

CHAIRMAN

RANKING MEMBER

ONE HUNDRED FOURTEENTH 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

MEMORANDUM**June 22, 2015**

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on “Examining the Administration’s Approval of Medicaid Demonstration Projects”

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.”

This hearing will specifically address Section 1115 Demonstrations; Section 1115 of the Social Security Act allows states to use federal Medicaid matching funds in operating Medicaid demonstration programs, even where federal rules would not otherwise permit such programs. To receive approval for an 1115 waiver, the Secretary of Health and Human Services (HHS) must determine that the demonstration project promotes the Medicaid program’s objectives, and it would not cause federal spending to exceed what the government would have spent, absent the demonstration project.¹

I. BACKGROUND

Established along with Medicare by the Social Security Amendments of 1965, Medicaid today covers more than 71 million Americans.² Medicaid plays a significant role for children, the

¹ See Hearing Memorandum, *infra* at 2-4 (for detailed discussion of Sec. 1115 waiver).

² Nearly 71.1 million individuals were enrolled in Medicaid and CHIP in March 2015.⁷ This enrollment count is point-in-time (on the last day of the month) and includes all enrollees in the Medicaid and CHIP programs who are receiving a comprehensive benefit package (online at <http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/2015-march-enrollment-report.pdf0.>).

disabled, and the elderly. Most Medicaid enrollees are children, but a majority of Medicaid spending is for the elderly and people with disabilities. In contrast, spending on parents and non-elderly childless adults represents a much smaller proportion of the program; states have historically provided more restrictive eligibility for parents than for children, and prior to passage of the Affordable Care Act (ACA), nondisabled childless adults under age 65 were categorically excluded from Medicaid by federal law.

The Medicaid program finances nearly half of all births nationwide, and covers more than 1 in 3 (33 million) children. In fact, 75 percent of children living below the poverty line are covered by Medicaid.³ The Medicaid program is also a critical component of care for seniors; 1 in every 7 elderly Medicare beneficiaries are also Medicaid beneficiaries.⁴ For the elderly and those with disabilities,⁵ Medicaid plays a particularly important role in providing long term services and supports (LTSS); the program is the primary payer of LTSS, representing 51 percent of total national LTSS spending in 2013.⁶

The Medicaid program is the second-largest item in state budgets, after elementary and secondary education, and the third-largest federal domestic program, after Social Security and Medicare. In FY 2013, combined state and federal Medicaid spending totaled \$438 billion,⁷ which was the largest share of federal funds made to the states.

Medicaid's hybrid structure, which involves a mix of federal and state financing and control, is, in many respects, the defining feature of the Medicaid program. States must follow broad federal rules in order to receive federal matching funds, but have flexibility to design their own version of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs regarding who and what services are covered and how those services are provided and paid for.

³ Kaiser Family Foundation. *Medicaid at 50*. (May 6, 2015) (online at <http://kff.org/medicaid/report/medicaid-at-50/>).

⁴ In FY 2012, elderly and disabled enrollees accounted for 21 percent and 42 percent, respectively of Medicaid expenditures. And, 200,000 additional enrollees aged 65 or older signed up for Medicaid from 2014-2015. HHS, *FY2016 Budget in Brief: CMS Medicaid Services*. (online at <http://www.hhs.gov/about/budget/budget-in-brief/cms/medicaid/index.html#services>).

⁵ *Id.*

⁶ Kaiser Family Foundation, *Medicaid and Long-Term Services and Supports: A Primer* (May 8, 2015) (online at <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>).

⁷ Kaiser Family Foundation. *Medicaid at 50*. (May 6, 2015) (online at <http://kff.org/medicaid/report/medicaid-at-50/>).

Each state has a Medicaid state plan that outlines Medicaid eligibility standards, provider requirements, reimbursement methods, and health benefit packages among other program design criteria; however a number of these requirements can be waived, per the approval of the HHS Secretary. Medicaid authorizes several waiver and demonstration authorities to provide states with the flexibility to operate their Medicaid programs. Under the various waiver authorities, states may try new or different approaches to the delivery of health care services, or adapt their programs to the special needs of particular geographic areas or groups of Medicaid enrollees. One such authority that is increasingly popular among the states, Section 1115 Research and Demonstration Projects, is the topic of this hearing.

