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MEDICAID DEMONSTRATIONS

More Transparency and Accountability for Approved Spending Are Needed

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June 24, 2015

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GAO Highlights

Highlights of GAO-15-715T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

The long-term sustainability of the $500 billion joint federal-state Medicaid program is important for the low-income and medically needy populations that depend on it. Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to waive certain Medicaid requirements and to authorize federal and state expenditures that would not otherwise be allowed under Medicaid, for experimental or pilot projects likely to promote Medicaid objectives. Spending under section 1115 demonstrations has increased rapidly from about one-fifth of Medicaid expenditures in fiscal year 2011 to close to one-third in fiscal year 2014. Expenditure authorities in approved demonstrations have been used by states to expand Medicaid coverage to individuals and for other purposes. HHS policy requires that demonstrations not increase federal costs for the Medicaid program.

This testimony addresses (1) the types of expenditure authorities HHS has approved for non-coverage-related purposes and whether the approval documentation shows how they promote Medicaid objectives, and (2) HHS's policy and processes for ensuring demonstrations are not likely to raise federal costs. The testimony is based on GAO's April 2015 report on expenditure authorities in demonstrations approved from June 2012 through mid-October 2013 (GAO-15-239) and several GAO reports issued from 2002 to 2014 addressing HHS's policies and practices for ensuring demonstrations are budget neutral.

View GAO-15-715T. For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In April 2015, GAO found that under Medicaid section 1115 demonstrations—experimental or pilot projects to test new ways of providing services which account for nearly one-third of Medicaid expenditures—the Department of Health and Human Services (HHS) had authorized expenditures not otherwise allowed under Medicaid for a broad range of purposes beyond expanding coverage. How these expenditure authorities promoted Medicaid objectives was not always apparent. In the 25 states' demonstrations GAO reviewed, two types of non-coverage-related expenditure authorities—state-operated programs and funding pools—were significant in the amounts of spending approved. GAO found that

- HHS allowed five states to spend up to $9.5 billion in Medicaid funds to support over 150 state-operated programs. The programs were wide-ranging in nature, such as workforce training, housing, and public health programs, and operated by a wide range of state agencies, such as educational institutions, corrections, aging, and public health agencies, and could have received funding from other sources.
- HHS allowed eight states to spend more than $26 billion to establish capped funding pools through which states could make payments to hospitals and other providers for a range of purposes, including payments to incentivize hospital infrastructure or other improvements.

How the approved expenditures for the state-operated programs and funding pools would promote Medicaid objectives was not always clear in HHS's approval documentation. For example, some state programs approved for funding appeared to be only tangentially related to health coverage for low-income individuals. Although section 1115 of the Social Security Act provides HHS with broad authority in approving expenditure authorities that, in the Secretary's judgment, are likely to promote Medicaid objectives, GAO found that HHS has not issued specific criteria for making these determinations.

In multiple reports, issued from 2002 to 2014, GAO also found that HHS's policy and process for approving state spending limits under demonstrations have lacked transparency and have not ensured that demonstrations will be budget neutral to the federal government. The criteria and methods used to set spending limits were not always clear or well supported, such that approved spending limits for some demonstrations were billions of dollars higher than what was supported. For example, for five demonstrations GAO reviewed in 2013 and 2014, using assumptions suggested by HHS's policy, GAO found that spending limits would have been $33 billion lower than what was actually approved.

In its 2015 report and prior work, GAO has made multiple recommendations to HHS aimed at (1) improving the transparency of approved spending and how it furthers Medicaid purposes and (2) ensuring Medicaid demonstrations do not increase federal costs. HHS generally agreed to improve its expenditure authority approval documentation, but did not agree with several other recommendations aimed at improving its approval policies and processes and transparency. GAO maintains that, unless HHS takes the actions necessary to implement GAO's prior recommendations, tens of billions of dollars could be at risk.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today as you examine federal approval of state Medicaid demonstrations, a significant and growing proportion of Medicaid expenditures. Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to waive many traditional federal Medicaid requirements when approving Medicaid demonstrations.[1] The Secretary can use the authority to provide states with flexibility for experimenting with delivering services outside Medicaid's traditional rules. However, certain parameters apply. Under law, Medicaid demonstrations must, as determined by the Secretary, be likely to promote Medicaid objectives. By policy, demonstrations should be budget neutral, that is, should not increase the federal government's costs for Medicaid. One key aspect of the broad authority under section 1115 is that it allows the Secretary to approve new types of expenditures under demonstrations. Expenditure authorities approved in these demonstrations allow states to receive federal funds for costs that would not otherwise be eligible for federal matching funds under Medicaid. In other words, the Secretary may allow states to effectively turn what otherwise would not be considered an allowed Medicaid cost into a covered Medicaid cost, as part of their demonstrations.[2] Expenditures for demonstrations are a rapidly increasing proportion of Medicaid expenditures. In fiscal year 2011, section 1115 demonstrations governed about one-fifth of Medicaid expenditures, rising to nearly one-third of total Medicaid expenditures in fiscal year 2014, an estimated $89 billion in federal funds.

