



GAO

Accountability \* Integrity \* Reliability

---

United States Government Accountability Office  
Washington, DC 20548

July 24, 2007

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

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

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

The Honorable Sherrod Brown  
United States Senate

Subject: *Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern*

States provide health care coverage to about 60 million low-income individuals through Medicaid, a joint federal and state program established under title XIX of the Social Security Act (the Act). Title XIX of the Act established parameters under which states operate their Medicaid programs, such as requiring states to cover certain services for certain mandatory groups of individuals such as low-income children; pregnant women; and aged, blind, or disabled adults.<sup>1</sup> The Secretary of Health and Human Services, however, possesses authority to allow states to depart from these requirements under certain conditions. Under section 1115 of the Act, the Secretary may waive certain Medicaid requirements and authorize Medicaid expenditures for experimental, pilot, or demonstration projects that are likely to assist in promoting Medicaid objectives. Medicaid section 1115 demonstration projects vary in scope, from targeted demonstrations, which are limited to specific services and populations, to comprehensive demonstrations, which affect Medicaid populations statewide, cover a broad range of services, and account for the majority of a state's Medicaid

---

<sup>1</sup>See Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-352 (1965) (adding new sections 1901-1905 and amending sections 1109, 1115 of the Social Security Act, codified, as amended, at 42 U.S.C. §§ 1309, 1315, 1396-1396d).

expenditures.<sup>2</sup> Since 1982, the Secretary has approved comprehensive demonstration projects in a number of states, including Arizona, Florida, Hawaii, Oregon, Tennessee, and Vermont.

In 1994, the Department of Health and Human Services (HHS) established in the *Federal Register* the department's policies and procedures for evaluating Medicaid section 1115 demonstration<sup>3</sup> proposals, including processes for soliciting public input at both the state and federal levels.<sup>4</sup> At the state level, for example, states were expected to post notice of proposals in major newspapers, hold public hearings about the proposal, or take certain other steps to solicit public input. At the federal level, HHS indicated that it would notify interested organizations when it received a demonstration proposal; publish monthly notices of all new and pending demonstration proposals in the *Federal Register*; allow for a 30-day comment period after new proposals were received; acknowledge, if feasible, receipt of comments; and refrain from approving or disapproving proposals until at least 30 days after proposals were received.

In July 2002, we reported that HHS had not consistently provided an opportunity at the federal level for the public to learn about and comment on pending demonstrations in accordance with its 1994 policy.<sup>5</sup> We concluded that public input was important at the federal level in part because approved demonstrations represent federal policy that may have influence beyond a single state. A federal-level process also provides more visibility and transparency for all affected and interested parties, including Congress. Because HHS disagreed with our recommendation that the agency provide for a federal public input process—indicating instead that it planned to post notice of proposed (pending) and approved demonstrations to its Web site—we suggested that Congress consider requiring the Secretary to improve the public notification and input processes at the federal level to ensure that individuals affected by section 1115 demonstrations have an opportunity to review and comment on proposals before they are approved. Congress has not yet enacted legislation that responds to this recommendation.

---

<sup>2</sup>For the purposes of this report, we use the Department of Health and Human Services' (HHS) Center for Medicare & Medicaid Services (CMS) definition that "comprehensive Medicaid section 1115 demonstrations" include those that affect a broad range of services for Medicaid populations statewide; in addition, we add the criterion that the comprehensive demonstrations we reviewed account for greater than 50 percent of a state's Medicaid expenditures.

<sup>3</sup>For purposes of this report, we refer to "Medicaid section 1115 demonstrations," "section 1115 demonstrations," "demonstration projects," and "demonstrations" interchangeably.

<sup>4</sup>In September 1994, HHS published in the *Federal Register* its policy on public participation during the demonstration approval process. At the federal level, HHS's policy stated that the department would post notice of pending demonstrations in the *Federal Register*; notify organizations that request information; and acknowledge, if feasible, comments received. At the state level, HHS's policy expected states to facilitate public involvement in developing demonstration proposals, such as by holding public hearings, convening commissions with open public meetings, enacting state legislation regarding the demonstrations, or posting information in newspapers. See *Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures*, 59 *Fed. Reg.* 49,249 (Sept. 27, 1994).

<sup>5</sup>GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, [GAO-02-817](#) (Washington, D.C.: July 12, 2002).

Since our 2002 report, and our subsequent 2004 report on 1115 demonstration approvals,<sup>6</sup> HHS has continued to review and approve waivers of federal requirements for new comprehensive demonstration proposals. At your request, we reviewed recently approved comprehensive demonstrations, including the process HHS used to obtain public input on these proposals. This correspondence addresses

- implications for beneficiaries of recently approved comprehensive Medicaid demonstrations and
- the extent to which the Secretary ensured opportunities for public input during the approval process.

Our review encompassed recently approved comprehensive demonstration programs in two states, Florida and Vermont. These were the two demonstration programs meeting our criteria of (1) being approved by HHS from July 2004 (when we last reviewed HHS-approved section 1115 demonstrations) through December 2006 and (2) being comprehensive, including accounting for greater than 50 percent of the state's Medicaid expenditures.<sup>7</sup> To assess the reliability of HHS information on states' Medicaid expenditures, we reviewed HHS documentation on the collection of and quality assurance activities related to the data and interviewed knowledgeable HHS officials, and determined the data to be reliable for our purposes. To assess implications for beneficiaries of the Florida and Vermont demonstrations, we reviewed HHS's and states' documents, including proposals for these demonstrations and approved demonstrations' terms and conditions,<sup>8</sup> and federal and state laws; we also interviewed state and HHS officials, including officials from CMS.<sup>9</sup> To examine public input processes, we reviewed certain federal and state laws and guidance; interviewed HHS and state officials; interviewed representatives from national, state, and local stakeholder groups; reviewed information posted by HHS on its Web site; and reviewed documentation of public meetings and written responses to public comments. (See enc. I for a list of stakeholder groups interviewed for this correspondence.) Because the Florida and Vermont demonstrations were in their early implementation phase during our review, we focused our assessment largely on determining implications for Medicaid beneficiaries under

---

<sup>6</sup>GAO, *Medicaid Waivers: Recent HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns*, [GAO-04-480](#) (Washington, D.C.: June 30, 2004).

<sup>7</sup>Our findings from HHS's approval of these two states' demonstrations cannot be generalized to HHS's approval of other states' demonstrations. We used this criterion for purposes of our assessing HHS's process as it was applied in these particular cases of importance. These cases we considered important because the majority of the state's Medicaid spending was governed by the terms of the demonstration.

<sup>8</sup>For each demonstration it approves, HHS approval documents may include a demonstration approval letter, a demonstration fact sheet, the terms and conditions of the demonstration, and a description of waiver and expenditure authorities granted by the Secretary for the demonstration. The state documents its acceptance of HHS's approval with an approval acceptance letter. A demonstration's terms and conditions describe general requirements of the demonstration program, such as benefits, eligibility, populations covered, cost-sharing requirements, enrollment, evaluation, and allocated budget.

<sup>9</sup>Although HHS has delegated the administration of the Medicaid program, including the approval of section 1115 demonstrations, to CMS, we refer to HHS throughout this report because section 1115 demonstration authority ultimately resides with the Secretary, and, accordingly, other HHS components are involved in the review and approval of these demonstrations.

the terms of the states' demonstrations as approved by HHS. We did not, however, consider implications of these demonstrations with respect to other aspects of federal oversight of the Medicaid program.<sup>10</sup> We conducted our review from June 2006 through June 2007 in accordance with generally accepted government auditing standards.

## Results in Brief

Recently approved Medicaid section 1115 demonstrations in Florida and Vermont have mixed implications for beneficiaries in terms of coverage and eligibility. The demonstrations are implementing different methods for administering each state's Medicaid program and, as of March 2007, had been under way less than 8 months in Florida and less than 18 months in Vermont. Consequently, the actual effect of the demonstrations on beneficiaries was not yet known.

- **Florida's demonstration program.** Approved by HHS in October 2005 and launched in July 2006, Florida's demonstration program is designed to give Medicaid beneficiaries more options in selecting health care plans and benefits. In the initial phase of the demonstration, certain Medicaid beneficiaries in two counties are required to enroll in managed care benefit plans. Managed care plans compete for Medicaid beneficiaries by offering different coverage options, including customized benefits, subject to certain limitations. For example, some plans could offer supplemental coverage for nonemergency dental benefits or over-the-counter pharmaceuticals not offered by other health plans. If beneficiaries do not choose a plan, they are automatically enrolled into a plan by the state, and coverage can be limited to emergency medical services and nursing home level care for beneficiaries for up to 30 days pending beneficiaries' enrollment in a managed care plan. Unlike many other previous Medicaid managed care systems, managed care plans in Florida have the authority to design benefit packages subject to approval by the state. Medicaid beneficiaries are notified about changes in their benefits from year to year and are responsible for determining whether plans continue to meet their health care needs. Medicaid beneficiaries may also voluntarily "opt out" of Medicaid coverage altogether and use a state-paid Medicaid premium toward their costs to enroll in an employer-sponsored insurance plan or—if they are self-employed—in a commercial benefit plan. In making this choice, however, these individuals, including mandatory Medicaid beneficiaries,<sup>11</sup> would no longer be entitled to mandatory Medicaid benefits; for example, children would no longer be entitled to mandatory comprehensive screening and treatment benefits if their parents enrolled in an employer-sponsored or commercial benefit plan that did not provide these benefits. Medicaid beneficiaries can choose a new benefit plan each year. If they opt out of Medicaid but later desire to enroll in one of Florida's Medicaid demonstration managed care plans, they need to wait for a qualifying event or open enrollment period before reenrolling. Initially implemented in a two-county

---

<sup>10</sup>In a separate letter to the Secretary of Health and Human Services, we discuss concerns about the consistency of the Florida and Vermont demonstrations with federal law. See B-309734, July 24, 2007.

<sup>11</sup>Mandatory Medicaid beneficiaries are those individuals who must be covered under a Medicaid program, such as children under age 6 in families with incomes at or below 133 percent of the federal poverty level and pregnant women whose family income is below 133 percent of the federal poverty level. (See enc. II for a summary of mandatory Medicaid benefits, eligibility requirements, and cost-sharing limits.)

area, the components of the demonstration are planned for statewide implementation by June 2010.<sup>12</sup>

- **Vermont’s demonstration program.** Approved by HHS in September 2005 and launched the following month, Vermont’s demonstration created a single, state-operated managed care organization to cover virtually all of the state’s Medicaid population.<sup>13</sup> The demonstration is designed to contain costs; to improve system accountability and quality of care; and, by potentially delivering services to Medicaid beneficiaries for less and reinvesting savings, to allow the state to serve more of its uninsured population. As a condition of approval, HHS required that the state be at risk for paying any costs for the demonstration beyond an established spending limit; however, the state has additional flexibility beyond traditional Medicaid requirements to change benefits, increase cost-sharing requirements, and alter eligibility for nonmandatory Medicaid beneficiaries. For example, the state is authorized to change the covered benefit package offered to certain groups of beneficiaries, such as nonmandatory groups that previously received Medicaid coverage at the state’s option, without additional HHS approval as long as the changes result in no more than a 5 percent increase or decrease each year from the prior year’s total Medicaid expenditures.

Officials in both states took steps to obtain public input in line with HHS’s 1994 policy, but HHS did not provide opportunity for public input at the federal level once the proposals were received or post the states’ proposals on its Web site before approving them. Instead, HHS relied on Florida and Vermont officials to obtain and respond to public comments. Both states provided opportunities for public input—for example, by holding public hearings and posting drafts of the demonstration proposal on the states’ Web sites. Even so, stakeholders in each state and at the national level said they lacked access to specific information about aspects of the proposals that directly affected beneficiaries or lacked sufficient time to review and comment on the proposals. In Vermont, for example, the state’s Medical Care Advisory Committee, established by the state to facilitate consumer input in state Medicaid policy, voted against approval of the demonstration proposal because members said they lacked sufficient time and information to understand the proposal. In Florida, stakeholders said that information about the demonstration proposal provided during public meetings was insufficient for adequately understanding implications and that, upon request, state officials did not provide key documents related to the demonstration, such as budget and demographic information related to the proposal. At the federal level, organizations representing individuals aged 50 and above, children and families, and other Medicaid beneficiaries affected by the Florida and Vermont demonstrations said that HHS did not post the proposals to its Web site or provide them with timely information about the demonstrations upon request. Unless Congress and HHS take actions in response to the matters for congressional consideration and recommendations to HHS presented in our July 2002 report, it appears likely that HHS will continue to approve waivers for comprehensive demonstration proposals—with potentially significant implications for program beneficiaries—without adequate opportunity for public input.

In commenting on a draft of this report, HHS said the department continues to disagree with our recommendation that the Secretary provide for an improved public input process at the

---

<sup>12</sup>Florida’s demonstration is expected to expand to five counties in 2007 and to expand statewide by 2010.

