

January 2008

**MEDICAID  
DEMONSTRATION  
WAIVERS**

**Recent HHS  
Approvals Continue to  
Raise Cost and  
Oversight Concerns**





Highlights of [GAO-08-87](#), a report to congressional requesters

## Why GAO Did This Study

Medicaid, a joint federal and state program, finances health care for 60 million low-income people. Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow demonstration projects that are likely to promote Medicaid objectives. Under federal policy, states must show that federal spending for proposed demonstrations will be no greater than if the state's existing Medicaid program were continued.

GAO examined the extent to which HHS ensured that recent comprehensive 1115 demonstrations—affecting a broad range of services for beneficiaries statewide—will (1) be budget neutral to the federal government and (2) maintain Medicaid's fiscal integrity. For demonstrations approved in 2005 (Florida and Vermont), GAO obtained information from federal and state officials and also relied on past reviews of other demonstrations.

## What GAO Recommends

GAO recommends that the Congress consider (1) requiring HHS to improve the demonstration review and approval process and (2) addressing HHS's authority to approve demonstrations such as Vermont's. GAO recommends that HHS reexamine Florida's spending limit. In its comments, HHS stated that its process was sufficient. GAO believes that the limit allows spending that should not be allowed.

To view the full product, including the scope and methodology, click on [GAO-08-87](#). For more information, contact Marjorie Kanof at (202) 512-7114 or [kanofm@gao.gov](mailto:kanofm@gao.gov).

# MEDICAID DEMONSTRATION WAIVERS

## Recent HHS Approvals Continue to Raise Cost and Oversight Concerns

### What GAO Found

HHS did not adequately ensure that Florida's and Vermont's Medicaid demonstrations will be budget neutral to the federal government before approving them. HHS approved spending limits that were higher than the limits that would have been granted if HHS had held the states to limits based on benchmark growth rates, that is, the lower of the state's historical spending growth or nationwide estimates of Medicaid growth. Although HHS allows states to deviate from these benchmarks if states can show that using them would not provide accurate projections, HHS's basis for approving the higher spending limits was not fully supported by documentation. In Florida, HHS approved a \$52.6 billion spending limit for the 5 year demonstration—\$6.9 billion more than the documentation supported. In Vermont, HHS approved a \$4.7 billion spending limit—\$246 million higher than supported.

HHS also did not ensure that the two demonstrations maintain Medicaid's fiscal integrity. In Florida, HHS allowed the state to establish a spending limit using a historical spending base that included payments HHS had previously identified as problematic. In 2005, an HHS review found several problems with the payment arrangement—problems that potentially resulted in inflated and inaccurate payments. In Vermont, where the state proposed operating a managed care organization, HHS agreed to an administrative reimbursement rate higher than what the state received prior to the demonstration. Under this arrangement, the state can use excess revenues to pay for health-related programs that were previously funded by the state and that do not exclusively benefit Medicaid beneficiaries, such as a grant to the University of Vermont medical school. A July 2007 GAO letter to the Secretary discussed concerns about this approval's consistency with federal law and recommended that the Secretary reexamine Vermont's demonstration and, where appropriate, either modify its terms or seek statutory authority for it to continue in its current form.

Concerns about HHS's demonstration approval process in this report are consistent with those GAO has raised in past reviews of other states' demonstration proposals. In 2002 and 2004, GAO recommended that HHS take steps to strengthen its fiscal oversight of Medicaid by improving the Medicaid demonstration review and approval process, in part by (1) clarifying criteria for reviewing and approving states' demonstration spending limits, (2) better ensuring that valid methods are used to demonstrate budget neutrality and (3) documenting and making public material explaining the basis for any approvals. HHS has not taken action on these recommendations and maintains that its process is sufficient. Because HHS continues to disagree with these recommendations and with the need to reexamine the Vermont demonstration, GAO is elevating these issues to the Congress for consideration.

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## Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
HIFA	Health Insurance Flexibility and Accountability
OMB	Office of Management and Budget
PAS	Provider Access System
SCHIP	State Children’s Health Insurance Program
UPL	Upper Payment Limit

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United States Government Accountability Office  
Washington, DC 20548

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January 31, 2008

The Honorable Henry A. Waxman  
Chairman  
Committee on Oversight and Government Reform  
House of Representatives

The Honorable John D. Dingell  
Chairman  
Committee on Energy and Commerce  
House of Representatives

The Honorable Frank J. Pallone, Jr.  
Chairman  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

The Honorable Sherrod Brown  
United States Senate

Medicaid is a federal-state program that finances health care services for about 60 million low-income individuals, including children and aged or disabled adults. Established in 1965 under title XIX of the Social Security Act, Medicaid consists of more than 50 distinct state-based programs that cost the federal government and states an estimated \$317 billion in fiscal year 2005.<sup>1</sup> Each state administers its Medicaid program within federal requirements established in statute and regulations, and the federal government shares in the cost of each state's program by paying an established share of reported expenditures.<sup>2</sup> Under section 1115 of the Social Security Act, however, the Secretary of Health and Human Services may waive certain federal requirements for demonstrations that the

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<sup>1</sup>Each of the 50 states and the District of Columbia, Puerto Rico, and four U.S. territories have Medicaid programs.

<sup>2</sup>Under federal law, the states and federal government share in Medicaid expenditures according to a formula that provides a more generous federal match for states in which per capita income is lower. See Social Security Act § 1905(b) (codified, as amended, at 42 U.S.C. § 1396d(b) (2000)).

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Secretary deems likely to promote Medicaid objectives—allowing states to test and evaluate new approaches for delivering Medicaid services.

In the early 1980s, the Department of Health and Human Services (HHS)<sup>3</sup> adopted a policy that required states to document that their proposed demonstrations would be budget neutral<sup>4</sup> to the federal government, that is, the federal government will spend no more with the demonstrations than without them. Each demonstration operates under a negotiated budget neutrality agreement that places limits on federal Medicaid spending over the life of the demonstration. A spending limit governing a demonstration is based on the projected costs of the existing Medicaid program without the demonstration. States estimate the cost of continuing their existing Medicaid programs by projecting growth in per person costs and beneficiary enrollment over the 5-year standard demonstration period. HHS policy guidance states that spending limits are based on estimates of growth (growth rates) that are the lower of (1) the state's historical growth for Medicaid in recent years or (2) Medicaid growth rates projected for the nation. These estimates are termed benchmark rates in this report.<sup>5</sup>

In 1995, 2002, and 2004, we reported that HHS had not adequately ensured that approved Medicaid demonstrations would be budget neutral to the federal government.<sup>6</sup> The core of our findings included that (1) HHS approved spending limits that were based on projections of growth that exceeded state-specific and nationwide benchmarks, (2) HHS approved

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<sup>3</sup>Although the Secretary of HHS has delegated the administration of the Medicaid program, including the approval of section 1115 demonstrations, to the Centers for Medicare & Medicaid Services (CMS), we refer to HHS throughout this report because section 1115 demonstration authority ultimately resides with the Secretary and, accordingly, other HHS offices and agencies are involved in the review and approval of these demonstrations. A federal review team, including officials from the Office of Management and Budget, HHS's Assistant Secretary of Planning and Evaluation, and HHS's Health Resources and Services Administration, assists CMS by reviewing and commenting on states' proposed demonstrations.

<sup>4</sup>Budget neutrality is a requirement in place through HHS policy but is not a statutory requirement for Medicaid demonstrations.

<sup>5</sup>HHS officials consider spending limits to be a product of negotiations that are informed by HHS's policy to consider the state's historical experience and projections of growth in the President's Budget. HHS's benchmarks are contained in HHS's budget neutrality policy as described for section 1115 demonstration proposals under the Health Insurance Flexibility and Accountability (HIFA) initiative. HHS considers this policy to be applicable for all section 1115 demonstration proposals.

<sup>6</sup>A list of related GAO reports appears at the end of this report.

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spending limits that included costs that were impermissible or inappropriate, and (3) the basis for HHS's approval of states' demonstration spending limits was unclear and the process by which this was done was largely undocumented. We have also reported numerous times since the early 1990s about some states' financing arrangements that took advantage of the flexibility in the Medicaid program to boost the federal support they received for the program at little or no cost to states. Under one such financing arrangement, for example, states made illusory Medicaid payments to certain government-owned providers—payments in excess of standard Medicaid reimbursement rates, otherwise known as supplemental payments—to obtain the federal share on the supplemental payments, then required providers to return most or all of the payments to the state.<sup>7</sup> We concluded that such practices undermined the fiscal integrity of the program, and HHS in recent years has sought to curtail them. Both of these issues—lack of budget neutrality and concerns about fiscal integrity—have contributed to our designating Medicaid as a high-risk program since 2003.<sup>8</sup>

You expressed interest in the costs of Medicaid section 1115 demonstrations to the federal government and asked us to examine recent demonstration proposals approved by HHS. We selected demonstrations based on when they were approved—we selected demonstrations approved from July 2004 through December 2006—and whether they were comprehensive and accounted for the majority of the state's Medicaid expenditures.<sup>9</sup> Two section 1115 demonstrations that HHS approved—for Florida and Vermont in 2005—met these criteria. Both demonstrations involve expanding the use of managed care to deliver services to Medicaid

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<sup>7</sup>For more information on inappropriate supplemental payment arrangements, see GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: Feb. 13, 2004).

<sup>8</sup>GAO, *High-Risk Series: An Update*, [GAO-07-310](#) (Washington, D.C.: January 2007).

<sup>9</sup>Section 1115 demonstrations vary in scope, from targeted demonstrations limited to specific services or populations, to comprehensive demonstrations affecting Medicaid populations and services throughout a state and including most of a state's Medicaid expenditures. We reviewed demonstrations that were comprehensive in scope. For the purpose of our work, we defined comprehensive 1115 Medicaid demonstrations as those that (1) affect beneficiaries statewide, (2) cover a broad range of services, and (3) include most of a state's Medicaid expenditures. We did not consider to be comprehensive demonstrations that target specific populations or account for a small portion of a state's total Medicaid spending. We also limited our review to demonstrations approved from July 2004 (when we last reviewed HHS-approved section 1115 demonstrations) through December 2006.

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beneficiaries: in Florida, by requiring certain Medicaid beneficiaries to enroll in competing state-approved managed care plans; in Vermont, by creating a single state-run managed care organization. We have already reported to you on certain aspects of HHS's approval of demonstrations in Florida and Vermont. In July 2007, we reported that demonstrations in Florida and Vermont have mixed implications for beneficiaries and that opportunities for public input to HHS during the approval process were limited.<sup>10</sup> Also in a July 2007 letter to the Secretary of HHS, we reported concerns about the consistency of the Florida and Vermont demonstrations with federal law: in Florida, about HHS allowing limits on covered benefits and cost sharing in excess of statutory limits without addressing statutory restrictions on its authority to do so; in Vermont, about HHS allowing the state to operate its own Medicaid managed care organization through a contract between two related state agencies and, through this arrangement, to apply Medicaid funds to programs previously funded by the state.<sup>11</sup> This report addresses the extent to which the Secretary of HHS ensured, before approving them, that the Florida and Vermont demonstrations will (1) be budget neutral to the federal government and (2) maintain the fiscal integrity of the Medicaid program.

To determine the extent to which HHS ensured that the demonstrations in Florida and Vermont will be budget neutral, we examined each state's projection of the combined federal and state spending needed to continue its existing Medicaid program. We compared the assumptions about cost and beneficiary enrollment growth used to develop the demonstration spending limits approved by HHS against our estimates of spending limits had HHS's benchmarks been used. We asked officials of the state Medicaid agencies, HHS, and the Office of Management and Budget (OMB) for explanations and quantitative support for spending projections that used

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<sup>10</sup>For example, certain beneficiaries in Florida have more options in selecting health care plans and benefits, but bear increased responsibility for ensuring that their chosen plans maintain the benefits and services that meet their needs; beneficiaries in Vermont may have their covered benefit packages increased or decreased, which the state can do within certain limits without prior approval from HHS. HHS did not provide for public input to the demonstration proposals at the federal level (to HHS) before approving them. See 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).

<sup>11</sup>GAO, *Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act*, B-309734 (Washington, D.C.: July 24, 2007).

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growth assumptions exceeding HHS benchmarks and estimated the spending limits supported by these explanations and documentation.<sup>12</sup>

To determine the extent to which HHS ensured that the two demonstrations will maintain the fiscal integrity of the Medicaid program, we evaluated HHS's process for reviewing section 1115 demonstration proposals and whether the demonstrations held potential for inappropriately leveraging federal Medicaid funds. We reviewed Florida and Vermont demonstration-related materials, including the demonstration proposals and supporting documentation, correspondence between HHS and the two states, and the special terms and conditions that govern implementation, operation, and evaluation of approved demonstrations. We also reviewed HHS documentation related to the states' Medicaid financing methods and supplemental payment arrangements. And we met with state and federal officials, including officials from HHS's Office of the Actuary, the Division of Family and Children's Health Programs Group (the division within the Centers for Medicare & Medicaid Services (CMS) that reviews section 1115 demonstration proposals), the Division of Reimbursement and State Financing (the division within CMS that monitors the appropriateness of state financing arrangements), and from OMB. Appendix I more fully discusses our scope and methodology. We conducted our work from June 2006 through January 2008 in accordance with generally accepted government auditing standards.

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## Results in Brief

HHS did not adequately ensure that Florida's and Vermont's Medicaid demonstrations will be budget neutral to the federal government before approving them. The spending limits that HHS approved for the two demonstrations were higher than the limits that would have been granted if HHS had held the states to limits based on HHS's benchmark growth rates. Although HHS allows states to deviate from these benchmarks if states can show that using them would not provide accurate projections, HHS's basis for approving the higher spending limits was not fully supported by documentation. HHS provided support for part of the increase but not for the entire amount.

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<sup>12</sup>We considered an explanation to be quantified in support of higher growth if the explanation corrected a verifiable anomaly in either the state's historical data or nationwide estimates of Medicaid growth.

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- For Florida, HHS approved a 5-year spending limit for the demonstration estimated at \$52.6 billion,<sup>13</sup> an amount \$6.9 billion higher than supported. HHS approved demonstration spending limits based on projections of cost growth that exceeded HHS's benchmarks of the state's own recent history of Medicaid program growth and estimates of Medicaid growth nationwide. Specifically, HHS approved cost growth rates for one group of beneficiaries based on a selected period of unusually high growth from Florida's historical experience and cost growth rates for another group of beneficiaries based on unsupported increases to nationwide estimates.
  - For Vermont, HHS approved a 5-year spending limit for the demonstration of \$4.7 billion, an amount \$246 million higher than supported. Similar to what it did for Florida, although to a lesser degree, HHS approved a spending limit using rates for projecting enrollment growth that were higher than the state's historical growth and projections of Medicaid growth nationwide and did not fully support its reasons. HHS also allowed Vermont to boost its spending limit by allowing the state to include projections of spending that were "hypothetical" in the state's \$4.7 billion spending limit, specifically funds that the state could have spent on a previous Medicaid section 1115 demonstration but did not spend.

HHS also did not ensure that demonstrations in Florida and Vermont maintained the fiscal integrity of the Medicaid program prior to approving them.

- In Florida, HHS allowed the state to use spending from a supplemental payment arrangement that the state had in place prior to the demonstration as the basis for allowed spending under the demonstration. A 2005 HHS financial management review found several problems with this earlier arrangement, which involved supplemental payments to certain hospitals. The review found that Florida had incorrectly calculated the level of supplemental payments for which federal Medicaid funds were obtained, potentially resulting in inflated and inaccurate payments. Without correcting these problems, HHS allowed Florida to use the spending under the prior hospital supplemental payment arrangement as the basis for the spending allowed under the demonstration. To address problems with inaccurate methods and data for calculating allowable supplemental payment amounts used by other states, we had, in 2004, recommended that HHS establish appropriate methods for states'

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<sup>13</sup>Florida estimated this amount based on applying the agreed-upon limit for per person spending under the demonstration to the state's projected enrollment over the duration of the demonstration.

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calculations of supplemental payments, but HHS has not implemented this recommendation for any state.

- In Vermont, HHS allowed the state to operate its own managed care organization and to claim federal matching funds for payments to the organization, and agreed to reimburse Vermont for the administration of its public managed care organization at a rate higher than that typically paid to state Medicaid agencies. Specifically, the financing arrangement allows the state to pay its managed care organization for administrative costs at a rate that—although typical for private managed care organizations—is higher than the rate paid to Vermont before the demonstration and that of most state Medicaid agencies. Under this arrangement, HHS allowed the state to retain excess revenues<sup>14</sup> and use these funds to support health-related programs that were previously funded by the state and that do not exclusively benefit Medicaid beneficiaries, such as a grant to the University of Vermont medical school. In July 2007, we raised concerns about this approval’s consistency with federal law.<sup>15</sup> In particular, the approval of the Vermont demonstration raised the question whether the Vermont Medicaid agency could enter into a managed care contract with one of its own offices and receive federal matching funds for lump-sum payments to that office rather than for payments based on actual costs.

The findings in this report are consistent with certain findings in our earlier reports and indicate that action is still needed to ensure the transparency of added costs to the federal government associated with section 1115 demonstrations and to maintain Medicaid’s fiscal integrity. HHS has not addressed long-standing concerns with the demonstration approval process, including the validity of its methods for determining budget neutrality, the basis for its approval of states’ spending limits, and the transparency of the review process. Further, HHS continues to maintain that its approval of Vermont’s demonstration is consistent with federal law, but has not addressed the concerns raised in our July 2007 letter. Consequently, this report includes two matters for congressional consideration:

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<sup>14</sup>We use the term excess revenue to refer to funds remaining after the managed care organization has paid necessary medical and administrative expenses; excess revenue has also been referred to as savings in past reports.

<sup>15</sup>See B-309734, July 24, 2007.