Historically, many states sought section 1115 demonstrations to provide health coverage to individuals who could not be covered under traditional Medicaid rules. But in recent years, the Department of Health and Human Services (HHS) has approved demonstrations for many other purposes.

[1]42 U.S.C. § 1315(a). Although the Secretary of Health and Human Services has delegated the administration of the Medicaid program, including the approval of section 1115 demonstrations, to the Centers for Medicare & Medicaid Services, we refer to HHS throughout because section 1115 demonstration authority ultimately resides with the Secretary.

[2]This authority has been used, for example, to allow states to pay managed care premiums for Medicaid beneficiaries, before Medicaid law allowed states to enroll beneficiaries in managed care.

My testimony today will cover our work related to the Secretary's approvals of Medicaid demonstrations. My remarks will summarize some of our key findings about HHS's approvals, in particular (1) the types of expenditure authorities for non-coverage-related purposes that HHS has recently approved and whether approval documentation shows how they promote Medicaid objectives, and (2) HHS's policy and processes for ensuring that approved Medicaid demonstrations are not likely to raise federal costs.

My remarks on the types of expenditure authorities HHS has approved are based on findings from our April 2015 report, which examined expenditure authorities approved in demonstrations for non-coverage-related purposes and the criteria HHS used to determine whether expenditure authorities were likely to promote Medicaid objectives.[3] For that report, we examined new demonstrations, as well as extensions or amendments to existing demonstrations, approved by HHS from June 2012 through mid-October 2013. We identified a total of 25 states that received approvals during this time. We examined the approval documents for each demonstration, including the special terms and conditions, which set forth HHS's conditions and limitations for the demonstration; interviewed HHS officials; and obtained additional documentation from HHS to identify the criteria used for approval and how the department documented that states' demonstrations met such criteria. My remarks regarding HHS's policy and processes for ensuring that Medicaid demonstrations are budget neutral are based on multiple reports we have produced on this topic since 2002.[4] For these reports, we reviewed documentation for selected new comprehensive demonstrations at the time, as well as budget neutrality analyses prepared by the states and submitted to HHS. We compared the spending limits approved by HHS with our estimates of the spending limits following HHS's policy. We also reviewed HHS's policy and interviewed agency officials. The reports cited provide further details on our scope and methodology.

[3]GAO, *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives,* GAO-15-239 (Washington, D.C.: Apr. 13, 2015).

[4]See Related GAO Products at the end of this statement for reports issued on Medicaid section 1115 demonstrations.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid is a joint federal-state program that finances health care coverage for low-income and medically needy individuals. In fiscal year 2014, Medicaid covered on average an estimated 65 million beneficiaries at an estimated cost of over $500 billion.[5] States pay for Medicaid-covered services provided to eligible individuals under a federally approved Medicaid state plan, and the federal government pays its share of a state's expenditures.[6]

States that wish to change their Medicaid programs in ways that deviate from certain federal requirements may seek to do so under the authority of an approved demonstration. Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and to allow costs that would not otherwise be eligible for federal matching funds—through "expenditure authorities"—for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. The demonstrations provide a way for states to test and evaluate new approaches for delivering Medicaid services. To obtain approval, states submit applications for section 1115 demonstrations to HHS for review. Upon approval, HHS issues an award letter to the state and an approval specifying the Medicaid requirements that are being waived, the expenditure authorities approved, and the special terms and

[5]Estimated Medicaid expenditures are for medical assistance payments and administration costs and, along with estimated enrollment, are based on projections for fiscal year 2014 reported in Centers for Medicare & Medicaid Services, Office of the Actuary, *2013 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2013).

[6]The federal share of each state's Medicaid expenditures is based on a statutory formula known as the Federal Medical Assistance Percentage. The percentage for each state is calculated, in part, on the basis of the state's per capita income and by statute can range from 50 to 83 percent. 42 U.S.C. §§ 1396b(a)(1), 1396d(b).

conditions detailing the requirements for the demonstration. HHS typically approves a section 1115 demonstration for a 5-year period that can be amended or extended.

Under HHS policy in place since the early 1980s, section 1115 demonstrations should be budget neutral to the federal government. In other words, the Secretary should not approve demonstrations that would increase federal costs for the state's Medicaid program beyond what the federal government would have spent without the demonstration. To have a budget-neutral demonstration, 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.[7] Once approved, each demonstration operates under a negotiated budget neutrality agreement that places a limit on federal Medicaid spending over the life of the demonstration, typically 5 years. According to HHS's policy, demonstration spending limits are based on states' projected costs of continuing their Medicaid programs without a demonstration. The higher the projected costs without a demonstration, the more federal funding states are eligible to receive for the demonstration. HHS's policy calls for establishing a spending base using a state's actual historical spending from a recent year and projecting spending over the course of the demonstration using certain growth rates established in policy.[8]

[7]For example, individuals who were not previously eligible for Medicaid could be covered under a state's demonstration without new costs to the federal government if the state were saving Medicaid funds through efficiencies under the demonstration, such as by implementing managed care. Or states could demonstrate budget neutrality by redirecting existing Medicaid funding, such as Disproportionate Share Hospital funds, which states receive in a capped allotment for purposes of offsetting eligible providers that have uncompensated care costs for Medicaid and uninsured individuals, to cover costs under the demonstration.