<sup>13</sup>Populations not covered by the state managed-care organization include individuals enrolled in the state’s long-term care demonstration and the State Children’s Health Insurance Program (SCHIP).

federal level. HHS said that sufficient opportunities are available at the state level and that a new federal-level requirement could create legal challenges that would delay HHS's and states' implementation of innovative demonstrations. We disagree with HHS's contention that its current policies and practices allow for sufficient public input. For example, stakeholders reported they lacked access to specific information about the proposals during the public input process. Also, HHS told us in 2002 that it planned to post proposed demonstrations on its Web site, but has not since established this policy in a written form in HHS guidance,<sup>14</sup> and has not followed this practice in the case of recently approved demonstrations in Florida and Vermont. Furthermore, HHS did not explain or provide a basis for its contention that allowing for federal input could create legal challenges. Therefore, we disagree with HHS's suggestion that a public process should be limited in order to avoid legal challenges. Because of long-standing concerns with inadequate opportunities for public input in the process and because a notice-and-comment period at the federal level would provide for a more open and transparent process for all parties, we maintain our earlier recommendation that Congress consider requiring the Secretary to institute such a process.

We also provided a copy of a draft of this report to Florida and Vermont. Florida stated that our draft report did not provide an accurate representation of the demonstration structure as it selectively represented certain aspects of Florida's demonstration and omitted or underemphasized other innovative and integral aspects of the program. We maintain that our report accurately describes the major components of Florida's demonstration. We did, however, update the report to discuss a component of the demonstration that Florida said was important, specifically, information on a financial benefit to encourage healthy behaviors; about \$34,000 had been used by beneficiaries as of March 2007. Vermont, while disheartened that some stakeholders noted that the state's public input process was somehow weak or not well rounded, stated that our draft report was thorough, thoughtful, balanced, and complete.

## **Background**

Medicaid is one of the largest programs in federal and state budgets. In fiscal year 2005, the most recent year for which complete information is available, total Medicaid expenditures were an estimated \$317 billion. States pay qualified health providers for a broad range of covered services provided to eligible beneficiaries. The federal government reimburses states for its share of these expenditures. The federal matching share of each state's Medicaid expenditures for services is determined under a formula defined under federal law and can range from 50 to 83 percent.<sup>15</sup> Each state administers its Medicaid program in accordance with a state Medicaid plan, which must be approved by HHS.<sup>16</sup> Traditional Medicaid programs represent an open-ended entitlement, meaning the state will enroll all individuals who are eligible for Medicaid, and both the state and the federal government will pay, without

---

<sup>14</sup>When asked for a copy of its policy, HHS officials clarified that the expectation that waiver applications be posted on the Web site is not contained in formal HHS policy guidance, but in performance plans for certain CMS division managers.

<sup>15</sup>See Social Security Act §§ 1903(a)(1), 1905(b) (codified, as amended, at 42 U.S.C. §§ 1396b(a)(1), 1396d(b)). States with lower per capita income typically receive higher federal matching shares.

<sup>16</sup>A state Medicaid plan details the fundamental characteristics of a state's program such as the mandatory and optional populations a state's program serves; the amount, scope, and duration of mandatory and optional services the program covers; and the rates of and methods for calculating payments to providers.

limitation, their share of state expenditures for people covered under a state's approved Medicaid plan.

States have considerable flexibility in designing their Medicaid programs, but under federal Medicaid law, states generally must meet certain requirements for which benefits are to be provided and who is eligible for the program, and states may impose only nominal deductibles, coinsurance, or co-payments on some Medicaid beneficiaries for certain services.<sup>17</sup> For example, states are required to cover certain services, such as physician, hospital, and nursing facility services, as well as early and periodic screening, diagnostic, and treatment (EPSDT) services for children (under the age of 21). States can receive federal matching payments to cover certain optional services, such as prescription drugs, vision, and dental services, but if they do so, they must generally provide the same benefits to all covered beneficiaries. Groups of individuals that states are required to cover under the state plan are known as "mandatory" populations, and states may choose to provide Medicaid coverage to additional optional groups of individuals.<sup>18</sup> Generally, optional Medicaid beneficiary groups share characteristics similar to the mandatory groups, but have higher incomes and states may cover these individuals under a state plan. Expansion eligibility groups are those individuals who do not fall under statutorily defined Medicaid eligibility categories but whom states are able to cover under a section 1115 demonstration.

Under section 1115 of the Social Security Act, the Secretary has authority to waive certain federal Medicaid requirements and authorize Medicaid expenditures for experimental, pilot, or demonstration projects that are likely to assist in promoting Medicaid objectives.<sup>19</sup> States have used the flexibility granted through section 1115 to implement major changes to existing state Medicaid programs. For example, some states have used Medicaid section 1115 demonstrations to introduce mandatory managed care for their Medicaid beneficiaries; other states have expanded Medicaid coverage to additional populations or services.

Recognizing that people who may be affected by a demonstration project "have a legitimate interest in learning about proposed projects and having input into the decision-making process," HHS established procedures in a 1994 *Federal Register* notice for both a federal- and a state-level public notice-and-comment process.<sup>20</sup> At the state level, the requirements of this policy have remained essentially unchanged since the notice was issued on September 27, 1994. In directing states to facilitate public involvement and input during the development of proposed demonstrations, the notice describes a variety of ways that states may create opportunities for public input, such as holding public hearings, convening commissions with open public meetings, enacting state legislation regarding the

---

<sup>17</sup>See Social Security Act §§ 1902(a)(10)(A), 1905(a), 1916, 1916A (codified, as amended, at 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a), 1396o, 1396o-1).

<sup>18</sup>Social Security Act § 1902(a) (10)(A)(i), (ii) (codified, as amended, at 42 U.S.C. 1396a(a)(10)(A)(i), (ii)). In 2006, income thresholds for Medicaid eligibility as a percent of the federal poverty level in Florida were 200 percent for infants, 133 percent for children age 1–5, 100 percent for children age 6–19, 185 percent for pregnant women, 22 percent for nonworking parents, and 58 percent for working parents. In Vermont, income thresholds in 2006 were 300 percent for infants and children up to age 19, 200 percent for pregnant women, 185 percent for nonworking parents, and 192 percent for working parents. The federal poverty level for a family of four in 2006 was \$20,000.

<sup>19</sup>Social Security Act § 1115 (codified, as amended, at 42 U.S.C. § 1315).

<sup>20</sup>59 *Fed. Reg.* at 49,250-251.

demonstrations, or posting information about demonstration proposals in newspapers. HHS's policy also instructs states to include in their formal 1115 demonstration proposals a brief narrative describing the process used to obtain public input.<sup>21</sup> In the 1994 notice, HHS indicated that it would post notice of new and pending demonstrations in the *Federal Register*; allow for a 30-day comment period; notify certain organizations of the receipt of demonstration proposals; acknowledge, if feasible, comments made; and refrain from approving or disapproving proposals until at least 30 days after proposals were received.

### **Demonstrations in Florida and Vermont Have Mixed Implications for Beneficiaries, but Actual Effects Are Unknown**

Recently approved demonstrations in Florida and Vermont implement different methods for administering each state's Medicaid program and have potentially wide-ranging implications for beneficiaries. In Florida, for example, beneficiaries have greater flexibility to choose among different benefit plans, but could face the loss of some benefits, limits on covered services, or additional cost-sharing requirements, and beneficiaries could face up to 30 days with limited coverage before being enrolled in a managed care benefit plan. Vermont may use savings from managed care operations to fund additional health care initiatives, but the state is at financial risk should demonstration costs exceed the approved spending limit, with uncertain implications for beneficiaries should that happen. Because the demonstrations were in early stages of implementation at the time of our review, the actual effect on beneficiaries of their various components was not yet known.

#### Florida's Demonstration Provides Beneficiaries More Choice, but Beneficiaries Assume Risk for Their Choice of Plans, under Which Benefits Could Be Limited

Florida's demonstration proposal, which Florida submitted and HHS approved in October 2005, gives beneficiaries a more active role in determining their health care by requiring them to choose from a number of managed care plans in their area. Under the demonstration, HHS gave authority to the state to develop and pay risk-adjusted premiums<sup>22</sup> to managed care plans that cover beneficiaries, and to establish an annual maximum benefit limit for adults.<sup>23</sup> The state in turn is requiring most beneficiaries, including aged and disabled persons and

---

<sup>21</sup>In addition to HHS's 1994 policy, a May 3, 2002, letter issued by HHS to state Medicaid directors reiterated that the public should continue to be involved in the development of demonstrations and that HHS will continue to review demonstrations to ensure that states are following public-notice procedures. The letter stated that the states have responsibility for providing opportunity for public input, for example, through public forums, legislative hearings, placement of information on the state's Web site with a link for public comments, or distribution of draft proposals for comment. Letter to state Medicaid directors 02-007 (May 3, 2002), available at <http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage> (downloaded Feb. 15, 2007).

<sup>22</sup>Florida calculates risk-adjusted premiums for Medicaid beneficiaries based on eligibility groups, age, and gender for a specific geographic area and then adjusts for risks associated with health status.

<sup>23</sup>For plans accepting risk for comprehensive coverage only, the plan would be responsible for care up to a \$50,000 limit per beneficiary. Once the plan reaches \$50,000, the state reimburses the plan at 95 percent of the state's current Medicaid fee-for-service rate for costs accrued up to the \$550,000 annual maximum benefit limit for nonpregnant adults. For plans accepting risk for both comprehensive and catastrophic care, the plan is responsible for care of nonpregnant adults up to the \$550,000 annual maximum benefit limit.



certain families and children,<sup>24</sup> to choose from a number of managed care plans offering a variety of benefit packages (beneficiaries are automatically enrolled in a plan if they do not make a choice), or they can opt out of Medicaid and enroll in employer-sponsored benefit plans or, in the case of those who are self-employed, in commercial benefit plans. By choosing a benefit plan or opting out of Medicaid to purchase employer-based or commercial insurance, however, beneficiaries may also experience reduced benefits or increased cost sharing such as co-payments or deductibles. Florida's demonstration program began in July 2006 in two counties, Broward and Duval, and is scheduled to expand statewide by 2010.

Selected features of the Florida demonstration and implications for beneficiaries include the following:

- **Managed care plans have flexibility to offer state-approved benefit plans tailored to specific groups of beneficiaries:** Participating managed care plans can vary the amount, duration, and scope of benefits offered to individual beneficiaries who share demographic characteristics or who have varying levels of medical need, and they can drop or impose cost sharing on certain services as long as the required cost sharing is within those limits approved for services under the state Medicaid plan. According to state officials, managed care plans must provide the same level of coverage available under the state plan with respect to children under age 21 and pregnant women.<sup>25</sup> Managed care plans are encouraged to compete for enrollees by offering customized benefit packages—for example, by including additional services or lower cost sharing—targeted to specific populations. To ensure that all benefit plans offer sufficient coverage, the state must approve all benefit packages offered to Medicaid beneficiaries.<sup>26</sup> Managed care plans participating in the demonstration as of March 2007<sup>27</sup> offered similar plans, in that they each covered certain basic Medicaid benefits, such as hospital inpatient and outpatient services, ambulance services, and maternity services. However, some participating plans offered beneficiaries additional services, such as adult dental benefits, over-the-counter pharmacy benefits, and frail- or elder-care services that were not offered by other plans. Some plans limited beneficiaries to 60 lifetime visits for home health services—consistent with Florida's state-plan-required coverage—while others expanded this service to 210 visits annually per beneficiary. Several plans had no limits on the amount or cost of prescription drugs a beneficiary may use, while others limited the number of monthly prescriptions that beneficiaries were allowed or the annual covered

---

<sup>24</sup>Specifically, the state is requiring aged and disabled persons receiving cash assistance under the Supplemental Security Income program and children and families receiving cash assistance under the Temporary Assistance to Needy Families program to participate in the demonstration. The demonstration will initially exclude several special-needs groups currently receiving Medicaid services, such as foster-care children, individuals with developmental disabilities, and individuals residing in nursing homes or psychiatric facilities.

<sup>25</sup>In commenting on a draft of this report, Florida indicated that managed care plans must also provide the same level of coverage available under the state plan to Supplemental Security Income (SSI) beneficiaries, and must provide emergency services to all enrollees in the demonstration.

<sup>26</sup>To meet requirements of the demonstration, a managed care plan must cover all the categories of mandatory services, as well as optional services covered under Florida's state plan when indicated by historical data. The plan, however, may cover services in differing amount, duration, and scope as long as the plan can demonstrate that its proposed benefits are actuarially equivalent to historical utilization levels and are sufficient to cover the needs of the vast majority of enrollees.