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- The Congress should consider requiring increased attention to fiscal responsibility in the approval of section 1115 Medicaid demonstrations by requiring the Secretary of HHS to improve the demonstration review process through steps such as (1) clarifying criteria for reviewing and approving states' proposed spending limits, (2) ensuring that valid methods are used to demonstrate budget neutrality, and (3) documenting the basis for any approvals.
  - The Congress should consider addressing whether demonstrations that allow states to operate public managed care organizations and retain excess revenue to support programs previously funded by the state—including the Vermont demonstration—are within the scope of the Secretary of HHS's authority under section 1115 of the Social Security Act.

In this report we are also recommending that the Secretary of HHS calculate the level of supplemental payments for which Florida could have obtained federal Medicaid funds in the absence of the proposed demonstration, using appropriate methods and accurate data sources, and adjust Florida's spending limit accordingly.

In commenting on a draft of this report, HHS strongly disagreed with our findings, conclusions, and recommendation. HHS commented that the draft report did not accurately characterize the demonstration programs or HHS's budget neutrality policies. HHS also noted that the draft did not adequately account for the likelihood of differences in professional interpretation of quantifiable analyses or adequately acknowledge HHS's efforts to ensure Medicaid compliance and fiscal integrity. HHS emphasized that the demonstrations are approved at the discretion of the Secretary of HHS and that HHS's review of demonstration proposals includes both budgetary and programmatic elements. With regard to HHS's approval of the Vermont demonstration, HHS disagreed with our concerns and earlier recommendation to reexamine the demonstration and, where appropriate, either modify the demonstration's terms or seek statutory authority for it to continue in its current form. HHS maintained that issues of legal authority were adequately and appropriately addressed in the information provided to us during the course of our fieldwork.

We believe our findings, conclusions, and recommendation remain valid. Our characterizations of the programs and policies were based on documentation obtained from HHS and states and discussions with federal and state officials, and we believe we have captured them accurately. We acknowledge that the Secretary has some discretion when approving section 1115 demonstrations. As noted in this report, budget neutrality is a

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long-standing HHS policy, but is not required by law. We maintain, however, that to provide accountability and transparency in federal spending for the Medicaid program, the Secretary's approvals should be based on clearly articulated policies and spending limits that are consistent with these policies. Whenever HHS's decisions and spending estimates met these tests, we accepted them. We did not, however, accept estimates when program officials could not document or clearly articulate the reasoning they had used, demonstrate how this reasoning was consistent with budget neutrality and fiscal integrity principles, and explain how the resulting spending limits were derived. Because our findings in Florida and Vermont are consistent with findings from our earlier work, we believe that actions to improve the demonstration approval process—including the criteria used, the methods allowed to determine budget neutrality, and the documentation to support the final approved limits—are needed. Given HHS's opposition to taking recommended actions, we believe that elevating certain long-standing recommendations for congressional consideration is a necessary step.

We also provided a draft of this report to Florida and Vermont. Florida stated that during the negotiations of the demonstration proposal, state officials worked closely with HHS to ensure that all data and documentation were provided in a timely and accurate manner to support the proposal. Vermont indicated that the state had assumed an unprecedented amount of risk related to program expenditures in exchange for the flexibility granted by the Secretary and that state and federal staff had engaged in extensive discussion and analysis of Vermont's historical expenditures, cost and caseload trends, and program policies in arriving at the final spending limit. On the basis of our review of available documentation, we agree that the states provided data and documentation to HHS supporting their demonstration proposals. Our concern remains, however, with the lack of documentation—from the states or HHS—showing how the final spending limits were derived, particularly since they were based on assumptions about cost and enrollment growth that were higher than HHS's benchmarks. In addition, our legal concerns about the Vermont demonstration remain. Consequently, we have elevated this matter to the Congress for consideration.

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## Background

Medicaid is one of the largest programs in federal and state budgets. In fiscal year 2005, Medicaid expenditures totaled an estimated \$317 billion. States pay qualified health providers for a broad range of covered services provided to eligible beneficiaries. The federal government reimburses

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states for a share of these expenditures. The federal matching share of each state's Medicaid expenditures for services is determined by a formula defined under federal law and can range from 50 to 83 percent.<sup>16</sup>

Each state administers its Medicaid program in accordance with a state Medicaid plan that must be approved by HHS.<sup>17</sup> Traditional Medicaid programs represent an open-ended entitlement, meaning the state will enroll all eligible individuals who apply for Medicaid, and both the state and federal government will pay their shares of expenditures for individuals covered under a state's approved Medicaid plan. States have considerable flexibility in designing their Medicaid programs, but under federal Medicaid law, states generally must meet certain requirements for what benefits are provided and who is eligible for the program.

Medicaid demonstrations provide a way for states to innovate outside of many of Medicaid's usual requirements. Under section 1115 of the Social Security Act, the Secretary has authority to waive certain federal Medicaid requirements and authorize otherwise unallowable expenditures for "experimental, pilot, or demonstration projects" that are likely to promote Medicaid objectives.<sup>18</sup> States have used the flexibility granted through section 1115 to implement major changes to existing state Medicaid programs. For example, some states used Medicaid section 1115 demonstrations in the 1980s and 1990s to introduce mandatory managed care for their Medicaid beneficiaries.

Since the early 1980s, HHS has required that states show that their proposed section 1115 demonstrations will be budget neutral to the federal government—that is, federal expenditures under a state's demonstration will not be greater than if the state had continued its existing Medicaid program. HHS requires states to show that proposed

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<sup>16</sup>See Social Security Act §§ 1903(a)(1), 1905(b) (codified, as amended, at 42 U.S.C. §§ 1396b(a)(1), 1396d(b)). States with lower per capita income typically receive higher federal matching shares.

<sup>17</sup>A state Medicaid plan details the populations a state's program serves; the amount, scope, and duration of the mandatory and optional services the program covers; and the rates of and methods for calculating payments to providers.

<sup>18</sup>Section 1115 allows waivers of requirements in Medicaid and several other programs authorized under the Social Security Act. See Social Security Act § 1115 (codified, as amended, at 42 U.S.C. § 1315); see also section 2107(e) of the act (codified, as amended, at 42 U.S.C. § 1397gg(e)) regarding the applicability of section 1115 to the State Children's Health Insurance Program.

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demonstrations are budget neutral by preparing 5-year projections of spending (1) under the current Medicaid program and (2) under the proposed demonstration. HHS policy states that for a demonstration to be considered budget neutral, the federal share of projected Medicaid expenditures under the demonstration can be no greater than the federal share of projected Medicaid expenditures based on continuing the existing Medicaid program.

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### Budget Neutrality Is Based on the Projected Cost of the Existing Medicaid Program

Because HHS bases spending limits for proposed demonstrations on the projected cost of continuing an existing Medicaid program, a state has an incentive to maximize its projected costs. HHS policy states that the federal share of spending on demonstrations will be limited by spending limits calculated from two components:

- **Spending base.** States select a recently completed fiscal year that establishes base levels of funding for services and programs affected by the proposed demonstration—a state’s “spending base.” States also identify beneficiary groups for inclusion in the proposed demonstration. These beneficiary groups can, at the Secretary’s discretion, include individuals enrolled in other demonstrations a state may be operating and beneficiaries from the State Children’s Health Insurance Program (SCHIP), which provides health coverage to children in families whose incomes, while low, are above Medicaid’s eligibility requirements.<sup>19</sup>
- **Growth rates.** States should submit to HHS 5 years of historical data for per person costs and beneficiary enrollment in their existing Medicaid programs, including quantified explanations for anomalies in their historical trends. HHS policy says that spending limits should be based on growth rates that are the lower of state-specific history or estimates of nationwide growth for the beneficiary groups included in the demonstration (referred to in this report as benchmark growth rates). HHS’s guidance is specific to per person cost growth rates and does not explicitly address the application of enrollment growth rates; however, HHS refers to state historical and nationwide enrollment growth rates in

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<sup>19</sup>HHS policy identifies three general categories of beneficiaries that can be included in section 1115 demonstrations: (1) mandatory populations, referring to beneficiaries who must be covered under a Medicaid state plan; (2) optional populations, referring to beneficiaries who can be covered under a state plan, regardless of whether they are covered at the time the demonstration is approved; and (3) expansion populations, referring to beneficiaries who cannot be covered under a Medicaid or SCHIP state plan, and who can only be covered through the Secretary’s authority under section 1115.

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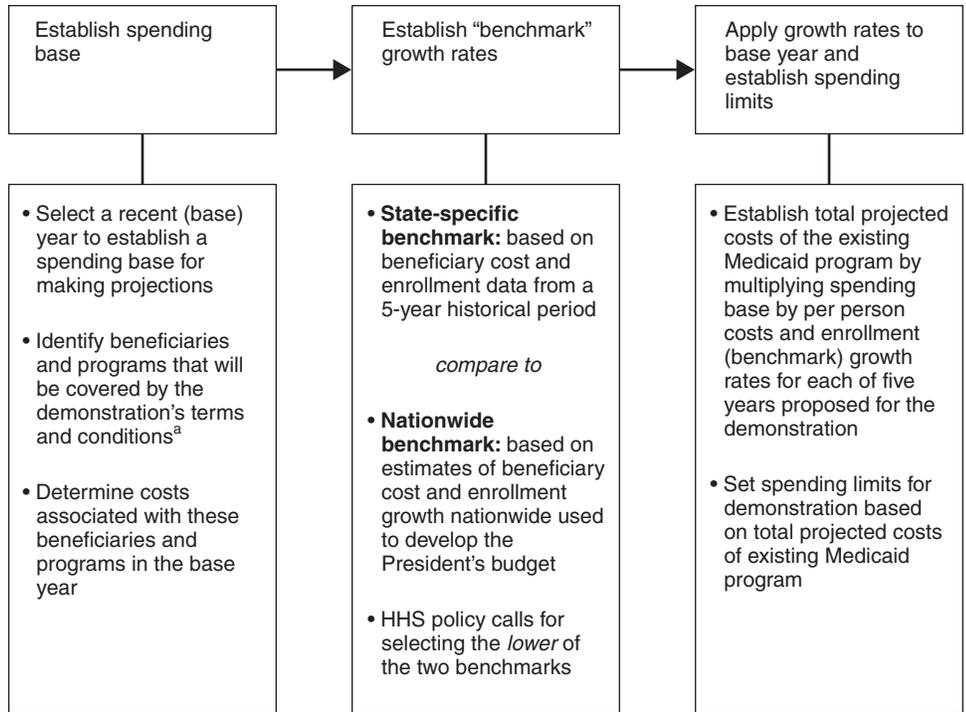
considering the spending limits. Nationwide estimates of cost and beneficiary enrollment growth are developed by CMS actuaries to assist OMB in preparing the President's Budget.

To project the costs of continuing a state's existing Medicaid program, HHS policy calls for applying the benchmark growth rates to the state's spending base over a 5-year period to establish total projected costs absent the demonstration.<sup>20</sup> HHS sets spending limits for proposed demonstrations based in part on these total projected costs (see fig. 1).

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<sup>20</sup>HHS considers this guidance to apply to proposed section 1115 demonstrations. The guidance was originally published for section 1115 demonstrations under the HIFA initiative. HIFA section 1115 demonstrations are intended to utilize private health insurance coverage options to provide coverage to more people. According to HIFA guidance, HHS policy is to apply the lower of state-specific experience—using 5 years of Medicaid data—or the President's Budget Medicaid baseline for the eligible groups covered by the demonstration.

**Figure 1: Overview of Process for Projecting the Future Cost of a State’s Existing Medicaid Program**



Source: GAO analysis of HHS information.

<sup>a</sup>A state may propose, for example, that certain groups of beneficiaries, such as aged and disabled beneficiaries, will operate under the terms of the state’s approved state Medicaid plan rather than under the terms of the demonstration. In the Florida and Vermont demonstrations, major Medicaid beneficiary groups—aged, blind, and disabled beneficiaries and families and children—were included in the demonstrations.

HHS allows states to use higher-than-benchmark growth rates if they can establish that historical or nationwide data do not accurately depict anticipated growth in the state Medicaid program. HHS considers spending limits to be a product of negotiations that are informed by HHS’s policy to consider the state’s historical experience and projections of growth in the President’s Budget. In addition, HHS’s policy indicates that states, in providing HHS with state-specific historical growth rates, must quantify any anomalies in the trends.

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## Recent Demonstrations Approved in Florida and Vermont Allow Significant Changes in How These States Operate Their Medicaid Programs

Recently approved section 1115 Medicaid demonstrations in Florida and Vermont significantly change the operation of the two states' Medicaid programs. Both demonstrations expand the use of managed care by requiring most Medicaid beneficiaries to enroll in managed care plans:<sup>21</sup> Florida through state contracts with multiple managed care plans to provide services and Vermont by creating a single managed care organization operated by an office within the state Medicaid agency.<sup>22</sup>

**Florida:** Approved by HHS in October 2005 and launched in July 2006, Florida's demonstration is designed to give Medicaid beneficiaries different options for health care plans and benefits through increased use of managed care plans to provide Medicaid coverage to beneficiaries, in a competitive environment.<sup>23</sup> In the initial phase of the demonstration, certain Medicaid beneficiaries in two counties are required to enroll in state-approved managed care plans. Managed care plans compete for Medicaid beneficiaries by offering different coverage options, including customized benefits and cost sharing, subject to certain limitations. Unlike many other previous Medicaid managed care systems, managed care plans in Florida have the authority to design benefit packages subject to approval by the state. Initially implemented in a two-county area, the managed care components of the demonstration are planned for statewide implementation by June 2010.<sup>24</sup> Another key component of Florida's demonstration was the establishment of a pool of funds to finance

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<sup>21</sup>Managed care organizations can reduce costs by relying on a primary care physician who acts as a gatekeeper for obtaining other health services, such as hospital or specialty medical care.

<sup>22</sup>The special terms and conditions for the approved demonstrations in Florida and Vermont do not include a specific maintenance-of-effort requirement. For certain 1115 demonstration initiatives such as HIFA, HHS policy has not permitted states to receive additional federal matching payments for previously state-only health service programs under the demonstrations. Federal financial participation could not be claimed for any existing state-funded program because, for example, the expectation was that the state would expand benefits through the demonstration. This requirement was called maintenance of effort.

<sup>23</sup>Florida's demonstration also includes (1) choice counselors to help beneficiaries make informed decisions when selecting a Medicaid reform health plan, (2) a program of enhanced benefits to promote and reward healthy behaviors, and (3) a provision allowing Medicaid beneficiaries to voluntarily "opt out" of Medicaid coverage altogether and use a state-paid Medicaid premium toward their costs to enroll in an employer-sponsored insurance plan or in a commercial insurance plan if they are self-employed.

<sup>24</sup>According to Florida officials, statewide implementation of the demonstration is subject to approval by the Florida State Legislature.

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supplemental payments—payments above the state’s usual payment rate—to certain types of Florida health care providers. Known as the low-income pool, this component of the demonstration was designed in part to continue funding for a supplemental payment program for hospitals that the state had in place prior to the demonstration. Payments from the \$5 billion low-income pool (\$1 billion annually) are authorized for selected Medicaid providers statewide to help offset the cost of providing care to Medicaid beneficiaries and underinsured and uninsured individuals.<sup>25</sup>

**Vermont:** Approved by HHS in September 2005 and launched the following month, Vermont’s demonstration is designed to contain costs and, by potentially delivering services to Medicaid beneficiaries for less and reinvesting excess revenue, to allow the state to serve more of its uninsured population. Under the demonstration, Vermont created a single, state-operated managed care organization to cover virtually all of the state’s Medicaid population.<sup>26</sup> HHS approved a managed care arrangement whereby the state Medicaid agency contracts with one of its own components (the Office of Vermont Health Access) to operate as a managed care organization.<sup>27</sup> The Office of Vermont Health Access receives monthly actuarially certified lump-sum payments from the state Medicaid agency, which in turn receives the federal share of these lump-sum payments. The monthly payment is intended to cover the medical costs and administrative expenses of serving enrolled beneficiaries. Vermont also received authority to retain “savings,” that is, any excess revenue generated by the state managed care organization, and apply them

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<sup>25</sup>Florida law made the state’s authority for pursuing the proposed demonstration contingent in part on federal approval to preserve the upper payment limit funding mechanism (the supplemental payment arrangement). Fla. Stat. Ann. § 409.91211(1)(b).

<sup>26</sup>Populations not covered by the state managed care organization include individuals enrolled in the state’s long-term care demonstration and SCHIP.

<sup>27</sup>To receive the federal share for capitation payments made to a managed care organization, a state is required to enter into a contract with a managed care organization. See Social Security Act § 1903(m)(2)(A)(i)(codified, as amended, at 42 U.S.C. § 1396b(m)(2)(A)(i)). HHS approved the agreement between the Vermont Medicaid agency and its Office of Vermont Health Access as such a contract.

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to programs that meet certain agreed-upon health objectives, such as increasing health insurance coverage.<sup>28</sup>

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**Concerns about Budget Neutrality of Medicaid Demonstrations and Certain Excessive Supplemental Payments Are Long-standing**

On several occasions since the mid-1990s, we have reported concerns that HHS had approved Medicaid demonstrations that were not budget neutral to the federal government.

- In 1995 we reported that HHS applied new, more flexible budget neutrality guidance allowing three states to consider “new methodologies” for determining budget neutrality of proposed demonstrations. Based in part on these new methodologies, HHS had approved spending limits for these demonstrations that were not budget neutral and could increase federal Medicaid expenditures.<sup>29</sup>
- In 2002, we reported that HHS approved spending limits for demonstrations that were not budget neutral to the federal government by allowing two states to include inappropriate or impermissible costs in their spending projections. We recommended that HHS ensure that valid methods are used to demonstrate budget neutrality by developing and implementing consistent criteria for reviewing and approving states’ budget neutrality analyses. HHS disagreed with the recommendation, stating that its methods were valid.<sup>30</sup>
- In 2004, we reported that HHS approved spending limits for section 1115 demonstrations in four states that were not budget neutral to the federal government. These states projected the costs of their Medicaid programs at rates of growth exceeding state-specific and nationwide benchmarks for Medicaid cost and enrollment growth without documenting the rationale for the higher growth rates. We recommended that HHS (1) clarify criteria for reviewing and approving spending limits of states’ proposed demonstrations and (2) reconsider the spending limits of recently

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<sup>28</sup>Vermont is also allowed to change the covered benefit package offered to certain groups of beneficiaries, such as nonmandatory groups that previously received Medicaid coverage at the state’s option, without additional HHS approval as long as the changes result in no more than a 5 percent increase or decrease each year from the prior year’s total Medicaid expenditures.