[8]HHS policy requires the use of a benchmark growth rate, which is the lower of the state-specific historical growth rates for a recent 5-year period or estimates of nationwide Medicaid growth. Nationwide estimates are developed by Centers for Medicare & Medicaid Services' actuaries to assist the Office of Management and Budget in preparing the President's budget.

HHS Approved Expenditure Authorities Allowing States to Fund State Programs and New Types of Funding Pools Without Clearly Showing How They Furthered Medicaid Objectives

HHS approved expenditure authorities for a broad range of purposes beyond expanding Medicaid coverage to individuals, including state-operated programs and funding pools. However, how these programs and funding pools would further Medicaid objectives was not always apparent from HHS's documentation. Recent approvals highlight the need for specific criteria and clear documentation to show how demonstrations further Medicaid purposes.

HHS Approved Expenditure Authorities Allowing States to Fund State Programs, but How Programs Would Promote Medicaid Objectives Was Not Always Clear

In our April 2015 report examining recent demonstration approvals in 25 states, we found that HHS had approved expenditure authorities allowing 5 states to receive federal Medicaid matching funds for state expenditures for more than 150 state-operated programs. Prior to the demonstrations, these programs were not coverable under Medicaid. The 5 states were approved to spend up to $9.5 billion in Medicaid funds (federal and state) for these programs during their current demonstration approval periods, which ranged from 2.5 to 5 years.[9]

The state programs were operated or funded by a wide range of different state agencies, such as state departments of mental health, public health, corrections, youth services, developmental disabilities, aging, and state educational institutions. Prior to being included in the demonstrations, these programs could have been financed with state or non-Medicaid federal funding sources, or a combination of these, such as state appropriations or non-Medicaid federal grant funding. Under the demonstrations, states must first allocate and spend state resources for programs to receive federal Medicaid matching funds. The federal

[9]On average, states were approved to spend nearly $2 billion each in combined federal and state funding for state programs, and the number of programs approved for federal matching funds in each state ranged from 2 programs in one state to more than 40 programs in each of two states. Of the 154 state programs approved for Medicaid funding during our review period, 85 had been previously approved by HHS. The $9.5 billion approved is for programs in all five states and includes amendments to and extensions of previously approved funding and some new funding.

matching funds received could replace some of the state's expenditures for the programs, freeing up state funding for other purposes. For example, states could use the freed-up state funding to invest in health care quality improvement efforts or health reform initiatives or simply to address shortfalls in states' budgets.

The expenditure authorities for state programs supported a broad range of state program costs that would not otherwise have been eligible for federal Medicaid funding. Although many of the programs offered health-related services, such as prostate cancer treatment and newborn immunizations, not all were necessarily income-based. In addition to programs providing health-related services, other state programs authorized to receive funding included those providing support services to individuals and families, for example, to non-Medicaid-eligible individuals; those providing access to private insurance coverage for targeted groups; and those funding health care workforce training programs. Overall, state programs that were approved for federal Medicaid funds appeared to be wide ranging in nature.

How funding for these state-operated programs would likely promote Medicaid objectives was not always clear from HHS's approval documents. We found that the documents did not consistently include information indicating what, specifically, the approved expenditures for state programs were for and, therefore, how they would likely promote Medicaid objectives. State programs approved by HHS were generally listed by program name in the special terms and conditions of each state's approval, but often without any further detailed information. Examples of state program names listed in the approval documents included a healthy neighborhoods program, grants to councils on aging, childhood lead poisoning primary prevention, and a state-funded marketplace subsidies program. A full listing of the state programs funded by expenditure authorities we reviewed is included in appendix I.

Further, we found that several state programs approved for federal Medicaid funds appeared, based on information in the approvals, to be only tangentially related to improving health coverage for low-income individuals and lacked documentation explaining how their approval was likely to promote Medicaid objectives. For example, the purposes of some programs approved included funding insurance for fishermen and their families at a reduced rate; constructing supportive housing for the homeless; and recruiting and retaining health care workers. For two of the five states we reviewed, HHS's approvals included additional details beyond the program names about the programs—including program

descriptions and target populations—in the special terms and conditions. Such information can help explain how the programs may promote Medicaid objectives; however, we found that even when such information was included, HHS's basis for approving expenditure authorities for some state programs was still not transparent. For example, one state received approval to claim matching funds for spending on a state program that issues licenses and approves certifications of hospitals and other providers in the state. While the terms and conditions delineated the program's mission and funding limits, it did not explicitly address how the program related to Medicaid objectives. The approvals for the other three states, accounting for nearly half of the more than 150 state programs in our review, lacked information on how the state programs would promote Medicaid objectives, such as how they would benefit low-income populations.

