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Washington, DC 20548

B-309734

July 24, 2007

The Honorable Michael O. Leavitt
Secretary of Health and Human Services

Subject: *Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act*

Dear Mr. Secretary:

In response to a congressional request, we are evaluating Medicaid demonstration projects in Florida and Vermont approved by the Department of Health and Human Services (HHS) under section 1115 of the Social Security Act (the act).[1] During the course of our work, we identified several issues that raise concerns about the consistency of these demonstration projects with federal law.[2] With respect to Florida, our concerns center on HHS's decision to waive requirements to provide covered benefits and limit cost sharing without addressing statutory limitations on its authority to do so. In the case of Vermont, HHS authorized the state to operate its own Medicaid managed care organization and, through this arrangement, to apply federal Medicaid matching funds to programs previously funded by the state. Given our concerns with these demonstration projects, discussed in detail below, we are bringing them to your attention. We recommend that you reexamine these projects in light of our concerns and, where appropriate, either modify the terms of these projects or seek statutory authorization for them to continue in their current form.

BACKGROUND

Through the Medicaid program established by title XIX of the act, the federal government shares with states the expense of furnishing medical services to certain low-income individuals. States operate their Medicaid programs under HHS

[1] 42 U.S.C. § 1315 (2000).

[2] We did not examine the extent to which arrangements in other states raise similar legal concerns. By letter of March 15, 2007, we solicited the views of the General Counsel of HHS on several questions about the Florida and Vermont demonstration projects. By letter of April 26, 2007, the Director of the Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services (CMS), responded to our inquiries. Throughout this letter, we refer to this response as the CMS Letter.

approved plans and must meet certain statutory requirements for covered services, eligibility, and beneficiary cost sharing, among other things.[3] Section 1115 of the act, however, authorizes HHS to waive compliance with certain federal statutory requirements, as well as to authorize costs that would not otherwise be included as Medicaid expenditures, "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid program]."[4] By its own terms, section 1115 provides HHS with broad discretion to approve state initiatives that depart from federal statutory requirements, subject to a determination that they are experimental in nature and likely to assist in promoting program objectives. Describing these limitations, one court emphasized that section 1115 was not enacted "to enable states to save money or to evade federal requirements, but to 'test out new ideas and ways of dealing with the problems'" programs were designed to address.[5]

In October 2005, HHS approved Florida's 5-year demonstration project, Florida Medicaid Reform, to allow the state to give Medicaid beneficiaries more options with respect to their health care coverage.[6] Florida requires certain Medicaid beneficiaries to participate in the demonstration and enroll in designated managed care plans offered by organizations that compete for enrollees by designing customized benefit packages that may differ from the set of benefits covered under Florida's state plan. Alternatively, Medicaid beneficiaries required to participate in the demonstration may "opt out of Medicaid" and enroll instead in employer-sponsored plans or, if self-employed, private health plans.[7] These beneficiaries receive only the benefit of a premium paid by the state towards the cost of the employer-sponsored or private health plans.[8]

In September 2005, HHS approved Vermont's 5-year demonstration project, Global Commitment to Health, under which the Office of Vermont Health Access (OVHA)—an office within Vermont's Medicaid agency, the Agency of Human Services (AHS)—operates the state's sole managed care organization to provide coverage to the vast majority of Vermont's Medicaid population, subject to a fixed dollar limit on federal Medicaid funds.[9] To implement the demonstration, AHS entered into an

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[3] *See, e.g.,* Social Security Act §§ 1902(a)(10)(A), 1905(a), 1916 (codified at 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a), 1396o (2000)).

[4] 42 U.S.C. §§ 1315(a)(1), (2)(A) (2000).

[5] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (citations omitted).

[6] The demonstration period is from July 1, 2006, through June 30, 2011. *Florida Waiver Authorities,* p. 1.

[7] *See Florida Medicaid Reform Section 1115 Demonstration, Special Terms and Conditions (Florida STCs),* #36, 40, pp. 10, 13.

[8] *See Florida STCs*, #68-70, pp. 19-20.

