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THE NEW MEDICAID AND  
CHIP WAIVER INITIATIVES

*Prepared by*

Cindy Mann

The Kaiser Commission on Medicaid and the Uninsured

February 2002

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**The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.**

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## **Introduction**

Broader use of waivers to restructure Medicaid coverage and an expedited process for states to obtain waivers will undoubtedly be at the center of Medicaid policy in the coming year. Waivers permitting states to receive federal Medicaid financing for coverage that does not meet federal standards or that extends beyond federal options are not new – nearly one-fifth of Medicaid spending falls under section 1115 waiver authority. The waivers being considered now, however, could move beyond the expansions in coverage and revisions in benefits and service delivery that have been approved in the past and bring about fundamental changes for Medicaid beneficiaries. The broad and diverse group of people served by Medicaid, including children, parents working at low-paying jobs that do not offer health insurance coverage, and elderly and disabled people with significant medical needs, could be affected.

This issue paper reviews Medicaid's legislative framework and the breadth and limits of the flexibility provided to states under current law and then describes new federal waiver policy and how that policy might affect key aspects of the Medicaid program. The next phase of waiver activity is likely to set new precedents for two reasons. First, the federal government has signaled its interest in granting waivers that permit major changes in how Medicaid and, to a lesser extent, the State Children's Health Insurance Program (CHIP) operate. Through guidance issued in August 2001 (referred to as the "Health Insurance Flexibility and Accountability" or HIFA initiative), states are offered the flexibility to expand coverage but also to reduce benefits, increase cost sharing, and set limits on the number of low-income people served. Second, the downturn in the economy and rising health care costs are pushing states to constrain state spending. States may therefore look to HIFA for new cost-saving options.

Waivers can be useful tools to demonstrate new ways to provide coverage and deliver services to vulnerable populations, but waivers also can raise difficult questions. The new federal waiver policy encourages coverage expansions, but it does so by putting new flexibility—but no new money—on the table. Some states, prompted by budget pressures, are looking to rely on the flexibility offered by the new waiver policy principally to reduce costs. Whether or not a waiver includes a coverage expansion, people with very limited incomes, including many with significant medical problems, may be left with fewer benefits and higher costs. Some people could lose their coverage and their access to needed services.

At the heart of the current waiver discussion is the tension between the federal guarantees to Medicaid beneficiaries and state interest in gaining broader flexibility to set program rules without compromising federal funding. Underlying this issue are fundamental questions relating to what constitutes adequate coverage for low-income individuals and whether the waiver process is the appropriate venue for revisiting Medicaid's minimum coverage standards.

Monitoring these waiver proposals and assessing the implications for coverage and access to care for low-income and vulnerable populations will be a central focus of the Kaiser Commission on Medicaid and the Uninsured's work over the next year.<sup>1</sup>

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<sup>1</sup> See also, J. Lambrew Ph.D, *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview*, prepared for the Kaiser Commission on Medicaid and the Uninsured, July 2001, and J. Guyer, *The Role of Medicaid in State Budgets*, Policy Brief, Kaiser Commission on Medicaid and the Uninsured, October 2001.

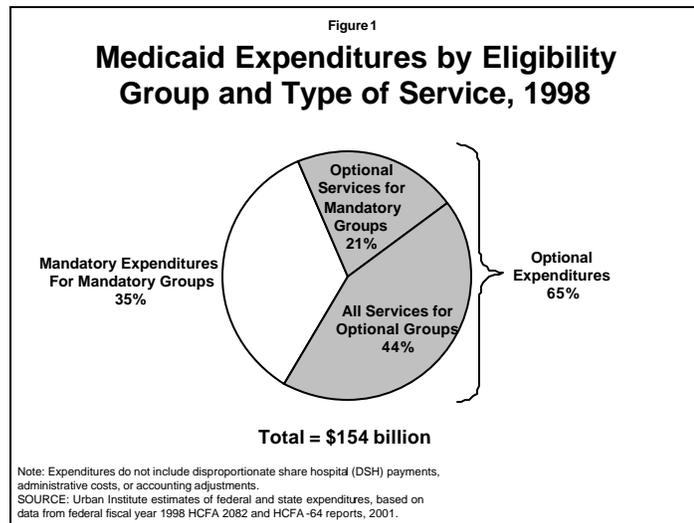
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## Chapter 1

### The Basic Structure of Medicaid and CHIP: Federal Standards and State Flexibility

It is often said that there is no single Medicaid program, but rather 50 Medicaid programs. Each state decides how to structure eligibility, benefits, service delivery and payment rates within guidelines established by federal law. The federal standards, which govern the annual expenditure of over \$200 billion in federal and state funds, have evolved over the course of the more than 35-year history of the program. The rules can be complex and sometimes confounding. Overall, however, they accord states considerable, but not unlimited, flexibility to set their eligibility standards, structure their benefits, and establish their service delivery systems.



In exchange for federal financial participation (on average, the federal government pays 57 percent of the cost of Medicaid), states agree to cover certain groups of individuals (referred to as “mandatory groups”) and offer a minimum set of services (referred to as “mandatory benefits”). States also can receive federal matching payments to cover additional (“optional”) groups of individuals and provide additional (“optional”) services. Spending on optional groups and optional benefits accounts for two-thirds of all Medicaid spending. (Figure 1)

The decision by a state to cover an optional population or to provide optional benefits has important implications not just for Medicaid beneficiaries but also for state or local jurisdictions and health care providers that otherwise might be paying for or providing health services to low-income residents. Federal matching payments through Medicaid often allow states to partially refinance the cost of services that states, counties and cities have traditionally provided at their expense or to pay for services that otherwise might be written off by providers as bad debt or charity care.<sup>2</sup> Mental health services are a notable example.

<sup>2</sup> For a discussion of state efforts to increase federal funding for public health and mental health services, see Coughlin, Zuckerman, Wallin, and Holahan, “A Conflict of Strategies: Medicaid Managed Care and Medicaid Maximization,” *HSR*, 34, April 1999, pp. 281, 284.

## *Eligibility Under Current Medicaid Law*

Medicaid covers four groups of low-income people: children and their families, pregnant women, and elderly and disabled people. For each group, federal law sets basic parameters on who must be covered if a state chooses to participate in Medicaid (all do). These populations are referred to as mandatory groups.

- States must cover pregnant women and young children (under age six) with family incomes at or below 133 percent of the poverty (\$19,977 for a family of three in 2002) and older children (up to age 18) with family incomes at or below 100 percent of poverty (\$15,020 for a family of three in 2002). Parents also must be covered, but at much lower income levels. On average, the upper income eligibility level for parents in the mandatory eligibility group is 41 percent of the poverty level (\$6,158 for a family of three in 2002). States also must extend transitional (temporary) Medicaid assistance to certain low-income families who would otherwise lose coverage due to an increase in earnings or child support.
- Elderly and disabled individuals must be covered, in most states, if they are eligible for Supplemental Security Income (SSI), or, in some states, if their incomes are below levels similar to the SSI income limits (on average, 74 percent of the poverty level). In addition, low-income Medicare beneficiaries must be assisted through coverage of their Medicare Part B premiums and, in some cases, their Medicare cost-sharing.

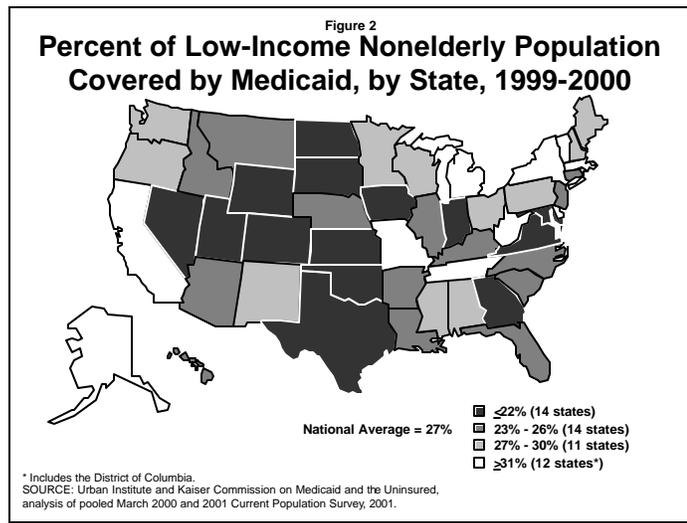
States have broad but not unlimited flexibility to extend Medicaid coverage to other (“optional”) eligibility groups, including children, parents, pregnant women, elderly, and disabled persons whose income and resources are above the mandatory levels. For example, most of the elderly people who receive nursing home care financed by Medicaid are covered at state option. Federal law, however, does not give states the option to cover childless adults unless they fit into one of the other eligibility groups (e.g., they are elderly or disabled). The extent to which states exercise options to cover optional groups varies widely. Massachusetts and Vermont cover 41 percent of their low-income non-elderly residents through Medicaid, compared to Virginia, which covers 14 percent of its low-income non-elderly residents through Medicaid.<sup>3</sup> (Figure 2, next page)

Once a state decides to participate in Medicaid, in order to receiving federal matching funds, the state must enroll all people who apply and are eligible under either a mandatory group or optional group. Enrollment caps and waiting lists are not permitted. States, however, set the scope of the entitlement to Medicaid with respect to optional

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<sup>3</sup> Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on pooled data from the March 2000 and 2001 Current Population Survey. The extent to which a state covers low-income persons is partly a function of its Medicaid optional coverage choices, but also reflects other factors such as the extent to which low-income people in the state have access to affordable employer-based coverage, how effectively the state informs eligible people about the program, and the simplicity of its application and renewal process.

coverage, since states can scale back or eliminate optional eligibility and optional benefits.<sup>4</sup>



### *Benefits Under Current Medicaid Law*

In order to meet the diverse needs of Medicaid beneficiaries, states may receive federal Medicaid matching payments for a broad array of services. Not all services, however, must be covered. As is the case with eligibility, benefits under Medicaid are either mandatory or optional.