<sup>27</sup>As of March 2007, 16 plans were under contract to provide services for the Florida demonstration.

cost for prescription drugs. Nearly half of the plans required beneficiaries to pay some form of co-payments, while the remaining plans did not have co-payment requirements. Whereas before the demonstration all beneficiaries meeting the same eligibility requirements received the same benefits as covered under the state Medicaid plan, under the demonstration, Medicaid beneficiaries could enroll in a participating plan based on the particular benefit package offered by managed care plans, much as they would in the commercial insurance market. In addition, unlike many other previous Medicaid managed care systems, managed care plans may change benefit packages annually with state approval. After beneficiaries are notified each year about changes in their benefits, they are responsible for determining whether their plans continue to meet their health care needs. Under the demonstration, beneficiaries can remain with the same plan or can choose a new plan each year during a designated open enrollment period. Beneficiaries need to review their plans each year to ensure that they understand how benefits may be changing.

- **Beneficiaries can have the state contribute towards the purchase of available employer-sponsored insurance or commercial health insurance and voluntarily opt out of Medicaid:** Under Florida’s demonstration, beneficiaries can choose to “opt out” of Medicaid and have the state use their Medicaid premium toward paying the costs of employer-sponsored health insurance or, if they are self-employed, towards individually purchased commercial health insurance. HHS has authorized the state to pay for such costs up to the state-established Medicaid premium and receive federal matching payments for these expenditures. Although employer-sponsored or commercial benefit plans must meet minimum state licensing standards, these plans are not subject to benefit package requirements applicable to plans participating in the demonstration and, therefore, may offer fewer benefits than plans participating in the demonstration. Also, these plans may have greater cost-sharing requirements, such as deductibles, co-payments, and higher monthly premiums than those the state would allow for plans participating in the demonstration.<sup>28</sup> By choosing to opt out of Medicaid, beneficiaries from mandatory populations could receive fewer benefits through employer-sponsored health plans. For example, children of parents who opt out and who previously had comprehensive Medicaid coverage for a broad range of EPSDT services could potentially have their benefits reduced. Medicaid beneficiaries who opt out of Medicaid have 90 days to choose to enroll instead in a Medicaid managed care plan. After 90 days, the beneficiary must remain with the employer-sponsored insurance and can make no further changes, including enrolling in a Florida Medicaid managed care plan, until the next employer-sponsored open enrollment period, unless the enrollee no longer has access to employer-sponsored coverage. If a beneficiary loses eligibility for participation in the employer-sponsored plan, the state has a process for “opting back in” to a Medicaid managed care plan.
- **Choice counselors will assist beneficiaries with choosing benefit plans or with opting out of Medicaid, but beneficiaries must assume risk for their choices:** Through the mandatory enrollment of beneficiaries into managed care plans that they choose, Florida’s demonstration emphasizes individual involvement in selecting from benefit plan options, and the state expects to gain valuable information about the effects of infusing market-based approaches into a public entitlement program. To assist beneficiaries with their choices, Florida is providing counselors—called “choice

---

<sup>28</sup>Under the demonstration, HHS approved a waiver of a statutory requirement that establishes limits on the imposition of cost-sharing on Medicaid populations and services, thereby allowing the state to authorize participation by beneficiaries in employer-sponsored or commercial health plans that may impose cost sharing amounts that exceed such limits.

counselors”—to provide information about choosing a benefit plan and about opting out of Medicaid. According to the demonstration’s terms and conditions, independent choice counselors will provide beneficiaries with information about each plan’s coverage, benefits and benefit limitations, cost-sharing requirements, network and contacts, performance measures, results of consumer satisfaction reviews, and access to preventive services. Because the choice of benefit plans could have significant implications for beneficiaries, how well Florida implements choice counseling is critical to beneficiaries’ understanding their options and making sound choices regarding which benefit plan best meets their needs. As of March 2007, it was too early to evaluate the effectiveness of choice counselors in helping beneficiaries choose benefits plans.

- **Florida may limit retroactive eligibility and benefits for new beneficiaries:** Under the demonstration, Florida may limit eligibility to the date of an individual’s Medicaid application and need not provide Medicaid coverage for new beneficiaries retroactively, that is, for up to 3 months before the date the individual applied for assistance. Under the statutory requirements for Medicaid, if an applicant is found eligible for Medicaid, a state plan must make medical assistance retroactive for up to 3 months. HHS approved a waiver of this statutory requirement for the demonstration. In addition, Florida could, if it chooses, restrict newly eligible beneficiaries’ coverage for Medicaid services for up to 30 days after a beneficiary is determined to be eligible, but before a benefit plan is selected or before the state assigns a beneficiary to a benefit plan. During this 30-day period, or until a beneficiary selects a benefit plan or is assigned to one, Florida can restrict his or her care to only emergency medical services and nursing home level of care.<sup>29</sup> Florida Medicaid officials, however, informed us that pregnant women and children under 21 years of age will continue to have retroactive eligibility for up to 3 months prior to the date of application,<sup>30</sup> will receive full state plan benefits, and are also exempt from receiving limited benefits for up to 30 days before they are enrolled in a managed care plan.

According to Florida officials, another key component of the demonstration is the enhanced benefit program to promote healthy behaviors. Under the program, accounts are established to provide incentives to enrollees for participating in state-defined activities that promote healthy behaviors. An individual who participates in certain state-defined activities that promote healthy behavior is given up to \$125 per state fiscal year in “credits” in an individual enhanced benefit account to use for certain health-care-related expenditures. As of March 2007, beneficiaries had used about \$34,000 of \$1.7 million credited to their accounts under the program.<sup>31</sup>

---

<sup>29</sup>Under the demonstration, HHS approved a waiver of a statutory requirement that would otherwise have required the state to provide mandatory benefits to all mandatory and optional Medicaid beneficiaries, thereby allowing the state to limit coverage, for up to 30 days, pending enrollment in a managed care organization, to emergency services and nursing home level of care.

<sup>30</sup>In commenting on a draft of this report, Florida said that although HHS granted a waiver so that the state was not required to provide retroactive eligibility for up to 90 days prior to the application, the state had not as of June 2007 implemented this component of the program.

<sup>31</sup>In March 2007—the latest month for which data were available—about \$15,000 of \$524,000 credited by the state under the program had been used by Medicaid beneficiaries. About 1,000 of 19,000 enrollees receiving credits had used them.

Florida began implementation of this demonstration program in July 2006; however, beneficiaries were not enrolled in benefit plans until September 2006. As of March 2007, more than 165,000 beneficiaries were enrolled in benefit plans. At the time of our review, the demonstration program was not yet far enough along to determine the effect on beneficiaries and the extent to which providing beneficiaries with increased choices, along with the increased risk associated with those choices, was improving care.

Vermont's Demonstration Grants the State New Flexibility, but Some Beneficiaries May Have Benefits Reduced and Eligibility Delayed or Denied

Vermont's demonstration, submitted in April 2005 and approved by HHS in September 2005, provides the state with the flexibility necessary to administer most of the state's Medicaid program in a more centralized manner. The demonstration, which began in October 2005, allows the state to operate its own managed care organization. Under the demonstration, an office within the state's Medicaid agency was converted to a publicly operated managed care organization responsible for providing services and managing costs for most of the state's Medicaid program.<sup>32</sup> The demonstration proposal indicated that changes to the state's Medicaid program under the demonstration would be transparent to most Medicaid enrollees in the short term: the demonstration would not change delivery or coverage of services to beneficiaries.

Selected features of the Vermont demonstration and implications for beneficiaries and providers include the following:

- **Expected cost savings could enable Vermont to serve more of the state's uninsured population:** HHS permitted the state to convert its Office of Vermont Health Access, which is within the state's Medicaid organization, into a single, state-run managed care organization. As described in the demonstration proposal, the demonstration is designed to put in place a series of health care options responsive to priorities supported by the governor and state legislature, including improved access to health care for Vermont's uninsured, cost containment within Medicaid, and improved system accountability and quality of care. Under the demonstration, the state is provided flexibility, including the ability to use creative payment mechanisms, rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid. The state expects the new state-run managed care organization to be more efficient. By employing a cost-containment strategy, which includes standardizing provider reimbursement systems and managing chronic care, the new state Medicaid structure and finance arrangement could help state officials address Medicaid deficits that had been projected to occur in Vermont. Under the demonstration, the state automatically enrolled nearly all Medicaid

---

<sup>32</sup>In addition to the recently approved comprehensive 1115 demonstration in Vermont (known as Global Commitment to Health), the Secretary approved Vermont's Long Term Care demonstration in June 2005. The Long Term Care demonstration enables the state to provide long-term care beneficiaries home-and community-based alternatives to institutional or nursing home care. The Global Commitment to Health and Long Term Care demonstrations encompass Vermont's entire state Medicaid program, with the exception of Medicaid Management Information System (MMIS) costs, State Children's Health Insurance Program (SCHIP) payments, and disproportionate share hospital (DSH) payments. DSH payments are a form of Medicaid financing that allows states and HHS to compensate those hospitals that care for a disproportionate number of low-income Medicaid and uninsured patients in a state. Unlike other federal Medicaid matching payments, federal Medicaid DSH payments do not flow to states on an open-ended basis. Instead, these payments are allocated among states as defined under federal law. States may claim federal matching funds for DSH payments made to qualifying hospitals up to these ceilings.

beneficiaries in the new state-run managed care organization. In doing so, according to the state's Medicaid director, it hoped to introduce chronic-care management and disease prevention services for enrollees, such as smoking-cessation programs. State officials indicated that savings generated by the demonstration could be applied to previously state-funded programs, such as those for the state's uninsured.

- **Expenditures for Medicaid services are allowed to increase or decrease up to 5 percent annually for nonmandatory beneficiaries:** Under Vermont's demonstration, HHS provided the state the authority to change the benefit package for the nonmandatory eligible population as long as the changes result in no more than a 5 percent cumulative increase, or decrease, each year in total Medicaid expenditures.<sup>33</sup> The state is required to notify HHS of any such change in the benefit package but is not required to receive HHS approval for the changes. If Vermont's Medicaid program incurs financial setbacks or continues to run deficits, these beneficiaries could potentially experience a reduction in benefits offered by the state, such as the number of prescriptions allowed or number of doctor visits permitted each month, as long as these reductions do not decrease state expenditures for Medicaid by more than 5 percent annually.
- **Optional and expansion Medicaid populations may see an increase in their share of costs:** Under the demonstration's terms and conditions, HHS permitted Vermont to maintain or increase premiums and co-payments for services for optional and expansion Medicaid populations—as long as such cost sharing for children in optional and expansion populations does not exceed 5 percent of a family's income. The state is not required to obtain HHS approval for changes to premiums and co-payments within the range specified in the demonstration's terms and conditions if they do not exceed 5 percent of a family's gross income for eligible children. The state agreed to maintain the state plan co-payments and premium provisions for the mandatory population.
- **Optional and expansion Medicaid populations may experience a change or delay in eligibility:** Under the demonstration's terms and conditions, Vermont agreed to maintain eligibility established in the demonstration's base year for mandatory beneficiaries but was authorized, for optional and expansion populations, to impose enrollment caps or eliminate eligibility during the 5-year demonstration. The state can limit enrollment and impose waiting lists for these groups; however, such changes must be approved by HHS.
- **Financing approach limits federal risk but shifts risk to state and potentially to all beneficiaries and providers:** Another component of Vermont's demonstration is a spending limit, which, if exceeded, would end federal matching payments for Medicaid services paid under the demonstration. By establishing a spending limit on federal matching funds, HHS transfers financial risk from the federal government to the state, with implications for all beneficiaries and providers. If the state experiences an unexpected increase in Medicaid beneficiaries or expenditures during the demonstration period, it could reach or exceed the demonstration's spending limit. The state would then have to finance the demonstration using only state funds. Without available federal matching funds to continue to cover the demonstration's required costs to provide services, options available to the state to reduce expenditures could include reducing

---

<sup>33</sup>Vermont is not obligated to provide state plan services to optional or expansion beneficiaries but can instead provide coverage as approved by HHS, which includes inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care.

benefits and increasing cost sharing requirements, cutting back on populations served, or decreasing provider payment rates.

Vermont began implementation of this demonstration program in October 2005, and the demonstration proposal indicated that, initially, delivery of services to beneficiaries would not change. Nearly all Medicaid beneficiaries were enrolled in the demonstration at the time it was initiated, and as of December 2006, the latest month in which information was available, more than 141,000 beneficiaries in Vermont were enrolled. At the time of our review, the demonstration program was not yet far enough along to assess the financial effects of the demonstration on beneficiaries' benefits, coverage, or eligibility, including the accuracy of the spending projections approved for the demonstration.

### **States Provided Opportunities for Public Input on Proposals but Details Were Lacking, and HHS Did Not Provide for Input at the Federal Level**

In Florida and Vermont, beneficiaries and other stakeholders had a number of opportunities at the state level to provide public input and comment during the development of demonstration proposals. Despite these opportunities, local stakeholders in each state we spoke to told us that state officials did not provide sufficient information or time to review the proposals prior to their submission for federal review and approval. At the federal level, HHS did not provide formal public notice or the opportunity to comment. Also, contrary to its stated policy of posting demonstration proposals on its Web site prior to approval, HHS did not do so in the case of Florida or Vermont.

