

ONE HUNDRED SIXTEENTH 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) 225-2927  
Minority (202) 225-3641

June 27, 2019

The Honorable Alex M. Azar  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is examining the U.S. Department of Health and Human Services' (HHS) administration of the Medicaid program. Recent actions by the state legislatures in Utah and Tennessee suggest that one or both states may soon request waiver authority to cap their Medicaid programs, threatening access to care for millions of people in these states. I am deeply troubled by these developments, and with the reports that the Centers for Medicare & Medicaid Services (CMS) plans to release guidance to states on how they may cap spending on their Medicaid programs, either through a block grant, a per capita cap, or some other mechanism.<sup>1</sup> Equally troubling are reports that CMS Administrator Seema Verma "has urged [Alaska] to be the first state to receive Medicaid dollars as a block grant."<sup>2</sup> In view of these reports, and recent state action in Tennessee and Utah to request waivers to block grant their programs, I write to request additional information about HHS's actions related to block granting or otherwise capping the Medicaid program.

In 2017, Congress considered and rejected converting Medicaid to a block grant or per capita cap when such a change was a centerpiece of the failed Republican effort to repeal the Affordable Care Act. Capping Medicaid funding, whether through a block grant or a per capita cap, would be devastating to those who rely on the program. The President's budget estimates

---

<sup>1</sup> Politico, *Trump wants to bypass Congress on Medicaid plan* (January 11, 2019).

<sup>2</sup> Letter from Michael Dunleavy, Governor of Alaska, to Donald Trump, President of the United States (March 1, 2019).

that such a change would cut \$1.4 trillion from Medicaid over 10 years.<sup>3</sup> Cuts of that magnitude would threaten access to services for children with complex medical needs, people with disabilities, seniors, and others in the community who receive care from safety net providers that are largely financed by Medicaid. The American Hospital Association has said the deep cuts from such a proposal “would reduce federal Medicaid funding to unsustainable levels” and “will have serious negative consequences for communities across America.”<sup>4</sup>

Congress recognized that changing the financing structure of Medicaid to implement a block grant or per capita cap requires a statutory change, and the President’s 2020 budget acknowledges that legislation is needed to do so.<sup>5</sup> Moreover, federal law does not give the Secretary authority to change Medicaid’s structure to a block grant or per capita cap through administrative action. In order to implement a block grant or per capita cap, the Secretary would need to effectively waive Section 1903 of the Social Security Act (the Act), which states that “the Secretary... shall pay to each State which has a plan approved under this title, for each quarter... an amount equal to the Federal medical assistance percentage... of the total amount expended during such quarter as medical assistance under the State plan.”<sup>6</sup> Section 1115 authorizes the Secretary to waive certain enumerated sections of the law if doing so “is likely to assist in the promotion of the objectives of [Medicaid]”<sup>7</sup>, which, according to the statute, is “to furnish medical assistance” to eligible individuals.<sup>8</sup> Therefore, for the Secretary to waive part of the Medicaid program, it must satisfy a two-prong test: first, it must be one of the enumerated sections listed in Section 1115, and second, it must promote the objectives of the Medicaid program.

Capping the Medicaid program fails both requirements. Section 1903 is not one of the enumerated sections listed in the statute the Secretary can waive. Congress never intended for the Secretary to have the ability to waive the federal funding provisions (financing requirements); if it had, the statute would clearly state it, as it does with other sections of the law. To argue otherwise defies the plain language and clear statutory framework of Section 1115. Furthermore, it defies logic to argue that limiting medical assistance promotes the objective of “furnishing medical assistance.” Capping the Medicaid program would result in reduced or loss of benefits for individuals, loss of coverage, and imperil the financing of critical health care

---

<sup>3</sup> Department of Health and Human Services, *FY2020 Budget in Brief*. ([www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf](http://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf)).

<sup>4</sup> Senate Committee on Finance, Statement of the American Hospital Association, *Hearing to Consider the Graham-Cassidy-Heller-Johnson Proposal*, 115th Cong. (September 25, 2017).

<sup>5</sup> See note 3.

<sup>6</sup> Social Security Act, Pub. L. No. 74-271: § 1903(a).

<sup>7</sup> Social Security Act, Pub. L. No. 74-271: § 1115.

<sup>8</sup> Social Security Act, Pub. L. No. 74-271: § 1901.

providers. In other words, it would reduce the amount of medical assistance, not assist in furnishing it.

