# *Issues in Missouri Health Care 2011*

## Transforming Missouri Medicaid: Federal Waiver Options and Processes

# Acknowledgement

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# Issue Statement

Two key programs, Medicaid and the Children's Health Insurance Program (CHIP), are important sources of financing for health care services for low-income Missouri adults and children. Both programs are financed jointly by the state and federal governments, and are operated by states under federal guidelines that are set forth in law, regulation, and policy letters issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees these programs.

Under waiver authority created by Congress, CMS can grant a state's request to deviate from statutory and/or regulatory requirements that may stand in the way of service expansion or innovation. While MO HealthNet already operates elements of the Medicaid program in Missouri pursuant to a number of waivers, the ongoing transformation of the program and efforts to cover the uninsured may benefit from further flexibility attained through additional waivers.

# Background

The fundamental principle behind waivers is that it is appropriate to allow states to deviate from the normal rules of the program in order to meet public policy goals under certain circumstances. These goals can include improving care coordination through managed care arrangements, supporting the rights of elderly and disabled persons to receive care in the home setting instead of an institution, and covering the uninsured. Deviations from the rules are limited; the individual limits are discussed in the subsections below.

There are various types of waivers related to Medicaid and CHIP. One key feature of them all is a limit on expenditures, although the calculation of the limit varies by waiver type. This tends to create a great deal of confusion when waivers are discussed, particularly in the context of covering the uninsured, so these expenditure limits are explained below. Each of the following subsections presents a discussion of the purpose of the waiver authority, the provisions of law that can be waived, how the budget limit is calculated, the process for obtaining a waiver, and the timeline involved in seeking and renewing waivers.

# Section 1915(b) Waivers

**Purpose**

Under Section 1915(b), CMS can give states the authority to require that Medicaid beneficiaries enroll in managed care plans. Once a beneficiary is enrolled in a managed care plan, he or she is guaranteed access to a network of doctors, hospitals, and other providers. This is not always the case outside managed care, because it can sometimes be difficult to locate a doctor who accepts Medicaid patients. Since managed care plans are required to demonstrate that they have a viable network, finding a doctor who accepts Medicaid should not be an issue in managed care. Managed care plans under Medicaid are also held to standards concerning quality of care, such as identifying individuals with chronic diseases and linking them with needed care, and

meeting targets for preventive health screening. In addition, there are enrollee protections such as the right to change managed care plans if the care received is not adequate. These rules cannot be waived under Section 1915(b).

**What can be waived**

There are three general Medicaid requirements that can be waived under Section 1915(b). These are referred to as statewideness, freedom of choice, and comparability. Each is discussed in turn.

- *Statewideness:* Section 1902(a)(1) under Medicaid requires that a state must operate its Medicaid program the same way in all areas of the state. It is not permissible, for example, to only offer certain benefits in urban areas or to exercise more generous eligibility criteria in some areas and not others. Under Section 1915(b), a state can have a different managed care program design in certain areas or limit the availability of managed care on a geographic basis. This is in recognition of the fact that it may not be possible to have a managed care network, or a sufficient choice of plans, in all areas of the state.
- *Freedom of choice:* Section 1902(a)(23) refers to the fact that under normal circumstances, Medicaid beneficiaries may seek care from any provider who accepts Medicaid. Under Section 1915(b), states may restrict freedom of choice to providers in the managed care network, with certain exceptions. The managed care regulations do allow for out-of-network care in certain circumstances, and family planning services may always be accessed from any provider.
- *Comparability:* Section 1902(a)(10)(B) refers to the Medicaid requirement that the state offer a consistent benefit package across all the different eligibility groups that are covered in the Medicaid program. Under Section 1915(b), comparability may be waived for the express purpose of allowing managed care plans to offer benefit enhancements. Examples of the types of additional benefits that may be offered are smoking cessation classes and weight loss programs.

