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Ranking Member  
Committee on Finance  
United States Senate

The Honorable Fred Upton  
Chairman  
Committee on Energy and Commerce  
House of Representatives

### **Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns**

Section 1115 of the Social Security Act authorizes the Secretary of the Department of Health and Human Services (HHS) to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for demonstration projects that promote the objectives of the Medicaid program.<sup>1</sup> A significant and growing portion of federal Medicaid expenditures, which totaled \$265 billion in fiscal year 2013, is for care provided under section 1115 demonstrations, which allow states to test and evaluate new approaches for delivering and financing Medicaid services.<sup>2</sup> Under the Patient Protection and Affordable Care Act (PPACA),<sup>3</sup> states may opt to expand their Medicaid programs by covering adults with incomes at or below 133 percent of the federal poverty level (FPL) under their state plan.<sup>4</sup> In August 2013, Arkansas proposed an unprecedented alternative to this expansion under the authority of a section 1115 demonstration. In September 2013, HHS approved Arkansas's demonstration proposal to expand its program by allowing federal Medicaid funds to be used to provide premium assistance to enable newly eligible beneficiaries to purchase private insurance offered through the state's health insurance exchange.<sup>5</sup> This approved demonstration, for the

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<sup>1</sup>42 U.S.C. § 1315(a). The federal government and states share in the financing of Medicaid expenditures with the federal government matching most state expenditures for services on the basis of a statutory formula known as the Federal Medical Assistance Percentage (FMAP). The FMAP may range from 50 to 83 percent, which depends, in part, on a state's per capita income.

<sup>2</sup>In 2013, \$70 billion in federal funds, or about one-fourth of the \$265 billion in federal Medicaid expenditures, were for services, coverage initiatives, and delivery system redesigns provided under section 1115 demonstrations.

<sup>3</sup>Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA.

<sup>4</sup>Beginning in 2014, states may cover non-elderly, non-pregnant adults under their state plan with incomes at or below 133 percent of the FPL. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility for this population, which effectively increases this income level to 138 percent of the FPL. In this report, we refer to this population as "newly eligible beneficiaries."

<sup>5</sup>PPACA required the establishment of health insurance exchanges (hereafter referred to as exchanges)—also known as marketplaces—in all states. Through the exchanges, eligible individuals can compare and select private health plans, known as qualified health plans (QHPs). QHPs offered through the exchanges are required to meet certain benefit design, consumer protection, and other standards.

state of Arkansas, is the first of its kind testing the use of premium assistance in purchasing exchange coverage for a state's entire Medicaid expansion population. Subsequently, in December 2013, HHS approved another state's—Iowa's—demonstration to use premium assistance to purchase private insurance on its exchange for a more limited group of newly eligible beneficiaries. HHS has indicated that these demonstrations will help inform the planning and approval of future state demonstrations.<sup>6</sup>

HHS policy requires that section 1115 demonstrations be budget-neutral to the federal government; that is, the federal government should spend no more under a state's demonstration than it would have spent without the demonstration.<sup>7</sup> 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. The spending limit set by HHS is generally based on state projections of what the state's existing Medicaid program would have cost the federal government absent the demonstration.

You asked that we develop information about HHS's approval of the use of Medicaid funds to provide premium assistance to enable newly eligible beneficiaries to purchase coverage offered on the exchange in Arkansas and how HHS ensured the demonstration would not increase federal costs. For this report, we examined (1) what HHS approved under the Arkansas demonstration; (2) the extent to which HHS has ensured that the Arkansas demonstration is budget-neutral; and (3) the extent to which other states have approached HHS to seek information on or approval for implementing an approach similar to Arkansas.

To describe what HHS has approved under the Arkansas demonstration and assess the extent to which HHS ensured the budget neutrality of the demonstration, we reviewed the demonstration documentation, including the application and the budget neutrality analysis submitted by the state, HHS's approval letter, and HHS's special terms and conditions for approving the demonstration. We examined the basis of HHS's approved spending limit for the demonstration and determined whether it was based on expenditures that the state made, expenditures the state could have made but did not (i.e., hypothetical costs), or both. We then compared the spending limit approved by HHS with our estimates of the spending limit absent any hypothetical costs. We calculated our estimates using the historical expenditure data submitted by the state as the basis of its cost projection, state enrollment projections, and the growth rate approved by HHS for the demonstration.<sup>8</sup> For our analysis, we did not compare the underlying spending data used to develop the spending limit to source documentation on spending or determine whether the baseline expenditures included impermissible costs. To the extent baseline spending or projected enrollment were overstated or understated, our estimates of the spending limit could also be overstated or understated. We determined that the historical expenditure data were sufficiently reliable for the purpose of estimating the spending limit absent hypothetical costs. These data were submitted by the state and used by HHS to

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<sup>6</sup>Under PPACA, HHS may approve a new type of waiver, state innovation waivers, beginning in 2017. States may apply to waive certain federal requirements established under PPACA, including: the requirement to offer premium tax credits and cost-sharing reductions for coverage purchased through an exchange; the requirement for individuals to maintain coverage (known as the individual mandate); and the penalties imposed on employers whose employees purchase coverage through an exchange and receive premium tax credits. States may combine these waivers and section 1115 demonstrations by submitting a single application to HHS.