- Mandatory services include inpatient and outpatient hospital care, physician services and laboratory tests.<sup>5</sup> In addition, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are mandatory for children. EPSDT requires regular health, vision, dental and hearing screenings as well as treatment services prescribed for a child.
- Other services are provided at state option. They include medical services that typically are covered by private health insurance, such as prescription drugs, as well as services that are not available under most private plans but that states may choose to provide because of Medicaid beneficiaries' low-incomes and/or special health care needs. Home health care, dental care, eyeglasses, prosthetic devices, and physical or speech therapy are examples of optional services states may cover under Medicaid.<sup>6</sup> (Figure 3, next page)

<sup>4</sup> If a state rolls back Medicaid eligibility for children below the levels in effect in that state in March 1997 the state may not receive CHIP funding. This "maintenance of effort" provision was adopted to ensure that CHIP funds would be used to expand coverage to uninsured children rather than substitute for Medicaid coverage that had been available in a state prior to CHIP.

<sup>5</sup> A more limited set of services is mandatory for the optional "medically needy" group (in general, people who "spend down" to Medicaid eligibility because their medical expenses exceed their income). In addition, states are not required to provide the full Medicaid package of benefits to certain pregnant women and to low-income Medicare beneficiaries who qualify for assistance with Medicare premiums and cost sharing.

<sup>6</sup> As noted above, under EPSDT these services are mandatory services if needed by a child.

**Figure 3  
Medicaid Benefits**

<u>“Mandatory” Items and Services</u> <sup>7 8</sup>	<u>“Optional” Items and Services</u> <sup>9</sup>
<i>Acute care</i>	
Physicians’ services	Medical care or remedial care furnished by licensed practitioners under state law
Laboratory and x-ray services	Prescribed drugs
Inpatient hospital services	
Outpatient hospital services	
Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	Diagnostic, screening, preventive, and rehabilitative services
Family planning services and supplies	
Federally-qualified health center (FQHC) services	Clinic services
Rural health clinic (RHC) services	
Nurse midwife services	
Certified nurse practitioner services	
	Primary care case management services
	Dental services, Dentures
	Physical therapy and related services
	Prosthetic devices, Eyeglasses
	TB-related services
	Other specified medical and remedial care
<i>Long-term care</i>	
Nursing facility (NF) services for individuals 21 or over	Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental diseases (IMD)
	Intermediate care facility for individuals with mental retardation (ICF/MR) services
	Inpatient psychiatric hospital services for individuals under age 21
Home health care services (for individuals entitled to NF care)	Home health care services
	Case management services
	Respiratory care services for ventilator-dependent individuals
	Personal care services
	Private duty nursing services
	Hospice care
	Services furnished under a PACE program
	Home- and community-based (HCBS) services (under waiver, subject to budget neutrality requirements).

<sup>7</sup> Transportation services are not a statutory benefits category. However, states are required to ensure necessary transportation for beneficiaries to and from providers, 42 CFR. 431.53, and federal Medicaid matching funds are available for transportation expenses, 42 CFR. 440.170(a).

<sup>8</sup> A narrower list of mandatory services applies to “medically needy” groups.

<sup>9</sup> Since the EPSDT rules require states to cover any treatment service that a child may need if the service could be covered under Medicaid, Medicaid coverable services are not optional for children.

Under federal law, a state that chooses to provide an optional service must provide that service to all of its “categorically” eligible enrollees; for example, a state that offers physical therapy to elderly individuals receiving SSI also must offer physical therapy to disabled individuals receiving SSI.<sup>10</sup> In all cases, however, services may only be provided to a particular Medicaid beneficiary if the service is “medically necessary.” There is no federal definition of medical necessity.

Medicaid rules also allow states discretion to limit the scope of any particular service, including a mandatory service, although, again, the discretion is not absolute. States can limit mandatory and optional services (with the exception of EPSDT) as long as the scope of the service available to beneficiaries is sufficient “to reasonably achieve its purpose.”<sup>11</sup> Limits on prescription drug coverage and hospital stays are not uncommon among states.<sup>12</sup>

States have particularly broad flexibility to design their Medicaid service delivery system and set provider payment rates. Before 1997, states needed a waiver to require Medicaid beneficiaries to enroll in managed care, but with the growth of managed care Congress revised the law to give states the option to require most Medicaid beneficiaries to enroll in managed care. Waivers are no longer needed. In addition, the Medicaid statute accords states broad flexibility to set their provider payment rates as long as the rates are “consistent with efficiency, economy and the quality care.”<sup>13</sup> The longstanding flexibility permitted states in this area was broadened in 1997 with respect to payments to hospitals and nursing homes.<sup>14</sup> If, however, payment rates discourage provider participation to the point where access is effectively denied, federal law may require states to pay higher provider payment rates.<sup>15</sup>

One indicator of the flexibility available to states to structure their benefits and set provider rates is the range in the cost of Medicaid coverage across states. In 1998, New Hampshire spent three times the amount that Mississippi spent to cover a child under Medicaid, and New York spent almost twice the national average to cover disabled individuals. (Figure 4 next page)

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<sup>10</sup> All mandatory and most optional groups are “categorically eligible.” A different and more limited set of benefits can be provided to the optional “medically needy” group.

<sup>11</sup> Medicaid regulations, 42 CFR sec. 440.230.

<sup>12</sup> R. Schwalberg et al, Health Systems Research, Linda Elam, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Outpatient Prescription Drug Benefits: Findings From a National Survey and Selected Case Study Highlights*, October 2001.

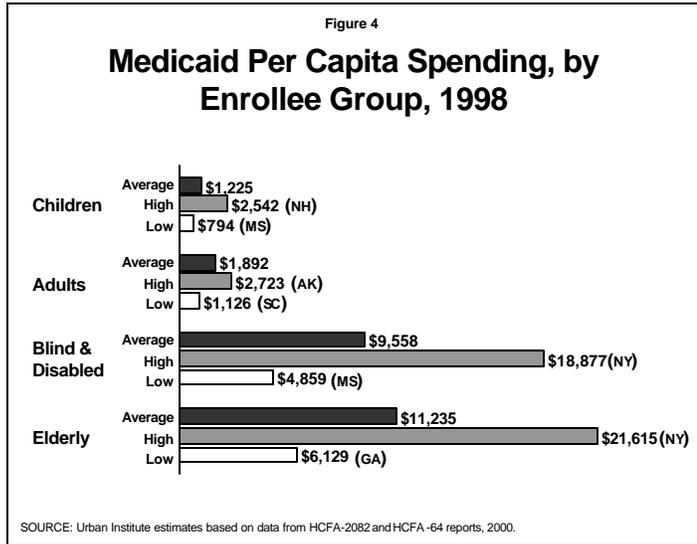
<sup>13</sup> Section 1902(a)(30)(A) of the Social Security Act.

<sup>14</sup> The 1997 Balanced Budget Act repealed the so-called Boren amendment, which required that rates for institutional providers be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.”

<sup>15</sup> See, for example, State Medicaid Director letter, January 18, 2001, with respect to children’s access to dental care. <http://www.hcfa.gov/medicaid/smd118a1.pdf>.

### *Premiums And Cost Sharing Under Current Medicaid Law*

Because the traditional population served by Medicaid has little or no ability to pay for medical services, federal law limits the premiums and the amount of cost sharing permitted under the program. Premiums are not allowed except in limited situations, and certain groups of individuals and some services are fully or partially exempt from cost sharing.



- Co-payments and deductibles are not allowed for services furnished to children.
- Pregnancy-related services, emergency services and family planning services and supplies are exempt from cost sharing.
- In most other cases “nominal” cost sharing is permitted.<sup>16</sup>

Another feature of Medicaid cost-sharing rules is that services cannot be denied to Medicaid beneficiaries who cannot afford the co-payment or other charge, although they remain liable for the cost. In addition, Medicaid providers cannot “balance bill” Medicaid beneficiaries for any portion of the charges (beyond allowable cost-sharing amounts) relating to a Medicaid covered service.

### *The State Children’s Health Insurance Program*

CHIP was adopted in 1997. It provides capped federal funds to states to expand coverage to children who were not eligible for Medicaid under state standards in place in March 1997. States can use their CHIP funds either to expand Medicaid coverage for children or create or expand a separate CHIP program. Medicaid program rules apply in CHIP-funded Medicaid expansions. In separate CHIP programs, states have broader authority to design their programs subject to federal minimum standards.

