

Connecticut Medicaid Managed Care Council

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Overview of Medicaid Waivers

Federal law requirements and options determine States' administration of their Medicaid and State Children's' Health Insurance Program (SCHIP) programs. The law gives the Secretary of Health & Humans Services (HHS) the authority to establish waivers that allow states to use federal Medicaid or SCHIP dollars in ways that do not conform to existing federal standards and options. The Centers for Medicare & Medicaid Services (CMS) approves the waivers enabling states to chose how the State organizes care for Medicaid/SCHIP recipients within various coverage models, expands eligibility beyond existing Medicaid eligible beneficiaries or develop research projects that have policy merit.

Connecticut currently operates the HUSKY A (Title XIX) program under a 1915(b) waiver. HUSKY B (Title XXI) is defined within the State SCHIP Plan. This SCHIP program is a non-entitlement program that has a covered benefit package based on modifications of the State Employee Health Plan.

Almost all states have recently had serious fiscal downturns. This has led some states to seek to reduce state spending through restructuring their Medicaid & SCHIP programs under the broad 1115 waiver authority. Additionally, recent Congressional actions have:

- Increased States' federal match percentages for a year beginning April 2003. Connecticut now receives a 52.95% Medicaid match compared to the 50% FMAP.
- Allowed some states, including Connecticut, to allocate 20% of their unspent SCHIP capped allotments for services provided to children >150% federal poverty level (FPL).

In an effort to achieve a balance budget, Connecticut's 2003 legislation (SB 2001) mandates the Department of Social Services reorganize aspects of the delivery service model for HUSKY A and HUSKY B:

- The Medicaid mandates, which will require a 1115 Research and Demonstration waiver, include adding new or increased cost sharing (i.e. premiums/co-pays) for children and families with income at or above 50% FPL, changing the managed care benefits to one similar to the State Employee plan, and denying prescriptions to those adults that have failed to pay their pharmacy co-pays for 6 months.
- Mandated changes to HUSKY B, which would be done through an amendment to the State SCHIP Plan, include adding premiums to band 1 recipients (185-235% FPL) and converting the benefit structure to one similar to the State's largest HMO benefit plan.

This brief overview of the waivers pertinent to the Medicaid & HUSKY programs is based on the CMS waiver fact sheets. More information can be obtained from the CMS web site: <http://www.cms.gov/>, click on state waivers under the topics section of the home page.

1915(b) Freedom of Choice Waivers

- The waiver provides the Secretary of Health & Human Services the authority to waive certain requirements of section 1902 of the Social Security Act that relate to the provision of care and services to Medicaid eligible beneficiaries. Under this waiver, states can mandate beneficiary enrollment in managed care, create specialty care carve-out service delivery systems, or provide enhanced services through savings from managed care. This waiver authority cannot be used for eligibility expansions.

1115 Waiver Research & Demonstration Projects

Section 1115 of the Social Security Act provides the Secretary of Health & Human Services with broad authority to authorize experimental projects that would promote the objectives of the Medicaid statute. The 1115 Waiver allows states the flexibility to design a specific research/demonstration project that tests new ideas that have policy merit that may include:

- Expanded eligibility for those currently not eligible for the Medicaid program,
- Expanded service provisions that are not otherwise matched by federal dollars.
- Health care reform that would allow states to expand managed care models.

The 1115 Waiver projects, usually approved for a five-year period, do not require a broad statewide application. States must demonstrate budget neutrality for the duration of the project time period.

Health Insurance Flexibility & Accountability (HIFA) 1115 Demonstration Initiative

The HIFA demonstration initiative is a form of the section 1115 waiver. The HHS has recently been promoting this type of waiver to encourage states to create comprehensive health coverage expansions that target populations below 200 percent of the federal poverty level (FPL) without using additional federal resources. These broad statewide initiatives provide states with programmatic flexibility in exchange for demonstrating increased health coverage within existing federal resources.

Potential State Financing Avenues

According to the Kaiser Commission April 2003 report, these program expansions could be financed within existing federal allotments by:

- Restructuring coverage in a way to reduce state spending. This can include enrollment caps, increased cost sharing through co-pays & premiums, covered benefit reductions.
- Refinance existing Medicaid –covered populations through the use of SCHIP dollars. States' SCHIP allotments are capped but associated with a higher federal match than the Medicaid match (i.e. Connecticut's Medicaid match is 52.95% V. 65% SCHIP match). States are also allowed to redirect unspent DSH dollars to expand eligibility groups.
- Use of SCHIP dollars for populations other than children (i.e. adults with/without children).

CMS Guidance to States

The CMS provides states with guidance for program proposals and budget parameters. General guidelines include:

