United States Government Accountability Office

Report to Congressional Requesters

April 2015

MEDICAID DEMONSTRATIONS

Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives

Accessible Version

GAO-15-239

April 2015

MEDICAID DEMONSTRATIONS

Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives

GAO Highlights

Highlights of GAO-15-239, a report to congressional requesters

Why GAO Did This Study

Medicaid, an over $500 billion joint federal-state program, provides health care coverage to low-income individuals. Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive certain Medicaid requirements and authorize expenditures not otherwise allowed for demonstration projects likely to promote Medicaid objectives. HHS has approved expenditure authorities to allow states to expand Medicaid coverage to populations not otherwise eligible, as well as for other purposes, such as funding for state programs.

GAO was asked to review approved expenditure authorities in recent section 1115 demonstrations. This report examines (1) expenditure authorities approved for purposes of Medicaid coverage, (2) expenditure authorities approved for purposes other than Medicaid coverage, and (3) the criteria HHS uses to determine whether expenditure authorities for purposes other than Medicaid coverage are likely to promote Medicaid's objectives and the documentation of the basis for its approvals. GAO reviewed approval documents for new, extended, or amended section 1115 demonstrations approved by HHS in all 25 states with approvals between June 2012 and October 2013, and interviewed HHS officials.

What GAO Recommends

GAO recommends that HHS issue criteria for assessing whether expenditure authorities are likely to promote Medicaid objectives and document the use of these criteria in HHS's approvals of demonstrations.

View GAO-15-239. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

Under Medicaid section 1115 demonstrations, the Department of Health and Human Services (HHS) authorized expenditures not otherwise allowed under Medicaid for a range of coverage-related purposes. HHS approved expenditure authorities to expand coverage to previously uncovered populations in most of the 25 states' demonstrations that GAO reviewed; however, it also modified existing expenditure authorities to end or limit coverage under states' demonstrations as new coverage became available in 2014 under the Patient Protection and Affordable Care Act (PPACA).

In the 25 reviewed states, HHS approved expenditure authorities for a broad range of purposes beyond Medicaid coverage. Two types of noncoverage-related expenditure authorities were significant in terms of approved spending amounts. In 5 states, HHS approved expenditure authorities allowing the states to spend $9.5 billion in Medicaid funding during their current demonstration approval periods (about 2 to 5 years) to support about 150 state programs that would not otherwise have been eligible for federal Medicaid funding. The state programs included those providing health services, insurance subsidies, and workforce training. They were operated or funded by a wide range of state agencies, such as state departments of mental health, aging, and developmental disabilities that may be receiving non-Medicaid federal grants and funds. HHS also approved expenditure authorities in 8 states allowing states to spend more than $26 billion during their current demonstration approval periods (about 15 months to over 5 years) for new types of supplemental payments to hospitals and other providers through capped funding pools for a range of purposes, which included payments to incentivize delivery system or infrastructure improvements.

Although section 1115 of the Social Security Act provides HHS with broad authority to approve expenditure authorities that, in the Secretary's judgment, are likely to promote Medicaid objectives, HHS has not issued specific criteria for making these determinations. Further, HHS's approval documents are not always clear as to what, precisely, approved expenditures are for and how they will promote Medicaid objectives. For example, HHS's approvals in three states authorizing the use of federal Medicaid funds for more than half of the state programs GAO reviewed lacked clear information on how the programs would promote Medicaid objectives, such as how they would benefit low-income populations. In addition, HHS's approvals authorizing funding pools for incentive payments did not always provide clear explanations of how payments to hospitals would promote Medicaid objectives. Finally, approval documentation for some but not all approvals provided assurances that Medicaid funds would not be used for purposes addressed by other federal funding streams. Without clear criteria for assessing how proposed expenditure authorities states are seeking will promote Medicaid objectives, and without clear documentation of the application of those criteria, the bases for HHS's decisions involving tens of billions of Medicaid dollars are not transparent to Congress, states, or the public.

In commenting on a draft of this report, HHS partially concurred with the recommendation on issuing criteria, listing the general criteria it uses. But GAO maintains that more-specific, written guidance is needed. HHS concurred with the recommendation on documentation.

Contents

Tables

Abbreviations

AIDS	acquired immunodeficiency syndrome
DSH	Disproportionate Share Hospital
DSHP	designated state health program
DSRIP	Delivery System Reform Incentive Payment
FMAP	Federal Medicaid Assistance Percentage
FPL	federal poverty level
HCBS	home- and community-based services
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
MAGI	modified adjusted gross income
MCO	managed care organization
PPACA	Patient Protection and Affordable Care Act
UPL	Upper Payment Limit

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

April 13, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

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

Medicaid, a joint federal-state program that finances health care coverage for low-income populations, covered an estimated 65 million beneficiaries at an estimated cost of over $500 billion in fiscal year 2014.[1] Under the program, states claim federal matching funds for Medicaid expenditures from the Department of Health and Human Services (HHS), which oversees the program at the federal level.[2] Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.[3] Expenditure authorities approved in these section 1115 demonstrations allow states to receive

[1]Medicaid is an entitlement program that finances the delivery of health care services to low-income and medically needy individuals. Estimated Medicaid expenditures are for medical assistance payments and administration costs and, along with estimated enrollment, are based on projections for fiscal year 2014 reported in Centers for Medicare & Medicaid Services, Office of the Actuary, *2013 Actuarial Report on the Financial Outlook for Medicaid* (Washington D.C.: 2013).

[2]The federal government matches most state expenditures for Medicaid services on the basis of a statutory formula known as the Federal Medical Assistance Percentage (FMAP). The FMAP for each state is calculated, in part, on the basis of the state's per capita income. Federal law specifies that the FMAP must range from 50 percent to 83 percent. 42 U.S.C. §§ 1396b(a)(1), 1396d(b).

[3]42 U.S.C. § 1315(a). Although the Secretary of Health and Human Services has delegated the administration of the Medicaid program, including the approval of section 1115 demonstrations, to the Centers for Medicare & Medicaid Services, we refer to HHS throughout because section 1115 demonstration authority ultimately resides with the Secretary.

federal funds for costs that would not otherwise be matchable under Medicaid. The demonstrations, including their associated expenditure authorities, provide a way for states to test and evaluate new approaches for delivering Medicaid services. Section 1115 demonstrations account for a significant and growing proportion of federal Medicaid expenditures. In fiscal year 2014, section 1115 demonstrations accounted for close to one-third of total Medicaid expenditures.[4]

Expenditure authorities approved in section 1115 demonstrations can allow states to extend Medicaid coverage to populations or services that would not otherwise be eligible under traditional Medicaid programs. For example, an approved expenditure authority might allow a state to claim federal matching funds for coverage of adults who would not otherwise qualify under Medicaid eligibility criteria, or to alter the state's Medicaid benefit package for certain covered populations, for example, by covering services that otherwise would not be eligible for federal matching funds. Beyond expanding Medicaid coverage to populations or benefits not covered under traditional Medicaid, HHS has also approved expenditure authorities for a variety of other purposes. For example, we previously reported on states that had obtained approval under their section 1115 demonstrations to claim federal matching funds for supplemental payments made to providers to help cover their uncompensated care costs.[5]

We have had long-standing concerns with HHS's policy, process, and criteria for reviewing and approving Medicaid section 1115 demonstrations. These concerns have centered on HHS's implementation of its policy requiring that section 1115 demonstrations be budget-neutral to the federal government, that is, that the federal government's expenditures under a state's Medicaid program with a demonstration should be no higher than they would have been without the demonstration. The budget neutrality requirement applies to all costs

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

[5]Supplemental payments are separate from and in addition to payments made at a state's regular Medicaid rates. *See* GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, GAO-13-384 (Washington, D.C.: June 25, 2013).

under the demonstration, including those permitted under expenditure authorities. In several reports issued between 2002 and 2013, we reported that by not following its own budget neutrality policy and not providing clear support for its decisions to fund certain demonstrations, HHS approved spending limits that were billions of dollars higher than what the federal spending would have been if the states' existing Medicaid programs had continued.[6] While the budget neutrality requirement conceptually sets a limit on costs authorized under expenditure authorities, our concerns about HHS's ability to ensure that demonstrations remain budget neutral provide reason to examine the authorities approved.[7]

Given the potential for increasing federal Medicaid spending through Medicaid demonstrations, you asked us for information on the expenditure authorities in demonstrations that HHS has recently approved. For recently approved expenditure authorities in new, amended, or extended demonstrations, this report examines (1) expenditure authorities for purposes related to Medicaid coverage; (2) expenditure authorities for purposes other than Medicaid coverage; and (3) the criteria HHS uses to determine whether expenditure authorities for purposes other than Medicaid coverage are likely to promote Medicaid's objectives and how the agency documents the basis for its approvals.

To examine expenditure authorities approved for purposes related to Medicaid coverage and other purposes, we reviewed new section 1115

[6]GAO-13-384; GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns,* GAO-08-87 (Washington, D.C.: Jan. 31, 2008); *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 Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns*, GAO-04-480 (Washington, D.C.: June 30, 2004); and *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

[7]In the past, we have recommended that the Secretary of Health and Human Services improve the demonstration review process, and because the Secretary disagreed with these recommendations, we also suggested that Congress consider acting on our findings. In particular, we suggested increased attention to fiscal responsibility in the approval of section 1115 Medicaid demonstrations by requiring the Secretary to improve the demonstration review process. See GAO, *2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits,* GAO-14-343SP (Washington, D.C.: Apr. 8, 2014), 149-153.

demonstrations, as well as extensions or amendments to existing demonstrations, approved by HHS from June 2012 through mid-October 2013, to ensure we captured the most recent approvals available at the time we implemented our review.[8] Specifically, using HHS's online database of approved section 1115 demonstrations, we identified a list of demonstrations that included approved expenditure authorities and asked HHS to confirm this list. We also asked HHS for information on any additional demonstrations that the agency had approved within that time. Through this process we identified 25 states that received approval for new demonstrations, extensions of expiring demonstrations, or amendments to ongoing demonstrations during our review period.[9] For each such approval, we examined the list of expenditure authorities and the demonstration's relevant special terms and conditions, which set forth HHS's conditions and limitations on the expenditure authorities. For new and extended demonstrations, we included all expenditure authorities listed in the demonstrations in our scope; for amendments to ongoing demonstrations, we included any new or modified expenditure authorities in our scope.[10] We did not review any approvals issued prior to June 2012, even if they pertained to ongoing demonstrations. Once we identified all the new and modified expenditure authorities approved by HHS, we categorized them as either relating to Medicaid coverage, such as those allowing states to cover new populations, or relating to other purposes, such as those allowing states to receive federal matching funds for state programs, that is, programs that were primarily funded by the state before the demonstration. For the expenditure authorities that allowed states to claim funds for state programs, we developed a list of the specific state programs using information in the approval documents, which HHS verified. We also identified any spending caps associated with

[8]HHS's approval of a demonstration includes the approval of expenditure authorities. In this report, we refer to HHS's approval of a demonstration and HHS's approval of expenditure authorities interchangeably.

[9]We examined only comprehensive Medicaid 1115 demonstrations, that is, those authorizing more than one category of service; we did not include in our scope demonstrations that were financed solely using Title XXI funding (Children's Health Insurance Program) or that were limited to a narrow set of services, such as family planning or human immunodeficiency virus (HIV) treatment. In total, we examined 28 demonstrations, as three states were approved to operate more than one demonstration.

[10]For amendments to ongoing demonstrations, we reviewed the HHS approval letters, expenditure authorities, and special terms and conditions and identified any modifications to the expenditure authorities or the conditions and limitations imposed on these authorities under the special terms and conditions.

certain expenditure authorities to the extent that information was available. To supplement our document review, we interviewed HHS officials and obtained additional information and documentation as needed, such as prior approval documents, to discern whether expenditure authorities in our review were new or were extensions or modifications of existing expenditure authorities.

To examine the criteria HHS uses to approve expenditure authorities for purposes other than Medicaid coverage and how the agency documents that the expenditures would likely further Medicaid program objectives, we reviewed expenditure authorities and relevant special terms and conditions for the demonstrations, interviewed HHS officials, and obtained additional documentation from HHS to identify the criteria used for approval and how the department documented that states' 1115 demonstrations met such criteria. Our work focused on an analysis of HHS's approvals of demonstrations and did not examine the extent to which states spent the funds that were approved.

We conducted this performance audit from August 2013 to April 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Each state administers its Medicaid program in accordance with its own state plan, which must be reviewed and approved by HHS, and must delineate, among other things, the groups of individuals to be covered, services to be provided, and methodologies for providers to be reimbursed. Within broad federal requirements, states have flexibility in deciding which individuals to cover and the range of medical services to provide in their Medicaid programs. For example, states generally must cover certain "mandatory" populations and benefits, such as low-income children and pregnant women and inpatient and outpatient hospital services, but they also have the option of covering "optional" categories of individuals and benefits such as children with higher family incomes. Additionally, coverage of certain institutional services is mandatory under Medicaid, while coverage of most home- and community-based services

(HCBS) is optional for states. States may also choose from different delivery systems, such as fee-for-service or managed care.[11]

Under Medicaid, states pay health care providers based on provider claims for eligible services rendered to Medicaid beneficiaries. In addition to payments for covered services, states often make Medicaid supplemental payments to providers, which are typically lump sum payments that are separate from and in addition to payments made to providers using regular Medicaid payment rates. One type of supplemental payment states may make to hospitals is Disproportionate Share Hospital (DSH) payments. Congress created the DSH program to help hospitals serving Medicaid and uninsured patients offset their uncompensated care costs, within facility-specific and state-specific caps, or limits. States may also make other supplemental payments under their state plan, sometimes referred to as "Upper Payment Limit (UPL) payments," to providers such as hospitals and nursing homes. These payments are based on the difference between the amount that Medicaid paid for services using regular Medicaid payment rates and the UPL, which is an estimate of what the federal Medicare program would pay for similar services.[12] In recent years, some states have also made supplemental Medicaid payments to providers under section 1115 demonstrations.

