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EXAMINING THE ADMINISTRATION'S APPROVAL OF MEDICAID DEMONSTRATION PROJECTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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EXAMINING THE ADMINISTRATION'S APPROVAL OF MEDICAID DEMONSTRATION PROJECTS

WEDNESDAY, JUNE 24, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Capps, Schakowsky, Butterfield, Castor, Schrader, Kennedy, Cárdenas, and Pallone (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Graham Pittman, Legislative Clerk; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Traci Vitek, Detailee, Health; Dylan Vorbach, Staff Assistant; Gregory Watson, Staff Assistant; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Democratic Health Policy Advisor; Samantha Satchell, Democratic Policy Analyst; and Arielle Woronoff, Democratic Health Counsel.

Mr. PITTS. The subcommittee will come to order. The chairman will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Medicaid is a lifeline for some of our Nation's most vulnerable patients. The administration and Congress have a duty to ensure that taxpayer dollars used for Medicaid are spent in a manner that promotes its core objectives and helps our neediest citizens. Unfortunately, a recent report from the nonpartisan Government watchdog agency, the Government Accountability Office (GAO), again raises serious concerns about the administration's management and oversight of Medicaid funds.

Under Section 1115 of the Social Security Act, the Secretary has the authority to approve Medicaid demonstration projects that are likely to promote program objectives. However, the GAO found that

CMS did not have explicit criteria for determining whether, and did not clearly articulate how, demonstration projects met the statutory requirement to promote Medicaid objectives. GAO also reported that several State programs approved for Federal Medicaid funds appeared, on their face, to be only tangentially related to improving health coverage for low-income individuals.

This committee has a duty to ensure that taxpayer dollars used for Medicaid are spent in a manner that promotes its core objectives and helps the most vulnerable patients. Yet, GAO's findings raise significant questions about the degree to which the administration is consistently complying with its own criteria. These criteria were not even articulated by CMS until GAO asked. And these criteria do not exist anywhere in CMS' regulations. They are not even listed on their Web site.

When CMS has a process that is not transparent nor predictable, a process in which CMS often approves a demonstration for one State but denies a similar demo for another State, that process is, understandably, perceived by States and other stakeholders as inconsistent, unfair, and unaccountable. It is unfortunate that CMS declined to participate in this important hearing, despite our best efforts. We gave the agency 2 weeks' notice, offered 2 different potential hearing dates. Nevertheless, despite all the people that work at CMS, the administration declined to make anyone available to testify.

CMS' refusal to come today would be unfortunate under any circumstance, but it is particularly concerning since roughly one in three Medicaid dollars, nearly $150 billion in fiscal year 2014, are spent on 1115 demonstrations. CMS has a responsibility to Medicaid patients, to States, to taxpayers, to be transparent with their criteria for approving or disapproving State demonstrations. And yet, they declined to come before a committee of jurisdiction to explain their criteria or their process. The agency's absence from this hearing is really striking. Accordingly, yesterday, we extended another invitation to CMS to testify before this committee on Medicaid on July the 8th, and we look forward to their participation.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Medicaid is a lifeline for some of our Nation's most vulnerable patients. The administration and Congress have a duty to ensure that taxpayer dollars used for Medicaid are spent in a manner that promotes its core objectives and helps our neediest citizens.

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With that, I would like to welcome all of our witnesses for being here today. I look forward to your testimony. I yield the remainder of my time to the distinguished gentleman from Indiana, Dr. Buchson.

Mr. PITTS. With that, I would like to welcome all of our witnesses for being here today. I look forward to your testimony, and I yield the remainder of my time to the distinguished gentleman from Indiana, Dr. Bucshon.

Mr. BUCSHON. Thank you, Mr. Chairman.

I wanted to briefly highly that the State of Indiana recently received an 1115 waiver for the Medicaid to implement to help the Indiana Plan 2.0. As many of you know, the Healthy Indiana Plan was a very successful program implemented under former Governor Mitch Daniels, and rather than expand traditional Medicaid, Governor Pence created HIP 2.0 to cover our State's most vulnerable population, but not require that they go on traditional Medicaid.

There are over 283,000 Hoosiers to this point enrolled in the program, and actually 71 percent of those opt to pay in and pay more to get dental and vision coverage. This program can be a model used across the country on how to provide coverage to our most vulnerable population.

However, this waiver almost didn't happen. We are going to hear from our witnesses about how complicated this process can be. It took the State of Indiana 2 years; that is one congressional term, to get the waiver. This was not a new program; this was an extension of an already successful program. Not only did it take 2 years, but it took Governor Pence directly reaching out to President Obama several times to get an answer. We received the waiver for 3 years. Let me repeat again, it took 2 years and several conversations directly with the President to get the waiver in place. Something needs to change in this process.

I hope that going forward, CMS is going to learn from the hoops that they made Indiana jump through, and make it easier for States like Indiana to do what is already working. I look forward to ensuring Indiana can continue HIP 2.0 when this waiver expires, and to hearing—I look forward to hearing the testimony today.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman. Good morning and thank our witnesses for being here today. I would like to thank the Chair for having this hearing on the topic of Medicaid demonstration waivers, and I look forward to today's discussion.

Medicaid provides healthcare coverage for more than 70 million Americans. It is our Nation's most vital healthcare safety net program. Today, it covers more than one in three children, and is a critical component of care for seniors. One out of every seven Medicare beneficiaries is also a Medicaid beneficiary. For millions of American families, the Medicaid Program is the only way they can gain access to coverage for appropriate healthcare services. It is a simple truth; our State and Federal Government save money by investing in health care, and Medicaid coverage is a key component of such investment.

The joint State-Federal nature of Medicaid structure is the defining feature of the program. Since its creation, States have had the flexibility to design their own version of Medicaid within the basic framework of broad Federal rules, in order to receive matching funds. If a State wishes to change its Medicaid Program in ways that depart from some Federal requirements, it may seek to do so under the authority of approved demonstration or a waiver. Section 1115 waivers are a very broad type of Medicaid waiver.

In recent years, these waivers have become increasingly utilized by the States. In fiscal year 2014, Section 1115 demonstration waivers accounted for almost ⅓ of all Medicaid spending. While each 1115 waiver is different in scope and focus, they all must promote the objectives of the Medicaid Program and be budget-neutral for the Federal Government.

Over the last 2 decades, the Government Accounting Office, the GAO, has raised concerns about Medicaid waiver policy. Many of the GAO's longstanding recommendations were included in the Affordable Care Act, and I want to thank CMS for the agency's commitment to improving transparency throughout the approval process. Per a requirement of the Affordable Care Act, CMS has issued a final rule to ensure meaningful public input in the waiver process, and enhanced transparency. Today, we will hear from GAO about its body of work on Medicaid waivers and additional improvements that can be made.

While the Supreme Court made Medicaid expansion voluntary for each State, expansion authority provides an explicit, almost entirely federally funded pathway for States to offer coverage for all nonelderly adults living below 138 percent of the poverty line. Because of this, States have a clear option and do not need to use 1115 waivers to expand eligibility for this population. Waivers are still being used to make other programmatic changes, especially as States continue to consider expanding Medicaid. Some of these proposals have sought to impose premiums, cost-sharing charges, and work requirements on beneficiaries. Robust research does not support the arguments for such provisions. Premiums have been

shown to deter participation in coverage, and lead to high administrative costs. Work requirements have no place in a safety net healthcare program, and ignore the fact that the vast majority of new eligible adults—beneficiaries already work but do not have access to affordable care through their employer. States have flexibility—considerable flexibility under existing Medicaid authority. Enacting punitive, unsubstantiated policies like work requirements under the guise of flexibility does not advance the conversation about improved transparency and innovative care models. When people have access to regular health examinations, immunizations, and preventative care, they are dramatically more likely to be healthy and productive adults. Coverage rather than uncompensated care pools is the best way to promote the health of the American people, and the viability of our healthcare system at large. CMS has maintained that this will be one of the three guiding principles moving forward.

That said, 1115 waivers retain the vital purpose of affording States with a way to pursue innovative delivery programs, expand eligibility to individuals not otherwise eligible for Medicaid and CHIP, and pilot initiatives that supports the objections of the Medicaid Program. Medicaid is a safety net for everyone because we are all one medical crisis away from financial ruin, and more people who have coverage and access to necessary care, the better the system works.

I look forward to hearing today's panelists about the important topic, and working with my colleagues on the committee. We have a great opportunity to build on success, and continue to strengthen the Medicaid Program for current and future beneficiaries.

And I yield back my time.

[The prepared statement of Mr. Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN

Good morning, and thank you for being here today. I thank the chairman for having this hearing on the topic of Medicaid demonstration waivers, and look forward to today's discussion.

Medicaid provides health care coverage for more than 70 million Americans. It is our Nation's most vital health care safety net program.

Today, it covers more than 1 in 3 children, and is a critical component of care for seniors. One out of every 7 Medicare beneficiaries is also a Medicaid beneficiary.

For millions of American families, the Medicaid program is the only way they can gain access to coverage for appropriate health care services.

It is a simple truth: our Federal and State Governments save money by investing in health care, and Medicaid coverage is a key component of such investment.

The joint State-Federal nature of the Medicaid structure is a defining feature of the program. Since its creation, States have had flexibility to design their own version of Medicaid, within the basic framework of broad Federal rules in order to receive matching funds.

If a State wishes to change its Medicaid program in ways that departs from certain Federal requirements, it may seek to do so under the authority of an approved demonstration or "waiver." Section 1115 waivers are a very broad type of Medicaid waiver.

In recent years, these waivers have become increasingly utilized by the States. In fiscal year 2014, Section 1115 demonstration waivers accounted for almost one-third of all Medicaid spending.

While each 1115 waiver is different in scope and focus, they all must promote the objectives of the Medicaid program and be budget neutral for the Federal Government.

Over the last two decades, the Government and Accountability Office (GAO) has raised concerns about Medicaid waiver policy. Many of GAO's longstanding rec-

ommendations were included in the Affordable Care Act, and I want to thank CMS for the agency's commitment to improved transparency throughout the approval process.

Per a requirement of the Affordable Care Act, CMS has issued a final rule to ensure meaningful public input in the waiver process and enhanced transparency. Today, we will hear from GAO about their body of work on Medicaid waivers and additional improvements that can be made.

While the Supreme Court made Medicaid expansion voluntary for each State, expansion authority provides an explicit—almost entirely Federal-funded—pathway for States to offer coverage for all non-elderly adults living below 138 percent of the poverty line. Because of this, States have a clear option and do not need to use 1115 waivers to expand eligibility for this population.

Waivers are still being used to make other programmatic changes, especially as States continue to consider expanding Medicaid. Some of these proposals have sought to impose premiums, cost-sharing charges, and work requirements on beneficiaries. Robust research does not support the arguments for such provisions.

Premiums have been shown to deter participation in coverage and lead to high administrative costs. Work requirements have no place in a safety net health care program, and ignore the fact that the vast majority of newly eligible adult beneficiaries already work, but do not have access to affordable coverage through their employer.

States have considerable flexibility under existing Medicaid authority. Enacting punitive, unsubstantiated policies like work requirements under the guise of "flexibility" does not advance the conversation around improved transparency and innovative care models.

When people have access to regular health examinations, immunizations, and preventative care, they are dramatically more likely to be healthy, productive adults.

Coverage, rather than uncompensated care pools, is the best way to promote the health of the American people and the viability of our health care system at large. CMS has maintained that this will be one of three guiding principles moving forward.

That said, Section 1115 waivers retain their vital purpose of affording States with a way to pursue innovative delivery systems, expand eligibility to individuals not otherwise eligible for Medicaid and CHIP, and pilot initiatives that support the objectives of the Medicaid program.

Medicaid is a safety net for everyone, because we are all one medical crisis away from financial ruin, and the more people who have coverage and access to necessary care, the better the system works for us all.

I look forward to hearing from today's panelists about this important topic, and to working with my colleagues on the committee.

We have a great opportunity to build on past successes and continue to strengthen the Medicaid program for current and future beneficiaries.

Thank you, and I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the chairman of the full committee, Mr. Upton, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman.

This year, the Medicaid Program turns 50. Over that half a century, Medicaid has provided critical health coverage for some of our Nation's most vulnerable populations. Medicaid is the world's largest health insurance program, with as many as 72 million people being covered by the program for at least some period of the current year. And in the next fiscal year, 344 billion Federal dollars will be spent on Medicaid, and by 2024, Federal-State spending on Medicaid is expected to top $1 trillion.

Today, roughly one in three Medicaid dollars is spent through an 1115 waiver approved by the Secretary of HHS. Section 1115 of the Social Security Act authorizes the HHS Secretary to waive certain Federal Medicaid requirements and allow costs that would not oth-

erwise be eligible for Federal matching funds for demonstration projects that are likely to assist in promoting Medicaid objectives. These are critical tools for States to experiment and evolve their Medicaid Programs as they seek to modernize and improve them to better serve patients. For example, Michigan has used a waiver to successfully provide HSA-like health accounts to encourage participants to become more active health care consumers. Yet today we will hear from the nonpartisan Government watchdog, GAO, which has repeatedly raised questions about CMS' approval process for those waivers.

Whether it is GAO's concerns about budget neutrality, approval criteria, or the process for approvals and renewals, these are indeed important and fair questions to ask. We need a better understanding about how the billions of dollars CMS is approving promote Medicaid's core objectives.

I want to thank the second panel, in particular, former Governor Barbour, for being here to share his ideas about how to improve CMS' management of the funds. I know that nearly every member of this subcommittee has heard frustrations from State officials at one point about the uncertainty and timeframes surrounding the approval or renewal of an 1115 waiver. While State leaders are trying to balance their budgets, pass legislation, it is essential that CMS' process is transparent and certainly predictable.

Recent analysis and media coverage has raised questions over the degree to which CMS is effectively picking winners and losers in the waiver review process. CMS has a duty, both to patients and taxpayers, to States, all stakeholders, to do more to increase the transparency, accountability, and consistency of their approval process. In fact, if CMS is doing a decent job, increased oversight and scrutiny will only bring their good efforts into the light. However, if there are shortcomings, this subcommittee will play its role in making the process more transparent, accountable, and fair for all involved. At the end of the day, it is about ensuring our most vulnerable receive the care that they deserve.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

This year, the Medicaid program turns 50 years old. Over that half a century, Medicaid has provided critical health care coverage for some of our Nation's most vulnerable populations.

Medicaid is currently the world's largest health insurance program, with as many as 72 million people being covered by the program for at least some period of the current year. In the next fiscal year, 344.4 billion Federal dollars will be spent on the Medicaid program. And by 2024, Federal-State spending on Medicaid is expected to top $1 trillion annually.

Today, roughly one in three Medicaid dollars is spent through an 1115 waiver approved by the Secretary of Health and Human Services. Section 1115 of the Social Security Act authorizes the HHS Secretary to waive certain Federal Medicaid requirements and allow costs that would not otherwise be eligible for Federal matching funds for demonstration projects that are likely to assist in promoting Medicaid objectives.

These are critical tools for States to experiment and evolve their Medicaid programs as they seek to modernize and improve them to better serve patients. For example, Michigan has used a waiver to successfully provide HSA-like Health Accounts to encourage participants to become more active health care consumers.

Yet today we will hear from the nonpartisan Government watchdog, the Government Accountability Office, which has repeatedly raised serious questions about CMS' approval process for these waivers.

Whether it is GAO's concerns about budget neutrality, approval criteria, or the process for approvals and renewals, these are important and fair questions. Congress needs a better understanding about how the billions of dollars CMS is approving promote Medicaid's core objectives.

I also want to thank the second panel, in particular former Governor Barbour, for being here to share their ideas about how to improve CMS' management of these funds. I am confident that nearly every member of this subcommittee has heard frustrations from State officials at one point about the uncertainty and timeframes surrounding the approval or renewal of an 1115 waiver. While State leaders are trying to balance their budgets and pass legislation, it is essential that CMS' process is transparent and predictable.

Recent analysis and media coverage has raised questions over the degree to which CMS is effectively picking winners and losers in the waiver review process. CMS has a duty—to patients, to taxpayers, to States, to all stakeholders—to do more to increase the transparency, accountability, and consistency of their approval process. In fact, if CMS is doing a decent job, increased oversight and scrutiny will only bring their good efforts into the light. However, if there are shortcomings, this subcommittee will play its role in making the process more transparent, accountable, and fair for all involved. At the end of the day—it's about ensuring our most vulnerable receive the care they deserve.

I yield 1 minute to Dr. Burgess.

Mr. UPTON. I yield the balance of my time to Dr. Burgess.

Mr. BURGESS. I thank the chairman for yielding. And I just want to underscore what he said. And, Governor Barbour, it is going to be good to have you before our panel again. I know you have been here before. And I think one of the failings when we initiate discussions on healthcare policy is our failure to include the Governors in the discussion because, after all, our Governors are the ones who have the principle role in a shared Federal-State program, like Medicaid. Our Governors are the ones who actually have the responsibility of the deliverable for their citizens, as well as they have to administer their own healthcare programs for their State employees, and they have great expertise in this area, and too often, we overlook that expertise. So I am grateful you are here with us today.

The topic itself is one that holds a great deal of interest for me, and I am, therefore, glad, Chairman Pitts, that we are holding this hearing. Back home in Texas, we do have an 1115 waiver, had it for a number of years, and it has allowed a positive transformation in care delivery.

Conserving State flexibility within Medicaid allows States to structure their programs in a way that best meets their population's needs. Every administration uses the 1115 negotiations to further their particular objectives, and thus, maybe a discussion on more transparency is warranted. But for this administration, Medicaid expansion has been the leading factor, the number one factor, in negotiations. It has been publicly noticed that even though the Supreme Court has ruled that the administration may not coerce a State into expanding its Medicaid under the ACA, that maybe, in fact, what is happening when the State comes to talk about an 1115 waiver.

In April, the Center for Medicare and Medicaid Services explicitly linked funding for Florida's low-income pool to Medicaid funding, although progress has been made recently. Expansion is not a viable option in Texas, where it was previously estimated that it would cost the State as much as $27 billion over a decade.

Mr. Chairman, I am grateful we are holding the hearing today, and look forward to the testimony of our witnesses and their answering our questions.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

The ranking member of the full committee, Mr. Pallone, has sent me a message. He said he would be late to get to the hearing, would miss opening statements. He has asked to designate Ms. Castor to have his opening statement time. So without objection, Ms. Castor, you are recognized for 5 minutes for your opening statement.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Well, thank you, Chairman Pitts and Ranking Member Green, and thank you for calling this important hearing on the Medicaid demonstration projects.

It was the Congress, through amendments to the Social Security Act and laws relating to Medicaid, that granted States new and broad flexibility to test what works. All States are different. Through what are called the Section 1115 waivers, or demonstration projects, States have great flexibility to deliver care in more efficient ways. But each waiver has a time limit, because demonstration projects are intended to be analyzed to ensure they are working, and that they are using taxpayer dollars wisely. And there are a couple of important parameters. These are typically 5-year demonstration projects with certain extensions, 3-year extensions. You negotiate with CMS. And we say that the States, and these are some of the principles, States and the Federal Government cannot spend more than they would have spent without the waiver. And that is an important safeguard on taxpayer dollars.

So I appreciate the GAO and your thoughtful analysis of these waivers. It is very opaque to the average person. You have advocated for more transparency and accountability. Congress responded in the Affordable Care Act, and CMS has followed through with that direction, but I think we can all agree we still have more to do. So I will look forward to your testimony today on how we can continue to work to make these demonstration projects and waivers more transparent.

Now, many States have experimented with low-income pools, these uncompensated pools of cash, where the local governments, State Governments, Federal Government, pools money to pay for uncompensated care. Now, the uncompensated care pools are intended to support healthcare providers that provide uncompensated care to uninsured and underinsured State residents. They are not healthcare programs. They don't allow people to get primary and preventative care, and they don't protect people from financial harm resulting from medical debt, and that is why they have come under great scrutiny. They were very important before the adoption of the Affordable Care Act because the uninsured levels across America were so high. Hospitals, doctors, community health centers simply couldn't cover the costs of uncompensated care without the help of the low-income pool dollars. And these were especially vital to the State of Florida as we transition from traditional Med-

icaid to Medicaid managed care. And I was an advocate in past years for very healthy, uncompensated care pools.

But now we are in a whole different world. With the broad expansion of coverage under the Affordable Care Act, these billions of dollars in pools of cash don't make financial sense anymore. So CMS put States on notice some years ago. They put Florida on notice in 2011 that the low-income pool would not survive in its current form, because it doesn't make sense to simply write a check to a hospital or a State that isn't as financially responsible as providing coverage to your citizens. After being on notice since 2011, Florida got a 1-year extension of LIP until June 30, 2015, with the understanding that it would conduct an independent review of its payment system intended to allow for the development of a sustainable, accountable, actuarially sound Medicaid payment system, and that LIP would be different. Florida knew that it was expected to change the way it pays providers, and provides health services to its low-income residents. They got into trouble this spring because the Governor, even though he was on notice, included the full LIP uncompensated care pool number in his budget, and the Republican-led State senate wanted a coverage model, so they went into a budget impasse. And fortunately, they have resolved it. Unfortunately, they did not adopt a coverage model, and we are on notice that the LIP funds are going to diminish over time. This will be an important lesson for other States across the country. And we need to be—we need to focus on coverage that is more financially secure for States, the Federal Government, and eliminate this risk of unnecessary expenditure of taxpayer dollars. So I will look forward to the discussion on that today as well.

Thank you very much. I yield back my time.

Mr. PITTS. The Chair thanks the gentlelady.

That concludes the opening statements. As usual, the written opening statements of the members will be included in the record.

We have two panels today. And on our first panel we have Ms. Katherine Iritani, Director of Health Care, the Government Accountability Office. Thank you very much for coming. Your written will be made a part of the record. You will have 5 minutes to summarize your testimony before questions. And so at this point, you are recognized for 5 minutes for your opening statement.

STATEMENT OF KATHERINE M. IRITANI, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. IRITANI. Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am pleased to be here to discuss GAO's work on Medicaid demonstration spending. Demonstrations comprise a significant and fast-growing component of the over-$500 billion Medicaid Program. With the broad waiver and spending authority conferred upon the Secretary of HHS under Section 1115 comes responsibility for ensuring that demonstrations further Medicaid objective and do not increase Medicaid costs.

My testimony today is based on GAO's April report examining HHS' approvals of new costs approved for 25 States' demonstrations. I will also discuss a body of work from 2002 to 2014, examining HHS' review process for ensuring that demonstrations do not raise Federal costs.

Based on this work, we have three main concerns with HHS approvals. First, with transparency. HHS' bases for approvals of new costs not otherwise eligible for Medicaid were not always apparent in recent approvals. Nor have been the bases for approved spending limits for the demonstrations which govern total allowed spending. Second, accountability. HHS has not issued specific criteria for how it determines that approved spending is furthering Medicaid objectives, nor has HHS issued specific criteria for how it reviews and approves demonstration spending limits. Without criteria, stakeholders and overseers may not share a common understanding of how major decisions occur. The third concern, fiscal impact. Based on our reviews and multiple demonstrations approvals, we have longstanding concerns that the Secretaries approve spending limits that could potentially increase Federal Medicaid costs by tens of billions of dollars.

I will turn now to our report findings. In April, we reported that HHS has approved States to obtain Federal Medicaid funds for a broad range of purposes. Two prominent types of new costs not otherwise eligible for Medicaid were approved. The first was for State-operated programs. HHS allowed five States to spend up to $9.5 billion for more than 150 State-operated programs that, prior to the demonstration, were funded by the State and potentially other Federal sources. The programs were wide-ranging in nature. They included workforce education and training, insurance subsidy, housing, licensing, loan repayment, and a broad array of public health programs. The Federal Medicaid funds the States received could replace some of the States' expenditures for the programs, and free-up State funding for other purposes. HHS' approval documents were not always clear about what the State programs were for or how they related to Medicaid. Further, approvals did not always provide assurances that new Medicaid funds for these programs would be coordinated with other funding streams.

The second prominent type of spending approved was funding pools to make new payments to hospitals and other providers for broad purposes. HHS approved six States to spend up to $7.6 billion for funding pools for uncompensated care costs. Five States were allowed to spend up to $18.8 billion for incentive payments to providers to improve health care delivery and infrastructure. Again, approval documents were not always clear regarding how the spending would further Medicaid objectives, and not duplicate other Federal funding streams.

Now let me to turn to our work on budget neutrality, which examined the extent HHS has ensured that demonstrations will not raise Federal costs. Our longstanding body of work examining over 20 demonstrations found that HHS allowed most States to use questionable assumptions and methods to project how much their Medicaid program would cost without the demonstration. Such projections, once approved, become the basis for total spending allowed under the demonstration. In our most recent reports in 2013 and '14, we estimated that HHS approved spending for five States' demonstrations that was about $33 billion higher than what the documentation supported.

In conclusion, Medicaid demonstrations provide HHS and States a powerful tool for testing and evaluating new approaches for im-

proving the delivery of services to beneficiaries. Medicaid demonstrations can also set precedents that are adopted by other States, and raise potential for overlap with other funding streams. Given the fast-growing and significant amount of Federal spending governed by these demonstrations, we believe there is an urgent need for improved accountability and transparency in HHS' review and approval process.

