

**Congress of the United States**  
**Washington, DC 20515**

September 15, 2014

The Honorable Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Administrator Tavenner:

We write today out of concern over the Centers for Medicare & Medicaid Services' (CMS's) lack of rigorous evaluation of Medicaid waivers. Last year, the Government Accountability Office (GAO) reported that CMS's approval process for Medicaid Section 1115 waivers "raises cost concerns and lacks transparency."<sup>1</sup> Troublingly, a new report by GAO that examines CMS's role in approving a Medicaid waiver for Arkansas's Medicaid expansion of the program under the Patient Protection and Affordable Care Act (PPACA, also referred to as "Obamacare") raises serious concerns about the cost-effectiveness and budget neutrality of Arkansas's demonstration program.<sup>2</sup>

In September 2013, CMS approved a demonstration program for Arkansas, which provided the state the authority to use federal Medicaid funds to provide premium assistance to adults newly eligible for Medicaid under PPACA to purchase private insurance offered through the state's health insurance exchange. Under CMS's terms for the approved demonstration, which runs from 2014 through 2016, newly eligible adults, including adults with incomes between 0 and 133 percent of FPL, are to shop for coverage offered on the exchange through the state's web-based portal and select a qualified health plan (QHP). The QHP is to issue the insurance card and the state is to pay the premium directly to the QHP on behalf of the individual. Arkansas estimated that 200,000 adults would enroll under the demonstration. Enrollment in QHPs began on October 1, 2013, with eligibility effective January 1, 2014.

The Medicaid program has a long history of premium assistance programs in which states use Medicaid to subsidize the cost of private health insurance for eligible individuals. We believe states should have flexibility to design benefits for their citizens and many states have chosen to use premium assistance programs as a vehicle for providing health insurance coverage to Medicaid eligible populations.<sup>3</sup> A 2010 review by GAO found that there were 47 premium assistance programs at that time: 30 premium assistance programs funded solely by Medicaid, 6

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<sup>1</sup> "Approval Process Raises Cost Concerns and Lacks Transparency," GAO-13-384: Published: Jun 25, 2013. Publicly Released: Jul 18, 2013.

<sup>2</sup> "Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns," GAO-14-689R, September 2014. Available online: <http://www.gao.gov/products/gao-13-384>

<sup>3</sup> See GAO, Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs, GAO-10-258R (Washington, D.C.: Jan. 19, 2010)

programs funded solely by CHIP, and 9 programs were funded by both Medicaid and CHIP.<sup>4</sup> However, a key requirement of such programs is that they are cost-effective; that is, the cost, including premiums and cost-sharing, are likely to be less than the cost of providing care directly through state Medicaid programs.

In addition, Section 1115 of the Social Security Act authorizes the Secretary of the Department of Health and Human Services (HHS), working through CMS, to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for demonstration projects that promote the objectives of the Medicaid program. Similar to the cost-effectiveness requirement for premium assistance programs, CMS policy requires that Section 1115 demonstrations be budget-neutral to the federal government; in other words, the federal government should spend no more under a state's demonstration than it would have spent without the demonstration.

Therefore, we are troubled to learn that CMS approved a spending limit for Arkansas's 1115 Medicaid waiver without taking into consideration that Arkansas's proposal specifically assumed the state would make significantly higher payments to providers under expanded coverage than would otherwise be made under the traditional Medicaid program. CMS did not request any data to support the state's assumptions.

Despite CMS's failure to review the details of Arkansas's proposal, the state's waiver assumptions generate real extra costs for federal taxpayers. GAO estimated that the spending limit that CMS approved for the state demonstration is \$778 million higher than it would have been if actual payment rates for services provided to newly-eligible adult beneficiaries were included across the duration of the proposal. GAO also noted that CMS waived its cost-effectiveness requirement for Arkansas's premium assistance program, allowing the state to use its own tests of cost-effectiveness without any external validation.