<sup>7</sup>Budget neutrality for Medicaid section 1115 demonstrations is not required under federal law or regulations.

<sup>8</sup>The historical expenditure data submitted by the state represented Medicaid expenditures for an adult population that the state determined to be similar to the newly eligible beneficiaries—certain low-income, non-disabled parents who were eligible under the state's traditional Medicaid program.

represent the baseline cost of what the state's existing Medicaid program would have cost absent the demonstration, prior to adjustments HHS allowed to account for expected costs under the demonstration. To supplement our review and analysis, we interviewed HHS officials about their approval of the demonstration, the basis for the spending limit for the Arkansas demonstration, and the steps taken to assess the reasonableness of the state's budget neutrality analysis. We also interviewed HHS officials about the extent to which other states had received HHS approval to demonstrate a similar approach to that of Arkansas—using Medicaid funds for premium assistance to purchase private coverage on exchanges for those newly eligible under PPACA—or were seeking or considering seeking HHS approval for such an approach. We did not assess other states' proposals or HHS's approval of other demonstrations.

We conducted this performance audit from April 2014 to August 2014 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.

## **Results in Brief**

In approving Arkansas's Medicaid Section 1115 demonstration, HHS allowed Arkansas to test whether using premium assistance to purchase coverage offered on the exchange will, among other things, improve access to care for individuals newly eligible under PPACA. Specifically, under the demonstration, HHS approved Arkansas to receive federal Medicaid funds to purchase private coverage offered on the exchange for individuals newly eligible for Medicaid and required the state to pay directly for any services covered under its traditional Medicaid program that are not covered by exchange plans.

In approving the demonstration, HHS did not ensure budget neutrality. Specifically, HHS approved a spending limit for the demonstration that was based, in part, on hypothetical costs—significantly higher payment amounts the state assumed it would have to make to providers if it expanded coverage under the traditional Medicaid program—without requesting any data to support the state's assumptions. We estimated that, by including these costs, the 3-year, nearly \$4.0 billion spending limit that HHS approved for the state's demonstration was approximately \$778 million more than what the spending limit would have been if it was based on the state's actual payment rates for services provided to adult beneficiaries under the traditional Medicaid program. In addition, HHS gave Arkansas the flexibility to adjust the spending limit if actual costs under the demonstration proved higher than expected, and HHS officials told us that the Department granted the same flexibility—one which HHS has not provided in the past—to 11 other states implementing demonstrations that affect services for newly eligible beneficiaries. Finally, HHS in effect waived its cost-effectiveness requirement that providing premium assistance to purchase individual coverage on the private market prove comparable to the cost of providing direct coverage under the state's Medicaid plan—further increasing the risk that the demonstration will not be budget-neutral.<sup>9</sup>

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<sup>9</sup>Under the demonstration, HHS provided the state with the authority to receive federal Medicaid funds for premium assistance and cost-sharing payments for newly eligible adults enrolling in plans through Arkansas' exchange under an expenditure authority. According to HHS officials, the purpose of this authority was to make the cost-effectiveness requirement not applicable to expenditures, thereby allowing the state to use its own tests of cost-effectiveness. For purposes of this report, we refer to the flexibility provided under this authority as a "waiver" of the cost effectiveness requirement.

As of June 2014, HHS had approved one additional state's—Iowa's—demonstration to use premium assistance to purchase exchange coverage. Iowa's demonstration is more limited in scope in that it covers only a portion of the expansion population, those with incomes of 101 percent to 133 percent of the FPL. As with its approval of the Arkansas demonstration, HHS gave Iowa the flexibility to adjust its spending limit and waived the cost-effectiveness requirement. According to HHS officials, as of June 2014, three other states had indicated an interest in implementing a similar approach.

We provided a draft of this report to HHS for comment, and HHS's comments are attached as enclosure I. In its written comments, HHS disagreed with our findings that HHS's budget neutrality policy and process did not ensure that the Arkansas demonstration will be budget-neutral. We maintain the validity of our findings. HHS also provided technical comments which we incorporated as appropriate.