Mr. Chairman, this concludes my statement, and I am happy to answer any questions.

[The prepared statement of Ms. Iritani follows:]

United States Government Accountability Office

Testimony

Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

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MEDICAID DEMONSTRATIONS

More Transparency and Accountability for Approved Spending Are Needed

Statement of Katherine M. Iritani
Director, Health Care

GAO-15-715T

GAO Highlights

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

June 24, 2015

MEDICAID DEMONSTRATIONS

More Transparency and Accountability for Approved Spending Are Needed

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.

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

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Mr. PITTS. The Chair thanks the gentlelady. I will begin the questioning and recognize myself 5 minutes for that purpose.

Ms. Iritani, in your testimony you indicated that CMS has four general criteria against which it reviews Section 1115 demonstrations to determine whether the Medicaid Program's objectives are met. However, did anyone outside of CMS know about these criteria until the GAO did its report?

Ms. IRITANI. No. The first time we saw those criteria was when CMS and HHS responded to a draft of our report.

Mr. PITTS. So to be clear, these criteria are not even in regulation?

Ms. IRITANI. Correct.

Mr. PITTS. So did CMS create them out of thin air, or where did they come from?

Ms. IRITANI. We asked for CMS' criteria during the course of our review, and that criteria were not provided until they reviewed a copy of the report.

Mr. PITTS. Now, you raised concerns that the criteria that CMS enumerated for its review of the demonstration programs are far too general. Can you please elaborate on these concerns, explain the risk associated with the lack of more specific and transparent criteria?

Ms. IRITANI. The general criteria that CMS said that they used included things like increasing and strengthening coverage for low income and Medicaid, increasing access to and stabilizing providers and provider networks available to Medicaid and low income, improving health outcomes for Medicaid and low income, increasing efficiency and quality care. We did not believe that these criteria were sufficiently articulated in terms of the link to Medicaid, and the documentation that we reviewed regarding the approvals was not clear as to how they made their decisions about what to approve.

Mr. PITTS. Now, the part of the Federal statute on 1115 waivers is very short; just four pages. So the Secretary of HHS has tremendous latitude under the law to fund some demonstration projects, while denying others. Are there any statutory criteria requiring the Secretary to be consistent?

Ms. IRITANI. There are not. The statute is quite broad with regard to the Secretary's authority for approving purposes that, in her or his judgment, further Medicaid objectives.

Mr. PITTS. What is to stop the agency from playing favorites; picking winners and losers, via the waiver process?

Ms. IRITANI. Well, we believe that more transparent criteria and standards for approvals are needed, and more oversight.

Mr. PITTS. Now, one of the worries that I and many of my colleagues have is that the Medicaid Program too often promises coverage, but effectively denies care. An NPR story this week entitled, California's Medicaid Program Fails to Ensure Access to Doctors, told the story of Terry Anderson. She signed up for California's Medicaid Program earlier this year, hoping she would finally get treatment for her high blood pressure, but she faced challenges accessing care in a timely manner. Would it make more sense for CMS to stop spending money on the low-priority items, and free-

up more Federal dollars for better oversight and direct care for patients?

Ms. IRITANI. We would agree that Medicaid funds should be spent for Medicaid purposes. And the approval documentation that we reviewed for the demonstrations did not articulate how many of the approved expenditures were furthering Medicaid objectives, which is why we have recommended that the Secretary issue criteria as to how he or she assesses whether or not approved spending is furthering Medicaid purposes.

Mr. PITTS. The Chair thanks the gentlelady. My time has expired.

The Chair recognizes the ranking member of the subcommittee, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Thank you again for your testimony. We hear a lot of criticism of the lack of flexibility of CMS for waivers, but what I heard in your testimony and seen in multiple reports going back decades is that many actually—maybe actually too much flexibility in how the budget neutrality and other features of waivers have been administered. My question is, GAO is asking for clearer standards and more transparency, just like CMS has recently taken steps to provide in its approach to Florida and other States with uncompensated care pools. Is that correct?

Ms. IRITANI. That is correct.

Mr. GREEN. In reviewing the GAO's recommendation over the last—recommendations over the last 20 years, it appears as though your recommendations have remained the same until only recently. Isn't it true that the majority of these recommendations were not acted upon up until the Obama administration and the Affordable Care Act, which placed many of your recommendations into action?

Ms. IRITANI. That is correct.

Mr. GREEN. OK. Given the large amount of Federal dollars at stake in waivers, would you agree that it is important for CMS to make it—to take its time in evaluating the proposals and getting additional information from the States to ensure that each State's proposal is for a project that is in line with the objections—objectives of the statute?

Ms. IRITANI. We would agree that there is more need for transparency for criteria around how they make their decisions, around better methods allowed for predicting how much the Medicaid Program would cost without the demonstration, which becomes the basis for the spending limits allowed.

Mr. GREEN. Well, and I don't think any up here would disagree with we need more transparency in dealing from CMS

I want to clarify a point in your testimony that may be misleading to some of my colleagues. GAO mentions that some of the funds that go to the designated State health programs has been supported by both political parties for more than a decade, could have received funding from other Federal sources—could that—the designated State health programs receive funding from other Federal sources. As you may know or may not know, it is very common for small programs to leverage multiple funding streams to provide services. However, that is concern—what is concerning is in this case, from my understanding, the lack of documentations and po-

tential, therefore, for Medicaid Federal matching dollars to be given based on other Federal funding not as a match for the State dollars as is appropriate under the Medicaid Program. That duplication of funds is the issue that GAO is concerned about. Is that correct, Ms.——

Ms. IRITANI. That is correct.

Mr. GREEN. OK. The GAO is not determining what is or is not appropriate for Medicaid objective because that determination lies with the Secretary of HHS. And our States—rather, the GAO is recommending that better documentation reflect the tide of Medicaid objectives for these funds, and that CMS ensure that States are not drawing down Federal matching funds based on the input of other sources of Federal funds. Is that pretty accurate?

Ms. IRITANI. Yes, that is correct. I think our concern with the approval documentation around potential duplication was that there was variation in the level of protections in the approval documentation with regard to assuring that if programs were receiving Federal funds from other sources, that they were offsetting those against the Medicaid funds that they received.

Mr. GREEN. OK. Thank you, Mr. Chairman. I yield back my time.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you very much, Mr. Chairman. Ms. Iritani, it is great to have you here.

And I have been focused on this budget waiver neutrality debate, to the chagrin of some of some of my friends, and actually I think my own State, because the concern has been, since there is no transparency or clear answer, the premise is, which I agree, properly done, that give States their authority to meld their own program, you also get better outcomes and you will get a savings. I mean that is what we are always told. And if not a savings, there is an implied aspect in 1115 that says at least it should be neutral, but for the past 10 years you all have looked at this, and what have you found?

Ms. IRITANI. Yes, we have found that the documentation did not support that spending limits were budget neutral. We found that it is likely that Federal Medicaid costs could be increased significantly for Medicaid based on these demonstration approvals.

Mr. SHIMKUS. So just using the facts of dollars, the claims, they are not being substantiated by the facts. The facts don't substantiate the claims that States have made that we can build a better mousetrap, provide better care, and actually have a savings to the Medicaid system.

Ms. IRITANI. Yes.

Mr. SHIMKUS. So—and again, to the chagrin of even my State, because as—the State of Illinois, we are almost a failed State these days. Our pension obligations far outstrip per capita any in the union. Medicaid is also a big driver. So there is sometimes an intent, I—so I am not being encouraged, let me put it this way, to ask these questions on budget neutrality because of, I think, a desire for the States to be able to gain the system a little bit, based upon the vagueness of what CMS is doing. And I hate to kind of

tell—weave the story this way, but it is—I think it is just a—it is a fact, based upon the numbers.

So we have dropped a bill, H.R. 2119, I don't know if you are familiar with it, and I know your position of not commenting on legislation, but the intent of the bill is to do at least an analysis and have the chief actuary of the CMS certify that the proposed budget neutrality or implied savings is actually there. I mean it is a guess, but at least it has actuaries doing the number crunching to say, yes, we believe the State, we think there is going to be a savings, at a minimum there is going to be budget neutrality. If we brought in and had that actuary analysis before a decision was rendered, do you think that would be helpful?

Ms. IRITANI. Yes, I think that what I can say is that, in a recent—we have noted that the actuary isn't involved in the process typically. In our most recent report in 2014, the—which was looking at the budget neutrality of one State's approval, we did note that the actuary was asked to review the State's proposal, including the proposed spending limits and the basis for it, and had raised questions with it, but was—but—and asked for further documentation that was not provided by the State. And the spending limit was approved, and we found that it was likely going to raise Federal costs.

Mr. SHIMKUS. So, you know, that story kind of just supports our concern and the reason why we dropped the bill, and it is a very—it is very short. But what we require then is a certification process by the actuaries which would then, I think, empower them to make sure they get all the information they need to be able to make a—to certify based upon the best available information that this is going to be budget neutral or, in essence, an implied savings.

So I appreciate you being here. It is a tough issue. Money is always what you fight about. So thanks for coming.

I yield back my time.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman, for holding this hearing, and to our witness for your testimony. I am happy we have this opportunity to come together to talk about these important Medicaid waivers; something that has really, truly helped my State respond creatively to its challenges and provide healthcare coverage to many more than before.

Our Nation faces a significant challenge of caring for our growing patient population with limited resources, and as was mentioned, the challenge even with the number of providers available to meet the needs. We must ensure that the Medicaid Program has the flexibility through these waivers to address these needs. As has been said, these waivers are negotiated between the State and CMS, but especially as we have seen in California, the agreement affects many more stakeholders once it is in place. Recognizing this fact, the ACA included an important provision to encourage broader stakeholder input during the waiver process. Now there is a formulized process for the broader coalition of stakeholders to contribute, and I think that range of perspectives has created better

and more effective waiver programs. I think both sides of the aisle agree that this aspect of transparency is so vitally important.

Ms. Iritani, can you talk more about how public comments have helped and will help to increase transparency throughout the Medicaid waiver process?

Ms. IRITANI. Certainly. Yes, we raised concerns with the lack of transparency in the approval process, dating back to the early 2000s. In a report in 2002, we talked to a number of different States and advocacy groups and others about demonstrations that had been recently approved that significantly affected beneficiaries, and found that there are great concerns about groups even being able to see a copy of the proposal prior to the approval. In some cases, I think that there were FOIAs involved to try to get transparency over what was being approved. And the Patient Protection Affordable Care Act did require a public input process at the Federal level, which we think greatly enhances transparency of what is being proposed, and provides for input to the process prior to the approval. So we would agree that that is an important reform.

Mrs. CAPPS. And so you have seen progress since this has been initiated?

Ms. IRITANI. We have not looked at public——

Mrs. CAPPS. You are not——

Ms. IRITANI [continuing]. Input since——

Mrs. CAPPS [continuing]. Measuring it.

Ms. IRITANI [continuing]. Since the law was passed. But——

Mrs. CAPPS. OK.

Ms. IRITANI. But we——

Mrs. CAPPS. Do you intend to?

Ms. IRITANI [continuing]. We agree that it has increased transparency.

Mrs. CAPPS. I mean, how are States responding to these kind of comments?

Ms. IRITANI. We have looked at that. In terms of how are States responding to the proposals?

Mrs. CAPPS. The proposals and the process of the whole transparency issues.

Ms. IRITANI. We have not looked at that, at how States are responding to the process.

Mrs. CAPPS. Do you see this as part of your overall objective, or is it up to somebody else to do this piece of it?

Ms. IRITANI. Well, we would be happy to look at that. The work that we have been requested to do in recent years has focused on budget neutrality and the new costs that were approved in the demonstrations.

Mrs. CAPPS. Which is a lot to be assigned to and be——

Ms. IRITANI. Yes.

Mrs. CAPPS [continuing]. Grappling with in light especially, in my view, of the total, I won't say overwhelm, but increase in volume. I mean there has really been a sea change. You want to explain—I have a few more seconds left, and what are some of the issues that you have faced, or how has this process been received?

Ms. IRITANI. The public input process?

Mrs. CAPPS. Right.

Ms. IRITANI. Well, you know, as I say, we haven't looked at it since it was implemented, but we did look at the regulations that implemented it and agree that it was responsive to our recommendations that they provide for a Federal input process.

Mrs. CAPPS. Um-hum. So we are on the path, but it is early yet to interpret any results, is that what I am hearing you say?

Ms. IRITANI. I would say it is an important step to improving transparency, yes.

Mrs. CAPPS. Right, but we need to keep checking back and—do you have the means by which you can accomplish some of these goals?

Ms. IRITANI. I would be happy to work with the subcommittee on work——

Mrs. CAPPS. Thank you.

Ms. IRITANI [continuing]. Looking at that.

Mrs. CAPPS. I thank you for the time. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you. I am over. Good morning. It is good to be with you, and thank you for your work.

I want to ask about one demonstration project that was authorized in the Affordable Care Act that relates to the Institution for Mental Disease exclusion, IMD exclusions, for emergency care for people with psychiatric conditions. As part of comprehensive mental health reform, this committee will be deciding and considering modifications in these IMD exclusions to increase access to timely and cost-effect short-term psychiatric care as opposed to boarding in emergency rooms, and that is what I understand is the demonstration report that is—was worked on for that study.

Can you tell the committee, if you are aware of this, what CMS has learned from current Medicaid emergency psychiatric demonstrations, and which created an exception for this IMD exclusion for adult Medicaid enrollees who have been determined to have emergency psychiatric conditions? Are you aware of any of this?

Ms. IRITANI. I am not. That demonstration was not within the scope of our work.

Mr. MURPHY. Is that something that you would be able to look at, because it is—was one of the demonstration programs? Is it totally excluded from your work to review that?

Ms. IRITANI. I believe that that is a separately authorized—not under the 1115——

Mr. MURPHY. Well, let me ask a little bit more about this because I mean I value your input on this——

Ms. IRITANI. Um-hum.

Mr. MURPHY [continuing]. But I understand the final evaluation though for the demonstration will be completed in the fall of 2016, so it is still ongoing. Do you have any advice or suggestions you could make to this committee to help us shape how we review these to make the most effective policies, for example, on these IMD exclusions? Is that something you would be able to advise us on?

Ms. IRITANI. Well, I need to see more specific information, but yes, we would be happy to talk to the subcommittee about new work on this——

Mr. MURPHY. Thank you.

Ms. IRITANI [continuing]. Issue.

Mr. MURPHY. And also with CMS support, extending the current Medicaid emergency psychiatric demonstration until at least the final evaluation is available. The—because we have an initial 2013 report, but we don't have—I mean the rest is going to take some more time. And what we see is in the States involved, because we limit hospitals to have less than 17 beds because it seems to only cover people who are suicide or the most severe cases, it still leaves us in a position where we are having problems putting these pieces together. We want to provide effective care for people, we want to do it in the most cost-effective way, but also recognizing that you can be cost-effective—you can do cost care without providing anything. We don't want to do that. We want to make sure we are providing effective services. And believe that the Government Accountability Office is a record of really helping us look at and analyze those numbers, so I would be grateful if that is something you could help us with. It is a key issue that this committee has got to deal with, because otherwise what happens with Medicaid, for people ages 22 to 64, is they have nowhere to go. We had a recent hearing in this subcommittee where Senator Creigh Deeds of Virginia was here. His case was one where he took his son to a hospital in Virginia, and the hospital said we don't have any beds. And what happens so often is these men and women are—they may be boarded in an emergency room, they may be tied to a bed, if they are assaultive they may be given chemical sedatives, and they say there is just no room, and it is this Medicaid rule which was based upon closing down those old institutions and hopefully having some other support services. If we close the institutions down, we don't have enough hospitals because Medicaid has said you can't have them. And so in his case, he took his son home. His son took a knife and tried to kill his father. Slashed him up pretty bad. Father escaped. Luckily, some driver picked him up as he was running up, but unfortunately, his son killed himself.

Now, I know that these aren't the cost-effective measures that GAO looks at, but it is something we all care deeply about. How do you put a number on that? How does he put a number on his son's life? And given the 40,000 suicides that occurred in this country last year, given the 43,000 drug overdose deaths that occurred in this country last year, those numbers are staggering and they are getting worse every year, so we have to effect this.

So your input, GAO's input, I would value greatly as we help address this to find—to look at these numbers and costs and saying this is not acceptable to this committee, it is not acceptable to this country. Quite frankly, it is not acceptable to the human race that we have done this, and the outcomes too often are death.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

And now recognize the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman.

Ms. Iritani, what is the rate of Medicaid reimbursement compared to private insurance coverage in general?

Ms. IRITANI. That is going to vary by service and State. Oftentimes, fee-for-service Medicaid rates may be lower, but again, it is going to vary.

Mr. SCHRADER. They are pretty—they are always lower, and significantly lower. I know in my State it is very dramatic. It is hard to get providers sometimes to see Medicaid patients unless they are a mix because the rate is, you know, almost ½, and sometimes not even covering the cost of these services.

What is the rate of—well, is there a general rate of medical inflation that GAO uses to estimate savings when they are evaluating these different programs and——

Ms. IRITANI. We apply HHS' own criteria for how States should develop spending limits, and that criteria is that States should project what Medicaid will cost, which becomes the basis for the spending limit, based on the lower of either the State's historical spending trends in recent years, or the President's budget projections of Medicaid growth for the Nation as used in the President's budget.

Mr. SCHRADER. But wouldn't you say it is always more than the general rate of inflation?

Ms. IRITANI. I——

Mr. SCHRADER. Medical inflation is generally higher than regular inflation.

Ms. IRITANI. I cannot——

Mr. SCHRADER. Well, the answer is yes.

Ms. IRITANI. OK.

Mr. SCHRADER. I mean there is not a State in this country that——

Ms. IRITANI. Um-hum.

Mr. SCHRADER [continuing]. Doesn't budget for a higher rate of medical inflation for its healthcare programs compared to services and supplies——

Ms. IRITANI. Uh-huh.

Mr. SCHRADER [continuing]. You know. My State was easily 3, 4, or sometimes 5 times, historically——

Ms. IRITANI. Um-hum.

Mr. SCHRADER [continuing]. Prior to the advent of the ACA, which has now driven down healthcare expenditure increases dramatically. A little shocked that GAO doesn't have this information, actually.

Isn't it correct that, for these designated State health programs, that these have been around a long time? Not recent——

Ms. IRITANI. Some of the approvals——

Mr. SCHRADER [continuing]. Figment of this—

Ms. IRITANI. Some of the original approvals of the demonstrations we reported on in our recent report had been approved years ago, yes.

Mr. SCHRADER. So prior to this administration?

Ms. IRITANI. Yes.

Mr. SCHRADER. OK. Good. Good. And isn't it accurate that CMS, with your latest report, has agreed with most all of your recommendations and is inclined to supposedly work to improve them?

Ms. IRITANI. Yes, we had three recommendations around issuing criteria about how to further Medicaid demonstration objectives

around improving the documentation about how they apply that criteria, and about making sure that they consistently provided assurances and approvals that there wouldn't be duplication of funding.

Mr. SCHRADER. Good.

Ms. IRITANI. And they agreed with two of those, documentation-related recommendations. They partially agreed with the first one, indicating that they had general criteria that they used. They did not commit to issuing criteria.

Mr. SCHRADER. And I guess I have a concern as I listened to your testimony and some of the queries by some of my colleagues. I am a little concerned we are—you are encouraging CMS to actually get into the micromanagement of these State waivers, and I think that is a big concern. Criteria defining how States have to have, or have to have certain procedures in place, and—shouldn't we be outcome-based, shouldn't we be outcome-focused, don't we just want to see more coverage for more people, better healthcare outcomes? I mean that is something that my colleagues and I can evaluate. Some of my medical physician colleagues, they perhaps have the greater degree of understanding, but for those of us in the lay field, I feel more comfortable evaluating the outcomes, not defining criteria by which these States, who we are trying to give more flexibility to give better coverage to more people over the long-haul. That really should be the goal. I am concerned that CMS may interpret, or my colleagues may interpret, your queries as to wanting to micromanage these States, and I think that is the wrong way to go. I think that is really the wrong way to go. Don't you feel that outcomes are the most important criteria by which we should judge success in these programs?

Ms. IRITANI. I would agree that improved outcomes for Federal spending is important. Healthcare costs are increasing and we are concerned about the long-term sustainability of the Medicaid Program. The—our work has really focused on the spending aspect and the approvals of the spending. And certainly, I think the goal of many demonstrations is to improve outcomes, but given the longstanding policy that they not raise Federal costs, I think that has been the focus of our work, and that is where we think reforms are needed because it is the long-term sustainability of the program that is—could be at risk.

Mr. SCHRADER. I yield back. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognizes Dr. Burgess 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

And just picking up on Representative Schrader's questions, and the observation of outcomes versus micromanagement at CMS, we as physicians are always held to the standard we are going to pay for performance, and we are going to pay for value not volume. Do you ever provide or look to a pay-for-performance standard for CMS when evaluating these programs?

Ms. IRITANI. We have not looked at that, but I know some of the demonstrations I think are evaluating that.

Mr. BURGESS. Well, it just seems like, again, we are all too willing to burden every physician across the land with new require-

ments, and yet never ask the same of the bureaucracy, and really, we ought to be for patients before we are for the bureaucracy.

I do have a question, it may require an answer in writing, but let me pose it to you. And I will get it to you in writing because the answer may be longer than time will permit us to do here. But we have heard several times this morning that applying for one of these waivers, an 1115 waiver, can be burdensome, time-consuming. I know it happened in Texas. Mr. Bucshon referenced Indiana. Can you discuss ways in which the Department of Health and Human Services could streamline the approval process for the 1115 waiver?

Ms. IRITANI. Our work is really focused on the approval processes for the spending, and we have examined the approval times, which vary greatly among demonstrations. There are many factors that we have been told contribute to that.

Mr. BURGESS. Well—but I would like, if you would, and I apologize for interrupting because—but time is short, I would like your evaluation of why that variability exists. Again, we in health care, if we had that degree, or when we have that degree of variability, people are always willing to ask questions and point fingers at us, just like that same standard applied to CMS when issuing these waivers. Just very briefly, according to your report, the Department of Health and Human Services actually did not have specific criteria for these 1115 waivers. Now they do, but do you have a sense of what the criteria was before you issued your report?

Ms. IRITANI. They did not have any written criteria regarding how they made these approvals.

Mr. BURGESS. So it was flip a coin, draw straws, just how I feel that morning when I get up? No criteria at all?

Ms. IRITANI. Officials told us that it wasn't within the Secretary's interests to specify criteria.

Mr. BURGESS. Well, that brings up the point, because we kind of watched what is happening down in Florida, and now that expansion of Medicaid is the number 1 issue for the Obama administration going forward, this is the sine qua non of President Obama's legacy is the expansion of Medicaid. It really does seem like that power is being brought to bear on a State that had a functional 1115 waiver for their low-income pool, now it needs to be re-upped but the pressure is coming that you have to do something different that you haven't been doing before. Am I wrong to get that impression?

Ms. IRITANI. Well, we would agree that transparency is needed in the approvals and approval process, and the criteria that is used, and our concerns have been longstanding based on reviews of many, many States' demonstrations.

Mr. BURGESS. Well, the good news for both of us is that this is the most transparent administration in the history of the country, so we, I guess, can take some degree of solace on that.

The question about the neutrality, and you brought that up a couple of times, when approaching and approving these 1115 waivers, but GAO has had some concerns about this, actually going back into 2008, into the Bush administration. Center for Medicare and Medicaid Services has consistently asserted the policies are adequate and applied consistently, but really, to me, they are not.

Could you share with us, and again, this may be an answer in writing because of time, but can you share with us ways that you think Congress could use to remedy this issue?

Ms. IRITANI. Yes, we believe congressional intervention would be helpful in this case. As I mentioned in my statement, our concerns about the approvals are longstanding. I think we have a report dating back to the mid-'90s on the budget neutrality process raising concerns, and the Secretary has consistently disagreed with our recommendations to reform the criteria and process around approving the spending limits. So we have elevated the recommendations that we made to the Secretary about improving the process as a matter for congressional consideration.

Mr. BURGESS. Well, I thank the gentlelady for her testimony. I will submit those questions in writing.

And, Mr. Chairman, if I could, if you would yield to me for a unanimous consent request?

Mr. PITTS. The gentleman may proceed.

Mr. BURGESS. Chairman, I request unanimous consent to enter into the record a letter by my attorney general in Texas, Ken Paxton, several other attorneys general, about the issue of the 1115 waivers. And I would ask——

Ms. CASTOR. And, Mr. Chairman——

Mr. BURGESS [continuing]. For its inclusion in the record.

Ms. CASTOR [continuing]. I reserve the right to object.

Mr. PITTS. All right. The——

Mr. BURGESS. Again, I make the unanimous consent request——

Mr. PITTS. He has made——

Mr. BURGESS [continuing]. As a matter of——

Mr. PITTS [continuing]. The unanimous consent request. Do you object?

Ms. CASTOR. I would just like to make a short statement, and then I would——

Mr. PITTS. All right, the Chair recognizes the gentlelady.