### **Florida and Vermont Provided Opportunities for Public Notice and Comment, but Stakeholders Reported That Only Limited Information Was Available**

Florida and Vermont followed HHS's guidance regarding public notice and comment, each holding multiple public forums and posting information on state Web sites and in newspapers. Stakeholders in each state, however, reported that the information provided was primarily broad concepts, lacking the specificity they needed to offer constructive comments or ask meaningful questions. For example, stakeholders said that public documents did not adequately describe growth trends used to develop the demonstrations' budgets. In both Florida and Vermont, the state legislatures were active in soliciting public input and reviewing versions of the demonstration proposals as they were developed. Stakeholders in each state, however, reported that they were not given sufficient time to review the proposals once they were made public and prior to the state submitting the formal proposal to HHS for review and approval.

#### **Florida's Public Notice-and-Comment Process**

Florida Medicaid officials followed HHS's policy for public process at the state level by conducting stakeholder presentations and posting a draft of the proposed demonstration on the state's Web site for 30 days during September 2005. Before submitting a proposal to HHS on October 3, 2005, the Florida State Medicaid Director and state officials from the Agency for Health Care Administration (AHCA), the agency responsible for the state's Medicaid program, made presentations to the public about general concepts of the demonstration, during which the public could comment as well as learn about the demonstration. Concerned about the proposal and the speed at which it was progressing, Florida's legislature had earlier enacted legislation that authorized AHCA to implement the demonstration, subject to parameters defined under state law and as approved by HHS. The state law also required

AHCA to post drafts of the section 1115 demonstration proposals on the state's Web site for 30 days for public comment before submitting it to HHS and to obtain approval from the state legislature before submitting and implementing the demonstration proposals.<sup>34</sup> The state legislature also sponsored several public forums to solicit public input on the proposal.

Some stakeholders we spoke to, including those representing beneficiaries, reported that information about the proposal was not available, for example, budget and demographic information and nursing home and pharmaceutical costs. Two stakeholders representing hospitals and a large managed care organization in Florida made positive comments about the way the state created opportunities for public input during the development of the proposal. However, two state-level organizations—one representing individuals aged 50 and older and one that provides legal services to low-income individuals—filed formal public information requests for material not made available to stakeholders during the development of the demonstration proposal after these organizations were unable to acquire documents through other means. In October 2005, soon after the state submitted its proposal to HHS, the organization that represents individuals aged 50 and older filed a public-records request to obtain a copy of a state-sponsored analysis of Medicaid expenditure trends. Organization officials told us they received the requested analysis, but only after repeated requests. Another organization—a state-level group providing legal services to low-income people—after experiencing difficulty obtaining sufficient information on the proposal from state Medicaid officials during public meetings, in December 2004 filed a Freedom of Information Act request with HHS for copies of draft proposals, state plan amendments related to the demonstration, budget and demographic information, and correspondence between HHS and state officials. As of June 2007, 20 months after HHS approved the demonstration proposal in Florida, the organization had not received the requested documents from HHS.<sup>35</sup> In addition, stakeholders in Florida expressed concern that the state's Medical Care Advisory Committee<sup>36</sup> did not participate in the development of the demonstration proposal because it had not convened while the demonstration proposal was under development and review.

#### Vermont's Public Notice-and-Comment Process

Vermont Medicaid officials followed HHS's requirements for public process at the state level, and the final demonstration proposal submitted to HHS included a record of public comments and the responses offered by the state Medicaid officials. Officials from the Vermont Agency of Human Services and Office of Vermont Health Access, both responsible for administering the state's Medicaid program, held three public hearings during which they received public questions and comments. Additionally, the Vermont legislature made several changes to the proposal before voting to approve the demonstration. For example, counsel to the legislature advised the state legislature that HHS would not have authority to approve a Medicaid demonstration as a block grant, as the governor and state Medicaid officials had

---

<sup>34</sup>Fla. Stat. ch. 409.91211 (2006).

<sup>35</sup>In commenting on a draft of this report, HHS acknowledged that its response to this request was pending.

<sup>36</sup>Under federal regulations, states are required to establish a Medical Care Advisory Committee to advise the Medicaid agency about health and medical care services. This committee must include members of consumer groups who, along with other members, must have the opportunity to participate in the development of Medicaid policies and administration, including furthering the participation of recipient members in the agency program. In Vermont, the committee is known as the Medicaid Advisory Board. See 42 C.F.R. § 431.12.

initially proposed. As required under state law, the Vermont legislature oversees the demonstration by approving any changes made to demonstration components or financing.<sup>37</sup>

Stakeholders in Vermont also reported difficulties in obtaining sufficient information on the demonstration proposal, such as the effect of the demonstration on benefits for beneficiaries and methods the state used to formulate the demonstration's projected savings. Local stakeholders we interviewed told us that the level of detail provided by Vermont Medicaid officials in presentations was limited to broad examples used to illustrate how the demonstration would operate and that state officials could not offer a comprehensive explanation of the demonstration's implementation. These stakeholders told us they were unclear about many of the implications for beneficiaries. Members of the state's Medical Care Advisory Board, established by the state to facilitate consumer input to its Medicaid policies, told us that they had lacked time and information to review the demonstration proposal prior to its formal submission to HHS for review and approval and had voted in April 2005—just before the proposal was submitted to HHS—not to approve its going forward. The board did not receive information it had requested from the state on federal matching formulas, disenrollment rates, historical cost and caseload trends, programs included in the budget projection, or how the demonstration interacts with the state budget. Because the board's role was advisory, however, the state submitted the demonstration proposal despite the board's lack of support.

#### At the Federal Level, HHS Did Not Provide Notice and Opportunity for Public Comment by Stakeholders

At the federal level, HHS did not provide a process for public notice and comment on either Florida's or Vermont's proposed demonstrations. In January 2007, HHS officials reiterated statements made to us by HHS officials in 2002 that the agency no longer followed the federal public notice-and-comment process in its 1994 policy published in the *Federal Register* and instead was posting pending and approved demonstration proposals to its Web site. (Table 1 shows the differences between the 1994 and 2007 federal-level policies.) However, some national stakeholders reported that HHS did not post the proposals to its Web site before approving the Florida and Vermont demonstrations. Further, HHS had not posted to its Web site a demonstration amendment proposal submitted by Vermont Medicaid officials to HHS in September 2006 until mid-April 2007.<sup>38</sup> All of the national stakeholders we queried about the demonstration amendment told us that they were unaware of the proposed amendment and that neither HHS nor state Medicaid officials had provided them a copy.

---

<sup>37</sup>Vt. Stat. Ann. tit. 33 §§ 1901, 1901a, 1901e (2006).

<sup>38</sup>In commenting on a draft of this report, HHS indicated that it considered the September 2006 submission a concept paper and did not consider the amendment as a formal application until December 2006.



**Table 1: Comparison of HHS’s 1994 and 2007 Policies on Public Notice and Comment at the Federal Level**

Federal action	1994	2007
State notified as to adequacy of intended public process	✓	✓
Monthly notice of all new and pending proposals published in <i>Federal Register</i>	✓	
<i>Federal Register</i> notice published indicating that HHS is accepting written comments on proposals	✓	
List maintained of organizations requesting notice of receipt of demonstration proposal	✓	
Organizations notified when proposal received	✓	
Thirty-day comment period provided before decision on proposal	✓	
Acknowledgment issued for receipt of all comments	✓	

Source: 59 *Fed. Reg.* at 49,249 (Sept. 27, 1994) and HHS officials.

In January 2007, HHS officials told us—as they had told us in 2002—that the department no longer adhered to the 30-day waiting period to accept and consider comments before rendering a decision on a demonstration proposal as described in the agency’s 1994 policy. For example, in Florida, HHS approved the state’s demonstration proposal 16 days after the state submitted the formal proposal to HHS.<sup>39</sup> Nearly all of the national stakeholders we interviewed told us that this window was not enough time to allow them to review and comment on Florida’s final proposal. Further, stakeholders said that HHS does not notify interested groups or the public when HHS receives a demonstration proposal for review. As a result, in contrast to the department’s 1994 policy, beneficiaries and other interested parties may be unaware that HHS has received a proposal until after the proposal has been approved, as some reported was the case for Florida.

Several national stakeholders reported that requests they made to HHS for information about both demonstrations went unanswered. These stakeholders told us that such information helps their organizations to evaluate proposed demonstrations before providing comments and to assist local stakeholders in understanding the implications of proposed demonstrations.

The Medicaid Commission recently endorsed compliance with policies requiring a public input process at the federal level for achieving Medicaid reform.<sup>40</sup> In December 2006, the commission issued a report to the Secretary of Health and Human Services, which recommended, among other things, that compliance with existing policies regarding public notice of section 1115 demonstration proposals, such as HHS’s 1994 public notice-and-comment policy, be monitored and enforced. The report recommended that HHS and states enforce existing federal and state laws and regulations so that stakeholders such as beneficiaries, providers, and family members may provide input while new programs and delivery models affecting them are developed and implemented. The Medicaid Commission found that information and perspectives offered during public comment periods constituted

<sup>39</sup>For Vermont’s demonstration, the HHS approval process took more than 5 months; state Medicaid officials submitted the proposal to HHS on April 15, 2005, and received HHS approval on September 27, 2005.

<sup>40</sup>The Medicaid Commission, appointed in July 2005 by the Secretary, was charged by the Secretary with identifying reforms necessary to stabilize and strengthen Medicaid. The commission issued its report and recommendations in December 2006.

important feedback and recommended that HHS and state officials elicit public feedback when state Medicaid agencies pursue policies that would restructure state Medicaid programs.

A broad range of national stakeholder organizations have also raised concerns to Congress about the need for an improved federal-level process for public input during HHS review of demonstration proposals. A group of nearly 60 national stakeholder organizations sent a letter in February 2006 to the Chairman and Ranking Member of the Senate Committee on Finance, expressing concern that significant and complex policy changes are made to the Medicaid program through section 1115 demonstrations, often with little opportunity for public input. This group of national stakeholders further stated that it wanted to ensure that major changes made to Medicaid were subject to appropriate public input and congressional oversight and that the ramifications of these changes for beneficiaries were well understood.

Views varied among the national stakeholder groups we interviewed concerning the need for a public input-and-comment process at the federal level. National stakeholder organizations representing state governors and legislatures did not believe that additional measures were required at the federal level to provide for public input. These groups—the National Governors Association, National Conference of State Legislatures, and the Center for Health Transformation—told us that state-level public input processes were sufficient for providing information and opportunities for comment and that additional action at the federal level would not add to stakeholders’ understanding of demonstration proposals. In contrast, national stakeholder groups we interviewed that represent beneficiaries generally told us that a process for public comment at the federal level was important to their organizations. In November 2006, a panel of 16 representatives from a broad range of national stakeholder organizations described the relationship between HHS’s current actions and their organizations’ activities:

- **Providing public input during the federal approval process.** Representatives said that providing public input on topics that affect their constituents is a significant responsibility for their organizations during the federal approval process. HHS did not, however, provide an opportunity for national groups to offer public input during the approval process for the Florida and Vermont demonstrations. An official from a national group representing community health centers said, for example, that HHS had not provided the organization an opportunity to offer input to the pending demonstration proposals, both of which affect health centers in those states. Officials from other national groups confirmed that HHS directs their organizations to offer input to states rather than to HHS, even after HHS has received a formal demonstration proposal from a state. In addition, an official from a national organization providing legal services to low-income individuals, including Medicaid beneficiaries, said that HHS has no formal process to notify national stakeholders of pending proposals received for HHS review and that if advocates and organizations did not actively seek out information through other channels, they would not be aware of pending demonstration proposals.
- **Providing technical assistance to local affiliates and beneficiaries.** Representatives told us that information from HHS on proposed demonstrations during the approval process is critical for their organizations to provide technical assistance to beneficiaries and local affiliates, particularly if the state-level public input process was insufficient. For example, an official from a national organization representing children with behavioral health issues (many of whom are Medicaid beneficiaries) commented that local members often call the national organization to ask for information about demonstration proposals pending in their own state. Likewise, an official from an organization representing

individuals with Alzheimer’s disease said that state and local chapters rely on the national organization for expertise and information on public policy issues, including proposed Medicaid demonstrations. An official from a national group providing social services to low-income seniors told us that the group uses information provided by HHS to inform its constituency of implications of new or untested Medicaid policies on long-term care services. Officials from other national groups we contacted also told us that HHS did not provide requested information related to pending demonstrations in Florida and Vermont, including copies of the proposals.