**Cost effectiveness**

As mentioned above, every waiver authority has its own specific budget test. Under Section 1915(b), the underlying principle is that managed care should be "cost effective" when compared with standard fee-for-service Medicaid. Previously, CMS required states to compare their costs under Section 1915(b) managed care programs with the fee-for-service costs for the same benefits provided to an equivalent population. In recognition of the fact that states operate fewer programs on a fee-for-services basis—so such comparisons are no longer feasible—CMS ended this practice a few years ago. Instead, states demonstrate cost-effectiveness by demonstrating that cost growth in the Section 1915(b) waiver program is within reasonable projected levels.

**Process**

Like other waiver authorities, states are required to seek approval from CMS. CMS has 90 days to approve or deny the request for a Section 1915(b) waiver, but may "stop the clock" with a request for additional information that would be needed to approve the request. Once the state

formally responds to the request, a second 90-day clock begins. It is not unusual for states and CMS to have many informal conversations before the clock restarts, in the interest of developing a response that renders the application approvable. Section 1915(b) waivers are submitted on an application template designed by CMS.

**Timing**
Section 1915(b) waivers must be renewed every two years.

## Section 1915(c) Waivers

**Purpose**
Section 1915(c) is used to offer home and community-based services (HCBS) as an alternative to institutional care. Services such as home health care, adult day care, home modifications, and Meals on Wheels are used to avoid or delay placement in a nursing home or other institution such as a hospital or intermediate care facility for the mentally retarded (ICF/MR). Section 1915(c) has been a tool in attacking the so-called "institutional bias" in Medicaid, which is created by the fact that in many states, a more generous income eligibility threshold is used for individuals who live in an institution than for those who live in the community. Examples of groups that states elect to serve under Section 1915(c) waivers are the elderly, the disabled, individuals with mental retardation and developmental disabilities, individuals with a traumatic brain injury, individuals with autism, and individuals with severe mental illness. In order to be served under a Section 1915(c) waiver, the individual has to meet institutional level of care criteria. Unlike other Medicaid services, HCBS waivers can be limited to a set number of clients, and states can maintain waiting lists. This practice addresses the concern that there would be a "woodwork effect" creating a great deal of demand for these services.

**What can be waived**
As in Section 1915(b), statewideness and comparability can be waived. In addition, as suggested above, the rules surrounding income eligibility for individuals living in the community, Section 1902(a)(10)(C)(i)(III), can be waived. This means that states can use the same standard for community-based individuals as they do for those in an institution such as a nursing home.

**Cost neutrality**
The budget test for Section 1915(c) waivers is based on comparing the cost of institutional care with home and community-based services. In other words, the state has to demonstrate that it costs no more to deliver care under the waiver than would be the case if the individuals were served in institutions. Based on the population that is served under the waiver, the basis of comparison can be nursing home costs, hospital costs (such as for children with mental illness), or ICF/MR costs. States can choose whether to apply this test on a person-by-person basis or in the aggregate across the waiver.

**Process**
The process for review and approval of Section 1915(c) waivers is the same as for 1915(b). These waivers are also submitted on a template designed by CMS.

**Timing**
Initial approval of waivers is for three years; renewals are for five years.

## Combination Waivers

It is important to note that Sections 1915(b) and 1915(c) can be used jointly. A state would use a combination waiver to provide home and community-based care in a managed care environment. This is a very promising area in long-term care; however, combination waivers have many complexities, including the fact that the approval periods cannot be synchronized because they are set forth in the federal statute.

## Section 1115 Demonstrations

Purpose: Section 1115 is a "research and demonstration" authority, meaning that its purpose is to test innovative approaches to delivering care in Medicaid or CHIP. The fact that an approach has been tested and proven to be effective under Section 1115 (such as managed care) has, in some instances, led Congress to make it easier for states to adopt this approach in the future. Section 1115 waivers have been used in both Medicaid and CHIP over the years to accomplish a number of public policy goals, such as:

- Expanding Medicaid or CHIP eligibility to additional low-income uninsured individuals,
- Lowering the Medicaid birth rate by providing free family planning services to women who would not otherwise be eligible,
- Testing new service delivery models (one example is a health savings account [HAS] model approved in 2007 for the state of Indiana), and
- Allowing for consumer-directed long-term care.

