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

June 22, 2015

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing Entitled "Examining the Administration's Approval of Medicaid Demonstration Projects"

I. INTRODUCTION

On Wednesday, June 24, 2015, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "Examining the Administration's Approval of Medicaid Demonstration Projects."

II. WITNESSES

Panel 1

- Katherine Iritani, Director, Health Care, Government Accountability Office.

Panel 2

- Haley Barbour, former Governor of Mississippi and Founding Partner, BGR Group;
- Matt Salo, Executive Director, National Association of Medicaid Directors; and
- Joan Alker, Executive Director, Georgetown University Center for Children and Families.

III. BACKGROUND

Medicaid Overview

Medicaid, a joint as Federal-State program that finances health care coverage for low-income populations, will cover an estimated sixty-nine million beneficiaries in Fiscal Year (FY) 2016 for which the Federal share of Medicaid outlays is expected to be approximately $344.4 billion. Under the program, States claim Federal matching funds for Medicaid expenditures from the Department of Health and Human Services (HHS), which oversees the program at the Federal level.

The Federal government establishes general guidelines for the program, while States administer their own Medicaid programs. The Federal government matches State expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which is set

by a statutory formula and can be no lower than fifty percent. Participating States are required to cover individuals who meet certain minimum categorical and financial eligibility standards.

How Medicaid 1115 Demonstrations Work

Section 1115 of the Social Security Act (Act) authorizes the Secretary of HHS to waive certain Federal Medicaid requirements and allow costs that would not otherwise be eligible for Federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.[1] Section 2107(e) of the Act states that the waiver authorities in section 1115 of the Act apply to the Children's Health Insurance Program (CHIP) in title XXI of the Act in the same manner as they apply to the Medicaid program in title XIX of the Act.

Because the Secretary may waive requirements under Section 1115, a State benefitting from this authority is said to have received "an 1115 waiver." Similarly, the other two types of Medicaid waivers that HHS may grant for Medicaid managed care or home and community based services also may be referred to by the sections of Federal statute under which they are governed.[2]

Importantly, expenditure authorities approved in section 1115 demonstrations allow States to receive Federal funds for costs that would not otherwise be matchable under Medicaid. The demonstrations, including their associated expenditure authorities, provide a way for States to test and evaluate new approaches for delivering Medicaid services.

In recent years, 1115 demonstrations have been used by some States to expand Medicaid up to 138 percent Federal poverty limit (FPL) for childless adults, as outlined under Patient Protection and Affordable Care Act (PPACA).[3] Section 1115 demonstrations also have been used by six States to implement Delivery System Reform Incentive Payment (DSRIP) programs, which provide Medicaid funds for States to make supplemental payments that would not otherwise be permitted under Federal managed care rules and as tools for investing in provider-led efforts intended to improve health care quality and access.[4] However, CMS has also noted that in the past, some demonstrations have "constrained eligibility or benefits in ways not otherwise permitted by statute . . . some demonstrations have provided for a more limited set of benefits than the statute requires for a specified population, implemented cost-sharing at levels that exceed statutory requirements, or included enrollment limits."[5]

Section 1115 demonstrations account for a significant and growing proportion of Federal Medicaid expenditures. The Government Accountability Office (GAO) has noted that in FY

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[1] http://www.ssa.gov/OP_Home/ssact/title11/1115.htm. Note: While the statute gives this authority to the Secretary of HHS, most of the oversight of Medicaid demonstrations is delegated to the Administrator of the Centers for Medicare and Medicaid Services (CMS).
[2] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html
[3] http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers
[4] In its June 2015 report, MACPAC indicated that clear and consistent federal guidance about DSRIP program design, policies, and goals is needed.
[5] http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/html/2012-4354.htm

2014, section 1115 demonstrations accounted for close to *one-third* of total Medicaid expenditures.[6] Yet, GAO found that in FY 2011, "$57.5 billion in [F]ederal funds, or about one-fifth of the $260 billion in Federal Medicaid expenditures, were for services, coverage initiatives, and delivery system redesigns provided under section 1115 demonstrations in [forty] [S]tates."[7]

In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. HHS has approved expenditure authorities to allow States to expand Medicaid coverage to populations not otherwise eligible, as well as for other purposes, such as funding for State programs.

HHS policy requires that section 1115 demonstrations be budget-neutral to the Federal government; that is, the Federal government should spend no more under a State's demonstration than it would have spent without the demonstration.[8] To show budget neutrality, generally a State must establish that its planned changes to its Medicaid program—including receiving Federal matching funds for otherwise unallowable costs—will be offset by savings or other available Medicaid funds.

