United States Senate
WASHINGTON, DC 20510

August 14, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Becerra and Administrator Brooks-LaSure,

I am writing to update my request for a response to my June 11, 2024, letter regarding the Department of Health and Human Services' (HHS) statutory authority to extend the unwinding period of Medicaid's continuous eligibility requirements (referred to as "Medicaid unwinding"). The Center for Medicaid and CHIP Services' (CMCS) recently announced an extension of the Medicaid unwinding period through June 30, 2025. The recent administrative actions taken by CMCS and higher-than-expected Medicaid enrollment calls into question whether the federal government is realizing the $22.1 billion savings it used to offset spending elsewhere.[1, 2]

I am increasingly interested in the agency's response to my June 11 letter given the most recent increases in mandatory Medicaid outlays projected by the Office of Management and Budget (OMB) and the non-partisan Congressional Budget Office (CBO). Recently, OMB's mid-session review for fiscal year 2025 noted that factors contributing to the $1.179 trillion higher deficit over the 10-year budget window include an estimated $764 billion net increase in Medicaid spending due to higher projected enrollment in part due to the Medicaid unwinding.[3] Furthermore, CBO's June 2024 baseline noted, "new information related to the [Medicaid] unwinding of the program's continuous eligibility policy increased projected enrollment and boosted projected outlays over the 2025–2034 period by $67 billion."[4] Congress must have a detailed understanding of your agency's recent action and ensure it aligns with the statutory authority provided to you by the legislative branch.

[1] Congressional Budget Office (CBO), "Summary - Estimated Budgetary Effects of Divisions O through MM of the Consolidated Appropriations Act, 2023 (Public Law 117-328), as Enacted on December 29, 2022," January 12, 2023, https://www.cbo.gov/system/files/2023-01/PL117-328_1-12-23.pdf.
[2] Note: CBO estimated that for the $22.1 billion in savings, $15.0 billion was for the enrollment effect of ending continuous eligibility and $7.1 billion was for the phasing down of the enhanced federal medical assistance percentage (FMAP).
[3] Office of Management and Budget (OMB), "Mid-Session Review Budget of the U.S. Government Fiscal Year 2025," July 19, 2024, https://www.whitehouse.gov/wp-content/uploads/2024/07/msr_fy2025.pdf.
[4] CBO, "An Update to the Budget and Economic Outlook: 2024 to 2034,' June 18, 2024, https://www.cbo.gov/publication/60039.

In addition, the Government Accountability Office (GAO) published a report on July 18, 2024, titled, "Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19,"[5] which raises further questions. To ensure Congress understands your agency's s actions, I request a response to my June 11 letter and detailed answers to the following questions by no later than August 30, 2024:

1. The GAO report found that California was erroneously maintaining coverage for 175,000 individuals who should not have been enrolled.[6]
   a. Has California ended this system defect?
   b. What was the root cause of the defect in California?
   c. What amount is California required to pay back to the federal government for this defect?
   d. What amount has California paid back to the federal government?

2. Have other states, in addition to California, erroneously maintained coverage for individuals who should have not been enrolled? Please provide a list of those states and the associated number of individuals enrolled. If CMS does not have a list of states, please provide details of steps the agency has taken in partnership with states to ensure individuals have not erroneously maintained coverage.

3. A *Wall Street Journal* article states, "[a] report from the Office of Health Policy estimated that in 2021, as Medicaid membership was swelling, 15 percent of working enrollees reported having both Medicaid and employer-sponsored health coverage. Including dependents, that translated into over four million people, a number that likely was much higher at the 2023 peak. Add to that a study that showed that millions of people were unaware that they still had Medicaid in 2022 and you have a big chunk of people not using services that are being paid for."[7]
   a. Given this reporting, what efforts is CMS taking in partnership with states to ensure individuals who have maintained Medicaid coverage through an ex parte review do not have employer-sponsored health coverage?
   b. What specific oversight mechanisms is CMS using to ensure states are not erroneously maintaining coverage for individuals who should not be enrolled?
   c. What actions has CMS taken to ensure third-party liability requirements are met in light of 15 percent of working enrollees reported having both Medicaid and employer-sponsored health coverage? I note that the most recent HHS Office of Inspector General's report on third-ability liability found that a significant amount of money is at risk of not being recovered.[8]

[5] Government Accountability Office (GAO), "Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19," July 18, 2024, https://www.gao.gov/products/gao-24-106883.
[6] *Id*, at 7.
[7] Waiver, David, "Medicaid Was a Boon to Insurers During the Pandemic. Now, Not So Much," July 25, 2024, https://www.wsj.com/health/healthcare/medicaid-was-a-boon-to-insurers-during-the-pandemic-now-not-so-much-0d4645a0.
[8] U.S. Department of Health and Human Services (HHS) Office of Inspector General, "Medicaid Third-Party Liability Savings Increased, But Challenges Remain," January 14, 2013, https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/medicaid-third-party-liability-savings-increased-but-challenges-remain/.