[9] *See Global Commitment to Health Section 1115 Demonstration, Special Terms and Conditions (GC STCs),* #32, 51, pp. 16, 22. The demonstration period is from October 1, 2005, through September 30, 2010. *Vermont Waiver Authorities*, p. 1. For the purpose of this demonstration, state legislation authorized OVHA to serve as a publicly operated managed care organization. Vt. Stat. Ann. tit. 33 § 1901 (2006).

intergovernmental agreement with OVHA under which AHS makes monthly capitation payments to OVHA.[10] HHS approved the intergovernmental agreement as a comprehensive risk contract between the state and a managed care organization and found that it complied with federal regulations governing Medicaid managed care.[11] Accordingly, AHS receives federal Medicaid matching funds for the capitation payments it makes to OVHA.

Under the demonstration, savings from the AHS payments to OVHA are used for programs previously funded by the state.[12] For purposes of the demonstration, Vermont enacted legislation establishing the Global Commitment Fund (Fund) within the state treasury, which consists of capitation payments made by AHS to OVHA.[13] OVHA enters into agreements, with other state entities and with providers, for the delivery of Medicaid services, and payments are made from the Fund for these services. In addition, payments authorized by OVHA are made from the Fund to state agencies and departments that have entered into agreements with OVHA for "allowable managed care organization investments."[14] These state agencies and departments provide services previously funded by the state that do not exclusively benefit those eligible for Medicaid.

DISCUSSION

Florida Medicaid Reform—Waiver of Requirement to Provide Mandatory Benefits

For Florida Medicaid Reform, HHS waived a statutory requirement that states cover specific hospital and medical benefits for groups of individuals required to be covered under its state plan (referred to as "mandatory populations"). Specifically,

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[10] *See Final Intergovernmental Agreement Between AHS and OVHA for the Administration and Operation of the Global Commitment to Health Waiver* (Sept. 30, 2005). Capitation payments are payments that a state agency makes periodically on behalf of each recipient enrolled under a contract for the provision of medical services under the state plan, regardless of whether the particular recipient receives services during the period covered by the payment. 42 C.F.R. § 438.2 (2006).

[11] Under a risk contract, the contractor assumes risk for the cost of covered services and incurs loss if the cost of furnishing the services exceeds the payments under the contract. 42 C.F.R. § 438.2 (2006). A comprehensive risk contract covers services identified in federal regulation. *Id.*

[12] *See GC STCs,* #40, p. 17. These programs fall into four broad categories identified in the demonstration terms and conditions: (i) reducing the rate of uninsured and/or underinsured in Vermont; (ii) increasing the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries; (iii) providing public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and (iv) encouraging the formation and maintenance of public-private partnerships in health care.

[13] *See* Vt. Stat. Ann. tit. 33 § 1901e (2006). The state legislature also established the "State Health Care Resources Fund," in the state treasury to finance the state share of expenditures made under this demonstration. *See* Vt. Stat. Ann. tit. 33 § 1901d (2006).

[14] Vt. Stat. Ann. tit. 33 § 1901e (2006).

HHS waived section 1902(a)(10)(A) of the act, which requires states to cover specific benefits, including inpatient hospital services, outpatient hospital services, and laboratory and X-ray services, for these individuals.[15] HHS approved this waiver to allow Florida to limit benefits for newly eligible beneficiaries covered by the demonstration to emergency medical services and nursing home level of care for up to 30 days pending their selection of managed care plans (or automatic enrollment in managed care plans by the state). According to CMS, this waiver was designed to ensure that all non-emergency care would be delivered to Medicaid beneficiaries participating in the demonstration through a single delivery system that could coordinate and manage care. The waiver also allows Florida not to provide these required benefits to those who enroll in employer-sponsored or private health plans.[16] The benefit packages for these individuals are defined exclusively by the employer-sponsored or private health plans and may be more limited than the package of benefits covered under the state plan.[17] As discussed below, both aspects of the waiver raise concerns given statutory limitations on HHS's authority.

While HHS has broad authority under section 1115 of the act to waive requirements of section 1902, this authority is not unlimited. Section 1902(l)(4)(A) of the act expressly limits the agency's authority to allow states to curtail benefits through a section 1115 waiver, stating that HHS must require states providing services under such a waiver to cover the same benefits for certain pregnant women and children as would be required under a state plan.[18] The pregnant women and children covered by section 1902(l)(4)(A) are: (i) pregnant women with family income at or below 133 percent of the federal poverty level (FPL), (ii) children under age 6 with family income at or below 133 percent of the FPL, and (iii) children aged 6 to 19 with family income at or below 100 percent of the FPL.[19] Therefore, with respect to these pregnant women and children, HHS may not authorize a state to forego its obligation to cover the statutorily defined set of benefits described above through a waiver under section 1115.