<sup>16</sup> The Secretary of the Department of Health and Human Services establishes the nominal amounts by regulation. Deductibles cannot exceed \$2 per month per family, co-payments may range from \$.50 to \$3.00, depending on the cost of the service, and co-insurance requirements cannot exceed five percent of the service cost. Medicaid regulations, 42 CFR 447.54.

- Eligibility. CHIP provides funds to states to cover uninsured low-income children.<sup>17</sup> Children under 200 percent of the poverty line are the target population, but states may use their CHIP funds to cover children at higher income levels. The federal law does not create an entitlement for children; enrollment caps and waiting lists are permitted in separate CHIP programs.
- Benefits. State CHIP programs must adopt a benefit package that meets CHIP minimum standards or a CHIP “benchmark,” which are generally tied to commercial plans available broadly or specifically for state employees. Certain services, such as well-baby and well-child care, must be covered.
- Premiums and cost sharing. Total out of pocket costs (premiums, co-payments, deductibles, enrollment fees) for children covered in separate CHIP programs cannot exceed five percent of family income.<sup>18</sup> In addition for children with incomes below 150 percent of poverty, premiums and cost sharing charges cannot exceed the “nominal” amounts prescribed by the Secretary (based on the schedule published for certain groups of beneficiaries enrolled in Medicaid). Cost sharing cannot be imposed on preventive services.

#### *The Medicaid and CHIP “State Plan” Process*

Each state must develop a Medicaid “State Plan,” which identifies the options it has chosen to implement in Medicaid. States must also prepare a CHIP state plan in order to draw down federal CHIP funds. State plans (and amendments) are submitted to Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) for review and approval and provide a public record of the rules that operate under each state’s program.<sup>19</sup>

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<sup>17</sup> Certain groups of uninsured children are excluded, such as children whose parents are covered by a state employee health plan, and children who are legally present but who entered the country on or after August 22, 1996.

<sup>18</sup> By regulation, Native American children are exempt from cost sharing in CHIP.

<sup>19</sup> Medicaid state plans are posted at <http://www.hcfa.gov/medicaid/stateplan/default.asp>.

## Chapter 2

### Changing the Rules Through Waivers: Waiver Activity in the Past

Section 1115 of the Social Security Act grants the Secretary of the Department of Health and Human Services the authority to waive certain requirements of the Social Security law, including certain requirements in Medicaid and CHIP. The Secretary's waiver authority is not limited to the Medicaid and CHIP programs; indeed, Congress established the authority to waive provisions of the Social Security Act before either Medicaid or CHIP was created.

Section 1115, as applied to Medicaid, essentially allows the Secretary to provide federal Medicaid matching funds to a state that is providing coverage that does not meet federal minimum standards or that extends beyond available federal options. While this waiver authority is broad, it is limited in a number of ways. There must be an "experimental, pilot or demonstration project" and the project must be "in the judgment of the secretary, likely to assist in promoting the objectives of the program." In addition, the waiver authority is limited to certain specified provisions of the Medicaid law. For example, section 1115 does not reference that part of the statute that sets the federal matching rates for Medicaid, and, therefore, the Secretary cannot use waiver authority to change these rates. However, since many of the eligibility provisions in the Medicaid program are subject to waiver authority, waivers can be used to provide federal Medicaid funds at the regular matching rate to states seeking to extend coverage to individuals who otherwise could not be covered under Medicaid.

Waivers have allowed states to experiment with the provision of new benefits, like hospice care or community-based care as an alternative to nursing home care, to extend family planning services to women, and to provide coverage to uninsured or underinsured individuals with HIV. In recent years, several states have relied on waivers to require Medicaid beneficiaries to enroll in managed care, to extend coverage to new groups of people, or to require premiums and cost sharing when coverage has been extended beyond to children and others with incomes well above traditional Medicaid coverage levels. Some waivers have stirred considerable controversy, but many have enjoyed broad support.

#### *Section 1115 Medicaid Waiver Process*

Prior to the new HIFA guidance, there had not been any clearly delineated federal guidance on Medicaid waiver policy. In general, states developed their waiver proposals for consideration by the Secretary following a format designed by the Health Care Financing Administration (HCFA, now CMS). The waiver review process has been managed by CMS with the involvement of other agencies within the Department of Health and Human Services and the White House Office of Management and Budget. While the process allowed for a thorough review of the proposal by various federal agencies, with some notable exceptions, the process was slow, often involving several

rounds of negotiations, and has been subject to frequent criticism from states and other interested groups.<sup>20</sup>

Because waivers can result in major changes in the way a state's Medicaid program operates and affect millions of dollars in state and federal spending, over the years there has been some pressure to open up the waiver process. In a notice issued by the Secretary and published in the Federal Register in 1994, the Department pledged to assure that the public had notice of waiver proposals and the opportunity to submit comments at both the state and federal levels. Notice of all proposed waivers was to be published in the Federal Register on a monthly basis, and comments received would be reviewed during a 30-day period prior to the approval or denial of any Medicaid section 1115 waiver.<sup>21</sup> The 1994 notice also committed the Department to prepare a decision memorandum at the time a waiver is granted or denied and to maintain an administrative record generally consisting of:

- The formal demonstration application from the state
- Issue papers sent to the state and the state's responses
- Public and Congressional comments sent to the Department and any responses
- The Department's decision memorandum; and
- The final terms and conditions for the waiver

In practice, at least in recent years as fewer states submitted new section 1115 proposals, the review process did not follow the steps outlined above. Monthly notices of proposed waivers are no longer published, waiver documents are not routinely made available to the public, and there is no system to ensure that public comments are received before the Department acts on a waiver. In some cases where the public has been aware of a waiver proposal, comments have been submitted at the federal level and meetings between commenters and federal officials have been held.

CMS does routinely require states to certify that they have provided an opportunity for the public to comment on a waiver proposal before it is submitted to the federal agency for review. The nature and scope of that public review process, except with respect to federally recognized American Indian and Alaska native tribes, is left largely to the state. As outlined in the 1994 Federal Register notice, the requirement for public comment at the state level can be met by activities ranging from holding public hearings and establishing a state commission to publishing a legal notice in state and local newspapers that a waiver is being considered and that public comments will be accepted. Because of the unique relationship between the federal government and tribal governments, a higher standard for the state/ tribe consultation process in the context of section 1115 waivers has been established by CMS.<sup>22</sup>

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<sup>20</sup> Congress has occasionally intervened to promote more timely resolutions of waiver negotiations in situations when a state is seeking to extend or renew a waiver that has been operating in a state. Time frames for the waiver renewal process were established in 1997 legislation and again in legislation enacted in 2000. See subsections (e) and (f) of section 1115 of the Social Security Act.

<sup>21</sup> Federal Register, September 27, 1994

<sup>22</sup> States must notify federally recognized tribes in their state of the anticipated submission of a waiver (or a waiver renewal) proposal at least 60 days prior to submission and provide an opportunity for comment

### *Section 1115 Medicaid Waiver Policy*

Past waiver policy can be gleaned from a review of the Medicaid section 1115 waivers that have been granted, but the approved waivers tell only part of the story. In almost all cases, waivers have been approved after months of review and negotiations between the federal agencies and the state Medicaid agency, sometimes with the direct involvement of the Secretary and the Governor. As a result, the terms and conditions of approved waivers often vary significantly from the waivers originally proposed by states. Since the process of arriving at the final set of terms and conditions is not open and no public record tracking the proceedings is available, it difficult to identify and analyze the waivers that have been sought but not approved.

In fiscal year 2001, 17 states had statewide section 1115 Medicaid waivers, and California had an 1115 Medicaid waiver for Los Angeles County only.<sup>23</sup> Many of these waivers would not be necessary today, particularly given new managed care and family coverage options made available to states since the time these waivers were first approved. (Figure 5, next page)

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by the tribe and discussion with the tribe. CMS, State Medicaid Director Letter, July 17, 2001, SMDL #01-024, [www.hcfa.gov/medicaid/letters/smd/71701.pdf](http://www.hcfa.gov/medicaid/letters/smd/71701.pdf).

<sup>23</sup> Ohio's section 1115 demonstration ended on June 30, 2001. For a fuller description of the Section 1115 waiver process and a discussion of waivers previously granted, see J. Lambrew, Ph.D, and *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview*, prepared for the Kaiser Commission on Medicaid and the Uninsured, July 2001.