4. The GAO report states, "[a]s of April 2024, CMS had taken formal action to recoup federal funds for one state's noncompliance with unwinding data reporting requirements, using enforcement authority established in the Consolidated Appropriations Act, 2023."[9] This is referring to CMS' enforcement action taken against Nevada for failing to report complete call center data as required by that law.[10]
   a. What amount has Nevada paid back to the federal government?
   b. Does CMS intend to use its enforcement actions against a state after June 30, 2024, for noncompliant activities prior to July 1, 2024?

5. GAO found that "[s]ome of the most common flexibilities CMS approved for Medicaid unwinding related to how states verify enrollees' income and assets and how states update enrollees' contact information."[11]
   a. Please provide the agency's assessment for program integrity risks using older data to verify enrollees' income and assets.
   b. Based on this assessment, what percentage of federal Medicaid spending for fiscal years 2023, 2024, and 2025 is potentially at risk of being improperly spent as a result of the ex parte flexibilities?

6. The GAO report states that CMS is permitting the use of historical data to estimate how many enrollees would be renewed using older income data.[12] It also states that as a result of an April 2024 final review, CMS is allowing states to "obtain updated enrollee contact information from reliable sources, including managed care plans or the U.S. Postal Service, without independently confirming that information with enrollees."[13]
   a. Please provide an analysis of the reliability of address data provided by managed care plans and the U.S. Postal Service. This analysis should include the percentage of enrollees who have a reliable address for either data source.
   b. Is the agency conducting analysis or oversight on the accuracies of these methods to determine if they are reliable practices? Please provide the agency's findings.

7. The GAO report states, "as of April 2024, CMS had not documented the oversight practices that reflect lessons learned during unwinding or developed plans for how or when the agency would implement them."[14] HHS's response did not indicate if and when this would be done. I agree with GAO's statement, "[w]ithout documentation of the oversight practices the agency learned were needed to better ensure compliance, it is unclear how or when these practices would be implemented."[15] I request a specific timeline for when the agency will document its oversight practices and lessons learned along with a robust plan to ensure the stated practices comply with federal statutes.

[9] Government Accountability Office (GAO), "Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19," July 18, 2024, https://www.gao.gov/products/gao-24-106883.
[10] *Id*, at 23.
[11] *Id*, at 9.
[12] *Id*, at 11.
[13] *Id*, at 11-12.
[14] *Id*, at 12.
[15] *Id.*

8. The GAO report states, "[w]hen approving these [temporary] flexibilities for unwinding, CMS sought to balance protecting enrollees' access to care with program integrity concerns."[16] Is it the agency's official position to compromise on statutory obligations to protect against fraud, waste, and abuse in the name of balance?

9. It is my understanding that the Public Assistance Reporting Information System (PARIS), a federal-state partnership that ensures the integrity of public assistance programs by detecting and deterring improper payments,[17] did not conduct the May 2024 quarterly match for the April-June quarter[18] or the August 2024 quarterly match for the July-September quarter.[19] PARIS is used to check if a beneficiary is receiving duplicate benefits in two or more states. According to your agency's most recent Financial Report, from August 2022 to May 2023 "states submitted over 334.9 million records for matching and received average match records of 2.6 million unique social security numbers each quarter."[20]
   a. Why did a May 2024 or August 2024 quarterly match not take place?
   b. What is the financial risk to the federal government for not conducting these quarterly matches?
   c. Please provide the date of the next match and how HHS intends to conduct matches retrospectively for the quarters not matched.
   d. Given the flexibilities your agency has offered on ex parte reviews, how are states capturing duplicative benefits if PARIS matches have not occurred in the most recent quarter?
   e. What oversight is the federal government doing to protect taxpayer dollars from being used for duplicative benefits?

I look forward to your timely answers to my questions.

Sincerely,

Chuck Grassley

Charles E. Grassley
Ranking Member
Committee on the Budget

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[16] *Id*, at 10-11.
[17] HHS, Administration for Children & Families, "PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM," https://www.acf.hhs.gov/paris/about#:~:text=The%20Public%20Assistance%20Reporting%20Information,detecting%20and%20deterring%20improper%20payments.
[18] HHS, Administration for Children & Families, "PARIS Transmittal 2024 -6: Update next PARIS match May 2024," May 8, 2024, https://www.acf.hhs.gov/paris/training-technical-assistance/paris-transmittal-2024-6-update-next-paris-match-may-2024.
[19] HHS, Administration for Children & Families, "Transmittal 2024-09: PARIS MATCH AUGUST 2024," July 31, 2024, https://www.acf.hhs.gov/paris/training-technical-assistance/transmittal-9-paris-match-august-2024.
[20] HHS, Agency Financial Report – Fiscal Year 2023," https://www.hhs.gov/sites/default/files/fy-2023-hhs-agency-financial-report.pdf.