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[15] 42 U.S.C. § 1396a(a)(10)(A) (2000); *see also* Social Security Act §§ 1905(a)(1)-(5), (17), and (21) (codified at 42 U.S.C. §§ 1396d(a)(1)-(5), (17), and (21) (2000)).

[16] *Florida Waiver Authorities,* #8, pg. 2.

[17] Under the demonstration, Florida is not required to provide benefits that would result in coverage equivalent to that provided under the state plan. *Florida STCs*, #70, p. 20.

[18] 42 U.S.C. § 1396a(l)(4)(A) (2000). Section 1902(l)(4)(A) states, "In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) [of section 1902] and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) [of section 1902] in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title."

[19] *Id.; see also Social Security Act* §§ 1902(l)(1), (2) (codified at 42 U.S.C. §§ 1396a(l)(1), (2) (2000)). The statutory provisions contained in section 1902(l)(4)(A) refer to individuals described in sections 1902(l)(1) and (2). Subsection (l)(1) refers to pregnant women and children of varying ages and subsection (l)(2) provides corresponding family income levels. The scope of section 1902(l)(4)(A) is thus determined by reading the referenced provisions of section 1902(a)(10)(A) and sections 1902(l)(1) and (2) together.

During the initial phase of the demonstration, "poverty-related children"—that is, children whose family incomes fall within certain limits—were required to participate in the demonstration and either be enrolled in managed care plans or employer-sponsored or private health plans.[20] There is significant overlap between these "poverty-related" children and the groups of children identified in section 1902(l)(4)(A). In addition, certain pregnant women included in section 1902(l)(4)(A) are expected to participate in the demonstration by its fifth year. Notwithstanding the requirements of section 1902(l)(4)(A), the terms and conditions governing the demonstration permit Florida to cover only emergency and nursing home level of care services for beneficiaries for up to 30 days pending enrollment in managed care plans and to not ensure the full range of benefits required under the state plan for those who enroll in employer-sponsored or private health plans.

In response to our inquiries, CMS confirmed that HHS had not waived section 1902(l)(4)(A) and stated that Florida was not actually limiting coverage for children and pregnant women for up to 30 days pending their enrollment in managed care plans.[21] However, the terms and conditions governing the demonstration and the decision memorandum approving the demonstration state that beneficiaries will be eligible for only emergency services and nursing home level of care during this period.[22] Since HHS may not waive section 1902(a)(10)(A) for the pregnant women and children identified in section 1902(l)(4)(A), it should take steps to ensure that the state does not improperly limit services to these individuals pending their enrollment in managed care plans under the demonstration.

The waiver of section 1902(a)(10)(A), and failure to maintain the protection required by section 1902(l)(4)(A), could have a more significant impact on those "opting out of Medicaid" and enrolling instead in employer-sponsored or private health plans since the package of benefits provided could be more limited than under the state plan.[23] With respect to this issue, CMS stated in essence that those eligible for Medicaid decline Medicaid eligibility by choosing the demonstration benefit of employer-

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[20] "Poverty-related children" are defined as (i) children up to age 1 with family income up to 200 percent of the FPL, (ii) children up to age 6 with family income up to 133 percent of the FPL, and (iii) children up to age 21 with family income up to 100 percent of the FPL. *Florida STCs,* #30, p. 9.

[21] CMS Letter, pp. 2-3. According to the terms and conditions of the demonstration, once enrolled in managed care plans, children and pregnant women protected by section 1902(l)(4)(A) will receive required benefits. Managed care plans must cover all categories of mandatory services, including medically necessary services for pregnant women and early periodic screening, diagnosis, and treatment services for children under 21, as well as needed optional services covered under Florida's state plan as indicated by historical data. In addition, while the amount, duration, and scope of covered services may vary, plans may not have limits more restrictive than those in the state plan for children under the age of 21 and pregnant women. *See Florida STCs,* #49, p. 15.

[22] *See Florida STCs,* #36, p. 11. In addition, Florida law appears to provide that Medicaid recipients covered by the demonstration are not eligible for any services pending their enrollment in managed care plans since it provides that they are not eligible for mandatory or optional services. *See* Fla. Stat. Ann. § 409.91211 (West 2007).