## **Background**

For many years, section 1115 demonstrations offered the only avenue for states to provide Medicaid coverage to otherwise ineligible childless adults. Although states have flexibility under their traditional programs to, among other things, establish provider payment rates and cover many types of optional benefits and populations, demonstrations provide a way for states to innovate outside of many of Medicaid's otherwise applicable requirements.<sup>10</sup> For example, states may test ways to obtain savings or efficiencies in how services are delivered in order to cover otherwise ineligible populations.

HHS policy requires that section 1115 demonstrations be budget-neutral to the federal government. According to HHS policy, the spending limits for demonstrations are to be based on the projected cost of continuing states' existing Medicaid programs without a demonstration. The higher these projected costs, the higher the spending limit, and the more federal funding states are potentially eligible to receive for the demonstration, in the form of a federal match on their actual expenditures. The spending limits can be either an annual per-person limit or an aggregate spending limit that remains fixed for the entire length of the demonstration, or a combination of both. Spending limits for demonstrations are calculated by establishing a spending base and applying a rate of growth over the period of the demonstration. The spending base generally reflects a recent year of state expenditures for populations included in the demonstration.

PPACA authorizes states to expand Medicaid coverage to adults with incomes up to 133 percent of the FPL, and provides enhanced federal funding for these newly eligible beneficiaries. Specifically, states are to receive an increased federal match for newly eligible individuals at 100 percent for 2014 through 2016.<sup>11</sup> For new populations, such as those newly eligible under PPACA, demonstration spending limits are based on state projections of cost for the population, which are developed using historical spending data. According to HHS policy, states must provide a justification for the projections, including a description of the data sources and methodology used for their estimates.

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<sup>10</sup>States establish Medicaid payment rates to providers, subject to certain federal requirements. For example, under federal law, payments to providers must be economical, efficient, and made at a level that ensures access to care comparable to those not in the Medicaid program in the same geographic area. See 42 U.S.C. § 1396a(a)(30)(A).

<sup>11</sup>42 U.S.C. § 1396d(y).

Federal law allows states to require Medicaid beneficiaries to enroll in employer-sponsored insurance and use federal Medicaid funds to provide premium assistance for this coverage, provided that such premium assistance is cost-effective.<sup>12</sup> A number of states have used this authority to provide premium assistance for Medicaid beneficiaries enrolled in employer-sponsored coverage. States, however, may also receive federal Medicaid funds to provide premium assistance to Medicaid beneficiaries who voluntarily purchase private coverage on the individual market, which includes enrollment in qualified health plans (QHPs) offered through the exchanges. States must meet certain requirements to offer this assistance, including ensuring that premium assistance is cost-effective, hereafter referred to as the cost-effectiveness requirement. Specifically, HHS requires that the total cost of purchasing private insurance coverage must be comparable to the cost of providing direct coverage under the state's Medicaid plan.<sup>13</sup>

We have had long-standing concerns with HHS's policy, process, and criteria for reviewing and approving section 1115 demonstrations, including the lack of transparency in the basis for approved spending limits.<sup>14</sup> We have previously reported that HHS's budget neutrality policy and process did not provide assurances that demonstrations would be budget-neutral to the federal government. Among other concerns, we reported that HHS allows methods for establishing the spending limit that we believe are inappropriate, such as allowing states to include hypothetical costs—expenditures that the state could have made under its Medicaid program but did not—in establishing the baseline for the spending limits. As a result of these findings, we made recommendations to HHS to improve the budget neutrality process and reexamine spending limits.<sup>15</sup> HHS disagreed with our recommendations and, as of June 2014, HHS has not addressed these issues. In 2008, because HHS disagreed that changes to the budget neutrality policy and review process were needed, we suggested that Congress consider requiring the Secretary of HHS to improve the demonstration review process by, for example, better ensuring that valid methods are used to demonstrate budget neutrality and documenting and making public the basis for such approvals.

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<sup>12</sup>42 U.S.C. § 1396e.

<sup>13</sup>In June 2013, HHS issued regulations clarifying, among other things, that states may receive federal Medicaid funds for premium assistance to purchase coverage on the individual market under their traditional Medicaid program and that such coverage must be cost-effective. HHS defined the total cost of coverage as the cost of premiums and cost sharing, administrative costs and the cost to the state of providing Medicaid benefits not covered by the individual health plan. 42 C.F.R. § 435.1015(a)(4). According to HHS, this cost-effectiveness requirement is applied on an annual basis. HHS officials also told us that states have some flexibility in how to construct a cost-effectiveness calculation and these calculations have generally been done on an annual, one-year (versus multi-year) basis.

