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Testimony of
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STATEMENT OF JOAN C. ALKER

Good morning Chairman Pitts and members of the Committee. Thank you very much for the opportunity to testify at today's hearing. My name is Joan Alker, and I am the Executive Director of the Georgetown University Center for Children and Families and a Research Associate Professor at Georgetown University's McCourt School of Public Policy.

For the past twelve years, much of my work at Georgetown has focused on studying and commenting on Medicaid Section 1115 waiver policy. I very much appreciate the Committee's interest in this somewhat arcane but vitally important issue. As you know, a significant proportion of Medicaid's expenditures – almost one-third in FY 2014¹ -- flow through Section 1115 authority. In addition to the funding, important policy decisions about the structure of the Medicaid program – including how beneficiaries will be able to access needed medical care – are often made through Section 1115 research and demonstration proposals.

It is worth reminding ourselves of the statutory intent behind Section 1115. These waivers are the broadest class of waivers permitted in the Medicaid program, and they were conceived of by Congress as a way to allow states to pursue new approaches that promote the objectives of the Medicaid program. They are also intended to be research and demonstration waivers which are evaluated, and, in my opinion, those evaluations should be independent and robust.

I would like to commend the Government Accountability Office (GAO) for its long history of excellent work on this issue. For the past two decades, GAO has issued many invaluable reports raising questions and concerns about Medicaid waiver policy. These issues have arisen regardless of which party – Democrats or Republicans – controlled the executive branch.

¹ Government Accountability Office, "Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives," (April 2015).

Today, I will focus on two areas of concern raised by the GAO over the years that I also feel strongly about: 1) transparency and the need for robust public input into waiver policy, and 2) budget neutrality.

The good news from my perspective is that, after twenty years of scrutiny, we are finally making significant progress on both of these issues. Still, there is more work to be done.

Transparency

Because so many important decisions about Medicaid policy and financing are made through the waiver process I believe that it is vitally important that there be a robust process for public comment and input at both the state and federal levels.

Congressional oversight of the waiver process has a long and bipartisan history – in 2004, then Senate Finance Committee Chairman Charles Grassley (R-IA) and Ranking Member Senator Max Baucus (D-MT) requested GAO reports, and sent a letter to then CMS Administrator Mark McClellan expressing concerns over the lack of transparency, and, subsequently introduced legislation to establish public input into the Section 1115 approval process.

While it took many years after Senator Grassley and Senator Baucus began championing the issue, the passage of P.L. 111-148 (the Affordable Care Act) was a significant step forward. Their work to ensure that a robust process for public comment at both the state and federal levels was incorporated into law as part of the Affordable Care Act.

The Obama Administration supported this need for greater transparency, and final regulations implementing these provisions were issued by the Department of Health and Human Services on February 22, 2012.² The regulations specify how the public comment process must occur at both the state and federal levels and establish a timeline for the approval process. For a full analysis of what the regulations require, I would like to submit

² 42 CFR 431.400-431.428 (2012).

for the record an issue brief that I co-authored for the Kaiser Commission on Medicaid and the Uninsured.³

While these changes have led to dramatic improvements in the process, I would like to suggest two areas that the Committee might consider that would lead to greater transparency in the waiver process.

First, the public input requirements currently only apply to new Section 1115 applications or renewals but not to amendments to existing Section 1115 waivers. Since so many states already have Section 1115 waivers, many important changes occur through amendments to existing waivers. For example, the recent proposal by the state of Florida to extend financing for its Low Income Pool (LIP) did not officially trigger a public comment period although both the state and the federal governments did accept comment and they are to be commended for that. But there is no requirement in the regulations – and prior to the ACA requirements for waivers more broadly this did not occur with any consistency at the state or federal levels. Thus I believe this would be a valuable amendment to existing law to improve transparency.

Second, while significant progress has been made with respect to having waiver applications and approvals available online at Medicaid.gov, we see a gap in the materials that CMS is currently posting there. Many important documents, such as operational protocols, quarterly and annual reports, and other significant deliverables required in Section 1115 special terms and conditions, are not publicly available on Medicaid.gov, and I would recommend that those be made publicly available as soon as possible.

Budget neutrality

³J. Alker & S. Artiga, “The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers,” Kaiser Family Foundation (March 2012), available at <http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>.

Another important area of GAO oversight in the past twenty years has been the question of budget neutrality. Again, GAO has found that Administrations of both parties have approved budget neutrality Section 1115 agreements which, in GAO's judgment, were not adequately supported by sound documentation and specific and explicit criteria.

Budget neutrality is complex, and the Secretary's discretion with respect to how it is approached should be subject to the following principles in my view:

1. Budget neutrality agreements should never compromise the fundamental financing structure of the Medicaid program (i.e., the matching structure and/or a hard limit on federal spending as was approved in the Vermont Global Commitment to Health waiver in 2005.)
2. Budget neutrality proposals should always be subject to a robust public comment process at both the state and federal levels, and sufficient information should be provided to the public so that they may offer informed and relevant comments;
3. Budget neutrality agreements must be constructed to support a demonstration that meets the ultimate test – does the demonstration support the objectives of the Medicaid program?

In its most recent report of April 2015, the GAO raised concerns about explicit and documented criteria for budget neutrality arrangements. In the past few months, we have seen some encouraging signs from the Obama Administration in regard to how Secretary Burwell plans to approach budget neutrality arrangements going forward. Recent actions taken with respect to the state of Florida suggest that the Administration has taken GAO's recommendations at least partially to heart in a way that I have not observed in previous Administrations.

The state of Florida has had a broad Section 1115 Medicaid waiver in place since 2006. The bulk of the waiver agreement pertains to the state's move to managed care, and at least in its first incarnation, a relatively unusual form of managed care. As part of this waiver agreement, in 2006 U.S. Department of Health and Human Services approved a special source of funding for Florida known as the Low Income Pool, which is distributed to safety net providers through a complex and not very transparent set of arrangements. The state of

Florida has recently been engaged in a very high profile and public fight with CMS about the future of the LIP.

On April 14, 2015 then-Acting and now CMS Director Victoria Wachino sent a letter to Deputy Secretary for Medicaid Justin Senior which clearly stated three principles by which CMS would approach their review of Florida's LIP. The principles outlined in the letter are:

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.
3. Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

In addition to sending this letter to the state of Florida, press reports indicated that CMS also made calls to eight other states that currently have some kind of uncompensated care pool through a Section 1115 waiver arrangement, and shared these same principles to signal their intent to apply these criteria across states.

In the past twenty years, I have not seen a publicly available letter of this type emerge from CMS with clearly stated principles by which CMS will approach future budget neutrality arrangements. While I am certain this issue will continue to need monitoring, it is encouraging that CMS chose to issue this guidance.

In conclusion, Section 1115 Medicaid waivers are a vitally important area of public policy and I appreciate the Committee's expressed interest in this area. The past few years have shown clear signs of progress with respect to greater transparency and significantly improved opportunities for public comment and input. This improvement in transparency is to be celebrated but continued oversight is necessary. "Waiver watchers" will no doubt need to continue their work.

Thank you very much for the opportunity to testify this morning.