The use of 1115 waivers is widespread. A majority of States currently has an 1115 demonstration waiver, or had one in recent years. As of 2011, forty-one States operated sixty-six different 1115 waivers.[9] Several States have multiple waivers, and at least one State has operated virtually its entire Medicaid program under a waiver for more than thirty years.

In February 2012, CMS published a final regulation implementing provisions of section 10201(i) of PPACA. This section of PPACA outlined new transparency and public notice procedures for experimental, pilot, and demonstration projects approved under section 1115 of the Act relating to Medicaid and CHIP. CMS said the final rule would "increase the degree to which information about Medicaid and CHIP demonstration applications and approved demonstration projects is publicly available and promote greater transparency in the review and approval of demonstrations."[10] At the same time that CMS finalized the regulation, the agency sent a State Medicaid Director letter to explain the requirements.[11] The final regulation became effective on April 27, 2012.

Concerns With CMS's 1115 Demonstration Approval Process

Budget Neutrality

Nonpartisan observers have long raised concerns about the degree to which 1115 demonstration waivers may be responsible for increasing Medicaid's Federal outlays. In a series

[6] http://www.gao.gov/assets/670/669582.pdf
[7] GAO report GAO-13-384, page 2.
[8] From CMS's website: "Demonstrations must be 'budget neutral' to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver." http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html
[9] https://www.macpac.gov/wp-content/uploads/2015/01/Overview_of_Medicaid.pdf
[10] http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/html/2012-4354.htm
[11] http://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf

of reports over the past decade, the GAO has raised serious concerns about the transparency, integrity, and accountability of CMS's 1115 waiver approval process.

For example, GAO recently found CMS "approved spending limits that were based on assumptions of cost growth that were higher than its benchmark rates, and that, in some cases, included costs [S]tates never incurred in their base year spending."[12] As a result of its many findings in this area and a lack of action by HHS to respond to GAO recommendations for improvement, GAO has suggested that Congress "require HHS to improve its budget neutrality process, in part, by improving the review criteria and methods, and by documenting and making clear the basis for approved limits."[13]

GAO found that "by not following its own budget neutrality policy and not providing clear support for its decisions to fund certain demonstrations, HHS approved spending limits that were billions of dollars higher than what the [F]ederal spending would have been if the []States' existing Medicaid programs had continued."[14]

More recently, in approving Arkansas's 1115 demonstration expanding Medicaid to childless adults under PPACA, HHS gave the State the authority to test whether providing premium assistance to purchase private coverage offered on the health insurance exchange improves access to care for enrollees. While this approach was heralded in many circles as groundbreaking or innovative, it should not be a surprise if these exchange enrollees have better access than beneficiaries enrolled in traditional Medicaid. That is because HHS did not ensure that the demonstration would be budget-neutral. GAO found that "HHS approved a spending limit for the demonstration that was based, in part, on hypothetical costs—significantly higher payment amounts the [S]tate assumed it would have to make to providers if it expanded coverage under the traditional Medicaid program—without requesting any data from the [S]tate to support the [S]tate's assumptions." As a result, GAO estimated that, by including these costs, the three-year, nearly $4.0 billion spending limit that HHS approved for the State's demonstration was approximately $778 million more than what the spending limit would have been if it was based on the State's actual payment rates for services under the traditional Medicaid program.

Furthermore, HHS gave Arkansas the flexibility to adjust the spending limit if actual costs under the demonstration proved higher than expected, which increases the risk to the Federal government. A review of Arkansas data shows that costs have been far above the State's initial projections.[15] GAO reported that HHS officials said the Department granted the same flexibility to adjust the spending limit to eleven other States implementing demonstrations that affect services for newly eligible beneficiaries under PPACA.[16] This decision will likely make

[12] http://www.gao.gov/assets/660/655484.pdf
[13] http://www.gao.gov/assets/660/655484.pdf
[14] http://www.gao.gov/assets/670/669582.pdf
[15] http://www.gao.gov/products/GAO-14-689R and http://thefga.org/research/arkansas-private-option-medicaid-expansion-is-putting-state-taxpayers-on-the-hook-for-millions-in-cost-overruns/
[16] The flexibility to adjust budget neutrality projections without having to amend the terms and conditions of the demonstration has not been provided for demonstrations outside those related to Medicaid expansion. The terms and conditions encompass the requirements for the demonstration, which include the conditions and limitations on approved expenditure authorities as well as specific reporting and evaluation requirements for the demonstration period.

later comparisons of per capita spending under traditional Medicaid and exchange coverage look more favorable to exchange coverage than it otherwise would.

Approval Criteria

In a recent report, GAO reviewed new section 1115 demonstrations, as well as extensions or amendments to existing Medicaid demonstrations, approved by HHS from June 2012 through mid-October 2013.[17] In total, GAO reviewed twenty-eight demonstrations across twenty-five States. The findings from GAO raise serious concerns.