<sup>14</sup>See 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); *Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern*, [GAO-07-694R](#) (Washington, D.C.: July 24, 2007); *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, [GAO-08-87](#) (Washington, D.C.: Jan. 31, 2008); and *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, [GAO-13-384](#) (Washington, D.C.: June 25, 2013).

<sup>15</sup>Specifically, we recommended that HHS reconsider its approved spending limits for demonstrations in various states including Arizona, Florida, Illinois, South Carolina, Texas, and Wisconsin.

## **HHS Approved Arkansas's Demonstration to Expand Medicaid to Low-Income Adults through Premium Assistance for Private Health Coverage Purchased through the Exchange**

In September 2013, HHS approved Arkansas's demonstration, giving the state the authority to provide health insurance coverage to adults newly eligible for Medicaid under PPACA outside of the traditional fee-for-service (FFS) Medicaid model, in which health care providers are paid directly by the Medicaid program for each service provided. Under HHS's terms for the approved demonstration, which runs from 2014 through 2016, newly eligible adults, including adults with incomes between 0 and 133 percent of FPL,<sup>16</sup> are to shop for coverage offered on the exchange through the state's web-based portal and select a QHP. The QHP is to issue the insurance card and the state is to pay the premium directly to the QHP on behalf of the individual. In the event that an individual does not select a QHP, the state is to automatically assign one. Arkansas estimated that 200,000 adults would enroll under the demonstration. Enrollment in QHPs began on October 1, 2013, with eligibility effective January 1, 2014.

Under the approved demonstration, the demonstration population is eligible for the same benefit package as outlined in the state's alternative benefit plan, which has a more limited set of benefits than the traditional Medicaid benefit package but a more generous set than is required of QHPs.<sup>17</sup> Under the terms of the approved demonstration, services that are covered under the state's alternative benefit plan but not in the QHP package, known as wrap-around benefits, are to be provided through the state's Medicaid FFS program.<sup>18</sup> Cost-sharing under the demonstration would also be the same as is detailed in the state's Medicaid plan. For individuals in the demonstration population, enrollment in a QHP is mandatory, and a choice between at least two QHPs is guaranteed under the terms of the demonstration. All expenditures under the demonstration are to be financed by the federal government because the demonstration population is eligible for enhanced federal matching funds under PPACA—100 percent in the 3 years of the demonstration.

According to the state's application, the demonstration was designed to address two potential access issues facing the newly eligible population: continuity of coverage and access to care. The state projected that the newly eligible adults would likely have frequent income fluctuations that would lead to changes in eligibility for the different affordable coverage options—Medicaid or advanced premium tax credits and cost sharing reductions available to subsidize coverage

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<sup>16</sup>Eligible adults include childless adults between ages 19 through 64 and with incomes between 0 to 133 percent of FPL, and parents between the ages of 19 through 64 with incomes between 17 percent and 133 percent of FPL. Parents with incomes under 17 percent of the FPL are covered under the state's traditional Medicaid program. The demonstration excludes those deemed to be medically frail. In addition, American Indians and Alaska Natives are excluded from the demonstration unless they elect to be included.

<sup>17</sup>Federal law permits states to seek approval to provide certain groups of Medicaid beneficiaries with alternative benefit plan coverage, under which the benefits must be equivalent to statutorily specified benchmark coverage through their traditional Medicaid program. In general, alternative benefit plan coverage may be more limited than traditional Medicaid coverage but more generous than QHPs. For example, although alternative benefit packages may not cover all the services that are covered under traditional Medicaid, they must cover certain types of services such as family planning, benefits that QHPs are not required to offer.

<sup>18</sup>These services include non-emergency medical transportation, out-of-network family planning, and, for those under the age of 21, early periodic screening diagnosis and treatment services.

purchased through exchanges.<sup>19</sup> These eligibility changes could result in coverage gaps and changes in benefits, provider networks, premiums, and cost-sharing. Under the demonstration, individuals could stay enrolled in the same QHP regardless of whether their coverage is financed through Medicaid or federal subsidies. In addition to maintaining continuity of coverage, the state's application proposed that the demonstration would provide better access to care than the traditional Medicaid program. According to the state's proposal, the state's existing network of Medicaid FFS providers was at capacity. By purchasing QHP coverage for newly eligible beneficiaries, the state suggested it could improve access to care because beneficiaries would have access to expanded provider networks through their QHPs.