Section 1115 Demonstrations

If a state wishes to change its Medicaid program in ways that deviate from certain federal requirements, it may seek to do so under the authority of an approved demonstration, outside its state plan. For example, section 1115 demonstrations can enable states to test new approaches to beneficiaries' health care delivery to generate savings or efficiencies by expanding benefits to cover populations that would not otherwise be eligible for Medicaid or altering the Medicaid benefit package for categories of covered populations while still qualifying for

[11]Under Medicaid, states may contract with managed care organizations to provide or arrange for medical services and prospectively pay the plans a fixed monthly rate, or capitation payment, per enrollee.

[12]Medicare is the federal health program that covers individuals aged 65 and over, individuals with end-stage renal disease, and certain disabled individuals. Supplemental payments under the Medicaid UPL are subject to aggregate limits by provider type, but there are no limits on the amounts paid to individual providers. See, for example, 42 C.F.R. §§ 447.272, 447.321.

federal matching funds.[13] While the expenditure authorities included in the demonstrations are often approved to expand Medicaid coverage, HHS also allows states to make changes to their existing expenditure authorities, which can include limiting or ending previously approved coverage. To obtain approval under section 1115 of the Social Security Act, a state's demonstration must, in the Secretary's judgment, be likely to promote Medicaid objectives.

States submit applications for section 1115 demonstrations to HHS for review by a federal review team, led by HHS.[14] The federal review may consist of negotiations, including the exchange of questions and answers between the review team and the state. If the demonstration is approved, HHS issues an award letter to the state and an approval specifying the Medicaid requirements that are being waived, the expenditure authorities approved, and the special terms and conditions. The special terms and conditions encompass the requirements for the demonstration, which include the conditions and limitations on approved expenditure authorities as well as specific reporting and evaluation requirements for the demonstration period. HHS typically approves an 1115 demonstration for an initial 5-year period that can be amended or extended. In general, HHS can withdraw a state's authority to claim federal funding for expenditures in an 1115 demonstration under certain circumstances, including if the agency determines that the demonstration no longer promotes the objectives of the Medicaid program.

In order to receive HHS approval for a Medicaid section 1115 demonstration, a state must generally show that the demonstration is budget neutral. To do so, generally a state must establish that its planned changes to its Medicaid program—including receiving federal matching funds for otherwise unallowable costs—will be offset by savings or other available Medicaid funds. For example, individuals who were not previously eligible for Medicaid could be covered under a state's demonstration without new costs to the federal government if the state

[13]Without this authority, states generally would be required to provide Medicaid benefits in the same amount, duration, and scope to all beneficiaries covered under the state plan. See 42 U.S.C. § 1396a(a)(10)(B), 42 C.F.R. § 440.240.

[14]The review team includes representatives from the Office of Management and Budget, other agencies within HHS as applicable, and HHS Secretarial Offices, including the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Financial Resources.

were saving Medicaid funds through efficiencies under the demonstration, such as by implementing managed care.[15] Each approved demonstration has a federal spending limit for purposes of determining budget neutrality. As specified in the special terms and conditions for each demonstration, yearly expenditure targets may be exceeded, but total spending over the time period of the demonstration must be at or under the overall limit.

Effect of the Patient Protection and Affordable Care Act (PPACA) on Medicaid Coverage

For many years, section 1115 demonstrations offered the only avenue for states to provide Medicaid coverage to childless adults, who were generally ineligible under the program, but this changed with the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010.[16] PPACA brought significant changes to the Medicaid program, including giving states the option to expand Medicaid eligibility to nearly all adults with incomes at or below 133 percent of the Federal Poverty Level (FPL), thus removing the program's historic exclusion of childless adults from Medicaid eligibility. States opting to cover newly eligible adults qualified for enhanced federal matching funds beginning January 1, 2014.[17]

In addition to providing states with the option to expand Medicaid, PPACA also provided new income-based subsidies to make private health insurance coverage more affordable for certain low- and moderate-

[15]In another example, states may also demonstrate budget neutrality by redirecting existing Medicaid funding, including DSH payments, to cover costs under the demonstration.

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

[17]Under PPACA, states may expand Medicaid to nonpregnant, nonelderly adults, ages 19 to 64, who are not eligible for Medicare and whose modified adjusted gross income (MAGI) does not exceed 133 percent of the FPL. PPACA also imposes a 5 percent income disregard when calculating MAGI, which in effect raises this income limit to 138 percent of the FPL. PPACA provides states with an enhanced match for newly eligible Medicaid beneficiaries. The enhanced federal match rate for newly eligible enrollees is100 percent for 2014 through 2016, with incremental decreases until it reaches 90 percent in 2020 and beyond. States that already covered adults up to 100 percent of the FPL at the time of PPACA's enactment under a section 1115 demonstration could also receive an increase in their regular federal match rate, which would equate to the same enhanced match for newly eligible enrollees over time. States are required to submit a state plan amendment to receive these enhanced match rates.

income individuals. Specifically, PPACA required the establishment of health insurance exchanges in each state, where, starting January 1, 2014, eligible individuals can purchase health insurance coverage from participating plans. In addition, eligible individuals with low- and moderate-household income may qualify for federal subsidies for this coverage. Individuals with household income between 100 and 400 percent of the FPL may be eligible for federal premium tax credits and individuals with household income between 100 and 250 percent of the FPL may be eligible for cost-sharing reductions.

HHS's Approvals Often Modified Existing Expenditure Authorities to Limit Medicaid Coverage under Demonstrations as a Result of PPACA's New Coverage Options

Among the variety of coverage-related expenditure authorities approved or modified by HHS during our review period, there were certain prevailing themes. While HHS did approve some expenditure authorities that extended coverage to new populations or for new benefits, HHS also modified existing expenditure authorities in several states to end or limit coverage of low-income adults or premium assistance payments under states' demonstrations, as new coverage options became available under PPACA. In addition, in almost half of the states we reviewed, HHS approved or modified expenditure authorities to provide HCBS to certain populations or to provide full Medicaid coverage to populations already receiving HCBS. (See app. I for coverage-related and other types of expenditure authorities approved in all 25 states.)

HHS's Recent Approvals in More Than Half the States Reviewed Served to Limit Coverage of Low-Income Adults and Payments for Premium Assistance under Demonstrations as New Coverage Options Became Available

In 20 of the 25 states we identified with recent approvals, HHS had approved new or modified existing expenditure authorities for Medicaid coverage, premium assistance, or both, for low-income adults; however, often the approvals were to limit the duration of this coverage as new coverage options became available under PPACA.[18] Twelve of the 20 states had covered low-income adults not eligible for Medicaid prior to 2014 under demonstrations and then had opted to expand Medicaid coverage to low-income individuals starting January 1, 2014, as allowed under PPACA.[19] In most of these 12 states, HHS modified states' existing expenditure authorities to end their coverage of low-income adults or permitted them to allow this coverage to expire under their demonstrations as of December 31, 2013; in 2 states HHS approved new expenditure authorities allowing the states to start covering low-income adults but just until the end of 2013.[20] Beginning in 2014, some of these populations would likely be covered under the states' Medicaid plans. Three of the states that limited coverage had not opted to expand Medicaid, as allowed under PPACA, at the time of our review.[21] These states received approval to modify their expenditure authorities to end Medicaid coverage for some individuals with incomes above 100 percent of the FPL under their demonstrations as of December 31, 2013, at which time these individuals could purchase coverage through the exchanges and may also qualify for federal subsidies for this coverage. These states were also approved to maintain coverage for certain individuals with

[18]The 20 states were Arkansas, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Missouri, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Tennessee, Utah, and Vermont. Other states may have expenditure authorities covering low-income adults, but there were no modifications to these expenditure authorities during our review period.

[19]The 12 states were Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Jersey, New Mexico, New York, Ohio, Oregon, and Vermont. Under PPACA these states obtained HHS approval to cover the Medicaid expansion population under their state plan. In addition, Arkansas also covered low-income adults not eligible for Medicaid prior to 2014 under a demonstration, but there were no modifications to the expenditure authorities during our review period.

[20]The two states—Illinois and Ohio—received approvals for new expenditure authorities during our review period to cover low-income adults for a time-limited transitional period until new coverage options became available through PPACA.

[21]The three states were Indiana, Louisiana, and Missouri.

incomes up to 100 percent of the FPL, who would not be eligible for the subsidies if they were to purchase coverage through the exchanges.[22]

Similar to coverage of low-income adults, HHS approved expenditure authorities for premium assistance in 7 of the 20 states during our review period, which often limited the duration of coverage under states' demonstrations as new coverage options were made available through the exchanges.[23] Under these approvals, the states were allowed to claim federal matching funds for different types of premium assistance payments, including those for employer-sponsored insurance and for individual private insurance—purchased either outside of or through the exchanges. Some states had expenditure authorities approved for more than one type of premium assistance. Appendix II provides information on the premium assistance programs included in the 1115 demonstrations we reviewed.

Employer-sponsored insurance. Six of the seven states had existing expenditure authorities for premium assistance for employer-sponsored insurance, and during our review period, most received approval to shorten the time frames for this coverage to coincide with the implementation of the exchanges. For example, while Vermont's demonstration is effective until December 2016, the state was approved to end premium assistance for employer-sponsored insurance on December 31, 2013, for several different populations.[24] Idaho received approval to offer premium assistance for individuals with incomes above 100 percent of the FPL through December 31, 2013, after which time these individuals can purchase coverage through the exchange and may

[22]For example, Louisiana received approval to cover uninsured adults residing in the greater New Orleans area, with incomes at or below 200 percent of the FPL through December 31, 2013, and then to limit eligibility to those in this population with incomes at or below 100 percent of the FPL, beginning January 1, 2014.

[23]The seven states were Arkansas, Idaho, Massachusetts, Oklahoma, Oregon, Utah, and Vermont. Other states may have expenditure authorities for premium assistance that were previously approved, but there were no modifications to these expenditure authorities during our review period.

[24]These populations included adults with children (with incomes from 185 through 300 percent of the FPL), childless adults (with incomes from 150 percent through 300 percent of the FPL), and some college students (with incomes through 300 percent of the FPL). If these populations purchase coverage through the exchange they may be eligible for federal subsidies for this coverage if they meet certain criteria, such as not having access to affordable employer-sponsored insurance.

be eligible for federal subsidies for this coverage if they meet certain criteria. The state also received approval to provide premium assistance through September 30, 2014, to individuals with lower incomes, who would not be eligible for federal subsidies if they chose to purchase coverage through the exchanges.[25] In contrast, some states received approval during our review period to extend or expand premium assistance for employer-sponsored insurance. For example, in September 2012, Utah—a state that had not expanded Medicaid as provided for under PPACA at the time of our review—received approval to expand income eligibility for its premium assistance program for employer-sponsored insurance for nonelderly workers from at or below 150 percent to at or below 200 percent of the FPL.

Individual insurance. HHS also modified expenditure authorities for premium assistance for private individual insurance coverage in three states—Massachusetts, Oregon, and Vermont—in anticipation of new coverage being available for purchase through the exchanges starting in 2014. For example, in Massachusetts and Vermont the duration of premium assistance was modified for certain adults with higher incomes—above 133 percent in Massachusetts and 150 percent FPL in Vermont—to end December 31, 2013, after which time these individuals could receive federal subsidies to purchase private insurance from the exchanges.[26] Massachusetts, however, did receive approval to provide premium assistance for certain disabled adults outside of the exchanges after December 31, 2013. In contrast to the three states that limited premium assistance for individual insurance coverage, another state was approved to expand coverage through premium assistance. Specifically, HHS approved a new demonstration in Arkansas, which became the first state to receive expenditure authority allowing federal Medicaid funds be

[25]Specifically, Idaho was approved to provide premium assistance through September 30, 2014 for nonpregnant childless individuals aged 18 and older with MAGI (a tax-based definition of income) below 100 percent of the FPL.

[26]Massachusetts and Vermont also received approval through a different expenditure authority to continue to provide private insurance subsidies starting January 1, 2014 to non-Medicaid-eligible populations.

used to provide premium assistance to enable newly eligible beneficiaries to purchase private insurance offered through the state's exchange.[27]

For Almost Half the States Reviewed, HHS Approved Expenditure Authorities Related to the Delivery of Home- and Community-Based Services

HHS approved expenditure authorities in 12 of the 25 states we reviewed[28] that allowed states either to target certain populations to receive HCBS or to provide full Medicaid coverage to populations that were eligible to receive HCBS through other Medicaid authorities.[29] Some of these states received approvals for both options. HCBS encompasses a wide range of services to help individuals who have limited ability to care for themselves—such as some elderly individuals, some individuals with human immunodeficiency virus/ acquired immunodeficiency virus (HIV/AIDS), and some individuals with disabilities—to remain in their homes or live in a community setting instead of receiving these services in an institution, such as a nursing facility.[30] HHS officials noted that states are increasingly seeking expenditure authority under their 1115 demonstrations to cover these types of long-term care services and supports.