II. SECTION 1115 RESEARCH AND DEMONSTRATION PROJECTS

States may operate their programs in ways that vary from certain federal requirements under the authority of an approved demonstration, or “waiver”. Section 1115 of the Social Security Act gives the HHS Secretary broad authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. According to CMS, these demonstrations, which give states additional flexibility to design and improve their programs, can demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid;
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.⁸

There are currently 63 Section 1115 demonstration projects currently pending before or approved by the Centers for Medicare and Medicaid Services (CMS).⁹ Not every state has an 1115 waiver, whereas some states have more than one.

Section 1115 demonstration projects range in their comprehensiveness, from encompassing virtually the entire Medicaid program, to a more selective focus on specific services. For instance, states can obtain comprehensive waivers that make broad changes in Medicaid eligibility, benefits and cost sharing, and provider payments or focus more narrowly on expanding certain services such as family planning or services delivered to those living with HIV/AIDS.¹⁰

⁸ See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

⁹ See http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html

¹⁰ The ACA also created an additional Section 1115A waiver authority, which allows the Centers for Medicare and Medicaid Innovation (CMMI) to fund demonstrations in the Medicaid program with states.

Section 1115 demonstrations account for a growing share of federal Medicaid expenditures; in FY 2014, Section 1115 demonstrations accounted for close to one-third of all Medicaid spending.¹¹

While Section 1115 waivers differ substantially, there are three common elements:

- **A demonstration project authorized under Section 1115 must assist in promoting the objectives of the Medicaid program.** The Secretary is authorized to waive compliance with certain Federal Medicaid requirements and provide matching funds for costs that would otherwise not be allowable, but also must ensure that any 1115 proposal is in keeping with the overall objectives of the Medicaid program.¹² CMS has highlighted four broad criteria for 1115 demonstrations: They must: (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. So, as an example, while HHS has approved the use of premiums in Medicaid expansion waivers, it has not allowed states to condition coverage for beneficiaries with incomes below the poverty line on payment of premiums.¹³
- **Section 1115 waivers are required to be budget neutral for the federal government.** Federal spending under a state's waiver cannot be more than projected federal spending would have been for the state without the waiver. Budget neutrality is enforced over the life of the waiver, so spending in one year can exceed what would have otherwise been spent in that year as long as spending over the term of the waiver falls below what the state would have otherwise spent.
- **Waivers are approved through a series of negotiations between states and HHS.** The approval process officially begins when a state submits a waiver application to CMS, which is subject to state and federal public notice and comment requirements. In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years.

A. The Affordable Care Act

While more can be done, the ACA took major steps to improve the transparency of the waiver approval process in Medicaid, in line with longstanding recommendations from the GAO

¹¹ Government Accountability Office, *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives* (April, 2015)

¹² Section 1115 provides authority for the Secretary to waive solely those provisions included in Section 1902 of the Medicaid Act. In contrast, the Secretary lacks authority to waive provisions of Section 1902 that are governed by independent provisions outside of Section 1902.

¹³ See Schubel, J. & Solomon, J. *States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility*, Center on Budget and Policy Priorities (April 9, 2015).

to allow for public input at the state and federal level and to standardize approval documentation and the public availability of waiver proposals and supporting material. The ACA provision¹⁴ was the result of more than a decade of bipartisan work to address longstanding concerns raised by the GAO, which found, over the course of several reports, that the public did not have sufficient opportunities to learn about and comment on pending waivers at the federal level, and that public input at the state level varied substantially.¹⁵ Specifically, the ACA required HHS to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver process. The ACA also requires that Section 1115 waivers be evaluated on a periodic basis and that states submit reports on the implementation of their demonstration projects. On February 27, 2012, CMS published a final rule implementing new transparency and public input requirements for Medicaid 1115 demonstration waivers.

Under the new regulatory structure, CMS has standardized some demonstration application documents so that the public and CMS can meaningfully assess states' applications, including a template and budget worksheet that provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. CMS also created a new publicly accessible database on Medicaid.gov with waiver documents posted, and requires a 30-day public comment period at the federal level.