<sup>29</sup>GAO, *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs*, [GAO/HEHS-96-44](#) (Washington, D.C.: Nov. 8, 1995).

<sup>30</sup>GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, [GAO-02-817](#) (Washington, D.C.: July 12, 2002).

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approved demonstrations. We also recommended that HHS document and make public the basis for any section 1115 demonstration approvals, including the basis for cost and enrollment growth rates used to set spending limits, and ensure that states comply with reporting and evaluation requirements.<sup>31</sup> HHS concurred with our recommendations to make public the basis for its approvals, but did not concur with our recommendations on clarifying approval criteria and reconsidering recently approved demonstrations using these criteria.<sup>32</sup>

Our past work also includes reports addressing concerns with aspects of HHS's oversight of certain state supplemental payment arrangements that threatened the fiscal integrity of Medicaid's federal-state partnership. States, with HHS approval, can make supplemental Medicaid payments—payments above the state's usual Medicaid payment rates for certain services, such as nursing home care—and they often do so for appropriate reasons. For example, states may make supplemental Medicaid payments to certain safety net providers that serve a large share of high-cost Medicaid beneficiaries. However, our work since the early 1990s examining some of these arrangements found that many states were, in essence, finding ways through the arrangements to inappropriately increase the federal share of Medicaid spending at little or no cost to the state.<sup>33</sup> In February 2004, for example, we reported that states were taking advantage of Medicaid upper payment limit (UPL) provisions, resulting in excess federal payments. The UPL is the upper bound on what the federal government will pay as its share of Medicaid costs for different classes of covered services, and this limit often exceeds what states actually pay providers for services.<sup>34</sup> This difference creates a “gap” between what states typically pay for services and the UPL. Some states took advantage

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<sup>31</sup>In 2006, HHS developed a plan intended to mitigate federal risk with respect to budget neutrality of section 1115 demonstrations, once approved. This plan includes HHS reviews of spending under the approved demonstrations to ensure that the spending complies with the predetermined spending ceilings that HHS approved. OMB incorporated these reviews as a performance metric in its 2006 assessment of Medicaid under the Program Assessment Rating Tool. In 2007, HHS required Wisconsin to return \$10.2 million to the federal government after notifying the state that it had exceeded spending limits for its previously approved section 1115 demonstration.

<sup>32</sup>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).

<sup>33</sup>See [GAO-04-228](#).

<sup>34</sup>The UPL is based on how much Medicare, the federal government's health care program for seniors and some disabled people, would pay for comparable services.

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of this gap between their usual payment rates and what Medicaid could pay under the UPL by making large supplemental payments to government providers, acquiring a federal share of those payments, and subsequently requiring the providers to return most or all of the supplemental payments to the state. These states have collected billions of excessive federal dollars in past years and often used these returned payments and the accompanying federal funds to finance their own share of the Medicaid program. We have reported on, and HHS has attempted to curb, such recycling of federal Medicaid funds.

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## HHS Did Not Adequately Ensure the Budget Neutrality of Medicaid Demonstrations in Florida and Vermont before Approving Them

HHS approved 5-year demonstration spending limits for Florida and Vermont based on projections of cost and beneficiary enrollment growth rates that exceeded HHS's own benchmarks—that is, the lower of the state's recent historical experience or estimates of Medicaid growth nationwide—without adequate support for these deviations. For each state, HHS provided support for some, but not all, of the increase above these benchmark levels. For Florida, the unsupported difference totals about \$6.9 billion of the \$52.6 billion in projected spending over the 5-year demonstration. For Vermont, the unsupported difference totals about \$246 million over its 5-year demonstration. HHS approved higher-than-benchmark growth rates in calculating spending limits for the demonstrations and, in the case of Vermont, allowed the state to include hypothetical projected expenses inappropriately. In particular, HHS allowed Vermont to include projected costs in its spending limit based on costs that had been budgeted for and allowed under a previous 1115 demonstration but that had not been spent. Although HHS provided some documentation to justify the deviations from its benchmarks that it approved, HHS did not justify all the deviations. In some cases, HHS officials told us that the higher growth rates were the results of negotiations. However, such negotiations were not always fully documented.

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## Spending Limit for Florida's Demonstration Not Fully Supported

HHS approved a spending limit for Florida's demonstration that exceeded the amount HHS could have approved under its benchmark policy, but did not fully support the additional spending. Florida's spending limit has two primary components, beneficiary services and supplemental payments to safety net hospitals. Beneficiary services account for the bulk of Medicaid spending and include the medical costs of demonstration enrollees. For

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beneficiary services, HHS established annual per person limits on federal funds for medical services to groups of beneficiaries.<sup>35</sup> Projected over the 5 years of the demonstration, these per person limits would result in estimated Medicaid spending of about \$47.6 billion. However, under HHS's benchmark policy of limiting projected growth to the lower of a state's recent historical experience or nationwide estimates of Medicaid growth, the maximum spending allowed would have been a projected \$38.6 billion, or about \$9 billion less. HHS supported deviations from its benchmarks that would allow spending projected at an estimated \$40.7 billion—\$2.1 billion above the level the benchmarks would have allowed, but still \$6.9 billion less than what it approved.

Table 1 shows the spending limit originally proposed by Florida and agreed to by HHS. It also shows the spending limit that would have resulted using the benchmark growth rates of the lower of the state's historical growth or the growth projected in the President's Budget, as well as the estimated spending limit that HHS and state officials supported through explanations and documentation.

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<sup>35</sup>In Florida, HHS approved annual per person limits—or “per capita caps”—on federal Medicaid funds for services to groups of beneficiaries, rather than an aggregate spending limit such as Vermont's. Under this type of limit, spending is limited for costs per person, but a state does not have to accept financial risk for unexpected growth in enrollment. For purposes of demonstrating budget neutrality, Florida calculated its estimated overall spending limit by multiplying its per person limits by projected enrollment.

**Table 1: Spending Limit for Florida’s Medicaid Demonstration as Proposed, Approved, and Calculated under HHS’s Benchmark Policy and Supported by HHS’s Explanations**

Dollars in billions

	Spending limit as proposed and approved		GAO estimate of spending limit calculated using HHS benchmarks and as supported by HHS explanations	
	Proposed by Florida	Approved by HHS	Spending limit using HHS benchmarks	Spending limit supported by HHS explanations
Beneficiary services <sup>a</sup>	\$47.1	\$47.6	\$38.6	\$40.7
Supplemental payments	5.9	5.0	5.0 <sup>b</sup>	5.0
<b>Total</b>	<b>\$53.0</b>	<b>\$52.6</b>	<b>\$43.6</b>	<b>\$45.7</b>

Source: GAO analysis of data from HHS and Florida.

<sup>a</sup>Amounts are based on applying annual per person allowed spending to expected Medicaid enrollment for two different eligibility groups: (1) aged, blind, and disabled beneficiaries and (2) families and children. Amounts are for total federal and state spending. The federal government matched Florida expenditures at a rate of 58.76 percent in 2007.

<sup>b</sup>HHS budget neutrality policy does not establish benchmarks for estimating growth of supplemental payment arrangements such as the one Florida proposed for its demonstration. The \$5.0 billion projected amount for supplemental payments that HHS approved is consistent with the projected amount using the state’s reported growth. A further discussion of the basis for HHS’s approval of this amount is found in the next section of this report.

A further discussion of HHS’s explanations of its approvals follows.

**Higher Spending Limit in Florida Is Based on Assumptions of Cost Growth That Exceed Benchmarks**

Projected spending on medical services to beneficiary groups in Florida is based on assumptions of per person cost and beneficiary enrollment growth rates for two primary groups of Medicaid beneficiaries: (1) the aged, blind, and disabled and (2) children and families. Florida submitted to HHS 5 years of historical data and calculations of cost growth rates over this period for the two groups. HHS, in turn, compared Florida’s state-specific history to estimates of Medicaid growth for these beneficiary groups nationwide. However, neither Florida’s proposed nor HHS’s approved spending limit is based on projected spending using the lower of the state-specific or nationwide benchmarks consistent with HHS policy. Instead, according to HHS and state officials, Florida proposed—and HHS approved—higher per person cost growth based on adjustments to the growth rates that were made during negotiations between HHS and state officials that were not documented.

The cost growth rates HHS accepted in negotiations were substantially above those that would have been allowed under HHS’s benchmark policy.<sup>36</sup> As table 2 shows, HHS approved cost growth rates of 8 percent for both aged, blind, and disabled beneficiaries, and for families and children—lower than Florida was proposing for the first group, and slightly higher than Florida was proposing for the second group.<sup>37</sup> Under HHS’s benchmark policy, which calls for basing spending limits on projections of growth at the lower of state-specific history or estimates of Medicaid growth nationwide, the approved cost growth rates would have been 4.80 percent for aged, blind, and disabled beneficiaries and 3.11 percent for children and families.

**Table 2: Comparison of Florida’s Per Person Growth Rates as Proposed and Approved under HHS’s Benchmark Policy and Supported by HHS’s Explanations**

Rates in percentages				
	Cost growth rates as proposed and approved		HHS benchmark rates and rates supported by explanations	
	Proposed by Florida	Approved by HHS	HHS benchmark <sup>a</sup>	Rate as supported by HHS explanations
Aged, blind, and disabled	8.73	8.00	4.80 (N)	6.45
Children and families	7.96	8.00	3.11 (S)	3.77

Source: GAO analysis of data from HHS and Florida.

<sup>a</sup>Lower of state historical spending (S) or estimates of Medicaid growth nationwide (N).

**Part, but Not All, of Increase above HHS’s Benchmarks Supported**

HHS officials allow states to use higher cost growth rates if state officials can establish that state-specific or nationwide data do not accurately depict expected growth in the state Medicaid program. HHS’s policy indicates that states are to provide quantified explanations of growth rate

<sup>36</sup>Seemingly small changes to per person cost growth rates are amplified by the high volume of beneficiaries that access Medicaid services and the number of years across which these cost growth rates are applied. For example, a 1 percent decrease in the per person cost growth rate for Florida’s aged, blind, and disabled beneficiaries reduces projected spending under the demonstration by \$879 million over 5 years; a 1 percent decrease in the per person cost growth rate for families and children reduces projected spending under the demonstration by \$1.4 billion over 5 years.

<sup>37</sup>Aged, blind, and disabled beneficiaries make up a much smaller percentage of Florida’s Medicaid population than do Medicaid-eligible families and children. Data provided to HHS by Florida indicate that in state fiscal year 2004, for example, Florida attributed about 16 percent of Medicaid enrollment among those groups included in the proposed demonstration to aged, blind, and disabled beneficiaries and about 84 percent to families and children.

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anomalies. For the Florida demonstration, HHS officials explained and provided public or internal documents to support part, but not all, of the increases to benchmark cost growth rates that HHS approved.

1. For aged, blind, and disabled beneficiaries, HHS allowed adjustments to nationwide estimates of cost growth to account for effects of the Medicare prescription drug benefit, but quantified explanations for only part of the approved increase. HHS officials explained that the implementation of the Medicare Part D prescription drug benefit, which would have the effect of shifting the cost of many prescription drugs out of the Medicaid program and into Medicare, caused a sharp decrease in estimated costs for aged, blind, and disabled Medicaid beneficiaries nationwide in 2006. This decrease in the cost growth rate for that unusual year lowered the nationwide benchmark growth rate for these beneficiaries. HHS officials adjusted for the effects of the Medicare prescription drug benefit by removing drug-related expenditures from the nationwide estimates over the time period under review and recalculating estimated nationwide cost growth. As a result of these adjustments, HHS provided quantified explanations to the deviation from its benchmark and supported projected cost growth of 6.45 percent for aged, blind, and disabled beneficiaries—higher than the 4.80 percent allowed under its benchmark policy. HHS officials indicated that the remaining deviation from the benchmark was attributable to adjustments they made to the growth rate to account for an expected increase in enrollment of low-cost beneficiaries.<sup>38</sup> HHS officials, however, did not identify and correct anomalies in the nationwide enrollment data to support the additional increase in cost growth from 6.45 percent to the 8 percent HHS approved for the demonstration.
2. For families and children, HHS claimed that higher growth over a selected time period more accurately reflected cost growth. According to HHS's guidance, state-specific growth rates are based on 5 years of historical data.<sup>39</sup> HHS, however, allowed Florida to calculate a cost

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<sup>38</sup>Specifically, HHS officials removed annual growth for one year in which per person costs decreased (-1.4 percent growth), and replaced it with annual growth based on the average growth from two surrounding years (7.9 percent growth).

<sup>39</sup>Specifically, HHS's guidance says that states, in supporting budget neutrality, should submit to HHS 5 years of historical data and that spending limits are based on growth rates that are the lower of state-specific history or estimates of nationwide growth for the beneficiary groups in the demonstration. However, HHS's guidance does not specifically define state-specific historical rates as calculated over 5 years.

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growth rate for its families and children based on data from a truncated period of higher growth of 3 years and 9 months. Cost growth over this shortened period of time was 5.88 percent, as compared to cost growth of 3.11 percent when using data from the full 5 years leading up to Florida's base year. HHS officials explained that they allowed Florida to selectively use the higher years of data to calculate its growth rates for two reasons: (1) that the shortened time period replaced earlier years of unusually low cost growth with more recent data and (2) that HHS had recently approved a higher cost growth rate for a subset of this particular beneficiary group in renewing an ongoing Medicaid managed care demonstration. HHS officials did not, however, identify and correct an anomaly in the state's earlier data, nor did HHS document and explain why the state was allowed to establish its spending limits using growth rates that were based on anticipated higher growth under the demonstration. In particular, the state, in its application, stated that it anticipated higher cost growth under the demonstration due to greater use of managed care by Medicaid children and families. A review of Florida's historical cost growth that includes more recent data cited by HHS officials, and that uses data from a 5-year period as indicated by HHS policy, supports a cost growth rate of 3.77 percent.

HHS officials maintained that HHS's methods for ensuring budget neutrality are valid and indicated that the department's budget neutrality decisions are, to some extent, the product of negotiations. HHS officials also said that HHS can assign growth rates that vary from the results of analysis of historical data and the President's Budget projections if officials are convinced that the trends are merited.

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### Spending Limit for Vermont's Demonstration Also Not Fully Supported

To a lesser degree than Florida, HHS approved a spending limit for Vermont's demonstration based on assumptions of beneficiary enrollment growth that exceeded HHS's benchmarks. HHS approved a spending limit of \$4.7 billion for Vermont's 5-year demonstration. This spending limit, however, is \$180 million above the maximum supported by HHS and the state in explanations and documentation. HHS also allowed Vermont to include in its spending limit funds that were "hypothetical," that is, \$67 million in funds that had been approved as budget neutral for a prior section 1115 demonstration but that the state had not actually spent.

Table 3 shows the spending limit as originally proposed by Vermont and as agreed to by HHS. It also shows the limit that would apply if HHS benchmarks had been used and the limit that HHS and state officials explained and supported in documentation. Although HHS reduced

Vermont’s proposed spending limit by over \$1.4 billion, this reduction resulted from an agreement that the state not include the financing of three major programs in the demonstration. These three programs that were removed from the state’s initial proposal—a long-term care demonstration, payments to hospitals under the Disproportionate Share Hospital program, and SCHIP—account for most of the \$1.4 billion and will continue to be operated and reimbursed apart from the Vermont demonstration, thus having no affect on the budget neutrality of the demonstration.<sup>40</sup>

**Table 3: Spending Limit for Vermont’s Medicaid Demonstration as Proposed, Approved, and Calculated under HHS’s Benchmark Policy and Supported by HHS’s Explanations**

Dollars in billions

	Spending limit as proposed and approved		GAO estimate of spending limit calculated using HHS benchmarks and as supported by HHS explanations	
			Spending limit using HHS benchmarks	Spending limit supported by HHS explanations
	Proposed by Vermont	Approved by HHS		
Beneficiary services <sup>a</sup>	\$6.0 <sup>b</sup>	\$4.2	\$3.9	\$4.0
Other programs	0.2 <sup>c</sup>	0.5 <sup>d</sup>	0.5 <sup>e</sup>	0.5
<b>Total</b>	<b>\$6.2</b>	<b>\$4.7<sup>f</sup></b>	<b>\$4.4</b>	<b>\$4.5</b>

Source: GAO analysis of data from HHS and Vermont.

<sup>a</sup>Amounts for beneficiary services as approved were based on projecting cost and enrollment growth for four different eligibility groups: (1) aged, blind, and disabled beneficiaries; (2) children and families; (3) optional populations from an ongoing section 1115 demonstration; and (4) beneficiaries from a separate developmental services demonstration. Amounts are for total federal and state spending. The federal government matched Vermont expenditures at a rate of 58.93 percent for fiscal year 2007.

<sup>b</sup>Includes Vermont’s SCHIP (\$21 million) and costs associated with beneficiaries in a long-term care demonstration (\$1.2 billion).

<sup>c</sup>Disproportionate Share Hospital payments (\$183 million).

<sup>d</sup>Includes costs to administer Medicaid programs (\$405 million), unspent funds from an ongoing demonstration (\$67 million), and funds to replace the services of the Vermont State Hospital (\$54 million).