- Statewide initiatives allow states to coordinate private and public health insurance coverage options for the low income uninsured. States are strongly encouraged to develop initiatives that subsidize the purchase of private health insurance coverage:
 - Mandatory Medicaid populations would continue to receive the benefit package specified in the State Medicaid Plan.
 - Optional and expansion populations (see below) may be included in private group health plan premium assistance programs that have higher individual cost sharing and more limited benefit packages compared to a state's Medicaid State Plan.
 - Medicaid/SCHIP expenditures are not to supplant employer contributions to their employees' health coverage, nor replace coverage currently purchased by individuals. States should closely monitor changes in these areas.
- States may increase cost sharing and reduce the scope of benefit packages for some beneficiaries in order to fund expanded coverage for uninsured populations within existing Medicaid & SCHIP funding.
- The guidance defines eligibility groups:
 - Mandatory populations, those individuals the State must cover under Medicaid, including pregnant women, & children under age 6 years with incomes at or below 133%FPL, children ages 6-18 with incomes at or below 100%FPL and parents or caregivers with incomes at or below 77%FPL.
 - Optional populations are those children and parents above the minimum that the state does not have to cover but may cover under the waiver authority.
 - Expansion populations refer to individuals who could not be included in Title XIX (Medicaid) or XXI (SCHIP) coverage groups but can be covered under the section 1115 waiver authority (i.e. childless non-disabled adults under Medicaid).
- While states retain flexibility in deciding their Medicaid & SCHIP levels, states must continue to cover *mandatory* populations as specified in Title XIX. States may provide one of the benefit packages identified in Title XXI to optional/expansion populations and SCHIP eligible children that may be covered under the state plan:
 - A benefit package that is offered by an HMO that has the largest commercial, non-Medicaid enrollment in the State.
 - The standard Blue Cross/Blue shield preferred provider option benefit plan offered to Federal employees.
 - A health benefit plan that is offered and available to State employees.
 - A benefit package that is actuarially equivalent to one of the above plans.
- States have some flexibility in designing benefit packages and cost sharing parameters:
 - States are required to continue to provide the benefit package specified in their Medicaid State plan to mandatory populations. Cost sharing for this group is limited to 'nominal amounts' defined in Medicaid regulations.
 - The benefit package for optional populations should include basic services such as inpatient/outpatient hospital services, physicians' surgical/medical services, lab

& x-ray services, and well-baby & well-child care including age-appropriate immunizations.

- The benefit package for expansion populations must include a basic primary care package (services provided through a general practitioner, family practice, internal medicine, OB/GYN, pediatric practitioner). States have flexibility to establish limits on types of providers and types of services.
- States have flexibility in defining cost sharing for optional & expansion populations. However for recipients in the optional children group eligible for Medicaid or SCHIP, cost sharing should not exceed **5%** of the family income. Family premiums for an entire family covered in the plan need not adhere to this guideline; however the 5% limit does apply to cost sharing attributable to children in the family.

The Kaiser Family Foundation report (June 2003) on Section 1115 Medicaid & SCHIP Waivers; Policy Implications outline key issues raised by states' recent waiver activity:

- ✓ Enrollment caps for *existing* Medicaid beneficiaries may result in the elimination of an individual's entitlement to coverage & possible denials of or delays in coverage for eligibles.
- ✓ Benefit reductions, new or increased cost sharing for current recipients may reduce access for some existing recipients; potential increase in uncompensated care.
- ✓ While limited benefit packages and significant cost sharing for new beneficiaries will create new coverage, potential access barriers may arise.
- ✓ Use of Medicaid/SCHIP funds for premium assistance that does not meet federal minimum standard nor include supplemental coverage may provide greater access to providers previously not participating in Medicaid/SCHIP, but this gain in recipient access may be offset by barriers related to limited benefits, coverage restrictions and cost sharing.
- ✓ Covering adults without dependent children through SCHIP dollars will expand coverage to uninsured individuals but may reduce future children's coverage since SCHIP state allotments are capped.
- ✓ Creating different benefit and cost sharing groups will increase administrative complexity (and cost) and possible confusion among providers and recipients may decrease participation by these stakeholders in the newly designed delivery service model.

Within the context of SB 2001, Connecticut may consider the following as the State contemplates the implementation of the legislative mandates and any waiver process:

- What are the objectives and financial model for the proposed waiver?
- Who will be included in the expanded coverage group? Are there any safeguards for these 'new' populations in the event of ongoing or new budgetary shortfalls that might result in only partial expansions?
- What are the caveats for the 'expanded group' coverage (i.e. New Mexico's expansion primarily affects those adults @ <200% FPL that have *employers* who would pay a share of the required premiums)?

- How will any coverage group expansion costs be offset by benefit reductions/increased cost sharing?
- Regarding the benefit package changes:
 - How would EPSDT medical necessity services change in the SEHP-like program that may cover Medicaid optional children?
 - For those children with special needs in the HUSKY A ‘optional populations’ and in HUSKY B, will there be safeguards and access to wraparound Medicaid services such as the existing HUSKY PLUS?
 - Since co-pays target the provider community & their financial solvency, does the State anticipate increased barriers to provider participation and recipient access to care?
 - As we consider the effect of HUSKY B band 3 premiums on recipient disenrollments, what is the anticipated impact of more frequent enrollment/disenrollments due to the failure of low-income recipients to pay monthly premiums on health providers, access to and quality of care in the Medicaid/SCHIPS programs?
- There will be a significant administrative impact on the central & regional DSS offices and MCOs with the creation of even more coverage groups:
 - How will DSS manage information dissemination & program monitoring within their existing staff and administrative financial limitations?
 - What is the anticipated financial and operational effect of a significantly less stable enrolled population on MCO administrative and quality procedures? Will this have impact on the services for the remaining Medicaid ‘mandatory’ populations?

Sources for this overview and further information:

- Centers for Medicare & Medicaid Services (CMS): <http://www.cms.gov/>, click on ‘state waivers’ under the topics section.
- Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/>, click on ‘Medicaid’, Section 1115 Waivers at a Glance.
- CT budget summaries: www.cga.state.ct.us/ofa; www.cga.state.ct.us/olr