- **Informing HHS about lessons learned from past demonstrations.** Representatives said that HHS itself cannot necessarily track every implication for beneficiaries that could occur over a demonstration’s 5-year period for all the demonstrations it approves for different states. As a result, national stakeholders try to inform HHS on which provisions and procedures from former demonstrations have and have not worked and on what implications may have developed for beneficiaries. National groups told us they have an “experiential base” of knowledge about the past performance of demonstrations, which, through an open exchange of information with stakeholders, can benefit HHS officials in deciding whether to approve a demonstration proposal.
- **Monitoring changes to federal Medicaid policy.** Representatives also expressed concern that HHS has introduced major changes to federal Medicaid policy through approvals of state demonstrations and that public input at the federal level is an important requirement for monitoring and anticipating these changes. An official from a national organization representing providers of mental health services told us that the federal approval process for demonstration proposals has become so complex that changes in federal Medicaid policy have occurred without a complete paper trail available to the public showing how demonstration proposals were developed, which limits accountability and transparency for HHS.

### **Concluding Observations**

Both the Florida and Vermont demonstrations embody significant changes in how these states operate their Medicaid programs. In approving these demonstrations, HHS has approved state Medicaid reforms that depart from previously approved demonstrations. These reforms have potentially mixed implications for beneficiaries covered under the demonstrations in terms of how the demonstrations may affect their access to health care services. In Florida, which will test the effects of combining market-based commercial approaches with the delivery of services to the low-income Medicaid population, it is important that beneficiaries are fully informed and understand the trade-offs involved with their health care choices, especially if they are relinquishing certain Medicaid benefits, such as EPSDT. In Vermont, the federal financial risk is limited to a specified level, but the risk of increased costs due to unforeseen circumstances is assumed by the state—and could potentially result in program changes for beneficiaries and providers should the spending limit be exceeded. As HHS noted in issuing its 1994 policy, people who may be affected by a demonstration have a legitimate interest in learning about proposed demonstrations and should have an opportunity to provide input to the decision-making process. Although Florida and Vermont officials provided for public input and comment during the development of their proposals, many stakeholders reported seeking, but not obtaining, more time and information to understand and provide informed input on the proposed changes. A federal-level process does not exist that would allow stakeholders and beneficiaries to learn of, review, and provide input on the submitted proposals.

HHS's objective of expediting the waiver review and approval process is reasonable. But, as we stated in our 2002 report, public input into new demonstration proposals is important not only because such input helps ensure that demonstrations are consistent with overall Medicaid goals and that the waiver of certain statutory provisions is justified by the benefits obtained, but also because approved demonstrations represent federal policy whose influence may reach beyond a single state. A notice-and-comment opportunity at the federal level would provide for a more open and transparent process for all affected and interested parties, including Congress—something that, as shown by our earlier work and more recently in Florida and Vermont, may be better accomplished at the federal rather than state level. Unless Congress and HHS take action in response to the matters for congressional consideration and recommendations to the Secretary that we presented in our July 2002 report—namely that Congress consider requiring the Secretary to improve public notification and input at the federal level and that the Secretary provide for an improved process—it appears likely that HHS will continue to approve waivers for comprehensive Medicaid demonstrations without adequate opportunity for public input. Improvements should include, at minimum, posting pending demonstration proposals to the HHS Web site, implementing a 30-day comment period after receipt of a demonstration proposal before issuing a decision, and notifying interested parties of the receipt of proposals.

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

We provided a draft of this report for comment to HHS, Florida, and Vermont. Each provided written comments, which we summarize and evaluate below.

#### HHS's Comments and Our Evaluation

As in 2002, when we reported concerns with the lack of opportunity for public input to the section 1115 demonstration approvals, HHS disagreed with our recommendation that called for the Secretary to improve the opportunities for public input at the federal level. HHS expressed a view that opportunities for public input are more than adequate because states have a broad array of options for soliciting public input, and because HHS holds states accountable for complying with its 1994 policy and subsequent guidance regarding public input. HHS expressed concern that requirements that the department build a new process would create redundancy and slow the approval process, delaying states' creative approaches under the demonstrations. Of greatest concern to HHS was that federal legislation could create a pathway to court that would allow a single individual to delay implementation of a Medicaid demonstration and in so doing, disrupt a state's budget.

Our report points out that Florida and Vermont offered opportunities for public notice and comment consistent with HHS's policy for input at the state level; however, we do not agree that such a process at the state level precludes the need for input to HHS once a proposal is made final and submitted to HHS for approval. It is only at this point in the process that a state's final plans may be made clear. As discussed extensively by HHS in its comments, states may make significant changes to plans for the demonstration before submitting a proposal to HHS; stakeholders may not be aware of these changes or the plans as laid out in the final proposal.<sup>41</sup> Further, demonstrations have potentially far-reaching implications for beneficiaries beyond a state's borders, as approval of an innovative approach in one state

---

<sup>41</sup>In its comments, HHS acknowledged that demonstration proposals often evolve rapidly—alterations, additions, and deletions are made along the way, often on a more-than-daily basis. Further, states may not have labeled a particular document the "official or final submission."

paves the way for other states to follow suit through similar demonstrations. Finally, HHS did not explain or provide a basis for its contention that allowing for input at the federal level would create legal challenges. Therefore, we disagree with HHS's suggestion that a public process should be limited in order to avoid legal challenges. Although ensuring that opportunities for comment are available for 30 days or longer after a proposal is received could slow the current process—since HHS is approving some proposals more quickly, as in Florida—we believe this added time is a cost that is outweighed by the potential benefits in improved transparency and the potential for meaningful federal consideration of input from beneficiaries and others. We maintain that such a process is important for ensuring that precedent-setting decisions to waive Medicaid requirements are made after the consideration of concerns of stakeholder organizations and those affected by the decisions. Furthermore, because not all information key to stakeholders may be available to them during the state process and because the proposal might be changing significantly during the state's process, a notice-and-comment process that provides openness and transparency for all affected and interested parties at the federal level remains important for ensuring adequate public input to the final proposal as submitted to HHS. Consequently, we continue to believe our recommendation is valid.

HHS committed to several actions to ensure a transparent approval process which we summarize and respond to below.

- HHS noted that its 1994 policy predates widespread access to, and use of, the Internet. HHS said that it has a policy to post applications on its Web site within 10 days after the application, renewal, or amendment request is received.<sup>42</sup> HHS also stated its intention to add to the CMS Web site within the next several months a summary page of pending actions including state and federal contact information. We note that HHS did not have a 10-day-to-Web site policy during the course of our review and that HHS told us in 2002 that it planned to post waiver applications to its Web site but did not do so in the case of Florida and Vermont. When asked for a copy of its new 10-day policy, HHS officials told us that the policy was contained in division manager performance expectations and was communicated to staff who work with 1115 demonstrations.
- HHS also noted that CMS accepts and responds to written comments on demonstration proposals at any time. Officials had made this observation during our review, but also provided documentation indicating that they had received only one comment on the Florida demonstration and none on the Vermont demonstration during the process.

Finally, HHS offered several additional comments of a technical nature, including questioning our selection of Florida and Vermont as the focus of our review. HHS indicated that other state demonstrations have higher matching rates and high federal financial exposure; in particular, family planning demonstrations, for which states receive a 90 percent matching rate. We recognize HHS has approved many section 1115 demonstrations, some of which carry higher matching rates than the Florida and Vermont demonstrations. Yet we focused our work on recently approved comprehensive demonstrations, for which the majority of the state's Medicaid spending was directed by the demonstration's terms, precisely for the reason indicated by HHS—that these “two projects are significant demonstrations with far-reaching financial and programmatic implications.” Other recently approved section 1115 demonstrations identified by HHS either were not comprehensive, or did not affect more than

---

<sup>42</sup>Because of the widespread availability of the Internet, we are not reiterating the specific portion of our previous recommendation that HHS post proposals in the *Federal Register*.

50 percent of the state's Medicaid spending.<sup>43</sup> The family planning demonstrations that HHS highlighted as at high risk of federal financial exposure because of their high matching rates cover a small portion of many Medicaid services that states provide, and these demonstrations are not consistent with HHS's definition of "comprehensive." We incorporated other of HHS's technical comments where appropriate. HHS's comments are reproduced in enclosure III.

#### State Comments and Our Evaluation

In commenting on a draft of this report, Florida stated that our draft report did not provide an accurate and unbiased representation of its demonstration. In particular, Florida said the report did not acknowledge key aspects of the state's demonstration, such as the use of choice counselors to provide information to beneficiaries and the implementation of an enhanced benefit program. Florida said such omissions and underemphasized facts could lead to inaccurate conclusions about the nature of the demonstration and its implications for beneficiaries. Florida also said the report overemphasized the customized benefit packages and opt-out program components of its demonstration and did not adequately describe other important components. From our analysis of the demonstration's terms and conditions, we believe the draft report accurately reflects the major potential implications for beneficiaries over the 5-year demonstration period; we have nonetheless added information to our report on the enhanced benefit program which had not previously been described. Florida also took issue with the use of the phrase "commercial managed care plans," saying that the state is not *solely* contracting with commercial plans. Because the state did not consider all contracted plans as "commercial," we removed this word when describing the plans with which Florida contracts. We note that Florida acknowledges that its demonstration seeks to build upon the "commercial" market structure.

Florida also reiterated its extensive efforts to provide opportunities for public comment during development of the demonstration proposal and stated that it would not be prudent to duplicate the state's process at the federal level. Florida offered opportunities for public comment; nevertheless, stakeholders reported that information about the proposal was not available and two state-level groups filed public information requests to obtain this information. Stakeholders also expressed concern that Florida's Medical Care Advisory Committee—required by federal regulation to provide consumer input to the state on Medicaid policy development and program administration—did not participate in the development of the demonstration proposal. Finally, Florida provided several technical comments, which we incorporated as appropriate. Florida's comments are reproduced in enclosure IV.

Vermont stated that our draft report was thorough, thoughtful, balanced, and complete; nonetheless, state officials were disheartened that some stakeholders reported that the state's public input process was somehow weak or not well rounded. Vermont also noted that there is no more uncertainty regarding future benefit levels under the Vermont demonstration than there is without any demonstration at all, as optional Medicaid populations have always been subject to inclusion at states' discretion. Vermont's comments are reproduced in enclosure V.

---

<sup>43</sup>In addition to Florida and Vermont, we identified California and Iowa as states with recently approved comprehensive demonstrations. We estimated the portion of total state Medicaid expenditures covered in demonstration year one to be 4.6 percent and 4.4 percent, respectively.

-----

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

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



Kathryn G. Allen  
Director, Health Care Issues

Enclosures – 6

## Enclosure I

### **National, State, and Local Stakeholder Groups Contacted**

National stakeholder groups that GAO contacted:

- Alzheimer’s Association
- American Association of Homes and Services for the Aging
- AARP (formerly the American Association of Retired Persons)
- American Network of Community Options & Resources
- Center for Health Transformation
- Center on Budget and Policy Priorities
- Families USA
- Georgetown Health Policy Institute
- The Heritage Foundation
- March of Dimes
- National Association for Children’s Behavioral Health
- National Association of Community Health Centers
- National Conference of State Legislatures
- National Governors Association
- National Health Law Program
- National Health Policy Forum
- National Mental Health Association
- National Senior Citizens Law Center
- National Women’s Law Center
- Service Employees International Union

State-level and local stakeholder groups in Florida and Vermont that GAO contacted:

- Florida AARP
- Florida Association of Health Plans
- Florida Hospital Association
- Florida Legal Services
- Low Income Pool Council (in Florida)
- Florida Pediatric Society
- WellCare (in Florida)
- Vermont Association of Hospitals and Health Systems
- Bi-State Primary Care Association (in Vermont)
- Vermont Legal Aid
- Vermont Medical Care Advisory Committee (known as the Medicaid Advisory Board)



**Summary of Mandatory Federal Requirements for Traditional State Medicaid Programs**

---

**Summary of Mandatory Federal Requirements for Traditional State Medicaid Programs**

---

<b>Mandatory health benefits</b>	<p><b>States must cover, at a minimum, the following services under their state plans:</b></p> <ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Outpatient hospital services</li> <li>• Prenatal care</li> <li>• Vaccines for children</li> <li>• Physician services</li> <li>• Nursing facility services for persons aged 21 or older</li> <li>• Family planning services and supplies</li> <li>• Rural health clinic services</li> <li>• Home health care for persons eligible for skilled-nursing services</li> <li>• Laboratory and x-ray services</li> <li>• Pediatric and family nurse practitioner services</li> <li>• Nurse-midwife services</li> <li>• Federally qualified health-center services</li> <li>• Early and periodic screening, diagnostic, and treatment services for children under age 21<sup>a</sup></li> </ul>
<b>Mandatory eligibility groups</b>	<p><b>States must cover, at a minimum, the following individuals under their state plans:</b></p> <ul style="list-style-type: none"> <li>• Individuals eligible for Aid to Families with Dependent Children program (now known as Temporary Assistance for Needy Families, or TANF) if they meet requirements that were in effect in their state on July 16, 1996</li> <li>• Children under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL)</li> <li>• Pregnant women whose family income is below 133 percent of FPL</li> <li>• Supplemental Security Income recipients in most states</li> <li>• Recipients of adoption or foster care assistance under Title IV of the Social Security Act</li> <li>• Special protected groups</li> <li>• All children born after September 30, 1983, who are under age 19 and in families with incomes at or below FPL</li> <li>• Certain Medicare beneficiaries<sup>b</sup></li> </ul>
<b>Cost-sharing limits</b>	<p><b>States are limited to the following cost-sharing requirements under their state plans:</b></p> <ul style="list-style-type: none"> <li>• States may not impose enrollment fees or premiums on mandatory eligibility groups</li> <li>• States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid beneficiaries for certain services</li> <li>• Certain Medicaid beneficiaries must be exempt from this cost sharing, including pregnant women, children under age 18, and hospital and nursing home patients expected to contribute most of their income to institutional care</li> <li>• All Medicaid beneficiaries must be exempt from co-payments for emergency services, hospice services, and family-planning services<sup>c</sup></li> </ul>

---

Source: GAO analysis of federal laws and Department of Health and Human Services regulations and guidance.