<sup>e</sup>HHS’s budget neutrality policy does not establish benchmarks for estimating growth of administrative costs, for carrying forward surpluses from one demonstration to another, or for funding replacement services for state hospitals.

<sup>40</sup>In addition, HHS required Vermont to remove the projected costs for certain populations from an ongoing section 1115 demonstration. Vermont will be at risk for the cost of these populations.

**Higher Spending Limits in Vermont Are Based in Part on Assumptions about Beneficiary Enrollment Growth That Exceeded Benchmarks**

The \$1.4 billion in projected costs for SCHIP, disproportionate share hospital payments, and a long-term care demonstration was omitted from the original proposal, but Vermont will continue to receive federal funding for these programs independent of the demonstration.

Vermont submitted 5 years of historical cost and beneficiary enrollment data for assessment by HHS.<sup>41</sup> For per person costs, HHS required Vermont to hold growth rates in line with the department’s benchmark policy. For beneficiary enrollment, however, HHS approved growth rates that were higher than benchmark levels. For example, the benchmark rate for enrollment growth of aged, blind, and disabled beneficiaries was 1.52 percent per year; HHS approved a rate of 2.52 percent. For the largest group of beneficiaries under the demonstration—families and children—HHS approved an enrollment growth rate of 1.99 percent, higher than the 1.05 percent nationwide benchmark for this group (see table 4).

**Table 4: Comparison of Vermont’s Beneficiary Enrollment Growth Rates as Proposed and Approved under HHS’s Benchmark Policy and Supported by HHS’s Explanations**

Rates in percentages				
	Enrollment growth rates as proposed and approved		HHS benchmark rates and rates as supported by explanations	
	Proposed by Vermont	Approved by HHS	HHS benchmark <sup>a</sup>	Rate as supported by HHS explanations
Aged, blind, and disabled beneficiaries <sup>b</sup>	2.52	2.52	1.52 (S)	1.52
Children and families	1.99	1.99	1.05 (N)	1.05
Certain populations from an ongoing section 1115 demonstration	6.43	6.43	1.10 (N)	4.93
Beneficiaries from an ongoing developmental services demonstration	6.00	6.00	1.52 (S)	4.25

Source: GAO analysis of data from Vermont and HHS.

<sup>a</sup>Lower of state historical beneficiary enrollment (S) or estimates of Medicaid growth nationwide (N).

<sup>b</sup>This beneficiary group consists of several small beneficiary groups: two main subgroups are those receiving services through Vermont’s state Medicaid plan and those receiving services through an ongoing section 1115 demonstration. HHS approved a 3.52 percent enrollment growth rate for the former and a 2.52 percent growth rate for the latter.

<sup>41</sup>The state initially proposed including in the demonstration all beneficiaries statewide, including beneficiary groups from several other demonstrations and SCHIP. HHS required Vermont to continue to operate a long-term care demonstration and SCHIP independent of the proposed demonstration, and to remove those beneficiary groups from its spending base. On the other hand, HHS allowed Vermont to include beneficiaries from a demonstration that provided services to people with developmental disabilities as well as certain beneficiary groups from an ongoing section 1115 demonstration.

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Part, but Not All, of Increase  
Allowed above Benchmarks  
Supported

Similar to Florida, but to a lesser degree, a portion of Vermont's spending limit that exceeds HHS benchmarks was not supported. HHS used beneficiary cost and enrollment growth rates to provide the basis for Vermont's aggregate spending limit. Although HHS held Vermont's beneficiary cost growth rates to the lower of HHS's benchmarks, HHS did not do so with regard to enrollment growth rates. HHS approved enrollment growth rates that were proposed by Vermont but were higher than the benchmarks without adequate documentation for the higher growth rate (see table 4). HHS officials told us the higher growth rates were the results of negotiations. However, such negotiations were not well documented. For one group of beneficiaries—families and children—HHS approved an enrollment growth rate of 1.99 percent, consistent with the state's historical growth but almost twice the 1.05 percent nationwide benchmark for this group, without explanation. For another group—beneficiaries from an ongoing developmental services demonstration—HHS allowed the state to exceed the benchmark growth rate based in part on a state management plan to cover more people in the future by removing them from a waiting list for developmental services. For this same group, Vermont supported part, but not all, of the spending limit in excess of the benchmarks by presenting a more narrowly focused analysis of its historical enrollment data. Specifically, for this subset of the state's aged, blind, and disabled beneficiary group, Vermont officials identified enrollment growth of 4.25 percent, higher than the benchmark level for aged, blind, and disabled beneficiaries. HHS officials told us that they considered both state-specific and nationwide benchmarks before approving Vermont's requested enrollment growth rates. We estimate that the higher-than-benchmark enrollment growth rates approved by HHS that were not supported by explanation and documentation increased Vermont's spending ceiling by about \$180 million.<sup>42</sup>

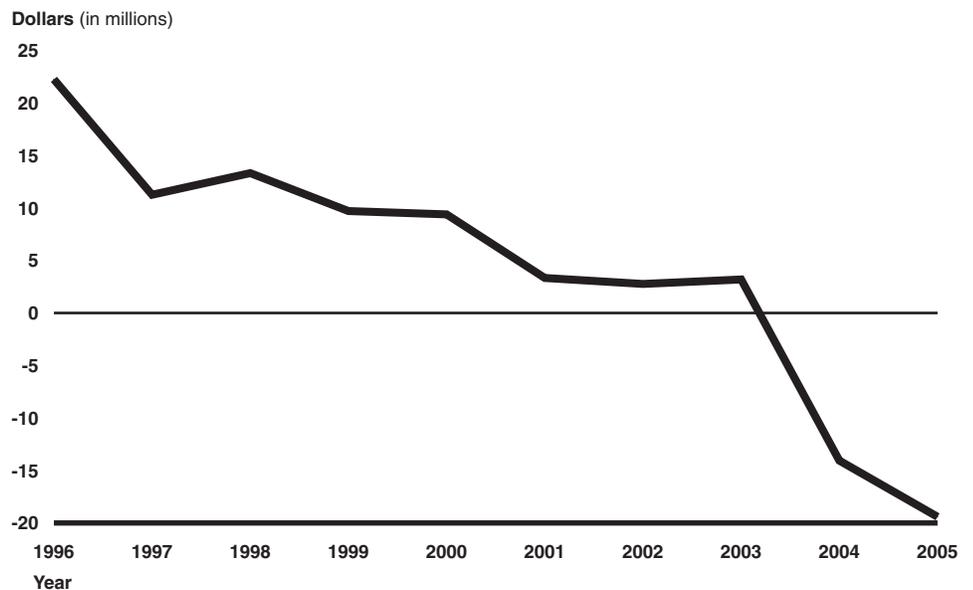
HHS also allowed Vermont to include in its spending limit the projected costs for "hypothetical" expenditures, that is, expenditures the state could have made but did not make. Specifically, HHS allowed Vermont to include in its spending limit nearly \$67 million that the state was authorized to have spent under an ongoing Medicaid section 1115 demonstration, but that was unspent under the program. At the time of its

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<sup>42</sup>As with Florida, changes in growth rates are amplified by the number of beneficiaries accessing Medicaid services and the number of years across which these growth rates are applied. For example, reducing the enrollment growth rate for families and children from 1.99 percent to the benchmark level of 1.05 percent reduces Vermont's spending limit by more \$32 million over 5 years.

proposal, Vermont had an ongoing 1115 demonstration called the Vermont Health Access Program that began in 1996 and was later extended. While program expenditures for the Vermont Health Access Program were well under that demonstration's spending limit in the early years of the demonstration, in 2004 the program began operating at a deficit as expenditures exceeded its annual spending targets (see fig. 2). Vermont ended this demonstration early because the state could no longer afford to incur the deficits. Because of its early completion, \$67 million under the spending limit for the demonstration was unspent.

**Figure 2: Vermont Health Access Program Surpluses and Deficits**



Source: GAO analysis of information from Vermont.

HHS policy requires a state to capture actual expenditures in its spending base, and the \$67 million allowed was a hypothetical expenditure that did not represent true expenditures of the state under its program. We have previously reported a concern about HHS's allowing states to include hypothetical costs in their spending limits. For example, in 2002, we reported that HHS had approved an inflated spending limit for one state by

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allowing the state to include projected costs of covering a population that the state had not actually covered under its program.<sup>43</sup>

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## HHS Has Not Ensured That Demonstrations in Florida and Vermont Maintain the Fiscal Integrity of the Medicaid Program

HHS has not ensured that demonstrations in Florida and Vermont maintain the fiscal integrity of the Medicaid program. In Florida, HHS approved the state's use of spending from a problematic supplemental payment arrangement that the state had in place prior to the demonstration as the basis for allowed spending under the demonstration, without correcting all identified problems. A 2005 HHS financial management review found several problems with the earlier financing arrangement that involved supplemental payments to certain hospitals and other health care providers. Among the problems, the HHS review found that Florida had incorrectly calculated the level of supplemental payments for which federal Medicaid funds could be obtained, resulting in inflated payments under the arrangement. Without taking corrective action, HHS allowed Florida to use the prior financing arrangement as the basis for allowed spending in a \$1 billion per year low-income pool under its current demonstration. We had, in 2004, recommended that HHS establish methods for states' calculations of supplemental payments, but HHS has not implemented this recommendation. In Vermont, HHS allowed the state to operate a managed care organization and, through this arrangement, retain excess revenue from payments to the organization for previously state-funded programs. In July 2007, we raised concerns about this demonstration's consistency with federal law. We recommended that the Secretary reexamine Vermont's demonstration and, where appropriate, either modify the terms of the demonstration or seek statutory authorization for the state to continue the demonstration in its present form.

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## Florida Allowed to Use Spending under a Problematic Supplemental Payment Arrangement as the Basis for Spending under the Demonstration

A key component of Florida's demonstration is a pool of federal, state, and local money to supplement payments to the state, or to hospitals, clinics, or other providers (see table 5). Florida agreed to discontinue its supplemental payment program under the terms of the demonstration, but to ensure continued funding for providers that had been receiving supplemental payments under the former program, requested HHS approval to make supplemental payments through a low-income pool. HHS approved a \$5 billion low-income pool that allows Florida to spend

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<sup>43</sup>See [GAO-02-817](#).

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\$1 billion per year for the 5 years of the demonstration for uncompensated medical care costs to the uninsured and underinsured, Medicaid costs above standard Medicaid reimbursement rates, health insurance premiums, and insurance products for such services provided to otherwise uninsured individuals.<sup>44</sup>

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<sup>44</sup>Under the demonstration, funds from the low-income pool may be used for health care expenditures (medical care costs or premiums) incurred by “the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall. . . and may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.”

**Table 5: HHS-Approved Distribution of Florida’s Annual Low-Income Pool of Federal, State, and Local Funds, Demonstration Year One**

Dollars in millions

<b>Categories of eligible provider access systems</b>	<b>Approved distribution of annual low-income pool funds<sup>a</sup></b>	<b>Description</b>
Hospitals that received supplemental payments under the former UPL program	\$141.1	Hospitals that serve a significant portion of Florida’s Medicaid, uninsured, and underinsured population, including those in rural areas, with emergency services, inpatient hospital care, specialty pediatric care, and primary care
Public, non-state-owned hospitals	578.0	Funds are distributed among four tiers of public hospitals depending on whether they receive local tax support and how much service they provide to Medicaid beneficiaries and those who lack adequate health insurance
Health care providers in communities in which the local government provides more than \$1 million to support care for individuals who lack adequate health care coverage	180.0	The local community for providers in this category must provide more than \$1 million in financial support for hospitals within its boundaries to fund care for the uninsured and underinsured
Hospitals that do not receive local government support for the uninsured or underinsured or whose local governments provide \$1 million or less to support care for individuals who lack adequate health care coverage	80.5	These health care providers must devote at least 10 percent of their care to Medicaid patients and those who lack adequate health insurance
Hospitals that operate poison control programs	3.2	Regional poison control centers affiliated with accredited medical schools or colleges of pharmacy in Tampa, Jacksonville, and Miami, as well as a data center in Jacksonville
Federal Qualified Health Centers	15.3	The state proposed distributing \$7.3 million to centers that qualify for state funds, but did not determine how to distribute the other \$8.0 million prior to HHS approval
County health initiatives to expand primary care services	2.0	Funds to expand primary care services in rural areas to Medicaid beneficiaries, underinsured, and other low-income uninsured individuals who do not qualify for Medicaid

Source: GAO analysis of information from Florida.

<sup>a</sup>Distributions from the low-income pool are subject to authorization by the Florida State Legislature.

At the time the demonstration was approved, however, HHS also had indications that Florida made excessive supplemental payments through the existing supplemental payment arrangement, and these concerns had not been resolved as of the time the demonstration was approved. A

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September 2005 HHS review of Florida’s financing arrangements<sup>45</sup> found that the methods and data used to calculate the amount of supplemental payments eligible for federal matching funds were unreliable. The reviewer, for example, found that Florida established Medicaid UPLs—which cannot exceed what Medicare would pay for the same services, and which determine the maximum amount of federal matching funds the state could obtain for its supplemental payment program—without making adjustments to account for the fact that Medicare beneficiaries are typically older and more expensive to treat. For example, the review found that the state’s estimate of what Medicare would pay for hospital services was nearly three times what Medicaid would typically pay, which the reviewer questioned. Not adjusting for the higher cost of treating Medicare patients inflates the state’s calculation of allowable payments under the program. HHS’s review also found that the data used to calculate the supplemental payment levels under Medicaid’s UPL contained errors and did not provide a reliable basis for determining the appropriate payment levels. HHS’s 2005 review did not estimate the actual allowable payments under the program or the extent that the prior supplemental payment arrangement was considered excessive or inflated.

HHS required the state to correct one issue the review had identified with the source of the state’s own funding for the supplemental payments it was making as a condition of approving the demonstration. However, HHS did not require Florida to address the problems with the methodology and data used to determine the amount of supplemental payments eligible for federal matching funds before projecting allowed spending under the demonstration. HHS’s required terms of the demonstration, however, did allow for future adjustments to the spending limit under certain circumstances.<sup>46</sup> In November 2006, HHS officials said that problems

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<sup>45</sup>These reviews were conducted by HHS funding specialists hired in 2004 and 2005 and resulted in a product known as a state funding profile. The funding profile documents the state Medicaid program’s organizational structure, programmatic structure, and budget process and is made available to HHS staff for oversight and informational purposes. According to HHS, the funding specialists are hired using Health Care Fraud and Abuse Control Program funds.

<sup>46</sup>Section 118 of the Special Terms and Conditions governing Florida’s demonstration allows HHS to adjust the spending limit under several circumstances. Specifically, “The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through SMD [state Medicaid director] letters, other memoranda on or regulations.”

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identified with the improper calculation of states' allowed supplemental payment amounts would be corrected at a later date.

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### Vermont Allowed to Use Medicaid Funds to Supplant State Funding for Certain Purposes

Under Vermont's demonstration, HHS authorized the state to operate its own managed care organization and, through this arrangement, to apply federal Medicaid matching funds to programs that were previously funded by the state and that do not exclusively benefit those eligible for Medicaid. Under this approach, the state's Medicaid agency—the Agency of Human Services—makes actuarially certified monthly lump-sum payments to one of its own offices. That office, the Office of Vermont Health Access, serves as the managed care organization for the Medicaid program. In state fiscal year 2006, for example, the state Medicaid agency made lump-sum payments to its Office of Vermont Health Access of \$65.4 million per month. The Agency of Human Services, in turn, receives federal Medicaid matching funds on these monthly payments. If Vermont can operate its public managed care organization and provide services to Medicaid beneficiaries for less than \$65.4 million per month, HHS allows the state, under the demonstration, to spend excess revenues on programs that meet any of four broad health care objectives: (1) increase health insurance coverage, (2) increase access to quality health care for Medicaid enrollees and those lacking adequate insurance, (3) improve health outcomes and quality of life for Medicaid-eligible individuals, and, (4) encourage public-private health care partnerships.

In fiscal year 2006—the first full year of the demonstration—the Vermont-operated managed care organization generated \$56.5 million in excess revenues and invested \$43 million of the funds into various programs. HHS allowed Vermont to invest the remainder of the excess revenues generated by the managed care organization in a reserve fund for future use. Over the 5 years of the demonstration, Vermont estimates that it will accumulate \$300 million in excess revenues. The state plans to use these excess revenues to supplant state funding for a number of programs that do not exclusively benefit Medicaid-eligible individuals (see table 6). For example, Vermont plans to use excess revenues from the demonstration to fund a grant for the University of Vermont and to provide loan forgiveness for doctors and dentists. Vermont officials indicated that state funds—freed up by investment of excess revenues from the demonstration—could then be used to reduce Vermont's budgetary constraints, projected in the demonstration's proposal as a \$656.8 million 5-year shortfall in state funds to pay for the state's own share of Medicaid expenditures.