[23] CMS suggested that very few individuals had exercised this option. CMS Letter, p. 2. We understand that as of March 31, 2007, four individuals were enrolled in employer-sponsored or private health plans.

sponsored or private health plans under Florida Medicaid Reform. As a result, they are entitled only to the payment of premiums under the authority of section 1115(a)(2) of the act, under which expenditures that would not otherwise qualify for Medicaid matching funds are regarded as matchable expenditures.[24]

The language of section 1902(l)(4)(A) does not support CMS's explanation. As noted above, section 1902(a)(10)(A) requires states to provide identified benefits to certain groups of individuals, including certain pregnant women and children. Section 1902(l)(4)(A) effectively prohibits states from denying those benefits to the same groups of pregnant women and children under demonstration projects. CMS acknowledged that section 1902(l)(4)(A) applied to Florida Medicaid Reform and did not dispute that individuals covered by that section were required to participate in the demonstration project. With respect to those enrolling in managed care plans, CMS stated that "even under customized benefit packages," required services must be provided.[25] In contrast, with respect to those choosing employer-sponsored or private health plans, CMS suggested that section 1902(l)(4)(A) did not apply because those at issue were a "non-State plan population" due to their choice of employer-sponsored or private coverage. However, section 1902(l)(4)(A) does not identify such a choice as a basis for not ensuring that states provide benefits to the children and pregnant women within the scope of that section.

Moreover, both the operation of the demonstration and information obtained from the state of Florida during our related evaluation suggest that the groups of individuals at issue are "state plan populations," notwithstanding their choice of employer-sponsored or private health plans. Those who "opt" for employer-sponsored rather than managed care plans nevertheless must qualify for Medicaid under the state plan and almost all of those required to participate in the demonstration project during its initial phase were required to be covered by Florida's state plan, some in categories explicitly referenced in section 1902(l)(4)(A).[26] Before individuals could "opt" for employer-sponsored or private health insurance and qualify for the state-paid premium under the demonstration project, Florida would necessarily have had to determine (or redetermine in the case of those already covered) that they qualified for Medicaid.[27] Further, HHS's

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[24] Responding to our inquiries about HHS's apparent failure to ensure that benefits would be provided to certain children and pregnant women, CMS said that section 1902(l)(4)(A) would not extend to individuals who have chosen not to apply under the state plan, and "instead have applied only for eligibility under the demonstration." CMS Letter, p. 2. In addition, in connection with the waiver of cost sharing limitations discussed below, CMS described those "opting" for employer-sponsored or private health plans as a "non-State plan population" and explained that they are "eligible only for demonstration benefits authorized under Section 1115(a)(2) [of the act]." *Id.* at 3. Demonstration documents describe these benefits as "employee costs of authorized employer-sponsored individual or family insurance coverage for individuals who would be eligible under the State plan but have elected not to apply under the State plan." *Florida Expenditure Authority* #1, p. 3.

[25] CMS Letter, p. 2.

[26] *See Florida STCs,* #30, p. 9 (describing these individuals as "mandatory Medicaid eligibles," with limited exceptions).

[27] *Id.* at #36, pp. 10-11 (stating that at the time of their eligibility determination, new enrollees will be informed of their option to select a managed care plan or "opt out of Medicaid," and that at the time of

determination that Florida's demonstration required a waiver of section 1902(a)(10)(A), which explicitly concerns those eligible for Medicaid under a state plan, signifies the agency's determination that those choosing employer-sponsored coverage were otherwise eligible for Medicaid under that section. Describing the operation of Florida Medicaid Reform, Florida officials confirmed this, stating

> Florida's 1115 Medicaid Reform Waiver does not change or affect Medicaid eligibility. An individual that opts out of Medicaid [under the demonstration] continues to be eligible for Medicaid. If a beneficiary is enrolled in an [employer-sponsored insurance] plan and later chooses to enroll in a [managed care] plan, then the beneficiary must wait until his/her open enrollment period . . . in order to request enrollment in the health plan. However, the beneficiary does not need to reapply to Medicaid. . . . If an individual were to opt out and enroll in the [employer-sponsored insurance] plan, but later lose Medicaid coverage due to excess income or assets, the beneficiary could reapply to Medicaid.[28]

The state of Florida's comments about the operation of the demonstration project also confirm that those who choose employer-sponsored or private health plans under Florida Medicaid Reform differ from individuals who effectively become eligible for Medicaid under a section 1115 demonstration project (referred to as "expansion populations"). The latter do not meet eligibility criteria for Medicaid under a state plan, but are treated as eligible exclusively by virtue of the demonstration project.[29] Under section 1115(a)(2) of the act, states may claim federal matching funds for the costs of services provided to these individuals even though they otherwise are not eligible for Medicaid. If they were to lose coverage due to a change in status, they, unlike participants in Florida Medicaid Reform, would have to establish their eligibility under the state plan.