Ms. CASTOR. I just want to point out that part of that letter is inaccurate when it comes to the State of Florida and what transpired there, since the State of Florida was on notice since 2011 that it was unlikely that the low-income pool was likely to survive in its current form, and due to the fact that CMS and the State of Florida have, in fact, negotiated the matter. The State did not expand Medicaid, and the LIP does survive. This simply points to the fact that we have all got to work harder to make sure we are working on behalf of the taxpayers. GAO has been critical of not allowing Federal waivers to spend extra money, and we have all got to be mindful of that. And if we take this tact that States have coverage, but they get these uncompensated care pools that don't have much accountability and transparency, that is not going to serve Medicaid patients very well, and the congressional intent to be strict and wise with taxpayer dollars.

But at this time, I will remove my objection. Thank you.

Mr. PITTS. Thank you.

Without objection, the letter is entered into the record.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. The Chair thanks the gentleman.

Now recognizes the gentlelady, Ms. Castor, 5 minutes for her questions.

Ms. CASTOR. Yes, I just have a quick question. The transparency regulations also require States to be more transparent; have hearings, have comment periods, but this is so difficult for folks who rely on Medicaid services back home, because remember, Medicaid really it serves primarily children, the disabled population, elderly in nursing homes, especially for States that have an expanded Medicaid. They have transitioned now, many States, to Medicaid managed care. And what I hear from folks at home is it is very difficult to have any real idea on where accountability lies, where they can go for recourse when they have an issue. For example, I had a woman in my office from Florida last week who has a severely autistic son, and she—under managed care, they have changed providers and she hasn't had the ability to weigh-in with policymakers on how care is going to be delivered to her son and other families.

Here is another example, doctors are extremely frustrated. I had a pediatric dentist in my office just a few weeks ago from Florida. He does the Lord's work in taking care of hundreds and hundreds of children across my State and their dental health care needs. And that is smart because you take care of dental health needs and you save the State and Federal Government money down the road. But they do not have any recourse into inquiring at the State level what is happening with changes in demonstration projects and waivers. Can the GAO take a closer look at how States can do a better job? Have you done that and what recommendations do you have to help these families, patients and providers, have more access to what is happening?

Ms. IRITANI. We haven't looked at the public input process since the year 2000s. We haven't been asked to, but we would be happy to work with your staff regarding re-examining how things are working.

As I said earlier, we thought that the Federal input process that was provided for in recent legislation was a very good step because, before, it was really just up to the States to get input, and that was often difficult for beneficiaries and others to weigh-in.

Ms. CASTOR. I will look forward to doing that with you.

Thank you. I yield back my time.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman. And thank you, Ms. Iritani, for being here today with us.

You know, based on your testimony and some of the questions and discussion today, it looks like CMS is creating overlap and duplication through its funding of State health programs. Under Section 1115, basically CMS is authorizing Federal matching funds for State programs, despite the fact that other Federal agencies already provide funding for these causes. It would seem that we are duplicating billions of dollars.

With that, could you discuss the steps that CMS is taking to ensure that the funding of these State-based programs does not result in overlap of duplication of Federal funding?

Ms. IRITANI. We found really mixed results in what CMS was doing in the documentation around—providing for assurances that the new spending that they were approving for the demonstrations would not duplicate other Federal funding sources. There were some States where the documentation would actually provide for a specific weighing-out of the different funding streams——

Mrs. ELLMERS. Um-hum.

Ms. IRITANI [continuing]. And requirements on how to offset——

Mrs. ELLMERS. Um-hum.

Ms. IRITANI [continuing]. The Medicaid funds with other Federal funding streams, but in many cases, there wasn't such a requirement, which raised concerns to us.

Mrs. ELLMERS. In your report, it lists 150 State programs for which CMS authorized Federal Medicaid funding, and many of the programs, based on their name, appear to be worthwhile and for good causes. I would like you to expand on how some of these programs promote Medicaid's objectives. And I want to give you three examples, and if you can just help us understand how this fits into the Medicaid space and should be approved for funding. How about licensing fees in Oregon?

Ms. IRITANI. Yes, you know, the point of our report is that we could not tell how that and other examples of the State programs that were approved actually related to Medicaid objectives.

Mrs. ELLMERS. So the other two now: one example I have, healthcare workforce retaining in New York. Now, certainly, we need a good, strong health workforce. Do you feel that that fits into the Medicaid space as well?

Ms. IRITANI. We felt like many of the approvals that CMS had approved were on their face only tangentially related to Medicaid.

Mrs. ELLMERS. Um-hum. Um-hum.

Ms. IRITANI. And without any criteria about how the Secretary was making these decisions——

Mrs. ELLMERS. Um-hum.

Ms. IRITANI [continuing]. We could not——

Mrs. ELLMERS. Determine.

Ms. IRITANI [continuing]. Make an assessment.

Mrs. ELLMERS. Yes. And then the last one I have is Fisherman's Partnership in Massachusetts. I am like you, I am just going to assume that you are going to say that also fits into that same characterization.

Ms. IRITANI. Yes.

Mrs. ELLMERS. And lastly, I just want to ask a little bit about the broad authority of the 1115 statute. What are the outer boundaries that the Secretary has to approve Medicaid funding?

Ms. IRITANI. The 1115 authority is very broad, and gives the Secretary discretion to waive certain Medicaid requirements in 1902, i.e., the Social Security Act, and approve new costs that are not otherwise eligible for Medicaid that, in the Secretary's judgment, are likely to promote Medicaid objectives. It is a broad authority.

Mrs. ELLMERS. I think that probably is about the best characterization. It is quite a broad authority, and gives quite an incredible amount of discretion.

Well, thank you, Ms. Iritani.

That is all I have, Mr. Chairman. Thank you. I yield back the remainder of my time.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognize the gentleman from California, Mr. Cárdenas, for 5 minutes for questions.

Mr. CÁRDENAS. Thank you very much, Mr. Chairman. Appreciate this opportunity to go through these issues, Ms. Iritani.

I hear of some of the concerns about budget neutrality, but I also understand that CMS has taken new steps to make their approach to budget neutrality more transparent and enhance understanding between CMS and the States. On October 5, 2012, the released a Section 1115 template for States to use in order to clarify the requirements and simplify the application process. This template includes instructions and an accompanying budget worksheet that provides guidance on some of the most commonly used data elements for demonstrating budget neutrality.

That being the case, is this a step in the right direction?

Ms. IRITANI. We would still maintain that much more is needed. That template that was issued provides guidance, but it is a voluntary—States do not need to use it. And CMS' written policy is quite outdated in terms of their typical practices for what they review and how they review things and what data they require, and we believe that more reforms to those things are needed to ensure that there is more consistency and approvals.

Mr. CÁRDENAS. Is it the case that, prior to October 2012, that HHS had not issued anything like this?

Ms. IRITANI. As far as I know, yes.

Mr. CÁRDENAS. OK. Well—so hopefully, what that means is HHS recognizes the—that they need to have a better transparency and understanding, and—with everybody involved when it comes to their responsibilities in giving the States this flexibility, correct?

Ms. IRITANI. I—the Secretary has consistently disagreed with our recommendations that any sort of reforms to their process for reviewing are needed, and this dates back to the early 2000s when we first made recommendations to the Secretary around transparency. And we have multiple reports, there is a list attached to my testimony statement, dating back to the mid-'90s. And regarding our recommendations to the Secretary on transparency and accountability in the review and approval of spending limits, the Secretary has consistently disagreed that anything is needed.

Mr. CÁRDENAS. Can you give us an example of one of those statements of disagreement, based on your reports?

Ms. IRITANI. We have recommended that the Secretary issue criteria for how they review and approve the spending limits, and provide for better documentation regarding the basis for approvals of the spending limits and make that publicly available, as well as ensure that States are required to use appropriate methods for projecting Medicaid costs.

Mr. CÁRDENAS. Um-hum.

Ms. IRITANI. And the Secretary has indicated that—generally has disagreed with—that any of those reforms are needed to the process. And that is why we have elevated our recommendations to the Congress as a matter for consideration to require the Secretary to do these things.

Mr. CÁRDENAS. So those objections on behalf of the Secretary based on those recommendations, are—was there any indication that it is something that they couldn't do, or just something that they disagree with? Because one of the problems that I have experienced being a policymaker for 18-plus years now is that it is one thing to make recommendations to a department or a Government entity, and it is another thing for them to admit that if we had the resources, maybe we would do so, but we don't have the people power or the resources to actually implement those recommendations. Is there any indication whatsoever that resources are an issue as well, on behalf of the department?

Ms. IRITANI. That has not been something that the Secretary has said. I think that their response has generally been that they are—they use consistent criteria, and that they have treated States consistently, and that they believe that their current policy and practices do not need reform.

Mr. CÁRDENAS. And overall, are you aware of States overall on balance not appreciating that flexibility, or that they do, in fact, want to continue that flexibility relationship with HHS and the individual States?

Ms. IRITANI. We have not, you know, discussed with States the spending limit process particularly but, you know, given that the Secretary has authority to approve new costs not otherwise matchable, and to approve spending limits that may be much higher than what, you know, the State has justified, I would think States would actually embrace it. But our concern, again, is with the long-term fiscal sustainability of Medicaid and, you know, how this affects the Federal budget and Federal taxpayers.

Mr. CÁRDENAS. Thank you. I yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman.

As a physician who has taken care of Medicaid patients for, you know, a couple of decades, this hearing is very valuable to me today. I want to point out that, you know, Medicaid is a critical program that we need to—that our citizens need and—but clearly, we need more oversight. I do want to point out that, in my view though, the traditional Medicaid is not good insurance coverage, and that has been shown already with the Medicaid expansion, under the Affordable Care Act where emergency room visits are actually up, not down, across the country. That is not my opinion, that is factual. And when I was a practicing physician, when I first came to Evansville, Indiana, there wasn't a single fellowship trained OB/GYN that would take a Medicaid patient in our community. Now, that has changed some now that physicians have been essentially kind of forced into being employed by hospitals, especially in that area. In one of the surrounding States surrounding Indiana, some of the anesthesiologists in my hospital didn't even both to bill Medicaid for the care that they provided for those patients because the State ran out of money before the end of the year, and the reimbursement was so low it didn't even make sense to spend the administrative costs to bill them.

So that said, some of the things you pointed out about where waivers are using—it appears to be given with no specific approval criteria. It is not in a rule, it is not in a statute, it is not in a law, and that has resulted in some money, billions of dollars, being spent on non-Medicaid really type spending that should be associated with that program. Further, spending money that could be used for direct patient care, as has been pointed out by a number of members. So it seems to me that specifically legislation likely is needed. Would you agree or disagree with that?

Ms. IRITANI. Well, we would agree that congressional intervention would—and oversight is—would be important to addressing these issues.

Mr. BUCSHON. Yes. And some States, as you probably know, have been operating under an 1115 waiver for decades, and some have suggested that as part of that process, Congress create a process where longstanding core elements of an 1115 waiver can effective be grandfathered into the State's State plan amendment, which directs the operation of the program. Do you have any thoughts on that?

Ms. IRITANI. I do not have a comment. Our work has not looked at that kind of process.

Mr. BUCSHON. Because it seems to me, I mean if you have a program in your State that is working, and you have been getting waivers for decades sometimes, that—during the, you know, how we utilize the Medicaid Program, we should just change it so that we don't have to continue to ask for these waivers. And, you know, Healthy Indian Plan 2.0, which was put into place after the original Healthy Indiana Plan was successful, and has data to prove so, you know, we had to fight for 2 years to get a waiver for something that has been shown to be effective, and also that the patients, over 90 percent, approve of. And it actually saved probably 2 or 3 percent in our Medicaid budget in our State, and has allowed us to cover individuals with a—low-income individuals with a program not—that is not traditional Medicaid, that actually reimburses providers at a level that they can accept. And so it actually is increasing access to patient care.

So I don't have a specific question, other than those comments. I think that many of the questions I have asked—I were—was going to ask have been answered, but just to say that, you know, it really is hard to believe that after decades of recommendations from you all, that we are still wasting money in the—it seems, in the Medicaid Program, at the same time where the reimbursement rates to providers is limiting access to direct care for patient. And it seems to me, Mr. Chairman, that we are going to need legislative action.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. Thank you for being here this morning.

Despite the fact that CBO has indicated that under ObamaCare, ACA's Medicaid expansion would, on balance, reduce incentives to work, and that a work requirement component for the able-bodied

would increase available resources for Americans. To date, CMS has refused to approve work requirements as a part of Republican State demonstration waivers. Is there anything in the Section 1115 statute that would prevent CMS from approving work-related requirements?

Ms. IRITANI. We have not encountered that kind of proposal in the work that we have done, so I can't comment on the Secretary's authority in that case. But as I mentioned, the 1115 does provide the Secretary with quite broad authority.

Mr. GRIFFITH. So a cursory view would not be unreasonable for some of us to think that that broad authority would not preclude a work component requirement for the able-bodied?

Ms. IRITANI. As I said, we haven't encountered that kind of requirement in our work, so I can't comment on that.

Mr. GRIFFITH. I appreciate that.

Since 1115 demonstration programs are intended to be experimental or pilot projects to test new ways of providing services, it is my understanding that each demonstration is to be evaluated. Has GAO reviewed the evaluations of demonstration programs, and if so, what have those evaluations taught about the ways to reform the Medicaid Program to provide better access and services to beneficiaries?

Ms. IRITANI. We have not been asked to look at that component of the demonstration, but you are correct, these demonstrations are supposed to be evaluations and have an evaluation component. We did, in the mid-'90s, in a report, discuss the major impact that some of these demonstrations had on beneficiaries and other things, and looked at the progress reports that States were submitting to CMS and also the planning for the evaluations, and found both were lacking. We made recommendations to the Secretary to improve both those things, and we have not since been asked to look at that.

Mr. GRIFFITH. Did they ever get back to you and say that they had implemented your recommendations that you made back in the mid-'90s?

Ms. IRITANI. They agreed with the recommendations at the time, and then at some point, and this is years ago, I think they said they were no longer—reform was no longer needed.

Mr. GRIFFITH. Thank you. I know that as a part of waiver renewal, some States send CMS evaluation reports that may be posted on the CMS Web site. Do you know if CMS also conducts its own analysis?

Ms. IRITANI. We haven't look at evaluations for years, so I can't comment on that.

Mr. GRIFFITH. All right. So you don't know if they are doing their own evaluations——

Ms. IRITANI. Well, what I do——

Mr. GRIFFITH [continuing]. Because of what the State says?

Ms. IRITANI. What I do know from our work from the——

Mr. GRIFFITH. Yes, ma'am.

Ms. IRITANI [continuing]. Mid-2000s is that, you know, the demonstration terms are typically 5 years, but they can be less, and that, you know, CMS required at the time that the State plan an evaluation and that they also, because they wanted to understand

how the demonstrations were working and if information was being collected to actually do the evaluation, they required progress reports. But, you know, that is, again, where we found that the progress reports weren't always, you know, complete or being turned in timely, et cetera. So we feel like the evaluation component of the, you know, the demonstration is—already is an important one.

Mr. GRIFFITH. And, of course, if CMS doesn't do their own evaluation of those demonstrations, it is kind of hard for them to really assess it if they are just relying on the States.

I do appreciate you being here today. Appreciate your testimony. Thank you so much for answering my questions.

And, Mr. Chairman, I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you very much. Thank you, Mr. Chairman, for yielding. And thank you for being here today and answering the questions.

I want to talk about the budget neutrality policy. In your testimony, you indicated that one of the problems with CMS' implementation of its budget neutrality is that it allowed some States to include hypothetical costs. Can you provide—define hypothetical costs that CMS has implemented and some examples of that?

Ms. IRITANI. Sure. There are two main components to basically the budget neutrality process and projecting the cost of Medicaid without the demonstration, which becomes a basis for the spending limit that would be allowed. One is a spending base, which is by the policy supposed to be based on actual historical expenditures for Medicaid in the State for the recent year. The other is the growth rates that project costs over the course of the demonstration.

CMS has, since we first started looking at this issue in the mid-'90s, allowed hypothetical costs that is in the spending base, so they would allow States to project or use baselines based on not what they were actually covering, historical costs, in their Medicaid Program, but what they could potentially cover, for example, populations, hypothetical populations that they could cover under the flexibility under the Medicaid Program, but were not covering, or payment rates. In more recent demonstrations we found that CMS has allowed States to assume that they would be paying providers more than they were actually paying, as part of their baseline for developing the spending limits.

Mr. GUTHRIE. And then so is there anything that stops CMS from applying budget neutrality to one State but not another State? Could they favor one State over another in the way they apply budget neutrality? Anything to stop them from doing that? And could this cost—you know, this seems to cost—could cost billions by allowing hypothetical costs.

Ms. IRITANI. There are tens of billions of dollars being approved in these demonstrations, and a lack of transparency over the basis.

Mr. GUTHRIE. So they could favor one State over—there is nothing to prevent them from favoring one State over another in that—

they make the decision on a State-by-State basis I guess is—and so they could——

Ms. IRITANI. I think oversight——

Mr. GUTHRIE. Needs to be——

Ms. IRITANI. Oversight.

Mr. GUTHRIE. OK. So what would GAO say to the charge that some have made that budget neutrality would prevent CMS from making an important investment in State innovations?

Ms. IRITANI. Could you repeat the question?

Mr. GUTHRIE. So what would GAO say to the charge that some have made that budget neutrality prevents CMS from making important investments in some State innovations?

Ms. IRITANI. Well, the whole concept of budget neutrality is that States would figure out how to innovate and get flexibility from traditional Medicaid rules, but within their current constraints of what they have been spending for Medicaid. I think it is one thing to innovate when you are getting a lot more money to do so.

Mr. GUTHRIE. Um-hum.

Ms. IRITANI. It is another thing to innovate with, you know, with flexibility around Medicaid's traditional requirements, but creating efficiencies in doing so and not raising costs for the program. And we think that is a very important concept again——

Mr. GUTHRIE. Um-hum.

Ms. IRITANI [continuing]. Getting back to the long-term sustainability of the program.

Mr. GUTHRIE. But if one State is receiving X amount of dollars and they want to innovate, and they say you can innovate within that X amount of dollars, but if one State is receiving X amount of dollars and CMS says you get X amount of dollars plus hypothetical cost dollars, that could be applied on a State-by-State and not consistent, correct? So that essentially, a State is getting more money to innovate, is that—am I reading that wrong——

Ms. IRITANI. Well——

Mr. GUTHRIE [continuing]. Or understanding that wrong?

Ms. IRITANI. Yes, different States ask—develop their spending limits different ways.

Mr. GUTHRIE. Well, thank you.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

And now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Appreciate it very much. Thank you for your testimony.

In Florida, we recently finished getting an 1115 waiver with CMS. I am sure you are aware. It was a long hard process that included a State lawsuit against the Federal Government over the process. Florida has had an uncompensated care fund which we call the LIP, the Low-Income Pool, for our Medicaid Program for almost a decade now. What should have been a simple process, in my opinion, to renew that fund turned into a long, drawn-out affair by CMS who decided to change the rules this year.

Ms. Iritani, when HHS reviews and issues 1115 waivers, do they follow precedent established with other approvals, or is every application reviewed from the beginning?

Ms. IRITANI. If I understand the question, is it when HHS approves a demonstration, does that set precedent for others?

Mr. BILIRAKIS. Yes, for others and maybe previous applications for that particular State as well. Or is that—do we have to start from the beginning?

Ms. IRITANI. Well, we have——

Mr. BILIRAKIS. First with others. Yes.

Ms. IRITANI. Well, we haven't look at differences in, you know, how HHS approves new approvals versus extensions versus amendments, which are all different ways that HHS can approve things. That said, you know, I think HHS, with every new approval, does set precedents for other States to follow. And there are many demonstrations that have been operating for many years——

Mr. BILIRAKIS. Right.

Ms. IRITANI [continuing]. As someone mentioned.

Mr. BILIRAKIS. OK, next question. HHS provides GAO with four general criteria—you stated that—that State programs must meet to receive the funding through the 1115 Medicaid waiver. However, the criteria are so broad that they can be interpreted in many different ways. The question: Is such activity fair to States and stakeholders, and does GAO think that HHS needs to issue regulatory guidance explaining these criteria?

Ms. IRITANI. Well, we believe that more specific criteria—written criteria are needed and—otherwise we believe that many questions about the basis for the decisions, as well as the consistency of approvals, will continue to rise.

Mr. BILIRAKIS. And I understand that GAO was not even aware of these criteria, is that correct?

Ms. IRITANI. Yes, correct.

Mr. BILIRAKIS. OK, next question. GAO's work suggests that there is likely significant duplicative Federal funding streams for State programs and the waivers and other HHS programs. Do we know if HHS reviews for duplicative payments prior to or after approval? If not, is there a mechanism for HHS to prevent duplication or at a minimum recoup duplicative funding, save billions of dollars for us?

Ms. IRITANI. We have not looked at how HHS monitors spending post-approval. We have looked at, you know, what protections they provided in the terms and—of the demonstrations regarding preventing duplication and found variation and, in some cases, no assurances that the new spending for Medicaid would not duplicate other purposes.

Mr. BILIRAKIS. OK, next question. In my estimation, there is a clear lack of uniformity in CMS decision-making. I think it is pretty obvious from the testimony. Are there criteria that could explain why 2 States of a similar nature get uncompensated care pools approved for different lengths of time? And I know my friend, Mr. Guthrie, touched on this as well.

Ms. IRITANI. There are no criteria that would explain that, and that is part of why we are recommending that there be criteria. We feel like that is important for transparency and for a common understanding of why the Secretary is making certain approvals.

Mr. BILIRAKIS. Thank you. One last question, if you don't mind. I have a few more seconds. Have you ever encountered an instance

when CMS would force a State to take an action that their Governor and the legislature did not want to take in order to renew the 1115 waiver that was already in existence?

Ms. IRITANI. I am not aware of that kind of circumstance, but we typically haven't—have looked really at the approvals at the Federal level.

Mr. BILIRAKIS. All right, very good. I yield back. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman.

Doctor, we—if we are facing serious budgetary challenges, wouldn't it be better for us to prioritize medical care for patients in Medicaid rather than some of the questionable projects being approved for Federal spending in these 1115 waivers?

Ms. IRITANI. We would agree that many of the approved new costs in the recent demonstrations, that documentation was lacking as to how they related to Medicaid purposes. And our position has always been that Medicaid funds should be for, ideally, covered Medicaid services for Medicaid beneficiaries. You know, the demonstrations give authority to the Secretary to approve new costs for purposes of the demonstration, but they should be furthering Medicaid objectives, and that is why we think there needs to be more articulation on the Secretary's part of how she makes the decisions.

Mr. LONG. So you do agree that it would be better to prioritize medical care for patients in Medicaid?

Ms. IRITANI. We would agree that, yes, Medicaid objectives should be the driving—is within—the 1115 is—should be the driving factor for decisions, and it is just not clear how the Secretary defines those.

Mr. LONG. OK. One of my big concerns about the growth of the Medicaid Program is there is the temptation to just cover more people. Everybody always wants to be philanthropic and, oh, let's cover more, cover more people, without ensuring that the access is timely and meaningful for these patients that they are wanting to cover. But from what I understand of GAO's work, CMS said they define low-income patients as 250 percent of the Federal poverty level. 250 percent, that is a fairly decent income in several districts around the country. And do you think it is appropriate for CMS to approve spending Medicaid dollars on what would be middle-class income in a lot of areas?

Ms. IRITANI. One of the things we were looking for when we looked at what new costs that CMS was approving was whether or not those costs, for example, with the State programs in the low-income pools, were for providers that were serving low income and Medicaid individuals. And didn't—found that some of the programs were for the general public and—or not clearly linked to low-income populations, and we find that questionable.

Mr. LONG. But do you think—so you do find it questionable, the 250 percent mark?

Ms. IRITANI. We have—you know, States have great flexibility to define how they define low income. You know, the poverty level—levels that they cover under Medicaid vary greatly. So we don't—

we feel like it is the Secretary's decision and discretion to define what she considers to be Medicaid purposes——

Mr. LONG. Which apparently——

Ms. IRITANI [continuing]. We just don't know what they are.

Mr. LONG. —is 250 percent.

Ms. IRITANI. It is, you know, within the authority of the Secretary to define how she defines low income and Medicaid——

Mr. LONG. OK, I have about a minute left here. So 1115 waivers are supposed to further Medicaid's objectives. Medicaid is a program which exists to provide access to medical care for vulnerable populations, so how does the administration get away with justifying some of these spending approvals?

Ms. IRITANI. The Secretary—and it is—and the response to our draft report, said that they had general criteria that we discussed earlier that they applied, and that they apply criteria consistently and treat States consistently. And that is the general response they had.

Mr. LONG. OK, thank you, Dr. Iritani.

And I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions.

Mrs. BROOKS. Thank you, Mr. Chairman.