We also found that HHS's approvals varied in the extent to which they provided assurances that Medicaid funding for state programs would not duplicate any other potential sources of non-Medicaid federal funding. In two of the five states we reviewed, the terms and conditions identified all other federal and nonfederal funding sources for each state program and included specific instructions on how states should "offset" other revenues received by the state programs related to eligible expenditures. The approval for a third state did not identify other funding sources received by each program but included a general program integrity provision requiring the state to have processes in place to ensure no duplication of federal funding. In contrast, the approvals for two states did not identify other federal and nonfederal funding sources for each program and lacked language expressly prohibiting the states' use of funding for the same purposes.

HHS Approved Expenditure Authorities Allowing States to Establish Funding Pools, but Links to Medicaid Purposes Were Not Always Transparent

Another major type of non-coverage-related expenditure authority that HHS approved allowed states to make new kinds of supplemental payments—that is, payments in addition to base payments for covered services—to hospitals and other providers. In our April 2015 report, we found that HHS approved expenditure authorities in eight states for pools of dedicated funds—called funding pools—amounting to more than $26 billion (federal and state share) over the course of the current approvals, which ranged from 15 months to over 5 years. These expenditure authorities allowed states to receive federal Medicaid funds for supplemental payments made to providers for uncompensated care or for delivery system or infrastructure improvements. In addition, some

states had funding pools approved for other varied purposes, such as graduate medical education.

- *Funding pools for hospital uncompensated care costs*. In our April 2015 report, we found that HHS approved expenditure authorities in six states to establish or maintain hospital uncompensated care funding pools for a total of about $7.6 billion (federal and state) in approved spending.[10]
- *Funding pools for incentive payments to hospitals*. HHS also approved new expenditure authorities in five states for funding pools to make incentive payments to promote health care delivery system or infrastructure improvements for nearly $18.8 billion (federal and state share) in spending.[11] These expenditure authorities were for payments to incentivize hospitals or their partners to make a variety of improvements, such as lowering hospitals' rates of adverse events or incidence of disease, improving care for patients with certain conditions, and increasing delivery system capacity.

As with approvals of expenditure authorities for state programs, we found that HHS's approvals of expenditure authorities for funding pools also did not consistently document how expenditures would likely promote Medicaid objectives. The approvals of incentive payment funding pools we reviewed established a structure for planning, reporting on, and getting paid for general, system-wide improvements—for example, increasing primary care capacity or lowering admission rates for certain diseases—but most provided little or no detail on how the initiatives related to Medicaid objectives, such as their potential impact on Medicaid beneficiaries or low-income populations. Further, the criteria for selecting providers eligible to participate in incentive pools were not apparent in most of the approvals we reviewed. HHS's approvals typically listed eligible providers but with no additional information about their role in providing services to Medicaid populations. For example, none of the terms and conditions for the five states' demonstrations that we reviewed established a minimum threshold of Medicaid or low-income patient

[10]The six states received approval of expenditure authorities for new uncompensated care pools or extensions to previously approved pools, ranging from $37.5 million over 15 months to $4 billion over 5 years in total approved spending.

[11]The five states received approval for expenditure authorities for new incentive payment pools or modifications to existing funding pools, ranging from $29.4 million to $11.4 billion in total approved spending, generally over a 5-year period.

volume as the basis for participation; however, three of the five states' approvals required that the payment allocations be weighted in part on measures of Medicaid or low-income patient workload.

We also found that the approvals for incentive payment funding pools varied in the extent to which they provided assurances that Medicaid funding for these initiatives would not duplicate other sources of federal funding. The terms and conditions for only one of the five states required the state to demonstrate that its funding pool was not duplicating any other existing or future federal funding streams for the same purpose. Two other states' terms and conditions required hospitals to demonstrate that incentive projects did not duplicate other HHS initiatives. The extent to which approvals for uncompensated care pools included protections against potential duplication of federal funds was somewhat mixed. The approvals placed some limits on the potential overlap between payments to individual providers from the uncompensated care pool and Medicaid's Disproportionate Share Hospital program, which provides allotments to states for payments to hospitals that serve a disproportionate share of low-income and Medicaid patients.[12] We found that HHS consistently included a requirement that when states calculate their Disproportionate Share Hospital payment limits for individual hospitals, they include as offsetting revenue any payments for inpatient or outpatient services the hospitals may have received from the uncompensated care pool. Aside from instructions about the Disproportionate Share Hospital program, however, the approvals generally did not explicitly prohibit other potentially duplicative sources of funding, such as grants awarded under other federal programs.