<sup>a</sup>Social Security Act §§ 1902(a)(10)(A), 1905(a) (codified, as amended, at 42 U.S.C. §§ 1396a(a)(10)(A), 1396d). Effective March 31, 2006, states also have the option of limiting coverage of services for certain Medicaid recipients to either benchmark coverage or coverage that provides a benefit package equal in value to benchmark coverage. Benchmark coverage is defined as (1) the Federal Employee Health Benefits Program (Blue Cross/Blue Shield) benefit plan, (2) the health benefits plan offered to state employees, (3) coverage offered by a health maintenance organization with the largest enrollment in the state, or (4) a package of benefits approved by the Secretary of Health and Human Services. SSA § 1937 (to be codified at 42 U.S.C. § 1396u-7).

## Enclosure II

<sup>b</sup>SSA § 1902(a)(10)(A)(i) (codified, as amended, at 42 U.S.C. § 1396a(a)(10)(A)(i)).

<sup>c</sup>SSA § 1916 (codified, as amended, at 42 U.S.C. § 1396o). Effective March 31, 2006, states may impose premiums on certain previously exempt Medicaid recipients with family incomes above 150 percent of the FPL. States may also impose more than nominal cost sharing on certain services such as nonpreferred drugs and nonemergency services provided in an emergency room. States also have the option of imposing co-payments on certain individuals in previously exempt populations. SSA § 1916A (to be codified at 42 U.S.C. § 1396o-1).

Comments from the Department of Health and Human Services (HHS)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW  
Washington, DC 20201

**JUN 6 2007**

**DATE:**

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

Kathryn G. Allen  
Director, Health Care  
Government Accountability Office

**FROM:** Leslie V. Norwalk, Esq.  
Acting Administrator

A handwritten signature in black ink, appearing to read "Leslie V. Norwalk".

**SUBJECT:** Government Accountability Office (GAO) Draft Report: "Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern" (GAO-07-694R)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on the above mentioned GAO draft report. We note that the report included no new recommendations for the Department of Health and Human Services ("HHS" or "the Department") or Congressional action, but reiterates a July 2002 recommendation (from report GAO-02-817, "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns") to establish a Federal public input process that includes, at a minimum, notice in the *Federal Register* and a 30-day public comment period.

We continue to disagree with this recommendation because the opportunity for public input remains more than adequate, as we detail below. The Department continues to take steps in partnership with States to ensure that there are many opportunities for interested parties to share their views. States have a broad array of options for soliciting public input, and States are in the best position to decide which public input process will be most effective. We continue to hold States accountable for having in place a public process for comments, as described in the September 27, 1994, *Federal Register* notice and later reaffirmed in subsequent policy guidance on May 3, 2002. Acceptable practices for new section 1115 demonstration proposals include: public hearings, commission process, State legislative process, the State's own administrative procedures Act, or publication in newspapers of large circulation. Legislation requiring the Department to build a new public input process would create redundancy and slow the demonstration

Page 2- Marjorie Kanof

approval process, delaying States' creative approaches to expanding coverage. Of greatest concern is that legislation could create a pathway to court which would allow a single individual thousands of miles away to hold up the decisions made by elected State legislators and governors responsible for their Medicaid programs perhaps for years, throwing a State budget into disarray.

Furthermore, the Department also stipulates in the Special Terms and Conditions (STCs) (in essence, the contract between Federal and State governments) governing a section 1115 demonstration that any subsequent program changes use a similar process. States seeking approval to amend substantive aspects of their demonstrations are required to describe in the amendment request the public process undertaken for the proposed change. We note that this latter requirement with respect to program changes is an enhancement under this administration to assure adequate public involvement; it has been in place now for nearly 4 years.

Further, we believe that the most effective involvement of stakeholders is through their local and regional branches, which may avail themselves of the public process used at the State level. This kind of up-front involvement of regional or local stakeholders can assist the State in shaping the demonstration, resolving concerns, and building support for the proposal ultimately submitted to the Department. We also contend that it is primarily the responsibility of the State government staff to ensure that there is adequate and appropriate involvement of outside stakeholder groups on a demonstration proposal; it is the responsibility of CMS staff to involve other Federal Government stakeholders, such as staff from other Department operating divisions, Department staff divisions, and the Office of Management and Budget, as appropriate.

The GAO report states that stakeholders in Florida and Vermont did not have adequate opportunities to provide input at the State level. In both the cases of Florida and Vermont, the States provided ample opportunity for review and comment to their citizens. In Vermont, the Medicaid reform proposal went through the State legislative process, which included multiple legislative hearings and testimony before the Health Access Oversight Committee, monthly meetings of the Medicaid Advisory Board, and consistent coverage by the media. Furthermore, solicitation of citizen and stakeholder input was provided from February to April of 2005 in a wide variety of forums, including the distribution of the concept paper, public announcements, public hearings, and a written comment period. A full description of the public process occupied an entire chapter of the State's final application. The chapter included a detailed chronology of events that allowed interested parties input into the design of the demonstration. The State also noted that 56 written comments were submitted by the deadline.

Likewise, the State of Florida also made a significant effort to provide opportunities for public comment during all stages of development of the demonstration. The Florida Agency for Health Care Administration posted Florida's section 1115 Medicaid Reform demonstration application on its Web site for a 30-day period prior to submitting the final application to CMS. The State reported that during the 30-day period, 92 written

Page 3- Marjorie Kanof

comments were received. The agency provided individualized written response to these comments.

However, the State's effort at building public awareness was not limited to this single 30-day period. The Florida Medicaid Reform demonstration, as submitted, was almost identical to the concept paper developed in early 2005. The concept paper was widely available for almost 7 months prior to the State's submission of an 1115 demonstration application. It was added to the Governor's Web site following a January 11, 2005, press release and provided an opportunity for questions and comments. This posting was followed by five public hearings between February and March of 2005. Prior to the concept paper, the Governor issued a white paper and the State held public workshops in June, July, August, October, and November of 2004. Clearly, by the time of the 30-day public notice period described in the preceding paragraph, the concepts that informed the Florida Medicaid reform proposal, and indeed many of the proposed programmatic details, were widely known for those parties that wished to stay abreast of the Governor's health reform plan.

With respect to the Department's listing of pending proposals in the *Federal Register*, we again note, as in previous Agency comments on the prior 2002 GAO report, that the now nearly 13-year-old notice predates widespread access to, and use of, the internet. Accordingly, over time, the Health Care Financing Administration (predecessor agency to CMS) discontinued the listing of pending proposals in the *Federal Register*. Additionally, States have since continued to demonstrate that they provide adequate public notice at the State level.

To provide information about section 1115 waiver applications and subsequent amendments, it is our policy to post waiver applications on our Web site within 10 days after the application, renewal, or amendment request is received. We note that CMS accepts and responds to written comments on all demonstration proposals at any time.

We also post other critical information on our Web site once a demonstration is approved. These items include demonstration program overviews, fact sheets, STCs, award letters, waiver and expenditure authorities lists, amendment proposals, and other significant communications with the State about the demonstration. We are also currently in the process of adding quarterly reports, annual reports, and demonstration evaluations completed to date. These additions will ensure stakeholders are fully informed with regard to program operations and outcomes. We believe that stakeholder access to information on operations and outcomes is equally important as the up-front stakeholder input during the development phase of a demonstration, as described in the Florida and Vermont examples above.

We also intend to add to the CMS Web site a summary page of pending actions including State and Federal contact information within the next several months. The summary will be updated as necessary to reflect current State activities. This new Web site feature will replace, in electronic fashion the *Federal Register* list highlighted in section VIII of the

Page 4- Marjorie Kanof

January 1994 *Federal Register* guidance. These additional documents and features on the CMS Web site will further enhance the Department's goal of transparency.

We also want to emphasize process issues with respect to the posting of demonstration proposals under discussion to the CMS Web site. As noted in our 1994 *Federal Register* notice, to reduce administrative burden on the States, the Department adopted a number of procedures, including expanding pre-application consultation with interested States. Through this consultative process, many demonstration proposals develop from very basic initial concepts into complex documents through an iterative process where information is passed back and forth between the State and the Department. An initial demonstration proposal often evolves rapidly into a vastly different document, such that regimented public posting and input solicitation may not keep up with changes to the document. Alterations, additions, and deletions are made along the way, often on a more-than-daily basis. In these instances, States may not have labeled a particular document the "official or final submission;" therefore, the Department intends to place increased emphasis on working with States to make such a determination and immediately post these documents. Heightened Departmental efforts in this area will ensure that all documents identified as formal submissions are posted in a timely fashion.

We also note that GAO took particular issue with the processing of the State of Florida's demonstration application. Specifically, the report notes with criticism that "HHS approved the State's demonstration proposal 16 days after the State submitted the formal proposal to HHS." Again, we emphasize the Department's commitment to pre-application consultation, as described above. The Department has continued this courtesy over 13 years and 2 administrations. Pre-application consultation with Florida, for instance, lasted over a year, during which time the public could involve itself through the State-level process, also described above.

Finally, the report raises several concerns about beneficiaries' information with regard to selection of a plan under the Florida demonstration. The Department strongly agrees that it is crucial that beneficiaries have access to full information about the benefits they receive before they choose their health care plans. In fact, in the case of Florida, the Department and the State agreed during negotiations that informed choice is a key element of what is being tested under the demonstration. The Choice Counseling Program performs this pivotal function under Florida Medicaid Reform in order to ensure that beneficiaries make such informed choices. The choice counselor provides information about each plan's coverage, benefits and benefit limitations, cost-sharing requirements, contact information, and data on access to preventive services. The choice counselor also provides information to individuals interested in opting out of Medicaid should the individual be interested in pursuing an employer-sponsored insurance option. Choice counseling materials are provided in a variety of ways including, print, telephone, and face-to-face.

The State of Florida began the effort to implement a Choice Counseling Program immediately upon approval of the demonstration in October 2005. The process included public meetings asking potential plans, advocates, and stakeholders how the program

Page 5- Marjorie Kanof

should be structured and how the program should assist in improving health literacy. The State contracted with a choice counseling vendor and worked with Florida State University to develop a Choice Counseling Certification Program to assist in training prospective counselors. The course is Web-based and consists of 10 training modules. The Department regularly requests updates on these aspects of choice counseling operations on monthly monitoring calls.

In summary, we continue to disagree with the recommendation that legislation be adopted to establish a Federal public notice process for section 1115 demonstration waivers. Public notice and comment opportunities are available at the State level, and we review waiver applications carefully to ensure that States have provided adequate public notice. In addition, we note that requiring the Department to build a new public posting and input solicitation process for waivers also would have broader implications. Establishing a procedure that treats a waiver application like a regulation would set a precedent that could be applied to other waiver applications as well as grant applications. The ensuing delays would make it difficult for States and the Department to come up with creative approaches to expand coverage and has implications for programs beyond Medicaid and the State Children's Health Insurance Program.

Additionally, CMS offers the following additional comments:

- Page 2 - We believe the first footnote is an inaccurate characterization of what constitutes a "comprehensive section 1115 demonstration." While it is true that we would generally expect a demonstration labeled "comprehensive" to be state-wide, it does not have to be "applicable to all populations and benefits under a State's Medicaid program." While that is one possibility, and that would indeed be regarded as comprehensive, we believe "comprehensive" could also be used to describe a demonstration that includes a majority of a substantial population. We also note that comprehensive demonstrations may in fact offer differential benefits to various populations (e.g., full Medicaid benefits to a Medicaid State plan population; something else for higher-income "expansion" groups).
- Page 17, second bullet — We note that the 5 percent cost-sharing cap parallels what is permissible under the title XXI statute so it is reasonable to define 5 percent as a "ceiling" underneath which cost-sharing may be applied (and varied as necessary).
- Page 17, third bullet — Vermont indeed has an enrollment cap which by its nature "changes or delays eligibility;" this is not a feature of the Vermont demonstration that uniquely affects enrollment in this particular State's program. Enrollment caps or waiting lists have been approved in other States for non-Medicaid State plan populations.
- Page 20, Status of Freedom of Information Act (FOIA) request — The response to the FOIA request is pending.