First, HHS did not have specific criteria for determining whether programs funded through section 1115 demonstrations were likely to promote Medicaid objectives. In response to GAO's query, HHS provided "general criteria" that it indicated are used to determine whether Medicaid objectives are met, including whether the demonstration will:

1. increase and strengthen coverage of low-income individuals;
2. increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations;
3. improve health outcomes for Medicaid and other low-income populations; or
4. increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

A demonstration need only meet *one* of these criteria for it to be considered as promoting Medicaid program objectives. However, according to GAO, these criteria are not specific enough to inform Congress, States, and other stakeholders of the agency's interpretation of its section 1115 authority. Moreover, these criteria—which CMS characterized as its longstanding criteria for evaluating and approving funding—are not transparent to stakeholders. These criteria are not in regulations or even on CMS's website.

Second, it was unclear how approved spending promoted Medicaid objectives, because HHS's demonstration approval documents did not always clearly articulate precisely what approved expenditures were for and how they will promote Medicaid objectives. During the time period of GAO's review, HHS approved (new, and extended or modified existing) expenditure authorities that allowed five States to collectively receive $9.5 billion in Federal matching funds for 154 State-operated programs; program that were previously financed with State or non-Medicaid Federal sources, or a combination of these.

However, several State programs approved for Federal Medicaid funds in these States appeared, on their face, to be only *very tangentially* related to improving health coverage for low-income individuals and HHS lacked documentation explaining how the programs related to the purpose of the demonstration or Medicaid objectives. For example:

- State programs included those providing health services for the general public, insurance subsidies, workforce training and programs to pay for licensing of health care facilities.

[17] http://www.gao.gov/products/GAO-15-239

- Some programs targeted a broad public health audience regardless of income levels and funded activities such as media campaigns, radio spots, posters, special community events, education, prevention and treatment activities, sponsorship of annual symposiums, and flexible assistance to individuals and their families statewide.

Third, CMS approvals allowed Medicaid dollars to subsidize middle class Americans—even at a time when there are waiting lists for the critically ill to receive care through Medicaid.[18] In explaining agency responses on the GAO report, HHS staff indicated that for purposes of 1115 demonstrations, the agency defines "low-income" as individuals or families with income at or below 250 percent of the Federal poverty level. In FY 2015, 250 percent FPL is $60,625 for a family of four, while the median income of Americans from FY 2009-FY2013 was $53,046 according to the U.S. Census.[19] Many State programs that were approved under demonstrations to receive Federal matching funds did not even target their services to serve low-income Americans, even when using HHS's definition of the term. Additionally, HHS has yet to articulate its threshold for "low-income" in a public and transparent manner.

Finally, many of the programs approved for the 1115 demonstrations duplicated other Federal, State, local, or non-governmental programs or funding opportunities.

Process for Approval and Renewals

There is no standardized process to apply for a Section 1115 demonstration, but CMS has issued program guidance that affects the approval process. This guidance is non-binding in nature and can be changed easily. Accordingly, as CRS has noted, "[S]tates often work collaboratively with CMS to develop their proposals [which] are subject to approval by CMS, the Office of Management and Budget (OMB), and. . . may be subject to additional requirements such as site visits before the program may be implemented under the agreed upon terms and conditions."[20]

Due to the significant statutory authority given to the Secretary in determining what gets approved or renewed in an 1115 demonstration, some States have expressed concerns over the lack of certainty over what criteria are applied in what manner by CMS to approve waivers. States have expressed frustration over how one State may be approved for a certain policy approach while another State is denied.

One frustration often voiced by State officials is the time it takes to negotiate and secure an 1115 waiver. HHS's February 2012 regulations specify a forty-five-day minimum Federal decision-making period for the review of 1115 waiver applications, but no maximum period. In contrast, there is a ninety-day time period in which CMS must act on State plan amendments.

Many argue that the waiver approval process is too often a barrier to innovation in Medicaid. A review by the American Action Forum found that the average review-to-approval

[18] http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/
[19] http://quickfacts.census.gov/qfd/states/00000.html
[20] Congressional Research Service, 2008 report, RS21054.

time was 190 days for all types of waivers.[21] But the average number of days for a State to gain approval for an entirely new Medicaid waiver was 337 days, according to the same analysis. This analysis does not account for the weeks, months, or more of discussions and negotiations between States and HHS prior to the official submission of the waiver application. For example, the Medicaid expansion in Indiana, often referred to as "Healthy Indiana Plan 2.0," took *two years* from the beginning of negotiations until the waiver was granted.[22] Many State-level officials argue that in order for Medicaid to better serve beneficiaries, States need to be able to make changes more quickly and efficiently in their programs.