[12]States are required by federal law to make Disproportionate Share Hospital payments to certain hospitals to offset these hospitals' uncompensated care costs for serving large numbers of Medicaid and uninsured individuals. These payments to hospitals are in addition to regular Medicaid payments they receive for services provided. Hospital payments are subject to a facility-specific limit, and state allotments are subject to an annual limit. Uncompensated care costs are the costs incurred in providing services during the year to Medicaid and uninsured patients minus any payments made to the hospital for Medicaid and uninsured patients for those services. See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

HHS's Recent Approvals Highlight the Need for Specific Criteria and Clear Documentation to Show How Expenditure Authorities Further Medicaid Objectives

While section 1115 of the Social Security Act provides HHS with broad authority in approving expenditure authorities for demonstrations that, in the Secretary's judgment, are likely to promote Medicaid objectives, as we reported in April 2015, according to HHS officials, the agency has not issued explicit criteria explaining how it assesses whether demonstration expenditures meet this broad statutory requirement.[13] HHS officials also told us that for a demonstration to be approved, its goals and purposes must provide an important benefit to the Medicaid program, but they did not provide more explicit criteria for determining whether approved demonstration expenditures would provide an important benefit or promote Medicaid objectives. HHS officials also said that it is not in the agency's interest to issue guidelines that might limit its flexibility in determining which demonstrations promote Medicaid objectives.

Given the breadth of the Secretary's authority under section 1115—the exercise of which may result in billions of dollars of federal expenditures for costs not otherwise allowed under Medicaid, we recommended in April 2015 that HHS issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives. HHS partially concurred with this recommendation, stating that all section 1115 demonstrations are reviewed against "general criteria" 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; and (4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks. HHS was silent, however, as to whether it planned to issue written guidance on these general criteria, and we maintain that these general criteria are not sufficiently specific to allow a clear understanding of what HHS considers in reviewing whether

[13]Federal standards for internal control of an agency's operations stress that in addition to the need for effective internal communications within an agency, management should also ensure there are adequate means of communicating with, and obtaining information from, external stakeholders that may have a significant impact on the agency's achieving its goals, such as states in the case of Medicaid demonstrations. See GAO, *Internal Control: Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). In our view, the criteria HHS uses for approving expenditure authorities for state programs and funding pools would be subject to such a communication requirement.

expenditure authorities are likely to promote Medicaid objectives. For example, although each of HHS's four general criteria relates to serving low-income or Medicaid populations, HHS does not define low-income or what it means to serve these individuals.

In our April 2015 report, we also emphasized the importance of HHS documenting the basis for its approval decisions and showing how approved expenditure authorities are likely to promote Medicaid's objectives. Without such documentation, HHS cannot provide reasonable assurance that it is consistently applying its criteria for determining whether demonstration expenditures promote Medicaid objectives. We recommended that HHS ensure the application of its criteria for assessing section 1115 demonstrations is documented in all approvals, to inform stakeholders—including states, the public, and Congress—of the basis for its determinations that approved expenditure authorities are likely to promote Medicaid objectives. HHS concurred with this recommendation, stating that it will ensure that all future section 1115 demonstration approval documents identify how each approved expenditure authority promotes Medicaid objectives.

Finally, we recommended that HHS take steps to ensure that demonstration approval documentation consistently provides assurances that states will avoid duplicative spending by offsetting as appropriate all other federal revenues when claiming federal Medicaid matching funds. In response, HHS said it would take steps to ensure approval documentation for state programs, uncompensated care pools, and incentive payment pools consistently provides assurances that states will avoid duplication of federal spending.

HHS's Policy and Process for Approving Spending Limits Lack Transparency and Do Not Provide Assurances That Demonstrations Will Be Budget Neutral

HHS's policy and process for approving state spending on Medicaid demonstrations lack transparency and do not provide assurances that demonstrations will be budget neutral for the federal government. Longstanding concerns support the need for budget neutrality policy and process reform.

HHS's Budget Neutrality Policy and Process Lack Transparency

GAO's prior work has found that HHS's policy and process for determining state demonstration spending limits lack transparency related to the criteria and evidence used to support state spending limits, and the most recent written policy, issued in 2001, does not reflect HHS's actual practices. Spending limits are based on states' estimated costs of continuing their Medicaid programs without the proposed demonstration. According to HHS policy, demonstration spending limits should be calculated by estimating future costs of baseline spending—using actual Medicaid costs, typically from the most recently completed fiscal year—and applying a benchmark growth rate (which is the lower of the state-specific historical growth rates for a recent 5-year period and estimates of nationwide Medicaid growth).[14] HHS officials reported that their policy and process allow for negotiations in determining spending limits, including adjustments to the growth rates used to project baseline costs. For example, if there are documented anomalies in historical spending data, adjustments can be made so that projected spending is accurate. However, HHS's policy does not specify criteria and methods for such adjustments or the documentation and evidence that are needed to support adjustments.

