

Connecticut
Medicaid Managed Care Council
Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307
www.cga.state.ct.us/ph/medicaid

Summary

Legislative Briefing with CMS on Medicaid Waivers & Cost Sharing

November 19, 2003

Participants:

Legislators: Sen. Toni Harp (Chair - Medicaid Council), Senators Aniskovich, Handley, Murphy, Prague, Roraback, and Representatives Currey, Fleischmann, McCluskey, Metz, Nardello, Orange, Pawelkiewicz, Roy, Ryan, Tercyak, Villano, Walker.

State Agencies: Rose Ciarcia and Dr. Mark Schaefer, Department of Social Services

Centers for Medicare & Medicaid Services (CMS), Boston Regional Office: Irvin Rich and Allen Bryan.

Sen. Harp welcomed the participants, and in particular the Centers of Medicare & Medicaid Services (CMS) representatives, noting that the purpose of the meeting is to provide legislators with information about Medicaid waivers and Medicaid rules related to recipient cost sharing. Sen. Harp stated that several CT waivers are pending CMS action and recent legislation will impact the content of a potential CT Health Insurance Flexibility & Accountability (**HIFA**) 1115 demonstration waiver.

Irvin Rich (CMS) stated that as states experience budgetary difficulties, the CMS encourages states to assess their state/federal programs and work to coordinate these programs through a waiver process, improving the effective use of existing resources. Mr. Rich stated that the finest health services alone would not help people be fully functioning citizens; states need to also consider employment opportunities and other factors.

The following reflects the discussion between CMS and legislators, including answers to questions submitted to Mr. Rich and Mr. Bryan prior to this meeting.

Objectives of Sec. 1115 Demonstration & Research Waivers

Through Sec. 1115 of the Social Security Act, states may “waive” certain existing federal standards and options in initiatives funded by existing federal Medicaid or SCHIP dollars. The **HIFA 1115** waivers provide states flexibility in designing comprehensive health coverage expansions to previously uninsured populations, targeting populations below 200% federal poverty limit (FPL), which could include coordination of private and public health insurance coverage options. Any waiver initiatives are expected to promote the objectives of the Medicaid statutes. In the discussion about various potential waiver components (i.e. co –pays, premiums,

etc) CMS related these to the important waiver goal of meeting the objectives of the Medicaid program (A review of state waivers can be obtained on the CMS web site: www.cms.hhs.gov, under 'state waivers and also the Kaiser Family Foundation site: www.kff.org, a 50 state update on eligibility, enrollment, renewal & cost sharing practices in Medicaid & SCHIP).

States are expected to use unspent dollars to expand health coverage to populations previously uninsured. Mr. Rich stated that Maine is the only state that proposes to use unspent Disproportionate Share Hospital (DSH) funds to finance coverage expansion to childless adults at 125% FPL.

Mr. Rich commented that a recent review of some waivers by the General Accounting Office (GAO) resulted in that federal agency's concern about use of a state's SCHIP dollar allotment for insurance expansions that include childless adults. Given the GAO criticisms, it is uncertain how Health and Human Services Secretary Thompson will respond to new waiver submissions that provide coverage for lower-income childless adults.

Public Process in waiver development and implementation

Mr. Rich distributed the Federal Register that outlines the public process PRIOR to the submission of a waiver proposal. Under Section VII, State Notice Procedures, the federal agency expects the states to include input from those affected by a demonstration project. Additionally "*The State shall include in the demonstration proposal it submits to the Department a statement briefly describing the process that it followed in implementing the process.... The Department may find a proposal incomplete if the process has not been followed*". The CMS stated that if they received letters from stakeholder groups indicating that they had no opportunity to comment and were not consulted in a waiver's development, it would raise serious concerns in CMS regarding approval of that waiver.

While CMS is not prescriptive about public input in the implementation of waivers, the intent is addressed in the document: "*..The Department may require periodic evaluations of how the project is being implemented. The Department will review, and when appropriate investigate, documented complaints that a State is failing to comply with requirements specified in the terms and conditions and implementing waivers of any approved demonstration*". According to Mr. Rich, it is difficult to stop a waiver once implemented, but revisions would be required if serious problems occur. A more rigorous evaluation would be done at the (5-year) waiver renewal period.

CMS Waiver and Medicaid State Plan Amendment Approval Process

Waiver Process: The Boston Regional office reviews CT waiver proposals with a team that includes representatives from the Baltimore office. If the waiver proposal is not flawed (i.e. it conforms with federal law) the Boston office would send the waiver to the Baltimore office for final approval. Mr. Rich stated that the Baltimore office takes into account public input, both

opposing and supporting comments, in reviewing the submitted waiver, as well as any research that has addressed the impact of provisions within the waiver on health care access. There is no specified time period in which CMS must approve or deny a waiver.