**Figure 5**  
**Major Medicaid Section 1115 Demonstrations Approved Through FY2001**

<b>State</b>	<b>Delivery System Change</b>	<b>Benefit/ Cost Sharing Change</b>	<b>Eligibility Expansion</b>	<b>New Eligibility Group</b>	<b>Year Implemented</b>	<b>Federal Spending (Millions, FY 2002)</b>
<b>Arizona</b>	X			N/A	1982	\$1,515
<b>Arkansas</b>		X	X	Children	1997	\$27
<b>Los Angeles County (CA)</b>	X			N/A	1996	\$231
<b>Delaware</b>	X	X*	X	Adults	1996	\$153
<b>Hawaii</b>	X	X*	X	Children, Adults	1994	\$76
<b>Kentucky</b>	X			N/A	1997	\$90
<b>Maryland</b>	X			N/A	1997	\$1,007
<b>Massachusetts</b>	X		X	Children, Adults, Disabled Individuals, Individuals with HIV	1997	\$1,889
<b>Minnesota</b>	X	X*	X	Children, Parents	1995	\$57
<b>Missouri</b>		X*	X	Children, Parents	1999	\$310
<b>New Mexico</b>		X	X	Children	1999	N/A
<b>New York</b>	X	X*	X	Adults	2001	\$7,959
<b>Oklahoma</b>	X			N/A	1996	\$585
<b>Oregon</b>	X	X	X	Adults	1994	\$348
<b>Rhode Island</b>	X	X*	X	Children, Parents	1994	\$83
<b>Tennessee</b>	X	X*	X	Children, Adults	1994	\$4,084
<b>Vermont</b>		X*	X	Children, Adults	1996	\$169
<b>Wisconsin</b>		X*	X	Parents	1999	\$12

Source: CMS, Center for Medicaid and State Operations, Family and Children's Health Programs Group, various state waiver terms and conditions, and State Health Care Reform Demonstrations: Fact Sheets. Federal spending is reported in the President's FY2003 Budget, Analytical Perspectives, Table 15-4.

Notes: "Adults" includes parents, childless adults, and pregnant women. "Parents" may also include pregnant women. Cost-sharing changes may include premiums.

\* These states apply the benefit/cost sharing change only to the expansion group within the waiver.

- Five waivers, accounting for 20 percent of all spending under the Medicaid 1115 waivers, were for delivery system changes only. These waivers were requested in order to require Medicaid beneficiaries to enroll in managed care. As noted above, managed care waivers are largely no longer necessary since states now have the option to require most beneficiaries to enroll in managed care under changes in the law adopted in 1997. Of the remaining waivers, many also involved managed care (for example, New York’s 1997 waiver, which accounts for more than half of the remaining dollars spent on section 1115 waivers, is primarily a managed care waiver).
- Eleven of the waivers allowed states to expand coverage to parents (either alone or in combination with other expansions). Like service delivery system waivers, waivers to expand coverage to parents are no longer necessary. Parent coverage expansions can be accomplished under options enacted as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
- Expansions for children also do not require waivers. Nine of the 17 waivers currently in effect expand coverage for children.
- States still need a waiver in order to expand eligibility for of childless adults. In 2001, seven states had section 1115 waivers to cover adults who otherwise could not be covered under Medicaid.

Waivers, however, often have multiple purposes. Even if a state could adopt an eligibility change without a waiver, it might still seek a waiver if it is looking to drop a mandatory benefit or charge premiums or co-payments for the new eligibility group beyond the levels allowed by law. States that expanded coverage through waivers did so in part because they were raising their program’s income eligibility to a point where the state believed that some of the individuals or families covered could afford to make a contribution toward the cost of coverage or services. As noted above, under the Medicaid statute, cost sharing is limited to nominal amounts in the absence of a waiver.

With some exceptions, states that have expanded coverage to somewhat higher income children or adults generally have not used waivers to make major changes in the Medicaid benefit package. One of the most widely known waivers, however – the Oregon Health Plan – did alter the Medicaid package in a significant way. While the waiver process is ordinarily out of public view, the Oregon waiver was one of a number of the more far-reaching waiver proposals that received a considerable amount of public attention and scrutiny. Submitted in 1991 but not approved until 1993, the Oregon waiver permitted the state to expand coverage to poor adults and to limit benefits to all persons covered under the waiver. The principle underlying the approach was to make more people eligible for Medicaid, but at the same time limit (some said “ration”) care based on state fiscal considerations.

Tennessee’s waiver proposal, submitted and approved in 1993, also attracted public interest. Its waiver expanded coverage to a large number of residents and, at the same time, required most beneficiaries to enroll in managed care. The demonstration project,

known as “TennCare,” covers uninsured and uninsurable adults and children up to 400 percent of the poverty line, although uninsured (but not uninsurable) adults who otherwise could not be covered under Medicaid are subject to an enrollment cap. Individuals with incomes above 400 percent of poverty can participate in TennCare by paying the full cost of coverage. At the time TennCare was being reviewed, mandatory managed care to the extent permitted under TennCare and the enrollment cap were quite controversial, as were some of the financing arrangements proposed under the waiver.<sup>24</sup>

A more recent high profile waiver concerned Wisconsin’s proposal, which was approved in 1999, to cover families with incomes up to 185 percent of the poverty. Concerns were raised about Wisconsin’s initial request to impose an enrollment cap on the children and parents covered by the expansion if enrollment rose above specified levels. The waiver ultimately did not include an enrollment cap and instead permitted the state to roll back its waiver expansion if necessary due to budgetary constraints.<sup>25</sup>

### *Section 1115 Medicaid Waiver Financing*

It has long been federal policy that section 1115 waivers must be “budget neutral” to the federal government, meaning that federal spending can be no higher under the waiver than it would have been without the waiver. The concept of budget neutrality protects the federal government from experiencing higher costs, but it has limited the extent to which states can use waivers to expand coverage to groups that could not have been covered without a waiver.

The rules for establishing budget neutrality have not been clearly laid out in the past, although, in 1994, the federal government stated its intention to implement budget neutrality “flexibly.”<sup>26</sup> In recent years, states have used various means to achieve budget neutrality in Medicaid waivers that sought to expand coverage. Several states combined expansions with a new managed care delivery system and used the anticipated managed care savings to offset the cost of the coverage expansion. Some states redirected disproportionate share hospital (DSH) payments from hospitals to offset the cost of an expansion. In addition, the federal government has considered waiver expansions that covered groups of individuals that could have been covered under Medicaid without a waiver to be “pass throughs.” Essentially, this has meant that to the extent that a state is covering a group under its waiver that it could cover without a waiver there is no budget neutrality issue for that new group.

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<sup>24</sup> An amendment to the TennCare waiver that would scale back the program substantially is under review at the federal level.

<sup>25</sup> As noted above, states can roll back optional eligibility without a waiver. Wisconsin’s waiver specifically permits the state to maintain coverage of families who were enrolled prior to the rollback; this also can generally be accomplished for families and children without a waiver. The waiver authority, however, eliminated any ambiguity with respect to Wisconsin’s authority to take such steps. Enrollment in the state’s waiver program, known as “Badgercare,” has exceeded projections, but supplemental funding was provided and to date the state has not taken action to roll back the expansion.

<sup>26</sup> Public Notice, Office of the Secretary, Department of Health and Human Services; Federal Register, September 27, 1994.

### *Section 1115 State Children's Health Insurance Program Waivers*

The 1997 legislation enacting the State Children's Health Insurance Program (CHIP) permitted Section 1115 waiver authority to extend to CHIP. Several states have been particularly interested in seeking CHIP waivers to finance expansions of coverage for parents of children eligible for Medicaid and CHIP. CHIP waivers are attractive because CHIP provides states with federal funding at a more favorable matching rate than is available under Medicaid, and some states have more CHIP funds than they expect to need to cover children.<sup>27</sup>

Unlike Medicaid, however, CHIP does not provide open-ended federal funding. Federal CHIP funds are made available to states through capped annual allotments that are set based on a formula established in the 1997 law that created CHIP. CHIP financing has two important implications for CHIP waivers. First, not all states can take advantage of a CHIP waiver to expand coverage to new populations, since some states will need all of their federal CHIP funds for children's coverage. Second, because unspent CHIP allotments are reallocated to states that have fully spent their allotments, one state's CHIP waiver may affect another state's ability to cover children under its CHIP program.

Federal CHIP waiver guidance issued in July 2000 allowed CHIP waivers to cover new populations up to the full amount of a state's CHIP allotment, as long as the state was covering children up to at least 200 percent of the federal poverty line and had adopted measures to promote participation rates among eligible children.<sup>28</sup> Under the July 2000 guidance, CHIP funds could be used under section 1115 waiver authority to cover parents and pregnant women but not childless adults. Pursuant to this guidance, four states were granted CHIP waivers to help finance expansions for parents (and in two states, pregnant women as well) as of August 2001. Since then, Arizona and California were granted CHIP waivers under the new HIFA waiver initiative described in the following chapter. (Figure 6, next page)

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<sup>27</sup> Because the federal CHIP law accords states broad authority with respect to children's eligibility, benefits and cost sharing, states have generally been interested in CHIP waivers to cover new populations, rather than to change the rules relating to children. A few states have requested CHIP waivers to provide benefits to children who cannot otherwise qualify for CHIP (e.g., because they have limited insurance coverage) and to use CHIP funds to provide children with benefits or services not otherwise coverable under CHIP.