Between 2002 and 2014, we have reviewed and reported on a number of HHS-approved demonstrations and found that adjustments made by states and allowed by HHS were not clear or well supported. We have also found that HHS's policy was inconsistent with its actual practices and was not adequately documented. For example, while HHS policy requires that states submit 5 years of historical data in developing spending limits, in June 2013, we reported that the agency's processes allowed states to use fewer years of actual spending and enrollment data and used estimated, rather than actual data, for other years.[15] Officials indicated that if estimates are used instead of actual data, the state must explain

[14]According to HHS's policy, a state's demonstration spending limit should be based on the projected cost of continuing the state's existing Medicaid program without the proposed demonstration, as determined by two factors: (1) the spending baseline for the population covered by the demonstration, and (2) the growth rate. HHS has guidelines and benchmarks for spending baselines and growth rates. For example, spending baselines must exclude certain expenditures, and growth rates must be based on the lower of (1) the state's historical growth for Medicaid in recent years and (2) the Medicaid trend rate projected for the nation in the President's budget. For purposes of this testimony we call these benchmark rates.

[15]GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, GAO-13-384 (Washington, D.C.: June 25, 2013)

any adjustments. But HHS officials did not have documentation for the agency's process or policy on when estimates are allowed or an explanation for what type of documentation of adjustments is required.

HHS Approved Spending Limits Have Not Ensured Demonstrations Are Budget Neutral

Between 2002 and 2014, we have reviewed more than a dozen states' approved comprehensive demonstrations and found that HHS had not consistently ensured that the demonstrations would be budget neutral. We found that HHS has allowed states to use questionable methods and assumptions for their spending baselines and growth rates in projecting spending, without providing adequate documentation to support them. In particular, HHS allowed states to make adjustments that allowed for cost growth assumptions that were higher than growth rates based on historical spending and nationwide spending, without adequate support for the deviations from these benchmarks included in its policy. HHS also allowed states to include costs in the baseline spending that the state never incurred. In some cases, these practices allowed states to add billions of dollars in costs to their projected spending. For example, in our 2013 report,[16] we found that

- One state's approved spending limit for 2011 through 2016 was based on outdated information on spending—1982 data were projected forward to represent baseline spending and state-specific historical spending growth for a recent period. Had baseline expenditures and benchmark growth rates been based on recent expenditure data that were available, the 5-year spending limit would have totaled about $26 billion less, and the federal share of this reduction would have been about $18 billion.
- Another state's approved spending limit for 2011 through 2016 included hypothetical costs in the state's estimate of its baseline spending; that is, costs the state had not incurred were included in the base year spending estimate. These costs represented higher payment amounts that the state could have paid providers during the base year, but did not actually pay. For example, the state base year included costs based on the state's hypothetically paying hospitals the maximum amount allowed under federal law, although the state had not paid the maximum amount. We estimated that had the state included only actual expenditures as indicated by HHS's policy, the

[16]GAO-13-384.

5-year spending limit would have totaled about $4.6 billion less, and the federal share of this reduction would have been about $3 billion.

Allowing questionable assumptions and methods increases projected spending and allows for significant increase in federal costs. We have found that had HHS developed demonstration spending limits based on levels suggested by its policy, spending limits would have been tens of billions of dollars lower. For example, for five states' demonstrations we reviewed in our 2013 and 2014 reports, we estimate that had HHS used growth rates consistent with its policy and allowed only actual costs in base year spending, demonstration spending limits would have been almost $33 billion lower than what was actually approved.[17] (See table 1.) The federal share of the $33 billion reduction would constitute an estimated $22 billion.

[17]GAO, *Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns,* GAO-14-689R (Washington, D.C.: Aug. 8, 2014); GAO-13-384.

Table 1: HHS Approved Spending Limits Compared with GAO Estimates based on Agency Policy for Selected Demonstrations Approved from January 2007 through September 2013

Dollars in millions, federal and state spending

State identifier	HHS-approved	GAO estimate using benchmark growth rates and actual costs	Difference
1	$72,679	$46,382	$26,297
2	10,626	10,211	416
3	12,075	11,303	772
4	142,394	137,827	4,567
5	3,953	3,175	778
Total	**$241,727**	**$208,898**	**$32,830**

Source: GAO analysis of HHS data. | GAO-15-715T

Notes: Spending for the first four states was for 5 years, which was the length of their approved demonstrations. Spending for the fifth state was 3 years, which was length of the approved demonstration. Numbers in the difference column are based on actual data and may differ from calculations using rounded data shown in the table.

Longstanding Concerns About HHS Spending Limit Approvals Support Need for Budget Neutrality Policy and Process Reforms

Our concerns with HHS's process and criteria are long-standing, and our recommendations for improving HHS's policy and process have not yet been addressed. On several occasions since the mid-1990s, we have found that HHS had approved demonstrations that were not budget neutral to the federal government, and we have made a number of recommendations to HHS to improve the budget neutrality process, but HHS has not agreed.[18] Specifically, we have recommended that HHS (1) better ensure that valid methods are used to demonstrate budget neutrality, (2) clarify criteria for reviewing and approving demonstration spending limits, and (3) document and make public the bases for