HHS approved expenditure authorities in 7 of the 12 states that allowed the states to provide HCBS under their demonstrations to specific populations. For example, Minnesota received approval to provide elderly individuals who had incomes above the state's Medicaid standards with

[27]Arkansas was the first state to receive HHS approval to provide coverage of the Medicaid expansion population, as defined under PPACA, through premium assistance for exchange-purchased coverage. Under HHS's terms and conditions for Arkansas's 3-year demonstration, enrollment in the premium assistance program is mandatory, and the state is required to provide coverage for any Medicaid benefits that are not covered by the exchange plans. The state will receive a 100 percent federal match for expenditures related to this population. For additional information on this demonstration, see GAO, *Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns,* GAO-14-689R (Washington, D.C.: Aug. 8, 2014).

[28]The 12 states are Delaware, Florida, Hawaii, Kansas, Maryland, Minnesota, New Jersey, New Mexico, New York, Tennessee, Texas, and Vermont. Other states may have expenditure authorities related to HCBS or HCBS populations that were previously approved, but there were no modifications to these expenditure authorities during our review period.

[29]Within their Medicaid programs, states may cover HCBS under their state plans, 1115 demonstrations, or certain other waiver authorities.

[30]HCBS can include chore services, personal care, private duty nursing, and case management, among other services.

coverage of HCBS to prevent premature entry into nursing facilities and prevent or delay the spending down of their resources to obtain Medicaid eligibility.

HHS also approved expenditure authorities in 8 of the 12 states that allowed the states to provide full Medicaid coverage under their demonstrations to populations that, prior to the demonstration, were eligible for HCBS. Within Medicaid, states may provide coverage of HCBS through various Medicaid authorities, including through section 1915(c) waivers.[31] Under 1915(c) waivers, states may provide coverage of HCBS for a targeted population that would, if not for the services provided under the waiver, require institutional care. Through expenditure authorities approved in their 1115 demonstrations, the 8 states were allowed to extend full Medicaid coverage to these populations. For example, Delaware was approved to provide full Medicaid benefits for elderly and disabled individuals and also children and adults with HIV/AIDS, who were previously eligible for HCBS.

According to HHS officials, each state that has opted to cover HCBS services or populations under 1115 demonstrations has done so a little differently with respect to how the demonstration works in conjunction with other Medicaid authorities the state may be using to cover HCBS. For example, officials noted that some states have incorporated coverage of all HCBS populations into their 1115 demonstrations, ending their coverage under separate 1915(c) waivers, in order to administer the program more easily. In another model, HHS approved one state—Kansas—to run its demonstration and 1915(c) waiver programs in parallel even though they may cover the same populations.[32] HHS officials stated that they are encouraging states to consider this model because maintaining 1915(c) waivers provides better assurances that states will understand and comply with the quality assurance reporting, beneficiary protection, and other requirements that specifically apply to the HCBS populations through both types of authorities.

[31]The 1915(c) waiver is authorized under section 1915(c) of the Social Security Act.

[32]In Kansas, one of the main purposes was to enroll individuals eligible under 1915(c) waivers into Medicaid managed care plans.

HHS Approved Expenditure Authorities for a Broad Range of Other Purposes, Including State Programs and New Types of Supplemental Payments

HHS approved expenditure authorities for a broad range of purposes beyond Medicaid coverage in the states we reviewed. Among these, two types allowed significant spending. HHS approved expenditure authorities that allowed states to spend up to $9.5 billion in Medicaid funds for state programs over the course of the demonstrations. HHS also approved expenditure authorities that allowed states to make more than $26 billion in new types of Medicaid supplemental payments to hospitals and other providers through capped funding pools. (See app. III for information about other noncoverage-related expenditure authorities approved by HHS.)

HHS Approved New or Modified Existing Expenditure Authorities for $9.5 Billion in Medicaid Funding for More Than 150 State Programs

During our review period, HHS approved new, and extended or modified existing expenditure authorities that allowed five states—California, Massachusetts, New York, Oregon, and Vermont—to receive federal matching funds for more than150 state-operated programs.[33] These five states were collectively approved to spend $9.5 billion in Medicaid funds for these programs during their current demonstration approval periods, which ranged from 2.5 to 5 years.[34] Expenditure authorities for some of these state programs were in place for longer periods, as demonstrations were extended or amended. (See app. IV for information on the length of time expenditure authorities for some state programs have been continuously approved over the course of their demonstrations.) Prior to being included in the demonstrations, these programs could have been financed with state or non-Medicaid federal funding sources, or a combination of these, such as state appropriations or non-Medicaid federal grant funding. These state programs include those providing outreach and treatment services for specific health conditions, insurance subsidy programs, and workforce development programs, and were operated or funded by a wide range of different state agencies, such as

[33]These programs, often referred to as designated state health programs (DSHP), may not have been exclusively supported by state funding and, in certain cases, may have received federal funds other than Medicaid funds.

[34]Of the 154 state programs approved for Medicaid funding during our review period, 85 had been previously approved by HHS. The $9.5 billion approved is for programs in all five states and includes amendments to and extensions of previously approved funding and some new funding.

state departments of mental health, public health, corrections, youth services, developmental disabilities, aging, and state educational institutions. The expenditure authorities provided federal funds to the state agencies to support these state programs, but unlike coverage-related expenditure authorities they did not confer Medicaid beneficiary status on the individuals served by the programs. To receive federal matching funds, states must first allocate and spend state resources for each health program. The federal matching funds received could replace some of the state's expenditures for the programs, freeing up state funding for other purposes. For example, states could use the freed-up state funding to invest in health care quality improvement efforts or health reform initiatives or simply to address shortfalls in states' budgets.

Massachusetts, New York, and Oregon received approval from HHS for federal Medicaid funding for more than 40 state programs each, and California and Vermont were approved for 17 state programs, collectively. Each approval specifies a limit on the total amount of Medicaid funds available in the aggregate for these programs and the time frame within which these funds must be claimed.[35] On average, states were approved to spend nearly $2 billion (in combined federal and state funding) for state programs for the entire demonstration approval period, which ranged from 2.5 to 5 years. See table 1 for information on the number of state programs included in expenditure authorities approved or modified during our review period.

[35]Some approvals also specified limits on the amount of federal matching funds a state could claim on an annual basis for state programs. HHS officials said that states may not exceed these annual limits. In addition, unspent funds generally do not roll over to subsequent years, unless specifically authorized under the demonstration.

Table 1: Expenditure Authorities for State Programs in Section 1115 Demonstrations Approved or Modified by the Department of Health and Human Services (HHS) from June 2012 through October 2013

State	Number of state programs	Length of approval period	New spending approved during our review (in millions)[a]	Total spending approved through end of approval period (in millions)[b]
California	15	5 years (11/1/10–10/31/15)	$0	$4,000
Massachusetts	49	2.5 years (12/20/11–6/30/14)	$63[c]	$863
New York	11	3 years (4/1/11–3/31/14)	$0	$3,000
	32	3.4 years (8/1/11–12/31/14)	$500	$500[d]
Oregon	45	5 years (7/5/12–6/30/17)	$1,127	$1,127
Vermont	2	3.25 years (10/2/13–12/31/16)	$31[e]	$31
Total	**154**		**$1,721**	**$9,521**

Source: GAO analysis of information from HHS. | GAO-15-239

Note: We reviewed approvals issued by HHS from June 2012 through mid-October 2013 for new or extended demonstrations or modifications to expenditure authorities of ongoing demonstrations.

[a]Reflects the amount of new spending (federal and nonfederal share) authorized in the approval during our review period. For California, the approval during our review period did not authorize new spending.

[b]Reflects total spending (federal and nonfederal share) approved to be spent during the approval period, not expenditures made during our review period.

[c]HHS approved new spending for two Massachusetts programs: (1) $8 million in premium subsidies for the orderly transition of enrollees in its Commonwealth Care program, and (2) an additional $55 million for premium subsidies for its state Health Connector program.

[d]In addition, according to HHS, New York previously received approval for up to $264.4 million for a state-funded Indigent Care Program, for which the state could elect to claim matching funds using the designated state health program process.

[e]For Vermont, the total spending limit reflects the limit HHS placed on one of two state programs, called the State-Funded Marketplace Subsidies Program. The terms and conditions did not specify a limit on the state's Mental Health Community Rehabilitation Services program.

The expenditure authorities approved by HHS during our review period supported a broad range of state program costs that would not otherwise have been eligible for federal Medicaid funding. While many of the programs offered health-related services, the populations served may have incomes too high to qualify for Medicaid. Among the many categories of approved programs were those providing health-related services; those providing support services, for example, to non-Medicaid-eligible individuals; those providing access to private insurance coverage for targeted groups; and those funding workforce training programs.

- **Health-related services**. Many of HHS's approved expenditure authorities in five states were for state programs offering a variety of health-related services not necessarily targeted to the Medicaid population. For example, these included programs for treatment of prostate or breast cancer, treatment of alcohol dependency, and immunizations and screenings for newborns across the state.
- **Support services**. HHS approved expenditure authorities for at least 50 state programs in four states that provide support services to families and individuals. These health programs coordinate care for the elderly and persons with chronic mental illness, developmental disabilities, and alcohol dependency, among other conditions, and were not necessarily targeted to the Medicaid population. Additionally, HHS approved funding for state programs providing respite care to caregivers of children with special health care needs, community services for individuals with head injuries, and short-term living arrangements for homeless adolescents transitioning to residential services.
- **Workforce training**. HHS approved expenditure authorities for states to use federal Medicaid funds for more than a dozen employment and workforce training programs. States were approved to use federal Medicaid funding for health care professionals' training and loan repayment, as well as for efforts to promote health care worker recruitment and retention in hospitals and nursing homes.
- **Private insurance subsidies for private health coverage purchased on exchanges**. HHS also approved expenditure authorities in two states—Massachusetts and Vermont—to spend up to a combined $86 million in Medicaid funds for their state-funded premium subsidy programs to provide additional assistance to individuals purchasing private insurance coverage through their states' exchanges, effective January 1, 2014.[36] Subsidies in these two states are offered at eligibility levels corresponding with section 1115 demonstration expenditure authority coverage that existed in these

[36]As of January 1, 2014, Massachusetts received approval for $55 million to provide premium subsidies for individuals with incomes above 133 percent of the FPL through 300 percent of the FPL who purchase private insurance through the state's exchange. Vermont received approval for up to nearly $31 million for premium subsidies for individuals with incomes through 300 percent of the FPL who purchase private health insurance through its exchange. HHS also approved $8 million for the orderly close-out of Massachusetts' Commonwealth Care premium assistance program from January 1, 2014, through March 31, 2014.

states' demonstrations up through December 31, 2013. Individuals eligible for this assistance are not Medicaid beneficiaries and instead may qualify for premium tax credits and cost sharing reductions for exchange-purchased coverage, as provided for under PPACA. Because these federal subsidies may not cover the entire cost of individuals' coverage, Massachusetts and Vermont requested expenditure authority to use Medicaid funding to provide additional assistance to individuals to offset any premium costs for insurance coverage purchased on the exchanges not covered through premium tax credits.[37]

HHS Approved New or Modified Existing Expenditure Authorities for More Than $26 Billion in New Types of Supplemental Payments to Hospitals through Funding Pools for Uncompensated Care and Incentive Payments for Delivery System Improvements

Another major type of noncoverage-related expenditure authority approved by HHS in eight states during our review period was that which allowed states to make new kinds of supplemental payments—that is, payments in addition to base payments for covered services—to hospitals and other providers. During our review period, HHS approved expenditure authorities for pools of dedicated funds—called funding pools—amounting to more than $26 billion over the course of the current approvals, which ranged from 15 months to over 5 years. These expenditure authorities were for flexible funding under funding pools, through which states were authorized to make supplemental payments for uncompensated care or for delivery system or infrastructure improvements. In addition, some states had funding pools approved for other varied purposes, such as graduate medical education. Demonstration funding pools are subject to the limitations set forth in the demonstration's special terms and conditions, which may differ from those applicable to supplemental payments made under state plans, such as Medicaid UPL and DSH payments.[38]

[37]For example, individuals who have incomes between 150 and 200 percent of the FPL and who qualify for premium tax credits generally must pay between 4 and 6.3 percent of their income toward premiums when purchasing a certain type of plan through an exchange.

[38]Pools for uncompensated care costs and provider incentive payments approved or modified during our review period typically specified annual as well as overall spending limits. According to HHS officials, states are typically prohibited from rolling over unspent funds to subsequent years unless specifically authorized. In contrast, supplemental payments under the Medicaid UPL are subject to aggregate limits by provider type, while supplemental DSH payments are subject to facility-specific and state-specific limits.

Funding Pools for Hospital Uncompensated Care Costs

During our review period, HHS approved expenditure authorities for hospital uncompensated care funding pools in Hawaii, Kansas, Missouri, New Mexico, and Tennessee, and modified an existing funding pool in California. The six funding pools, which total about $7.6 billion in approved spending, varied in amount and duration—from $37.5 million over 15 months in Missouri to $4.0 billion over 5 years in California. Payments were intended to cover providers' uncompensated care costs associated with both Medicaid and uninsured patients, similar to supplemental payments under the DSH program (see table 2).