As a condition of HHS's approval, the state is required to evaluate the demonstration, including whether it maintains or improves access for the demonstration population.<sup>20</sup> HHS approved Arkansas's evaluation plan in March 2014 and, according to the plan, the state will be evaluating whether the demonstration population has equal or better access to health care and better continuity of coverage than what they would have had under Medicaid FFS. The evaluation plan does not include measures that assess whether the demonstration will affect access for those in the FFS program. However, according to HHS officials, the FFS Medicaid population is included as a comparison group in the evaluation and a pre-demonstration baseline will be established for the group. Thus, HHS officials indicated that through the use of this data and ongoing monitoring, they would be able to identify any declines in access. Arkansas is required to submit the first set of results from the evaluation in March 2016.

### **HHS's Approval of the Arkansas Demonstration Did Not Ensure Budget Neutrality as the Demonstration Will Likely Raise Federal Costs, and Raises New Concern About HHS's Approval Process**

In approving the spending limit for the Arkansas demonstration, HHS did not ensure budget neutrality. HHS approved a spending limit that included hypothetical costs despite questionable state assumptions and limited supporting documentation. Specifically, Arkansas's projections of the cost of expanding Medicaid without the demonstration assumed the state would have had to pay its Medicaid providers rates comparable to private insurance payment rates—significantly higher rates than the rates the state was paying its FFS providers—to ensure access for newly eligible beneficiaries. For example, the state assumed that it would have to pay 67 percent above its FFS payment rate for primary care services and, for higher-cost services, such as inpatient and long-term care services, the state assumed it would have to pay 10 percent more. HHS approving officials told us that they thought the state's underlying concern about the insufficient capacity of the state's Medicaid provider network was valid given a projected 25 percent increase in the number of individuals covered under the state's Medicaid program. HHS officials did not request data to support the state's assertion. In addition, HHS officials told us they accepted the state's projection of the increased cost of expanding Medicaid in the absence of a demonstration without requesting data to support the state's assumptions about

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<sup>19</sup>PPACA provides subsidies for certain individuals enrolled in QHPs. Specifically, qualifying individuals and families with income between 100 percent and 400 percent of the FPL are eligible for premium tax credits, and individuals and families with income between 100 and 250 percent of the FPL are eligible for cost-sharing reductions. To qualify for these income-based financial subsidies, individuals must also meet certain criteria, which include not being eligible for other health insurance coverage such as Medicaid.

<sup>20</sup>Specifically, HHS listed a number of hypotheses for the state to consider evaluating, including that the demonstration population will have: (1) equal or better access to care, including primary care and specialty physician networks and services; (2) equal or better access to preventive care services; (3) lower non-emergent use of emergency room services; (4) fewer gaps in insurance coverage; and (5) continuous access to the same health plans and to providers.

specific payment increases.<sup>21</sup> HHS officials did request that CMS's Office of the Actuary (OACT) review the state's projections.<sup>22</sup> An OACT official told us that OACT questioned the reasonableness of the state's assumptions about the higher payment rates, including questioning the projected payment rates for physician, hospital, and pharmacy services. The OACT official told us they would have needed additional information from the state beyond what was provided in order to assess the validity of the assumptions. HHS program officials confirmed that they did not request further information from the state. They explained that, in assessing budget neutrality, they generally do not request or assess the data that drives state assumptions beyond the extent done in this case. We estimate that by including the costs associated with the hypothetical provider payment rate increases, the \$4.0 billion spending limit approved by HHS was about \$778 million more than what it would have been if based on the rates Arkansas was actually paying providers for services provided to adult beneficiaries under the traditional Medicaid FFS program.<sup>23</sup>

Furthermore, HHS gave Arkansas the flexibility to adjust the approved spending limit if costs, once the demonstration is underway, prove higher than expected. To make such an adjustment, the state is required to submit for HHS's review actual expenditure data for the demonstration that would justify such an adjustment.<sup>24</sup> Officials said that they have included the same flexibility to adjust the spending limit—a flexibility that has not been granted for demonstrations in the past—for 11 other state demonstrations that affect services for newly eligible beneficiaries, citing the lack of data on the potential cost of the expansion population when setting the spending limit for these demonstrations.<sup>25</sup> HHS officials told us that this flexibility to adjust budget neutrality projections without having to amend the terms and conditions of the demonstration has not been provided for demonstrations outside those related to Medicaid expansion. Typically, under demonstration budget neutrality agreements, the state must either seek an amendment requesting a revised budget neutrality calculation because of changes in circumstance, or bear the risk of costs being higher than projected. The flexibility to adjust the spending limit increases the risk to the federal government. Officials confirmed that HHS has no documented criteria for approving such an adjustment but told us that approval for such an adjustment would factor in a review of actual expenditure data and that such adjustments would be documented and made public. HHS officials told us that neither Arkansas nor any of the other 11 states had requested an adjustment to demonstration spending limits as of June 2014.