I think you have already heard a little bit about the Healthy Indiana Plan, and at the beginning of 2015, Indiana was fortunate enough to have its demonstration approved by CMS. Now, the Healthy Indiana Plan 2.0, or what we call HIP 2.0 as we call it, is really an extension, an expansion, and some changes made to a very successful Healthy Indiana Plan. Started under Governor Daniels, and then expanded and changed slightly under Governor Pence. It provides 350,000 uninsured Hoosiers with access to healthcare services, but what was very different about it, and I thought what was really so effective, started under the first HIP plan, was that individuals would pay small contributions, and this was a huge sticking point for CMS, ranging from $1 up to $27 a month based on their income level, into power accounts. And POWER accounts stand for personal wellness and responsibility—responsible accounts. Now, this allows people to create a sense of personal responsibility for their own health care, put in $1 a month, up to $27. And it took our State years, as the gentleman from my delegation has already stated, to get this type of plan approved. And it has had—demonstrated tremendous success. So after it was finally approved, after our Governor had to speak with the President personally about a very successful program in order to get it approved, the Governor sent—Governor Pence sent out entire delegation a letter suggesting that the manner—celebrating the success of finally getting it approved, but also the delay in the approval process itself caused so much stress and anxiety among the Hoosiers who were on the plan that it is just completely unnecessary. And it was all about the timing, quite frankly, that I am complaining about, and the manner in which the approval process took place.

It is my understanding CMS has no set time period, is that right, Ms. Iritani, about how to approve these requests for waivers. Is

that true that there is no time period in which the CMS director has to provide their decision on these requests, even of programs that are already in place?

Ms. IRITANI. I believe there is a time limit on extensions, but otherwise, no.

Mrs. BROOKS. And so if any changes or improvements want to be made to—really speaking of the fact that we haven't evaluated or delved into the evaluations, the evaluations, as I understand, of our HIP program were outstanding——

Ms. IRITANI. Um-hum.

Mrs. BROOKS [continuing]. And that is why we chose to expand it for more Hoosiers, and to change it to try to bring more Hoosiers into the program. The Upton-Hatch, Making Medicaid Work Blueprint included a proposal for a waiver clock. Would it make sense for a timeframe to be implemented related to these Section 1115 waivers, and what kind of guidance should we have from you and from your study of the waiver process, what should Congress be taking into consideration as we try and tighten the timeframe for these waivers for CMS to approve or to not approve these programs, because they keep our State legislators in knots, those who are receiving the benefits of these programs, what kind of factors should we consider in trying to put a timeframe around these decisions?

Ms. IRITANI. Yes, other than the 2013 report that I mentioned where we looked at the variation in the timeframes and the factors that CMS told us contributed, including the complexity and comprehensiveness of the proposals, we haven't addressed timeframes in our work. We have really focused on the spending limits and new spending approved, that has been the scope of our work.

Mrs. BROOKS. Do you agree though that the timeframe issue is a significant issue for the States?

Ms. IRITANI. Some of the factors that CMS said contributed to the more lengthy approval times included things like how comprehensive the proposal was. You know, some States operate their entire Medicaid demonstrations—or Medicaid Programs under the demonstrations, so it effectively changes the entire program. It could be the States need to go back to the legislatures to get new legislation, and when they do, then there may be changes to the proposal that CMS has to review. It is very complicated to sort out why things take so long.

Mrs. BROOKS. Thank you. Thank you for your work.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. And thank you, Ms. Iritani. Is that correct?

Ms. IRITANI. Yes.

Mr. COLLINS. Yes.

Ms. IRITANI. Thank you.

Mr. COLLINS. For all your testimony. This is an area, I guess you could say, of overall concern when, as I understand it, the CBO recently issued their 2015 long-term budget outlook, and in that, said that in just a little more than a decade our entitlement spending

will consume, along with service on our debt, 100 percent of the inflow of monies into the U.S. Government. If we look back 40-someodd years ago, it was $1 in $3; today, these same programs are $2 in $3, and it is truly a major concern when it would hit $3 in $3.

So something is going to have to give, and unfortunately in Congress, all too long the kick-the-can mindset of let me get past my next election is very much alive. And so here we have the CBO which should be—send a chilling effect to all of us that we have to make some changes. And Medicaid is certainly a major contributor on the expense side of those entitlement programs.

So my question really comes down to maybe asking you do you have some suggestions for Congress, and as we are looking at these 1115 waivers, and in particular I think your testimony indicated that some of these waivers really didn't go to the core proposition of what Medicaid is there for, but very tangentially associated with it, and it is even hard to get your arms around how some of these waivers are benefitting or could benefit us in the long-term. Do you have any idea how much—how many dollars are in that kind of bucket, and do you have any recommendations for anything Congress could do, however small that might be, to at least try to stem some of these expenses that we wouldn't have to have?

Ms. IRITANI. Yes, we share your concerns about the impact of these waivers. The spending trends of the funds that are governed by the terms of demonstrations are rising significantly. In 2011, we reported that about ⅕ of Medicaid spending was governed by the terms and conditions of demonstrations. In 2013, we said it was about ¼. In our most recent report it is almost ⅓ of Medicaid spending, the—over $500 billion program. So we believe that, given that the Secretary has disagreed with the need for reforms, that the Congress should consider requiring the Secretary to take certain steps to reform the process.

Mr. COLLINS. Well, I think we agree, and I certainly appreciate you being very forthright in that observation, and I really do thank you for your testimony.

And with that, Mr. Chairman, I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the vice chair of the full committee, Mrs. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And in the spirit of the College World Series, I am here to bat cleanup, and I am going to be fast so we can move to our second panel.

I am going to pick right up where Mr. Collins left off. $344 billion program, and ⅓ of that is now in the 1115 waivers, correct?

Ms. IRITANI. Well, total spending including Federal and State, is actually over $500 billion.

Mrs. BLACKBURN. So in total, over $500 billion, with that once they do the State match to the Federal.

Ms. IRITANI. Yes, $304 billion——

Mrs. BLACKBURN. OK.

Ms. IRITANI [continuing]. Federal, correct.

Mrs. BLACKBURN. All right. And one of the things that we are looking at with this, if I have my notes right, and I want to be sure that we have it right for the record, is that you have a lot of gray area here on how decisions are being made——

Ms. IRITANI. Um-hum.

Mrs. BLACKBURN [continuing]. That meeting the objectives has become very subjective, and that you have not gone in, if I understood your response to Mr. Bilirakis, you said that you all have not looked at spending post-approval, or looked at the outcomes, you have just looked at that process of pushing the money forward. Am I correct on that?

Ms. IRITANI. Yes.

Mrs. BLACKBURN. OK.

Ms. IRITANI. We have only looked at the approvals of the spending limits and the basis for them.

Mrs. BLACKBURN. OK.

Ms. IRITANI. And——

Mrs. BLACKBURN. But not the outcomes——

Ms. IRITANI. Correct.

Mrs. BLACKBURN [continuing]. Of the delivery. All right, and so that is something that we definitely need to circle back and do some oversight on. Let me go back to Ms. Castor's question. Did I understand you to say you have looked and reviewed the Federal end, but you have not looked at the public input process——

Ms. IRITANI. Not——

Mrs. BLACKBURN [continuing]. On the 1115 waivers?

Ms. IRITANI. Not since the mid-2000s.

Mrs. BLACKBURN. OK.

Ms. IRITANI.. That is when we raised concerns about the lack of a Federal public input process that was then addressed in the recent House reform legislation.

Mrs. BLACKBURN. OK, and I think that gets to part of Mrs. Brooks' question also. There have been mixed results, and you have mentioned that. You have States as diverse as what Indiana has done, you have Arizona which was one of your first 1115s. I am from Tennessee. We have a very mixed result history, if you will, with the 1115 waiver process. So I—it concerns me that you all have not done a deep dive, if you will, on looking at the outcomes, reviewing these results, looking at that public input process, going through that, because if I am following what you are saying, a conclusion would be that when you set up a demonstration project, and there are four criteria that have to be met for this to move forward, and with the subjective nature of the decisionmaking process, a State can meet one of four criteria and be approved and be considered a success. Is that correct?

Ms. IRITANI. I believe so. That is the——

Mrs. BLACKBURN. So they could have a failing grade, if you will. If you are on a grading scale of 100, and you meet one of four criteria, you are at 25 percent effectiveness, but CMS would consider that a success.

Ms. IRITANI. The criteria—the first time we saw them again was just in CMS' response to our report. They were not issued, you know, in any written guidance. And we have not since circled back to CMS to see how they apply it, but the way that they stated it in their response was that, basically, one of these criteria is——

Mrs. BLACKBURN. OK, and——

Ms. IRITANI [continuing]. You know, basically what we apply.

Mrs. BLACKBURN. And then setting the spending limits, they pretty much make it up as they go along, and are subjective in that approach, if I understood you correct in your response to Mr. Bucshon.

Ms. IRITANI. There is a lack of transparency, definitely——

Mrs. BLACKBURN. OK.

Ms. IRITANI [continuing]. How they are set.

Mrs. BLACKBURN. With that, Mr. Chairman, I yield back. And I thank you, Madam Director, for your time today.

Ms. IRITANI. Thank you.

Mr. PITTS. The Chair thanks the gentlelady.

And now recognize the ranking member of the full committee, Mr. Pallone, to bat cleanup, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. And I apologize that I wasn't able to be here until now.

And, you know, I may be repeating some things that already have been said or have been asked, and so, you know, forgive me for that. I just wanted to say that after close to 20 years of recommendations for more transparency into the Medicaid waiver process, the Affordable Care Act included a bipartisan provision to improve the transparency of Medicaid waivers in line with longstanding recommendations from GAO. Today, because of this provision, the public has meaningful opportunities to provide input into the waiver process of both the State and Federal level, and waivers are now evaluated on a periodic basis, and States submit reports on implementation, and this is a huge step in the right direction, in my opinion.

I am further encouraged by CMS' concurrence with GAO recommendations, specifically in their April 2015 report for better ongoing and transparent documentation of how States spend Medicaid dollars. This is a recommendation that prior administrations had refused to correct, and I continue to believe it is the right thing to do, ensure dollars are following our Medicaid beneficiaries.

But let me ask a couple of questions, if I can. In reviewing the GAO recommendations over the last 20 years, it appears as though your recommendations have remained the same until only recently. Isn't it true that the majority of these recommendations were not acted upon until Obama administration initiatives and the Affordable Care Act, which placed many of your recommendations into action?

Ms. IRITANI. Well, we have made many—over a dozen recommendations over the course of this time, and only a couple have been implemented, including the public input process that you mentioned that was implemented in 2012.

Mr. PALLONE. OK. And, of course, that was under the—under President Obama, 2012. Based on the GAO reports, it appears that GAO recommendations on the budget neutrality accounting principles have remained unchanged since as far back as the 1990s. So is it true to say that this fundamental disagreement between HHS and GAO has remained the same, regardless of which political party has controlled the presidency?

Ms. IRITANI. Yes.

Mr. PALLONE. OK. And then the last thing I wanted to ask, and to follow up on that, isn't it true that GAO went so far as to issue

a letter to HHS from GAO's chief legal counsel regarding budget neutrality issues in the prior administration—I mean under the last President Bush?

Ms. IRITANI. It is true in 2007, our legal counsel did issue a letter to the Secretary at the time, raising concerns with two States' approvals, yes.

Mr. PALLONE. And have you had to take such action under the current administration, under the Obama administration?

Ms. IRITANI. We have not.

Mr. PALLONE. OK. All right, thanks a lot.

Again, Mr. Chairman, I am not going to take up too much time because I came in at the end here, but thank you for the opportunity here.

Mr. PITTS. The Chair thanks the gentleman.

That concludes the questions of members present. We will have follow-up questions in writing. I know some of the members not here have questions. We will send those to you in writing. We ask that you please respond promptly. Thank you very much——

Ms. IRITANI. Thank you.

Mr. PITTS [continuing]. For your testimony this morning.

Now, as our staff sets up the table for the second panel, we will take a 3-minute recess.

The committee stands in recess.

[Recess.]

Mr. PITTS. OK, the time for recess having expired, we will reconvene the subcommittee. And I will introduce our second panel in the order of their presentations.

We are delighted to have today the Honorable Haley Barbour, former Governor of Mississippi, and Founding Partner of BGR Group, with us this morning. Mr. Matt Salo, Executive Director, National Association of Medicaid Directors. And Ms. Joan Alker, Executive Director, Georgetown University Center for Children and Families. Thank you each for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your testimony. There is a series of lights on—so when the yellow light goes on, that is 1 minute left, and red light means you can wrap up at your convenience.

And at this point, the Chair recognizes Governor Barbour, 5 minutes for your summary.

STATEMENTS OF HALEY BARBOUR, FORMER GOVERNOR OF MISSISSIPPI AND FOUNDING PARTNER, BGR GROUP; MATT SALO, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF MEDICAID DIRECTORS; AND JOAN C. ALKER, EXECUTIVE DIRECTOR, GEORGETOWN UNIVERSITY CENTER FOR CHILDREN AND FAMILIES

STATEMENT OF HALEY BARBOUR

Mr. BARBOUR. Thank you, Mr. Chairman. When I last testified before the committee, I was actually Governor. I want to make plain that I am not Governor anymore. I don't speak for the Governors or the Republican Governors, or even the Governor of Mississippi. This is what I think.

You know, States are trying to juggle demands of increasing health care costs while trying to balance their budget. Most of our States actually literally balance the budget every year, and this is a huge part of it. In 2014, the Federal Government spent $300 billion on Medicaid; $344 billion this year as I understand it, but also the States spend a ton of money on Medicaid. Medicaid expects in the next 10 years that that budget for the Federal Government is going to go to $575 billion. And when you put in what the States do, it will be about $1 trillion. About $1 trillion. So this is a big burden on the States' budgets and on the Federal budget. I think we all ought to remember that about ⅔ of all Federal spending is mandated for entitlements or payments on the national debt. That is—and that percentage is growing. Any discussion of Medicaid and our healthcare programs must include some mention of our ability to pay the bills that we are accumulating, because what we do today affects future generations' ability to pay the debt that we burden them with, and affects their chance to experience the American dream that we have been blessed to experience.

Since January of 2009, the Federal debt has gone up 73 percent, and that can't continue. We have to provide quality health care for the truly needy in a cost-effective manner, and one way to help do that is to give each State the flexibility to run its Medicaid Program in the manner that best meets the needs of its population. I personally believe Congress should give States authority to adjust their programs without any CMS waiver, as long as it is within the law. But at a minimum, the waiver process needs to be improved.

For instance, should States be able to ask some nondisabled adults if they prefer to pay a small copay if it better ensured their being able to see a doctor. Not really a problem in Mississippi. Eighty-three percent of our doctors take new Medicaid patients. But you all have already cited a story in California where somebody got on Medicaid and then couldn't see a doctor. In New Jersey, about 38 percent of doctors take new Medicaid patients. Wouldn't our patients be better off if they really did have a way to get care, even if it meant paying voluntarily, on their own choice, a small copay? I believe copays really help make the system work. When people miss an appointment, there ought to be a copay because they have cost somebody else an appointment, they have cost another Medicaid person or some other patient. I believe States should be allowed to do work requirements, or job training and retraining, for able-bodied adults who are on Medicaid. CMS is standing in the way of a lot of State innovation by not approving commonsense waivers, and taking long, long periods of time to improve—to approve the ones they do.

It has been talked about already about the opacity that this is not transparent, inconsistent standards, and the concerns about favoritism or about using waivers as a way to coerce States. CMS has reached an agreement principle with Florida on the Florida LIP program. The bottom line though is Massachusetts got theirs last year in October, about the same time that Florida was applying. The Medicaid Program in Florida asked CMS in the fall, and just now there is an agreement in principle. By the way, that agreement in principle cuts the contribution to the program by more

than ½ in the first year, and by ⅔ in the second year for what Florida will receive.

We do need transparency so that the States understand the process, how to get things approved, and I would say to you, not only should there not be different rules for different States, I believe when a State like Indiana institutes a program and it works well, and we test whether it is working well and find that the results are good, it ought to be an easier process for another State to adopt that. Things that work, we ought to encourage. If Oregon has something that works and we think it fits Mississippi, it ought to be easier to get a waiver for that than starting at scratch. So I would encourage the committee to go to block grants, but I would certainly encourage you to adopt a waiver clock, to adopt some rules about transparency, and remember, a successful program under a 1115 also ought to be allowed to become permanent if we see that the results are such, why should they have to go back every couple of years?

Sorry, I ran 14 seconds over. Pretty good with my accent.

[The prepared statement of Mr. Barbour follows:]

Testimony to the Energy and Commerce Subcommittee on Health

"Examining the Administration's Approval of Medicaid Demonstration Projects."

June 24, 2015

Haley Barbour, Governor of Mississippi 2004-2012 and Founding Partner, BGR Group

Thank you Chairman Pitts, Ranking Member Green and all the Members of the Subcommittee for inviting me here today. Four years ago I testified before this Committee as a concerned Governor on the state of the Medicaid program. Today, I am testifying as a former Governor who hopefully can lend a perspective of the challenges and opportunities faced by states. Four years ago, states were struggling with increasing Medicaid costs while trying to balance their budgets and the federal government was dealing with trillion dollar deficits and long term unsustainable debt.

Today, states are still trying to juggle the demands of increasing health care costs while balancing their budgets and funding other state priorities. On the federal side, deficits have come down in the short-term but are expected to rise exponentially in the not too distant future. The loads of accumulated debt and unfunded future liabilities are still issues that must be addressed. Under President Obama, the federal debt has increased by almost 73 percent to $18.3 trillion.

Last week the Congressional Budget Office released its Long-Term Budget Outlook. The document stated that the federal debt held by the public "is now equivalent to about 74 percent of the economy's annual output, or gross domestic product." CBO estimates that under our current trajectory, twenty five years from now the federal debt held by the public would exceed 100

percent of GDP. These are scary numbers and that is not even counting the tens of trillions of dollars in unfunded liabilities our government has already promised to spend in the future.

Debt levels exceeding 100 percent of GDP are not sustainable and we will not have the benefit of other countries bailing us out. Ignoring these problems will not make them go away but will make them much more difficult to manage in the future. The next generation of Americans and their kids are being saddled by our inability or unwillingness to control our spending.

At the end of the day we have to pay for what we are promising. Before the Supreme Court ruled the Medicaid expansion was voluntary, the Administration had proposed to reduce the higher FMAP promised for expansion populations through a "blended rate" proposal. Now it has backtracked on that proposal. But, backing away from its funding promise less than two years after the law was enacted was certainly an admission of the financial difficulties facing the program. The Administration may have changed its tune now but the budget numbers will not allow the current growth in Medicaid spending to continue.

I understand this hearing is not about our deficits and debts but any discussion about the future of Medicaid and our health care programs must include some mention of our ability to pay for the bills we are accumulating today because it will affect the ability of future generations to pay for their priorities and experience the excellence of the American economy. This is not political philosophy, it's just honest accounting and basic math.

In 2014 the federal government spent $300 billion on Medicaid. In only ten years that number is estimated by CBO to be over $575 billion, nearly double. When you add in the state's share the Medicaid program will cost close to a trillion dollars a year. Mandatory spending programs are already drowning out our ability to pay for things like highways or adequately fund our military.

Currently, approximately two-thirds of all federal spending is mandated for entitlements or paying interest on the debt.

So the question becomes: how can we provide quality health care for the truly needy in the most cost-effective manner? I believe a critical solution is empowering each state to run its Medicaid program in the manner that best meets the needs of its population. Give states more statutory options that allow them to innovate on plan design and health care delivery – rather than forcing them to go through a long and drawn-out waiver process for common-sense improvements. States should be able to tailor Medicaid benefits in ways that make sense for the populations they serve. Allowing states to better tailor benefit design for differing eligibility categories based on the unique characteristics of the group can save money while actually even improving the quality of care provided.

If Medicaid is really for the patients it serves, shouldn't we ask them what they want? Let's scrap the paternalism and put the patient at the middle of this. For example, would some non-disabled adults welcome the chance to pay a small co-pay if it ensured them better or more timely access to a doctor? States should ask them and be free to respond to their health care needs. After all, in the many states where doctors will not see new Medicaid patients, a Medicaid card just proves the adage that having an insurance card does not necessarily mean having access to care.

I'm reminded of the experience of my good friends in Indiana – Governor Pence and former Governor Mitch Daniels. In Indiana, the Medicaid program surveys its beneficiaries to gauge their satisfaction and inform its program management. And the results are truly outstanding. Indiana recently noted that more than 71 percent of enrolled HIP 2.0 members are participating in the HIP Plus program, which provides vision and dental benefits. HIP Plus also enables

members to avoid co-payments because they make monthly payments into a type of health savings account.

States should have more freedom to require more personal responsibility for the Medicaid program. If Medicaid enrollees are benefitting from the program, is it so radical to ask them to contribute a small amount? Doing so would reduce costs but also benefit those beneficiaries who use services responsibly. Despite the contention that emergency room visits would go down under PPACA, a recent survey by the American College of Emergency Physicians reports that ER visits are increasing. A January 2014 study of Oregon residents enrolled in Medicaid found those on the program used the ER 40 percent more than those without insurance and often for primary care service and non-emergency services. The emergency room is the most expensive site of service in our entire health system. States should be able to institute enforceable, appropriate co-pays for non-disabled individuals on Medicaid when those individuals improperly use the ER – without going through the unpredictable hurdles of an 1115 waiver process and playing "mother-may-I" with CMS. This is a modest proposal built on the idea of personal responsibility.

If you or I – or anyone not on Medicaid – misses a doctor's appointment without notice, the person is charged a small fee. People tend not to miss doctor appointments because they do not want to pay the penalty. Yet, if a Medicaid patient misses an appointment, doctors can try to charge a penalty but it is not enforceable. For some doctors, missed appointments are their number one frustration with the Medicaid program. If they allot six slots a day to Medicaid patients altogether, and only half show up then they miss out on three paying patients and three other Medicaid patients don't get to see the doctor. When doctors' frustrations boil over they stop taking Medicaid patients, which hurts the responsible patients on the program who have a

tougher time finding a physician. This would not be appropriate for all Medicaid patients, but why should states have to ask CMS for permission to allow providers to charge a non-disabled adult a modest co-pay? If the Administration believes low-income consumers are smart shoppers on the Exchanges, why do they have the gentle prejudice of small expectations? After all, Exchange enrollees face co-pays, deductibles and cost-sharing. Is there something so fundamentally different between an adult at 138 percent FPL and 139 percent FPL?

Medicaid is a government benefit funded by taxpayers to provide care to those in need. Some states have advocated instituting work requirements or job-training for able-bodied adults as a condition of receiving Medicaid benefits. Adults who can work should be incentivized to work if they want to continue receiving government benefits. This would decrease costs by making people self-sufficient, while also positively affecting individual health outcomes. Plus, letting states test work or job training requirements especially makes sense given that CBO estimates that expanded Medicaid eligibility under the ACA will, on balance, reduce incentives to work. Unfortunately, the Administration has steadfastly opposed this common-sense reform when Republican governors have requested it in their 1115 waivers. But if the purpose of 1115 waivers is to test different delivery system and benefit design ideas in Medicaid, what are the bureaucrats at CMS so afraid of?

Justice Louis Brandeis famously stated "a state may, if its citizens choose, serve as a laboratory." Today, many states want to be the laboratories of democracy, but CMS is standing in the way by not approving common-sense waivers that could unleash a revolution of state experimentation and innovation. I am increasingly convinced that change only happens when Congress – like the good members of this Committee – passes legislation to break off the shackles of CMS's rules. Even if these rules are well-intended, and even if they are well-executed – which we know they

often are not, based on GAO's testimony – state legislators, governors and providers are far better positioned to direct and implement innovative ideas in their states than is CMS.

PPACA created the Center for Medicare and Medicaid Innovation (CMMI). It was designed to test different models to see what would work in health care delivery. Yet we already had and still have 50 laboratories to test innovative programs to improve health outcomes and reduce costs. However, CMS and the rigidity of the federal Medicaid rules as well as the opaque and inconsistent standards for waiver applications are preventing states from truly developing plans that fit their individual populations and testing new programs that can be templates for others.

For states, CMS has the heavy hand where it is judge and jury on whether a state can start or continue an innovative program under a waiver. However, when CMMI wishes to conduct a demonstration project or expand an existing project those determinations are shielded from all outside review. Specifically the law states there should be no administrative or judicial review of those decisions. The irony is thick but shameful. CMS in Washington wants unfettered discretion to conduct its own demonstrations, but then forces states to come hat in hand when they want to test something new. This is an embarrassing double-standard. Are the virtues of CMMI bureaucrats so elevated, or different from the motivations of state leaders across our country?

Over the past few months the issue of state flexibility has been in the news because of Florida's Low Income Pool program. The state of Florida devised a program they believe works best for their state. The Low Income Pool provides reimbursement to hospitals and other providers for uncompensated care. The current budget for that program is $2.1 billion a year divided by the state and federal government based off of Florida's Medicaid match rate. Originally, CMS told

the state it would cut off all funds for the Low Income Pool program. CMS has since taken a few steps back saying they will only cut the program in half this year. They have stated their intention to eliminate payments in subsequent years because the state of Florida decided not to expand its Medicaid program for able-bodied working adults.