Table 2: Expenditure Authorities for Hospital Uncompensated Care Funding Pools in Section 1115 Demonstrations Approved or Modified by the Department of Health and Human Services (HHS) from June 2012 through October 2013

State	Description of expenditure authority	Length of demonstration approval period[a]	New spending approved during our review (in millions)[b]	Total spending approved through end of approval (in millions)[c]
California	Demonstration amended to modify an existing uncompensated care pool by (a) adding $445 million in unspent funds reallocated from another pool, and (b) allowing up to $30.9 million in uncompensated care payments to Indian Health Service clinics and tribal providers.	5 years (11/1/10–10/13/15)	$445.0	$4,016[d]
Hawaii	Extended authority for payments for uncompensated care costs incurred by certain hospitals and nursing facilities for inpatient, outpatient, and long-term care for Medicaid beneficiaries and uninsured individuals.	5.25 years (10/1/13–12/31/18)	$302.0	$302.0[e]
Kansas	New authority for payments for uncompensated care costs that eligible hospitals experience as a result of providing medical services to Medicaid beneficiaries and uninsured individuals.	5 years (1/1/13–12/31/17)	$344.3	$344.3
Missouri	Extended authority for payments to support primary and specialty care in St. Louis region for past expenditures on uncompensated ambulatory care.	1.25 years (9/27/13–12/31/14)	$37.5	$37.5[e]
New Mexico	New authority for payments to hospitals that previously received Upper Payment Limit (UPL) payments to defray the actual uncompensated cost of inpatient and outpatient hospital services provided to New Mexico's Medicaid-eligible or uninsured individuals.	5 years (1/1/14–12/31/18)	$344.4	$344.4
Tennessee	Extended authority for payments for uncompensated care through five pools, each targeted to a specific hospital type: (1) Essential Access Hospitals, (2) Critical Access Hospitals, (3) government-operated hospitals that submit certified public expenditures, (4) a state Medical college, and (5) all other Tennessee hospitals (with certain exclusions).	3 years (7/1/13–6/30/16)	$2,600.0	$2,600.0
Total			**$4,073.2**	**$7,644.2**

Source: GAO analysis of information from HHS. | GAO-15-239

Note: We reviewed approvals issued by HHS from June 2012 through mid-October 2013 for new or extended demonstrations or modifications to expenditure authorities of ongoing demonstrations.

[a]In some cases, the time period the state was authorized to make pool payments did not encompass the entire demonstration approval period.

[b]Reflects the amount of new spending (federal and nonfederal share) authorized in the approval in our review period.

[c]Reflects total spending (federal and nonfederal share) approved to be spent during the demonstration, not expenditures made during the review period.

[d]Although the initial approval for California's demonstration preceded our review period, HHS approved two amendments during our review period that added Indian Health Service and tribal providers to the list of eligible facilities and reallocated $445 million in funds initially approved as part of another funding pool. The other funding pool—called the Health Care Coverage Initiative—was a county-based effort to enroll individuals with incomes between 134 and 200 percent of FPL. According to HHS officials, the $445 million reallocated to the uncompensated care pool reflects funds available from counties that did not participate in the coverage initiative.

[e]The spending limits for Hawaii's and Missouri's uncompensated care pools are determined by the statewide limit on Disproportionate Share Hospital (DSH) payments, less any DSH payments made. For Missouri's demonstration, the uncompensated care spending limit is further reduced by any payments made under three smaller funding pools—two related to administrative costs, limited to $2,450,000 for one of the funding pools and $1,050,000 for the other, and a third pool for one specialty provider's overhead costs, limited to $2,900,000.

The expenditure authorities for uncompensated care pools generally allowed states to claim federal matching funds for payments to hospitals for inpatient and outpatient uncompensated care costs, as can be done with DSH funds. In some cases, HHS also authorized uncompensated care pools for broader uses, including for other services and provider types. For example, the amendment to California's demonstration approved during our review period created a new category of payments for Indian Health Service clinics and tribal providers in nonhospital settings, which would not be permitted under DSH.[39]

Funding Pools for Incentive Payments to Hospitals

During our review period, HHS approved new expenditure authorities for funding pools to make incentive payments to promote health care delivery system or infrastructure improvements in Kansas, New Jersey, and New Mexico, and modified existing funding pools in California and Texas. The five funding pools, which total nearly $18.8 billion in approved spending, varied in amount—from $29.4 million in New Mexico to $11.4 billion in Texas, generally over a 5-year period. These expenditure authorities were for payments intended to incentivize hospitals, and in some cases

[39]Specifically, California was authorized to make supplemental payments to Indian Health Service and tribal clinics for uncompensated primary care costs associated with uninsured individuals treated at the facilities with incomes up to 133 percent of the FPL and for uncompensated costs for certain Medicaid services, previously eliminated by the state, furnished to uninsured and Medicaid-enrolled individuals.

The amendment also reallocated $445 million from another funding pool included in the demonstration to fund California's initiative to increase coverage among low-income uninsured individuals—referred to as the Health Care Coverage Initiative—to its uncompensated care pool. HHS officials told us that these transferred funds reflected amounts allocated to counties that did not implement a low-income coverage initiative.

their partners,[40] to make a variety of infrastructure and delivery system improvements, such as lowering hospitals' rates of adverse events or incidence of disease, improving care for patients with certain conditions, and increasing delivery system capacity. According to HHS officials, payments from these pools are not related to the costs of the improvements but rather are established by hospitals, with the state's and HHS's approval, as the payments for achieving designated milestones. The nature of the milestones depends on the project type. For example, under New Jersey's pool, called a Delivery System Reform Incentive Payment (DSRIP) program, hospitals must complete projects designed to improve health care quality, efficiency, or population health from a menu of disease-specific focus areas, such as asthma, diabetes, and chemical addiction.[41] See table 3 for expenditure authorities for incentive payment pools that were approved or modified by HHS during our review period.

[40]Texas's demonstration requires that eligible hospitals form regional health care partnerships with other providers, such as community mental health centers and local health departments, when identifying community needs and developing project plans to qualify for incentive payments.

[41]Most states in our review that have received approval for incentive pools refer to them as Delivery System Reform Incentive Payment (DSRIP) pools. An exception is New Mexico, which refers to its program as the "Hospital Quality Improvement Incentive" pool.

Table 3: Expenditure Authorities for Incentive Payment Pools in Section 1115 Demonstrations Approved or Modified by the Department of Health and Human Services (HHS) from June 2012 through October 2013

State	Description of expenditure authority	Length of demonstration approval period[a]	New spending approved during our review (in millions)[b]	Total spending approved through end of approval (in millions)[c]
California	Demonstration amended to modify an existing Delivery System Reform Incentive Payment (DSRIP) pool by adding $165 million in additional funding for projects that support efforts to provide access to high-quality, coordinated, and integrated care to patients with human immunodeficiency virus (HIV).	5 years (11/1/10–10/31/15)	$165.0	$6,671.0[d]
Kansas	New authority for DSRIP pool to provide incentive payments to two hospitals for achieving specified metrics related to reforming the health care delivery system and quality improvement initiatives.	5 years (1/1/13–12/31/17)	$60.0	$60.0
New Jersey	New authority for DSRIP to fund hospital activities that enhance access to health care, the quality of care, and the health of the patients and families they serve. Project focus areas are behavioral health, HIV/acquired immunodeficiency virus (AIDS), chemical addiction/substance abuse, cardiac care, asthma, diabetes, obesity, and pneumonia.	4.75 years (10/1/12–6/30/17)	$583.1	$583.1
New Mexico	New authority for Hospital Quality Improvement Incentive payments to incentivize hospitals' efforts to improve the health and quality of care of the Medicaid beneficiaries and uninsured individuals that they serve through improved performance on designated outcome measures.	5 years (1/1/14–12/31/18)	$29.4	$29.4
Texas	Amendment modifying DSRIP funding rules to allow state to require local government entities to contribute through intergovernmental transfers to the DSRIP's administrative costs (no change to funding level).	4.75 years (12/12/11–9/30/16)	$0	$11,418.0[e]
Total			**$837.5**	**$18,761.5**

Source: GAO analysis of information from HHS. | GAO-15-239

Note: We reviewed approvals issued by HHS from June 2012 through mid-October 2013 for new or extended demonstrations or modifications to expenditure authorities of ongoing demonstrations.

[a]In some cases, the time period the state was authorized to make pool payments did not encompass the entire demonstration approval period.

[b]Reflects the amount of new spending (federal and nonfederal share) authorized in the approval in our review period.

[c]Reflects total spending (federal and nonfederal share) approved to be spent during the demonstration, not expenditures made during the review period.

[d]Although the initial approval for California's demonstration preceded our review period, HHS approved an amendment during our review period that added a new category of eligible projects,

along with additional funding, to an existing pool. According to HHS officials, the $165 million added to the funding pool was still within the overall spending limit for the demonstration.

[e]Although the initial approval for Texas's incentive pool was received in 2011, HHS approved an amendment during our review period that allows the state to require local government entities, which can be the providers themselves, to fund the program's administrative costs. This action affects the source of nonfederal funding for incentive pool administration, but not the total approved spending levels.

Funding Pools for Other Purposes

HHS approved or modified expenditure authorities for other funding pools for varied, and in some cases unspecified purposes. These included, for example,

- $250 million for temporary "transition payments" to New Jersey hospitals that previously received supplemental payments under New Jersey's Medicaid state plan to cover the gap between year 1 of the demonstration and year 2, when the state's incentive payment pool was to begin.[42]
- $175 million for additional supplemental payments to two public hospitals in Tennessee, the purposes for which were not specified in the approval, plus $125 million for graduate medical education.
- $2.9 million in Missouri to support one specialty provider's overhead costs, which per the special terms and conditions could include costs associated with purchasing billing software, hardware for systems, extended hours of operation, salaries, benefits and payroll taxes, professional and contractual services, supplies, insurance, occupancy costs, depreciation, and other miscellaneous costs.

See appendix V for total spending limits associated with the funding pools of all 11 states that received new or modified expenditure authorities related to funding pools (for any purpose) during our review period—that is, total spending for all funding pools included in the demonstrations, including for pools created prior to our review period.

[42]Payments from New Jersey's incentive payment pool were intended to replace the supplemental payments the state had been making under its state plan, subject to the Medicaid Upper Payment Limit; however, the demonstration was structured so that the pool did not begin until year two of the demonstration, leaving a 1-year funding gap. The initial approval included $166.6 million in transition payments for these hospitals in order to maintain a consistent level of funding during that gap. Then, due to a 6-month delay in implementing the DSRIP, New Jersey's demonstration was amended to provide an additional $83.3 million in transition payments while reducing its DSRIP by an equal amount.

HHS's Criteria and Approval Documents Were Not Always Clear as to How Approved Expenditures Would Further Medicaid Objectives

Although section 1115 of the Social Security Act provides HHS with broad authority to approve expenditure authorities that, in the Secretary's judgment, are likely to promote Medicaid objectives, HHS has not issued specific criteria for making these determinations. Further, HHS's approval documents were not always clear as to what precisely approved expenditures were for and how they would promote Medicaid objectives. In addition, the approval documents did not always specify how states were to avoid duplication with other federal funding received. In the absence of clear criteria for approving expenditure authorities and clear documentation of the application of those criteria, the bases for HHS's decisions—involving tens of billions of Medicaid dollars—are not transparent to Congress, states, or the public.

HHS Has Not Issued Specific Criteria for Assessing Whether Expenditure Authorities for State Programs and Funding Pools Promote Medicaid Objectives

While section 1115 of the Social Security Act provides HHS with broad authority in approving expenditure authorities for demonstrations that, in the Secretary's judgment, are likely to promote Medicaid objectives, HHS officials said the agency has not issued explicit criteria explaining how it assesses whether demonstration expenditures meet this broad statutory requirement. Federal standards for internal control of an agency's operations stress that in addition to the need for effective internal communications within an agency, management should also ensure there are adequate means of communicating with, and obtaining information from, external stakeholders that may have a significant impact on the agency's achieving its goals, such as states in the case of Medicaid demonstrations.[43] In our view, the criteria HHS uses for approving expenditure authorities for state programs and funding pools would be subject to such a communication requirement. However, HHS officials informed us that the agency has not communicated specific criteria for assessing these expenditure authorities. For example, HHS's website identifies different policy approaches that states may seek to test through demonstrations—such as the use of innovative service delivery systems to improve care, increase efficiency, and reduce costs—but does not specify how HHS will evaluate states' proposals to determine whether the proposed demonstration expenditures are likely to promote Medicaid objectives. In particular, HHS officials said that they have not issued specific written criteria that by themselves would require HHS to approve

[43]GAO, *Internal Control: Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

or disapprove expenditure authorities for specific state programs or funding pools. HHS officials also told us that for a demonstration to be approved, its goals and purposes must provide an important benefit to the Medicaid program, but they did not provide more explicit criteria for determining whether approved demonstration expenditures would provide an important benefit or promote Medicaid objectives.