Florida Medicaid Reform—Waiver of Limits on Cost Sharing

As part of Florida Medicaid Reform, HHS also waived statutory limits on the imposition of cost sharing requirements on Medicaid beneficiaries so that Florida could authorize coverage of employer-based or private health plans with cost sharing requirements in excess of those limits.[30] Specifically, the agency waived section

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their eligibility redetermination or their open enrollment period, current enrollees will be required to enroll in a managed care plan, but may "opt out of Medicaid" at any time). In addition, describing the automatic enrollment criteria, the terms and conditions state that each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. *Id.* at #38, p. 12.

[28] Letter from Thomas W. Arnold, Deputy Secretary for Medicaid, Florida Agency for Health Care Administration, to Marjorie Kanof, Health Care Managing Director, GAO, May 23, 2007.

[29] *See Spry v. Thompson,* 487 F.3d 1272 (9th Cir. 2007) (discussing the distinction between those eligible for Medicaid under a state plan and expansion populations, and overturning a district court holding that populations eligible for Medicaid only under the terms of a section 1115 demonstration project must be deemed to be eligible under a state plan and therefore subject to section 1916 of the act).

[30] *Florida Waiver Authorities,* #4, p. 1. The Deficit Reduction Act of 2005 (DRA) provided states with additional flexibility to impose cost sharing requirements on certain individuals in previously exempt

1902(a)(14) of the act, which incorporates section 1916 of the act by reference. With respect to individuals eligible for coverage under state plans, section 1916 prohibits states from imposing cost sharing under their plans for a variety of services, including services to those under 18 and services to pregnant women, and provides that states may impose only nominal cost sharing under their plans for other services.[31] Those who "opt out of Medicaid" and enroll in employer-sponsored or private health plans under the Florida demonstration are required to share costs as specified by these plans, even if such cost sharing is higher than what the state would be authorized to impose under section 1916.[32]

While section 1916(f) contemplates waivers of the cost sharing limits found in other parts of section 1916, it also establishes criteria for the imposition of other than nominal cost sharing under any waiver authority. It provides, for example, that cost sharing may not be imposed under any waiver authority unless the waiver is for a demonstration that tests a unique and previously untested use of co-payments and does not last longer than 2 years.[33] HHS did not apply the criteria of 1916(f) to the waiver of cost sharing limitations in the Florida Medicaid Reform demonstration. CMS explained that since those who enroll in employer-sponsored or private plans elect not to apply for benefits under the state plan, they fall outside the scope of section 1916 and section 1916(f) and, accordingly, that the waiver of section 1902(a)(14) approved as part of the Florida demonstration was not required.[34] As discussed above, CMS referred to the population at issue as being "eligible only for demonstration benefits authorized under Section 1115(a)(2) [of the act]," namely the premium payments.[35]

Like CMS's response to our inquiry regarding the requirement to provide benefits to certain pregnant women and children, its comments here do not explain why the demonstration did not trigger section 1916 and therefore why the demonstration did not require a waiver of the cost sharing limitations contained in that section. To the extent that CMS made essentially the same point with respect to this issue—that is, that as a matter of eligibility, those enrolling in employer-sponsored or private health plans qualify only for benefits as defined by the terms of the demonstration project—the agency's comments raise similar concerns. Almost all of the individuals

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populations and to impose more than nominal cost sharing on certain services under a state plan amendment. Pub. L. No. 109-171, §§ 6041-6043, 120 Stat. 4, 81-88 (2006) (to be codified at 42 U.S.C. § 1396o-1). HHS's waiver of limitations on cost sharing for Florida Medicaid Reform did not involve the additional flexibility under the DRA.

[31] 42 U.S.C. §§ 1396o(a)(2), (3) and (b)(2), (3) (2000).

[32] Under the demonstration, Florida is not required to provide any cost sharing assistance or to account for differences between the employer-sponsored or private health plans and Medicaid. *Florida STCs*, #83, p. 23.