Many times, a Section 1115 demonstration is based on a unique concept developed by a state. However, sometimes CMS generates guidance to alert states that the federal government is favorably inclined to approve Section 1115 waivers that follow a certain model. One example of this is the Health Insurance Flexibility and Accountability (HIFA) waiver model that CMS announced in 2001.[1] Several states still have HIFA waivers that were approved subsequent to this announcement.

Missouri previously had a Section 1115 demonstration, approved by CMS in 1998, that expanded eligibility to additional parents and children, though the parent expansion was never fully implemented. This comprehensive waiver has been replaced with one that provides only family planning services to women losing Medicaid eligibility after the birth of a child.

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1 HIFA waivers may be used for coverage expansions as long as they include a public-private coordination component such as employer sponsored insurance. Some of the most publicized HIFA waivers were used to expand coverage to childless adults with limited benefit packages; a policy that has been phased out by the Children's Health Insurance Reauthorization Act (CHIPRA).

**What can be waived**

One reason Section 1115 has allowed states to pursue such a huge variety of program designs is that there are few limits on what can be waived. Unlike the other waiver authorities, Section 1115 gives the Secretary of Health and Human Services (HHS) very broad latitude to waive anything in Section 1902 of the Social Security Act (SSA). Section 1902 is the part of the SSA that describes how states must run their Medicaid programs. In addition, the Secretary can essentially "waive" Section 1903, which describes the items that can be reimbursed under Medicaid. This means costs that could not ordinarily be included in Medicaid – such as coverage of ineligible groups including non-disabled adults without dependent children – can be included under Section 1115. There are some types of expenditures that can never be included, irrespective of the waiver authority. This can be because they are described in a section of the statute not affected by Section 1115, or the statute explicitly states that the requirement cannot be waived. One example of this is coverage for certain immigrants. Also, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) specifically prohibits the Secretary of HHS from allowing CHIP programs to use waivers to provide family coverage, and phases out the use of waivers to cover parents or childless adults.

**Budget neutrality**

Given that the waiver authority is very broad, CMS saw a need to place some budget constraints on Section 1115 waivers. Unlike the other waiver authorities, the Section 1115 budget neutrality requirements are not set forth in statute but have evolved in policy statements.

In general, the budget neutrality requirement is that the waiver not cost the federal government more than the cost without the waiver. In order to gain approval, a state has to show CMS a comparison of with-waiver and without-waiver expenditures. While the waiver is operational, the actual with-waiver costs are continuously compared with the without-waiver allowance. The without-waiver allowance is flexible enough to recognize that states may choose to implement certain changes through a Section 1115 waiver that they could otherwise make without a waiver. One example of this would be expanding eligibility to additional parents. For costs that could not be incurred under the standard Medicaid program (e.g., non-disabled childless adults), the state needs to identify an offset, such as funds that would otherwise be paid to hospitals under the Medicaid program for uncompensated care. Because the mechanics of measuring budget neutrality are not set forth in law, this is often an area of intense negotiation between the state and federal governments for each individual waiver.

The above discussion relates to budget neutrality in the Medicaid context. For the CHIP program there is no budget neutrality requirement, since each state's CHIP funds are limited to a statutory allotment. The only requirement for CHIP is that the waiver and the regular state CHIP program not exceed the state's allotment. If the state runs out of money in its CHIP allotment, the basic CHIP program has to be funded before the waiver program.