Recent reports suggest that you plan to take administrative action to make changes in Medicaid financing despite the fact that there is no statutory authority to implement a block grant or per capita cap through a section 1115 demonstration project, or “waiver.”<sup>9,10</sup> Your recent approval of Utah’s waiver already appears to exceed your authority in the statute.<sup>11</sup> It allows the state to cap enrollment based on available state appropriations and gives states the authority to deny coverage to people whenever it experiences budget pressures or simply decides it has spent enough on coverage for eligible adults without any accountability or oversight by CMS, in violation of the statute. An HHS spokesperson said that CMS believes “that only when states are held accountable to a defined budget can the federal government finally end our practice of micromanaging every administrative process.”<sup>12</sup> This suggests that you are considering allowing states to cap state spending on Medicaid by limiting enrollment or otherwise changing eligibility or benefits to stay within their self-imposed spending caps. Like Utah’s enrollment cap, this would undermine the fundamental structure of Medicaid, which provides a guarantee of coverage to all people who qualify.

HHS’ communication to Alaska also strongly suggests that you are not interested in public feedback that is critical to any waiver. Federal law requires that 1115 waivers go through several steps prior to a final decision by the Secretary, including an opportunity for public notice and comment at the state and federal level.<sup>13</sup> These are important steps in deliberating the merits and drawbacks of significant policy changes; they are not merely a check-the-box exercise in order for HHS to implement an ideologically-driven agenda. The revelation that CMS Administrator Verma “urged [Alaska] to be the first state to receive Medicaid dollars as a block grant” suggests that the agency has prejudged the approach prior to any opportunity for public comment.<sup>14</sup> This calls into question the integrity of whether HHS is evaluating these waivers on the merits and the law, and the level of scrutiny HHS will apply to such waivers.

As the Chair of the Committee on Energy and Commerce with jurisdiction over Medicaid, it is my responsibility to ensure that the program is administered in compliance with

---

<sup>9</sup> See note 1.

<sup>10</sup> Modern Healthcare, *Medicaid block grant waiver reports revive hospitals' funding worries* (January 16, 2019).

<sup>11</sup> Letter from Seema Verma, Administrator, Centers for Medicare & Medicaid Services, to Nathan Checketts, Director, Utah Department of Health (March 29, 2019) ([www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf)).

<sup>12</sup> See note 10.

<sup>13</sup> Social Security Act, Pub. L. No. 74-271: § 1115(d).

<sup>14</sup> See note 2.

federal law. Allowing states to cap their Medicaid spending based on their own budget decisions without regard to the adequacy of the funding to provide coverage and full benefits to all eligible individuals would have devastating consequences for those who rely on Medicaid for their medical care. The plain language of the statute prohibits the Secretary from approving a waiver that requests a block grant or per capita cap in Medicaid through a cap on federal funds. Legislative history and the Administration's own budget acknowledge that converting Medicaid to a block grant or per capita cap would require a statutory change. Other changes that allow states to develop their own caps are similarly outside your authority. Accordingly, it is troubling to learn that you are putting your radical agenda ahead of your responsibility to implement the law faithfully.

In order to oversee your administration of the Medicaid program, please provide the following no later than July 15, 2019:

1. All documents, including briefing memos and drafts, related to the State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity, or related to using section 1115 authority or section 1332 authority to implement a Medicaid block grant, per capita cap, or otherwise cap Medicaid expenditures.
2. All cost and coverage estimates prepared by HHS, including the CMS Office of the Actuary, the Office of Management and Budget (OMB), or contractors or subcontractors for HHS or OMB, related to the State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity, a Medicaid block grant, or Medicaid per capita cap.
3. A list of all personnel, and their titles, involved in approving the decision to draft or release the State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity.
4. All documents, including the relevant A-19, briefing materials, and background materials related to the President's budget proposal "Empowering States and Consumers to Reform Health Care."
5. All cost and coverage estimates prepared by HHS, including the CMS Office of the Actuary; OMB; or contractors or subcontractors for HHS or OMB; related to the President's budget proposal "Empowering States and Consumers to Reform Health Care."
6. All emails regarding the State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity, block grants, per capita caps, or section 1115 waivers between Calder Lynch and Nathan Checketts, Utah Director of Medicaid and Health Financing.
7. All documents and communications regarding the State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity; block grants, per capita



caps, or section 1115 waivers between Seema Verma, Calder Lynch, Brady Brookes, Mary Mayhew, and Christopher Traylor and officials in the states of Utah, Alaska, Georgia, and Tennessee, including but not limited to individuals in the office of the Governor and the State Medicaid Director.

8. All documents related to the State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity, block grants or per capita caps provided to the Department of Health and Human Services by contractors or subcontractors.

I appreciate your attention to this matter. If you have any questions, please contact Rick Van Buren with the Committee staff at 202-225-5056.

Sincerely,

A handwritten signature in blue ink, reading "Frank Pallone, Jr." in a cursive style.

Frank Pallone, Jr.  
Chairman