Putting aside for a moment the fact that this position meets the definition of coercion, states should not have to rely on the benevolence of CMS bureaucrats in order to run their programs in the manner they determine is most appropriate for their state. What works for the state of Florida may or may not work for other states, but Florida should have the authority and flexibility to make those choices for itself. Moreover, CMS has a basic responsibility to be more accountable to states and all taxpayers. In the fall of 2014, the Medicaid program in Florida asked CMS if it would approve any form of uncompensated care pool. Yet, despite repeated emails, calls, meetings, and other engagements, CMS did not answer this basic threshold question until April of this year. Why should unelected staff at CMS have the ability to hold hostage a state's budget – not based on a negative policy decision – but based on the lack of any decision whatsoever?

An April 2015 Government Accountability Office report found that more than twelve employment and workforce training programs were being funded by federal Medicaid dollars via waivers. When a workforce development program gets federal funding, but a program that reimburses hospitals for uncompensated care for low-income individuals is held up due to the Administration's political preference, any objective person must start to question whether the approval process is being subjectively administered. It is little wonder that the GAO report concluded that "in the absence of clear criteria, the bases for HHS's decisions are not transparent to Congress, states, or the public." For states, that simply means we are not sure of the rules of the road and CMS can change them at will. The waiver process should be reformed by having

broad, public criteria so that if a state's waiver meets one of the criteria, it is approved. Different rules should not be made for different states, and states certainly should not have their Medicaid waivers denied because it, within its rights, chose not to expand their Medicaid programs.

Additionally, the back and forth negotiation with CMS is both time consuming and resource intensive. An August 2014 American Action Forum study found the approval time for a new waiver lasted on average 337 days. And this finding only accounts for the time between when a state submitted a full, final application and when it was approved. It likely underreports all the discussions and informal negotiations that preceded the formal waiver application. Waiting almost a year to get approval for a waiver is difficult when states are crafting their budgets. In 2013 Chairman Upton and Chairman Hatch released a paper aptly named "Making Medicaid Work." Within the paper were several recommendations to improve the waiver approval process, which I applaud. Instituting an improved waiver consideration clock would help states plan for when a decision may be reached on their application. Now, I would encourage this Committee to pass legislation adopting a waiver clock which would force CMS to reply to states in a more timely and transparent manner throughout the 1115 process. Why shouldn't CMS be held to account to at least return calls, take meetings, and make decisions – up or down – in a transparent and timely manner?

The proposal also speaks to waiver reciprocity. If a state submits a waiver request similar to a waiver already approved by another state then there should be an expedited and streamlined process for approval of that waiver. There is no need for a state to wait for an answer and be subjected to rounds of information requests when a similar waiver has already been approved. The idea of states as laboratories of democracy is they can learn from each other and copy successful policies and programs.

Again, I recommend you pass legislation to give states the authority to get Medicaid programs without waivers, but at the very least, improve the waiver process. There are a lot of good ideas this Committee could start to act on. The framework, the ideas, and the energy from the states are real and actionable. I would encourage members to flesh out these ideas into legislation as there is time and interest.

In summary, the federal government should allow states to once again be the incubators of innovation. States, if given the opportunity and greater ability to manage their own programs, can provide the federal government more certainty over the long-term spending path of the Medicaid program while providing the truly needy with critical health care.

Mr. PITTS. You are pretty good. Thank you.

The Chair recognizes Mr. Salo, 5 minutes for your summary.

STATEMENT OF MATT SALO

Mr. SALO. All right, thank you, Mr. Chairman, Ranking Member Green, members of the committee.

I represent the 56 State and territorial Medicaid agency directors. We have talked a lot about how big Medicaid is. I don't want to belabor that, but I do want to underscore how complex it is, and I think a lot of people don't fully appreciate that.

We cover, yes, a lot of children, lot of pregnant women, lot of low-income families, but we also cover a lot of individuals with disabilities; intellectual, developmental, physical, as well as a lot of people who need long-term services and supports. In fact, we are the largest payer in the healthcare system of long-term care, of mental health, of HIV/AIDS care, et cetera. It is a complex, it is a difficult program.

Our members are responsible and accountable for the program. They are striving to provide the best possible health care to the citizens we serve, and also be wise stewards of the taxpayer dollar. They are also hard at work actively driving program reform.

Now, less people think that driving program reform means that the underlying program is broken. I would say unequivocally, no. And, in fact, I would posit to you the challenges of the broader U.S. healthcare system, which is failing us. Take a look at this. Costs—health care cost inflation has exceeded CPI for decades. Health care is now 18 percent of the Nation's GDP. We have suboptimal outcomes to show for that. We also have profound political division about what the future is—of health care is. But I think an important piece here is that we have also had decades of either proactive or passive policies in this country of either ignoring or actively shifting responsibility for many of these difficult populations directly to Medicaid, and that is why we are the largest payer for the most complex, the most expensive, and the most difficult to serve populations in this country.

So what are we doing about it? We are actively trying to reform a healthcare system, a fee-for-service system that does not serve these populations well. As Dennis Smith once said, fee-for-service, FFS, ought to stand for fend for self, because that is what we are requiring of the sickest, the frailest, and the most complex patients.

This—but this is hard, and part of the challenge is that the statute at 50 does not allow us to do what we need to do, so we rely on waivers. And we have been relying on waivers for decades to drive program improvement. In Arizona in 1982, in a number of States in the mid-'90s, with the private option in Arkansas and other States who have done the expansion recently. With Indiana, as we have heard, and with many other States that are doing DSRIP or other types of programs. We have a long history of success with this, and accountability does exist. There are evaluations, there is reporting, and even though GAO may not particularly like it, there are budget neutrality calculations. And finally, there is significant public input.

Which is not to say we think the system is working perfectly. We think there are a number of changes that can and should be made. We have been fairly vocal in what these kinds of things should be. Our short—is the system should be more of an HOV program, and the HOV for us stands for healthy patients, outcomes, and value to the taxpayer and value to the healthcare system. These principles ought to drive what we are doing and how we are able to do it.

We have a number of ideas that we—I am more than happy to talk about; ways that we can get there. Some are incremental, some are bigger, some of them will require congressional input. One of those, as Governor Barbour referenced, is sort of a pathway to permanency, and we can talk more about how that might play out. But I do also think there is a—we need more—we do need more timely approvals and renewals. We can talk about what that might look like, but I think a big challenge, in all honesty, is capacity; capacity at CMS to be able to do the reviews in a timely manner. And I think we need to keep in mind that there needs to be a balance between transparency and flexibility. The flexibility—we do need transparency, but we do need the flexibility to innovate, and I think we need to be careful about proscribed definitive checklists of what can or what cannot be done because that sets a ceiling for what can be innovated, not a floor. And I think we need to be very mindful about how do we spread the innovation once we know that it works.

So let me close on this and just say that I think a lot of States spend a lot of time, energy, resources, on chasing paper trails, on trying to, you know, prove to everyone's satisfaction budget neutrality or other types of process requirements, too much time arguing about the cost per unit of widgets that do not contribute to the overall value of the healthcare experience, and that we need to start investing more in State capacity to actually drive the changes that we seek. And I would be happy to talk about some solutions to that as well. Thank you.

[The prepared statement of Mr. Salo follows:]

Testimony of

Matt Salo

Executive Director

The National Association of Medicaid Directors

Before the

United States House of Representatives Committee on Energy and Commerce; Subcommittee on Health

on

"Examining the Administration's Approval of Medicaid Demonstration Projects"

June 24, 2015

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Chairman Pitts, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify today on a crucial topic for our nation's health care delivery system.

Intro

My name is Matt Salo, and I am the Executive Director of the National Association of Medicaid Directors (NAMD). NAMD is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. Our members drive major innovations in health care while overseeing Medicaid, which is the nation's health care safety net. NAMD serves as the voice for state Medicaid Directors in national policy discussions, supports state-driven policies and practices that strengthen the efficiency and effectiveness of Medicaid and actively monitors emerging issues in Medicaid and health care policy

Medicaid is the nation's most vital health care safety net program, providing health coverage for more than 72 million Americans. The program, which spent more than $450 billion last year, is jointly funded by federal and state governments, but administered by states under broad federal standards.

Medicaid provides health coverage to millions across America, including eligible children, pregnant women, low-income families, elderly adults, people with chronic conditions and people with physical, developmental or behavioral needs. Medicaid funds close to 50 percent of all births and is the primary payer of long-term care in this country. Medicaid also provides most of the nation's funding for HIV/AIDS-related treatments and mental health services, among other forms of health care. More than 40 percent of Medicaid spending is aimed at addressing the shortfalls of the Medicare program for individuals dually eligible for both.

Health Care Innovation – The Charge

To believe its critics, Medicaid must be either broken or overrun with fraud, waste and abuse. These charges are short sighted, lack context, and fail to understand that it is in fact the broader US health care system that needs significant improvement. The US health care system faces many challenges: health care cost inflation, sub-optimal health care outcomes, and -- due to decades of both proactive as well as passive policies -- a tectonic shift of responsibility for the sickest, frailest and most complex patients directly to Medicaid.

The good news is that Medicaid is taking this challenge head-on. There is a widespread desire amongst Medicaid Directors to reorient the health care system to achieve better care, better health and lower costs. To successfully achieve this vision, because they are responsible for the oldest, sickest, frailest and most complex and costly patients in the country, Medicaid programs must serve as a platform for innovation and system-wide care improvement.

The Challenge

The challenge, however, is that the underlying Medicaid statute is not structured to meet this need. The statute is now 50 years old, and often reflects a health care reality that no longer exists. States must seek federal approval to waive portions of the statute that would otherwise prevent such mainstream approaches as managed care or home and community-based alternatives to nursing home care. Every single state operates multiple waivers, representing a growing majority of the entire program under a variety of poorly aligned authorities.

While states, in partnership with the federal government, have used these waiver authorities to drive transformational improvement in the health care system, it remains a sub-optimal way to administer the program, and changes are necessary to ensure the continued success of state reform efforts.

State Medicaid Directors and NAMD have been vocal in the need for improvements, innovation and the transformative power of Medicaid. Our paper on creating a climate for innovation in Medicaid can serve as a guiding point in this conversation. And while not the focus of this hearing, it is important to note

that far greater challenges exist when trying to coordinate systemic improvement across state Medicaid programs and Medicare.

The Good News

States have for decades successfully leveraged the flexibility associated with the 1115 research and demonstration waiver process to achieve many different and critical goals for Medicaid. This authority allowed the state of Arizona to initially adopt Medicaid in 1982 with a revolutionary approach of managed care for the majority of its beneficiaries, a process made complete when it expanded managed care to elderly and disabled populations later that decade.

This authority allowed numerous states in the 1990s to both expand coverage while at the same time expanding the use of private managed care organizations to improve beneficiary health care. Tennessee, Oregon, Hawaii, Massachusetts and many others blazed new trails in these areas.

More recently, several states have utilized the 1115 waiver approach to craft alternative approaches to the Medicaid expansion envisioned in the Affordable Care Act. Arkansas began this innovation with the development of the private option, and was soon followed by states like Michigan, Iowa and Pennsylvania who all adopted a variety of other approaches in order to craft expansion alternatives that made sense in those states. Notably, Indiana demonstrated the ability for the 1115 waiver authority to fully embrace different approaches to consumer engagement with its Healthy Indiana 2.0 program.

Still other states have pursued the 1115 waiver model to craft Delivery System Reform Incentive Payment (DSRIP) models. States as varied politically and geographically as Texas, California and New York are all hard at work transforming the health care culture through these approaches right now.

There are many more examples of delivery system and payment reform innovation, and this testimony should not be taken as an exhaustive catalogue.

Accountability and Oversight

With great power comes great responsibility, and all of these approaches involve significant investment on behalf of both the state and our federal partners to ensure that not only are these efforts achieving

critical health care improvement targets, but that we are both being wise stewards of the taxpayer dollar.

This accountability takes many forms: a formal evaluation process at the end of every major waiver period; voluminous reporting requirements that hit upon both process and outcomes; a budget neutrality test to ensure that the federal government not spend more on the waiver than it might have in the absence of the waiver; and finally a public input process that is replicated both at the state level and then again at the federal level for both initial waivers and amendments.

Because we take these obligations very seriously, states and the federal government should consider accountability that is meaningful – meaning that both the states and the federal government should be able to use data and reports to evaluate the programs in terms of the health of populations and the progress towards the ultimate goals of reducing cost and improving health. An **efficient** system of evaluation and reporting should be built with that goal in mind - so that both the states and the federal government can benefit from understanding the impact of the proposed transformation.

GAO's Concerns

The GAO and others have raised concerns about some of the safeguards in place, including around budget neutrality, and the extent to which certain innovations are consistent with the purpose of the program.

GAO is clearly frustrated with the ever-increasing complexity of Medicaid's role in the delivery of health care services to vulnerable populations, as well as how Medicaid is actively trying to transform the misaligned incentives inherent in the system. Their recommendations clearly impart their desire for Medicaid to be so constrained as to fall prey to simple financial auditing, but Medicaid's purposes as authorized by Congress in numerous expansive acts, as expanded by the Supreme Court through cases like Olmstead, and as applied in states over the last five decades are clearly of a scale and complexity that makes such simple accounting extremely difficult, if not impossible.

The degree of variation evident in Medicaid, its programs, services and populations served is effectively limitless, so it is difficult to see how CMS could, as GAO suggests, impose "written, specific" guidelines

for approval and continuation of *waivers* of Medicaid without introducing arbitrary and unintended limits on state creativity in meeting their citizens' needs.

To stress a point, these waivers are synonymous with innovation. Innovation itself is inherently uncertain and does not lend itself to strict empirical constraints based purely on historic growth rates and statutory limits. Of course there will be a tension between the need for innovation on the one hand, and the desire for federal budget constraints and predictability on the other. But is important to note that a fixation on a finite set of data points will strangle the innovation we so desperately need.

It is also vital to note that states are using federal investment through Section 1115 demonstrations to enable transformation of Medicaid systems that can/will lead to reducing costs, providing higher quality care and improving the health of beneficiaries. Such investment is necessary if there is to be true transformation that will serve both the state and federal governments' goals of reducing costs while improving care.

One critical take-away is that all of these changes and improvements in the delivery and payment systems are easy to talk about, but very difficult to implement. At their core, these reforms can be viewed as fundamentally transforming the business model of health care as well. The key responsibility for government payers is to ensure that providers are given the tools they need to help transform their practice to be able to succeed. Therefore, up-front investments and the ability to look across multi-year periods for achieving budget neutrality are critical to program success.

Decades of experience has shown us that these investments cannot be done "on the cheap", and the wide spectrum of providers affected (hospitals, primary care physicians, long term services and supports, behavioral health specialists) cannot on their own operationalize the changes necessary to thrive in the new business model.

It is, therefore, abundantly clear that the process requires greater flexibility and ability for states and our federal partners to negotiate system improvements, not less.

What must change?

As much as we have achieved over the past several decades of reform, much more can be done. The progress we have made has not been easy, and the statutory and regulatory frameworks can be significantly improved and modernized.

The federal-state partnership must be improved to ensure focus on coordination, health outcomes, program integrity and efficiency, not on process measures or antiquated notions of program design. The current policies and procedures often bog states down in endless, repetitive reporting and change requests and do not prepare states with the tools Medicaid needs to succeed. Further, the culture of Medicaid oversight does not foster innovation—as exemplified by the restrictive way states must pursue demonstrations—and it does not provide a pathway to rapidly diffuse and broadly adopt successful program reforms.

Ultimately we must develop a new business practice to enable states to test and quickly standardize successful models that focus on Healthy people, Outcomes, and Value -- an H.O.V. program, if you will. At its core, a Medicaid H.O.V. program could improve the current demonstration process to provide a more rational path to achieve better care, better health and lower costs.

Components of this should include:

Creating a pathway to permanency. If something has been proven to be effective, after a couple of waiver cycles states should be able to retain that flexibility permanently into their program and without requirements to continually adapt the model to "research" something new. Every few years, as it has for the past 30, Arizona has devoted significant staff resource time to rolling out what should be pro-forma renewals of what has been, by all accounts, a model program.

Managed care is no longer the boogeyman of health care, for example, and should no longer require a waiver to implement. But neither is managed care an automatic success everywhere it is implemented. Managed care is a tool, a means to an end, and like all tools, must be utilized properly for it to be

effective. The irony here is that by devoting significant staff resources to waiver approvals and renewals, states must divert attention away from where organizational expertise is needed – specifically focusing on how contract design, oversight and enforcement are fundamental to ensuring that managed care is successful.

More timely reviews and approvals. The current process simply takes too long. CMS is constrained by numerous obligations to review and approve state activity, and the lack of timely approval can greatly impede state reform efforts. We have noted significant delays in many areas, ranging from managed care capitation rate setting to HCBS transition plan approval, to say nothing of the obligations that CMS will shoulder once the proposed managed care regulations are finalized. These processes already can take too long and must be streamlined. A possible solution could include developing a functional clock similar to the state plan amendment process.

A better balance between transparency and flexibility. While a definitive checklist of what can be approved and how might provide some clearer guidance, it may also itself become obsolete, and would not necessarily allow CMS discretion to allow states to innovate beyond what is currently considered. CMS has recently begun publication of waiver applications and approvals online, which enables not only stakeholders and Congressmen, but also states themselves to easily assess what CMS has approved and why. The present hearing illustrates the welcome attention that such transparency brings to Medicaid's broad purposes, complexity, and need for investments in innovation.

State Medicaid Directors understand the federal government's desire for consistency across time and among states in the level of flexibility and in the general level of support CMS provides for state innovation. While we agree that this support should be generally strong, the nature of innovation is such that there must be evolution in what is undertaken. This means that states should not be limited by yesterday's standards, and every development in program improvement should be able to be brought forward to employ by others as they become ready.

They also understand the balance that must be struck as innovations spread across the states. The simple fact that one state has been successful does not necessarily mean that all other states will be immediately able to replicate that success. But it does mean that we have an obligation to facilitate the learning and advancements that will allow those other states to adopt and succeed with new approaches.

They also understand that not all experiments work, and that CMS will need to evaluate the success or failure of the innovations states are engaged in. In the most recent 1115 approvals HHS has worked with states to enhance evaluation plans, and to supplement state efforts with federal data and analytic support. Indeed, the federal government is likely to learn more in exploiting between-state variation than states are in observing changes only within their own borders, especially when 1115-supported experiments comprise the whole state and lack a true "control group."

Conclusion

State Medicaid Directors have been driving some of the most significant reforms to not only the Medicaid program, but the underlying health care system in history. These changes range from integrating care for the Medicare-Medicaid dual eligibles, constructing consumer-focused managed long term services and supports for a variety of populations, integrating behavioral health care services into the traditional acute care model, and adopting innovative approaches to improve health for high-cost, high need populations. 1115 waivers have been the tool Medicaid has used to drive many of these changes, and Medicaid Directors are proud of the progress we have made. But it is equally clear that the process can be improved in order to sustain these improvements and broadly disseminate them – to help ensure that these common sense reforms become the baseline, not the exception.

Working together states and the Federal government (both Congress and the Administration) could better position Medicaid for these challenges. The nation's Medicaid Directors have identified numerous shared goals with our federal partners. We believe that we have shared principles that should be

adopted in transforming the business practices and culture of the federal –state partnership that is the foundation of the Medicaid program.

Ultimately, state Medicaid Directors face more than programmatic hurdles in their race to bend, shape and re-tool their programs. The recommendations we have laid out will make it easier to develop and adopt system reforms, but improving the federal oversight and renewal process is not the only challenge that states face in their pursuit of excellence. For many states, staffing and expertise are in short supply. State and federal governments must be challenged to view investments in Medicaid administration, infrastructure and organization as some of the most important investments that can be made. Medicaid is more than 50 different Fortune 500 companies, and deserves the kinds of investments that successful Fortune 500 CEOs can afford to make – in hiring the right personnel, arming them with the right training, and empowering them to succeed.

Thank you for the opportunity to testify on behalf of the nation's Medicaid Directors, and I look forward to answering whatever questions you may have.

Mr. PITTS. The Chair thanks the gentleman.

Now recognizes Ms. Alker, 5 minutes for her opening statement.

STATEMENT OF JOAN C. ALKER

Ms. ALKER. Thank you so much, Chairman Pitts, Ranking Member Green, and members of the committee.

I really appreciate the opportunity to be here today because I have been studying Medicaid waiver policy for many, many years now, and while I find it fascinating, many think it is sort of boring. So I am thrilled that you are interested in this issue.

I would also like to commend the GAO for their long history of excellent work on this issue. It has been 20 years now that GAO has been writing reports that I have been reading, raising questions and concerns about Medicaid waiver policy, and these issues have arisen regardless of which party; Democrats or Republicans, have controlled the Executive Branch.

And today, I am going to focus on two areas of concern raised by the GAO; the need for transparency and robust public input, as well as the question of budget neutrality. And the good news from my perspective is that after 20 years of scrutiny by GAO and others on these issues, I think we are finally making significant progress on both of these issues, but there is still some work that needs to be done.

So first on the issue of transparency, I do believe it is vitally important to have a very strong and robust process for public comment at both the State and the Federal levels. This is an idea that has long bipartisan support. Senators Grassley and Baucus worked on this on the Senate side. And language was included, as you heard, in the Affordable Care Act, and that was implemented through regulations in 2012 by the Obama administration.

So these changes have led to dramatic improvements in the public comment process, but I would like to make a few suggestions to the committee for you to consider that might lead to greater transparency and better public input in the waiver process.

The first suggestion is that current public input requirements 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, there are many important changes that occur through the amendment process. So I believe it would be a valuable amendment to the law to ensure that amendments were also subject to the public input requirements.

Second, while significant progress has been made with respect to having waiver applications and approvals online at Medicaid.gov, there is more work to be done here. Many important documents such as operational protocols, quarterly and annual reports, and other significant deliverables often required in terms and conditions that come with Section 1115 waivers are not always publicly available on Medicaid.gov, and I would urge you to urge CMS to make sure those are publicly available as soon as possible.

And then finally I will just say, I think the suggestion came up from a number of committee members earlier in the day, I think it would be terrific to have GAO do a report that looks specifically at how the public comment process is working, particularly at the State level.

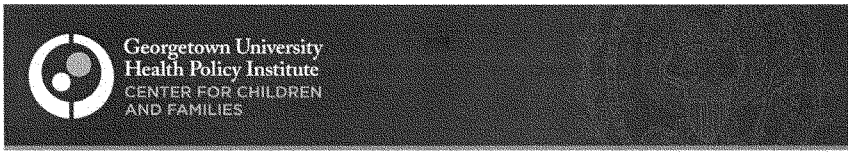
Now, let's turn to budget neutrality. Again, GAO has found that administrations of both parties have approved budget neutrality, Section 1115 agreements, which in GAO's judgment were not adequately supported by sound documentation and adequate methodology.

So budget neutrality is very complex and, of course, when the Secretary makes decisions about what State programs to include or how to assess budget neutrality, the Secretary is responding to State requests. CMS is not just making these things up; CMS is always responding to a State's request. And so by definition, every State's request is different. But I think in the past few months we have seen some encouraging signs from the Obama administration with respect to how Secretary Burwell plans to approach budget neutrality agreements going forward. In particular, on April 14, 2015, CMS Director, Vikki Wachino, sent a letter to the State of Florida indicating three principles by which they would approach their review of Florida's low-income pool, which has been discussed here today. In addition to sending this letter to 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 agreement. These were both States that have done Medicaid expansion and States that have not done Medicaid expansion, and they have shared the same principles to signal their intent to apply these criteria across States. Even more recently, I understand CMS has started including specific ways in which expenditures authority, and I believe this is part of the Oregon health plan extension that was just approved, where they tie, in the Secretary's judgment, how those expenditure authorities are linked to the objectives of these programs.

So both of these actions that I have just described, something that I have never seen before in the last 20 years, so that is encouraging to me, but I do think we will need to continue to monitor this issue very closely.

So thank you very much for the opportunity to testify.

[The prepared statement of Ms. Alker follows:]



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

Before the
United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Hearing on
"Examining the Administration's Approval of Medicaid Demonstration Projects"

June 24, 2015

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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 2014[1] -- 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.

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

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.

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 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.

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[2] 42 CFR 431.400-431.428 (2012).
[3] J. 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/.

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

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.

Mr. PITTS. The Chair thanks the gentlelady, and thanks all of you for your testimony.

We will begin questioning now. I will recognize myself 5 minutes for that purpose.

Governor Barbour, yesterday, 10 Republican attorneys general wrote Chairman Upton expressing their concern over CMS' coercion to try and get Florida to expand Medicaid under the Affordable Care Act. As you know well, the Supreme Court's NFIB v. Sebelius ruling made such an expansion voluntary for States. Do you believe the administration's actions here are legally problematic?

Mr. BARBOUR. I do. These attorneys general are there because of something we have been talking about; the lack of transparency, the lack of real hard rules so you don't—you have so much discretion. And certainly, States see it as coercion because they did not choose to expand Medicaid under the ACA. So that appears to be the case. We will see what the court decides. But I will say this, for a lot of States, this idea of 1115 waivers would affect them tremendously, and they think they are not getting their waivers treated the same, and there is some evidence of that. If you look at the low-income pool program in Massachusetts and the one in Florida, both of them have been in effect for a long time, yet Massachusetts was approved last year, well before the time needed so that they could plan for their budget. Florida got really hung up, ended up going through a special session because they didn't get approved the same time as Massachusetts. So I think that is why these people are thinking that.