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<sup>21</sup>According to HHS officials, a key consideration of their review was that the demonstration is intended to test the value of the investment and that a rigorous evaluation is required.

<sup>22</sup>According to HHS officials, typically, OACT does not participate formally in the review of state budget neutrality calculations for section 1115 demonstrations. Officials characterized OACT's review of Arkansas' cost projections as an informal review.

<sup>23</sup>In projecting costs of covering the demonstration population under the traditional FFS program, Arkansas used expenditure data for low-income, non-disabled adults with children who were previously eligible to establish baseline spending. The data established a base unit cost for the various types of services that would be covered under the demonstration. The state then adjusted those unit costs to reflect the assumed higher payment rates, and HHS used the adjusted costs for the basis of the spending limit. We estimated the magnitude of Arkansas' hypothetical costs by calculating an estimate of what the spending limit would have been based on the state's unadjusted base costs—which reflect what providers were paid historically for the comparison proxy population—and comparing it with HHS's approved spending limit, which was developed using the state's adjusted costs.

<sup>24</sup>For each calendar year of the demonstration, the state must submit documentation to support an adjustment of the spending limit by October 1 of the preceding year.

<sup>25</sup>The 11 states are Arizona, California, Iowa, Massachusetts, Michigan, New Jersey, New Mexico, New York, Oregon, Rhode Island, and Vermont.



Finally, HHS waived the requirement that premium assistance to purchase coverage on the individual market be cost-effective, further increasing the risk that the demonstration will not be budget-neutral. Rather than apply HHS's test of cost-effectiveness—that the cost of purchasing coverage be comparable to the cost of providing direct coverage under Medicaid—HHS allowed Arkansas to apply a state-developed test of cost-effectiveness. HHS officials told us that under the state's test, the demonstration could cost more than the costs of providing coverage in the state's Medicaid FFS system and still be deemed cost-effective by HHS. Specifically, under HHS's terms, Arkansas's test of cost-effectiveness is expected to factor in the results of the full 3 years of the demonstration and to account for the value of other impacts such as gains in continuity of coverage and improvements in service delivery and health outcomes. HHS officials said that the rationale for permitting an alternative test of cost-effectiveness was to capture the cost implications of certain qualitative effects of the demonstration such as reduced "churn"—that is, the disruption that would be caused by the fluctuation in beneficiary eligibility—in the insurance marketplace.

### **One State Has Received HHS's Approval to Implement a Similar Demonstration, and Several Other States Have Indicated an Interest in Doing So**

As of June 2014, HHS has granted approval to one state—Iowa—to implement a demonstration using an approach similar to that of Arkansas's for a more limited population and has provided similar spending flexibility. Iowa received approval from HHS in December 2013 for a 3-year demonstration that runs from 2014 through 2016, under which the state will use premium assistance to purchase insurance on the state's exchange for newly eligible Medicaid beneficiaries who have incomes between 101 and 133 percent of the FPL, a smaller portion of the Medicaid expansion population than was included in the Arkansas demonstration.<sup>26</sup> As it did in the Arkansas demonstration, HHS, in effect, waived the cost-effectiveness requirement for using premium assistance to purchase coverage on the individual market and, as noted earlier, gave Iowa the flexibility to adjust the spending limit for the demonstration if costs proved higher than expected.

In addition to Arkansas and Iowa, HHS officials told us that three other states have indicated interest in using premium assistance to purchase coverage offered on the exchanges in their states to expand their Medicaid programs. Officials told us that, as of June 2014, Pennsylvania had a pending application for a demonstration that included an approach of using premium assistance to purchase exchange coverage as one of its options for expanding Medicaid. According to officials, during the review process the state decided against this approach and directed its efforts toward a different model of providing private coverage. In addition to Pennsylvania, HHS officials told us that as of June 2014, two other states—New Hampshire and Utah—have shown some indication of pursuing a similar approach but have not submitted a demonstration application.