In the absence of explicit, written criteria, HHS officials described using other approaches for assessing expenditure authorities for state programs and funding pools for alignment with Medicaid objectives. HHS officials said that HHS considers each proposed demonstration on its own merits. Further, HHS officials said they consider how the programs or pools relate to and are connected with overall Medicaid program objectives and other aspects of the demonstration. In assessing expenditure authorities for state programs previously funded by the states, HHS officials said they consider two criteria. First, HHS considers whether the proposal supports a compelling demonstration purpose. Second, HHS considers how the proposed state programs are suitable candidates for federal participation that align with the objectives of the Medicaid statute. HHS officials said they have told states that HHS is less open to approving Medicaid matching funds for state programs in certain categories, such as prisons and corrections, bricks and mortar, and debt relief or restructuring, although at least one state received approval for a program that builds housing for the homeless. HHS officials said that funding pools for uncompensated care must provide necessary support to providers whose continued operation and participation are essential to the delivery of health care to low-income populations. Officials also said that funding pools for incentive payments are assessed in terms of the health care quality improvement and system redesign objectives proposed, their relevance to Medicaid beneficiaries, the inclusion of the most appropriate providers, and whether the incentives are appropriate. In discussing why HHS has not made these considerations public, HHS officials said that it is not in the agency's interest to issue guidelines that might limit its flexibility in determining which demonstrations promote Medicaid objectives. However, without such guidance, the rationale for the agency's approvals of expenditure authorities is not transparent.

Approval Documents Did Not Always Specify What Expenditures Were for and How They Would Promote Medicaid Objectives

Demonstration approval documents in the states we reviewed with expenditure authorities for state programs or funding pools did not consistently include information indicating what, specifically, the approved expenditures were for and, therefore, how they would likely promote Medicaid objectives. Federal standards for internal control provide that all decisions, such as demonstration approvals, must be clearly documented and such documentation should be promptly and accurately recorded and available for review.[44]

Among the five states with approved expenditure authorities for state programs, two had approvals that included detailed information about the programs—including program descriptions and target populations—in what the agency refers to as "claiming protocols." HHS officials explained that claiming protocols for state programs outline the methods by which the state will identify appropriate expenditures and other revenues supporting the programs. HHS required the two states (California and Oregon) to submit and receive approval for the claiming protocols as a condition for claiming federal Medicaid matching funds. It included the claiming protocols as attachments to the special terms and conditions of the states' approvals, which lay out the state's obligations under the demonstration. The information provided in the claiming protocols can help explain how the programs may promote Medicaid objectives. However, even when claiming protocols were included, HHS's basis for approving expenditure authorities for some state programs was not clear. For example, one state received approval for an expenditure authority for a state program that issues licenses and approves certifications of hospitals and certain other providers in the state. The state's claiming protocol delineated the program's mission and funding limits but did not explicitly address how the program related to the purposes of the demonstration or to Medicaid objectives.

The approvals for the other three states (Massachusetts, New York, and Vermont), authorizing nearly half of the state programs in our review, did not include claiming protocols for most state programs and otherwise lacked clear information on how the state programs would promote Medicaid objectives, such as how they would benefit low-income

[44]GAO/AIMD-00-21.3.1.

populations.[45] Several state programs approved for federal Medicaid funds in these states appeared, on their face, to be only tangentially related to improving health coverage for low-income individuals and lacked documentation explaining how their approval was likely to promote Medicaid objectives. For example, among the programs approved were a program that funds insurance for fishermen and their families at a reduced rate; a program that constructs supportive housing for the homeless; and a program that recruits and aims to retain health care workers. Overall, state programs that were approved for federal Medicaid funds appeared to be wide ranging in nature. Table 4 shows the state programs approved by HHS during our review period, which were generally listed by program name in the special terms and conditions of each state's approval, but often without any further detailed information.[46]

[45]When Massachusetts first received approval to fund state programs under its demonstration in 2006, the special terms and conditions of the approval included some information on the program objectives and funding streams of the state programs, and an amendment to New York's demonstration in 2013 required the state to submit a claiming protocol for those state programs in New York that were newly approved. However, in both cases, information on previously approved state programs was not included in the special terms and conditions of the states' recent approvals, which specify the current requirements for the demonstrations.

[46]Identifying the mission of the state health programs approved for federal Medicaid funds was not within the scope of our review. Upon request, HHS provided some additional information on these programs; however, this information was not included in the terms and conditions for the demonstrations. For two approved programs in New York, HHS was able to provide only the names of the programs, citing gaps in its administrative records.

Table 4: State Programs Funded by Expenditure Authorities in Section 1115 Demonstrations Approved by the Department of Health and Human Services (HHS) from June 2012 through October 2013, as Listed in HHS's Approvals

California	Massachusetts	New York	Oregon	Vermont
State Only Medical Programs • California children's services program • Genetically handicapped persons program • County mental health services • Breast and cervical cancer treatment program • Prostate cancer treatment program • Acquired Immunodeficiency virus (AIDS) Drug Assistance Program • Expanded access to primary care • Medically indigent adult long-term care program • Department of developmental services • Every woman counts cancer detection program • County medical services program **Workforce Development Programs** • Song Brown healthcare workforce training program • Steven M. Thompson physician corps loan repayment program • Mental health loan assumption program	**Department of Mental Health** • Recreational therapy services • Occupational therapy services • Individual support • Community mental health center continuing care • Homeless support services • Individual and family flexible support • Comprehensive psychiatric services • Day services • Child/adolescent respite care services • Day rehabilitation • Community rehabilitative support • Adult respite care services **Department of Corrections** • Shattuck Hospital services **Department of Public Health** • Community health centers • CenterCare • Renal disease • Sexual assault nurse examiners program • Growth and nutrition programs	**Health Care Reform Act Programs** • Healthy New York • AIDS drug assistance • Tobacco use, prevention and control • Health workforce retraining • Recruitment and retention of health care workers • Telemedicine demonstration • Pay for performance initiatives **Office on Aging Programs** • Community services for the elderly • Expanded in-home services to the elderly **Office of Children and Family Services Programs** • Committees on special education direct care programs **Department of Health Programs** • Early intervention program services • Human immunodeficiency virus (HIV)-related risk reduction • Childhood lead poisoning primary prevention	**Addictions and Mental Health Program Group** • Non-residential adult • Child and adolescent • Regional acute psychiatric inpatient • Residential treatment for youth • Adult foster care • Older/disabled adult • Special projects • Community crisis • Supported employment • Homeless • Residential treatment • Non residential adult (designated) • Alcohol and drug special projects • Alcohol and drug residential treatment—adult • Continuum of care **Children, Adults and Families Program Group** • System of care • Community based sexual assault • Community based domestic violence • Family based services	• State-funded marketplace subsidies program • State-funded mental health community rehabilitation services

California	Massachusetts	New York	Oregon	Vermont
• Training program for medical professionals, California community colleges, state universities, and the University of California	• Prostate cancer prevention-screening component • Hepatitis C • Multiple sclerosis • Stroke education and public awareness • Ovarian cancer screening, education, and prevention • Diabetes screening and outreach • Breast cancer prevention • Universal immunization program • Pediatric palliative care • Children's medical security plan **Executive Office of Elder Affairs** • Prescription advantage • Enhanced community options • Home care services • Home care case management and administration • Grants to councils on aging **Center for Health Information and Finance** • Fisherman's partnership • Community health center uncompensated care payments	• Healthy neighborhoods program • Local health department lead poisoning prevention programs • Cancer services programs • Obesity and diabetes programs • Tuberculosis treatment, detection and prevention • Tuberculosis directly observed therapy • Tobacco control • General public health work • Newborn screening programs **Office of Mental Health** • Licensed outpatient programs • Care management • Emergency programs • Rehabilitation services • Residential (non-treatment) • Community support programs **Office for People with Developmental Disabilities Services** • Day training • Family support services • Jervis clinic • Intermediate care facilities • Home- and community based services residential	• Foster care prevention • Enhanced supervision • Nursing assessments • Other medical • Project for parenting • Personal care **Seniors and People with Disabilities Program Group** • Family support • Children long-term support • Oregon project independence **Public Health Division Program Group** • Licensing fees • General microbiology • Virology • Chlamydia • Other test fees • State support for public health • Newborn screening (used for match for maternal and child health block grant) • Prescription drug monitoring program • HIV community services • HIV/tuberculosis • Sexually transmitted diseases	

California	Massachusetts	New York	Oregon	Vermont
	Massachusetts Commission for the Blind • Turning 22 program—personal vocational adjustment • Turning 22 program—respite • Turning 22 program—training • Turning 22 program—co-op funding • Turning 22 program—mobility • Turning 22 program—homemaker • Turning 22 program—client supplies • Turning 22 program—vision aids • Turning 22 program—medical evaluations **Massachusetts Rehabilitation Commission** • Turning 22 program services • Head injured programs **Department of Veterans' Services** • Veterans' benefits **Health Connector** • Health connector subsidies • Commonwealth care transition	• Supported work program • Day habilitation • Service coordination/plan of care support • Pre-vocational services • Waiver respite • Clinics—article 16 **Office of Alcoholism and Substance Abuse Services** • Outpatient and methadone programs • Crisis services—ambulatory • Prevention and program support services **Office of Temporary and Disability Assistance** • Homeless health services	**Oregon Youth Authority** • Mental health treatment • Drug and alcohol **Division of Medical Assistance** • Organ transplants for formerly medically needy **Office of Private Health Partnerships** • Oregon medical insurance pool **Oregon State Hospital** • Gero-neuro psychiatric facilities **Workforce Development and Education Program Group** • Undergraduate and graduate health professions education	

Source: Department of Health and Human Services. | GAO-15-239

HHS officials stated that, beginning in 2012, the agency required all states to develop claiming protocols for state programs with more-specific information on their purposes. In its approval of amendments to New

York's demonstration in 2013, HHS required the state to develop a claiming protocol for 20 new state programs but did not require a claiming protocol for any of the 26 existing state programs approved for continued funding. Similarly, in its 2013 approval of amendments to Massachusetts's demonstration, HHS did not require the state to submit a claiming protocol for 49 existing state programs. In the case of Vermont, HHS officials said that a claiming protocol was not needed to support funding for one program because it was modeled closely on a previously approved demonstration program. HHS officials also said that during the time of our review, they began requesting that states proposing that Medicaid cover certain state programs under demonstration expenditure authorities complete a spreadsheet tool that, among other things, helps to identify and exclude the costs of services for which Medicaid should already be paying.[47]

As with approvals of expenditure authorities for state programs, HHS's approvals of expenditure authorities for funding pools also did not consistently document how expenditures would likely promote Medicaid objectives. The approvals of incentive payment funding pools we reviewed (California, Kansas, New Jersey, New Mexico, and Texas) established a structure for planning, reporting on, and getting paid for general, system-wide improvements—for example, increasing primary care capacity or lowering admission rates for certain diseases—but most provided little or no detail on how the initiatives related to Medicaid objectives, such as their potential impact on Medicaid beneficiaries or low-income populations. One exception is New Mexico, which was required to select outcome measures that reflected areas of high need for Medicaid and uninsured patients. Further, the criteria for selecting providers eligible to participate in incentive pools were not apparent in most of the approvals we reviewed. HHS officials said that the hospitals that are identified as eligible for incentive payments are those that are expected to have the most impact on efficiency and quality of care for Medicaid populations and that often the hospitals selected are those that have historically received the most supplemental payments, which are generally allocated to providers serving Medicaid populations. However, such selection criteria were not apparent in HHS's approvals, which listed eligible providers but with no additional information about their role in

[47]Although the spreadsheet tool requires states to document Medicaid program funding, it does not track other federal funding sources.

providing services to Medicaid populations. For example, none of the terms and conditions for the five states' demonstrations established a minimum threshold of Medicaid or low-income patient volume as the basis for participation; however, three states' approvals (New Jersey, New Mexico, and Texas) required that the payment allocations be weighted in part on measures of Medicaid or low-income patient workload.

Approval Documents Did Not Always Specify How States Were to Avoid Duplication with Other Sources of Federal Funding

HHS's approvals also varied in the extent to which they provided assurances that Medicaid funding approved for state programs would be claimed appropriately and would not duplicate any other potential sources of non-Medicaid federal funding. In two of the five states reviewed—California and Oregon—the claiming protocols attached to the terms and conditions clearly identified all other federal and nonfederal funding sources for each state program. These protocols also included specific instructions on how the states should "offset" other revenues received by the state programs related to eligible expenditures and how to determine the appropriate federal match based on net expenditures exclusive of any Medicaid beneficiaries receiving services through the same program.[48] In a third state, Massachusetts, HHS's approval included a general program integrity provision that required the state to have processes in place to ensure that there would be no duplication of federal funding, but the state was not required to develop a claiming protocol accounting for other federal funding sources for its 49 state programs. Further, our review of the expenditure authorities for state programs in two states—New York and Vermont—found that the approvals for 25 state programs did not require claiming protocols or otherwise lacked language expressly prohibiting the states' use of federal funding for the same purpose. Combined, the state programs in Massachusetts, New York, and Vermont accounted for 74 state programs approved for about $4 billion in total spending. As previously discussed, HHS officials said they started using claiming protocols after 2012; however, at the time of our review, these practices were not applied to previously approved state programs. In

[48]Many of the state programs included in expenditure authorities that HHS approved were for public health, aging, mental health, workforce training, and other health priorities that are supported by other (non-Medicaid) federal sources. For example, the federal Centers for Disease Control and Prevention provides funding to address many of the same issues addressed by state programs approved for Medicaid funding in our review, such as tobacco cessation, lead poisoning prevention, breast and prostate cancer screening, and diabetes.

addition, in 2012, HHS established an optional application template to assist states in the development of their section 1115 demonstration proposals that included a financing form with instruction for states to identify other federal funds used for the demonstration. The form notes that this information will help HHS identify potential areas of duplicative efforts.