**Table 6: Examples of Vermont’s Use of Excess Medicaid Revenues under Its Demonstration**

Dollars in millions

<b>State-funded health care program</b>	<b>Examples of state fiscal year 2007 investments in health-related programs</b>	<b>Description</b>
Residential care for youth/substitute care	\$10.54	Funds for residential care for youth in need of intensive behavioral health services.
Mental health programs	8.25	Funds to support access to mental health care and treatment services for children and adults.
Department of Education school health services <sup>a</sup>	6.40	School health services include the professional services of nurses, occupational therapists, physical therapists, mental health counselors, certified mental health workers, psychologists, personal care aides, and other medical professionals.
University of Vermont-Vermont physician training	3.87	A grant to train medical professionals. Funding is used to support training of medical professionals and provide services to Medicaid-eligible, uninsured, and underinsured Vermonters.
Department of Corrections programs	2.95	Funds to promote community-based and residential treatment services for former inmates.
Substance abuse treatment	2.80	Funds for a program providing treatment services for individuals who lack health care coverage. Substance abuse treatment includes outpatient, intensive outpatient, residential, detoxification, and pharmacological treatment services.
Aid to Aged, Blind, and Disabled Community Care Level III	2.62	Funds to support payments to community care level III aged, blind, and disabled recipients. By law, eligible recipients receive a subsistence amount compatible with decency and health standards.
Blueprint for Health Program	1.98	Funds for a statewide program intended to advance innovative solutions and provide support to help doctors and patients effectively manage chronic disease.
Health laboratory	1.91	Funds to cover the nonfederal costs of running the public health laboratory, which identifies disease-causing agents in specimens from human, animal, and environmental sources.
Tobacco Cessation Program	1.65	Funds to reduce the use of tobacco among Vermonters, with an emphasis on discouraging young people from starting to smoke.
WIC Coverage-Special Supplemental Nutrition Program for Women, Infants, and Children	1.17	Funds to improve health by informing families about good health practices and by providing nutritious foods to eligible recipients. The program offers women, infants, and children health screenings and nutrition and health education.
Flexible Family/Respite Funding	1.14	Funds to support eligible families with children or adult family members with developmental disabilities, to enhance their ability to live together.

Source: GAO analysis of information from Vermont.

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Note: In state fiscal year 2007, Vermont also used excess revenues to invest in other health-related programs, including the state's Health Care Authority, Veterans Home, Essential Person Program, and Civil Union. In state fiscal year 2007, excess revenue investments totaled more than \$46.5 million in these and other health-related programs. This total does not include 2007 spending on Department of Education school health services, which was pending as of November 2007.

<sup>a</sup>Vermont officials indicated that spending on Department of Education school health services represents state fiscal year 2006 expenditures. State fiscal year 2007 expenditures for this program were pending as of November 2007.

The Vermont arrangement generates excess administrative reimbursement in two ways. First, HHS allowed the Agency of Human Services to pay its Office of Vermont Health Access at a rate that, while typical for private managed care organizations, is higher than the rate Vermont had been paid prior to the demonstration and higher than average Medicaid agency administrative costs. Second, because the payments for which matching funds are provided are lump-sum payments that include the managed care organization's administrative costs, HHS pays a higher portion of the administrative costs associated with the managed care organization than it pays for administrative costs in the rest of Vermont's Medicaid program or in Medicaid programs in other states. At the state's historical rate and in a proportion consistent with other states' administrative costs, Vermont would have received an estimated \$71 million less.<sup>47</sup>

The reimbursement attributable to administrative costs could help ensure that the state has excess revenues for the state's purposes, including supplanting state funding for non-Medicaid programs. A September 2005 independent review and risk analysis conducted by a consultant to Vermont concluded that the likelihood that there would be savings under the demonstration available to be used for programs formerly funded with state dollars was very high for two reasons. First, the spending limit and corresponding premium structure of the managed care organization assumed a 9 percent administrative cost component, which is typical for private managed care organizations but nearly double the average state Medicaid agency administrative costs. According to the consultant, such costs typically run in the 3 to 5 percent range. According to HHS data,

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<sup>47</sup>Over the course of the 5-year demonstration, we estimated that excess administrative reimbursement could total up to \$71 million in part because Vermont was allowed under the demonstration to receive a higher-than-traditional administrative reimbursement level. Under traditional administrative claiming, Vermont would receive about \$157 million based on \$4.3 billion in payments to the managed care organization (assuming 7.3 percent administrative claims matched at 50 percent). Under the terms of its demonstration, Vermont could claim as much as \$228 million (assuming 9 percent administrative claims matched at 58.93 percent, its 2007 federal matching rate).

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administrative costs averaged 4.6 percent nationwide in fiscal year 2005. Second, unlike the situation where the state contracts with a private managed care organization, there is an incentive to pay the state-operated managed care organization on the high end of the actuarial range approved for the managed care premium because any excess payments can be used for state-funded programs.<sup>48</sup>

This financing arrangement allows Vermont to increase federal Medicaid payments to the state without a commensurate increase in state Medicaid spending. The state agency, by making a payment to itself in excess of the cost of providing Medicaid services, generates federal matching funds, which can be used to supplant state spending on certain programs. This supplanted state money, in turn, can be used to reduce Vermont's projected \$656.8 million 5-year shortfall in state funds for Medicaid, thus generating even more federal matching funds in a process known as recycling. Curtailing practices that allow states to reduce the proportion of Medicaid spending for which they are responsible has been part of the ongoing congressional scrutiny of Medicaid programs.<sup>49</sup>

In a letter to the Secretary of HHS, we raised concerns about the Vermont program's consistency with federal law. These concerns stemmed from HHS's decision to allow the state to operate its own managed care organization and, through this arrangement, to apply federal Medicaid matching funds to programs previously funded by the state. The approval of the Vermont program raised the question whether the Vermont Medicaid agency could enter into a managed care contract with one of its own offices and receive federal matching funds for lump-sum payments to that office rather than for payments based on actual costs. The letter also noted that in connection with its managed care regulations, HHS has expressed concerns about states obtaining federal matching funds through managed care contracts for state-funded services for which such funds would not ordinarily be available. Given our concerns, we recommended that the Secretary of HHS reexamine the demonstration and, where appropriate, either modify its terms or seek statutory authorization for it to continue in its current form.<sup>50</sup>

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<sup>48</sup>See Health Management Associates, *Vermont Global Commitment Independent Review and Risk Analysis*, September 2005.

<sup>49</sup>For more information on state recycling of federal Medicaid funds, see [GAO-04-228](#).

<sup>50</sup>B-309734, July 24, 2007.

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## Conclusions

After examining HHS's approvals of demonstrations in Florida and Vermont, our long-standing cost and oversight concerns related to HHS approvals of comprehensive Medicaid demonstration proposals remain. In determining the budget neutrality of proposed demonstrations, HHS approved spending limits for Florida and Vermont that exceeded its own benchmarks without adequately supporting the basis for the deviations. Our findings in Florida and Vermont are similar to the concerns we raised in our earlier reports—during its budget neutrality process, HHS did not adequately support the deviations from benchmark rates that it allowed in the development of states' spending limits, or clearly document and make public the basis for the approved limits. When combined, the spending limits approved for Florida and Vermont are nearly \$7.2 billion more than what the documentation and explanations support for the demonstrations. Given the significant federal expenditures for these demonstrations, improved accountability and transparency in HHS's budget neutrality process, including in the approval of states' spending limits, is warranted.

HHS's approvals in Florida and Vermont also raise concerns about precedents they establish that affect the federal and state partnership and fiscal integrity of the Medicaid program. By allowing Florida to use spending from a prior supplemental payment arrangement as the basis for new spending without correcting known problems, and by allowing Vermont to create its own state-run managed care organization and use excess revenue to fund other state programs, HHS has not taken the steps needed to ensure that Medicaid funds are used for Medicaid purposes. HHS has not corrected the problems it found with historical spending under Florida's supplemental payment arrangement—historical spending that was used to set the spending limit under the demonstration—and reexamined the level of Florida's spending limit accordingly. We believe a related recommendation from our 2004 report on the fiscal integrity of state Medicaid supplemental payment arrangements remains valid: that the department establish uniform guidance to states setting forth acceptable methods for calculating supplemental payment arrangements, such as the one that served as the basis for Florida's low-income pool. Such guidance could help ensure that payments under ongoing supplemental payment arrangements, and any related demonstration proposals, are appropriate in the future. HHS agreed to implement this recommendation in responding to our 2004 report, but as of December 2007 had not done so.

Our concerns about HHS approvals extend beyond those related to costs and oversight. The Secretary's approval of the Vermont demonstration establishes a precedent for future proposals, but raises legal concerns. As

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of January 2008, HHS had no plans to implement our July 2007 recommendation to address concerns with the demonstration's consistency with federal law. Because HHS disagrees with this recommendation—and other recommendations we have made to improve the demonstration review process—we are elevating this and other recommendations to the Congress for its consideration.

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## Matters for Congressional Consideration

The Congress should consider requiring increased attention to fiscal responsibility in the approval of section 1115 Medicaid demonstrations by requiring the Secretary of HHS to improve the demonstration review process through steps such as (1) clarifying criteria for reviewing and approving states' proposed spending limits, (2) better ensuring that valid methods are used to demonstrate budget neutrality, and (3) documenting and making public material explaining the basis for any approvals.

The Congress should consider addressing whether demonstrations that allow states to operate public managed care organizations and retain excess revenue to support programs previously funded by the state—including the Vermont demonstration—are within the scope of the Secretary of HHS's authority under section 1115 of the Social Security Act.

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## Recommendation for Executive Action

To help ensure that the Florida demonstration will maintain the fiscal integrity of the Medicaid program, we recommend that the Secretary of HHS ensure that the level of supplemental payments for which the state could have obtained federal Medicaid funds in the absence of the proposed demonstration is calculated using appropriate methods and accurate data sources, and adjust the approved spending limit appropriately.

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## Agency and State Comments and Our Evaluation

We provided a draft of this report for comment to HHS, Florida, and Vermont. All three provided written comments which we summarize and evaluate below. The full text of HHS's comments is reprinted in appendix II along with our response to certain comments. Florida's and Vermont's comments are reprinted in appendixes III and IV, respectively. HHS and each state also provided technical comments, which we incorporated as appropriate.

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## HHS Comments and Our Evaluation

In commenting on a draft of this report, HHS strongly disagreed with our findings, conclusions, and recommendation, stating that the draft report mischaracterized the nature of the approved demonstration programs and HHS's budget neutrality policies. We based our characterizations of HHS programs and policies on documentation obtained from HHS and states and interviews with HHS and state officials; we believe we have captured and reported them accurately. In its comments, HHS also said that our analysis did not adequately account for the likelihood of differences in professional interpretation in quantifiable analyses. HHS emphasized that the demonstrations are approved at the discretion of the Secretary of HHS and that the review of demonstration proposals includes both budgetary and programmatic elements. We recognize that the Secretary has some discretion in approving demonstrations and in establishing policies and processes for doing so. But we believe that to maintain accountability and transparency in the Medicaid program, of which section 1115 demonstrations are a major component, the Secretary has the responsibility to approve demonstrations based on clearly articulated policies and spending limits that are consistent with these policies. In conducting our work and preparing the draft report, we accepted HHS's explanations for spending limit amounts that deviated from HHS's benchmarks when they were clearly articulated and documented. Our draft report acknowledged these explanations in noting that some of the deviations from the benchmarks were explained. We did not, however, accept estimates when program officials could not clearly articulate the reasoning they had used, demonstrate how this reasoning was consistent with budget neutrality and fiscal integrity principles, and explain how the resulting spending limits were derived.

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## HHS Comments Related to Past GAO Reviews on 1115 Demonstration and Fiscal Integrity Issues

HHS commented that we unnecessarily cite points from prior reviews regarding section 1115 demonstrations. We cite our earlier work to provide a broader perspective and context for our discussion about individual states. We also use our prior work as a basis to highlight actions that we have recommended that HHS take and that relate to problems we identified in this review, but that HHS has not acted upon. We believe it is an important part of our work to underscore recurring problems as well as areas where HHS has made significant progress.

HHS also said that we had not given the agency sufficient credit for the steps it has taken to ensure fiscal integrity within the Medicaid program, stating that we overlooked and understated the progress HHS has made since the early 1990s to curtail improper financing arrangements. HHS said that the draft report inappropriately focused on our 2004 report that did

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not address related issues and omitted mention of our other relevant reports, including those that had recognized HHS's efforts. The reports we have cited were those that focused on areas relevant to the scope of this work. We have acknowledged in earlier reports that the agency has taken a number of steps in recent years to strengthen Medicaid's financial management, but in the particular areas of concern here—the demonstration criteria, methods, and documentation for agreed-upon spending limits—HHS has chosen not to make changes that would better ensure accountability and transparency. In 2002 and 2004, we recommended that HHS undertake these changes. Because it has not, we now raise these as a matter for congressional consideration.

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### HHS Comments Related to the Application of Budget Neutrality Policy

HHS stated that there are multiple methods of establishing that a project is budget neutral and that each agreement must be considered as part of a larger picture, and suggested that we inappropriately characterized HHS's internal guideline as a "benchmark policy" and then criticized HHS for making minor adjustments for real-world factors that could affect a state's spending. We presented the information on HHS's policy in the draft report as found in written HHS guidelines on its Web site in March 2007 and as told to us by HHS officials. As noted in the draft report, HHS's policy for reviewing and approving demonstration proposals and their spending limits lacks transparency. HHS's complete policy should be clearly identifiable, in writing, and publicly available. Furthermore, we disagree that adjustments that account for billions of dollars in federal spending, without documentation and explanation, are of a minor nature. Agreements that commit the federal government to reimbursing states tens of billions of dollars should be documented and include explanations of the basic reasoning behind the final spending limits, including the adjustments to benchmarks that have been approved.

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### HHS's Comments Related to Approvals of Florida and Vermont Demonstrations

HHS noted that one of its most significant concerns about the draft was that it failed to acknowledge that HHS had capped Medicaid program growth in Florida, which had averaged 13 percent in recent years. We disagree. As noted in the draft report, HHS approved a per person spending limit for Florida's demonstration; however, there is no aggregate cap on spending in Florida similar to that in Vermont, where HHS placed a cap on total spending.

HHS also strongly disagreed with our recommendation that it recalculate the Florida spending limit using appropriate methods and data sources and adjust the spending limit accordingly. HHS indicated that Florida's

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data and methods for calculating payments for its supplemental payment program were irrelevant to the development of the Florida demonstration. We disagree that Florida's calculations were not relevant to the Florida demonstration, since Florida's historical payments were used as a basis for the low-income pool spending limit under the demonstration, and as a result, the spending limit allows for continuation of spending that a HHS review suggests should not have been allowed.

With regard to HHS's approval of the Vermont demonstration, HHS disagreed with our concerns and prior recommendation to reexamine the terms of the demonstration and, where appropriate, to either modify its terms or seek statutory authority for the demonstration to continue in its current form. HHS maintained that issues of legal authority were adequately and appropriately addressed in the information provided to us during the course of our fieldwork. We disagree and note that HHS has not addressed the concerns raised in our July 2007 letter.

HHS also commented that our concern regarding excessive reimbursement for administrative expenditures for the public managed care organization in Vermont was unwarranted because all demonstration revenue must be spent for demonstration purposes and costs matched by federal funds would be clearly identified. Our concern remains that the broad scope of costs identified as for "demonstration purposes"—for example, funding the state public health laboratory—can allow Vermont to shift costs to the federal government that were previously funded by the state and that do not exclusively benefit individuals eligible for Medicaid.

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## Comments from Florida and Vermont and Our Evaluation

We provided a draft of this report to Florida and Vermont. Florida stated that during the negotiations over the demonstration waiver, state officials worked closely with HHS to ensure that all data and documentation were provided in a timely and accurate manner to support the waiver application. Vermont indicated that the state had assumed an unprecedented amount of risk related to program expenditures in exchange for the flexibility granted by the Secretary and that state and federal staff had engaged in extensive discussion and analysis of Vermont's historical expenditures, cost and caseload trends, and program policies in arriving at the final budget neutrality spending limit. Vermont also questioned our finding that HHS agreed to reimburse the state's administrative expenditures under the demonstration at a rate higher than prior to the demonstration, indicating that an independent actuary relied on Vermont's historical administrative expenditures in developing this component of the capitation rate.

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We agree that the states provided data and documentation to HHS to show the basis for their demonstration proposals. Our concern remains, however, with the lack of sufficient documentation showing how the final spending limits were derived, particularly since they were different from the proposals and were based on assumptions about cost and enrollment growth that were higher than HHS's benchmarks. Finally, we base our finding that HHS agreed to reimburse Vermont at a rate higher than what the state received prior to its demonstration in part on our review of the independent actuary's report.

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As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff members have any questions, please contact me at (202) 512-7114 or [kanofm@gao.gov](mailto:kanofm@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are acknowledged in appendix V.



Marjorie E. Kanof  
Managing Director, Health Care Issues

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# Appendix I: Scope and Methodology

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Section 1115 of the Social Security Act provides the Secretary of Health and Human Services the authority to approve demonstration projects that test policy innovations likely to further the objectives of certain programs, including Medicaid. Under section 1115, the Secretary has authority to waive provisions of the Social Security Act, allowing states to operate demonstrations, and to provide federal Medicaid matching funds for states' costs that otherwise cannot be matched under federal law.

Section 1115 demonstrations vary in scope, from targeted demonstrations limited to specific services or populations, to comprehensive demonstrations affecting Medicaid populations and services throughout a state and including most of a state's Medicaid expenditures. For example, a section 1115 demonstration in Virginia that the Department of Health and Human Services (HHS) approved in July 2002 affects limited Medicaid services—family planning services—for about 8,300 beneficiaries. A section 1115 demonstration in New York that HHS approved in July 1997, on the other hand, changes the delivery of a broad range of Medicaid benefits for over 2.5 million beneficiaries from fee-for-service to managed care.

Our review addressed the budget neutrality<sup>1</sup> and fiscal integrity of recently approved, comprehensive section 1115 demonstrations. We selected demonstrations to include in this review based on when they were approved and whether they were comprehensive and accounted for a major portion of the state's Medicaid program. Specifically, we selected demonstrations based on the following:

1. Approval by HHS from July 2004 (when we last reviewed HHS-approved section 1115 demonstrations<sup>2</sup>) through December 2006.
2. Meeting HHS's definition of comprehensive, that is, those that affect a broad range of services for Medicaid populations statewide.
3. The demonstration accounted for greater than 50 percent of the state's Medicaid expenditures.

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<sup>1</sup>Budget neutrality is a requirement in place through HHS policy but is not a statutory requirement for Medicaid demonstrations.

<sup>2</sup>[GAO-04-480](#).