[33] Social Security Act §§ 1916(f)(1), (2) (codified at 42 U.S.C. §§ 1396o(f)(1), (2) (2000)).

[34] CMS Letter, p. 4.

[35] *Id.* at 3.

required to participate in the demonstration during the initial phase were also required to be covered under the state plan. While Florida will make premium payments on behalf of those who enroll in employer-sponsored or private health plans under the authority of section 1115(a)(2) of the act, these individuals differ from those who otherwise do not meet eligibility criteria under the state plan, but for whom the cost of services nonetheless gives rise to federal reimbursement, that is, expansion populations. While the limitations on cost sharing contained in section 1916 would not apply to such expansion populations,[36] CMS's comments do not adequately explain why the cost sharing limitations would not apply to Florida Medicaid Reform participants who, though enrolled in employer-sponsored or private health plans, remain eligible under Florida's state plan.

Vermont's Global Commitment to Health

To receive federal Medicaid matching funds for capitation payments made to a managed care organization, a state is required to enter into a contract with an entity determined to be a managed care organization.[37] This type of contract is generally referred to as a comprehensive risk contract and must meet specific statutory and regulatory requirements.[38] HHS approved the interagency agreement between AHS and OVHA as such a contract. HHS also approved the planned use of savings from capitation payments under the "contract" for programs previously funded by the state.

HHS's approval of the Global Commitment to Health raises the question whether AHS and its component, OVHA, could enter into a contract as that term is used in the act because a contract implicitly requires an agreement between two parties.[39] The statutory definition of the term "managed care organization" is very broad[40] and does not specifically address whether state agencies may contract with their own components.[41] Statutory provisions concerning one particular state, however, suggest that explicit authority would be needed for a state to contract with another state office or agency as a Medicaid managed care organization. Section 4113 of the Omnibus Budget Reconciliation Act of 1987 added a new paragraph to section

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[36] *See Spry* at 1277.

[37] Social Security Act § 1903(m)(2)(A)(i), (iii) (codified at 42 U.S.C. § 1396b(m)(2)(A)(i), (iii) (2000)).

[38] *See id.* at 1903(m)(2)(A); 42 C.F.R. §§ 438.1, 438.2, and 438.6 (2006).

[39] *See, e.g., Taller & Cooper v. Illuminating Electric Co.*, 172 F.2d 625 (7th Cir. 1949); *see also* Restatement (Second) of Contracts § 9 (stating that a contract requires at least two parties as the law does not provide remedies for a breach of promise to oneself).

[40] *See* Social Security Act § 1903(m)(1)(A) (codified at 42 U.S.C. § 1396b(m)(1)(A) (2000)). The definition includes "a health maintenance organization . . . , or any other public or private organization" meeting specified requirements.

[41] HHS regulations define the term "grantee" as the entire state and, therefore, suggest that state agencies cannot enter into contracts with their components. *See* 45 C.F.R. § 92.3 (2006) (defining the term "grantee" to mean "the government to which a grant is awarded and which is accountable for the use of the funds provided" and noting that "the grantee is the entire legal entity even if only a particular component of the entity is designated in the grant award document.").

1903(m) of the act, expressly defining the term "contract" for purposes of the managed care provisions to include an arrangement under which New Jersey would operate its own health maintenance organization.[42] New paragraph (6)(A) stated "in the case of [New Jersey], the term 'contract' shall be deemed to include an undertaking by the State [Medicaid] agency . . . to operate a program meeting all requirements of this subsection."[43] New paragraph (6)(B), also added by section 4113, imposed a number of conditions on the "undertaking." Among other things, it required New Jersey to establish a separate entity responsible for operating the managed care program, but provided that a subdivision of the Medicaid agency could serve as that entity.[44]

CMS acknowledged the specific provision regarding New Jersey, but stated that the provision was necessary primarily because New Jersey, in contrast to Vermont, originally declined to organize its publicly operated managed care organization as a distinct organizational entity (and therefore the arrangement could not be characterized as either a risk contract or an intergovernmental agreement).[45] The agency's comment is not responsive to the issue. As discussed above, section 1903(m)(6) defined the term "contract" to include an arrangement under which the New Jersey Medicaid agency would operate as a managed care organization and listed the conditions under which that definition would apply. Accordingly, the provision did not merely require New Jersey or other states to establish distinct organizational entities as a prerequisite to their serving as managed care organizations; rather, it expressly permitted the New Jersey Medicaid agency to operate such an organization and, therefore, to contract with itself. The absence of similar statutory language regarding Vermont suggests that Congress did not contemplate such an arrangement in that state.[46] CMS also pointed to the history of payments to state-owned hospitals and other facilities and stated that it has not precluded state Medicaid agencies from entering into contractual relationships with