Regarding funding pools for incentive payments, only one state's terms and conditions required the state (Kansas) to demonstrate that its funding pool was not duplicating any other existing or future federal funding streams for the same purpose, and two other state's terms and conditions (New Jersey, Texas) required hospitals to demonstrate that incentive projects do not duplicate other HHS initiatives. Apart from including explicit protections against duplication in the terms and conditions, HHS officials said they ask providers to disclose other federal funding they may be receiving or expect to receive that could represent duplicative funding and that they also search federal funding databases to identify potentially duplicative funding.

The extent to which approvals for uncompensated care pools included protections against potential duplication of federal funds was somewhat mixed. The approvals placed some limits on the overlap between payments from the uncompensated care pool and the DSH program but generally did not address all other federal sources of funding.[49] In the five approvals we reviewed with expenditure authorities for hospital uncompensated care pools (California, Hawaii, Kansas, New Mexico, Tennessee), HHS consistently included a requirement that when states calculate their hospitals' DSH payment limits, they include as offsetting revenue payments received from the uncompensated care pool for inpatient or outpatient services. In the aggregate, however, if states establish uncompensated care pools under demonstrations alongside their state DSH programs, total Medicaid uncompensated care spending within a state—that is, DSH and uncompensated care pool payments combined—could result in the use of section 1115 funds to fill

[49]Beyond Medicaid DSH payments, approvals did not explicitly prohibit other potentially duplicative federal sources of funding, such as grants awarded under other federal programs. Other potentially duplicative federal funding sources include Medicare DSH payments generated by the Medicaid volume on which shortfalls accrued or tax expenditures for uncompensated costs claimed as a community benefit to justify nonprofit status.

requirements already addressed by statewide DSH allotments. In two of the six states we reviewed with uncompensated care pools (Hawaii and Missouri), HHS imposed an overall limit on total uncompensated care payments (pool payments plus DSH payments) equal to the statewide DSH allotments authorized by Congress. In the other four states, HHS did not impose such a limit, such that total payments for uncompensated care could result in the use of section 1115 funds to fulfill a purpose otherwise limited by statewide DSH allotments.[50]

Conclusions

Section 1115 demonstrations account for a significant and growing proportion of expenditures under the Medicaid program. Ensuring the long-term sustainability of the program is important for the tens of millions of low-income beneficiaries who depend on Medicaid to cover their medical costs. Section 1115 Medicaid demonstrations provide a way for states to test and evaluate new approaches for delivering Medicaid services to beneficiaries. Under these demonstrations, the Secretary of Health and Human Services has broad authority to waive certain Medicaid requirements and approve expenditures for which states would not otherwise be able to receive matching funds. In doing so, the Secretary has responsibility for ensuring the prudent use of federal Medicaid resources, including ensuring that Medicaid expenditures under a demonstration will not significantly increase federal costs for Medicaid above what they would have been without the demonstration. Given the breadth of the Secretary's authority under section 1115—the exercise of which may result in billions of dollars of federal expenditures for costs not otherwise allowed under Medicaid—explicit criteria are needed to illuminate how HHS determines that new demonstration spending promotes Medicaid objectives. Without explicit criteria, HHS's decision-making will remain obscure to internal and external stakeholders, including Congress, the states, and the public, and opportunities for effective communication on this subject will remain elusive.

In addition, without documenting the basis for its approvals, HHS cannot provide reasonable assurance that it is consistently applying its criteria for

[50]We did not compare actual amounts spent under states' uncompensated care funding pools to actual DSH payments, but, for scale, the fiscal year 2012 DSH allotment for California was about $1.1 billion. At about $4 billion over 5 years, the uncompensated care funding pool approved under California's demonstration nearly doubles the DSH level of spending on uncompensated care.

determining whether demonstration expenditures promote Medicaid objectives. Based on our review, some of the Secretary's approvals of 1115 demonstrations included information that documented how new expenditure authorities would promote Medicaid's objectives, for example, by including information on how the demonstration related to health coverage for low-income populations. However, other approvals did not. For example, some of the demonstrations were for programs related to health care for the general population without an articulated link to low-income individuals or only tangentially related to improving their health coverage, while others were for funding pools for incentive payments made for a broad array of infrastructure improvements and other broad purposes. Given the amount of money involved and the broad array of purposes for which expenditure authorities have been approved, it is important that HHS document the basis for its decisions that approved expenditure authorities are likely to promote Medicaid's objectives. Furthermore, demonstration approvals should document how new federal Medicaid expenditures will be coordinated with other federal funding streams available to states for the same or similar purposes to avoid duplication.

Recommendations for Executive Action

To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, we are recommending that the Secretary of Health and Human Services take three actions:

1. Issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives.
2. Ensure the application of these criteria is documented in all HHS's approvals of section 1115 demonstrations, including those approving new or extending or modifying existing expenditure authorities, to inform internal and external stakeholders, including states, the public, and Congress, of the basis for the agency's determinations that approved expenditure authorities are likely to promote Medicaid objectives.
3. Take steps to ensure that Medicaid demonstration approval documentation consistently provides assurances—such as through claiming protocols or the application template—that states will avoid duplicative spending by offsetting as appropriate all other federal revenues received when claiming federal Medicaid matching funds.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from HHS, which are reprinted in appendix VI. In its response, HHS partially concurred with one of the recommendations and concurred with the other two recommendations.

In responding to our recommendation that HHS issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives, HHS said that it partially concurred. HHS said that all section 1115 demonstrations are reviewed against "general criteria" to determine whether Medicaid objectives are met, including whether the demonstration will (1) increase and strengthen coverage of low-income individuals; (2) increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations; (3) improve health outcomes for Medicaid and other low-income populations; and (4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks. HHS also said that at times, it has issued what it considered to be criteria for certain types of demonstrations, such as those focused on substance-use delivery system reform or on services to individuals with HIV, through an informational bulletin or State Medicaid Director's Letter. HHS committed to taking additional steps in the future to require that demonstration approval documents more clearly articulate how section 1115 authority is being used to help states address evolving trends or needs in their Medicaid programs.

HHS's response was silent, however, as to whether it planned to issue written guidance on the general criteria noted in its response. Further, we maintain that the general criteria are not sufficiently specific to allow a clear understanding of what HHS considers to be approvable Medicaid purposes. During the course of our review, HHS officials said that it is not in the agency's best interest to issue guidelines that might limit the agency's flexibility in determining which demonstrations promoted Medicaid objectives. Based on HHS's response to our recommendation, we remain concerned that the agency has not altered its position. Even if HHS were planning to issue the four criteria noted in its response, they are no more specific than the broad policy approaches currently described on HHS's website and therefore would be insufficient to inform stakeholders of the agency's interpretation of its section 1115 authority. For example, although each of HHS's four general criteria relates to serving low-income or Medicaid populations, HHS does not define low-income or what it means to serve these individuals. Several state programs that were approved for Medicaid spending that we reviewed

appeared, on their face, to be only tangentially related to improving health coverage for low-income individuals. Similarly, investments in broad delivery system reforms that were approved for Medicaid spending would seemingly benefit all patients served by these systems, not necessarily only or mostly those with low incomes. Unless HHS issues written guidance that more precisely explains how such demonstrations must relate to serving low-income and Medicaid populations, the rationale for the agency's approvals of expenditure authorities that can amount to billions of dollars in federal funding is not transparent.

HHS concurred with our other two recommendations, saying that it will (1) ensure that all future section 1115 demonstration approval documents (including those for new demonstrations, renewals, and amendments) will identify how each approved expenditure authority promotes Medicaid objectives, and (2) take steps to ensure that section 1115 demonstration approval documentation for state programs, uncompensated care pools, and incentive pools consistently provides assurances that states will avoid duplication of federal spending. HHS also provided technical comments, which we incorporated as appropriate.

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

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made key contributions to this report are listed in appendix VII.

Katherine M. Iritani
Director, Health Care

Appendix I: Summary of Types of Expenditure Authorities Approved from June 2012 through October 2013

Table 5 summarizes Department of Health and Human Services (HHS) approvals of expenditure authorities included in demonstrations approved or modified between June 2012 and mid-October 2013. Approvals were for new demonstrations, extensions of demonstrations due to expire, and amendments that modified the expenditure authorities of ongoing demonstrations. This information includes the type of approval(s) received, the demonstrations' names and approval periods, and the types of approved expenditure authorities for coverage-related and non-coverage-related purposes. Expenditure authorities for coverage included expansion to populations such as low-income adults, the addition of benefits including home- and community-based services (HCBS), and premium assistance used to purchase health insurance. Non-coverage-related expenditure authorities included funding for state programs, funding pools, and other purposes.

Table 5: Types of Expenditure Authorities in Section 1115 Demonstrations Approved by the Department of Health and Human Services (HHS) from June 2012 through October 2013

			Approved expenditure authorities							
			Coverage-related			Non-coverage-related				
State (Type of approval received during review period)	Demonstration name	Demonstration approval period[a]	Expansion populations	Home- and community -based services and other additional benefits	Premium assistance[b]	State programs	Uncompensated care funding pools	Incentive payment funding pools	Other funding pools[c]	Other[d]
Arkansas (New)	Arkansas Health Care Independence Program - Private Option	September 27, 2013, through December 31, 2016			X					
California (Multiple amendments)	California Bridge to Health Reform	November 1, 2010, through October 31, 2015	X			X	X	X		X
Delaware (Extension with changes)	Delaware Diamond State Health Plan	September 30, 2013, through December 31, 2018	X	X						
Florida (Extension)	Florida MEDS-AD	January 1, 2014, through December 31, 2014	X	X						X
Hawaii (Extension with changes)	Hawaii QUEST Expanded	October 1, 2013, through December 31, 2018	X	X			X			X
Idaho (Amendment)	Idaho Medicaid Non-Pregnant Childless Adult Waiver (Adult Access Card Demonstration)	October 1, 2013, through September 30, 2014	X		X					

State (Type of approval received during review period)	Demonstration name	Demonstration approval period[a]	Approved expenditure authorities							
			Coverage-related			Non-coverage-related				
			Expansion populations	Home- and community-based services and other additional benefits	Premium assistance[b]	State programs	Uncompensated care funding pools	Incentive payment funding pools	Other funding pools[c]	Other[d]
Illinois (New)	Illinois Cook County Care	October 26, 2012, through December 31, 2013	X							
Indiana (Extension)	Healthy Indiana Plan	January 1, 2014, through December 31, 2014	X							X
Iowa (Amendments)	IowaCare	September 1, 2010, through December 31, 2013	X						X	
Kansas (New)	KanCare	January 1, 2013, through December 31, 2017		X			X	X		
Louisiana (Extension)	Greater New Orleans Community Health Connection	September 30, 2013, through December 31, 2014	X							
Maryland (Extension)	HealthChoice Program	November 1, 2013, through December 31, 2016	X	X						X
Massachusetts (Amendments)	MassHealth	December 20, 2011, through June 30, 2014	X	X	X	X			X	
Minnesota (New)	Minnesota Reform 2020	October 18, 2013, through June 30, 2018	X	X						

State (Type of approval received during review period)	Demonstration name	Demonstration approval period[a]	Approved expenditure authorities							
			Coverage-related			Non-coverage-related				
			Expansion populations	Home- and community-based services and other additional benefits	Premium assistance[b]	State programs	Uncompensated care funding pools	Incentive payment funding pools	Other funding pools[c]	Other[d]
Missouri (Extension)	Gateway to Better Health	September 27, 2013, through December 31, 2014	X	X			X		X	
New Jersey (New, followed by amendment)	New Jersey Comprehensive Waiver	October 1, 2012, through June 30, 2017	X	X				X	X	
New Mexico (New)	Centennial Care	January 1, 2014, through December 31, 2018	X	X			X	X		X
(Amendment)	New Mexico State Coverage Insurance Demonstration	January 1, 2010, through September 30, 2014	X							X
New York (Multiple amendments)	Federal-State Health Reform Partnership/ Partnership Plan	March 31, 2011, through December 31, 2014[e]	X	X		X				X
Ohio (New)	MetroHealth Care Plus	February 5, 2013, through December 31, 2013	X							
Oklahoma (Extension with changes, followed by amendment)	SoonerCare	January 1, 2013, through December 31, 2015	X		X					X

State (Type of approval received during review period)	Demonstration name	Demonstration approval period[a]	Approved expenditure authorities							
			Coverage-related			Non-coverage-related				
			Expansion populations	Home- and community-based services and other additional benefits	Premium assistance[b]	State programs	Uncompensated care funding pools	Incentive payment funding pools	Other funding pools[c]	Other[d]
Oregon (Amendment and extension followed by multiple amendments)	Oregon Health Plan	July 5, 2012, through June 30, 2017	X	X	X	X				X
Tennessee (Extension)	TennCare II	July 1, 2013, through June 30, 2016	X	X			X		X	X
Texas (Amendment)	Texas Healthcare Transformation and Quality Improvement Program	December 12, 2011, through September 30, 2016		X				X		
Utah (Amendment)	Primary Care Network	July 1, 2010, through June 30, 2013	X		X					
Vermont (Extension)	Global Commitment to Health	October 2, 2013, through December 31, 2016	X	X	X	X			X	

Source: GAO analysis of HHS information. | GAO-15-239

Note: Table includes approvals of Medicaid 1115 demonstrations issued by HHS between June 1, 2012, and October 18, 2013, that included new expenditure authorities or that extended or amended existing expenditure authorities of ongoing demonstrations. Expenditure authorities associated with these demonstrations that were approved either before or after this period are not included in the table. Some states had multiple expenditure authorities approved; an X indicates the state had at least one expenditure authority of that type approved.