· **State Plan Amendments:** The Boston Regional Office reviews and approves CT State Medicaid Plan amendments within 90 days of final submission of the amendment(s) to CMS. The CMS Administrator has the final authority to deny State Plan amendments.

Medicaid Co-pays and Premiums

CT 2003 legislation (PA03-3, PA03-1) requires the DSS to impose premiums and co-payments for Medicaid medically needy individuals and HUSKY A families and children. The CMS was asked to discuss federal rules related to Medicaid cost sharing.

Premiums

Premiums may be applied to those in the *medically needy* category that “spend down” to the medically needy income limit (MNIL) to become eligible for Medicaid coverage. Medicaid eligibility can be denied for failure to pay premiums by medically needy individuals (1916 SSA).

The Code of Federal Regulations (CFR) 447.51 requires that Medicaid agencies do not impose enrollment fees, premiums, and other charges on *categorically needy* individuals. This group typically includes mandatory Medicaid coverage groups (pregnant women & children < 6 years @ 133%FPL, children 6-19 years @ 100%FPL, SSI recipients, individuals/couples living in medical institutions, families who meet the AFDC eligibility requirements in effect July 16, 1996).

Service Co-payments

Medicaid may impose a *nominal* deductible, coinsurance, co-payment or similar charge upon categorically and medically needy individuals for any service under the State plan (CFR 447.53).

· Exclusions from cost sharing include children < 18 years (<21 years, at the option of the State), pregnant women, family planning services and supplies, institutionalized individuals (i.e. hospital, long-term care facility, other medical institutions).

· In order for a state to waive the federal rules on co-pays, a separate co-pay waiver would need to be submitted; this cannot be part of an 1115 waiver. Mr. Rich stated that no state has submitted a co-payment waiver.

· Minimum and maximum income-related charges are defined in CFR 447.52 (see attachment). For example a charge of \$1.00/month can be imposed on a 1-2 person family with a monthly gross income of \$150 or less, a 3-4 person family with \$300 or less/month gross income, 5 or more person family with a \$350 or less/monthly gross income.

· The State is required to submit a State plan amendment on Medicaid (FFS) co-pays, documenting the calculation of the applied co-pay. The CFR 447.54 outlines maximum co-payments related to state payment for the services: \$.50 co-pay for services \$10 or less, \$1 for services \$10.01-\$25 dollars, \$2 co-pay for services \$25.01-\$50 and \$3 co-pay for services >\$50.

· Under CFR 447.53 (e) no provider may deny services to an individual eligible for the services because of inability to pay the cost sharing. Mr. Bryan cautioned that it might appear

that other states have denied services for failure to pay co-pays; however in many cases the denial of services is connected to a waiver (Utah) or may be for administrative services (Delaware). *The CMS will need to review the CT state plan amendment or waiver proposal in order to assess the State's compliance with federal regulations.*

Provision of federally mandated services under a HIFA waiver

CT legislation restructures the HUSKY A (Medicaid) benefits and may lead to the elimination of Early Periodic Screens, Diagnosis and Treatment (EPSDT) services for some children in HUSKY A. Mr. Bryan stated that services identified in 1902 and 1905 of SSA be potentially waived under an 1115 waiver. In order to do this, CT would submit an 1115 HIFA waiver proposal and then request a waiver of EPSDT requirements. Mr. Bryan is not aware of any state 1115 waiver that proposes waiving EPSDT requirements. States can reduce optional services through a State Medicaid Plan Amendment, but cannot reduce mandatory services without a waiver.

Expansion populations under an 1115 HIFA waiver

The 2003 Legislation has language to reduce benefits, impose cost sharing without expanding coverage to those other than in the state-funded State Assistance program (SAGA). Dr. Schaefer (DSS) stated the Department is in the process of preparing a concept paper that will outline coverage expansions and details of the proposed waiver that would be ready in the spring of 2004. The CMS cannot comment until the details of the waiver are reviewed.

Waiver Cost Neutrality

States establish baseline program costs and negotiate the trend lines with CMS in establishing 'cost neutrality' for the waiver; however the state discussions with CMS regarding cost neutrality are not the core of the waiver approval process. States are expected to expand health insurance coverage with existing federal allotments. While there are no additional funds available if a state exceeds the existing federal dollars, CMS works with the state to configure expenditures for future waiver years. The CMS stated they have not received guidance on waivers that may apply, on the state level, a Medicaid 'block grant' approach.

Public/Private Collaborative Health Coverage Initiatives

States with HIFA waivers have included some type of employer subsidy in insuring previously uninsured populations (i.e. Arizona, Colorado, Oregon, Illinois). New Mexico has gone further by developing joint purchasing of health insurance for lower-income individuals with HMO's, employers, the state and federal government with enrollee cost sharing. The CMS does not provide guidelines regarding crowd out provisions (time period the person is without insurance prior to eligibility in the waiver program) although some states have included this provision in their waivers. Currently, CMS would reject employer contribution as part of the state federal match.