Page 6- Marjorie Kanof

- Page 22 — With reference to the Catamount Health amendment to the Vermont demonstration, we note that CMS informed the State that its September 2006 submission would be regarded as a concept. The actual formal submission date was December 15, 2006. We also note that the Catamount Health legislation was passed in the Vermont legislature with a good deal of attention in May 2006, so it is unlikely that stakeholders were unaware of the impending proposal.

- Page 26 — The report states, “National stakeholders try to inform HHS on which provisions and procedures have and have not worked and what implications may have developed for beneficiaries.” We welcome such input.

- Page 26 — In “Concluding Observations,” the report notes that Florida and Vermont have features that depart from previously-approved projects. We note that this is the nature of a demonstration project under section 1115 of the Social Security Act. By definition, they allow departure from past practice (whether in Medicaid State plan or other authority), and CMS has attached an important evaluative component in both of these demonstrations. Moreover, during the entrance conference, in an effort to put section 1115 demonstrations in context; we suggested GAO look at several demonstration projects approved since 2004. However, GAO targeted Florida and Vermont out of several comprehensive demonstrations currently approved. While these two projects are indeed significant demonstrations with far-reaching financial and programmatic implications, there are other demonstration types with higher matching rates, and, concomitantly, high Federal financial exposure. These the GAO neglected to include in its scope of work. Family planning section 1115 demonstrations, in which State spending is matched at 90 percent, provide one clear example.

- Page 27 — There is a specific reference to unforeseen circumstances affecting the State and the attendant financial exposure for the State. This is the nature of an aggregate cap where the spending ceiling is a pre-determined fixed number. We believe the STC’s that CMS negotiates with States, including those pertaining to budget ceilings, are both comprehensive and contain sufficient safeguards to address emergency circumstances. They are binding to both parties to the agreement, the Federal Government and the States.

- Page 28 — Public input is again identified as somehow having been less than “adequate;” we disagree -- see discussion above.

The CMS again appreciates the opportunity to review and comment on the subject draft report.



Comments from the State of Florida



CHARLIE CRIST  
GOVERNOR

ANDREW C. AGWUNOBI, M.D.  
SECRETARY

May 23, 2007

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

Dear Dr. Kanof:

Thank you for providing the Agency for Health Care Administration, the single state agency for administering the Florida Medicaid program, with the opportunity to comment on the draft report entitled *Medicaid Demonstration Waivers: lack of Opportunity for Public Input during Federal Approval Process Still a Concern (GAO-07-694R)*. As requested by your staff, we are providing our requested technical corrections in Attachment A; otherwise, our comments are below.

As provided for under Section 1115 of the Social Security Act, the Secretary for Health and Human Services has broad authority to grant waivers of statutory provision to implement experimental, pilot, or other demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Florida was granted such a waiver in order to implement our state legislated reform project in October 2005. The draft report focuses on recent waivers approved in Florida and Vermont, and attempts to address the following issues:

- Implications for beneficiaries as a result of recently approved comprehensive Medicaid demonstrations; and
- The extent to which the Secretary ensured opportunities for public input during the approval process.

We support the Government Accounting Office's (GAO's) efforts to evaluate Florida's Medicaid Reform effort and analyze the above issues. Florida understands the need to carefully monitor the impact of our demonstration in meeting the established goals as it has the potential to fundamentally reshape the Medicaid program and make it more effective. Florida also recognized the importance of obtaining public input as part to the demonstration process and made significant efforts to ensure that Florida's 1115 Florida Medicaid Reform Waiver was developed in a manner that considered the impact on beneficiaries and provided the opportunity for meaningful public input.

To address the above objectives, Florida believes that the GAO's report should provide an accurate and unbiased representation of events. Medicaid is a very complex program governed by many complex statutory and federal requirements. Operating under a waiver further

2727 Mahan Drive, MS# 8  
Tallahassee, Florida 32308



Visit AHCA online at  
<http://ahca.myflorida.com>

Dr. Marjorie Kanof  
May 23, 2007  
Page 2

complicates the Medicaid program. Therefore, to understand Florida's 1115 research and demonstration waiver program and draw accurate implications, there must be a fundamental and accurate representation and understanding of the demonstration program structure.

From our perspective, the report falls short of the objective as there is selective representation of certain aspects of Florida's 1115 Medicaid Reform Waiver while other innovative and integral concepts are omitted entirely or underemphasized. The draft report contains some factual errors regarding our program design and actual structure of Florida's 1115 Medicaid Waiver program is relegated to footnotes. These errors are related to the description of the program as well as the phrasing used to describe the program. While page 10 recognizes the actual effects are unknown at this time, the report draws some speculative conclusions regarding the impact of Florida's 1115 Medicaid Reform Waiver. As a result, the report provides a slanted review of our program and may lead a reader to draw inaccurate conclusions about the implications. Below is an outline of our concerns and recommendations for the report to ensure that it more accurately represents our Medicaid Reform efforts.

#### **Results in Brief**

In this section of the draft report, a description of Florida's demonstration program is provided. As indicated above there are several items that are incorrect and should be corrected prior to publishing the report. Below are our comments regarding this section.

- Page 5 describes Florida's demonstration program. The description focuses exclusively on the customized benefit packages and the opt-out program. This section fails to mention the Enhanced Benefits program and the expanded Choice Counseling Program created under Florida's 1115 Medicaid Reform Waiver. As indicated in the waiver document, patient empowerment and responsibility are fundamental principles of Reform, and are designed to encourage recipient participation. To advance this goal, Florida created the Enhanced Benefits Program as an integral component of the program design. The program has been well received by virtually all stakeholders. The program has the potential to positively impact an individual as it provides them with new incentives to seek preventive health care. The state expects this will ultimately lead to healthier individuals and reduce future health care costs. The Choice Counseling Program was significantly expanded for the population affected by Florida's 1115 Medicaid Reform Waiver: face-to-face choice counseling (a local choice counseling presence), at-home visits, education sessions, extended call center hours, and the development and implementation of an independent certification process for choice counselors are unique to the Medicaid Reform Choice Counseling Program. While these were significant parts of Florida's 1115 Medicaid Reform Waiver, they were completely omitted in the 'Results in Brief' description of the waiver.
- Pages 5 and 11 use the phrase "commercial managed care plans." The use of the term commercial appears to be a misnomer as it traditionally refers to a line of business. Under Florida's 1115 Medicaid Reform Waiver, beneficiaries are required to enroll in managed care plans. These plans still must meet the requirements of a Medicaid plan established by Congress under Sections 1903(m) and Section 1932 of the Social

Dr. Marjorie Kanof  
May 23, 2007  
Page 3

Security Act. While Florida's 1115 Medicaid Reform Waiver seeks to build upon the commercial market structure, the State is not solely contracting with commercial plans. We request that the word commercial be deleted when describing contracted plans under Florida's 1115 Medicaid Reform Waiver.

- Page 5 states, "... and if they opt out of Medicaid and desire to enroll in a Medicaid plan at a future date, they would need to reapply to Florida's Medicaid program." This is incorrect. As written, this appears to imply that if a beneficiary opts out of Medicaid and enrolls in his or her employer-sponsored insurance plan (ESI) plan, then he/she must reapply for Medicaid at a later date if the beneficiary chooses to enroll in a Medicaid plan. This is inaccurate as Florida's 1115 Medicaid Reform Waiver does not change or affect Medicaid eligibility. An individual that opts out of Medicaid continues to be eligible for Medicaid. If a beneficiary is enrolled in an ESI plan and later chooses to enroll in a Medicaid Reform health plan, then the beneficiary must wait until his/her open enrollment period or his/her employer's open enrollment period in order to request enrollment in the health plan. However, the beneficiary does not need to reapply to Medicaid. Additionally, if the beneficiary loses eligibility for participation in the ESI plan (for example, is no longer employed by that employer), then there is a process for that beneficiary to request enrollment in a Medicaid Reform health plan prior to the annual open enrollment period.
- Page 5, description of the Opt-Out Program, we believe that it is essential that the draft report recognize that this is a completely voluntary option with a process for 'opting back in' if the beneficiary loses eligibility for participation in the ESI program. These facts should be recognized in other sections of the draft report when describing opt out.

**Demonstration in Florida and Vermont Have Mixed Implications for Beneficiaries, But Actual Effects Are Unknown.**

Under this section, the draft report identifies potential implications for beneficiaries. Below are our comments regarding this section.

- Page 10 states that, "In Florida, for example, beneficiaries have greater flexibility to choose among different benefit plan, but could face, ... new cost sharing requirements." Under Florida's 1115 Medicaid Reform Waiver, managed care plans are allowed to charge cost sharing consistent with regulations specified in 42 CFR 438.108. Therefore, the health plans can charge cost sharing consistent with the nominal levels currently approved for services covered under the State Plan. These represent existing costs sharing requirements – these are *not new cost sharing requirements*. Many plans chose to eliminate any cost sharing requirements, while other plans decided to implement cost sharing for select services. This should also be corrected on page 12.
- Page 10, footnote 21, is incorrect. The paragraph should refer to comprehensive only. Medicaid Reform health plans that accept comprehensive and catastrophic coverage are at full risk and Florida will not pay any excess claims.

Dr. Marjorie Kanof  
May 23, 2007  
Page 4

- Page 11 describes the flexibility of plans to offer state-approved benefit plans tailored to specific groups of beneficiaries. However, key facts regarding the design and evaluation of the program are identified in footnotes 23 and 24. Specifically, plans have the flexibility to provide a customized benefit package to non-pregnant adults only. A Medicaid Reform health plan must continue to cover all medically necessary services for pregnant women and children. These are integral design issues that should be described in the text of the draft report instead of footnoted. Since the report highlights that beneficiaries who opt out of Medicaid do not have access to other Medicaid services, including EPSDT, the reader could be left with the incorrect impression that such protections do not exist for pregnant women and children in a Medicaid Reform health plan. We request that footnotes be incorporated into the text of the report so that inaccurate conclusions will not be made.
- Page 12 states, "Some plans limited beneficiaries to 60 lifetime visits for home health services, while others expanded this service to 210 visits annually per beneficiary." While this is accurate, the draft report does not put this in context with current coverage under the State Plan. Without knowing the current coverage requirements, the reader is left wondering the impact of the flexibility. Under the State Plan, Florida Medicaid covers up to 60 lifetime home health visits without a prior authorization and then additional visits subject to prior authorization. Therefore, Reform health plans covering 60 lifetime visits without prior authorization is consistent with coverage outside of Florida's 1115 Medicaid Reform Waiver.
- Page 12 states that beneficiaries can opt out into a commercial health insurance. This is incorrect as only self-employed Medicaid beneficiaries who would be purchasing their own insurance may opt out into a commercial health insurance plan (other Medicaid beneficiaries could opt-out into ESI plans). Please clarify the participation requirement.
- Page 13 states that when beneficiaries opt out of Medicaid they could not re-apply to the Florida Medicaid Program. As indicated above, this is inaccurate as Florida's 1115 Medicaid Reform Waiver does not change Medicaid eligibility. If an individual were to opt out and enroll in the ESI plan, but later lose Medicaid coverage due to excess income or assets, the beneficiary could reapply to Medicaid. If they were to regain eligibility, then the beneficiary would be allowed a new choice of selecting a Medicaid Reform health plan or reenrolling in his/her ESI plan. The reenrollment timeframes outlined apply to a beneficiary that is enrolled in an ESI plan and when he/she can disenroll from the ESI plan and enroll in a Medicaid Reform health plan. This language should be corrected.
- On page 14, the report states that the information available to choice counselors, moreover, may be incomplete. Specifically, stakeholders stated that the choice counselors did not have access to the health plans' drug formularies. If an individual is seeking this information, he/she is advised of, and can obtain it, directly by calling the Medicaid Reform health plan or visiting the plan's website. It should be further noted that prior to development of the procurement document for Choice Counseling services,

Dr. Marjorie Kanof  
May 23, 2007  
Page 5

public meetings were held to discuss the design of the Choice Counseling program. The need for the health plans' preferred drug list was not identified until several months after implementation of Medicaid Reform. The Agency has been working on methods to make this information more accessible. To date, Medicaid reform plans have made their PDLs available on their websites, and the Choice Counseling vendor has implemented a special needs unit to assist beneficiaries with complex conditions to ensure they have all the information necessary (including PDL information) to make an informed choice.