Importantly, under the ACA transparency regulation, states are also required to engage in a meaningful public input process prior to submitting a demonstration application. This process includes: public notice; a 30-day minimum public input process; at least two public hearings; and, a post-approval implementation forum to solicit public comment on implementation. The state must also compile a report of the issues raised through the public comment period and describe how the state considered those comments when developing its application. This process is important given the significant and direct impacts that Section 1115 demonstration projects could have on beneficiaries' access to care.

B. Remaining Concerns Raised by GAO About 1115 Demonstration Waivers

Concerns have been raised by the GAO and other independent analysts over the past twenty years about 1115 demonstration waivers. As noted, some longstanding recommendations by GAO and others were addressed in the ACA. However, there are remaining concerns that GAO has raised regarding the lack of written, specific criteria that would ensure spending authorized under section 1115 meets the criteria for approval of 1115 waivers particularly compliance with budget neutrality requirements.

The GAO's recommendations on this topic have been relatively consistent since the mid-1990s. These recommendations were most recently articulated in the April, 2015 report, "*Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers*

¹⁴ This provision is section 10201(i) of the Affordable Care Act.

¹⁵ Kaiser Commission on Medicaid and the Uninsured. The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers. March, 2012. (online at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8292.pdf>).

Medicaid Objectives.” GAO will testify on this report, but also on their full body of work, beginning in 1995, and including reports from 2002, 2004, 2007-8, and 2013-2014.

Regarding budget neutrality, GAO has recommended that HHS issue more specific criteria for how the agency will assess whether section 1115 spending promotes Medicaid objectives, improve documentation of budget neutrality, and take steps to ensure that states avoid duplicative spending by offsetting, as appropriate, all other federal revenues received when claiming federal Medicaid funds.

In the most recent report issued in April, CMS agreed with the GAO’s recommendations that it (1) ensure that all future section 1115 demonstration approval documents (including those for new demonstrations, renewals, and amendments) identify how each approved expenditure authority promotes Medicaid objectives, and (2) take steps to ensure that section 1115 demonstration approval documentation for state programs, utilizing uncompensated care pools and incentive pools provide assurances that they will avoid duplication of federal spending.¹⁶

CMS partially agreed with another recommendation from GAO regarding the issuance of specific criteria for evaluating whether 1115 waivers meet Medicaid objectives. The agency explained that it uses four broad principles already to guide approval (*see supra* at 3-4), and stated its intention to document the use of those principles in 1115 approvals moving forward.

III. RECENT TRENDS IN STATE 1115 DEMONSTRATIONS

A. Medicaid Expansion

Currently, 29 states have opted to expand Medicaid to low-income uninsured adults. Most states are implementing the expansion as set forth in the ACA, but a limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. These waivers allow states to implement the Medicaid expansion in ways that do not meet federal rules and still access enhanced federal matching funds for newly eligible adults.¹⁷ Currently, six states are implementing expansion through an 1115 demonstration waiver and a seventh will be submitting such a waiver for approval. While the waivers are each unique, they include some common provisions such as implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (for instance, non-emergency medical transportation), and using healthy behavior incentives.

Perhaps the first and most well-known “Medicaid Expansion Waiver” was the Arkansas model, approved in September 2013. Arkansas relies on existing “premium assistance” authority

¹⁶ Government Accountability Office. *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*. (April, 2015).

¹⁷ Under the ACA, the federal government will pay 100% of the costs of those newly eligible for 2014-2016 and then the federal share phases down to 90% in 2020 and beyond.

in the Medicaid statute. This authority allows states to purchase private coverage with Medicaid dollars -- typically to subsidize employee premiums for job-based coverage --so long as it is cost effective (i.e., doing so costs the same as or less than the cost of providing coverage through regular Medicaid). The Arkansas waiver allows the state to use federal Medicaid funds to purchase marketplace plans -- known as Qualified Health Plans (QHPs) -- for almost everyone newly eligible for Medicaid in the state.