<sup>28</sup> State Health Official letter, July 31, 2000. <http://www.hcfa.gov/init/ch73100.htm>

**Figure 6**  
**State Children's Health Insurance Program Section 1115 Waivers**  
**Approved as of January 2002**

<b>State</b>	<b>Medicaid Expansion</b>	<b>Separate CHIP Program Expansion</b>	<b>Date Approved</b>
<b>Arizona</b>	Childless adults under 100% FPL*	Parents between 100% and 200% FPL (to be implemented October 2002 subject to availability of funds)	12/12/01
<b>California</b>		Parents between 100% and 200% FPL (implementation subject to availability of funds)	1/25/02
<b>Minnesota</b>	Parents between 100% and 200% FPL*		6/13/01
<b>New Jersey</b>	Parents between 100% and 133% FPL	Parents between 134% and 200% FPL  Pregnant women between 185% and 200% FPL	1/18/01
<b>Rhode Island</b>	Parents between 100% and 185% FPL*  Pregnant women between 185% and 250% FPL*		1/18/01
<b>Wisconsin</b>	Parents between 100% and 185% FPL*		1/18/01

Source: CMS, Center for Medicaid and State Operations, Family and Children's Health Programs Group, various state waiver terms and conditions, and State Children's Health Insurance Program: Fact Sheets.  
 \* CHIP funding for these groups refinanced coverage that had already been approved under earlier waivers or optional expansions. The CHIP waiver provides the state capped federal matching funds at the CHIP enhanced rate.

## Chapter 3

### **The New Waiver Guidance: The Health Insurance Flexibility and Accountability Demonstration Initiative**

In August 2001, President Bush announced a new waiver initiative to promote coverage expansions within existing Medicaid and CHIP resources; encourage premium assistance programs; allow states broad flexibility to set Medicaid and CHIP program rules; and improve accountability with respect to the impact that the waiver initiatives might have on lowering the number of low-income uninsured people. The initiative, referred to as Health Insurance Flexibility and Accountability (HIFA), was described in guidance issued by the CMS.<sup>29</sup> (See, *Side-by-Side Comparison of HIFA Guidance and Medicaid and CHIP Statutory Provisions*, prepared by the Kaiser Commission on Medicaid and the Uninsured.)

The new initiative was announced by the Secretary of HHS at a meeting of the National Governors Association and reflects much of the approach to Medicaid reform promoted by NGA earlier in the year.<sup>30</sup> The Department's guidance offers a broad outline of the types of Medicaid waivers that will be approved, promising states a speedy review of waivers that meet the HIFA guidelines. According to the guidance, under certain conditions states will be permitted to substitute their own rules for statutorily established rules with respect to benefits, cost sharing and entitlement to free up funds to finance coverage to currently uninsured individuals. No additional federal funds will be available for expansions, except to the extent that a state might use available CHIP funds for such a purpose.<sup>31</sup>

The new waiver policy was promoted as a way to give states greater flexibility to expand coverage, but it is not clear whether states will be granted waivers to alter Medicaid program rules along the lines allowed under HIFA if the state's waiver proposal is aimed primarily or exclusively at curbing costs rather than expanding coverage.<sup>32</sup> The guidance made it clear that HIFA is only one route to Medicaid and CHIP section 1115 waivers, and that other waiver proposals would continue to be considered.

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<sup>29</sup> The waiver guidance and template can be found at the CMS website, <http://www.hcfa.gov/medicaid/hifademo.htm>.

<sup>30</sup> NGA's Medicaid reform recommendations can be found at [http://www.nga.org/nga/legislativeUpdate/1,1169,C\\_POLICY\\_POSITION^D\\_1431,00.html](http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_1431,00.html). In addition to seeking more flexibility to design Medicaid benefits, eligibility and cost sharing rules, the NGA position paper sought higher federal matching payments. See J. Holahan, Urban Institute, *Restructuring Medicaid Financing: Implications of the NGA Proposal*, prepared for the Kaiser Commission on Medicaid and the Uninsured, June 2001.

<sup>31</sup> As explained more fully below, the HIFA policy allowing states to use CHIP funds to finance coverage expansions reaffirms previous policy issued in July 2000 but somewhat expands on that earlier policy by allowing CHIP funds to be used to cover childless adults as well as parents and pregnant women.

<sup>32</sup> The Administrator of CMS, Thomas Scully, has stated that the HIFA initiative was not intended to result in an overall reduction in coverage.

### *HIFA Waiver Rules—Which Groups Are Affected?*

The HIFA guidance divides Medicaid and CHIP beneficiaries into three groups. Individuals in each of the three groups may be affected by a HIFA waiver, depending on how a state designs its waiver, but the level of programmatic flexibility accorded states under the waiver policy varies depending on whether the individuals are considered part of a “mandatory,” “optional,” or “expansion” group.

- Mandatory groups under the HIFA guidelines include individuals that states are required to cover under Medicaid, including elderly and disabled people receiving SSI, children age 6 and older with incomes up to the poverty level, and younger children and pregnant women with incomes below 133% of poverty. According to the guidance, the new programmatic flexibility being extended to states through HIFA waivers would not apply to mandatory groups. However, as discussed below, mandatory groups can be pulled into a HIFA waiver and affected by a HIFA waiver in order to help finance coverage of other groups of beneficiaries.<sup>33</sup>
- Optional groups include individuals who are not mandatory beneficiaries but who can be covered under Medicaid without a waiver. They include pregnant women, parents, children, and disabled and elderly individuals with incomes over Medicaid mandatory eligibility levels. Under HIFA, states are offered broad new flexibility with respect to the benefits and cost sharing rules that can be applied to optional groups, whether or not those groups are currently covered under a state’s Medicaid program or would be newly covered under the waiver. It also appears that with a waiver, states will be allowed to cap enrollment of optional groups, at least under some circumstances.<sup>34</sup>
- Expansion groups include those individuals who states cannot cover in either Medicaid or CHIP without a waiver. For Medicaid HIFA waivers, childless (nondisabled) adults under age 65 would be considered an expansion group, since states cannot cover them using federal Medicaid funds except through a waiver. For HIFA waivers where a state is seeking to cover individuals in a separate CHIP program, it appears that any adult (a parent, a pregnant woman or a childless adult) would be considered part of an expansion group. The HIFA guidance offers states even broader flexibility to design the rules for expansion groups as compared to optional groups.

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<sup>33</sup> This was the approach adopted in Utah’s HIFA waiver. Mandatory parents (i.e., those with incomes below 50 percent of the poverty line) were put under the waiver and new cost sharing was imposed on the parents in order to finance the expansion for other adults. The amount of the cost sharing imposed, however, was within limits permitted by federal Medicaid regulations.

<sup>34</sup> Utah’s HIFA waiver includes an enrollment cap for the newly covered groups, which include optional parents and disabled adults.

## *Financing Under HIFA Waivers*

The August HIFA guidance restates the longstanding federal policy that waivers must be “budget neutral,” but it spells out the way in which budget neutrality will be determined more clearly than in the past. It appears that most of the methods of achieving budget neutrality that have been commonly used in the past – identifying savings from managed care, redirecting current spending under DSH, and establishing “pass throughs” for new coverage that could be accomplished without a waiver – are available under HIFA. However, much of the opportunity to achieve savings through managed care has already been taken, and it is increasingly difficult in the current competitive market-driven health care environment to redirect DSH funds from hospitals to new coverage.

Two other potential sources of financing for expansions are identified in the HIFA guidance. The guidance offers states the opportunity to use unspent CHIP funds to expand coverage to other populations, including childless adults, up to the states’ CHIP allotment.<sup>35</sup> In addition, as discussed in more detail below, the guidance allows states to reduce federal and state costs under the waiver by limiting benefits, charging co-payments, deductibles and premiums, and capping the number of people who will be enrolled.

According to the HIFA guidance, in order to measure and enforce budget neutrality, each state under a HIFA waiver will be subject to a cap on federal expenditures. Over the course of the waiver (usually a five-year period), a state may receive federal matching payments for all of the individuals covered under the waiver, but it cannot receive more federal matching funds than it would have received for the individuals covered under the waiver *without consideration of the expansion group* (plus any CHIP funds or DSH funds that it has redirected to cover costs under the waiver).

The HIFA guidance spells out how the ceiling or cap on federal expenditures will be calculated. The cap is based on the state’s per person per month cost of the optional or mandatory groups that are covered under the waiver.<sup>36</sup> These per capita costs are determined at the outset of the waiver and are trended forward using either the Medical Care Consumer Price Index (MCPI) or a state-specific trend rate. (The expedited HIFA review process is only available if a state agrees to use the MCPI.) According to the guidance, no adjustments in the per capita costs will be permitted if utilization or the

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<sup>35</sup> See *Report on the Health Insurance Flexibility and Accountability (HIFA) Initiative: State Accessibility to Funding for Coverage Expansions*, CMS, October 4, 2001, Table 2. The Arizona HIFA waiver makes CHIP funds available to cover childless individuals. While CMS has not rescinded its July 2000 CHIP guidance, HIFA policy appears to override the portion of the earlier guidance that allowed CHIP waivers only for the purpose of covering children, parents and pregnant women.