Mr. PITTS. Thank you, Governor. And I will let each of the others also respond to this. It is my understanding that CMS has no set period of time for reviewing and responding to a request for an 1115 waiver, but CMS has to review and respond to other waivers for managed care and home and committee-based services within a certain timeframe. So my question is, would it make sense for a timeframe to be implemented related to the Section 1115 waivers?

Mr. BARBOUR. Yes, sir.

Mr. PITTS. Mr. Salo?

Mr. SALE. I think conceptually that makes sense because I do think the challenge is that you are correct, there is a lot of frustration that sometimes approvals and—or renewals can take a very long time to get. I would caution though that in practice, I would worry that a definitive clock might just—if we don't have the rules in—if we don't have the structure in place to ensure that CMS has the capacity to look through these, that a short clock might just get them to know faster——

Mr. PITTS. Ms. Alker?

Mr. SALO [continuing]. Which is not what we want. We want to be able to get to yes faster, and I think we need to focus on that. But certainly, to speed the process up.

Mr. PITTS. Ms. Alker?

Ms. ALKER. So I would say a few things. First of all, I think many of the recent substantial waiver approvals, like Arkansas and Iowa, happened pretty darned quickly. And we have to balance the committee's interest and the need for transparency and public input with this desire to have quick approvals, and I think we have

to find kind of the sweet spot where you allow sufficient time for public input and comment with adequate time for CMS to review this very complex policy and make decisions. And I will just give one example. The GAO in, I believe, 2007 did a report criticizing approvals at that time by the Bush administration of the Florida waiver and the Vermont waivers, and underscored the lack of public input. And I believe the world record approval for Section 1115 went from Governor Bush to President Bush, and it was 8 business days. So that wasn't great because, clearly, a lot of that was sort of wired out of the public eye. So again, I think we need to balance the need for timely and efficient Government action with the need for appropriate public comment and oversight by yourselves, as well as the public.

Mr. PITTS. Mr. Salo, you mentioned in your testimony the length of waiver process. You indicate it took nearly a year on average from the time a waiver application is submitted until it is approved. My understanding is that there are often months of negotiations that occur even before the application is submitted. Can you please discuss a little bit more the difficulty that such a lengthy process, nearly ¼ of a Governor's term, nearly ½ of a term of a Member of the House, like myself, creates for States and for Medicaid Program beneficiaries?

Mr. SALO. Sure. And I think, you know, I do want to be careful to acknowledge the—and respect the dialogue that has to go on between the States and their Federal partners on this. That dialogue is important. And, you know, and there is a certain amount of deference that we should allow the administration, any administration, as the payers of ½ this program. But as you pointed out, when you drag out these negotiations, oftentimes what you will have is amendments that need to follow, and other things that are related get backed up, and that can bring the effective, you know, functioning of good Government to a slow crawl. And that is not going to be in the best interests of the patients, it is not going to be in the best interests of the healthcare system.

Mr. PITTS. The Chair thanks the gentleman.

And now recognize the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Ms. Alker, my home State of Texas is next in line for renewal of their waiver, and I want to be clear I am proud of what my State has accomplished through the delivery system, reform efforts have dramatically improved the quality of care for the Medicaid beneficiaries, and look forward to working with CMS and Texas to start the process. But I also want to make sure that, as a former State legislator, I think it is almost medical malpractice not to expand Medicaid in—for the States based purely on politics, which is what we are doing. And in Texas, I know every hospital executive I know has asked the legislature expanded, just like they have in other States, because people are not being served. And so—but that is, again, the States' decision by the Supreme Court.

And I want to correct the record here because there is a lot of misinformation flying around about Texas is just like Florida. Isn't it true that some undeniable similarities that both of our States have so-called uncompensated care pools, but that part of their re-

spective Medicaid waivers and that Florida seems to have a tough time with. Ms. Alker, isn't it true that no one State has the same type of so-called uncompensated care pool?

Ms. ALKER. That is definitely true, and Texas' waiver, I would say, is a lot more complicated than Florida's.

Mr. GREEN. OK. And wasn't there a fact that the longer term issues at play with the structure of Florida's pool?

Ms. ALKER. Yes, in 2008 actually, GAO issued a report that criticized the budget neutrality assumptions underlying Florida's low-income pool.

Mr. GREEN. Is it true that Florida actually would have been able to get more Federal dollars from the expansion plan that was under—than that that was under consideration by the legislature?

Ms. ALKER. That is definitely true, and of course, those matching dollars would come in at 100 percent match currently, as opposed to their regular match rate which is about 60/40, so they would get a lot better return on investments by taking up the expansion dollars.

Mr. GREEN. Ms. Alker, Governor Barbour's written testimony is very critical in that—cost sharing in Medicaid, however, in 2013, CMS issued a final rule that revised Medicaid's cost sharing policies. The rule increased in the maximum allowable cost sharing amounts that the States can impose on Medicare beneficiaries, including individuals below the poverty line without a waiver. Ms. Alker, would you say that States have considerable flexibility to whether we agree or not with it—not here today implement cost-sharing policies for Medicaid?

Ms. ALKER. That is true, and I think one of the common misconceptions about Medicaid is that you have to get a waiver to do any—everything, and that is just not true. We see that time and time again. As you mentioned, States are allowed to impose nominal copays on the adult population, and they don't need a waiver to do so.

Mr. GREEN. OK. And again, in Governor Barbour's written testimony he noted that Medicaid providers should be able to charge beneficiaries a fine if they miss their appointments without notifying their doctors. And I am concerned that we are pushing ineffective policy we know don't work because, while CMS actually approved Arizona's request to impose a $3 missed provider fine back in 2011, the State ultimately let the authority expire because there was so little provider participation. Is that correct?

Ms. ALKER. Yes, I think that speaks to the issue that came up earlier, that we need really robust evaluations of waiver demonstrations that have happened in the past, some of which we already know that are not—simply not good policy.

Mr. GREEN. One of the issues I know with Arizona findings, but also like Georgia's emergency room demonstration, goes unnoticed. Do you think it is—or it might be worthwhile to explore how we can evaluate and make publicly available the results of these demonstrations so that we might learn what strategies work to actually improve care and lower cost?

Ms. ALKER. Absolutely. I am certain, obviously, as a public policy professor, very much a fan of evidence and research base to inform our public policy decisions. I would say a couple of things about the

evaluation process. I do believe that it would be a great question to ask CMS that they have commissioned an overall evaluation of some of these new Section 1115 waiver approvals—recent approvals, that that is in process. It would be great to learn more about that, because one thing I have observed is that sometimes in the evaluation process, particularly at the State level, that if you have the State paying the evaluator, that the researchers may not always be objective. So we need to ensure that we have independent evaluations to assess these policy choices going forward.

Mr. GREEN. OK. Mr. Salo, in balancing transparent flexibility, you noted that you fear strict guidelines for wavier approval might quickly become obsolete as our medical system advances. Would you agree that a set of broad principles should be—such as those put forth by the administration is, in fact, the best balance to achieve these program goals?

Mr. SALO. In short, I would say yes. I think it is more important to have broad guidelines than clearly delineated checklists because, let's face it, what is approvable today would not have been conceived of or approvable 15 years ago.

Mr. GREEN. Yes.

Mr. SALO. And it is in all likelihood the innovations that are going to be driving real healthcare system improvement 10 years from now, many of which we probably haven't thought of today. So we are going to need the ability to think about things very different. This is an iterative process. Innovation is a dynamic and fluid process.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman. I think, again, it just strikes me the mere fact that we are talking about waivers shows you that maybe the program itself needs to be changed so we don't have to have so many waivers. Same thing is probably true in education with No Child Left Behind, it needs reauthorized in a different way. We are giving waivers to States because of poor policy that needs to be changed by Congress, and it seems like this may be an area that needs to be addressed. We are continuing to address today, and as a healthcare provider, I can say it is, you know, coverage and not really delving into cost. And I think some of you in your testimony have pointed out that, you know, the rising cost of health care and the inflation in health care is something that has to be addressed. I mean we are not going to keep up with the cost of the system going up, like the Governor pointed out, if you don't start to address that as an issue and not just address coverage.

And if you are going to address coverage, you should address good coverage. And as I pointed out in the previous panel, I can tell you from experience that the Medicaid Program, although critical, is financially strapped and doesn't necessarily guarantee access to physicians. Again, Governor Barbour pointed out that in New Jersey, only 38 percent of physicians are taking new Medicaid patients.

So that said, and the other thing I—someone mentioned earlier that hospitals in certain States are asking for Medicaid expansion. I would too because it means a huge financial gain for the hospitals, and the implication that that means that it is, you know, for all truism of covering people is not necessarily the case. And I just wanted to point that out.

So with that, Mr. Salo, some have mentioned today that in recent years there has been greater transparency in the waiver process, such as through the adoption of requirements for public input both at the State and Federal level. The ability for the public to provide input on proposed Section 1115 waivers is very important, of course, but it sounds like there has been still a lack of transparency and consistency regarding CMS' criteria for assessing 1115 demonstration applications. How does this lack of transparency affect State Medicaid Programs, and what recommendations do you have for improving the demonstration application and approval process?

Mr. SALO. So I think a couple of things probably need to be done. Again, we—several of us have referred to this pathway to permanency. Because, as we have heard from GAO, ⅓ of all program spending is now incorporated into an 1115 waiver, pretty much—pretty soon that is going to become the norm, rather than the—than a different example. So—and a lot of the things that we have been doing, Arizona has been doing this for 30 years. Tennessee and other States have been doing it for decades. There are certain things we just shouldn't need to get a waiver for anymore, you know. Thoughtful managed care, coordinated care is one of them. Home and community-based alternatives to nursing home care is another example. If we can make the waiver process less necessary, if we can build some of those commonsense developments into the underlying program, we can free-up resources that can really be focused on real innovation, but I think it does still need to exist because as we are seeing with States like Massachusetts and New York and Texas and others where the delivery system incentive payments are being implemented, there are different things we need to try, and the system has to be accommodating to thinking outside of the box. And so I would say let's make the 1115 waiver process less necessary, but still nimble and fluid enough to be able to accommodate the innovations that need to happen, not just today, but tomorrow.

Mr. BUCSHON. Governor Barbour, you have some comments on that?

Mr. BARBOUR. Yes, Doctor, I agree with that. That is very in line with what I have said earlier. I would think for many things there shouldn't be any necessity for coming and seeking a waiver, particularly something that has already been proven to work well in other States. But one of the things that strikes me is, we ought to base this on results, and yet GAO's witness here told us that CMS doesn't even test the results, that they don't look at the outcomes, and that is news to me. I hope it is really—that that is not quite accurate. But certainly, that ought to be part of the test. Did it achieve what you said it was going to achieve, and budget neutrality wasn't within the money. I testified, Mr. Chairman, 4 years ago that if you would give us a block grant, we would take ½ the

annual increase in Medicaid that our State would be entitled to because I thought we could save way, way more than that. I think if you have a budget—if you have a waiver, and you don't meet budget neutrality, the State ought to have to pay it. You will get very good programs if the State knows they are on the line. And most States, I believe, most States wouldn't prefer that, but if that was the difference, they would take it.

Mr. BUCSHON. I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman.

A couple of comments, I guess. The course of the hearing, I find it astonishing that some States, some Governors find it a burden to take care of the most disadvantaged people in our society, that Medicaid is not something—especially when the Federal Government is kicking in 90 percent of the cost. I mean, I am a little budgeteer from Oregon, a small business person, if someone is going to pay 90 percent of the cost of something, I am going to find 10 percent of the money to get it done, especially for this population. And who are these people? Who are these shiftless people on Medicaid? They are children, they are seniors, they are disabled people. Eighty percent of the Medicaid population is that group. I don't consider that shiftless. Seventy percent of the people that are able to actually work, they are all on Medicaid, that little 20—70 percent of them working, and they can't afford health care. I mean Medicaid, 138 percent of poverty level, that is like, what, 14, $15,000 a year? I challenge any of us to try and live on something like that. Afford health care? You can't do that. Oregon had a small demonstration project that at the time I thought was very good. Yes, everyone should pay something for their health care. Let's see, we sort of do that under the ACA that is being demagogued on a regular basis. Yes, people that are lower income but can afford some—yes, we make them pay on a graduated basis, based on their income and their socioeconomic level, but somehow what we are hearing today, you know, we don't like that because it is Medicaid? Medicaid is tougher though. We had this demonstration project in our State and we found that those people that are on Medicaid, they have lots of issues, they have multiple risk factors, folks. It is not like you and I that just decide not to work. There may be a few of those but most have multiple issues. And, frankly, they are not going to pay $5, you know. And enlightened self-interest ought to dictate to every one of us, even if we don't care about children, seniors, disabled, or the people that have multiple risk factors, that if we don't take care of these folks, their diabetes cost is going to go into our health insurance premium. And that has been proven. That is one of the predicates over healthcare reform. Whether you like the ACA or not, that is one of the predicates of why healthcare reform is so important; to get the costs aligned like they should.

And there are some good projects out there though. I agree with the general sense of this panel that the whole waiver system, the whole Medicaid system itself seems to be antiquated, and we should update it to be, I believe, outcome and results-based. I agree

with that 100 percent. That is the future; not micromanaging. Very concerned when I heard GAO talking about, well, we have more criteria here and a little more definition there, and count more waits that are being processed on—that is not the goal. The goal is to have higher quality health care at, frankly, less cost. And the way to do that, and it is in the ACA, and like it or not, even without the ACA, it is coordinated care. Aligning things so you don't have the duplication that GAO talks about.

Oregon has a great demonstration project that they are doing right now that I think is very accountable. It is pretty gutsy. They say they got a bunch of money from CMS to develop this coordinated care organizations for Medicaid patients. That means that there are primary care docs, specialists, dentists, mental health professionals, coordinating the care for Medicaid patients so that they will know what each other is doing, they will have an accountability in there, and they get—they are—in return for this money, the goal was to keep—not only get better outcomes, but get better value, not just for the individual but for the taxpayer. Limit healthcare inflation to 2 percent through the duration of it.

And I—you know, as a health care—well, as a budget guy, I got—ran—helped run the budget back in Oregon back in the day. You know, healthcare costs for healthcare inflation, 6, 7, 8, 9 percent annually. It was a big deal. We always budgeted more than annual inflation on a regular basis, which was anywhere from, you know, 1½ to 2½ percent. So Oregon is going to keep it at 2 percent. That is impossible. Well, the results so far are pretty amazing. We are under 2 percent. Under 2 percent inflation because of the coordinated care system. Emergency visits, I don't know about other States, emergency visits are down 21 percent from a couple of years ago. That is substantial. Complications from diabetes down 10 percent already. This is the early stages of coordinated care. And chronic obstructive pulmonary diseases, you know, hospital stays, down 50 percent. That is what we are talking about. That should be the outcome-based type of information that every waiver should be judged by, and hopefully, ultimately, Medicaid reimbursement in general.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman, I appreciate it.

And good to see you, Governor.

Mr. BARBOUR. I remember your dad, Congressman.

Mr. BILIRAKIS. Good. Yes, thank you. Governor, some States have been operating under an 1115 waiver. You mentioned Arizona has been operating, I believe, since 1982, well, at least 30 years. Some have suggested Congress create a process where longstanding core elements of an 1115 waiver can be effectively grandfathered into the State Plan Amendment. Do you have any thoughts on that? And I know that the Doctor had mentioned that too. I am just following up on his question.

Mr. BARBOUR. Yes, sir. I think that is absolutely a step in the right direction. If you have a demonstration project that has dem-

onstrated that it works, that you are able to do it in a budget neutral or better way, and that the outcomes are what you were expecting and what you told was going to happen, if that is the case, at some point—it shouldn't be years and years and years later, at some point, you ought to just be able to make that permanent. And I think importantly to your sister States, if we are the laboratories of democracy, and if Florida has got something that really works, it ought to be easier for us to go adopt what Florida is doing, make it—make some adjustments for us, but generally adopt what is proven to work in another State if we choose to, and not have to go through a big long process that takes 337 days.

Mr. BILIRAKIS. Sounds good. Thank you.

Mr. Salo, one of the things that the many Republican Governors have been interested in, they are interested in using 1115 waivers to test consumer-directed accounts with modest copay structures to encourage health literacy and individuals participating in their own health care. I agree with that. CMS has approved a few demonstration programs for this but they have been stringent on the copays under the waiver program, I understand. How do you think that fact squares with the reality that consumers who make a few dollars more are suddenly expected to be shoppers on the exchanges, for example, at 133 percent of the Federal poverty level you could be on Medicaid with no copay, but at 134 percent of the Federal poverty level, you would be on the exchange with no copays?

Mr. SALO. Yes, I think the issue there is—and again with deference to the administration's priorities, every administration is going to have priorities about what it wants to see done with its share of the Medicaid dollars. The current administration is not a huge fan of copays in the Medicaid Program, but I think it is clear that a key point of what we need to do in the overall system to make health care better for people is that we have to have greater accountability, but for everyone. Yes, we need better consumer engagement, but we need to give—we need to make sure that consumers have the tools to be able to do that effectively. And we need to also make sure that providers; primary care physicians or what have you, are accountable. We have to give them the tools to be able to do that. And ultimately, whether it is a health plan or whether it is the State, we have to have the tools to create an environment where all of those other pieces can succeed. You know, we don't want to just leave anyone out there with, you know, "Here is a ticket, good luck out there." We have to create, you know, with—it is not the Peter Principle, it is the Peter Parker Principle: With great power comes great responsibility. We have a responsibility to be able to ensure that everybody within the system is going to succeed as we change it from a dysfunctional fee-for-service model to a better integrated, coordinated managed care model. And that is going to involve consumer engagement, provider engagement, and State engagement as well.

Mr. BILIRAKIS. Thank you. Last question. Governor, CBO has indicated Obamacare's Medicaid expansion would, on balance, reduce incentives to work, yet CMS has refused to approve work requirements as part of the Republican Governors' State demonstration

waivers. Are you aware of anything in Section 1115 that would prevent CMS from approving work-related requirements?

Mr. BARBOUR. No, sir, I am not. And clearly, having a plan where more people work in our economy—today, only 48 ½ percent of adult Americans have a full-time job. The labor participation rates are about 62.9 percent; the lowest since the '70s, before women had really come into the workforce in the numbers that they have in the last 40-some years. So yes, it is absolutely—now that we allow able-bodied childless people to be on Medicaid, there is absolutely no reason we shouldn't look back at Bill Clinton's welfare reform law, which had work or retraining requirements.

Mr. BILIRAKIS. Thank you very much.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman. And welcome, panel.

I would like to read from a Miami Herald article from about 6 months ago relating to Florida's Medicaid Program. It says, in a sweeping decision, the judge says Florida systematically has shortchanged poor and disabled children by providing inadequate money for their health care. A Federal judge Wednesday declared Florida's healthcare system for needy and disabled children to be in violation of several Federal laws, handing a stunning victory to doctors and children's advocates who have fought for almost a decade to force the State to pay pediatricians enough money to ensure impoverished children can receive adequate care. In his 153-page ruling, U.S. Circuit Judge Adalberto Jordan said lawmakers had for years set the State's Medicaid budget at an all—artificially low level, causing pediatricians and other specialists for children to opt out of the insurance program for the needy. In some areas of the State, parents had to travel long distances to see specialists. The low spending plans which forced Medicaid providers for needy children to be paid far below what private insurers would spend, and well below what doctors were paid in the Medicare Program for a more powerful group; elders, amounted to rationing of care, the order said. And here are a few examples of what the judge found. Almost 80 percent of children enrolled in the Medicaid Program are getting no dental services at all. By squeezing doctor payments, Florida health regulators left ⅓ of the State's children on Medicaid with no preventative medical care, despite the Federal legal requirements. And this was true for both children paying fee-for-service or under managed care. In addition, the judge wrote, an unacceptable percentage of infants do not received a single well child visit in the first 18 months of their lives. Florida health regulators sometimes switch needy children from one Medicaid provider to another without their parents' knowledge or consent. So these sweeping violations of Federal law within a demonstration project, and Medicare—Medicaid waiver raised a lot of questions.

And, Governor, I heard you said, well, for Florida—for all States, if it is working, maybe we should keep it. But clearly here, if something is not working, they need to take a look at it. I think everyone would agree.

So, Ms. Alker, you are fairly familiar with what has been happening in Florida. This is part of the reason that the low-income pool and these multibillion-dollar—in Florida, these large uncompensated care pools have gotten a lot of attention over past years. A lack of transparency in the way the funds are distributed by the State. They are distributed not by—they don't follow beneficiaries, they go—depending on—the pool of money goes to—depending on what counties have contributed. And they have raised serious questions about provider rates that have been cut over the years. What is to be done in a waiver situation when you have these uncompensated care pools, and yet providers, doctors are not being paid adequately, and children aren't getting the care they need?

Ms. ALKER. So I think you raised a number of issues, and one of the really important questions is having, I think, strong oversight of Medicaid managed care, particularly in Florida; there has been serious problems over the years with your managed care companies. And so part of what, you know, if you build it into the waiver process or through the new Medicaid managed care regs that CMS has just issued, that we really are going to need accountability for the taxpayer dollar with respect to these managed care companies. And I worry because I think that States have lost personnel, their departments are often underfunded, and they don't have the ability to oversee these managed care companies, ensure that we really are paying for care for very vulnerable children and others.

And I guess with respect to the uncompensated care pool, I think it is also important to emphasize, as you mentioned earlier, Representative Castor, that the low-income pool in Florida doesn't cover a single person, and uncompensated care pools don't cover people. They came out of a time when particularly States had very high uninsured rates, but coverage is really a better way to approach the healthcare needs of citizens of your State and others, because the low-income pool doesn't protect families from bankruptcy, it doesn't ensure that folks get primary and preventative care, and to my mind, it is a smarter use of taxpayer dollars to make sure that people get coverage so they get the primary and preventative care they need so they don't get sicker and have to wind up taking uncompensated care from your State's hospitals.

Ms. CASTOR. Thank you. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

And now recognizes the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. And I want to thank all of the witnesses today for your testimony on what we know is a major concern for all of us. And I may direct this to Governor Barbour. As the CEO of Mississippi, I can just tell you, in my past life, I was the county executive of the largest upstate county in New York, where Medicaid actually was 115 percent of our budget, of our property taxes. So every single dollar that we collected in property taxes, every single dollar we collected was not enough to cover our Medicaid burden, because in New York, the counties pay a portion of the fee. That is not true in a lot of States. I don't know what it was in Mississippi, but in New York our Medicaid costs are so outrageous that we pass a—you know, a big chunk of it down

to the 62 counties, to the point in Erie County, one of the poorest counties in the State of New York, home to Buffalo, it was 115 percent of our property tax levy. So we lived on only sales tax. The entire—everything we did with highways and roads and supports of our culturals, our prisons, our holding center, 100 percent of everything we did outside of Medicaid was sales tax revenue, which is not a predictable source.

So I will get back to commonsense. When commonsense meets good Government, I think that is a good day for all of us. And I want to talk about how nominal copays can make a big difference. I mean we teach our kids, you know, you raise 50 cents, I will give you 50 cents. You want a new bike, you go raise this, I will do that. A fundamental part of America is teaching people at a young age the value of $1, but in Medicaid, when there is no copay—let me tell you another story. I mean I can get pretty animated on this. We had in Erie County what we called the frequent fliers that use ambulances as a taxi service. They call 911, they climb in an ambulance, it takes them to the Erie County Medical Center, they get out and they start walking somewhere else. It was an—a free taxi cab, that is what it was, because we don't have a copay. I suggested why not a $50 copay. Fifty dollars to get into an ambulance and take you to the hospital, and we would even have a way to potentially, for some of those, waive that, but that would be more expensive than a taxi cab. So if you are looking for a taxi ride, call a taxi, don't call an ambulance. And I was told absolutely not, this isn't going to go that way. I chaired a commission, County Executives for Medicaid Reform, asking that we would have the ability at the county level to set up our own programs, and I was turned down on that one. So I just have a fundamental belief that having some level of pay, however little it is, invests a person in what it is they are getting, and that nothing in life should be free.

So, you know, do you have any comments, Governor?

Mr. BARBOUR. We try very hard to get CMS to agree to let us make copayments enforceable, and could not—we were not allowed to do that. Governor Daniels is quoted in some of the material, when they started the HIP program he—you know, everybody is going to have to pay something, and I think the lady from Indiana said it starts at $1 a month, but I remember him saying if you can afford a Big Mac you can afford the copayment. And for people to be—for patients to be participating in their health care, making decisions because of copays, the decision may be generic versus brand name, the decision may be something else, but as an old Scotch-Irish descendent, if it is a cash bar or a free bar, I know who drinks more. And if you—if it costs you something, if you have to be part of it, you are going to be a better healthcare receiver because you are going to be conscious about that. And the copays don't have to be very large, as you say, or as Governor Daniels says, where they have $1, a $1 copay. There is not anybody that can't afford $1 a month.

But anyway, I agree with you. My legislature we had Democratic majorities in both the House and Senate when I was Governor. They were for copays and enforceable copays. It is just commonsense.