CT Pending Waivers

The 1115 Transfer of Asset waiver is still pending at CMS. The Human Service Committee Chairs stated that this waiver did not have the approval of the Human Services Committee (one of the legislative committees of cognizance) and that advocates (i.e.AARP), consumers and the CT Bar Association objected to the waiver proposal. The CMS stated that in order to be responsive to the service needs of a state's population, the agency considers public input as part

of the waiver approval process. Given this CMS policy, legislators were puzzled as to why CMS has not rejected the waiver. Both Mr. Rich and Mr. Bryan noted that there are opposing and supporting views regarding the waiver provisions. The Boston Regional Office sent the waiver proposal to Baltimore because it complied with existing federal law. The reason it has not been acted upon by Baltimore probably reflects the divergent views related to the waiver elements. Mr. Bryan noted that Congress might be contemplating legislation during the next session that changes the penalty period from a retrospective to a prospective eligibility determination period. If that were to occur, CT and other states such as Massachusetts and Minnesota that have pending waivers, would no longer require a waiver for a change in the penalty period determination.

There was discussion about Medicaid determinations for SSI clients. There are State administrative expenses associated with the process and CMS was asked if the \$1600 asset could be eliminated and base Medicaid eligibility on gross income. The CMS stated that:

- An asset test is required for Medicaid eligibility unless an 1115 waiver is approved for this.
- CT is one of 11 states categorized as a 209(b) state, which means that more restrictive Medicaid eligibility criteria is applied for their aged, blind and disabled recipients than is used for SSI eligibility.
- Thirty- two states are categorized as 1634 (a) states, which means the state has a contract with the Social Security Administration to determine Medicaid eligibility at the same time as the determination for SSI benefits.

Mr. Bryan stated that a state could change it's category through a State Plan Amendment; however CT may want to look at states (Massachusetts, Vermont, Rhode Island, Maine) that either are 1634(a) states or converted to the 209(b) category. Costs are incurred with payments to the Social Security Administration for the concurrent Medicaid/SSI eligibility determinations.

Senator Harp thanked the legislators, Irvin Rich and Allen Bryan and the DSS for participating in the meeting. Clearly, the Medicaid program rules are complex and the waiver configuration is equally so. Senator Harp expressed her appreciation for the CMS representatives' clarification of the waiver process and looks forward to a future opportunity to further discuss questions as they arise when the Department of Social Services releases details of the proposed HIFA waiver.

Code of Federal Regulations: Public Health CFR 42, Subpart A-Payments: General Provisions

447.52 Minimum and maximum income-related charges.

For the purpose of relating the amount of an enrollment fee, premium, or similar charge to total gross family income, as required under § 447.51(d), the following rules apply:

(a) *Minimum charge.* A charge of at least \$1.00 per month is imposed on each --

- (1) One- or two-person family with monthly gross income of \$150 or less;
- (2) Three- or four-person family with monthly gross income of \$300 or less; and
- (3) Five- or more-person family with monthly gross income of \$350 or less.

(b) *Maximum charge.* Any charge related to gross family income that is above the minimum listed in paragraph (a) of this section may not exceed the standards shown in the following table:

Maximum Monthly Charge

		Family size		
		1 or 2	3 or 4	5
Gross family income (per month)				
<i>or more</i>				
\$150 or less.....	\$ 1	\$1	\$1	
\$151 or \$200.....	2	1	1	
\$201 to \$250.....	3	1	1	
\$251 to \$300.....	4	1	1	
\$301 to \$350.....	5	2	1	
\$351 to \$400.....	6	3	2	
\$401 to \$450.....	7	4	3	
\$451 to \$500.....	8	5	4	
\$501 to \$550.....	9	6	5	

\$551 to \$600.....	10	7	6
\$601 to \$650.....	11	8	7
\$651 to \$700.....	12	9	8
\$701 to \$750.....	13	10	9
\$751 to \$800.....	14	11	10
\$801 to \$850.....	15	12	11
\$851 to \$900.....	16	13	12
\$901 to \$950.....	17	14	13
\$951 to \$1,000.....	18	15	14
More than \$1,000.....	19	16	15

447.54 Maximum allowable charges.

(a) *Non-institutional services.* Except as specified in paragraph (b), for non-institutional services, the plan must provide that --

- (1) Any deductible it imposes does not exceed \$2.00 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is \$6.00;
- (2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and
- (3) Any co-payments it imposes do not exceed the amounts shown in the following table:

	Maximum
	copayment
States payment for the service	chargeable
recipient	to

\$10 or less.....	\$.50
-------------------	-------

\$10.01 to \$25.....	1.00
\$25.01 to \$50.....	2.00
\$50.01 or more.....	3.00

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983]