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[42] *See* Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, § 4113, 101 Stat. 1330, 1330-150 (1987) (adding new section 1903(m)(6) to the act, codified at 42 U.S.C. §1396b(m)(6) (2000)). In 1987, section 1903(m) of the act required states to enter into contracts with health maintenance organizations in order for expenditures made for their services to qualify for Medicaid matching funds. Although section 1903(m) has been amended since that time, the requirement that a state and an organization enter into a contract has remained.

[43] *Id.*

[44] *Id.*

[45] CMS Letter, p. 5. The legislative history of section 4113 indicates that action was taken with the intent to address "legal entity and contract problems" of the New Jersey arrangement. *See* 133 Cong. Rec. S29385 (daily ed. Oct. 27, 1987) (statement of Sen. Bradley).

[46] CMS officials told us that the statutory provision regarding New Jersey demonstrates Congress's intention that such models of service delivery and financing should be permitted where appropriate. By its own terms, however, the provision does not demonstrate congressional intent to authorize all states to employ such a model of service delivery, but only the intent to provide such authority to New Jersey. *See Collingsgru v. Palmyra Board of Education,* 161 F.3d 225, 232 (3d Cir. 1998) (explaining that the explicit mention of one thing in a statute implies that Congress intended to exclude similar things that were not specifically mentioned).

other "distinct units" of the state government.[47] While state agencies may enter into agreements with other state agencies, divisions, or providers for the purpose of providing Medicaid services or administering the Medicaid program, the agency's observations do not address the matter of authority for an agreement between an office within a state's Medicaid agency and that agency to qualify as a "contract" for purposes of the managed care provisions of the act.

Other statutory provisions applicable to Medicaid managed care contracts suggest that contractual arrangements are to involve an arms-length agreement between two parties. Specifically, a state may not enter into or renew a contract with a Medicaid managed care organization unless it has established a range of sanctions, which may include civil money penalties and the appointment of temporary management, to be imposed on the organization in certain circumstances, such as for failing to provide medically necessary items or services required to be provided to enrollees, or for misrepresenting or falsifying information provided to the state.[48] In the case of Vermont, the intergovernmental agreement does not identify sanctions that AHS could impose on OVHA for violations of the terms of the agreement and we are unaware of any provision of state law that does so. Indeed, it is unclear how AHS would effectively impose sanctions on its own subdivision.

Concerns about whether the arrangement between AHS and OVHA qualifies as a "contract" raise related questions about the basis under which federal Medicaid matching funds are available for the capitation payments made to OVHA and whether the arrangement should be treated like an interagency agreement for the provision of services under OMB Circular A-87.[49] Under the circular, costs of services provided by one agency to another within a state may include allowable direct costs plus a pro rata share of indirect costs.[50] Therefore, where services are provided under an interagency agreement, federal matching funds are available only for the costs incurred by the agency providing the services, or the expenditures made by that agency—here, OVHA—for its allowable direct and indirect costs of providing services. The circular does not provide for profit or other increments above cost—such as the savings in the AHS capitation payments to OVHA—and therefore does not provide a basis to treat savings as allowable costs for purposes of obtaining federal matching funds.[51]

In response to our inquiries about the operation of the AHS-OVHA arrangement, CMS advised that it may be viewed as either a comprehensive risk contract or as an intra-

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[47] CMS Letter, p. 5. CMS did not elaborate or explain what constitutes a "distinct unit" of state government.

[48] Social Security Act § 1932(e)(1) (codified at 42 U.S.C. § 1396u-2(e)(1) (2000)).

[49] As a general matter, HHS regulations limit the use of grant funds to "allowable costs," which are determined in accordance with OMB Circular A-87. 45 C.F.R. § 92.22 (2006).

[50] OMB Cir. No. A-87, *Cost Principles for State, Local, and Indian Tribal Governments,* Attachment A, § G, Interagency Services.