- Page 14 further states that Florida officials informed you that pregnant women and children under 21 years of age continue to have retroactive eligibility for up to 3 months prior to the date and will receive full state plan benefits, and this group is also exempt from receiving limited benefits for up to 30 days before enrolled in managed care plan. Please note that all individuals continue to be authorized for retroactive eligibility for up to 90 days. While the Centers for Medicare and Medicaid Services granted a waiver of Section 1902(a)(34) so that the State was not required to provide retroactive eligibility for up to 90-days prior to the application, the Agency has not implemented this component of the program.

**State Provided Opportunities for Public Input on Proposals but Details were Lacking, and HHS Did Not Provide for Input at the Federal Level**

Under this section, the draft report provides comments regarding the process used by Florida, Vermont, and DHHS to obtain public comments from stakeholders. The stakeholders stated that details of the proposal were lacking and expressed difficulty in obtaining responses to request for information submitted to the Agency. We address both issues below.

Florida made an extensive effort to provide opportunities for public comment during all stages of the waiver development as well as during the implementation period. Most notably, the Agency posted Florida's 1115 Medicaid Reform Waiver application on-line for 30 days. During this period of time, we received 92 written comments to which the Agency provided an individual written response to each letter received. This process of responding to public comment goes beyond any state or federal requirement and was provided by the Agency to ensure stakeholders comments were considered.

We regret that some stakeholders informed the GAO that they perceive Florida state officials did not provide sufficient information. We do not believe that is accurate as the 1115 Medicaid Reform Waiver application was posted for a 30 day comment period. Furthermore, the waiver was almost identical to the concept paper developed in March of 2005 and was widely available for almost seven months prior to our submission of the waiver application to the Centers for Medicare and Medicaid Services. As you note, two stakeholders representing hospitals and a large managed care organization made positive comments about the way the state created opportunities for public comment.

As you are aware, Medicaid is an extremely complex program. The Agency made every effort to provide information and obtain input from stakeholders; however, the apparent

Dr. Marjorie Kanof  
May 23, 2007  
Page 6

discrepancy in the perception of the opportunity for comments may be more attributable to these stakeholders understanding of the Medicaid program rather than the lack of opportunity for comments. For example, the draft report specifically states that information regarding nursing home costs was not available. As the report notes in footnote 22, beneficiaries residing in nursing homes are exempt from the program. As such, their costs were not material to program and were not included in budget neutrality analysis. Florida Medicaid made repeated efforts to clarify this with advocates but it appears that the group was still confused about the impact of the 1115 Medicaid Reform Waiver on Medicaid beneficiaries residing in nursing homes. The group may have been referencing another initiative called Florida Senior Care which was authorized by the Legislature. However, this program is unrelated to Florida's 1115 Medicaid Reform Waiver. As such, we request that you clarify or delete this reference.

In addition, the draft report notes that many requests were made for information and details regarding information related to budget neutrality of the waiver. Specifically, advocates noted that detailed analysis regarding trends were not made available to fully understand how the trends were developed. As indicated above, Medicaid is an extremely complex program and budget neutrality is one of the more difficult and complex aspects of the Medicaid program. Florida believes its 1115 Medicaid Reform Waiver provided a sufficient explanation of budget neutrality and the trends developed.

The draft report also notes that a state level group providing legal services to low-income people had difficulty obtaining sufficient information on the proposals in December 2004. This group submitted a request for all records, electronic and hard copy, in any medium, related to reform proposals, 1115 waivers, state plan amendments, including emails, calendars, etc. As noted in Attachment B, the Agency held workshops in June, July, August, October and November of 2004. The Governor's white paper was released in January 2005 which provided a broad framework for the demonstration. The State did not withhold documents as implied by the advocates. Rather, the State responded to all requests timely. In this one instance, the broadness and sheer volume of the request required extensive time to collect the information, review it to ensure it was appropriately included and to redact any beneficiary information as needed.

In addition, the group representing individuals age 50 and older stated that they only received a copy of a state-sponsored analysis of Medicaid expenditure trends in October 2005, after repeated requests. Florida's 1115 Medicaid Reform Waiver was posted on line prior to submission to the Centers for Medicare and Medicaid Services and included the cost trend data. Therefore, we are unclear what document was not made available and only provided after repeated attempts.

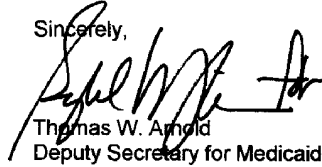
While we cannot speak to activities undertaken by DHHS to obtain public comment, the Centers for Medicare and Medicaid Services routinely inquired about the state's activities to obtain comments in an effort to ensure that public input was obtained. We believe that it would not be prudent to duplicate the public input process if the State has provided ample opportunity for input. While many national stakeholders felt that they should be able to submit comments directly to DHHS, this seems to usurp a State's ability to administer a

Dr. Marjorie Kanof  
May 23, 2007  
Page 7

Medicaid program. As Medicaid programs are designed at the State level, they differ in each state and Medicaid state officials work directly with state organizations. Most national organizations may not be sufficiently familiar with a particular state Medicaid program to provide comments to help improve the administration of the program. Further, many of the national associations represent provider groups which may have material interest in protecting their role in Medicaid. These goals are sometimes at odds with improving Medicaid to make it more efficient and effective. Therefore, we believe that such stakeholders should be directed back to the State to provide comment.

Again, we appreciate the opportunity to provide comments on your draft report and we reiterate the need for an accurate representation of our Medicaid Reform efforts. Should you have any questions about our comments, please contact me at (850) 488-3560.

Sincerely,



Thomas W. Arnold  
Deputy Secretary for Medicaid

TWA/lam

Enclosure

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

Comments from the State of Vermont



State of Vermont  
Agency of Human Services  
Office of the Secretary  
103 South Main Street  
Waterbury, VT 05671-0204  
[www.ahs.state.vt.us](http://www.ahs.state.vt.us)

[phone] 802-241-2220  
[fax] 802-241-2979

Cynthia D. LaWare, Secretary

May 22, 2007

Marjorie Kanof  
Managing Director, Health Care  
The United States Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Kanof:

I am writing in response to your letter dated May 8, 2007, to Joshua Slen, the Director of the Office of Vermont Health Access. The Agency of Human Services in Vermont is the Single State Agency for receipt of Federal Medicaid Revenues and as such Mr. Slen forwarded your letter to my office for response.

The State of Vermont appreciates the thorough and thoughtful draft report, and thanks you for the opportunity to provide comments from Vermont's perspective prior to it becoming final. Overall, I found the report to be balanced and complete. On page 6 you describe the Vermont Global Commitment to Health Waiver as "...designed to contain costs; to improve system accountability and quality of care; and, by potentially delivering services to Medicaid beneficiaries for less and reinvesting savings, to allow the state to serve more of its uninsured population." This statement represents one of the most concise and accurate descriptions that I have read.

On page 10 you state that "*Vermont may use savings from managed care operations to fund additional health care initiatives, but the state is at financial risk should demonstration costs exceed the approved spending limit, with uncertain implications for beneficiaries should that happen.*" I wish to offer that there is no more uncertainty regarding future benefit levels under the Vermont Waiver than there is without any waiver at all. Historically, Vermont has been in the forefront of broad inclusion (both populations and services) in its Medicaid program. This commitment continues as reflected in our 2006 Health Care Reform Legislation and continues in 2007 with a new comprehensive Oral Health Initiative proposed by the Governor and enacted into law by the General Assembly. By your own analysis of the Waiver Terms and Conditions, Vermont cannot make reductions to services for mandatory populations and by design all other optional populations have always been subject to inclusion by affirmative action on the part of both our state executive and legislative branches. By its very design the granting of "flexibility" carries with it the possibility that covered services and populations may change over time. I would argue that this differs from the traditional program design only in express authority and not in intent or practice. In other words, the State has constantly led the nation in covering populations and in offering a breadth of services.





Page 2  
Marjorie Kanof  
May 22, 2007

The ability to manage the Vermont program in a manner that provides for the alignment with the statewide implementation of the Blueprint for Health Initiative (a public-private partnership intended to transform the system of care across the state) is critically important component of the Waiver design. In fact, on page 16 of the report you indicate;

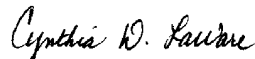
*Expected cost savings could enable Vermont to serve more of the state's uninsured population. ...As described in the demonstration proposal, the demonstration is designed to put in place a series of health care options responsive to priorities supported by the Governor and State Legislature, including improved access to health care for Vermont's uninsured, cost containment within Medicaid, and improved system accountability and quality of care. Under the demonstration, the state is provided flexibility, including the ability to use creative payment mechanisms rather than fee-for-service to pay for services not traditionally reimbursable through Medicaid.*

The series of initiatives partially identified in your report are integral to the comprehensive system reform effort in Vermont. The transformation of the health care system from one focused on acute interventions to one designed to care for chronic conditions across the lifespan involves dozens of separate but related changes in medical practice. The Waiver allows the state to continue its commitment to health care access and affordability for all Vermonters.

One aspect of the report that I found disheartening was the suggestion that Vermont's public input process was somehow weak or not well rounded. Please note that the public input process began in January 2005. The ongoing process involved multiple Public Announcements in statewide media, public hearings that were held in various locations around the State as well as broadcast on interactive TV, informational sessions and numerous updates to specific stakeholder groups, and continuous updates to comments, questions and answers posted on various State websites (see Attachment). All of this culminated in debate, testimony, refinements and ultimate approval of the waiver in our very public citizen legislature process.

Once again I would like to applaud your thoughtful analysis. My comments herein are intended to highlight some of the additional details and to draw out the important Vermont context without which the readers of your report might conclude that Vermont was in the process of changing policies that have been deeply imbedded in state policy for decades. The bottom line is that Vermont continues to be committed to broad access to health care and is continually exploring new innovative programs to provide better quality care efficiently to all Vermonters.

Sincerely,



Cynthia D. LaWare, Secretary  
Agency of Human Services

**Attachment**

**Medicaid Advisory Board Meetings**

The State of Vermont Global Commitment to Health Waiver was an agenda topic at the following MAB meetings:

1/27/05  
2/24/05  
3/28/05  
4/7/05  
6/5/05  
8/5/05  
9/05/05  
10/05/05

**Public Announcements**

February 24<sup>th</sup>, 2005 – Concept paper and notice of Public Hearings distributed to Medicaid Advisory Board, Vermont Legislature, Agency of Human Services Policy Executives and posted on the website home pages of the Agency of Human Services and the Office of Vermont Health Access.

February 25<sup>th</sup>, 2005 – Public Announcements published in statewide newspapers.

March 4<sup>th</sup>, 2005 – Second publication of Public Announcements in statewide newspapers.

**Public Hearings**

3/15/05 – Rutland, VT  
3/16/05 – Burlington, VT and on VT Interactive TV in Bennington, Brattleboro, Castleton, Johnson, Lyndonville, Randolph, Rutland  
3/17/05 – Williston, VT

**OVHA/AHS Website Postings**

Concept Paper - 2/24/05  
Comments, Questions and Responses – March 2005  
PowerPoint Presentation for Public Hearings – March 2005  
Global Commitment Waiver Proposal Final Version – 4/15/05  
MCO Implementation Workplan – Updated 9/23/05  
Questions and Responses – Updated 9/23/05  
Federal Terms and Conditions – Updated 9/23/05  
Federal Approval Letter - 9/28/05

Enclosure VI

### **Contact and Staff Acknowledgments**

#### **GAO Contact**

Kathryn G. Allen, (202) 512-7114 or [allenk@gao.gov](mailto:allenk@gao.gov)

#### **Acknowledgments**

In addition to the contact mentioned above, Katherine M. Iritani, Assistant Director; Ted Burik; Ellen W. Chu; Tom Moscovitch; Terry Saiki; Stan Stenersen; Hemi Tewarson; and Jennifer Whitworth made key contributions to this report.

(290553)

---

---

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

---

---

## GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

---

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site ([www.gao.gov](http://www.gao.gov)). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to [www.gao.gov](http://www.gao.gov) and select "Subscribe to Updates."

---

## Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office  
441 G Street NW, Room LM  
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000  
TDD: (202) 512-2537  
Fax: (202) 512-6061

---

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: [www.gao.gov/fraudnet/fraudnet.htm](http://www.gao.gov/fraudnet/fraudnet.htm)

E-mail: [fraudnet@gao.gov](mailto:fraudnet@gao.gov)

Automated answering system: (800) 424-5454 or (202) 512-7470

---

## Congressional Relations

Gloria Jarmon, Managing Director, [JarmonG@gao.gov](mailto:JarmonG@gao.gov) (202) 512-4400  
U.S. Government Accountability Office, 441 G Street NW, Room 7125  
Washington, D.C. 20548

---

## Public Affairs

Paul Anderson, Managing Director, [AndersonP1@gao.gov](mailto:AndersonP1@gao.gov) (202) 512-4800  
U.S. Government Accountability Office, 441 G Street NW, Room 7149  
Washington, D.C. 20548