<sup>36</sup> Although the guidance states that the new HIFA rules do not apply to mandatory groups, the guidance assumes that a state might put a mandatory group under the waiver. Presumably, a state might do this to give itself more “room” under the budget neutrality cap. For example, if a state put mandatory disabled individuals under the waiver, it might not be able to reduce benefits or impose cost sharing beyond the levels allowed by the Medicaid statute, but it could still achieve savings under the waiver by reducing per person costs through measures that do not require waiver authority. If the state froze or reduced provider payments or implemented a prior authorization process for pharmacy services (actions it can take without waiver authority), the reduction in spending for the disabled group might help the state keep its waiver costs within the bounds of budget neutrality.

actual cost of services pushes per person costs above projections. Over the course of the waiver, the state would claim federal matching payments for all groups covered under the waiver, including the expansion groups. However, federal payments under the waiver will be limited by the budget ceiling, which does not factor in the cost of the expansion groups. The state is at risk for costs that exceeds the cap.

Under these budget neutrality rules, a state that uses CHIP or DSH funds to finance all or part of the waiver will be able to rely on those funds to cover some or all of the new costs under the waiver. However, states without available or sufficient CHIP or DSH funds must reduce their spending on the mandatory or optional groups covered under the waiver in order to make room under the budget neutrality ceiling to claim federal matching payments for the expansion groups. Since no additional federal dollars are being made available to finance waiver expansions, the budget neutrality rules require states to demonstrate in their waiver application that the additional cost of covering the expansion groups (i.e., those who could not be covered except through a waiver) will be offset by CHIP or DSH funds or by projected reductions in the cost of the other groups covered under the waiver.

A per person cap on federal expenditures under section 1115 demonstrations is not new; per capita caps have been negotiated as part of budget neutrality agreements in waivers prior to HIFA. What is new under HIFA is the flexibility that will be allowed states to achieve savings under the waiver through broad programmatic changes, and, perhaps, a stricter application of the budget neutrality principles than has been used in the past.

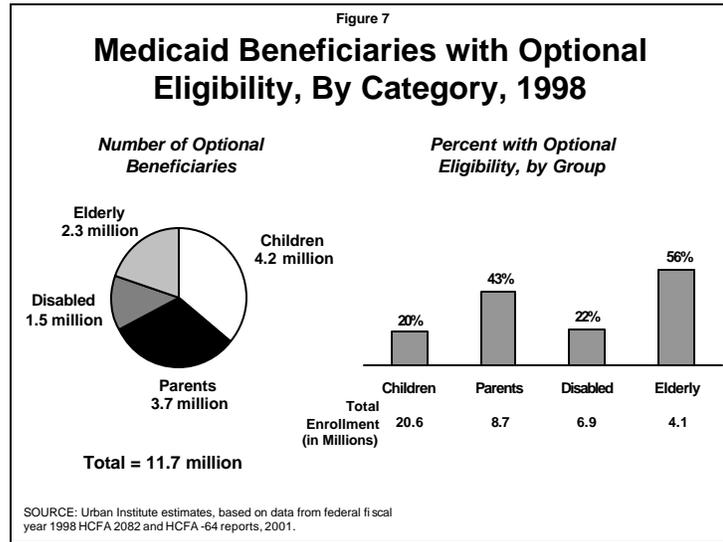
#### *HIFA Waiver Rules—Eligibility Expansions And Restrictions*

The HIFA guidance encourages states to use waivers to expand coverage, with an emphasis on covering people with incomes below 200 percent of the FPL. It is not clear whether every HIFA waiver must include an expansion or whether expansions must be comparable in size to any spending reductions (through benefit reductions, new cost sharing, or enrollment caps) that are approved through the waiver.

The guidance does not directly address eligibility restrictions, but the waiver template developed by CMS asks states to indicate whether they will be imposing enrollment caps on populations covered under the waiver, and it appears that enrollment caps will be allowed under HIFA waivers, at least for some populations. As noted above, states can cut back on Medicaid enrollment by scaling back or even eliminating optional eligibility for Medicaid, but without a waiver states cannot cap enrollment and deny or delay coverage to an individual who meets the criteria for Medicaid eligibility. By contrast, CHIP, which does not provide open-ended federal funding, permits states to cap enrollment and establish waiting lists.

## HIFA Waiver Rules- Benefits And Cost Sharing For Optional Beneficiaries

The HIFA guidance indicates that states will be allowed broad flexibility – beyond the level allowed under current law – with respect to the benefits and cost sharing rules that can be applied to optional beneficiaries covered under a HIFA waiver. In 1998, close to 30 percent of all Medicaid beneficiaries, including more than half of all elderly individuals and one out of five children and disabled individuals, were optional beneficiaries. (Figure 7)



- **Benefits.** Under the HIFA guidance, states can substitute a CHIP benefit package for Medicaid benefits for optional beneficiaries (including those currently covered by a state and those who may be covered through an eligibility expansion). The CHIP law set the minimum benefit requirements for children whose incomes are above Medicaid income eligibility levels and who are covered under separate CHIP programs. These minimum requirements are referred to as benchmarks and include:
  - The standard Blue Cross/Blue Shield preferred provider option available to federal employees
  - A health plan that is generally offered to state employees
  - The coverage plan that has the largest insured commercial, non-Medicaid enrollment offered by a health maintenance organization in the state
  - The actuarial equivalent of any of these plans
  - “Secretary –approved” coverage. There are no minimum requirements for Secretary-approved coverage.<sup>37</sup>
- **Cost sharing.** The HIFA guidance offers states broad flexibility to charge optional groups premiums, enrollment fees, deductibles, and co-payments. No limits are stated with respect to parents, pregnant women, elderly or disabled individuals. For children, total cost sharing must not exceed five percent of

<sup>37</sup> CHIP regulations, 42 CFR section 457.450.

family income; family premiums do not count toward this cost-sharing limit for children. (For example, if a state covered the entire family, the premium to enroll the family would not be counted towards the five percent cap on cost sharing that would apply to each child in the family.)

- Premium assistance. The HIFA guidance strongly encourages states to seek waivers to use Medicaid and CHIP funds to subsidize the purchase of private coverage, including employer-sponsored coverage. According to the guidance, the Secretary is prepared to grant more flexibility with respect to benefits and cost sharing to state premium assistance initiatives. This may mean that benefits might be limited to whatever benefit package was available under the employer plan, and that the Medicaid and CHIP beneficiaries the state covers through an employer plan would be required to pay the charges imposed by that plan.

#### *HIFA Waiver Rules- Benefits And Cost Sharing For Expansion Groups*

According to the HIFA guidance, the Secretary will grant states virtually unlimited flexibility with respect to benefits and cost sharing when an expansion group is concerned. No benefit standards or cost sharing limitations are established based on the income level or medical needs of the individuals in the expansion group.

- Benefits. “Basic primary care” must be offered. This must include physician services, but otherwise the term is not defined in the guidance.
- Cost Sharing. The HIFA guidance does not set any limits on the premiums, co-payments, and other cost sharing that a state might impose on expansion groups covered through a HIFA waiver.

#### *HIFA Waiver Process*

The HIFA guidance promises states “efficient and priority” reviews of waivers that meet the HIFA guidelines. CMS has attempted to simplify the HIFA waiver application process by providing states a template for applying for HIFA waivers. In the past, waivers proposals have been followed by questions to the state formulated by the Department review team. It is unclear whether this process will be followed with respect to HIFA waivers; such matters will likely be determined on a state-by-state basis.

The template requires the state to certify that it has used a public process to allow for the public to comment on the proposed HIFA demonstration. The guidance does not discuss whether there will be any opportunity for interested parties to provide comments for consideration when the waiver is reviewed at the federal level. To date, CMS has not provided notice of HIFA or other 1115 waivers or waiver amendments when they have been submitted and has not established a public comment period at the federal level.

## Chapter 4

### Issues Raised by the New Waiver Initiatives

The new waiver policy signals the federal government's interest in approving state proposals that could make sweeping changes in the basic federal statutory rules governing Medicaid. These changes could affect current Medicaid beneficiaries as well as newly eligible individuals and alter key elements of Medicaid, including the guarantee of coverage, the scope and affordability of the benefits provided, and the open-ended federal financing arrangement that governs the Medicaid program. This Chapter reviews some of the issues that will need to be addressed in assessing how the new waiver initiatives could affect these key elements of Medicaid, beginning with consideration of waiver authority and the waiver process.

#### 1. What Is The Appropriate Role Of Waivers?

The potential for waivers to result in major changes in coverage for children, families, elderly and disabled individuals raises basic questions about the balance between federal standards and state flexibility and whether waivers are the appropriate mechanism to through which key beneficiary protections adopted by Congress should be revisited. The scope of the changes that could be permitted under HIFA and related waiver policies in combination with a streamlined waiver review process raise important questions about the role of the waivers.