We used a two-step process to identify demonstrations that met our criteria. First, to identify comprehensive section 1115 demonstrations approved by HHS from July 2004 through December 2006, we reviewed a Centers for Medicare & Medicaid Services (CMS) report that listed all section 1115 demonstrations approved through February 2006 and updated the list through discussions with agency officials.<sup>3</sup> Four comprehensive demonstrations met these criteria: the California Medi-Cal Hospital Uninsured Care program; the Florida Medicaid Reform program; the IowaCare program, and the Vermont Global Commitment to Health program.

Second, to identify which of these four demonstrations met our third criterion that expenditures under the demonstration account for a majority of state Medicaid spending, we compared estimated first-year spending under the demonstration to 2004 total Medicaid spending in each state. First-year spending in two of the four states, California and Iowa, was less than 5 percent of total 2004 Medicaid spending, so we did not include these two states in our study. First-year demonstration spending in Florida and Vermont was projected to account for 59.9 and 117.2 percent, respectively, of 2004 Medicaid spending, so we included the demonstrations in these two states for further review in our study.

To determine the extent to which the Secretary of HHS ensured that Medicaid section 1115 demonstrations would be budget neutral to the federal government prior to approving them, we reviewed HHS's policies for determining budget neutrality as documented on HHS's Web site and in information provided by HHS officials. We examined each state's projection of the total spending needed to maintain its existing Medicaid program in the absence of the proposed demonstrations. Specifically, we assessed the extent to which each state's assumptions about per person cost and beneficiary enrollment growth conform to HHS's policy that these growth rates are the lower of state-specific or nationwide benchmarks of Medicaid growth.<sup>4</sup> In instances where per person and beneficiary enrollment growth rates exceeded the lower of these two benchmarks, we asked HHS and state officials for explanations and documentation to

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<sup>3</sup>Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Section 1115 Demonstrations, State Profiles: Approvals through February 28, 2006* (Washington, D.C.: 2006).

<sup>4</sup>We accessed HHS guidance on budget neutrality on March 23, 2007, from CMS's Web site: [http://www.cms.hhs.gov/HIFA/02\\_Guidelines.asp](http://www.cms.hhs.gov/HIFA/02_Guidelines.asp).

support the higher growth rates HHS approved. We also compared spending limits for the demonstrations—based on the per person cost and beneficiary enrollment growth rates HHS approved—against (1) our estimates of demonstration spending limits had HHS required Florida and Vermont to have spending limits consistent with benchmarks and (2) our estimates of the spending limits had HHS held per person cost and beneficiary enrollment growth in each state to levels we determined that HHS and state officials had explained with quantified support. HHS’s policy states that adjustments to benchmark growth rates should address anomalies in the underlying data.

To determine the extent to which HHS ensured that the Florida and Vermont demonstrations maintain the fiscal integrity of the Medicaid federal-state financial partnership, we evaluated HHS’s process for reviewing section 1115 demonstration proposals and reviewed related financial management reports. We interviewed HHS officials from the Center for Medicaid and State Operations that has direct oversight responsibilities for these demonstrations, including officials from the Division of Reimbursement and State Financing who reviewed funding of the demonstrations in Florida and Vermont to ensure consistency and compliance with federal requirements. We also interviewed state officials to gain their understanding of the waiver authorities HHS granted each state by approving its demonstration, as well as their understanding of the special terms and conditions that govern each demonstration. We also relied on the work conducted for an earlier study that reviewed the consistency of the Florida and Vermont demonstrations with federal law.

Our findings concerning HHS’s approval of these two states’ demonstrations cannot be generalized to HHS’s approval of other states’ demonstrations. We used the selection criteria discussed above for purposes of assessing HHS’s process as it was applied in these particular cases of importance. We considered these cases to be important because they allowed significant changes in the states’ Medicaid programs and the majority of the states’ Medicaid spending was governed by the terms of the demonstrations.

To assess the reliability of the data submitted by states to HHS to calculate historical state spending and enrollment growth rates, we reviewed the steps HHS takes to ensure the accuracy of spending data compiled in states’ automated Medicaid information systems. We obtained the data states’ submitted to HHS and reviewed them for anomalies and missing information. We also interviewed HHS and state officials knowledgeable about the data. We discussed limitations of the automated Medicaid data,

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such as potentially incomplete data and states' ability to revise data for up to 2 years, with HHS officials. Because the data used to establish spending limits were for a time frame for which the states' data should have been largely completed and finalized, we concluded that states' Medicaid spending and enrollment data are sufficiently reliable for the purposes of this report.

We conducted our work from June 2006 through January 2008 in accordance with generally accepted government auditing standards.

# Appendix II: Comments from the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



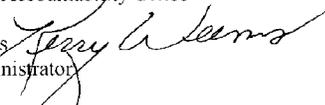
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator  
Washington, DC 20201

**DATE:** DEC 21 2007

**TO:** Marjorie Kanof  
Managing Director, Health Care  
Government Accountability Office

**FROM:** Kerry Weems   
Acting Administrator

**SUBJECT:** Government Accountability Office (GAO) Draft Report: "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns" (GAO-08-87)

## Overview

We appreciate the opportunity to comment on the GAO draft report, "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns" (GAO-08-87). Section 1115 demonstrations are an important tool for use at the Secretary's discretion to test innovations in health care delivery and coverage and by longstanding Department policy, must be budget neutral to the Federal Government. These demonstrations test important new ideas while extending health care coverage to thousands of low-income Americans who would otherwise lack that coverage.

The draft report discusses two approved demonstration projects, and contains only one substantive recommendation. There is no recommendation for executive action for the Vermont section 1115 Global Commitment to Health Demonstration. With respect to the Florida section 1115 Demonstration, the draft report recommends that the Secretary of the Department of Health and Human Services (HHS) "ensure that the level of supplemental payments for which the State could have obtained Federal Medicaid funds in the absence of the proposed demonstration is calculated using appropriate methods and accurate data sources" (p. 34). It further urges the Secretary to adjust the approved spending limit accordingly. We disagree with this proposed recommendation, for reasons set forth in the discussion below.

As we have noted through repeated meetings over the course of more than a year, involving hundreds of staff hours, we also disagree strongly with many of the characterizations and findings in the draft report in addition to that recommendation. The draft report makes numerous inaccurate assertions and characterizations with regard to both budget neutrality and Medicaid fiscal integrity. For example, the new draft report mischaracterizes the nature of these Secretarially-approved demonstration programs and the Secretarially-defined policies

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surrounding their approval, and does not adequately account for the likelihood of differences in professional interpretation in quantifiable analyses. Moreover, the draft report does not consider HHS' policies to focus limited federal resources to ensure Medicaid compliance and fiscal integrity in payments under ongoing State plans and demonstrations on a going-forward basis. As a result, the draft report seriously distorts HHS' efforts with respect to our fiscal integrity activities.

This Administration's unparalleled commitment to correcting financing issues within the Medicaid program has been extremely successful in ensuring that claimed Medicaid expenditures are based on appropriately financed expenditures that are not redirected for other purposes. Moreover, this Administration has approved significant demonstration projects that would expand Medicaid eligibility, coverage and access to providers. These are initiatives in which the Federal Government obtains a tangible result such as the creation of Provider Access Systems in Florida, coverage initiatives in California, and the universal coverage commitment in Massachusetts. These program components of section 1115 demonstrations have a serious real-world impact on the lives of many low-income people.

Restatement of Past HHS Responses to GAO on 1115 Demonstration Issues

In this draft report, GAO unnecessarily reasserts points made in prior reviews with regard to 1115 demonstrations. With regard to these points, HHS continues to stand by the responses we provided to the May 8, 2007 draft document, "Medicaid Demonstration Waivers: Lack of Opportunity for Public Input During Federal Approval Process Still a Concern" (GAO-07-694R). That response detailed the extensive efforts HHS has undertaken to make sure that the 1115 demonstration review process is transparent and to provide opportunities, as well as documenting the significant opportunities for public input during State legislative and administrative processes.

Also, GAO raised technical and legal questions pertaining to waivers granted to allow the implementation of the Florida and Vermont demonstrations, in a policy letter sent to Daniel Meron, General Counsel of HHS. We believe that the issues of legal authority, program effects on the beneficiary, cost-sharing, and the HHS evaluation process were all adequately and appropriately addressed in the April 26, 2007, response from Dennis Smith to Lynn H. Gibson, Managing Associate General Counsel of GAO.

Medicaid Fiscal Integrity

Disappointingly, the report is significantly lacking in its discussions pertaining to Medicaid fiscal integrity. The criticism of the Agency's efforts in the section of the GAO's draft report related to CMS' fiscal oversight of State financing is not supported by actual evidence. HHS believes GAO has overlooked and understated the progress that CMS has made since the early 1990s to

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curtail improper financing arrangements. Also, GAO has overstated its involvement, indicating that GAO has reported improper financing arrangements numerous times, but only citing one such report (from 2004). This is unfair and severely understates the Agency's significant efforts over the past 4 years to end impermissible financing arrangements. *We note further that our efforts to end such arrangements have been recently highlighted by the GAO itself in a March 2007 report.*

See comment 1.

This draft report continually references a February 2004 GAO report (MEDICAID: Improved Federal Oversight of State Financing Schemes is Needed GAO-04-228) to support an allegation that CMS has allowed improper State financing in the approval of both the Vermont and Florida 1115 demonstrations and to intentionally imply that CMS has not made efforts to ensure proper State financing since the release of GAO's February 2004 report. However, the primary scope of the February 2004 GAO report related to CMS' implementation of nursing home upper payment limit (UPL) transition periods, the significant majority of which have expired. According to the precise language of the referenced 2004 report, "GAO was asked to examine CMS' oversight of nursing home UPL arrangements, including the status of and the basis for transition period decisions." None of GAO's recommendations in the 2004 report addressed State financing, as is suggested by the following statement on page 7 in this report:

"Additionally, an earlier recommendation from our 2004 report on Medicaid fiscal integrity issues—a recommendation that HHS agreed to implement but thus far has not—that HHS establish uniform guidance to states that set forth acceptable methods related to state financing arrangements remains valid."

Because the 2004 GAO report did not address financing arrangements, this statement in the draft report is misleading. Moreover, this draft report erroneously suggests that Medicaid payment limit necessarily result in proper sources of State financing for the Medicaid program. This is inaccurate. A UPL test that complies with Federal requirements does not ensure that the financing of the non-Federal share of the Medicaid payments is proper. Instead, UPL demonstrations under the Medicaid State plan (i.e., Medicaid payment limits) and sources of the non-Federal share of Medicaid payments (i.e., State financing) are separate issues, governed by separate statutory and regulatory authority. (See Attachment 1 for further information related to CMS' position regarding the above-referenced recommendation in the February 2004 GAO report.)

See comment 2.

Additionally, this draft report omits mention of a March 2007 GAO report (MEDICAID FINANCING: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency GAO-07-214) in which GAO acknowledged significant fiscal oversight efforts on the part of CMS *including the fact that CMS had ended improper financing arrangements in 29 States*. Equally remarkable in this draft report is the omission of mention of the June 2006 GAO report (MEDICAID FINANCIAL MANAGEMENT: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts GAO-06-705), in which

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GAO acknowledged nine specific areas of improvement to CMS' Federal oversight efforts, including improved efforts to oversee State claims for Federal reimbursement, enhanced ability to address high-risk State funding practices, and the creation of goals to reduce inappropriate Federal reimbursement. The exclusive and continual reference to the GAO's February 2004 report to support current findings is troublesome.

This draft report inaccurately states that CMS acceptance of the data sources historically utilized by Florida to perform an inpatient hospital UPL demonstration under the Medicaid State plan reflects a lack of commitment on the part of CMS to the fiscal integrity of the Medicaid program. As described in detail below, Florida's historical use of certain data sources was largely irrelevant to the development of the Low-Income Pool under Florida's 1115 demonstration. In addition, the treatment of Florida was consistent with the treatment accorded other States. Consistent treatment of all States in the assessment of financing was a key recommendation of GAO's March 2007 report. As CMS indicated in its February 16, 2007 response to the GAO's draft 2007 report, CMS has instituted processes to ensure consistent treatment to all States, which included a series of standardized questions posed to all States under the Medicaid State plan amendment review process and a prospective termination of State financing arrangements that were inconsistent with Federal requirements. It appears the GAO omitted any reference to the March 2007 report because, by doing so, it would expose the illogical finding included in this report.

This draft also inaccurately faults CMS for allowing the Vermont managed care organization to be reimbursed in an amount greater than cost. Contrary to that assertion, the Special Terms and Conditions for Vermont specify that the managed care organization must spend all its revenue under the demonstration for demonstration purposes. GAO suggests that CMS allowed the State to retain excess revenue and use the funds to support health-related programs previously funded by the State and that do not exclusively benefit Medicaid beneficiaries. However, under the Vermont demonstration, CMS has ensured the transparent identification of costs for which Federal matching funds are available by clearly identifying the expenditures to which Vermont must adhere with the revenue received by the managed care organization.

Budget Neutrality—Unsubstantiated Allegations about Application of Policy

The HHS staff has spent significant time educating GAO staff on the subject of budget neutrality, in addition to the equally lengthy discussions on fiscal integrity noted above. As you may know, budget neutrality has been a longstanding Departmental requirement of health care reform projects that the HHS has approved since 1994, and across two different administrations. Budget neutrality is, by its nature, an important requirement, for it ensures that the Federal Government does not spend more under a demonstration project than it would have absent that demonstration. There are multiple methods of establishing that a project is budget neutral, and each budget neutrality agreement must be considered as part of a larger picture of whether a State's proposal, in the Secretary's estimation, promotes the objectives of the relevant title of the

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Social Security Act (in these instances, Title XIX). These projects are approved *at the discretion of the Secretary of HHS*, and this discretionary review includes both budgetary and programmatic elements. This, however, is *not* to say that there is no guidance for external

audiences or guidelines that are used in negotiations with States--or that HHS' application of these self-determined budget or program parameters have been arbitrary or inconsistent. Nor is it to say that "everything is negotiable" about budget agreements. HHS spends many staff hours with States providing technical assistance and education about budget neutrality.

The HHS has, as consistent with policy under this Administration, used as a starting point for discussions with States, a policy of using the lower of State historical spending or the projections from the President's Budget, sometimes referred to as the "lower-of" guideline.

States are required to provide historic experience with their proposals. This begins a review performed by a Federal team, and analyses are performed using the "lower-of" guideline provided above. What follows are discussions with States to determine if any of the historical experience was affected by unusual events that render the data suspect for trend development, and therefore the prediction of future spending.

The GAO has throughout its discussion documents and draft report, characterized our Agency's own internally-developed guideline as a "benchmark policy"-- and then criticized HHS for making relatively minor adjustments for real-world factors that could affect a State's spending. A few such examples include eligibility changes, benefit coverage changes (such as the implementation of Medicare Part D), claims processing abnormalities, and the like. In such instances the cost trend analysis can then be adjusted using techniques that are acceptable in statistical analysis and evaluations in order to yield a more "robust" analysis. GAO's characterization of our longstanding "lower-of" guideline as a "benchmark policy" misrepresents the guideline as being an inflexible standard. Instead it is applied as an initial position that is subject to adjustment based on actual expenditures experience based on our professional judgment. These adjustments, and the selection of the most appropriate "benchmark" are issues on which there can be differences in professional interpretation, as noted above. The draft report thus mischaracterizes the Department's policy.

We also believe that the application of GAO's apparent interpretation would severely limit the negotiating strength of an HHS Secretary under any Administration in promoting and testing new ideas in the health care marketplace.

#### State-Specific Comments and Issues

In the sections below we will address State-specific issues raised in this report, with respect to budget neutrality, program questions, and fiscal integrity. CMS officials spent countless hours meeting with GAO staff to provide explanation of the efforts put forth by CMS under the Medicaid State plan amendment financing initiative to ensure that Florida's and Vermont's

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Medicaid programs were properly funded. Unfortunately, the substance of those meetings has been omitted from this draft report, and we do not believe the information included in this report is accurately represented.

Florida-Specific Issues

The GAO contends that HHS did not adequately ensure that Florida's Medicaid demonstration would be budget neutral to the Federal Government before approving it, and also that HHS' basis for approving the higher spending limits was not fully supported by the documentation (page 6). HHS believes that the adjustments to the State's historic expenditure growth rates were both appropriate and consistent with HHS policy to develop rates that are projected to be most reflective of projected future without waiver Medicaid expenditures. The established agreement reflected a careful analysis of current spending and specifically limited how it could grow in the future. One of our most significant issues with regard to the draft report is that *GAO does not acknowledge in any way that HHS succeeded in capping Medicaid program growth in Florida which had averaged 13 percent in recent years.*

The GAO further contends that "HHS allowed Florida to use incorrectly calculated levels of supplemental payments as a basis for spending allowed under the demonstration" (page 5). Despite GAO's assertion that Florida's supplemental payment program is problematic, GAO does not provide the detail and financial data to support its position or an estimate of how the approved \$1 billion annual Low Income Pool (LIP) should have been adjusted as a result of the "deficient" supplemental payment program. Because of the lack of explanation by GAO, this seems to be in conflict with our principle of using actual rather than calculated numbers or estimates for without waiver trend line development. Additionally, as noted above, as a condition of the Florida health reform demonstration, HHS required the State to discontinue its inpatient supplemental program, *effectively freezing the growth of supplemental payments beyond the \$1 billion annual threshold.* Moreover, HHS required the State to establish new Letters of Agreement between the Florida Agency for Health Care Administration and the "Funding Sources" that support the LIP. This ensures that the sources of funding are appropriate; an assurance never before available to the Federal Government and Federal taxpayers.

Alarming also is the GAO position that HHS did not ensure the demonstration in Florida maintained the fiscal integrity of the Medicaid program prior to approval. As evidenced by materials provided by CMS to the GAO, Florida's financing of Medicaid institutional service payments, including supplemental payments, was initially reviewed under the same State plan fiscal oversight initiative that was applied to all States and that was documented in the GAO's March 2007 report. During that review, Florida provided CMS with the assurance that the source of the non-Federal share of Medicaid supplemental payments was derived from local tax revenue and that hospitals were able to retain 100 percent of the total computable expenditures.