**Process**
Unlike the other waiver authorities, there is no required time frame for federal review and decisionmaking on Section 1115 waiver proposals. Because of the amount of negotiation that is often required on budget neutrality and on programmatic issues (e.g., benefit package or cost sharing), years can pass between a state's waiver application and CMS's decision. There is also no set format for a Section 1115 waiver, except in some limited instances, such as HIFA, where CMS has published a recommended format.

**Timing**
Section 1115 waivers are approved for a five-year period. The waivers can be extended for three years at a time. In recognition of the fact that many states operate a significant portion of their Medicaid programs under a waiver, Congress added language to the SSA that provides for a streamlined extension approval process, providing that certain conditions such as budget neutrality are met.

# Legislation Affecting Waivers

No discussion of waivers would be complete without mention of the Deficit Reduction Act of 2005 (DRA). Under this Act, Congress added some options that were designed to eliminate the need for certain waivers. These include:

- Section 1937, which permits a state to offer a reduced benefit package to certain Medicaid populations;
- Section 1915(i), which permits a state to provide home and community-based programs without a waiver; and
- Section 1938, which permits states to set up an HSA feature for certain Medicaid beneficiaries.

Although Congress intended for the DRA to at least partially replace the need for waivers, it has become clear that some of the flexibility is so constrained as to be of limited usefulness to states. For example, when the state of Indiana wanted to incorporate an HSA feature into its Medicaid program, Section 1938 was not a viable option because this was being pursued in conjunction with an eligibility expansion. Instead the state made this change through a Section 1115 demonstration.

Section 1915(i), the HCBS state plan option, has had limited impact because unlike Section 1915(c), it does not confer the ability to apply institutional income rules for community-based individuals. The Patient Protection and Affordable Care Act (ACA) adds a new section to 1915(i) that allows states the option of providing services to individuals with income up to 300 percent of the Supplemental Security Income (SSI) Federal benefit rate (FBR).[2] Individuals served in this new eligibility group must meet eligibility requirements, but individuals do not have to be enrolled in

2 $2,022 monthly income per individual in 2010.

Medicaid for HCBS under a 1915(c), (d), or (e) waiver or 1115 demonstration program. For this eligibility group, states are also permitted to use institutional eligibility and post-eligibility cost sharing rules in the community, in the same manner they would under a 1915(c) waiver.[3] However, the new authority to provide HCBS services as a state plan benefit is not likely to be adopted by state Medicaid programs facing budget deficits. Rather, states will most likely avoid making HCBS services an entitlement in the near term and will continue to use the waiver approach as a means of financing the benefit incrementally.

## Implications

As noted above, waivers can allow states to pursue objectives that would not otherwise be permitted under federal law and regulation. Waivers have become commonplace, particularly those that allow for mandatory enrollment in managed care and those that allow for HCBS services for individuals who would otherwise require institutional care. Even Section 1115 has seen widespread use for both acute care and long-term care services. By far the most powerful tool in a state's arsenal for covering the uninsured has been Section 1115, provided sufficient offsets have been identified for new costs.

Missouri uses seven 1915(c) waivers to provide HCBS to a variety of aged, blind, and disabled populations. Also, since 1998, Missouri's Medicaid program (MO HealthNet) uses an 1115 waiver to provide expanded coverage to children up to 300 percent of the federal poverty level (FPL). The state can continue to use waivers to explore additional innovations and program improvements. However, ACA will potentially play a significant role in reducing the need for waivers to provide expanded coverage. Starting in 2014, the ACA expands Medicaid up to 133 percent of FPL for all non-Medicare, under-65 individuals. Many waivers that were originally used to expand coverage to these previously uninsured populations will now be unnecessary. Additionally, the ACA allows states to begin phasing in expanded coverage to these new groups prior to 2014 without waivers. State budget deficits will play a large role in determining the rate at which they will take up this latter option available through ACA.

3 State Medicaid Director Letter #10-013. http://www.hhs.gov/od/topics/community/iathcbssmd8-6-102.pdf. Retrieved 10/20/10.