[51] OMB Cir. No. A-87 at ¶ 5.

governmental cost reimbursement arrangement, or "a hybrid" of the two.[52] A "hybrid" of these two types of arrangements does not seem possible, however, because one is capitation-based and the other is cost-based, and, in any case, CMS pointed to no authority for such a "hybrid." More importantly, the arrangement appears problematic viewed as either a comprehensive risk contract or a cost-reimbursement arrangement. Under a comprehensive risk contract, federal Medicaid matching funds are available for capitation payments made to a managed care organization on an actuarially sound basis for services provided to Medicaid eligible individuals.[53] Federal regulations require states to document the actuarial soundness of the rates and to provide assurance that the rates are based only on services covered under the state plan (or costs directly related to providing these services, including administrative costs) provided under the contract to Medicaid eligible individuals.[54] Notably, the intent of this regulatory limitation was to prevent states from obtaining federal Medicaid matching funds "for things such as State-funded services for which [matching funds] would not ordinarily be available, by including them in [a contract with a managed care organization]."[55] However, under the Global Commitment to Health, HHS expressly approved the use of savings from capitation payments made to OVHA for programs previously funded by the state. These programs are generally carried out by other agencies and do not exclusively benefit those eligible for Medicaid so that federal Medicaid matching funds would ordinarily not be available for them.[56]

CMS also suggested that, since OVHA must fully expend the capitation payment for services for Medicaid-eligible individuals and the specified demonstration purposes, the arrangement between AHS and OVHA has more of the characteristics of a reasonable cost reimbursement payment methodology with the "contract" establishing the overall budget.[57] However, the arrangement between AHS and OVHA

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[52] CMS Letter, pp. 7-8.

[53] Social Security Act, § 1903(m)(2)(A)(iii) (codified at 42 U.S.C. § 1396b(m)(2)(A)(iii) (2000)).

[54] 42 C.F.R. § 438.6(c)(4)(i), (ii)(A), (B) (2006). The regulations also authorize managed care contracts to cover services for enrollees in addition to those services covered under the state plan, though the cost of such services may not be included when determining payment rates. *Id.* at 438.6(e). Explaining why such services may not be included, CMS stated that entities would "typically use 'savings,' (a portion of the risk payment not needed to cover state plan services) to cover [additional services]." *Final Rule, Medicaid Program; Medicaid Managed Care: New Provisions,* 67 Fed. Reg. 40,989, 41,005 (June 14, 2002).

[55] *Id.* at 41,000-41,001. Prior to the issuance of these regulations, CMS (then the Health Care Financing Administration) adopted a policy that HHS would not approve any state waiver application that contained a requirement for managed care organizations to use savings under the capitation rate for those not eligible for Medicaid. *See* Letter from Sally K. Richardson, Director CMSO, to state Medicaid Directors (June 24, 1998). As far as we know, CMS has not revoked this policy, and the Medicaid managed care regulations are consistent with it.

[56] According to state officials, in State Fiscal Year 2006, a total of $43 million was spent on "managed care organization investments" in a number of state agencies. Programs funded included those related to health profession education, health research and statistics, and public health laboratory services. We understand that Vermont anticipates approximately $300 million in "savings," or 7 percent of total capitation payments, over the life of the demonstration project.

[57] CMS Letter, p. 6.

allows OVHA to direct funds received in excess of costs (that is, savings) to programs of other state agencies. That is to occur only if capitation payments to OVHA yield excess funds, and then only to the extent of the excess. By definition, such savings represent an increment of payment above the direct and indirect cost of providing services and, thus, we see no basis to characterize this arrangement as one for reimbursement of costs.

CONCLUSION

Our analysis of Florida Medicaid Reform and the Vermont Global Commitment to Health raises several legal concerns. With respect to Florida, our concerns center on HHS's decision to waive requirements to provide covered benefits and limit cost sharing without addressing statutory limitations on its authority to do so. This matter is most relevant to those enrolling in employer-sponsored or private health plans. In the case of Vermont, the agency's approval of an agreement between the Vermont Medicaid agency and one of its own components as a managed care contract, with federal matching funds provided for capitation payments, also raises legal concerns. Given these concerns, we believe that the Secretary should reexamine these demonstration projects and, as appropriate, either modify their terms or seek statutory authorization for them to continue in their present form.

Sincerely yours,

Gary L. Kepplinger
General Counsel

cc: 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