[18]We have also raised concerns that some demonstrations had the potential to significantly affect beneficiaries, and that advocates and others had not had an opportunity to review and provide input prior to the demonstrations' being approved. We made recommendations to improve the ability of the public to comment on proposed demonstrations. Congress and HHS acted to establish a public input process at the federal level before demonstrations are approved. The Patient Protection and Affordable Care Act required the Secretary of Health and Human Services to issue regulations for section 1115 applications and extensions that address certain topics, including a state and federal public notice and comment process, submission of reports on implementation by states, and periodic evaluation by HHS. In response, on February 27, 2012, HHS published final regulations establishing these requirements for new section 1115 Medicaid demonstration applications and extensions. Pub. L. No. 111-148, § 10201, 124 Stat.119, 922 (2010); 77 Fed. Reg. 11,678 (Feb. 27, 2012).

approved spending limits. In 2008, because HHS disagreed with our recommendations—maintaining that its review and approval process was sufficient—we suggested that Congress consider requiring the Secretary of Health and Human Services to improve the department's review criteria and methods by documenting and making clear the basis for approved spending limits. In 2013, we further recommended that HHS update its written budget neutrality policy to reflect the actual criteria and processes used to develop and approve demonstration spending limits, and ensure the policy is readily available to state Medicaid directors and others. HHS disagreed with this recommendation, stating that it has applied its policy consistently.[19] However, based on multiple reviews of Medicaid demonstrations, we continue to believe that HHS must take actions to improve the transparency of its demonstration approvals.

In conclusion, section 1115 Medicaid demonstrations provide HHS and states with a powerful tool for testing and evaluating new approaches for potentially improving the delivery of Medicaid services to beneficiaries. In using the broad authority provided under section 1115, the Secretary has responsibility for the prudent use of federal Medicaid resources, including ensuring that demonstration expenditures promote Medicaid objectives and do not increase overall federal Medicaid costs. Our work has shown, however, that it has not always been clear how approved demonstration spending relates to Medicaid objectives. For example, several state programs that were approved for Medicaid spending that we reviewed appeared, based on information in the approvals, to be only tangentially related to improving health coverage for low-income individuals. HHS's approved expenditure authorities can set new precedents for other states to follow and raise potential for overlap with other funding streams. Similarly, we have had longstanding concerns, dating back decades, that HHS's policy and process for approving total spending limits under demonstrations have not always ensured that spending under demonstrations will not increase federal Medicaid costs. As section 1115 demonstrations have become a significant and growing proportion of Medicaid expenditures, ensuring that demonstration expenditures are linked to Medicaid purposes and are budget neutral is even more critical to ensuring the long-term sustainability of the program, upon which tens

[19]HHS acknowledged, however, that it has not always communicated its budget neutrality policy broadly or clearly.

of millions of low-income beneficiaries depend to cover their medical costs. Without clear criteria, policies, appropriate methods for developing spending limits, and improved documentation of the bases for decisions, HHS's demonstration approvals affecting tens of billions in federal spending will continue to lack transparency and to raise concerns about the fiscal stewardship of the program.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you might have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Katherine Iritani, Director, Health Care at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Catina Bradley, Assistant Director; Tim Bushfield, Assistant Director; Christine Davis; Shirin Hormozi; Linda McIver; Roseanne Price; and Emily Wilson.

Appendix I: State Programs Funded by Expenditure Authorities in Section 1115 Demonstrations

From June 2012 through mid-October 2013, five states received approval from the Department of Health and Human Services (HHS) for section 1115 demonstrations that included expenditure authorities allowing funding for state programs. Table 2 shows examples of the names of the state programs funded in the terms and conditions of each state's approval documentation. Often there was no further detailed information regarding the approved programs.

Table 2: Examples of State Programs Funded by Expenditure Authorities in Five States' Section 1115 Demonstrations Approved by the Department of Health and Human Services (HHS) from June 2012 through October 2013, as Listed in HHS's Approvals

State A	State B	State C	State D	State E
State Only Medical Programs • [State A] children's services program • Genetically handicapped persons program • County mental health services • Breast and cervical cancer treatment program • Prostate cancer treatment program • Acquired immunodeficiency virus (AIDS) drug assistance program • Expanded access to primary care • Medically indigent adult long-term care program • Department of developmental services • Every woman counts cancer detection program • County medical services program **Workforce Development Programs** • Song Brown healthcare workforce training program • Steven M. Thompson physician corps loan repayment program • Mental health loan assumption program	**Department of Mental Health** • Recreational therapy services • Occupational therapy services • Individual support • Community mental health center continuing care • Homeless support services • Individual and family flexible support • Comprehensive psychiatric services • Day services • Child/adolescent respite care services • Day rehabilitation • Community rehabilitative support • Adult respite care services **Department of Corrections** • Shattuck Hospital services **Department of Public Health** • Community health centers • CenterCare • Renal disease • Sexual assault nurse examiners program • Growth and nutrition programs	**Health Care Reform Act Programs** • Healthy [State C] • AIDS drug assistance • Tobacco use, prevention and control • Health workforce retraining • Recruitment and retention of health care workers • Telemedicine demonstration • Pay for performance initiatives **Office on Aging Programs** • Community services for the elderly • Expanded in-home services to the elderly **Office of Children and Family Services Programs** • Committees on special education direct care programs **Department of Health Programs** • Early intervention program services • Human immunodeficiency virus (HIV)-related risk reduction • Childhood lead poisoning primary prevention	**Addictions and Mental Health Program Group** • Non-residential adult • Child and adolescent • Regional acute psychiatric inpatient • Residential treatment for youth • Adult foster care • Older/disabled adult • Special projects • Community crisis • Supported employment • Homeless • Residential treatment • Non residential adult (designated) • Alcohol and drug special projects • Alcohol and drug residential treatment—adult • Continuum of care **Children, Adults and Families Program Group** • System of care • Community based sexual assault • Community based domestic violence • Family based services	• State-funded marketplace subsidies program • State-funded mental health community rehabilitation services