### **Concluding Observations**

Section 1115 demonstrations have long been an important tool to test new approaches to improve states' Medicaid programs. Arkansas's demonstration may prove an important test of whether using Medicaid funds to finance coverage offered through exchanges will improve access to care and continuity of coverage for the adult population that the demonstration aims to cover. However, the increasing use of demonstrations has shifted a significant portion of

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<sup>26</sup>Individuals in Iowa with incomes below the 100 percent FPL threshold will receive direct coverage through a newly created state-administered Medicaid managed care plan.

federal Medicaid funds into financing care that is not subject to all of the federal Medicaid requirements. While HHS policy requires that demonstrations be budget-neutral and therefore not increase the costs to the federal government, we have had long-standing concerns about the Department's ability to ensure budget neutrality given HHS's flexible approach towards approving spending for new demonstrations. These concerns have centered around how HHS allows states to use questionable methods and assumptions when developing cost projections that serve as the basis for demonstration spending limits, without providing adequate documentation to support these projections. We have made a number of recommendations in the past to improve the budget neutrality process for Medicaid demonstrations generally and reexamine spending limits for specific demonstrations. However, HHS has disagreed with those recommendations and has continued to use a process that lacks criteria and transparency and allows spending limits to include inappropriate costs. In 2008, because HHS disagreed that changes to the budget neutrality policy and review process were needed, we suggested that Congress consider requiring increased attention to fiscal responsibility in the approval of section 1115 demonstrations. Specifically, we suggested that Congress require the Secretary of HHS to improve the demonstration review process by, for example, better ensuring that valid methods are used to demonstrate budget neutrality and documenting and making public the basis for such approvals.

HHS's approval of \$778 million dollars of hypothetical costs in the Arkansas demonstration spending limit and the department's waiver of its cost-effectiveness requirement is further evidence of our long-standing concerns that HHS is approving demonstrations that may not be budget-neutral. HHS's approval of the Arkansas demonstration suggests that the Secretary may continue to approve section 1115 Medicaid demonstrations that raise federal costs, inconsistent with the Department's policy of budget neutrality. Moreover, the additional flexibility granted to Arkansas and 11 other states to increase the spending limit if costs prove higher than expected sets another precedent, further eroding the integrity of HHS's process. If, as it did with Arkansas, HHS allows states to use an approach to expanding Medicaid that is expected to cost more than expansion under the existing Medicaid program with fewer cost controls in place, there could be significant cost implications for the federal government. Efforts to ensure cost-effectiveness and budget neutrality in Medicaid expansion demonstrations have even greater fiscal implications given that states that choose to do so will receive enhanced federal funding for the newly eligible population.

### **Agency Comments and Our Evaluation**

We provided a draft of this report to HHS for comment. In its written comments, HHS disagreed with our findings that HHS's budget neutrality policy and process did not ensure that the Arkansas demonstration will be budget-neutral. Specifically, HHS disagreed with GAO's conclusion that HHS continues to allow states to use questionable methods and assumptions when developing cost projections that serve as the basis for demonstration spending limits without adequate documentation to support these projections. HHS stated that Arkansas provided an explanation of how the demonstration would achieve budget neutrality and the data to support its rationale. As noted in this report, we reviewed Arkansas's budget neutrality explanation as provided to HHS, and we found that the state's assumptions that the state would pay Medicaid providers significantly higher rates in the absence of the demonstration were questionable and supporting documentation was limited.

HHS also disagreed with our finding that HHS approved a spending limit that did not ensure budget neutrality because it included approximately \$778 million in hypothetical costs. HHS said that our estimate relied on a subset of the data HHS used to assess and determine the

spending limit and did not account for major program changes as a result of the expansion of Medicaid. In conducting our analysis, we reviewed all the data and information that HHS officials reviewed in developing the spending limit. In estimating the spending limit, we did not factor in questionable assumptions about provider payment rates, and we based our estimate on the historical expenditure data provided by Arkansas, which we believe is the appropriate subset of data for developing such an estimate. HHS also stated that our reading of the budget neutrality policy did not appropriately account for major program changes as a result of the expansion of Medicaid created by PPACA, and stated that in approving the new spending limit, they took into account market prices for similar populations. We continue to believe that a budget neutrality policy that allows for hypothetical costs based on assumptions that higher spending is allowed under Medicaid or, in this case, is necessary to ensure access, is flawed without sound supporting evidence. In our view, if the state was not paying these costs before the demonstration, these costs should not be approved under demonstration spending limits without strong evidence supporting the deviation from HHS's policy of relying on state historical spending for projecting future costs.

With regard to our finding that HHS, in effect, waived its cost-effectiveness requirement, HHS noted that it allowed the state to apply its own cost-effectiveness test to allow for a more expansive cost-benefit analysis than would be captured under the Department's test. As we acknowledge in our report, this demonstration may prove an important test of the benefits of using Medicaid to finance coverage offered on the exchanges. However, under the state's test the demonstration could cost more than the costs of providing coverage through the state's traditional Medicaid program, further increasing the risk that the demonstration will not be budget-neutral.

HHS comments are reproduced in enclosure I. HHS also provided technical comments, which we incorporated as appropriate.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services, appropriate congressional committees, and other interested parties. The correspondence is also available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this correspondence. Other key contributors to this correspondence included Susan Barnidge, Assistant Director; Jasleen Modi, Laurie Pachter, and Hemi Tewarson.