Even more troubling, the additional costs of this program may actually exceed GAO's estimate as Arkansas was provided the flexibility to adjust the spending limit if actual costs under the demonstration proved higher than expected, which data indicate is likely. Specifically, cost estimates have already risen steadily from an initial \$325 per member per month (PMPM) in November 2012,<sup>5</sup> to the \$478 benchmark for budget-neutrality that was established in 2013.<sup>6</sup> Following the launch, the program's costs have breached this level, rising further to \$496 PMPM.

While we are supportive of states' ability to use premium assistance programs to create innovative benefit designs for individuals in their state, we also have a responsibility to ensure that federal dollars are accounted for in a transparent and accurate manner. We remain troubled

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<sup>4</sup> Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs, 2010. Available online: <http://www.gao.gov/new.items/d10258r.pdf>

<sup>5</sup> "Estimated Medicaid-related impact of the ACA with expansion." *Arkansas Department of Human Services*. (Nov 13, 2012). <http://humanservices.arkansas.gov/director/Documents/Updated%20cost%20estimates%20for%20Medicaid%20expansion%20Nov%202012.pdf>

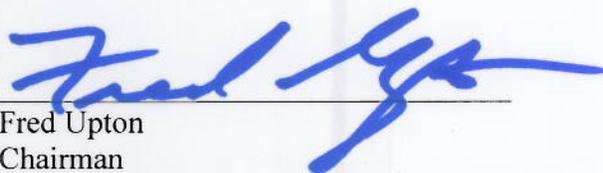
<sup>6</sup> "Arkansas Health Care Independence Program Proposed Evaluation for Section 1115 Demonstration Waiver." *Arkansas Center for Health Improvement*. (February 20, 2014). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ar.pdf>

over CMS's apparent disregard of the important details of Arkansas's expansion proposal. This disregard is especially notable since it calls into question the sustainability and replicability of Arkansas's proposal as federal taxpayers are currently footing 100 percent of the costs of the newly-eligible adult population under PPACA's expansion. Therefore, in the interest of protecting and ensuring the efficient and effective use of federal Medicaid dollars, we request answers to the following questions related to your review of demonstration proposals:

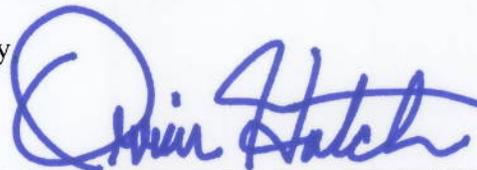
- 1) What evidence did CMS have to support Arkansas's claim that the state would have to pay significantly higher payment amounts to providers if it were to expand coverage under the traditional Medicaid program? Why did CMS allow such hypothetical costs to be included in cost projections?
- 2) Moving forward, what steps is CMS taking to monitor Arkansas's cost-effectiveness standard and documentation, and how will CMS determine if these standards are appropriate?
- 3) In light of the fact that Arkansas was provided the flexibility to increase the spending limit if actual costs under the demonstration are higher than projected:
  - a. How is CMS ensuring that the Arkansas demonstration program does not cost federal taxpayers more than it would have cost to cover this population under traditional Medicaid?
  - b. If CMS determines it is appropriate to allow Arkansas to spend more per member per month in its demonstration program than it would spend under traditional Medicaid, how does CMS decide this is fair, since disabled children and elderly frail adults face waiting lists in other parts of Medicaid?
  - c. Has CMS placed a cap on the amount of federal dollars available for this demonstration program?
  - d. What actions can, and will, CMS take to recoup federal dollars if the costs of Arkansas's demonstration program exceed the expected costs of covering this population under traditional Medicaid?
- 4) What steps is CMS taking to ensure and improve the budget neutrality and cost-effectiveness of similar demonstration proposals from other states?

Thank you for your attention to this important matter. We respectfully request your response by October 6, 2014. Please contact Josh Trent with the House Committee on Energy and Commerce Majority staff at (202) 225-2927 or Kim Brandt with the Senate Finance Committee Minority staff at (202) 224-4515 with any questions regarding this request.

Sincerely



Fred Upton  
Chairman  
House Committee on Energy and Commerce



Orrin G. Hatch  
Ranking Member  
Senate Committee on Finance