Mr. COLLINS. Well, and that is what I would say. It is commonsense meets Government. We should do something like this. In fact, to me, it should be part of the basic Medicaid Program because if we teach our 6-year-old kids the value of $1, and let's go out and do some work in the garage and clean up the house, and then you earn—and I will buy the—pay the rest of your bicycle, we fundamentally know that anything that is free has less value than something you even pay a nominal part for. So certainly within the 1115 program there should, in my opinion, definitely be a place for something for very small copays, and anyone who would debate otherwise I think is kind of leaving commonsense at the door, unfortunately.

Well, thank you again for your testimony. My time has expired. I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions.

Mr. KENNEDY. Thank you, Mr. Chairman. I want to thank the witnesses for coming today, and for your testimony on an extraordinarily important topic.

I apologize, I was bouncing around a little bit and so I think I missed some comments earlier about the Massachusetts low-income pool. So, Ms. Alker, I was hoping you might be able to clarify—I know my colleague, Ms. Castor, brought up the Florida low-income pool, and I think there were some comparisons that were made earlier. In your assessment, ma'am, are there any noticeable differences between the way that the—Massachusetts has set up its low-income pool and that of Florida?

Ms. ALKER. I think there are. I am not as familiar with Massachusetts. I think though when you look at the nine States that CMS has identified with these kinds of uncompensated care pools, they are all different from each other. And as I mentioned before, one important step forward is that CMS, earlier this year, sent a letter to Florida about the principles they are going to use to apply to all States, excuse me, going forward as they consider their uncompensated care pool, and they are applying those principles both to States who have expanded Medicaid, like Massachusetts, and States who have not, like Florida.

Mr. KENNEDY. Excuse me. Right. So thank you for pointing out at least one important distinction. I also wanted to talk about—this has come up a couple of times today, but the work requirements, and with regards specifically to an issue that has come up also a couple of times today, mental health. One group that is particularly hit hard by unemployment are individuals that are suffering with mental illness. Committee had a hearing just a couple of days ago on improving our mental healthcare system in this country, and it is an issue that I know a lot of us care an awful lot about.

In 2012, 17.8 percent of the seriously mentally ill were unemployed. This group of individuals could succeed at work if given the right opportunity for—excuse me, the right employment supports, which is why Medicaid coverage is so important. Medicaid—States to provide supportive improvements like skills assessments, assistance with job search, and completing job applications, job development and placement, job training, negotiations with prospective

employers. And Medicaid dollars can be leveraged to support State training programs for mental health providers who, in turn, serve low-income beneficiaries. In fact, Mississippi and Massachusetts have something in common. Both States are taking advantage of these types of opportunities. Mississippi is, I think, a great example of using Medicaid support to help State health programs. And, Governor, your State goes so far as to provide services to help individuals start their own businesses, such as helping the with a business plan, finding potential financing, and ongoing guidance once the business has been launched. Massachusetts is doing some pretty outstanding work as well when it comes to treating mental illness and substance abuse. Flexibility in that waiver process allows Massachusetts to leverage State dollars to conduct community support programs, psychiatric day treatment, and acute treatment for children and adolescents.

So, Ms. Alker, to start with you, do you agree that flexibility the States have today leverages Medicaid dollars to serve communities through the designated State health programs, and the—it is a hallmark of the Medicaid Program that should be protected?

Ms. ALKER. Well, so let me say two things, and then if it is oK, I would like to go back to the work requirement issue as well.

So the kinds of programs that you are mentioning, I mean this has been a hallmark of Section 1115 waivers for many decades now. This is not something new that the Obama administration has started doing, and also it is not something which the Obama administration just simply says we are going to give you money for. The States come to them with ideas and, you know, I think we would all agree, if it is a good idea that supports the objectives of the Medicaid Program, that then that is the kind of thing exactly the Section 1115 waiver should test. And so I think again, if we look at it from that long-term perspective, it is exactly what Mr. Salo was saying is that, over time, there are more innovative ideas that emanate from States, and that is a hallmark of Section 1115 waivers.

With respect to the work requirement question, because I think there is an intersection between the mental health issue and the work requirement that I would like to point out, work requirements strike me as a bad idea both from a policy perspective and they are possibly outside the purview of the Secretary's legal authority to approve, although I am not a lawyer so I am going to leave that to others to comment on it, but I think they are a bad idea for the following reasons. I think we all share the same objective here, which is we would like to see people work. We would like to maximize employment. But it seems to me that imposing the arbitrary work requirement may, in fact, have the precise opposite effect because you have folks perhaps who have a mental health condition that needs to be treated, and the health care—providing them with the health care will allow them to work in greater—there will be a greater chance of them becoming employed. So I worry very much that a work requirement would have precisely the opposite effect of what is intended.

Mr. KENNEDY. Thank you. And I am, unfortunately, over time, so I yield back 5 seconds.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the vice chair of the full committee, Mrs. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I want to thank each of you for your patience as we worked through the first panel, and then for staying with us. This makes for a long morning, we understand that, but as we look at the demonstration projects, we do want to come back in and review this, and maybe as the director said earlier in the first panel, be able to put some guidelines in place, and some more components for oversight and also for conduct, put these in the statute. So today is important for us.

Mr. Salo, I want to come with—to you. In your testimony, you had said that simple accounting for Medicaid is extremely difficult, if not impossible. And we are talking about a program that is probably the world's largest health insurance program, and the spending is pretty much on autopilot at the Federal level. Lot of problems with how this is playing out. And as a former State senator in Tennessee, and the experiment we had with TennCare, I fully understand the challenging nature of Medicaid and of working through these waivers in the 1115 program, but I want to give you a chance to explain this because surely, you are not suggesting that benefits cannot be quantified, and that dollars cannot be tracked effectively, or that accountability is not needed. So would you like to respond to that?

Mr. SALO. I would love to, thank you.

Mrs. BLACKBURN. Good.

Mr. SALO. So I guess what I am saying is I think what the GAO is searching for here is akin to—there is an old joke where there is a policeman walking down the street and he sees a guy on his hands and knees, looking for something in the street under the streetlight, and it is dark. And policeman comes over, says, you know, what are you doing? He says, I am looking for my keys. I lost my keys. So the policeman helps him. And he is there for like 5 or 10 minutes. He says, I can't find them, are you sure you dropped them here? He says, oh, no, I dropped them down the block, just the light is better over here. I think that is what is going on. I think the GAO is struggling for something that is really simple and really easy, that for the green eyeshade approach of, well, I can put this in a checklist, this is simple, this is simple, check, check, check. And I am here to argue that Medicaid is much more complex than that. I am not saying it doesn't need accountability. It does. It has. And I am not saying that we cannot—we should not track the dollars, track the benefits. You should, and we do. What I am saying is, I think what the GAO is pushing for may not actually be good for the ultimate value and health care—health of the program itself. That as we start getting into very narrow definitions——

Mrs. BLACKBURN. Well, sir, I am——

Mr. SALO [continuing]. Of what budget neutrality is——

Mrs. BLACKBURN [continuing]. Going to interrupt you right there. If the program is too expensive to afford, it is not good for anybody. And what we need to make certain is that we are looking at this from access to affordable health care, and to approach it from a viewpoint that, well, this is too challenging, the problem is too big

to solve so let's leave it on autopilot, that is not a responsible course of action, and that is something that we ought not to do, and it is exactly the reason we need to pull this back in and look at these 1115 waiver situations, and look at the subjectivity with which these waivers are being given.

Governor Barbour, I want to come to you. Talking about the subjective nature of this, and looking back through these uncompensated care pools, and you look at what happened with Massachusetts and Hawaii, and they are being given a much longer period of time for their extension on their pool as opposed to Florida, and I—what I don't like where this—you look at how this is playing out, and it seems like you have CMS treating States differently if they are friendly to the administration as opposed to those that are not friendly to the administration. And that is troubling to me. I think it is troubling to a lot of people that are looking at Medicaid and Medicaid delivery.

Mr. BARBOUR. Certainly, that is the contention of the attorneys general law suit, that because their States did not expand Medicaid, they are being coerced or they are being punished in doing this. GAO did not say different States get different treatment, but they did publish a list of who got their waivers redone, and it is pretty politically consistent. If you look down the list, they all voted for the same candidate for President. They got two senators in the same party. They all expanded Medicaid. Now, I can't look into anybody's heart and say they are—that is why they made the decision, but that is why we need more transparency, not just in a Democratic administrations, but in Republican administrations, of why did the decision get made.

Mrs. BLACKBURN. Thank you. Mr. Chairman, I have one other question for Governor Barbour. I will submit it—it has to do with eligibility— get an answer from him relative to that.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

That concludes the questions of the members present. We will have follow-up questions. We will send those to you in writing. We ask that you please respond promptly.

I remind members that they have 10 business days to submit questions for the record. Members should submit their questions by the close of business on Wednesday, July the 8th.

Another very important, interesting hearing. A critical program needs attention of Congress. This has been very informative. We thank you for coming.

And without objection, the subcommittee stands adjourned.

[Whereupon, at 1:11 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Mr. Chairman, thank you for calling today's hearing on Medicaid demonstration projects, and thank you to all of our witnesses for coming to testify.

Section 1115 waivers were established for the express purpose of allowing States to dream big in their Medicaid programs-to design and pilot new ways of delivering care that support the overarching objectives of the Medicaid program: to strengthen coverage, expand access to providers, improve health outcomes, and increase the quality of care for beneficiaries.

States already have extremely broad flexibility under an 1115 waiver, and that flexibility is a good thing. But in exchange, it's important that there remains strong public transparency and evaluation.

That's why I am pleased that after close to 20 years of recommendations for more transparency into the Medicaid waiver process, the Affordable Care Act included a bipartisan provision to improve the transparency of Medicaid waivers, in line with longstanding recommendations from GAO. Today, because of this provision, the public has meaningful opportunities to provide input into the waiver process at both the State and Federal level, waivers are now evaluated on a periodic basis, and States submit reports on implementation. This was a huge step in the right direction.

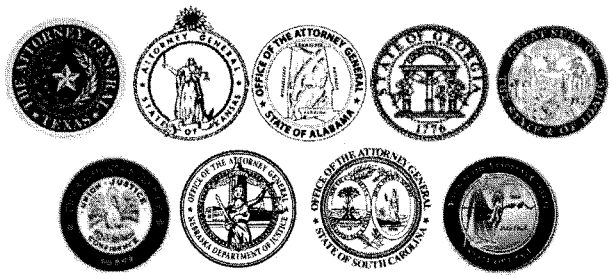
I am further encouraged by CMS' concurrence with GAO recommendations specifically in their April 2015 report for better ongoing and transparent documentation of how States spend Medicaid dollars. This is a recommendation that prior administrations had refused to correct, and I continue to believe it is the right thing to do to ensure dollars are following our Medicaid beneficiaries.

I was also encouraged by the administration's clear and public articulation over the past year with States regarding the specific criteria that it would use for approval of waivers for States with so-called "uncompensated care pools." In many past reports, GAO has expressed concerns with the structure and distribution mechanisms for uncompensated-care dollars that some States have used. This is another step in the right direction.

Despite these advancements, I believe there is still more to be done. A real conversation about improving transparency of Medicaid waivers, while carefully balancing the need to preserve State flexibility, is a conversation worth having.

To be clear, however, States already have broad flexibility. Disguising punitive, ideological philosophies like work requirements and increased cost-sharing as vital "flexibility" needed by States has no place in this conversation. Those are policies that undermine the foundation of our safety net.

There is a real opportunity today to evaluate and learn how to improve the Medicaid waiver process so we can provide better care to millions of people that count on Medicaid. I look forward to that discussion.



June 23, 2015

The Honorable Fred Upton
Chairman, Committee on Energy and Commerce
United States House of Representatives
2183 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton:

We the undersigned Attorneys General write to express our concern regarding the coercive efforts of the United States Health and Human Services, Center for Medicare and Medicaid Services ("CMS") to expand Medicaid by withholding unrelated health care funding on critical state programs. The United States Supreme Court has made clear that the federal government cannot compel states to administer federal programs and CMS' recent decisions to deny unrelated federal health care funding based on a state's non-expansion of Medicaid constitutes unlawful coercion.

Section 1115 of the Social Security Act, 42 U.S.C. §1315, authorizes state and federal partnerships to provide funding for healthcare providers offering services to underserved populations that would not otherwise be covered under Medicaid. At least twenty-two states have implemented Section 1115 programs in their states with CMS providing matching federal funding to offset costs for health care providers caring for uninsured, underinsured and other at-risk populations.

Florida's Low Income Pool ("LIP") is one example of a Section 1115 program, for which the federal government has provided substantial funding since 2005. Under Florida's LIP program, federal funding has been used to (1) Offset health care services for immigrants ineligible for reimbursement under Medicaid; (2) Support state and private medical schools and their teaching hospitals with slower patient turnover rates inherent

with the education of medical students; and (3) Support children's hospitals, which in Florida receive $125 million annually under the LIP. At least 5 states, including Arizona, California, Kansas, Tennessee, and Texas have programs substantially similar to Florida's LIP.

On April 15, 2015, after extensive negotiations regarding the continuance of funding of Florida's LIP, CMS informed Florida that it would no longer provide the over $1 billion in annual funding to support LIP unless and until Florida expanded its Medicaid coverage. CMS reached this conclusion even though Florida had repeatedly made clear that its LIP covers services separate and distinct from services that would otherwise be covered under an expanded Medicaid program.

Kansas, Tennessee, and Texas face similar threats regarding their uncompensated care pools and are experiencing increasing pressure from CMS to expand Medicaid in exchange for continued funding under Section 1115. And the stakes are high. If CMS does not approve funding Texas' LIP program, which expires in 2015, Texas stands to lose billions overtime in federal funding for hospitals.

We acknowledge that CMS has discretion under Section 1115 to approve programs. But CMS cannot make its determination based on a state's opting-out of Medicaid expansion. Because CMS has repeatedly linked Florida's non-expansion of Medicaid under the ACA to the non-renewal of funding for Florida's LIP, CMS' actions are unconstitutionally coercive.

In a hard-fought victory before the United States Supreme Court, the States successfully argued "the basic principle that the 'Federal Government may not compel the States to enact or administer a federal regulatory program." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012). While "Congress may use its spending power to create incentives for States to act in accordance with federal policies... when 'pressure turns into compulsion,'... the legislation runs contrary to our system of federalism..." Id. At 2602. When, as here, CMS' hardline on state Medicaid expansion "take[s] the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes." *Id.* at 2604.

On April 28, 2015, Florida Governor Rick Scott and Attorney General Pam Bondi sued CMS for unlawful coercive expansion of the state's Medicaid program. While CMS' unlawful action will play out in the Court system, we welcome assistance from Congress in reigning-in CMS, an agency insistent upon trampling the rights of our sovereign states to make critical policy decisions regarding Medicaid and, in terminating funding for critical health services, imperiling the lives of our most vulnerable citizens.

We appreciate the Committees investigation on this most critical matter.

Sincerely,

Ken Paxton
Attorney General of Texas

Derek Schmidt
Attorney General of Kansas

Luther Strange
Attorney General of Alabama

Pamela Jo Bondi
Attorney General of Florida

Samuel S. Olens
Attorney General of Georgia

Lawrence G. Wasden
Attorney General of Idaho

James D. "Buddy" Caldwell
Attorney General of Louisiana

Douglas Peterson
Attorney General of Nebraska

Alan Wilson
Attorney General of South Carolina

Sean Reyes
Attorney General of Utah

Copy: The Honorable John Boehner, Speaker, United States House of Representatives
The Honorable Nancy Pelosi, Minority Leader, United States House of Representatives
The Honorable Mitch McConnell, Majority Leader, United States Senate
The Honorable Harry Reid, Minority Leader, United States Senate

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
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July 21, 2015

Ms. Katherine M. Iritani
Director
Health Care Team
U.S. Government Accountability Office
701 5th Avenue
Seattle, WA 98104

Dear Ms. Iritani:

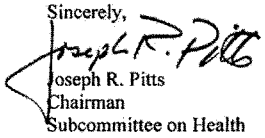
Thank you for appearing before the Subcommittee on Health on June 24, 2015, to testify at the hearing entitled "Examining the Administration's Approval of Medicaid Demonstration Projects."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on August 4, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 4, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Subject: Responses to Questions for the Record; Hearing Entitled *Examining the Administration's Approval of Medicaid Demonstration Projects*

Dear Chairman Pitts,

This letter responds to your July 21, 2015 request that we address several questions for the record related to the Subcommittee's June 24th hearing on Medicaid demonstrations. Our responses to the questions, which are in the enclosure, are based on our previous work and knowledge on the subjects raised by the questions.

If you have any questions about the letter or need additional information, please contact me on (202) 512-7114 or at iritanik@gao.gov.

Sincerely yours,

Katherine Iritani

Katherine M. Iritani
Director, Health Care

Enclosure

The Honorable Representative Pitts

1. **In approving 1115 waivers, CMS has provided expenditure authority that allowed states to make new kinds of supplemental payments through the creation of uncompensated care pools. My understanding is that in many cases this authority is necessary for some states who are shifting Medicaid populations from fee-for-service to managed care and thus no longer able to make supplemental payments without a waiver. Can you explain why the shift to managed care affects a state's ability to make supplemental payments?**

   Federal Medicaid regulations generally prohibit payments by a state Medicaid agency to providers for services rendered under a contract with managed care organizations.[1] In general this means that the statewide use of managed care precludes states from making supplemental payments to providers. Some states pursuing a shift to managed care under a section 1115 demonstration have been able to retain the ability to make supplemental payments through new expenditure authorities approved by, and at the discretion of, the Department of Health and Human Services (HHS). Our work has found that some states have substantially increased the amount of supplemental payments they make under section 1115 demonstrations. For example, one reviewed state claimed federal reimbursement for about $2.6 billion in supplemental payments in fiscal year 2011, the year prior to its demonstration and implementation of statewide managed care. Under the demonstration, which started in fiscal year 2012, the state was authorized to receive federal matching funds on $4.2 billion in supplemental payments for uncompensated care and delivery system improvements during the first year of the demonstration, and on $6.2 billion for each of the remaining 4 years.

2. **At the hearing you indicated that there is no set period of time for CMS to review and respond to a request for a new 1115 demonstration application. Is there a set period of time for CMS to review and respond to state plan amendments and other waivers, namely those authorized under section 1915(b) [managed care] and 1915(c) [home- and community-based services]? If so, what is the time period established for CMS review of those state program changes and waiver applications?**

   There are certain time frames established for the Centers for Medicare & Medicaid Services's (CMS) review of state plan amendments and states' proposals for 1915(b) and 1915(c) waivers.
   - State plan amendments are considered approved unless, within 90 days of receiving the request, CMS either denies the request or notifies the state that additional information is needed to make a determination. If CMS requests additional information, the 90-day review period begins on the day CMS receives that information.
   - The approval processes for section 1915(b) and section 1915(c) waivers are similar to those for state plan amendments. Such waivers are considered approved unless, within 90 days after the request is received, CMS denies the request or sends the state a written request for additional information. If additional information is requested, a new 90-day period begins the day the additional information is received.

   In comparison, there are generally no set timeframes within which CMS must review section 1115 demonstrations.[2] Following the Subcommittee's June 24, 2015, hearing on Medicaid demonstration approvals, CMS issued a bulletin describing a new "Fast Track" review process for certain extensions of Medicaid and Children's Health Insurance Program section 1115

[1] See 42 C.F.R. 438.60.

[2] Section 1115 of the Social Security Act does impose time frames for the review of certain extensions.

demonstrations.[3] The bulletin states that the fast track process will be available for states applying to extend established section 1115 demonstrations that are working successfully and for which the states are not seeking any major or complex policy changes . According to CMS, the review times for such extensions will be comparable to those for section 1915 waivers or state plan amendments.

3. **One frustration often voiced by State officials is the time it takes to negotiate and secure an 1115 waiver. For example, in Indiana, it took the governor 2 years to negotiate the waiver for HIP 2.0. What thoughts do you have about parameters Congress could put around the process to provide some certainty for states? What policy factors would we need to think through?**

In considering whether to impose parameters around the section 1115 waiver review process, it is important to balance the need for certainty and speed with transparency and effective oversight, given the complexity and scope of section 1115 demonstrations. These demonstrations—accounting for close to one-third of total Medicaid expenditures in fiscal year 2014—have been characterized as unique among Medicaid's waiver authorities because of the broad flexibilities granted to states in designing demonstrations. Unlike other waivers that have defined timeframes for HHS's review process, section 1115 demonstrations can have a much larger scope and involve more complicated changes to a state's Medicaid program. They can be narrowly tailored to specific services or populations or can cover most of a state's Medicaid program. Furthermore, states can use section 1115 waivers to alter the parameters of the Medicaid program for beneficiaries by increasing cost-sharing or reducing Medicaid benefits, and GAO's work has found that many waiver requests have sought to make such changes. In addition, given the broad flexibility HHS has to allow federal matching for costs not otherwise eligible for Medicaid funds, section 1115 demonstrations can have significant implications for federal Medicaid expenditures.

Given the flexibilities with section 1115 demonstration waivers, the timeframe for the review process, as we have noted in prior work, may be affected by a number of factors.[4] For instance, in some cases, prior to commencing a formal review, a state may submit concept papers to receive technical assistance, which may result in an extended dialogue between the state and HHS. The completeness of the application can also affect timeframes. If applications lack important details or data, HHS may request extensive clarification, and states may require additional time to respond. In our prior work, we found that HHS review times for section 1115 demonstrations varied significantly. In 2013, we found that for 46 reviews that HHS completed between January 2007 and May 2012, reviews took from 47 days to almost 4 years and averaged 323 days from the date of application to the date of the review decision; however, the majority—about 72 percent—of the reviews took a year or less to complete.

Flexibility and program experimentation must also be accompanied by accountability, including public input. In our past work, we raised concerns about the transparency of the demonstration approval process and recommended that the Department provide opportunity for public input

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[3]Centers for Medicare & Medicaid Services, *CMCS Informational Bulletin: Implementation of a "Fast Track" Federal Review Process for Section 1115 Medicaid and CHIP Demonstration Extensions* (Baltimore, Md.: July 24, 2015). See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB07242015-Fast-Track.pdf.

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

into HHS's consideration of section 1115 proposals.[5] The Patient Protection and Affordable Care Act included a provision requiring HHS to address this concern. HHS established a 30-day public comment period for section 1115 demonstration proposals under consideration and must wait at least 45 days before making a final determination.

As we noted above, CMS recently established a "fast track" process for reviews of certain extensions of section 1115 demonstrations that the agency considers to be less complex. Under the fast track process, states will submit streamlined application documents and, in reviewing these, CMS will observe timeframes comparable to those it uses to make decisions on section 1915 waivers or state plan amendments. CMS has identified specific policy areas as inherently complex and has excluded them from the fast track process. These areas include, among others, Medicaid expansion programs tied to enhanced federal medical assistance percentage, delivery and payment reforms that cannot be authorized under state plan authority, state programs, and enrollment caps and eligibility limitations. Our work would support CMS's decision to not apply a fast track process for complex waiver proposals.

4. **In your testimony, you noted that demonstration approvals varied in the extent to which they provided assurances that Medicaid funding for state programs would not duplicate other potential sources of federal funding. As a result, these demonstrations run the risk of resulting in billions of dollars of duplication of federal funding. What can CMS do to avoid such potential for duplication?**

   In our April 2015 report, we recommended that HHS take steps to ensure that demonstration approval documents provide assurances that states will avoid duplicative federal spending.[6] In our review, we found that the approval documents for some but not all states included detailed information about the state programs approved for funding, in what HHS refers to as "claiming protocols." The claiming protocols for these states identified all other federal and nonfederal funding sources for each state program. Further, they included specific instructions on how the states should "offset" other revenues received by the state programs related to eligible expenditures. We believe HHS needs to ensure that all approval documents provide assurances—such as through claiming protocols—that states will avoid duplicative spending by offsetting as appropriate all other federal revenues received when claiming federal Medicaid matching funds. HHS concurred with our recommendation, stating that it will require all future section 1115 approvals to include clear claiming protocols for both new and previously authorized state programs to verify there is no duplication of federal funding. Since the release of the final report, HHS has told us that additionally, for all current approvals, CMS will work with states to document how there is no duplication of federal funding as CMS processes demonstration actions.

5. **To what extent has the use of 1115 waivers and Medicaid expenditures related to these waivers increased over time? Can you please provide a chart demonstrating their growth (in number of waivers and total dollars governed by a waiver)?**
   a. **Does the increase in 1115 waivers point to the need for more state flexibility in Medicaid?**

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[5]GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns,* GAO-02-817 (Washington, D.C.: Jul. 12, 2002). See also, GAO, *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).

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

b. To what extent is the increase in expenditures related to 1115 waivers a result of the waivers not being budget neutral?

CMS's website does not capture summary statistics on either the use of 1115 waivers or total spending governed by waivers. We can glean some information on the general trends in use of these waivers from published reports.