Section 1115 demonstration programs are usually approved for five years and may be extended for three years, although some exceptions and variation apply. One concern historically expressed by States is the uncertainty created by a State not knowing if CMS will extend an expiring waiver or open up the entire waiver for renegotiation. Some States have been operating under an 1115 waiver for so long that they have suggested Congress create a process where longstanding core elements of an 1115 waiver can be effectively "grandfathered" into that State's State Plan Amendment (SPA), which directs the operation of the program.

Uncompensated Care Pools

One issue related to 1115 demonstrations that has gained notable attention in recent months is whether or not CMS will renew uncompensated care pools that are part of States' expiring 1115 waivers. According to GAO, from June 2012 through mid-October 2013, CMS approved or modified expenditure authorities for uncompensated care pools in six States for a total of about $7.6 billion in approved spending. The expenditure authorities, which varied from over fifteen months to over five years in duration, were intended to cover providers' uncompensated care costs associated with both Medicaid and uninsured patients, similar to supplemental payments under the Disproportionate Share Hospital (DSH) program. More recently, CMS has articulated a new policy preference for using Federal Medicaid funds to pay for Medicaid coverage (under Medicaid expansion as defined in PPACA) rather than services and care as provided under States' uncompensated care pools. By several counts, nine States currently have a waiver with an uncompensated care pool, including four States that have not expanded their Medicaid programs.[23]

CMS has suggested the agency plans to apply the same standards to all States receiving such waiver funding, regardless of whether they have expanded Medicaid under PPACA. When asked about one State, CMS commented:

> We've been in contact with those [S]tates that have uncompensated care pools and reiterated that we look forward to an ongoing dialogue to develop a solution that works for patients, hospitals and the taxpayer . . . . We told [S]tates that our letter . . . articulates key principles CMS will use in considering proposals regarding

[21] http://americanactionforum.org/research/breaking-down-barriers-to-medicaid-innovation-rethinking-medicaid-waiver-ap
[22] https://secure.in.gov/fssa/hip/files/HIP_timeline.pdf
[23] http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420741

> uncompensated care pool programs in their [S]tates, but that discussions with each [S]tate will also take into account [S]tate-specific circumstances.[24]

However, despite this, the Administration appears to have linked its reticence to renew uncompensated care pool funding in an 1115 waiver with its preference for Medicaid expansion under PPACA. CMS has general authority to not renew a State's 1115 waiver, including an uncompensated care pool operated as part of that waiver. However, uncompensated care pools address three of the four criteria CMS articulated using to determine if demonstration programs promote Medicaid program objectives. Specifically, such pools can increase access to, stabilize, and strengthen providers; improve health outcomes for Medicaid and other low-income populations; and increase the efficiency and quality of care for those populations.

Additionally, the legality of the agency's action to *directly link* the non-renewal of such funds to a policy preference for the State to expand Medicaid enters uncharted territory, since a court could potentially find the agency is improperly using existing Federal funding to pressure a State to take an action, which the Supreme Court ruling deemed optional (*NFIB vs. Sebelius).* While there is pending litigation on this issue, a court has not ruled definitely on this issue at this time.

Aside from the legal questions, CMS's decision to not renew a State's uncompensated care pool as part of its 1115 waiver certainly has a direct financial impact on the State and providers who care for Medicaid patients. This financial impact is greater in States that have not expanded Medicaid under PPACA. As a Robert Wood Johnson Foundation analysis has noted, these uncompensated care pools "vary in size, but can provide a large amount of funding to hospitals."[25] As this analysis details, States that have not expanded Medicaid under PPACA "face the prospect of both the loss of Medicaid DSH funds, and restructuring or reduction of their uncompensated care pools"—a potentially very significant reduction in funds for providers who provide care for Medicaid patients and other low-income individuals.[26]

IV. ISSUES

The following issues may be examined at the hearing:

- To what degree does CMS consistently apply its criteria for assessing Medicaid demonstration proposals? How were these criteria developed?
- What are the types of State programs being funded with Federal Medicaid dollars under demonstrations? How do they advance Medicaid objectives?
- What is the overall net effect of Medicaid demonstrations on Federal expenditures?
- How does the uncertainty a State experiences with the waiver application and approval process hamper State innovations in benefit and plan designs?

[24] http://www.advisory.com/daily-briefing/2015/04/22/cms-on-special-hospital-funds-and-medicaid
[25] http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420741
[26] http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420741

- How the demonstration process can be improved and reformed to be more transparent, predictable, and accountable to Medicaid patients, taxpayers, States, and other stakeholders?

V. STAFF CONTACTS

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