Katherine M. Iritani  
Director, Health Care

Enclosure

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

JUL 22 2014

Katherine Iritani  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid Demonstrations: HHS Approval Process for Arkansas' Medicaid Expansion Waiver Raises Cost Concerns" (GAO-14-689R).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink, reading "Jim R. Esquea", is positioned above the printed name and title.

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID DEMONSTRATIONS: HHS APPROVAL PROCESS FOR ARKANSAS' MEDICAID EXPANSION WAIVER RAISES COST CONCERNS (GAO-14-689R)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. Although GAO is not making any recommendations in this report, HHS would like to clarify a few points that may be misleading.

The Government Accountability Office (GAO) concluded that HHS allows states to use questionable methods and assumptions when developing cost projections that serve as the basis for demonstration spending limits without providing adequate documentation to support these projections. HHS disagrees as, consistent with our policy that budget neutrality calculations should be based on the best available data, the state provided an explanation of how the demonstration program will achieve budget neutrality and the data to support its rationale. The state used assumptions and projected costs that CMS determined were comparable to other states' estimates. These estimates were based on analysis of the impact of a dramatic and unique increase in adult Medicaid enrollment.

Further, GAO concluded that HHS disagrees with GAO's previous recommendations regarding changing the budget neutrality process and has continued to use a process that lacks criteria and transparency and allows spending limits to include inappropriate costs. GAO suggests the Arkansas approval is further evidence of GAO's long-standing concerns that HHS is approving demonstrations that may not be budget neutral, and suggests that the Secretary may continue to approve demonstrations that raise federal costs; including the additional flexibility granted to Arkansas and 11 other states to increase the spending limit if costs prove higher than expected.

HHS does not concur with GAO's suggestion that the process lacks criteria, transparency and includes inappropriate costs. As is explained in more detail below, CMS's calculation of these state's spending limits were based on the most reasonable and documented cost assumptions available regarding the interventions being operationalized under the demonstration.

HHS disagrees with GAO's assertion that HHS's budget neutrality policy and process do not assure that the Arkansas demonstration will be budget neutral. GAO estimates that HHS approved "approximately \$778 million more than what the spending limit would have been if it was based on the state's actual payment rates for services provided to adult beneficiaries under the traditional Medicaid program." This conclusion is inaccurate. GAO used only a subset of the data that CMS uses to assess and determine the appropriate estimates used in developing a budget neutrality model that corresponds with the state's proposed program intervention. GAO also relied on a very narrow reading of HHS budget neutrality policy that does not account for major program changes as a result of the expansion of Medicaid created by the Affordable Care Act.

HHS policy is that, in determining what expenditures would have been without a demonstration, we use the best available information; generally, that means the state's historical spending. However, because Arkansas sought to cover the new Medicaid eligibility group via a new benefit

package, we took into account market prices for similar populations. As GAO notes, “Arkansas used expenditure data for low-income non-disabled adults with children who were previously eligible to establish baseline spending. The data established a base unit cost for the various types of services that would be covered under the demonstration.” As the report further notes, budget neutrality calculations set only the upper limits on the federal funds available to states under the demonstration; in order to claim federal matching funds, states must have actual expenditures that are permissible under the terms of the demonstration.

Finally, regarding the cost-effectiveness test, as the report also notes, HHS allowed for the state to develop its own test to account for the value of factors such as gains in continuity of coverage and improvement in service delivery and health outcomes. This cost-benefit analysis process will yield valuable data applicable not only for this demonstration but also more broadly in terms of Medicaid policy. The state plan regulatory cost effectiveness test is a cost to cost comparison in a given year that does not contemplate the potential benefits of a premium assistance model such as the one Arkansas is pursuing that can be measured in a formally evaluated demonstration. The alternative approved for Arkansas, recognizing that a demonstration allows for more expansive cost-benefit analysis than a State Plan Amendment premium assistance program, allows for cost effectiveness to be studied over a longer period of time and includes previously unquantified factors. HHS will consider states’ ideas on cost effectiveness that include new factors introduced by the creation of Health Insurance Marketplaces and the expansion of Medicaid. For example, Arkansas may quantify savings from reduced churning (people moving between Medicaid and Exchanges as a result of fluctuating incomes), improvements in care and in health from reduced fragmentation and access to different providers, and increased competition in Marketplaces given the additional enrollees due to premium assistance. The evaluation of the demonstration will include specific analyses on the benefits produced by the model, which can then be examined in light of the cost of the demonstration.

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