[a]The demonstration approval period reflects the current approval period at the time of our review, not necessarily the start date of the demonstration. Some demonstrations have been extended by HHS multiple times. For approvals of extensions, the period shown reflects the effective dates of the extension. For cases in which amendments and extensions were approved, the period shown is inclusive of the current approval period and any extensions.

[b]Premium assistance under a demonstration may have been used to purchase different types of health insurance, including employer-sponsored insurance and insurance from the private market.

[c]Other funding pools are those established for purposes other than uncompensated care or incentive payments.

[d]We identified several "other" expenditure authorities HHS approved during this period not related to other categories, including payments to managed care contractors that received certain exceptions from otherwise applicable Medicaid requirements See app. III for more information on these "other" expenditure authorities.

[e]The demonstration approval period shown is inclusive of the approval periods for two demonstrations. The approval period for New York's Partnership Plan demonstration was August 1, 2011, through December 31, 2014. The approval period for the state's Federal State Health Reform Partnership demonstration was March 31, 2011, through March 31, 2014.

Appendix II: Expenditure Authorities Approved for Premium Assistance

Table 6 below shows expenditure authorities approved or modified by the Department of Health and Human Services (HHS) from June 2010 through mid-October 2013, allowing states to claim federal Medicaid matching funds for premium assistance payments under their section 1115 demonstrations. The table includes expenditure authorities that were newly approved, extended, or amended during this time period. (It does not include any expenditure authorities for premium assistance that may have been approved previously in these or other states and were in effect during this time period.) The table provides information on the effective dates of the expenditure authorities, the type of premium assistance approved, and the populations covered.

Table 6: Expenditure Authorities for Premium Assistance in Section 1115 Demonstrations Approved or Modified by the Department of Health and Human Services (HHS), June 2012 through October 2013

	Premium assistance		
Effective dates[a]	**Employer-sponsored**	**Individual**	**Population covered**
Arkansas: Arkansas Health Care Independence Program[b]			
9/27/13–12/31/16		X	Childless individuals, aged 19–64 with incomes at or below 133 percent of the federal poverty level (FPL); parents and other caretakers, aged 19–64, with incomes between 17 and 133 percent of the FPL.[c]
Idaho: Idaho Medicaid Non-Pregnant Childless Adult Waiver			
1/1/10–12/31/13	X		Uninsured, nonpregnant, childless individuals, aged 18 and above with modified adjusted gross incomes (MAGI)[d] at or above 100 percent of the FPL and countable gross family incomes at or below 185 percent of the FPL, who are employed by a small business (2–50 employees) or are the spouse of an employee of a small business.
1/1/10–9/30/14	X		Uninsured, nonpregnant, childless individuals, aged 18 and above with MAGI-determined incomes below 100 percent of the FPL, who are employed by a small business (2–50 employees), or are the spouse of an employee working for a small business.
1/1/10–12/31/13	X		Uninsured parents, aged 18 and above with MAGI-determined income at or above 100 percent of FPL and countable gross family incomes at or below 185 percent of the FPL, who are employed by a small business (2–50 employees), or are the spouse of an employee of a small business.
1/1/10–10/1/14	X		Uninsured parents, aged 18 and above, with MAGI-determined incomes below 100 percent of FPL, who are employed by a small business (2–50 employees) or are the spouse of an employee of a small business.
Massachusetts: MassHealth			
1/1/14–6/30/14	X		Individuals with MAGI income between 133 percent and 300 percent of the FPL, who work for employers with 50 or fewer employees, have access to qualified employer-sponsored insurance, and are ineligible for certain other subsidized coverage.
1/1/14–6/30/14		X	Nondisabled, insured children, aged 1–18, with household incomes above 200 and below 300 percent of the FPL.
12/20/11–12/31/13	X		Individuals with gross family incomes no more than 300 percent of the FPL, whose employer contributes at least 50 percent of the cost of health insurance benefits.
12/20/11–12/31/13		X	Uninsured individuals with incomes at or below 300 percent of the FPL, not otherwise eligible under the state Medicaid plan.

Effective dates[a]	Premium assistance: Employer-sponsored	Premium assistance: Individual	Population covered
12/20/11–6/30/14		X	Disabled adults and children who qualify for and are currently enrolled in certain programs to enroll in private health insurance.[e]
12/20/11–12/31/13 and 1/1/14-6/30/14		X	Individuals who are human immunodeficiency virus (HIV)-positive, aged 64 or younger, who are not institutionalized or nondisabled children, with incomes at or below 200 percent of the FPL through December 31, 2013, and thereafter above 133 percent and through 200 percent of the FPL, and are not otherwise eligible under Medicaid.[e]
12/20/11–12/31/13		X	Long-term unemployed, childless adults, aged 19–64, with incomes at or below 100 percent of the FPL, who are receiving Emergency Aid to Elders, Disabled, and Children or services from the Department of Mental Health.[e]
12/20/11–12/31/13		X	Long-term unemployed, childless adults, aged 19–64, with income at or below 100 percent of the FPL, who are not receiving certain services from other state agencies such as the Department of Mental Health.[e]
12/20/11–12/31/13	X	X	Individuals with incomes at or below 400 percent of the FPL receiving unemployment benefits.
12/20/11–12/31/13		X	Childless adults aged 21 and over with incomes above 133 through 300 percent of the FPL.
1/1/14–6/30/14		X	Individuals with incomes above 133 percent of the FPL through 300 percent of the FPL who are not Medicaid-eligible and are eligible for the advance premium tax credit for exchange plans.
Oklahoma: Sooner Care			
1/1/13 –12/31/14	X		Individuals who work for a qualifying employer and who are either (1) non-disabled, aged 19-64, Medicaid-eligible, with incomes above the Medicaid standard but no more than 200 percent of the FPL, and their spouses; (2) disabled and aged 19-64, with incomes up to 200 percent of the FPL and who are Medicaid-eligible; (3) full-time college students aged 19-22, with incomes no more than 200 percent FPL, no health insurance coverage and who are Medicaid-eligible; (4) foster parents and spouses with household incomes no more than 200 percent FPL; and (5) employees and spouses of not-for-profit businesses with 500 or fewer employees, and household incomes no greater than 200 percent of FPL.

Effective dates[a]	Premium assistance: Employer-sponsored	Premium assistance: Individual	Population covered
1/1/13–12/31/13 and 1/1/14–12/31/14		X	Individuals whose employer elects not to participate in the state's premium assistance employer coverage plan, or in some cases are self-employed or unemployed and who are either (1) non-disabled, aged 19-64, Medicaid-eligible, with incomes above the Medicaid standard but no more than 200 percent of the FPL (no more than 100 percent FPL starting 1/1/14), and their spouses; (2) disabled and aged 19–64, with incomes up to 200 percent of the FPL (no more than 100 percent FPL starting 1/1/14), who are Medicaid-eligible; (3) full-time college students aged 19–22, with incomes no more than 200 percent of the FPL (no more than 100 percent of the FPL starting 1/1/14), with no health insurance coverage, and who are Medicaid-eligible; (4) foster parents and spouses with household incomes no more than 200 percent FPL (no more than 100 percent of the FPL starting 1/1/14); (5) employees and spouses of not-for-profit businesses with 500 or fewer employees, and household incomes no greater than 200 percent of the FPL (no more than 100 percent of the FPL starting 1/1/14).
Oregon: Oregon Health Plan			
7/5/12–1/1/14	X	X	Individuals eligible for coverage under Medicaid but who elect to participate in Oregon's Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for employer-sponsored insurance or insurance purchased through the individual market.
7/5/12–1/1/14	X	X	Uninsured childless adults, who are not eligible for Medicaid/Medicare, with incomes up to and including 200 percent of the FPL, enrolled in Oregon's Family Health Insurance Assistance Program.
7/5/12–1/1/14	X	X	Uninsured parents of children who are eligible for Medicaid or the state's Children's Health Insurance Program, who are themselves ineligible for Medicaid/Medicare with incomes up to and including 200 percent of the FPL, enrolled in Oregon's Family Health Insurance Assistance Program.
Utah: Primary Care Network			
7/1/10–6/30/13	X		Non-disabled, low-income workers, aged 19–64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, and their spouses. Premium assistance providing 12 months of guaranteed eligibility to subsidize the employee's share of the premium.
	X		Non-disabled, low-income workers, aged 19–64, with incomes above the Medicaid standard but at or below 200 percent of the FPL, and their spouses. Premium assistance providing up to 18 months of eligibility to subsidize the costs of the employee's share of the premium for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986.[f]

Effective dates[a]	Premium assistance: Employer-sponsored	Premium assistance: Individual	Population covered
Vermont: Global Commitment to Health			
10/2/13–12/31/13	X		Adults with children, with incomes from 185 percent through 300 percent of the FPL; childless adults and noncustodial parents with incomes from 150 percent through 300 percent of the FPL; college students without children with incomes above 150 percent FPL through 300 percent of the FPL, or who have children with incomes below 150 percent or above 185 through 300 percent FPL.
10/2/13–12/31/13		X	Populations above, who have also been without health insurance coverage for a year or more and do not have access to qualified employer-sponsored insurance.

Source: GAO analysis of HHS information. | GAO-15-239

Note: Table includes approvals of Medicaid 1115 demonstrations issued by HHS between June 1, 2012, and October 18, 2013, that included new expenditure authorities or that extended or amended existing expenditure authorities of ongoing demonstrations. Expenditure authorities associated with these demonstrations that were approved either before or after this period are not included in the table. Some states had multiple expenditure authorities approved.

[a]The effective dates reflect the dates the expenditure authorities related to premium assistance were effective and not necessarily the entire demonstration approval period.

[b]Arkansas was the first state to receive HHS approval to provide coverage of the Medicaid expansion population, as defined under the Patient Protection and Affordable Care Act (PPACA), through premium assistance for exchange-purchased coverage. Under HHS's terms and conditions for Arkansas's demonstration, enrollment in the premium assistance program is mandatory, and the state is required to provide coverage for any Medicaid benefits that are not covered by the exchange plans. The state will receive a 100 percent federal match for expenditures related to this population.

[c]In 2014, the FPL for a single-person household was $11,670 and for a family of four was $23,850 in the 48 contiguous states and the District of Columbia.

[d]Modified adjusted gross income (MAGI) is a tax-based definition of income.

[e]This population only receives premium assistance if qualified cost-effective private insurance is available.

[f]29 U.S.C. §§ 1161-1168.

Appendix III: Other Expenditure Authorities Approved for Managed Care Organizations and Various State Activities

In addition to expenditure authorities for state programs and funding pool payments, the Department of Health and Human Services (HHS) approved expenditure authorities under section 1115 of the Social Security Act that provided federal Medicaid funds for a variety of other non-coverage-related purposes. Specifically, HHS approved expenditure authorities in several states to make payments to managed care organizations (MCO) that received certain exceptions from otherwise applicable Medicaid MCO requirements.[1] HHS also approved several expenditure authorities for states to claim federal matching funds for specific state activities not related to MCOs.

HHS approved expenditure authorities in eight states that provided for certain exceptions to otherwise applicable Medicaid MCO requirements. As a condition of receiving federal matching funds for capitation payments made to MCOs under their state plans, states must ensure that contracted MCOs comply with certain federal requirements. For example, MCOs must permit Medicaid enrollees to terminate enrollment for cause at any time and without cause during the first 90 days of enrollment and every 12 months thereafter.[2] In exercising its section 1115 authority, HHS authorized federal matching funds in a number of states for payments to MCOs that limited the time for Medicaid beneficiaries to disenroll without cause to less than the otherwise applicable 90 days.[3] HHS also approved other expenditure authorities related to states' management of their MCOs. For example, HHS relaxed otherwise applicable Medicaid MCO requirements in granting Hawaii approval under its demonstration for payments to MCOs in nonrural areas that do not provide enrollees with a choice of two or more plans. In another example, New Mexico received approval to allow the state to include the provision of a beneficiary rewards programs in calculating the MCO's capitation rates. Under the program, enrolled individuals who participate in state-defined activities

[1]MCOs are one system states use to deliver Medicaid services. States are able to control Medicaid costs by contracting with MCOs to cover services provided to Medicaid enrollees for a fixed, or capitated, monthly rate per enrollee. According to HHS, approximately 70 percent of Medicaid enrollees are served through these managed care delivery systems.

[2]42 U.S.C. § 11396u-2(a)(4)(A).

[3]For example, as an alternative to the 90-day disenrollment period, Indiana and Tennessee were allowed to limit the period to 60 and 45 days, respectively.

that promote healthy behaviors earn credits that may be used for approved health-related expenditures.

