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ONE HUNDRED EIGHTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-3641
Minority (202) 225-2927

June 5, 2023

The Honorable Christi Grimm
Inspector General
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Grimm:

The Medicaid program is at an important moment in its history as States prepare to begin the process of unwinding the continuous coverage requirements of the Families First Coronavirus Response Act (FFCRA). As you know, the FFCRA was passed in the early days of the COVID-19 pandemic as the economy was in freefall. State budgets were contracting, while millions of Americans were losing jobs as the country and economy shut down.

To mitigate the crisis, Congress provided an enhanced Federal Medical Assistance Percentage (FMAP) of 6.2 percent to States, along with the requirement that Medicaid coverage must be maintained through the COVID-19 Public Health Emergency (PHE). Congress did not anticipate that the PHE would last more than three years and lead to Medicaid rolls growing from about 70 million beneficiaries pre-pandemic to nearly 95 million beneficiaries today.[1] Many of those currently enrolled in the program should no longer be considered eligible, and now States could start their work to redetermine eligibility as early as April 1, 2023.

Nonetheless, issues surrounding enrollment concerns and improper payments were a major problem in Medicaid even before the pandemic and will still be a challenge for States once they are on the other side of the FFCRA unwinding. For example, research in 2019 indicated that millions of people were improperly enrolled in the program, whether because the individuals were not actually eligible for coverage in the first place or because of a failure to verify eligibility for a

[1] Jennifer Tolbert, Unwinding the Continuous Enrollment Provision: Perspectives from Current Medicaid Enrollees, (Mar. 9, 2023), https://www.kff.org/medicaid/issue-brief/unwinding-the-continuous-enrollment-provision-perspectives-from-current-medicaid-enrollees/.

beneficiary who should otherwise be considered eligible for coverage, due to failures by States to properly review beneficiary eligibility information like payroll data or proof of residency.[2]

Audits conducted by your office have confirmed these findings through the identification of a substantial number of both ineligible and unverified enrollees, who were placed in the program without proper review.[3] Similarly, according to a 2021 report from the Centers for Medicare and Medicaid Services (CMS), the federal government paid nearly $100 billion annually in improper Medicaid payments, with the majority of these payments made to individuals who are not eligible for the program or were enrolled without a proper review of their information.[4]

It is critical that CMS and States take action to reduce the number of improper Medicaid payments to ensure that taxpayer dollars are spent to care for the most vulnerable who Medicaid was designed to help.

To inform our efforts to improve Medicaid, we request at the appropriate time, a briefing on the work that the Office of Inspector General (OIG) is performing that focuses on State's unwinding of the continuous enrollment requirement. After the unwinding process has been completed, we also request that the OIG conduct audits of eligibility verification processes in States with high risk of improper payments due to eligibility errors as identified by CMS Payment Error Rate Measurement (PERM) audits. Specifically, we ask that you review and analyze the following relating to ineligible beneficiaries:

1. The reason for beneficiaries' ineligibility;
2. The types of factors and information considered at the time of enrollment;
3. The causes of incorrect eligibility determinations;
4. The approximate time individuals were ineligibly enrolled;
5. The approximate dollar amount spent on recipients who were ineligible;
6. The approximate dollar amount delivered to insurance companies on behalf of ineligible enrollees.

In addition to your review of improper payments identified by CMS PERM, we request a briefing on the work that the OIG has performed involving recipients of Medicaid who are receiving benefits in more than one state and Medicaid payments for people who are deceased.

Your assistance is appreciated. If you have any questions, please contact Gavin Proffitt with the Majority Committee staff at (202) 225-3641.

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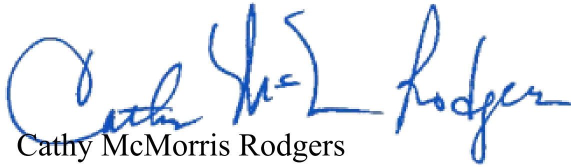
[2] Blase, Brian and Yelowitz, Aaron, The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments (November 25, 2019). Mercatus Research Paper, Available at SSRN: https://ssrn.com/abstract=3515323 or https://www.mercatus.org/research/research-papers/acas-medicaid-expansion
[3] DHHS Office of Inspector General, Prior Audits of Medicaid Eligibility Determinations in Four States Identified Millions of Beneficiaries Who Did Not or May Not Have Met Eligibility Requirements, A-02-20-01018, (Jan. 31, 2022), https://oig.hhs.gov/oas/reports/region2/22001018.pdf.
[4] Fiscal Year 2022 Improper Payments Fact Sheet, (Nov. 15, 2022), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2022-improper-payments-fact-sheet.

Sincerely,



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CC: Frank Pallone Jr., Ranking Member, Energy and Commerce Committee
Anna Eshoo, Ranking Member, Subcommittee on Health
Kathy Castor, Ranking Member, Subcommittee on Oversight and Investigations