Before and during negotiations with Arkansas state officials, HHS set limits on the use of waivers and other possible variations for states taking up the Medicaid expansion:

- **Expansions must extend Medicaid to adults all the way up to 138 percent of the poverty line.**
- **Enrollees whom the state requires to enroll in QHPs remain Medicaid beneficiaries.** As such, states must "wrap around" the QHP benefits to ensure that beneficiaries have access to the same benefits and are not subject to higher cost-sharing charges than if they were enrolled in regular Medicaid.
- **Expansion waivers must articulate a clear demonstration purpose that promotes Medicaid's objectives, as with section 1115 waivers granted prior to health reform.**

The agency has denied waiver authority thus far for provisions that do not promote Medicaid objectives, such as work requirements as a condition of Medicaid eligibility, or premiums for individuals with incomes below the federal poverty line that are enforceable through termination of coverage. Premium assistance waivers are only allowable for three years.

CMS has notably worked with states on increasingly complex benefit designs that allow states to expand Medicaid through potentially more viable political pathways that allow the states to expand coverage. However, Section 1115 waivers are intended as authority to pilot demonstration projects; to ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate the effects of these new Medicaid expansion waivers.

B. Principles for Uncompensated Care Pools

A number of states have used Section 1115 waivers to create new mechanisms, like capped funding pools, to reimburse providers for uncompensated care and to provide funding for delivery system reform. In connection with the waiver renewal process and in light of the new ACA authority to expand Medicaid to very low income childless adults, CMS has advised states with uncompensated care pools to transition the structure of these pools to better reflect the current post-ACA environment. Nine states currently have uncompensated care pools (AZ, CA, FL, HI, KS, MA, NM, TN, TX).

Florida, as the first state to have an expiring uncompensated care pool since passage of the ACA, has engaged with CMS over the amount of federal contribution to its Low-Income Pool, often referred to as its LIP.

Florida's LIP is a funding pool to support health care providers that provide uncompensated care to Florida residents who are uninsured or underinsured. It is not a health coverage program. CMS approved the LIP in 2005 as part of Florida's section 1115 demonstration project, which allowed Florida to fully transition from Medicaid fee-for-service to a Medicaid Managed Care arrangement.

During the transition to the new system, Florida created their LIP to support safety net hospitals, county health departments, and federally qualified health centers that treat Florida residents who are uninsured or underinsured. This includes care for Medicaid beneficiaries enrolled in managed care when payments to the managed care plans don't cover the full costs of care. In renewals of its waiver in 2011 and 2014, Florida continued its transition to managed care, achieving statewide implementation in August 2014, while continuing to use the LIP to support safety net providers.

The state share is funded almost entirely through contributions by, or on behalf of, providers that receive money from the pool. Once the providers have contributed funds to the LIP, Florida's Medicaid agency can draw down federal matching funds (at a matching rate of 60 percent) to fully fund the LIP.

It is worth noting that CMS has expressed other concerns with Florida's LIP that have nothing to do with coverage expansion – but rather, the lack of transparency in the way the funds are distributed by the state. Florida's LIP pool does not distribute funds to hospitals based on the level of uncompensated care funds provided, but rather based on how much a County contributed—and over the same time period, the state has cut provider rates significantly. Under the current structure of Florida's LIP pool, the agency has reiterated that the money for care does not follow beneficiaries, which is not in line with promoting long-held Medicaid objectives.

CMS articulated three clear principles for future approval of uncompensated care pools; these principles were outlined in letters to Florida's Medicaid director in April and May of this year:

1. Coverage, rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals, and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion;
2. Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals; and
3. Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

CMS has informed Texas and other states with uncompensated care pools that requests to extend their pools will be subject to the same principles that CMS is applying in Florida.

IV. WITNESSES

Panel I

Katherine M. Iritani
Director, Health Care
Government Accountability Office

Panel II

Haley Barbour
Former Governor of Mississippi
Founding Partner of BGR Group

Matt Salo
Executive Director
National Association of Medicaid Directors

Joan C. Alker
Executive Director of Georgetown University Center for Children and Families
Research Associate Professor, McCourt School of Public Policy