HHS also approved expenditure authorities for activities unrelated to MCOs. For example, Oklahoma was approved to receive matching funds for expenditures to embed health coaches within practices with a high number of patients with chronic disease or at high risk for poor health outcomes. Health coaches provide beneficiaries with a comprehensive initial evaluation, plan of care, educational materials, referrals, and self-management support. Missouri received approval allowing the state to continue to receive federal matching funds for expenditures incurred by a regional health commission for administrative activities related to the assessment of safety net benefits for the community.

Appendix IV: Duration of Expenditure Authorities for Some State Programs

The Department of Health and Human Services' (HHS) approvals of expenditure authorities for state programs previously financed by the states have been longstanding in some cases, particularly in cases when demonstrations were extended or amended. Table 7 shows the duration of some of the demonstrations that received HHS approval to extend expenditure authorities for state programs during our review period.

Table 7: Length of Time Expenditure Authorities for Some State Programs in Section 1115 Demonstrations Were Approved by the Department of Health and Human Services (HHS)

State	Initial effective date of expenditure authority HHS approved for any state program	Current end date of expenditure authority for at least one of the initially approved state programs	Length of time expenditure authority for at least one state program was approved (from initial approval to current end date of approval)
California[a]	October 5, 2007	October 31, 2015	8 years
Massachusetts	July 1, 2005	June 30, 2014	9 years[b]
New York	October 1, 2006	December 31, 2014	8.25 years
Oregon	July 5, 2012	June 30, 2017	5 years
Vermont	October 2, 2013[c]	December 31, 2016	3.25 years

Source: GAO analysis of HHS information. | GAO-15-239

Note: The initial effective date is the first time HHS approved Medicaid funding for any state program.

[a]Only 4 of the 15 California state programs approved by HHS for funding through October 31, 2015 were named in the initial 2007 expenditure authority.

[b]On October 30, 2014, HHS extended the expenditure authority for the state programs in Massachusetts for an additional 3 years through June 30, 2019.

[c]In October 2007, Vermont received federal funding through an 1115 expenditure authority for a premium assistance program for low-income individuals to purchase private insurance called Catamount Health. This program ended on December 31, 2013, the day before the expenditure authority began for Vermont's new marketplace subsidy program.

Appendix V: Total Funding Pool Spending Limits in Selected States

Table 8 summarizes the total funding pool spending limits for the 11 states that received approval from the Department of Health and Human Services (HHS) for expenditure authorities for funding pools included in demonstrations approved or modified during our review period, between June 2012 and mid-October 2013. For states in our scope due to modifications to ongoing funding pools, other funding pools may have been in place. This table shows total approved spending limits for all funding pools in those states' demonstrations, including those that were established before our review period. Funding pools were primarily for uncompensated care costs and incentive payments to carry out delivery system reform initiatives. Some states received approval for funding pools for other purposes—for example, additional supplemental payments in New Jersey and infrastructure payments for a specialty provider's overhead costs in Missouri.

Table 8: Total Funding Pool Spending Limits for States that Received New, Extended, or Modified Authority from the Department of Health and Human Services (HHS) for Expenditure Authorities under Section 1115 Demonstrations, from June 2012 to October 2013

	Funding pool spending limit (millions of dollars)			
State	**Uncompensated care payments**	**Provider incentive payments for delivery system and/or infrastructure improvement**	**Funding pools for other purposes**	**Total spending limit**
California	$4,016	$6,671	Health Care Coverage Initiative $1,260 Designated State Health Programs $4,000	**$15,947**
Hawaii	$302			**$302**
Iowa			Safety Net Care Pool $14[a]	**$14**
Kansas	$344	$60		**$404**
Massachusetts	$1,562	$234[b]	Designated State Health Programs $863[c]	**$4,674**[d]
Missouri	$38		Payments to St. Louis Regional Health Commission for administrative activities $1[e] Payments to St. Louis Regional Health Commission for managed care implementation $11 Community referral coordinator program (administrative costs) $2 Infrastructure payments $3[f]	**$55**
New Jersey		$583	Transition payments $250 Graduate medical education $90	**$923**
New Mexico	$344	$29		**$374**
Tennessee	$2,600[g]		Graduate medical education $125 Supplemental payments to two public hospitals $175	**$2,900**
Texas	17,582[h]	11,418		**$29,000**
Vermont			Public health, outreach, and infrastructure Unknown[i]	

Source: GAO analysis of information from HHS. | GAO-15-239

Note: We reviewed approvals issued by HHS from June 2012 through mid-October 2013 for new or extended demonstrations or modifications to expenditure authorities of ongoing demonstrations.

Funding pool spending limits for all categories—uncompensated care payments to providers, provider incentive payments, other, and overall total—represent the funding approved over the entire current demonstration period—that is, total spending for all funding pools included in the demonstrations, including for pools approved prior to our review period.

[a]The Safety Net Care Pool within Iowa's demonstration included three components: payments for durable medical equipment at one hospital, care coordination payments after inpatient hospitalizations, and payments to federally qualified health centers for laboratory and radiology services.

[b]Spending limit for Massachusetts's incentive payment pools reflects one of two such pools. The terms and conditions of the demonstration specified a $233.7 million limit for an Infrastructure and Capacity Building initiative. A Delivery System Transformation initiative was also approved, but without a limit specified other than the overall spending limit established for Massachusetts's Safety Net Care Pool, of which there are several components.

[c]The terms and conditions of the demonstration specified an $863 million limit for payments to Designated State Health Programs, which includes $55 million in subsidies for its Health Connector premium assistance program for individuals with incomes between 133 and 300 percent of the federal poverty level who purchase insurance through the state's exchange, and $8 million for the program that preceded Health Connector eligibility for this income group—Commonwealth Care.

[d]Spending limits for individual pools do not sum to total because not all components of Massachusetts's overall Safety Net Care Pool have designated spending limits.

[e]The terms and conditions of the Missouri demonstration specify a spending limit for administrative activities of St. Louis Regional Health Commission, the entity coordinating the demonstration, of $1,050,000 or 1 percent of the total demonstration's cost, whichever is less.

[f]The $2.9 million pool for provider infrastructure payments in Missouri's demonstration is dedicated to supporting a large specialty provider network in the St. Louis area participating in the demonstration. According to the terms of the demonstration, "allowable costs may include, but are not limited to, costs associated with purchasing billing software, hardware for systems, costs associated with extended hours of operation, salaries, benefits and payroll taxes, professional and contractual services, supplies, insurance, occupancy costs, depreciation, and other miscellaneous costs associated with provider operations."

[g]Spending limit for uncompensated care payments in Tennessee reflects the sum of five separate pools established for this purpose.

[h]Under the terms of Texas's demonstration, payments made from the uncompensated care pool in the first year (2012) could be, at the hospital's option, classified as transition payments. These are payments in the amount that hospitals previously received as supplemental payments under the Medicaid Upper Payment Limit for 2011. Unlike uncompensated care payments, transition payments are not based on documented uncompensated care costs.

[i]Vermont received expenditure authority allowing it to apply any savings it generates within the capitated rate it receives for administering its own Medicaid managed care program to a wide range of activities related to public health, outreach, infrastructure, and other activities.

Appendix VI: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 6 2015

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

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICAID DEMONSTRATIONS: Approval Criteria and Documentation Need Clarity to Illuminate How Spending Furthers Medicaid Objectives" (GAO 15-239).

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

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID DEMONSTRATIONS: APPROVAL CRITERIA AND DOCUMENTATION NEED CLARITY TO ILLUMINATE HOW SPENDING FURTHERS MEDICAID OBJECTIVES (GAO-15-239)

The Department of Health and Human Services (HHS) is committed to working in close partnership with states, as well as providers, families and other stakeholders to support effective, innovative, and high quality care through Medicaid and the Children's Health Insurance Program (CHIP). As part of that commitment, HHS works collaboratively with States through Section 1115 demonstrations to test innovative approaches and designs for Medicaid.

Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. These demonstrations give states additional flexibility to design and evaluate innovative policy approaches to improve their Medicaid programs including expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible and using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

As state and federal health policy is evolving rapidly, particularly in the area of payment innovation and delivery system reform, section 1115 demonstrations play a key role in States' ability to test new and innovative approaches. Section 1115 demonstrations must promote the objectives of the Medicaid program and all demonstrations are reviewed by HHS to determine whether these objectives are met. The demonstrations and programs reviewed in this report promote objectives including increasing and strengthening overall coverage of low-income individuals in the state and increasing the efficiency and quality of care through initiatives to transform service delivery networks. In our continued commitment to transparency, HHS will take additional measures to require that demonstration approval documents articulate how section 1115 authority is being used to assist States in addressing evolving trends or needs in their Medicaid programs.

In addition, HHS has implemented several initiatives to enhance transparency for Section 1115 demonstrations. The Affordable Care Act required the Secretary to set forth transparency and public notice procedures for experimental, pilot, and demonstration projects approved under section 1115 of the Social Security Act. HHS issued a final regulation on February 27, 2012, outlining the new regulatory requirements for initial section 1115 demonstration applications and extension requests, public notice procedures, and reporting and evaluation requirements. All Section 1115 demonstrations are available publicly and include the specific terms and conditions that must be followed as a result of the demonstration. Additionally, any 1115 demonstration request is subject to a public notice and comment process at both the state and federal level. States are required to solicit meaningful public input in the development of a section 1115 demonstration request prior to submission to HHS. When completed 1115 submissions are submitted to HHS, we also facilitate public comment on the demonstration prior to approval or disapproval.

GAO Recommendation #1

GAO recommends that HHS issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID DEMONSTRATIONS: APPROVAL CRITERIA AND DOCUMENTATION NEED CLARITY TO ILLUMINATE HOW SPENDING FURTHERS MEDICAID OBJECTIVES (GAO-15-239)

HHS Response

HHS partially concurs with this recommendation. Section 1115 demonstrations must promote the objectives of the Medicaid program and all demonstrations are reviewed by HHS against general criteria to determine whether these objectives are met. These criteria include whether the demonstration will:

1) Increase and strengthen overall coverage of low-income individuals in the state;
2) Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3) Improve health outcomes for Medicaid and other low-income populations in the state; or
4) Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

An additional explicit criterion for evaluating 1115 authorities is whether the section 1115 demonstration will be budget neutral – that is – whether federal expenditures under such demonstrations are projected to be no more than what the federal government would have spent in the Medicaid program absent the demonstration.

At times, such as when evaluations or other evidence have shown that a particular approach could be effective in improving Medicaid coverage, or when a new approach to Medicaid coverage under section 1115 emerges, HHS has issued criteria for these specific types of section 1115 demonstrations. For example, on October 29, 2014, HHS issued a Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) that included information on using section 1115 authority for demonstrations focused on substance-use delivery system reform. In March 2013, HHS released Frequently Asked Questions (FAQs) regarding premium assistance using section 1115 demonstration authority. In addition, on June 6, 2011, HHS issued a State Medicaid Director's Letter (SMDL) that included information on section 1115 demonstrations focused on serving individuals living with HIV.

In our continued commitment to transparency, HHS will take additional measures to require that demonstration approval documents more clearly articulate how section 1115 authority is being used to assist states in addressing evolving trends or needs in their Medicaid programs.

GAO Recommendation #2

GAO recommends that HHS ensure the application of these criteria are documented in all HHS' approvals of section 1115 demonstrations, including those approving new or extending or modifying existing expenditure authorities, to inform internal and external stakeholders, including states, the public, and Congress, of the basis for the agency's determinations that approved expenditure authorities are likely to promote the Medicaid objectives.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID DEMONSTRATIONS: APPROVAL CRITERIA AND DOCUMENTATION NEED CLARITY TO ILLUMINATE HOW SPENDING FURTHERS MEDICAID OBJECTIVES (GAO-15-239)

HHS Response

HHS concurs with this recommendation. HHS has included a discussion of the objectives of the demonstration project in the introductory summary of the Special Terms and Conditions (STCs) in recent demonstration approvals. In addition, in the STCs that require evaluation of the demonstration, we frequently require evaluation of specific authorities, including expenditure authorities that we have determined meet the objectives of the Medicaid program. In order to further enhance transparency in our 1115 decision-making, we plan, in all future section 1115 demonstration approvals (new demonstrations, renewals, and amendments), to identify in the approval documents how each expenditure authority we approve promotes the objectives of title XIX.

GAO Recommendation #3

GAO recommends that HHS take steps to ensure that Medicaid demonstration approval documentation consistently provides assurances – such as through claiming protocols or the application template – that states will avoid duplicative spending by offsetting as appropriate all other federal revenues received when claiming federal Medicaid matching funds.

HHS Response

HHS concurs with the recommendation and will require for all future section 1115 actions (new demonstrations, renewals, and amendments) additional, clear claiming protocols for both new and previously authorized designated state health programs (DSHPs) to verify there is no duplication of any federal funding. HHS will also require claiming protocols for expenditure authorities such as uncompensated care pools. Finally, in all current and future DSRIP approvals, HHS will require states to document how there is no duplication of federal funding.

It should be noted that currently there are standard terms in the "General Financial Requirements" section of all 1115 demonstration agreements that require no duplication of federal funding. For example, the "Sources of non-federal share" term states: "All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations." Additionally, in recent approvals, HHS has included a Program Integrity term which states, "The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration."

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, Director, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact name above, Catina Bradley, Assistant Director; Christine Davis; Anne Hopewell; Shirin Hormozi; Linda McIver; Perry Parsons; Roseanne Price; and Hemi Tewarson made key contributions to this report.