- *To what extent should the waiver process be used to determine which federal standards will apply as a condition of receiving federal Medicaid matching funds?*

The Medicaid program provides states with federal financing in exchange for coverage that meets certain minimum federal standards. States look to the waiver process to afford them more flexibility to design their Medicaid programs, but how should a state's desire for more flexibility be balanced with the interest in assuring that coverage financed in part with federal funds meets certain minimum federal standards? To what extent should minimum federal standards

#### **Washington State Waiver**

(Submitted November 2, 2001)

- Goal is to gain broad authority to make changes to benefits, cost-sharing, and eligibility in its existing Medicaid program
- Waiver proposal does not specify changes to be made; waiver would give the state the authority to determine which changes would be made and when, depending on state fiscal circumstances. However, CMS has sought more specificity.
- If approved, state could impose cost sharing for optional services for all groups (mandatory and optional) and premiums for all groups (mandatory and optional) with incomes above poverty.
- State also could reduce benefits for any optional group consistent with those offered under its state-funded Basic Health program.
- Proposed waiver would allow an enrollment cap for any Medicaid optional group.
- Waiver proposal includes a small coverage expansion to parents of Medicaid/CHIP children, using unspent Title XXI funds. Pre-existing condition exclusions apply.

established by Congress be subject to modification by federal agencies? If federal statutory standards relating to benefits, cost sharing and entitlement no longer guide the operation of the program, what criteria will the Department rely on to assure that waivers “promote the purposes” of Medicaid?

- *How will beneficiaries’ interests be represented and protected in the waiver review and approval process?*

The Secretary has promised states a quick turnaround for waiver reviews, addressing longstanding complaints from states about the length of time it often takes to move a waiver through the the process. But how will prompt action be balanced with a thoughtful and thorough review of waiver proposals, and how will beneficiary interests be represented in closed-door state-federal waiver negotiations? Given the scope of the changes that will come under consideration through the waiver process, will the Department provide public notice and a meaningful opportunity to comment on pending waivers at the federal level?

- *What questions will waivers be seeking to answer and how will waivers be assessed and evaluated?*

Under the law, section 1115 waivers are be used for research and demonstration projects and must have an evaluation element. The HIFA guidance states that the purpose of HIFA demonstrations is to reduce the number of uninsured individuals. To the extent that waivers are granted that expand coverage but also limit benefits, increase cost sharing or cap enrollment, has the demonstration purpose changed? Will demonstration objectives be clearly identified and data relating to those objectives be gathered in a timely fashion? The HIFA guidance requires evaluation and identifies coverage data that states should submit over the course of the waiver to show the progress in lowering the number of uninsured individuals, but will states also monitor the effects of changes on people who are losing benefits or being asked to pay more costs? Will access to care issues be tracked and measured, and, if so, how? How will states evaluate premium assistance and assess the value of the health care they are paying for through employer plans?

## 2. *How Will Waivers Affect Coverage?*

The HIFA guidance anticipates that reductions in coverage that would be authorized through a HIFA waiver would allow states to expand coverage to new populations. Fiscal pressures, however, may make it unlikely that many states will be coupling proposals to reduce costs with coverage expansions. These pressures have already prompted some states to propose new premiums or enrollment fees on very low-income people and to seek the authority to cap enrollment of current beneficiaries as well as newly eligible groups.

- *Will the HIFA policy stimulate new coverage expansions?*

By focusing on expansions in coverage, the guidance underscores the importance of taking action to reduce the number of Americans who lack health care coverage. Are new groups of people likely to get coverage through this initiative? Will additional federal funds be needed for states to extend coverage to currently uninsured groups?

- *Will expansions be required?*

A threshold issue, which is particularly pressing in light of the economic downturn and rising health care costs, is whether the Department will allow states to reduce benefits, impose cost sharing and limit enrollment primarily for the purpose of reducing state Medicaid costs. Will reductions in coverage and higher cost sharing for current beneficiaries be authorized even if no coverage expansion is proposed? Will changes in coverage rules be permitted if a proposed expansion is not certain because it is subject to an enrollment cap or conditioned on the availability of state funding? If waivers allow states new options for reducing their Medicaid costs, might those reductions be preferable to the options available to states without a waiver?

- *Will enrollment caps be permitted, and, if so, how will they affect coverage?*

At the same time that federal waiver policy is promoting expansions in coverage, it is allowing enrollment caps for at least some Medicaid groups. Enrollment caps are contrary to the basic federal requirement that all people who meet the Medicaid eligibility criteria be permitted to participate. Should enrollment caps be allowed when states have other options to reduce the number of people served by Medicaid (i.e., scaling back optional eligibility)? Are enrollment caps preferable to eligibility roll backs? How will the poorest or the sickest beneficiaries be affected if people are enrolled in a first come first serve basis? How will caps affect recent efforts to promote participation among eligible people? Will enrollment caps disrupt provider relationships and continuity of care since a large portion of people tends to move in and out of the program? Will people on waiting lists delay care until enrollment reopens? If so, will caps be effective in reducing program costs over the longer term?

- *How will new premiums or enrollment fees affect participation?*

Will premiums encourage participation because they make the program appear more like private coverage? Or will premiums deter eligible low-income uninsured people from applying for or retaining coverage? How will the impact on participation (positive or negative) be evaluated?

- *Will premiums discourage healthier individuals and families from enrolling?*

Premiums also can affect the composition of enrollees. Sick people are more likely than healthy people to pay premiums – even if the premium causes financial hardship – because their need for coverage is so great. To the extent that premiums deter enrollment among healthier individuals, will premiums result in a disproportionate number of sick and more costly people actually enrolled under the waiver? If so, will this boost the per person cost of coverage above the levels that are built into waiver’s budget neutrality formula and prompt states to make additional, unanticipated cutbacks? How would a shift in enrollment away from healthier individuals affect efforts to promote primary and preventive care?

- *How will premium assistance initiatives affect coverage?*

Will premium assistance (the subsidization of private coverage with Medicaid and CHIP dollars) be a cost effective way to expand coverage because states can take advantage of employer contributions to reduce the cost of coverage? To what extent will premium assistance programs divert limited funds to coverage of individuals who already have insurance? Will it improve continuity of coverage; are low-wage jobs steady sources of employment?

### 3. *How Will the New Waiver Initiatives Affect People’s Ability To Access Care?*

Federal benefit and cost-sharing rules are designed to provide a benefit floor and assure affordable access to care for the diverse populations covered under Medicaid. To encourage coverage expansions, HIFA allows states to reduce benefits below federal standards and to impose cost sharing (e.g., co-payments and deductibles) that exceed allowable levels under the law.

- *What is an appropriate or adequate benefit package for people covered under Medicaid?*

How should low-income and elderly and disabled Medicaid beneficiaries’ need for more comprehensive benefits be balanced against cost? What does it mean to be “insured”? Should any federal minimum benefit standards apply? Are CHIP benchmarks the appropriate standard for optional Medicaid groups?

- *Are some benefits better than no benefits?*

For people without any health care coverage, are very limited benefit expansions better than no expansion? Are bare-bones expansions important to undertake even if no additional federal funds are available and they are financed by reducing coverage for other groups of beneficiaries?

- *Will reductions in coverage shift costs to localities and to safety net providers?*

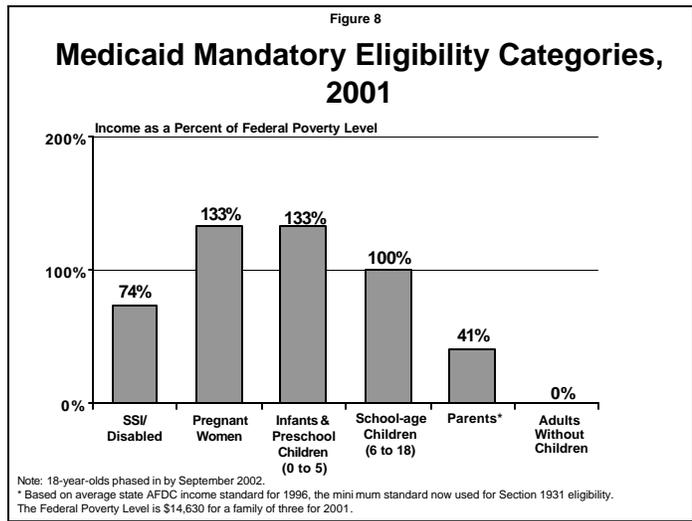
States have sometimes offered broadened benefit packages through Medicaid because local cities or towns had been paying for many of these services with state or local funding. Will reductions in the Medicaid benefit package shift costs back onto these payers? How will safety net providers that offer care regardless of payment be affected by reductions in the scope of Medicaid coverage?

- *Can Medicaid beneficiaries afford to contribute toward the cost of care, and will co-payments and deductibles affect utilization of needed services?*

Cost sharing is frequently used by private plans to reduce the cost of coverage and make health care consumers more cost conscious. At the same time, studies show that even relatively small cost sharing can prevent low-income individuals from receiving necessary care and lead to adverse health

outcomes. In some states, optional and expansion groups include people with incomes substantially above poverty levels, but they also include people with very low incomes. Any person eligible for Medicaid whose income is above the federal mandatory levels is “optional,” and those mandatory levels are generally quite low (Figure 8). In 32 states, for

example, parents with incomes below poverty would be in an optional group, and in 15 states the optional parent group includes parents with incomes below 50 percent of poverty. Can these parents afford even relatively small charges for services? At what income level are premiums and cost sharing affordable? Will cost sharing depress utilization of services that states (and the federal government) are still paying for through capitated managed care payments?