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While CMS accepted that written assurance from a Florida official, CMS continued to review Florida's financing through the Agency's financial management review (FMR) process, a process that was specifically applied to all States that agreed to terminate particular State financing arrangements and to certain States that provided CMS initial assurance of proper State financing. CMS initiated the FMR process in the affected States to ensure the States were

meeting the commitments made to end certain financing arrangements and to confirm assurances provided by certain States that State financing arrangements were consistent with Federal requirements.

By way of background, the basis for and scope of this type of FMR was to ensure nationally consistent policy application and to sustain CMS' legal position to challenge future claims; specifically, in the event a State continued to make claims for Federal matching funds in State fiscal year 2006 with (i) the same source of State financing they agreed to terminate at the end of their State fiscal year 2005; or (ii) with a source of State financing that was inconsistent with the assurance provided by the State under the Medicaid State plan amendment review process. CMS developed "internal-only" reports from the results of these FMRs while we monitored State claims during all affected States' fiscal year 2006. None of these types of FMRs were ever released to any of the affected States.

In the case of Florida, CMS performed an FMR specific to the State financing utilized by Florida to make supplemental Medicaid payment to hospitals. The scope of this review as delineated in the Atlanta regional office's 2005 financial management work plan, was to examine whether or not hospitals were returning any of their supplemental Medicaid payments to the local Government. As part of the internal-only report developed as a result of the FMR, the Atlanta Regional Office also incorporated concerns with the sources of data utilized by Florida to perform the inpatient hospital UPL calculations based on information that was included in the 2005 funding specialist profile.<sup>1</sup>

While the FMR did not reveal that hospitals were returning their supplemental Medicaid payments to the State, the FMR did raise concerns with the manner in which the local financing was utilized by the State as the non-Federal share of the Medicaid supplemental payments. CMS used the findings of the FMR to require Florida to make prospective changes to their Medicaid program.

We also take serious issue with GAO's characterization of the LIP associated with the Medicaid 1115 demonstration. Although this draft report accurately identifies the LIP as a key component of Florida's 1115 demonstration, the GAO's characterization of the LIP's design is inaccurate

<sup>1</sup> The funding specialist profile was established in 2005 and designed as an educational tool to assist the newly hired funding specialists in understanding the Medicaid State programs to which they were assigned. This tool included identification of budget, program, and financing. All funding specialists were required to complete these profiles, but such profiles were never considered to represent a formal Agency position and they were never formally released to States.

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and misleading. *Most importantly, the LIP was not designed to continue a supplemental payment program as alleged on page 13 of this draft report.* The GAO appears to concede elsewhere in the draft report that such characterization is inaccurate in its expressed acknowledgement that “Florida agreed to discontinue its supplemental payment program under the terms of the demonstration...” (page 26). The LIP was designed to utilize funding that had historically been used by hospitals to subsidize their care of the uninsured to expand the scope of

health care services available to Medicaid and uninsured individuals and to document such costs in a manner that was transparent to the Federal taxpayer.

The GAO points to State law referencing the UPL to support the position that the LIP was merely an extension of the State’s UPL program. However, it is irrelevant that “Florida law made the State’s authority for pursuing the proposed demonstration contingent in part on Federal approval to preserve the upper payment limit funding mechanism.” as is footnoted on page 13. It is not unusual for States to require this type of funding contingency for a program such as this demonstration before the State moves forward. The LIP, as designed in this demonstration, is based on historical State spending and is limited to documented costs to the State for providing health care. To the extent such costs exceed historical spending under the Medicaid supplemental payment program, Federal matching funds will not be available. Again, HHS is not credited for this noteworthy achievement.

The draft report questions the data sources utilized under the State of Florida’s historical inpatient hospital UPL demonstration and, in doing so, implies the LIP is inflated. CMS and Florida developed the LIP by determining the actual Medicaid supplemental payments that were made in excess of actual Medicaid costs. This portion of supplemental spending was moved into the LIP pool and formed the LIP ceiling. The State was required to remove all supplemental payments from the Medicaid State plan and could not make Medicaid payments to hospitals above Medicaid cost. Since the initial budget neutrality calculation was based on historical spending below the UPL and above Medicaid cost and then trended forward, this spending is clearly controlled.

Budget neutrality has historically been limited to a State’s actual current law Medicaid spending, meaning spending authorized under its approved Medicaid State plan. This spending would include approved supplemental payments that were under the State’s UPL.

It should be noted that Florida’s UPL demonstration under the State plan resulted in approximately \$1.6 billion of available spending (i.e., “gap”). However, Florida historically made Medicaid supplemental payments to hospitals in an amount that was approximately 58 percent of that total available spending under the UPL. Hence, the reference to an inflated UPL is misleading in that Florida’s spending did not “maximize” Medicaid supplemental payment spending under the UPL. To have limited the State’s spending under their UPL program, the questioned data would have needed to impact the UPL by inflating it nearly 50 percent. The UPL demonstration under the State plan successfully caps the State at a much lower amount.

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The CMS acknowledges that the Florida funding specialist profile initially questioned the accuracy of the data sources used by the State of Florida in calculating the UPL for inpatient hospital Medicaid supplemental payments. CMS does not have an historical enforcement practice of challenging the data used by States to perform the UPL demonstration under the State plan. As explained earlier, CMS reviews UPL demonstrations under the Medicaid State plan amendment review process and such review applies to the "methods" by which States calculate

UPLs, not the data sources utilized by States. Under this review process, CMS is bound by regulatory timeframes and requires States to demonstrate proper UPL "methodologies" supported by readily available data to States. This process of reviewing UPL demonstrations under the Medicaid State plan amendment process allows CMS to ensure the application of uniform guidance to States by setting forth acceptable methods to calculate their UPLs, which happens to be the precise direction of the continually referenced recommendation of the February 2004 GAO report.

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Of even greater significance is the GAO's apparent lack of understanding related to the structure of and limitations to the LIP. On page 28 of the draft report, the GAO incorrectly indicates that CMS did not require Florida to address the problems with the UPL methodology and the data used to determine the amount of supplemental payments when determining the amount available in the LIP under the demonstration. On the contrary, the special terms and conditions associated with the section 1115 demonstration require Florida to limit both Medicaid State plan spending and LIP spending to cost and to document allowable costs in a manner consistent with Medicare cost principles, including the use of the Medicare 2552-96 hospital cost report along with hospital accounting records and audited financial statements. Consequently, the design of Florida's LIP under the 1115 demonstration ensures that Federal matching funds will be limited to the "actual" cost of providing inpatient hospital services, not a reasonable estimate of what Medicare would pay (i.e., the UPL).

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The CMS did not address Florida's UPL program because the State has discontinued it and has elected to limit its spending to cost. For example, if hospitals only incur \$600 million of costs that are allowable under the Medicaid State plan or the LIP, Federal matching funds will only be available as a percentage of those actual allowable costs. Moreover, the GAO properly recognizes that the special terms and conditions allow CMS to adjust the spending limit under several circumstances including impermissible provider payments.

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Based on the structure of and limitation to the LIP, suggesting a retroactive adjustment to historical Medicaid supplemental spending is both an inappropriate and unnecessary step to ensure the fiscal integrity of Florida's 1115 waiver demonstration.

Vermont-Specific Issues

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As noted above, there was no recommendation for executive action for the Vermont section 1115 Global Commitment to Health Demonstration. In its general overview, the GAO speculates that in the approval of the Vermont section 1115 Global Commitment to Health Demonstration, HHS did not adequately ensure budget neutrality and the maintenance of fiscal integrity of the Medicaid program similar to its assertion with respect to Florida above. From what HHS can garner from the report, these contentions are based primarily on four issues: Vermont's publicly-run managed care organization (MCO), the use of a higher trend rate for enrollment growth, the use of "hypothetical expenditures" from the previous Vermont Health Access Plan (VHAP)

Demonstration to build a base ceiling, and the arrangement to pay administrative costs at a rate higher than previously paid. In prior efforts to provide the GAO with an expedient and comprehensive explanation HHS has already responded to many of these critiques. However, additional clarification is provided to further illuminate the Vermont case.

In 2004-2005, faced with the rising cost of health care and a State budget crisis Vermont approached HHS seeking approval under section 1115 authority to revamp its health care system to improve quality and access, while decreasing cost. In 2005, a new section 1115 demonstration, The Global Commitment to Health, was approved. The new demonstration incorporated the current Vermont section 1115 VHAP Demonstration, currently costing significantly more than originally projected, and transitioned the State Medicaid program into a publicly run MCO. This publicly-run MCO for the State of Vermont is similar in concept to the Health Insuring Organizations (HIOs)—also known as County-Organized Health Systems—in several counties in the State of California where a single publicly-run entity arranges and manages the care for Medi-Cal beneficiaries. We note that the HIOs were established by Congress in the mid-1980s and are exempt from certain Medicaid requirements, and cover many lives in that State (approximately 500,000 versus the Vermont Global Demonstration's approximately 140,000).

To begin, it is unclear why GAO characterizes accumulated savings from the expired VHAP Demonstration as "hypothetical" when credited to VHAP's successor, Vermont Global (pages 21 and 25 of the report and elsewhere). The Global Commitment to Health Demonstration was a continuation and expansion of VHAP, covering the same populations, including expansion populations. It has long been HHS policy to determine budget neutrality over the life of a demonstration, and there is no reason not to include a *clearly related* predecessor demonstration. Indeed, to make such an exclusion would be a significant departure from past policy on 1115 demonstrations across two Administrations. Furthermore, any "hypothetical" costs not spent secondary to the transition from the prior VHAP Demonstration to the Global Commitment to Health Demonstration certainly would have been expended if the current VHAP Demonstration had continued in its original form.

Under the Global Commitment to Health section 1115 Demonstration, Vermont is permitted to generate savings in the same manner as a privately-managed Medicaid MCO receiving Federal

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funds. However, per the special terms and conditions, Vermont is held to *additional* requirements placed on the publicly run MCO that ensure any savings generated are used to fund services and programs designed to serve the Medicaid and other low-income populations; meanwhile, the payments via the rate-setting are required to be compliant with actuarial certification requirements, as are all other Medicaid MCOs. Furthermore, the use of savings generated from traditionally categorically eligible Medicaid populations to expand services and programs to other low-income populations is a fundamental tenet of 1115 health care reform demonstrations. This, again, is longstanding HHS policy across administrations. The authority to approve this demonstration rests with section 1115 and 1903(m)(6)(A), as well as the ability of States to operate public MCOs under section 1915 and 1932.

See comment 13.

See comment 14.

Regarding enrollment projections related to budget neutrality for the Global Commitment to Health, it appears that GAO contradicts itself. While at some points in the document it states that HHS does not establish benchmarks for enrollment growth trends (page 10, for example), at other times it claims that the enrollment trends granted violate HHS benchmark policy (page 22). Unlike most approved section 1115 demonstrations, *both* enrollment and administrative costs are subject to the \$4.7 billion Global budget neutrality ceiling (or cap). This arrangement places the State at risk for ensuring *both* enrollment and administrative costs remain reasonable and provides the State with an incentive to reduce administrative costs and carefully monitor enrollment. This is, in fact, a more stringent requirement than those in place in most section 1115 demonstrations, where in fact, administrative costs are *not* usually subject to the budget neutrality ceiling. Moreover, as GAO itself highlights in the report (page 31), the projected administrative costs closely resemble that of the private industry.

#### Additional Technical Corrections and Other Comments

We also offer the following comments of a more technical nature.

- The text of the report suggests that HHS policy requires that all 5 years of historical data must be used for the historical trend analysis. This misimpression is addressed, but it is buried in a footnote (page 20, footnote 40). The Health Insurance Flexibility and Accountability Guidance that GAO emphasizes as documentation for the HHS Benchmark policy requires the “states to submit five years of historical data for assessment by CMS, with quantified explanations of trend anomalies,” with the purpose of selecting the most appropriate data and time period to use in the analysis.
- Page 7, a goal of the Florida demonstration is to provide beneficiaries with access that is broader than conventional managed care plans; it is also to include Provider Access Systems (PASs). We believe GAO should replace “state-approved managed care benefit plans” with “state-approved Managed Care Organizations (MCOs) and Provider Access Systems (PASs)”.

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- Page 10, CMS considers the GAO cited benchmarks to be wrong; especially the use of the 4.8 percent President's Budget trend rate for Aged, Blind and Disabled does not match-up with the expenditure data. The cost data provided by the State excluded Part D expenditures and did not include the expenditure and caseload experience of Medicare Savings Groups.
- Footnote 32 (page 15) is confusing and conflates information on two separate 1115 demonstrations for Wisconsin-- it does not clearly identify which demonstration is being discussed. Wisconsin was required to return \$10.2 million for exceeding spending limits for BadgerCare, while the prior 2004 GAO report referenced in the new draft report had criticized CMS' approach to budget neutrality for SeniorCare (a demonstration that focused on providing drug coverage to low-income seniors and which was implemented before the advent of Medicare Part D). HHS appreciates the notation on the 2007 return of \$10.2 million to the Federal Government because the State exceeded spending limits for BadgerCare; this appropriately acknowledges that HHS takes seriously its fiduciary responsibility to the Federal taxpayer. *We further note that with respect to SeniorCare, HHS was prepared to terminate it for failing to remain within approved spending limits. Despite the HHS position, Congress elected to extend the demonstration via legislative action.*
- Also in footnote 32, it is important to note that the collection of funds from Wisconsin for BadgerCare pre-dates the 2006 Program Assessment Rating Tool activity. Wisconsin had its second renewal during 2007; the collection of funds was an HHS-imposed requirement of the previous renewal.

#### Attachment 1

In response to the draft 2004 report, CMS concurred with the recommendation that "CMS establish uniform guidance for states, which would set forth acceptable methods to calculate their UPLs." However, CMS specifically indicated in our response that we "did not necessarily agree with the GAO's definition of a reasonable estimate of the UPL" and we did not "believe that an extensive laundry list of acceptable methods could be compiled that would address every payment methodology to every provider in every State." Moreover, the GAO's recommendation in the February 2004 report addressed the need for guidance on the "methodologies" to calculate UPLs, not on the data sources utilized by States. Technical comments included in CMS' response to the 2004 draft report, which are conveniently "not printed" by the GAO in the February 2004 report, specifically challenged the GAO's suggestion that a methodology requiring a demonstration of a "reasonable estimate" should rely on precise data sources. When calculating UPLs, States are estimating what Medicare would pay for similar services provided to Medicaid patients and States are required to perform such demonstrations on a prospective basis. The precision to which the GAO suggested States should calculate their UPLs was merely based on the ability of the GAO to spend a year and a half reviewing calculations from prior

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periods. This luxury does not exist for CMS and the States due to the State plan amendment effective date requirements and State budgeting processes.

The CMS has addressed proper UPL methodological demonstrations in 2 ways under the Medicaid State plan amendment review process, processes of which were recognized by the GAO in the February 2004 report. Specifically, CMS requires (as part of the five standard funding questions) States to provide a UPL demonstration from all States proposing to increase Medicaid reimbursements. During the State plan amendment review process, CMS evaluates the reasonableness of a State's UPL methodology but CMS does not validate the data sources utilized by the States. It is unreasonable to suggest that CMS validate the data sources of a prospective State estimate. CMS has not generally challenged data sources utilized by States to

perform UPL demonstrations and the GAO's February 2004 report does not specifically recommend such a requirement. CMS also requires States to identify the sources of the non-Federal share of Medicaid payments under the Medicaid State plan amendment review process, which has significantly reduced State interest in maximizing UPL demonstrations. Specifically, many States making supplemental Medicaid payments were not allowing the health care providers to retain the Medicaid supplemental payments to which they were entitled. Therefore, States enjoyed a significant incentive to maximize the UPL demonstrations. However, as CMS required States to terminate such financing practices, States have demonstrated little interest in pursuing aggressive UPLs.

Again, CMS appreciates the opportunity to review and comment on the draft report.

The following are GAO's comments to certain concerns raised in HHS's letter dated December 21, 2007.

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## GAO Comments

1. We refer to our 2004 report because of the significant role supplemental payments play in Florida's demonstration and our concern that HHS did not require the state to correct known problems with these supplemental payments before establishing a spending limit on the basis of historical payments. HHS stated that we did not address financing arrangements in our 2004 report, but we disagree. An objective of the 2004 report was to determine if HHS's continuing oversight of supplemental payment arrangements was sufficient to ensure that claims submitted by states were calculated appropriately and complied with Medicaid requirements. Although we noted that HHS had taken a number of steps to strengthen its oversight of these payment arrangements, we found that HHS had not issued guidance for states' use on appropriate methods for calculating their Medicaid Upper Payment Limit (UPL). We recommended that HHS establish uniform guidance that would set forth to states acceptable methods for calculating the UPL. Our concern in this report is that HHS approved a spending limit for Florida's low income pool based on the state's UPL without first requiring Florida to address problems HHS identified in Florida's methodology for calculating this UPL.

We disagree that the draft of this report erroneously suggested that Medicaid payment limits necessarily result in proper sources of state financing. As noted in the draft, we are concerned that HHS approved a spending limit for the low-income pool based on potentially inflated historical payments. Our draft report credited HHS for requiring Florida to correct the issue the department had identified with the source of the state's financing.

2. We disagree with HHS's characterization of the findings from our 2006 and 2007 reports. Although our 2006 and 2007 reports addressed HHS oversight of Medicaid and discussed agency actions to strengthen oversight, certain of the findings of these earlier reports resonate with our current findings. In 2007, for example, we found HHS review and approval of state plan amendments to be marked by a lack of transparency and clear guidance. And in 2006, although we noted recent improvements in the financial management processes HHS uses in its oversight of states, we found it too soon to assess their impact, and further noted additional weaknesses that HHS had not addressed.