Based on inventories conducted by the Congressional Research Service (CRS), the number of approved section 1115 demonstrations has increased over time. Specifically, CRS reported that in 2004 there were 19 states with comprehensive section 1115 demonstrations.[7] In 2008, CRS reported that this number had increased to 32 comprehensive section 1115 demonstrations across 26 states.[8] Our recent work suggests that the use of Medicaid 1115 waiver authority among states is still high.[9] In our April 2015 report, we identified 25 states that received approval for new comprehensive demonstrations or renewals or amendments to ongoing demonstrations, in a relatively short period (June 2012 to October 2013).[10] Although section 1115 demonstrations can provide states considerable flexibility to modify their Medicaid programs, we do not know all of the reasons states seek 1115 waivers, and believe these reasons are complex. Our recent work has shown that many states through 1115 demonstrations obtained flexibility to use federal funds to pay for services not typically covered under Medicaid. States have been approved to implement different coverage strategies or impose new cost sharing for certain beneficiary populations, and many states in recently approved demonstrations have also sought flexible funding for otherwise non-covered purposes such as new types of supplemental payments.

Summary information from CMS captured in GAO's reports also suggests that the amount and proportion of Medicaid expenditures made under section 1115 demonstrations has increased in recent years.

- In fiscal year 2011, $57.5 billion in federal funds, or about one-fifth of the $260 billion in federal Medicaid expenditures, were under section 1115 demonstrations.[11]
- In fiscal year 2013, $70 billion in federal funds, or about one-fourth of the $265 billion in federal Medicaid expenditures, were under section 1115 demonstrations.[12]
- In fiscal year 2014, an estimated $89 billion in federal funds were spent under section 1115 demonstrations, which accounted for close to one-third of total Medicaid expenditures.[13]

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[7]Congressional Research Service, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, CRS Report for Congress (Washington, D.C.: March 5, 2004). When speaking of 1115 demonstrations, we and others typically distinguish comprehensive demonstrations from those that provide for a single category of services, such as family planning.

[8]Congressional Research Service, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers* (update), CRS Report for Congress (Washington, D.C.: Sept. 11, 2008).

[9]See CMS's website for demonstrations at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

[10]See GAO-15-239.

[11]See GAO-13-384.

[12]See 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).

Although we do not know the extent that increased spending under demonstrations stems from HHS's approval of spending limits in excess of what was justified, we believe potential cost savings from HHS implementing more rigorous criteria and methods for reviewing spending limits could be in the tens of billions of dollars. For example, for five states' demonstrations we reviewed in our 2013 and 2014 reports, had HHS followed its budget neutrality policy, an estimated $33 billion in excess spending, with a federal share of approximately $22 billion, could have been avoided.[14]

6. **The Affordable Care Act included a provision that addressed a 2002 recommendation GAO made to increase the transparency of the waiver approval process. Specifically, the ACA provision, which was the result of a bipartisan effort, required HHS to issue regulations designed to ensure that the public has the opportunity to provide input on proposed section 1115 demonstration processes. In response to this provision, CMS issued regulations in February 2012. While this provision and the resulting regulations are a positive step in addressing GAO concerns, am I correct that this only addresses a rather small portion of the concerns GAO has raised with the 1115 waiver process? If so, what other changes to the 1115 waiver process has GAO recommended that have yet to be addressed?**

GAO has long-standing concerns about HHS's demonstration approval process, and while HHS has implemented several recommendations to improve accountability and transparency in its processes, HHS has yet to take actions that fully address the majority of the more than a dozen recommendations we have made about section 1115 demonstrations since the early 2000's. These recommendations have generally fallen into the following categories: ensuring budget neutrality, furthering Medicaid objectives, and ensuring that demonstrations are appropriately monitored and evaluated.

Ensuring Budget Neutrality: We have made multiple recommendations to HHS aimed at improving its process for approving demonstration spending limits, making determinations more transparent, and issuing an up-to-date written policy and making it widely available. HHS disagrees with the need for these recommendations, which remain unimplemented. HHS policy requires that section 1115 demonstrations be budget-neutral to the federal government—that is, that demonstrations should not increase federal spending over what it would have been if the state's existing Medicaid program had continued. Between 2002 and 2014, GAO reviewed HHS's approvals of over a dozen states' demonstration spending limits and found that HHS had approved spending limits that we estimated were billions of dollars higher than what federal spending would have been if the states' existing Medicaid programs had continued. In particular, we found that HHS has allowed states to use questionable methods and assumptions in developing their estimated costs without providing adequate documentation to support them. Between 2002 and 2004, we recommended that HHS (1) clarify criteria for reviewing and approving states' demonstration spending limits, (2) ensure that valid methods are used to demonstrate budget neutrality, and (3) document the basis for approval. Because HHS disagreed with or did not implement these recommendations, in 2008 we suggested that Congress consider requiring the Secretary of HHS to improve the process by, for example, better ensuring that valid methods are used to demonstrate budget neutrality and documenting

[13]See GAO-15-239. Calculation is based on expenditures for medical assistance payments only, which for fiscal year 2014 were $146.8 billion for section 1115 demonstrations and $466.5 billion for total Medicaid expenditures, as reported in the Medicaid Budget and Expenditure System, as of January 2015.

[14]See GAO-13-384 and GAO-14-689R.

and making public the basis for such approvals. In 2013, we found additional problems with HHS's written budget neutrality policy (most recently updated in 2001) not reflecting HHS's actual practices, and therefore made further recommendations. We 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. As with the earlier recommendations regarding clarifying its criteria, allowing only valid methods for developing spending projections, and making the basis for approvals transparent, HHS disagreed with this new recommendation.[15] We continue to believe that HHS must take actions to improve the transparency and accountability of its demonstration approvals and should fully implement our recommendations.

Furthering Medicaid Objectives: In our April 2015 report, as discussed in the June testimony, we had three recommendations. HHS agreed with two of these, and partially agreed with the third. HHS has reported to us in recent weeks on the status of its actions on our recommendations. We will examine HHS's actions and report publicly as to the status. Our three recommendations and HHS's responses were as follows:

- We recommended that HHS better ensure that section 1115 furthers Medicaid objectives by issuing criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives. HHS partially agreed with this recommendation, noting that all section 1115 demonstrations are reviewed against "general criteria" to determine whether Medicaid objectives are met. However, HHS did not indicate plans to issue these general criteria in writing, and we maintained that more-specific guidance is needed to improve transparency.
- We also recommended that HHS ensure that the use of these criteria is documented in its approvals of demonstrations; HHS concurred with this recommendation. In July of this year, HHS informed us of steps it had taken since the release of our report to clarify and document in approvals the criteria used to determine whether Medicaid objectives are being met. According to HHS, it has identified in recent approvals which of the general criteria each approved expenditure authority promotes. While this may add some transparency, we still regard HHS's general criteria as not sufficiently specific enough to inform stakeholders of the department's interpretation of its section 1115 authority. Moreover, these criteria are still not available as written guidance.
- Finally, in our report we recommended that HHS take steps to ensure that its approval documentation consistently provide assurances that states will avoid duplicative spending between federal Medicaid funds for demonstrations and other federal funds available to states for the same or similar purposes. As noted above, HHS agreed with our recommendation and told us in July 2015 that CMS will be requiring all future 1115 approvals to include information to verify that there is no duplication of federal funding and will work with states to document how there is no duplication of federal funding as it processes demonstration actions.

[15]Based on our broader concerns, we have also made several recommendations that HHS reconsider the spending limits approved for different state demonstrations examined in our work. In total between 2002 and 2013 we have made three state-specific recommendations covering five different state demonstrations. In each case, HHS disagreed with and has not implemented our recommendations.

Monitoring and Evaluating the Demonstrations: Finally, in our past work from the mid-2000's we recommended that HHS take certain actions to improve monitoring and evaluation in states' section 1115 demonstrations.[16] Specifically, we recommended that HHS ensure states develop rigorous evaluation designs and implement them by collecting and reporting the information needed for a full evaluation of the demonstration objectives. This recommendation was based on our review of demonstrations in four states that provided a prescription drug benefit to certain populations. In this review, we found that states had taken few steps toward implementing their evaluation plans, which were required as a condition of approval, and that HHS had not ensured that progress reports submitted by states contained sufficient information for monitoring whether the demonstrations were functioning as intended. HHS concurred with this recommendation at the time, but we closed this recommendation as unimplemented when the particular demonstration type was ended and no action had been taken.

7. **GAO's report entitled "Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives" raised concerns about overlap and duplication of programs funded under 1115 demonstrations with other federal funding. To what extent will GAO further review the extent of overlap and duplication resulting from 1115 demonstrations and CMS's actions to address the overlap and duplication in its annual reports on Duplication and Cost Savings?**

   In our next annual report on fragmentation, overlap, and duplication in the federal government, we plan to summarize our April 2015 report findings on approved expenditure authorities under section 1115 demonstrations and the gaps in the documentation with regard to how the approved spending would further Medicaid objectives and not duplicate other federal funding streams for similar purposes. We believe that if HHS were to take action to respond to our recommendations there is potential for significant federal cost savings.

8. **States using Medicaid managed care do not, all things being equal, have CMS approval to provide federal financial participation for state programs (at least for the managed care population) that are unrelated to health care or medical services. So, it seems to me that the use of managed care would prioritize federal dollars being spent *directly on care* or its related expenses, rather than lower-priority state programs which are, at best, only tangentially connected to Medicaid's objectives. Would you agree?**

   We would agree that, consistent with federal requirements, Medicaid payments under state plans should be used to finance Medicaid-covered items and services for eligible individuals, and that payments under section 1115 demonstrations should be used for services that help promote Medicaid objectives. In our review of recently approved section 1115 demonstrations, we found that expenditure authorities allowing states to claim federal matching funds for state programs were established separately from other authorities, including those allowing states to deliver services through managed care.

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

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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Minority (202) 225–3641

July 21, 2015

The Honorable Haley Barbour
BGR Group
601 Thirteenth Street, N.W.
Washington, D.C. 20005

Dear Governor Barbour:

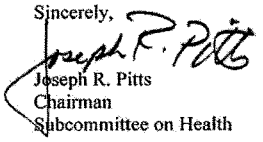
Thank you for appearing before the Subcommittee on Health on June 24, 2015, to testify at the hearing entitled "Examining the Administration's Approval of Medicaid Demonstration Projects."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on August 4, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

The Honorable Representative Pitts – Answers from Gov. Haley Barbour

1. For the first day of an extraordinary session in the Mississippi legislature, the cost for the Senate would be $20,753. For the House, the cost would be $44,783. That is a total of $65,535 for the full legislature, just for the first day. Each additional day of the special session in Mississippi would carry a total approximate cost of $44,000. I suspect a special session in Florida would be more expensive per day.

2. The Committee's hearing testimony from Matt Salo and the state Medicaid Directors is a good first step. The most important thing the Committee can do is to talk with Governors and state legislative leaders about what flexibility they need to best administer programs in their states. If Medicaid is truly going to be a state run program, states need more authority to tailor the program to their needs. Unfortunately, in recent years federal policy has been moving in the opposite direction. The federal CMS is no longer acting as a partner, but is pushing rigid dictates on the states without understanding the consequences of their unilateral requirements. Also, the Committee must clearly delineate the financial peril facing the Medicaid program at both the state and federal level. The current fiscal trajectory is simply unsustainable. Meaningful changes to Medicaid will not be realized until there is universal recognition of the actual fiscal challenges facing the program. People who care about the future viability of the program must accept that a continuation of the status quo will lead to the program's breaking down and jeopardizing care for the truly vulnerable.

The Honorable Representative Blackburn – Answer from Gov. Haley Barbour

1. Simply put, states should not be forced to pay for lottery winners to receive Medicaid benefits. However, this is just one more example of how excessive controls from the federal government are preventing states from instituting commonsense reforms. I believe that in general, there is too much reliance on 1115 waivers and the waiver process. The waiver process, especially as currently administered, provides too much control - and not enough transparency - to the federal CMS. There should be more state flexibility, without the subjective review of 1115 waivers by the CMS.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Majority (202) 225–2927
Minority (202) 225–3641

July 21, 2015

Mr. Matt Salo
Executive Director
National Association of Medicaid Directors
444 North Capitol Street
Washington, D.C. 20001

Dear Mr. Salo:

Thank you for appearing before the Subcommittee on Health on June 24, 2015, to testify at the hearing entitled "Examining the Administration's Approval of Medicaid Demonstration Projects."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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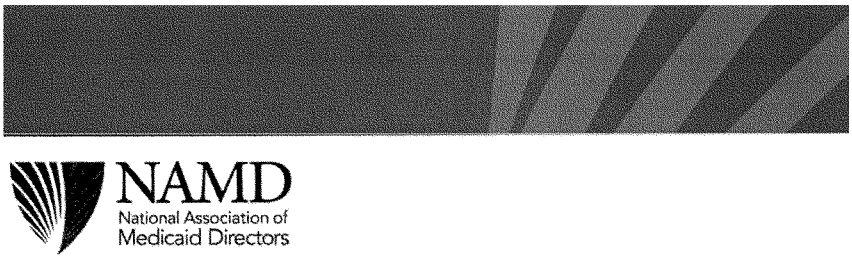
Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment



Responses of NAMD Executive Director Matt Salo to the House Energy and Commerce Committee Subcommittee on Health Questions for the Record

August 4, 2015

The Honorable Representative Pitts

In your testimony, you talk about a "path to permanency" for states that have been operating under an 1115 waiver for decades. I think this is a common-sense idea the Committee should explore. Have you given thought to what criteria would be needed for determining what states could be "grandfathered" in this manner?

The "pathway to permanency" concept is a means for the federal government to acknowledge the demonstrated successes of states in administering their Medicaid programs via alternative pathways under the 1115 waiver option. Depending on the state in question, these alternative pathways could be coverage expansions beyond the maximum federal poverty level (FPL) for certain eligibility groups, such as women and children, or they could be the fundamental model the state uses to deliver Medicaid services to the majority of its beneficiaries, such as statewide managed care. The overall goal of any pathway to permanency approach should be to recognize that the Medicaid statute as written 50 years ago does not reflect today's service needs nor the innovative approaches states are taking to meet those needs. This is the reason so many states utilize 1115 waivers, and is also why a permanent solution is needed to give states the certainty and stability they need to continue innovation and ensure existing innovations remain in place.

NAMD is pleased to see the Centers for Medicare and Medicaid Services (CMS) begin to acknowledge the viability of long-standing state innovations in the release of its informational bulletin on a "fast track" 1115 waiver renewal process, released on July 24, 2015. This bulletin outlines criteria under which existing 1115 waivers will be approved on an accelerated timeline comparable with the approval of state plan amendments or section 1915 waivers. These criteria include established demonstrations that have completed a full extension cycle without major changes and the waiver showing compliance with reporting of deliverables showing positive monitoring and evaluation results. However, this fast track approval process is not applicable to 1115 waivers that propose "major or complex changes," which include but are not limited to:

- Medicaid expansions tied to enhanced federal medical assistance percentage (FMAP);

- Delivery system reform, financing, and payment initiatives that cannot be authorized under state plan authority, including delivery system reform incentive payments (DSRIP);
- Demonstrations impacting dually eligible Medicare-Medicaid beneficiaries;
- Establishing home and community-based services (HCBS) programs;
- Demonstrations with caps on enrollment and eligibility limitations;
- Uncompensated care pools.

While we understand the rationale for CMS putting some of these restrictions in place to ensure sufficient federal oversight of the Medicaid program, we believe a true pathway to permanency will require more flexibility than what is allowed for under this fast track review policy. While this policy is a step in the right direction, the most innovative state approaches fall under the above-outlined "major or complex changes" which render them ineligible for expedited review. Unfortunately, this means these states' successful programs will not benefit from the policy and will continue to be subject to the full review process, which can be burdensome and inefficient for these states who should be held up as exemplars of innovation.

A true pathway to permanency must recognize that in many instances, states have met or exceeded the expectations embedded within the 1115 demonstration process. The fundamental criteria of an 1115 waiver is that the state's alternative model meets the objectives of the Medicaid program in a budget-neutral manner to the federal government. States that have operated a demonstration for multiple review cycles and have consistently demonstrated compliance and successful outcomes, regardless of the nature of that demonstration or the populations covered, should be eligible for expedited review of their waivers.

CMS could consider implementing a two-tiered expedited review process, applying its new "fast track" policy as formulated for demonstrations that do not address what the agency considers major or complex topics, and reserving a second expedited review policy for more innovative demonstrations which have been in place for two or more consecutive review cycles. This alternative review process should acknowledge that states which have operated demonstrations for this length of time and have been able to clear the full review and renewal process without difficulty have sufficiently demonstrated the viability of their demonstrations. Therefore, they should no longer be subject to the full review process and should not be expected to make the case for their innovations from scratch. This would free up badly needed administrative resources at both the state and federal level to focus on other aspects of the Medicaid program and give states the reassurance that their programs can continue operating into the future.

Furthermore, while much of the focus on permanency has revolved around the Section 1115 waiver authorities, there are a number of other waiver authorities that could be streamlined as well. Section 1915 of the Social Security Act allows for states to implement mandatory managed care (1915b) and home and community based alternatives to institutional care (1915c). Both of

these have been in place for more than 30 years and no longer represent deviations from the norm. We would therefore urge your consideration of statutory changes that would allow these types of approaches to become automatic components of the Medicaid state plan.

Today, Medicaid is the world's largest health insurance program and at the federal level the spending is on autopilot. Yet, you say in your testimony that simple accounting for Medicaid is extremely difficult, if not impossible. While I understand the shared federal-state nature of the program is challenging, surely you're not suggesting that benefits cannot be quantified, dollars cannot be tracked effectively, or that accountability is not needed. Can you please clarify and expound upon your point?

While it is the case that the Medicaid program has grown increasingly complex over its 50 year history and covers the sickest, frailest, and most medically complex patients in the country, NAMD does not mean to imply that this complexity belies the need for effective program oversight at either the federal or state level. We strongly believe in the need to ensure that Medicaid's taxpayer dollars are spent wisely and well. Medicaid Directors take their responsibilities for maintaining the Medicaid program's integrity and ensuring effective program outcomes extremely seriously, a responsibility that is shared by our federal partners at CMS. However, as states increasingly turn to new payment and delivery system approaches, such as bundled payments for episodes of care, value-based purchasing, and new capitation arrangements for managed care plans, the traditional oversight mechanisms called for by certain stakeholders like the Government Accountability Office (GAO) are not the most appropriate way to conduct oversight.

As Medicaid continues to innovate, the oversight mechanisms applicable to its innovations must themselves evolve. Medicaid's broad aims are to transition towards a healthcare system that rewards value, quality, and outcomes over volume of services delivered. Yet the type of oversight the GAO calls for does not reflect this objective or the reality of the Medicaid program today. GAO is constrained by a narrow interpretation of what constitutes federal budget neutrality. Its approach would stifle current and future innovation in the Medicaid program. Instead of focusing on this limited vision of oversight, Medicaid Directors and CMS understand that a more expansive and flexible standard is needed to verify effective program outcomes in areas as diverse as long-term care delivered in the community, complex behavioral health services delivered to person with serious mental illness, or services for the dually eligible coordinated with the Medicare program.

Indeed, the very purpose of the 1115 waiver program is to promote innovation, which inherently requires a different evaluative lens than the one applied to the traditional Medicaid program. The variation inherent in waivers across the nation's 56 Medicaid programs precludes a one-size-fits-all oversight approach of the type GAO believes appropriate. Instead, CMS correctly adopts waiver-specific evaluation plans which tailor oversight activities to the waiver's activities. While such an approach makes a high-level oversight review difficult to

conduct, it does not preclude effective and appropriate oversight of Medicaid waiver programs. It is precisely this type of approach that we encourage and support.

One frustration often voiced by State officials is the time it takes to negotiate and secure an 1115 waiver. For example, in Indiana, it took the governor 2 years to negotiate the waiver for HIP 2.0. What thoughts do you have about parameters Congress could put around the process to provide some certainty for states? What policy factors would we need to think through?

The length of time required to approve an 1115 waiver is often variable and at times extensive, an issue which arises in other aspects of the Medicaid program as well – most recently around the question of Medicaid managed care rate development approvals. We believe this is primarily due to the amount of information that is requested during these approvals and the relative scarcity of state administrative resources to furnish and analyze the requested data.

What would be most useful is for Congress to support enhanced administrative resources for the states. For example, many state administrative activities in Medicaid receive the minimum federal match of 50%. However, other high-priority activities, such as systems development, receive enhanced federal matches of 75% or even 90%. In times of budgetary constraints, Medicaid's administrative resources are often reduced, leaving fewer state staff on hand to oversee an increasingly complex program and conduct the analyses and negotiations necessary to see a waiver proposal approved. Providing states with the tools necessary to support their programmatic innovations with commensurate investments in administration would be a welcome step.

Though we appreciate the Committee's focus on the length of time waiver approvals can take, we do not believe a Congressionally-mandated deadline for waiver approvals is the correct direction to go in. Waivers are inherently complex and striking the right balance between innovation and oversight can be a delicate process. Finding the right balance among these priorities, and determining the length of time it takes to do so, is a function best left to CMS and the states.

We do agree, however, that the process can take far too long in many instances, and we should be doing more to encourage shorter turn-around timelines for approvals and renewals. Encouraging HHS to reduce unnecessary reporting, reviewing, and duplication could help achieve this goal without setting arbitrary time limits. States currently must deal with labor intensive applications and reviews, labor intensive reporting and report reviews, and labor intensive audits, much of which is not focused on our broad shared mission of improving beneficiary health outcomes. Reducing the complexity in the process can lead to greater accountability, which should be welcomed by all.

Congress can indicate its overall support for timely approvals of successful demonstrations in other states being translated to a different state, though even in these circumstances taking the

state's unique program and population into account would be better served by the enhanced administrative resources we call for above.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

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July 21, 2015

Ms. Joan Alker
Executive Director
Center for Children and Families
Georgetown University
3300 Whitehaven Street, N.W.
Washington, D.C. 20057

Dear Ms. Alker:

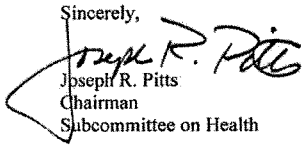
Thank you for appearing before the Subcommittee on Health on June 24, 2015, to testify at the hearing entitled "Examining the Administration's Approval of Medicaid Demonstration Projects."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on August 4, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

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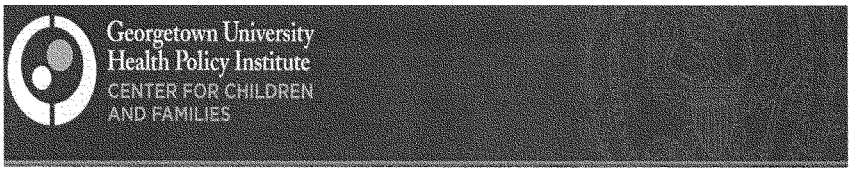

July 31, 2015

The Honorable Representative Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Chairman Pitts,

Thank you for the opportunity to testify before the Subcommittee on Health on June 24, 2015 at the hearing entitled "Examining the Administration's Approval of the Medicaid Demonstration Projects." Below are responses to the additional questions to be submitted for the record.

1. **Ms. Alker, can you talk about other ways the waiver has helped states move towards policies already being implemented at the federal level?**

   The early-expansion waiver in California was a key step in success of full ACA expansion in 2014. And it has been largely successful, getting many of the newly-covered population covered and allowing the state to now target its resources to enroll the harder-to-insure Americans. Our uninsured rate has dropped 50%-that is a huge accomplishment. Waivers are not just for getting ahead of larger program changes, they also spur innovation. When demonstration projects under the waivers are successful, the are then used as best practices for other states to follow. For instance, Iowa became the first state to offer supportive employment services to individuals with mental illness in 2007. I am proud that my home state of California followed Iowa's lead in our own waiver to ensure that individuals are empowered to be productive members of society.

   Throughout the history of the Medicaid program Section 1115 waivers have been used as a way to experiment with new approaches. There have been many examples of state innovation through Section 1115 demonstration projects that formed the basis of Congressional action to effectuate statutory changes. Indeed, covering adults without dependent children or a disability was a path pursued by a number of states (such as Tennessee, Massachusetts, Oregon and others) through waiver authority prior to the enactment of the Affordable Care Act.

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Another example is the Balanced Budget Act of 1997, which permitted states to move many groups of Medicaid beneficiaries into managed care without waiver authority after many states were doing this through waiver authority. I believe that it makes more sense for Congress to establish a state plan option for states on an approach for which there is policy consensus, rather than to enable fast track authority for waivers that may look similar. A state plan option is less burdensome for states and ensures that Congress is able to assess the appropriateness of using federal funds for new policy directions.

2. Ms. Alker, can you talk about how these demonstration projects are evaluated and then replicated in other states?

Section 1115 Research and Demonstration projects, in my view, should be subject to strict evaluation requirements before they are replicated. Unfortunately this has not always been the case. With the recent class of expansion waivers, CMS has put renewed energy and scrutiny to this category, which I believe is good. Often, however, evaluations commissioned by the state may not be truly independent and rigorous. For important policy developments – such as many of these expansion waivers such as Indiana, Iowa, and Arkansas -- I believe that every effort should be made to commission an external and independent evaluation at the federal level.

Thank you again for your time and consideration of these issues.

Sincerely,

Joan Alker
Executive Director
Georgetown University Center for Children and Families