- *What policies and procedures will be needed to ensure that co-payments and deductibles do not have particularly harmful consequences for disabled children and adults and people with chronic illnesses?*

Many Medicaid enrollees are high users of health care services due to their disability or chronic medical conditions. What policies and procedures could effectively protect them from incurring very high and unaffordable out-of-pocket costs? Will the expedited waiver review process include exploration of these issues?

- *Will co-payments or deductibles shift costs onto providers?*

Some states are considering waivers that would impose substantial co-payments for hospital admissions or other services. To what extent and under what circumstances would the burden of higher cost sharing be passed along to hospitals and other health care providers? If providers bear the burden of some cost sharing, will they be able to absorb these added costs? Will cost sharing for primary care prompt some Medicaid beneficiaries to delay more routine care and increase emergency room use?

### **Utah Waiver**

(Approved)

- Goal is to provide primary care coverage to adults who do not qualify for Medicaid (incomes range between 0 - 150% of poverty; some are currently covered under a state-funded medical assistance program).
- Expansion funded through reductions in benefits and new cost sharing for some mandatory and optional groups currently covered (includes parents receiving TANF with incomes below about 50% of poverty, parents who recently left TANF and medically needy adults)
  - Benefit reductions include limits on mental health services, vision, dental and hearing services, and physical therapy.
  - Co-payments/co-insurance include \$100 for inpatient hospital admissions, \$3 for physician visits, \$2 for prescriptions, 5% of cost of laboratory services over \$50, 10% of cost of dental services.
  - \$50 annual enrollment fee for medically needy group
  - \$500 out-of-pocket maximum per person per year.
- Expansion population would receive limited basic health services, with an emphasis on preventive care
  - Benefits limited to routine physician services and pharmacy coverage. No coverage for hospital (other than emergency) care, specialty care, mental health or substance abuse services.
  - Co-payments and co-insurance include \$5 for physician services and generic and approved brand name drugs; 5% coinsurance for lab services over \$50
  - \$50 annual application fee.
  - \$1000 out-of-pocket maximum per person per year.
  - State may cap enrollment

#### 4. How Will Waiver Financing Affect Medicaid And CHIP?

Medicaid waivers move state Medicaid programs away from open-ended federal financing to a capped financing arrangement. Under HIFA policy, the ceilings or caps on the amount of federal matching funds that will be provided will be adjusted based on the number of people covered and projected medical inflation, but they will not be adjusted if costs exceed projections due to higher than anticipated inflation, changes in utilization, technology, or the need to increase provider rates to maintain or improve access to care or the quality of care. In addition, expansions that are not financed with CHIP or DSH funds will need to be financed within the confines of the budget neutrality cap. While per capita caps under waivers are not new, the greater use of waiver authority and the potential for stricter budget neutrality rules than those that have been applied in the past raise a number of important issues for states and beneficiaries.

- *To what extent will waivers shift costs to states?*

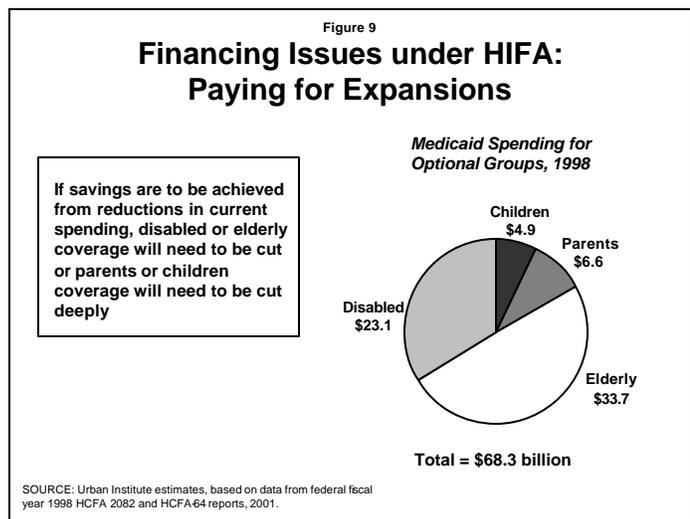
The budget neutrality caps will protect the federal government from experiencing new costs as a result of any expansions but will put states at risk for costs exceeding the agreed-to budget ceilings. Are states prepared to bear the risk of these higher costs?

- *To what extent will waivers prompt further reductions in coverage and services?*

If states find that their actual costs under the waiver grow faster than anticipated under the waiver caps, will states take additional steps (such as reducing or freezing provider payments) over the course of the waiver to keep costs within the budget neutrality ceiling?

- *How will waiver financing affect which groups of people states cover under waivers?*

Waiver financing rules may influence which populations states decide to cover through waivers. Elderly and disabled people are the high users of care and account for more than 80 percent of Medicaid spending for optional groups. But will states be reluctant to cover disabled and elderly people under a waiver because their per person costs can be difficult to accurately project due to changes in



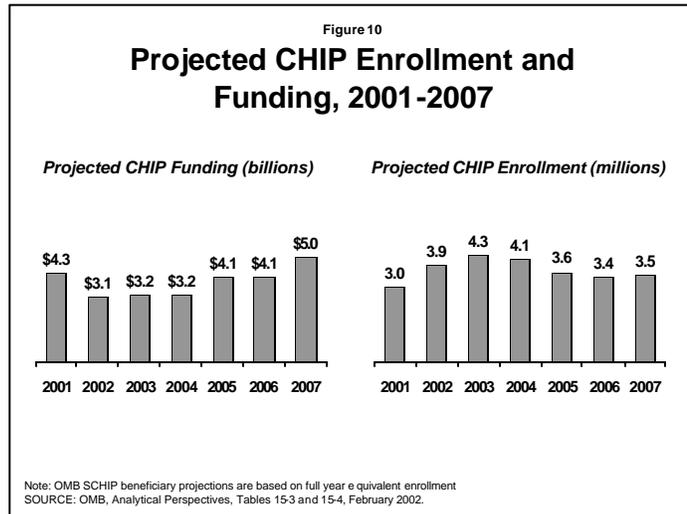
medical practice, technology and other factors? On the other hand, if states limit their spending reductions to children and parents, will they need to make even deeper reductions in coverage in order to reach their savings target? (Figure 9)

- *How will CHIP funding affect the potential for waiver expansions?*

How many states will have “excess” CHIP funds over the next several years? What will happen to an expansion funded with CHIP funds if CHIP enrollment of children rises above projections and “excess” CHIP funds are available for only part of the waiver period? Will unanticipated reductions in coverage be necessary to compensate for the loss of CHIP funding for the expansion group?

- *Will CHIP waivers make it more difficult for some states to maintain coverage for children?*

If states with excess CHIP funds use those funds to cover other populations, including childless adults, will other states lose access to reallocated CHIP funds they need to cover CHIP-eligible children? The Office of Management and Budget projects that CHIP enrollment will decline beginning in 2005 largely as a result of the “CHIP dip.” (Figure 10) Will the projected decline in CHIP enrollment be even deeper (or come sooner) if fewer funds are available for reallocation as a result of CHIP waivers?



### Arizona Waiver

(Approved December 12, 2001)

- Goal is to provide coverage to parents with incomes between 100% and 200% of poverty. Expansion goes into effect October 2002, subject to availability of funds.
- Waiver also refinances existing coverage for childless adults with incomes up to 100% of poverty by allowing state to use CHIP funds (at the enhanced matching rate) to cover this group of Medicaid beneficiaries.
- Waiver does not change benefits or cost sharing rules for any group covered prior to the waiver. Benefits and cost sharing for the newly covered parents will be the same as for children under the state’s CHIP plan.

## **Conclusion**

Medicaid is a program of many faces. It covers healthy children whose families have very limited incomes; newborns, children and adults with severe medical problems; pregnant women with no other source of coverage; and elders who rely on Medicaid for prescription drugs and long term care. Medicaid is also a major player in the health care market, in 1999, accounting for almost half of all nursing home care, more than one third of all maternity care, and 17 percent of all spending on prescription drugs and hospital services. It provides support to major health care institutions in cities, suburbs and rural communities and plays a significant but often hidden role in local economies. Medicaid also has a large impact on state budgets—accounting for 15 percent of state general fund expenditures and 43 percent of the federal grant funds received by states. Changes in Medicaid affect many people and a wide range of interests.

At a time when budget constraints and the rising cost of coverage are emerging as major issues for both the federal government and the states, waiver-based changes in Medicaid rules pose challenges for maintaining Medicaid coverage for its 40 million beneficiaries. Early indications are that the waiver activity ushered in by the HIFA guidance could lead to some significant reductions in Medicaid coverage. Some of these changes in coverage rules could result in new coverage for the uninsured. Regardless of the “pros” or “cons” of any particular set of proposals, an overriding question is whether and to what extent the basic rules governing Medicaid financing, benefits, cost sharing, as well as the entitlement to coverage should be reconsidered and reshaped through the waiver process out of public view and oversight. As the new era of waiver activity unfolds this basic question will be the subject of ongoing debate.

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