3. As discussed in the draft report, we are concerned that HHS allowed Vermont to seek reimbursement for administrative costs higher than that of other public health entities, and that HHS agreed to reimburse Vermont for a larger portion of these administrative costs than typically afforded other states. We disagree that HHS transparently identified costs for which federal reimbursement of excess revenues from the public managed care organization are available. As noted in the report, the purposes for which Vermont may spend these excess revenues are governed only by a set of broad health objectives. For example, HHS allowed Vermont to spend excess revenues on expenditures that increase access to quality health care for Medicaid enrollees and those lacking adequate insurance and that improve health outcomes and quality of life for Medicaid-eligible individuals.
4. Our draft report recognized HHS's discretion in making adjustments in the spending limits. For example, we accepted a projected \$2.1 billion in adjustments to the spending limits for Florida and Vermont because these adjustments were supported by quantified explanations. As noted in the draft, seemingly small changes to per person cost growth rates are amplified by the high volume of beneficiaries that access Medicaid services and the number of years across which these cost growth rates are applied. As noted in the draft, the seemingly small changes to the growth rates in Florida and Vermont resulted in nearly \$7.2 billion that we identified as not budget neutral.
5. As noted in the draft report, the established agreement did limit how Medicaid spending in Florida could grow in the future. Our concern, however, is that these spending limits are not budget neutral. Furthermore, we disagree with HHS's assertion that Florida's spending limits reflect projected future growth in the absence of the demonstration. For example, over \$5.5 billion in projected spending we identified as not budget neutral stems from an adjustment to reflect in part what the state projected would be higher anticipated costs of delivering Medicaid services in a managed care environment. These costs would not be incurred absent the demonstration, and as noted in the draft report, absent evidence supporting the approved changes to benchmark amounts, HHS should not have allowed them as a consideration in establishing a higher spending limit for the demonstration.

We also disagree that HHS capped Medicaid program growth in Florida. The agency approved per person spending limits rather than a total limit on programmatic spending. Thus Medicaid spending in

Florida may grow by more or less than 13 percent per year depending on enrollment in the program.

6. We believe the spending limit HHS approved for Florida's low-income pool was problematic because HHS did not require Florida to correct known deficiencies in the state's method for calculating historical supplemental payments that served as the basis for the spending limit. We did not estimate how the low-income pool should have been adjusted because HHS's September 2005 review—which identified the problems with Florida's calculation of its financing arrangement—did not estimate the actual allowable payments under the program or the extent that the prior supplemental payment arrangement was considered excessive or inflated. Consequently, we did not have the information available to us that would allow a detailed estimate of how the low-income pool spending limit should be adjusted. We believe that the concerns raised by HHS's own review should have been addressed prior to establishing a spending limit based on historical spending. As noted in the draft report, HHS should ensure that the level of supplemental payments for which Florida could have obtained federal Medicaid funds in the absence of the demonstration is calculated accurately, and adjust the approved spending limit accordingly.
7. By not requiring Florida to correct known deficiencies in the state's historical spending, we believe HHS did not ensure the fiscal integrity of Florida's low-income pool. In the draft report we credited HHS for requiring Florida to correct a problem the department identified with the manner in which Florida used local financing as the nonfederal share of its supplemental payments. Our concern remains, however, that HHS did not require Florida to correct a separate problem the department identified in the methods and data by which the state calculated the amount of supplemental payments eligible for federal matching funds under its program. By not requiring Florida to correct its method and data sources as a condition of approving the demonstration, HHS approved a spending limit for the low-income pool based on potentially inflated historical spending.
8. We believe that we accurately characterized Florida's low-income pool in this report. We agree that Florida discontinued its inpatient supplemental payment UPL program as a condition of the demonstration, and have clarified the language to indicate that HHS allowed Florida to develop the low-income pool in order to continue funding for a program of supplemental payments to providers.

9. HHS's estimation of the maximum amount Florida could have spent under its UPL is irrelevant to the discussion of the appropriate spending limit for the low-income pool. As we stated in the draft report, consistent with HHS policy, spending limits should be based on actual historical spending and quantified explanations for trend anomalies. We believe that, in the absence of reliable historical data, spending limits should be based on transparent, clearly articulated methodologies. Our concern is that HHS allowed Florida to base this spending limit on potentially inflated historical payments as a result of the state's flawed methodology for calculating its UPL.
10. HHS's efforts to limit and document Florida's Medicaid state plan spending and low-income pool spending under the demonstration do not speak to the extent to which HHS ensured the fiscal integrity and budget neutrality of the state's proposed demonstration prior to approving it. We are concerned that HHS approved growth rates for the demonstration without adequate support and did not require Florida to correct problems the department identified in the state's methodology for calculating its UPL.
11. To ensure that the spending limit on Florida's low-income pool is budget neutral and based on allowable historical spending, we believe that HHS should require Florida to correct problems the agency identified in Florida's methodology for calculating its UPL and adjust the spending limit for future payments made under the low-income pool accordingly. We are not suggesting a retroactive adjustment to the spending under the supplemental payment program. This recommendation is consistent with our long-standing conclusions that spending limits for proposed demonstrations should be based on valid methods.
12. We characterize accumulated savings from an expired demonstration in Vermont as hypothetical because they do not represent actual expenditures incurred during the historical period HHS reviewed in approving a new demonstration in Vermont. We do not object to consideration of actual expenditures from a predecessor demonstration in determining a spending limit for a new demonstration. But according to HHS's written budget neutrality guidance, surpluses generated early in the life of the expired demonstration would not have been available to Vermont in the absence of a new demonstration.
13. During the course of our review of the Vermont demonstration, we considered the statutory provisions cited by HHS, and nonetheless, as

indicated in the July 2007 letter,<sup>1</sup> had concerns about the consistency of the Vermont demonstration with federal law.

14. Our discussion and use of enrollment growth benchmarks reflect HHS's description of its policy, as written in guidance and as described by officials. During the course of our work, HHS officials told us that they considered benchmarks of enrollment growth in determining an aggregate spending limit for the Vermont demonstration. Yet HHS approved enrollment growth rates for the demonstration equal to, and in some cases exceeding, the highest rates HHS considered. Our main concern is that HHS's basis for approving these enrollment growth rates was not well documented. We believe that to maintain accountability and transparency in the Medicaid program, the Secretary's approvals should be based on clearly articulated policies and spending limits that are consistent with these policies.

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<sup>1</sup>B-309734, July 24, 2007.

# Appendix III: Comments from the State of Florida



CHARLIE CRIST  
GOVERNOR

ANDREW C. AGWUNOBI, M.D.  
SECRETARY

November 30, 2007

Dr. Marjorie Kanof  
Health Care Managing Director  
United States Government Accountability Office  
441 G Street, NorthWest  
Washington, DC 20548

Dear Dr. Kanof:

Thank you for providing the Agency for Health Care Administration, the single state agency for administering the Florida Medicaid program, with the opportunity to comment on the draft report entitled *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns (GAO-08-87)*.

As provided under Section 1115 of the Social Security Act, the Secretary for Health and Human Services has broad authority to grant waivers of statutory provisions to implement experimental, pilot, or other demonstration projects with the goal to assist in promoting the objectives of the Medicaid statute. Florida was granted such a waiver in order to implement our state legislated reform project in October 2005. The draft report focuses on recent waivers approved in Florida and Vermont, and examines the extent to which the Department of Health and Human Services ensured, before approving them, that the comprehensive 1115 demonstration waivers will: (a) be budget neutral to the federal government; and (b) maintain Medicaid's fiscal integrity.

We support the Government Accountability Office's (GAO's) efforts to evaluate Florida's Medicaid Reform effort and analyze the above issues. Florida understands the need to carefully monitor the impact of our demonstration in meeting the established goals. Find below our comments on the draft report.

#### *General Comment*

- During the negotiations of the demonstration waiver, Florida worked closely with the Centers for Medicare and Medicaid Services (CMS) to ensure that all data and documentation were provided in a timely and accurate manner to support our waiver application.

#### *Budget Neutrality*

- On page 12, Florida recommends the term "maintenance-of-effort requirement" be clarified in footnote #23 to avoid the misperception that something was missing from the special terms and conditions of the 1115 demonstration waiver. Per discussions with CMS, Florida was not expanding the population subject to managed care and therefore was not required to include this requirement as a part of the special terms and conditions. Through previous managed care efforts, Florida satisfied the maintenance-of-effort requirement.

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**Appendix III: Comments from the State of  
Florida**

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Dr. Marjorie Kanof  
November 30, 2007  
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*Budget Neutrality*

- On page 18, we recommend reformatting 'b' in alignment with the table on page 17 in order to provide a better flow of the table and the references.

*Low Income Pool*

- On page 28, the report states, "In November 2006, HHS officials said that the problems identified with the improper calculation of states' allowed supplemental payment amounts would be corrected at a later date." This statement is linked to footnote #48 which is located on page 29. The footnote indicates that correcting this problem in the case of Florida was unnecessary. Prior to and during negotiations for the demonstration waiver, Florida worked closely with CMS to resolve any concerns.

Again, we appreciate the opportunity to provide comments on your draft report. Should you have any questions about our comments, please contact me at (850) 488-3560.

Sincerely,



Thomas W. Arnold  
Deputy Secretary for Medicaid

TWA/lam

cc: Mr. Mark Thomas, Chief of Staff  
Mr. Clint Fuhrman, Deputy Secretary for Communications and Legislative Affairs

# Appendix IV: Comments from the State of Vermont



State of Vermont  
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Office of the Secretary  
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Cynthia D. LaWare, Secretary

November 20, 2007

Marjorie Kanof, MD  
Managing Director, Health Care  
United States Government Accountability Office  
441 G Street, NW  
Room 5A21  
Washington, DC 20548

Dear Dr. Kanof:

Thank you for the opportunity to review a copy of your proposed report entitled *MEDICAID DEMONSTRATION WAIVERS: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns* (GAO-08-87).

As you are aware, the nation faces a massive challenge related to health care. Public spending for health care continues to escalate; meanwhile, 47 million Americans lack basic health care coverage. The debate regarding how to address the health care crisis will continue at both the state and federal levels.

In Vermont, our Governor and Legislature recognized that the traditional approach for funding health care services was not financially sustainable. Absent meaningful reform, Vermont would continue to spend a greater percentage of its budget on health care with little or no opportunity to enhance access to health care or improve the Vermont health care delivery system.

Section 1115 of the Social Security Act provides the Secretary of the US Department of Health and Human Services with authority to grant state Medicaid programs the flexibility to pursue alternative approaches to meet the objectives of the Medicaid program. In light of challenges related to Medicaid at the federal level, we appreciate the Secretary's willingness to partner with Vermont by granting us the authority to pursue meaningful reform.

In exchange for the flexibility granted by the Secretary, the State of Vermont assumed an unprecedented amount of risk related to program expenditures. Federal spending for the vast majority of Vermont's Medicaid program is capped at an aggregate level over the course of the five-year demonstration.



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November 20, 2007

The State of Vermont's Administration and Legislature undertook an extensive review and analysis of spending projections and the proposed five-year spending limit for Global Commitment. Based on historical Medicaid growth rates in Vermont, Vermont program expenditures would exceed the aggregate spending cap established for the Global Commitment Demonstration. In the end, Vermont policymakers concluded that "business as usual" was not financially sustainable. Policymakers determined that the flexibility granted under the Demonstration would permit Vermont to engage in true reform and control program growth. By controlling program growth, Vermont's program would become financially sustainable and remain within the Demonstration's aggregate spending limit.

Vermont's Demonstration, the Global Commitment to Health, is premised on three basic objectives: 1) enhance access to health care services; 2) improve quality of health care; and 3) contain program costs. We believe these objectives are consistent with federal Medicaid policy and the goals of many other states. We believe that Vermont's experience will be a valuable resource for evaluating strategies for program reform throughout the country.

We have reviewed the draft report and understand that GAO has two primary findings related to the Vermont demonstration. GAO asserts that HHS did not adequately ensure that Vermont's Demonstration: a) will be budget neutral to the federal government; and b) maintains the fiscal integrity of the Medicaid program.

While we do not believe we are in a position to comment on whether HHS adhered to its policies and procedures, we would like to briefly share our experience in working with HHS and its federal partners.

State staff and federal staff engaged in extensive discussion and analysis of Vermont's historical expenditures, cost trends, caseload trends and program policies over the course of several months. These activities lead to the final budget neutrality limit established by HHS and accepted by Vermont. The process was both iterative and rigorous. Many of these discussions included staff from CMS Central Office, CMS Region I and the Office of Management and Budget. The discussions included detailed reviews of financial models, ad hoc claims analyses, trends analyses, and program spending reports.

As indicated previously in this letter, Vermont's decision to accept the aggregate budget neutrality limit was not an easy one and carried with it significant risk. The budget neutrality limit requires Vermont to implement reform strategies that enable it to stay within the specified spending limit.

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Additionally, the draft GAO report acknowledges that the rates paid by the Single State Agency to the public MCO must be actuarially certified. The independent actuary established payment rates using the same actuarial principles used to establish payment rates for Medicaid MCOs throughout the country. The rates are based on historical program expenditures and include only those services that are eligible for Medicaid coverage. We believe this requirement in the Demonstration's Special Terms and Conditions is one example of HHS's approach to maintaining the fiscal integrity of the Medicaid program.

We identified technical issues related to the draft report that you may want to consider as you finalize the report. These issues are listed below:

1. The opening section of the "Highlights" indicates that GAO found that "HHS did not adequately ensure that Florida's and Vermont's demonstrations will be budget neutral to the federal government." If GAO's finding is that HHS did not adhere to its internal policies for determining budget neutrality, it does not follow that the HHS did not ensure that the program will be budget neutral to the federal government. Absent entering into a demonstration agreement, spending growth is not limited to "benchmark" growth rates. Arguably, state-specific growth rates are a more accurate predictor of future growth trends within a particular state. If growth rates used to establish the Demonstration's expenditure ceiling are below state-specific experience (even if these growth rates are above the "benchmarks"), aggregate spending likely has been held to a lower level than would have been spent absent the demonstration.
2. The "Highlights" section also indicates that "HHS agreed to reimburse Vermont for the administration of its public managed care program at a rate higher than what the state received prior to its demonstration." We do not believe that this is accurate. The independent actuary relied on Vermont Medicaid's historical administrative expenditures in developing this component of the capitation rate. Second, the federal matching rate for payments to MCOs and the historical matching rates for administrative expenses in Vermont are very similar (approximately 60 percent). It also is worth pointing out that the Special Terms and Conditions require the public MCO to adhere to nearly all of the federal requirements that apply to private Medicaid MCOs. This requirement has resulted in the need to invest additional resources in the public MCO in order to meet federal managed care requirements. (This finding is repeated on Pages 6 and 30 and we believe it should be revised.)
3. On Page 28 of the draft report, GAO indicates that the demonstration enables the state to use federal matching funds to pay for programs previously funded by the state. We believe this section should be clarified to indicate that Federal matching

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funds are used to make capitation payments to the public MCO. Under the Global Commitment Demonstration, the public MCO receives an actuarially-certified, capitated payment in exchange for its commitment to provide all covered services to enrolled members. If the MCO incurs expenses in excess of its capitation revenues, then state-only dollars or MCO reserves will be used to reimburse covered services. Conversely, if the public MCO is able to manage service utilization through its program reform efforts, it will have excess revenues available to put into reserves or invest in the health care system. Unlike private Medicaid MCOs, the public MCO is restricted in how it can use excess capitation revenues. Pursuant to the Special Terms and Conditions, excess capitation revenues may only be used for specific, broad health objectives, as delineated on Page 29 of the draft GAO report. Essentially, the public MCO is required to re-invest savings into the Vermont health care system, benefitting Demonstration enrollees, uninsured Vermonters and the overall health care delivery system.

In summary, we believe the Vermont Global Commitment to Health Demonstration design is innovative and intended to address the challenges of public health care financing. We understand that true reform requires us to examine and evaluate program objectives broadly and outside the framework of traditional program policies and management methods. We believe the Demonstration's flexibility will enable Vermont to strengthen its health care delivery system while controlling program expenditures.

We appreciate the opportunity to provide comment regarding the draft report. Please feel free to contact me if you would like to discuss any of our comments.

Sincerely,



Cynthia D. LaWare, Secretary  
Agency of Human Services

cc: Joshua Slen, Director, OVHA  
Suzanne Santarcangelo, AIIS

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# Appendix V: GAO Contact and Staff Acknowledgments

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## GAO Contact

Marjorie E. Kanof, (202) 512-7114 or [kanofm@gao.gov](mailto:kanofm@gao.gov)

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## Acknowledgments

In addition to the contact named above, Katherine M. Iritani, Assistant Director; Kathryn Allen; Ted Burik; Tim Bushfield; Helen Desaulniers; Tom Moscovitch; Hemi Tewarson; Terry Saiki; Stan Stenersen; and Jennifer Whitworth made key contributions to this report.

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# Related GAO Products

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*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 Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act.* B-309734. Washington, D.C.: July 24, 2007.

*High-Risk Series: An Update.* [GAO-07-310](#). Washington, D.C.: January 2007.

*Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts.* [GAO-06-705](#). Washington, D.C.: June 22, 2006.

*Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight.* [GAO-05-836T](#). Washington, D.C.: June 28, 2005.

*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: Improved Federal Oversight of State Financing Schemes Is Needed.* [GAO-04-228](#). Washington, D.C.: February 13, 2004.

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

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

*Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging.* [GAO/HEHS-00-94](#). Washington, D.C.: August 18, 2000.

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

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**Related GAO Products**

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*Medicaid: Statewide Section 1115 Demonstrations' Impact on Eligibility, Service Delivery, and Program Cost.* [GAO/T-HEHS-95-182](#). Washington, D.C.: June 21, 1995.

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