patients in need. With these goals in mind, some considerations for the Committee as it evaluates the goals of the legislation include:

- What are other areas of Medicaid statute or regulation which may be modernized or improved to reduce outlays and free up resources for prioritizing patients on waiting lists?
- What is the best approach to target resources and reduce waiting lists without creating perverse incentives for States to grow their waiting lists to attract more Federal support?
- Since waiting lists can demonstrate unmet need, what is the appropriate role for private sector (for-profit and non-profit) resources and entities to play in preventing crowd-out and cost-shifting, and yet helping address unmet needs?

IV. DRAFT LEGISLATION

A. H.R. ____, The Prioritizing the Most Vulnerable Over Lottery Winners Act, Rep. Fred Upton

Under PPACA, States were required to transition to using Modified Adjusted Gross Income (MAGI) for determining Medicaid eligibility for most non-elderly and non-disabled individuals, children under the age of 18, and adults and pregnant women under the age of 65.

²²Under MAGI, income eligibility for Medicaid applicants and new enrollees is based on current

²⁰ <http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services-Programs-2013-Data-Update>

²¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

²² In addition, as a result of PPACA, states are no longer allowed to include asset or resource tests for the populations whose Medicaid eligibility is based on MAGI.

monthly household income.²³ MAGI-based income under Medicaid refers to income calculated using the same methodology used to determine MAGI in section 36B(d)(2)(B) of the Internal Revenue Code (i.e., it includes tax-exempt interest income earned or accrued, interest from U.S. savings bonds used to pay higher education tuition and fees, earned income of U.S. citizens living abroad that was excluded from gross income, and non-taxable portion of Social Security benefits), with some exceptions.

In particular, under Medicaid rules for calculating MAGI, irregular income received as a lump sum—such as lottery or gambling winnings, one-time gifts, or inheritances—is counted as income only in the month received.²⁴ As a result, lottery winners, including multi-million dollar winners, have been allowed to retain tax-payer financed Medicaid coverage. At first blush, lottery and gambling winnings may seem like insignificant economic resources for low-income individuals, or may seem inconsequential in scope. However, individuals with lower economic status are more likely to play the lottery than individuals with higher income. For example, one study found that “socioeconomic status was related to gambling with those in the lowest fifth SES group having the highest rate of lottery gambling (61%).”²⁵

Several States have found many Medicaid enrollees actually have lottery winnings. For example, in 2014, one State reported they had more than 6,000 lottery winners who were receiving or were part of a household receiving Medicaid.²⁶ Of this group, about 200 individuals had winnings of \$20,000 or more. State officials expressed concern that lottery winnings were prohibited from being counted beyond the month in which they were received, thus enabling high-dollar lottery winners to continue to obtain coverage, regardless of financial ability.²⁷

This legislation would eliminate an unintended consequence in the current statute and regulations by requiring States, for purposes of determining MAGI for Medicaid and CHIP eligibility, to consider monetary winnings from lotteries (and other lump sum payments) as if they were obtained over multiple months, even if obtained in a single month. This legislation would count lottery winnings above \$80,000 over multiple months, thus preventing individuals with significant financial means from inappropriately shifting the cost of their care to the Medicaid program. This legislation also envisions a hardship exemption by which States could continue to provide Medicaid coverage for an individual if the denial of coverage would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary of HHS.

²³ When redetermining eligibility for current Medicaid enrollees, States are permitted to use current monthly income and family size, or projected annual income and family size for the remaining months of the calendar year. For States that choose the latter measure, the rules for projected household income and family size under Medicaid differ as compared to the rules under the exchanges. Specifically, Medicaid requires the applicant to predict income and household size for the remaining months of the calendar year, whereas applicants seeking eligibility for premium tax credits must predict income and household size based on the tax year. See 42 C.F. R. §435.603(h)(2). States are required to use “reasonable methods” to account for changes in income such as, increases or decreases in income due to seasonal work. See 42 C.F.R. §435.603(h)(3).

²⁴ 42 C.F. R. §435.603(e).

²⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4103646/>

²⁶ http://www.michigan.gov/documents/dhs/LotteryReport_Legislature2014_2_472170_7.pdf

²⁷ http://www.mlive.com/news/index.ssf/2013/04/report_some_michigan_lottery_w.html

B. H.R. ____ The Verify Eligibility Coverage (VECA) Act, Rep. Bill Flores

In general, Medicaid coverage is only available for individuals who are U.S. citizens or have legal immigration status. However, under current law, State Medicaid programs are currently required to provide applicants who attest to being U.S. citizens or to having satisfactory immigration status and are determined otherwise eligible for Medicaid, a reasonable opportunity period to provide documentation that would verify their citizenship or eligible immigration status. States are required to enroll applicants in Medicaid and are eligible to receive federal matching funding for their care, during this reasonable opportunity period. As a result, individuals who are not citizens or eligible legal permanent residents may be enrolled and receive Medicaid benefits.

This legislation would close the loophole in current practice by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage. This common-sense protection simply ensures that federal taxpayer dollars in the Medicaid program are only used to provide care for individuals who are ultimately determined to be eligible for the program. The intent of the legislation is not to restrict States from using their own dollars to provide services to unlawfully present individuals, but merely to ensure the federal Medicaid program would not match those funds nor force States to provide such coverage.

C. H.R. 181 The Close Annuity Loopholes in Medicaid (CALM) Act, Rep. Markwayne Mullin

Individuals seeking Medicaid coverage for long-term care, including nursing home care, must have assets — income and resources — that are below established standards. The financial eligibility standards differ based on whether an individual is married or single. Federal law requires States to use specific minimum and maximum income and resource standards in determining Medicaid eligibility for married applicants when one spouse is in an institution, such as a nursing home (referred to as the institutionalized spouse), and the other remains in the community (referred to as the community spouse).

For example, the resources of both the institutionalized and community spouse are considered when determining initial eligibility for Medicaid coverage for nursing home care. The community spouse is able to retain an amount equal to one-half of the couple's combined resources, up to a State-specified maximum level. A community spouse's resources generally are not assessed again after his or her spouse is initially deemed eligible. Additionally, while the institutionalized spouse's income is considered when determining Medicaid eligibility, the income of the community spouse is not considered. The community spouse is allowed to retain all of his or her income.

Medicaid's treatment of married couples' income and resources has resulted in a loophole in Medicaid eligibility that allows married individuals to increase the amount of assets the community spouse is able to retain above State and Federal maximums. Specifically, GAO found that married applicants can increase the amount of assets the community spouse retains by using the couples' resources, which would otherwise be counted towards the institutionalized spouse's Medicaid eligibility, to purchase an irrevocable and non-assignable annuity that pays out income

to the community spouse.²⁸ Although annuities for the community spouse must be actuarially sound — they must pay out during the community spouse’s life expectancy — and must name the State as a remainder beneficiary, there are no other limitations on the time period in which annuities pay out. Additionally, there is no limit on the amount of income from the annuity, as the community spouse’s income is not countable as part of the institutionalized spouse’s eligibility.

GAO has noted that married applicants may use the couple’s resources to purchase an irrevocable annuity that pays potentially large amounts of income for the community spouse over a short period of time, thereby effectively returning the resources to the community spouse without affecting the institutionalized spouse’s Medicaid eligibility. According to GAO’s report:

“Medicaid officials, county eligibility workers, and attorneys who provided information on the value of annuities for the community spouse reported average values ranging from \$50,000 to \$300,000. Officials from one state reported seeing annuities for the community spouse worth more than \$1 million. Medicaid officials from one state indicated that they have seen annuities that disbursed all of the payments to the community spouse shortly after the annuity was purchased, while officials from another state said that annuities can have large monthly payments for the community spouse, such as \$10,000 per month.”²⁹

H.R. 181 would address this loophole in Medicaid policy by making half of the income generated from an annuity purchased by a community spouse within the 60-month Medicaid look back period — the period of time before applying for Medicaid in which an individual’s or couple’s assets are reviewed — countable for purposes of determining the institutionalized spouse’s Medicaid eligibility for long-term care. As a result, the income generated from an annuity purchased by married individuals for a community spouse would be treated, for purposes of Medicaid eligibility, in a manner equivalent to how the resources used to purchase the annuity would have been treated. This policy has the effect of requiring individuals with financial means to utilize more of their own financial resources before being eligible for Medicaid. This targeted policy helps prevent cost-shifting from individuals to the Medicaid program funded by taxpayers.

V. STAFF CONTACTS

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

²⁸ <http://www.gao.gov/assets/670/663417.pdf>

²⁹ <http://www.gao.gov/assets/670/663417.pdf>