State A	State B	State C	State D	State E
• Training program for medical professionals, [State A] community colleges, state universities, and the University of [State A]	• Prostate cancer prevention-screening component • Hepatitis C • Multiple sclerosis • Stroke education and public awareness • Ovarian cancer screening, education, and prevention • Diabetes screening and outreach • Breast cancer prevention • Universal immunization program • Pediatric palliative care • Children's medical security plan **Executive Office of Elder Affairs** • Prescription advantage • Enhanced community options • Home care services • Home care case management and administration • Grants to councils on aging **Center for Health Information and Finance** • Fisherman's partnership • Community health center uncompensated care payments	• Healthy neighborhoods program • Local health department lead poisoning prevention programs • Cancer services programs • Obesity and diabetes programs • Tuberculosis treatment, detection and prevention • Tuberculosis directly observed therapy • Tobacco control • General public health work • Newborn screening programs **Office of Mental Health** • Licensed outpatient programs • Care management • Emergency programs • Rehabilitation services • Residential (non-treatment) • Community support programs **Office for People with Developmental Disabilities Services** • Day training • Family support services • Jervis clinic • Intermediate care facilities • Home- and community-based services residential	• Foster care prevention • Enhanced supervision • Nursing assessments • Other medical • Project for parenting • Personal care **Seniors and People with Disabilities Program Group** • Family support • Children long-term support • [State D] project independence **Public Health Division Program Group** • Licensing fees • General microbiology • Virology • Chlamydia • Other test fees • State support for public health • Newborn screening (used for match for maternal and child health block grant) • Prescription drug monitoring program • HIV community services • HIV/tuberculosis • Sexually transmitted diseases	

State A	State B	State C	State D	State E
	[State B] Commission for the Blind • Turning 22 program—personal vocational adjustment • Turning 22 program—respite • Turning 22 program—training • Turning 22 program—co-op funding • Turning 22 program—mobility • Turning 22 program—homemaker • Turning 22 program—client supplies • Turning 22 program—vision aids • Turning 22 program—medical evaluations **[State B] Rehabilitation Commission** • Turning 22 program services • Head injured programs **Department of Veterans' Services** • Veterans' benefits **Health Connector** • Health connector subsidies • Commonwealth care transition	• Supported work program • Day habilitation • Service coordination/plan of care support • Pre-vocational services • Waiver respite • Clinics—article 16 **Office of Alcoholism and Substance Abuse Services** • Outpatient and methadone programs • Crisis services—ambulatory • Prevention and program support services **Office of Temporary and Disability Assistance** • Homeless health services	**[State D] Youth Authority** • Mental health treatment • Drug and alcohol **Division of Medical Assistance** • Organ transplants for formerly medically needy **Office of Private Health Partnerships** • [State D] medical insurance pool **[State D] State Hospital** • Gero-neuro psychiatric facilities **Workforce Development and Education Program Group** • Undergraduate and graduate health professions education	

Source: HHS. | GAO-15-715T

Related GAO Products

Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives. GAO-15-239. Washington, D.C.: April 13, 2015.

High-Risk Series: An Update. GAO-15-290. Washington, D.C.: February 11, 2015.

Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Concerns. GAO-14-689R. Washington, D.C.: August 8, 2014.

Cost Savings – Health – Medicaid Demonstration Waivers. GAO-14-343SP. Washington, D.C.: April 2014.

Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency. GAO-13-384. Washington, D.C.: June 25, 2013.

Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns. GAO-08-87. Washington, D.C.: January 31, 2008.

Medicaid Demonstration Projects in Florida and Vermont Approved under Section 1115 of the Social Security Act. B-309734. July 27, 2007.

Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern. GAO-07-694R. Washington, D.C.: July 24, 2007.

Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns. GAO-04-480. Washington, D.C.: June 30, 2004.

SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals. GAO-04-166R. Washington, D.C.: January 5, 2004.

Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns. GAO-02-817. Washington, D.C.: July 12, 2002.

Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs. GAO/HEHS-96-44. Washington, D.C.: November 8, 1995.