Medicaid Demonstration Projects and Waivers[i]

Introduction:

The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements.

Section 1115 Research & Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

Section 1915(b) Managed Care/Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

Section 1915(c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

Section 1115 Research & Demonstration Projects:

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

There are two types of Medicaid authority that may be requested under Section 1115:

- Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
- Section 1115(a)(2) – allows the Secretary to provide Federal financial participation for costs that otherwise cannot be matched under Section 1903.

Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

Application Process

There is no standardized format to apply for a Section 1115 demonstration, but the application must be submitted by the single state Medicaid agency. States often work collaboratively with CMS from the concept phase to further develop the proposal. A demonstration proposal typically discusses the environment, administration, eligibility, coverage and benefits, delivery system,

access, quality, financing issues, systems support, implementation time frames, and evaluation and reporting.

Proposals are subject to the Centers for Medicare & Medicaid Services (CMS), Office of Management and Budget (OMB), and Department of Health and Human Services (HHS) approval, and may be subject to additional requirements such as site visits before implementation. CMS does not have a specific timeframe to approve, deny, or request additional information on the proposal. Additionally, CMS usually develops terms and conditions that outline the operation of the demonstration project when it is approved.

1915(b) Waivers:

States may request Section 1915(b) waiver authority to operate programs that impact the delivery system of some or all of the individuals eligible for Medicaid in a state by

- mandatory enrollment of beneficiaries into managed care programs (although states have the option, through the Balanced Budget Act of 1997 to enroll certain beneficiaries into mandatory managed care via a State Plan Amendment), or
- creating a "carve out" delivery system for specialty care, such as behavioral health care.

Section 1915(b) waiver programs do not have to be operated statewide. They may not be used to expand eligibility to individuals not eligible under the approved Medicaid state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan.

To implement these programs, the Secretary may waive certain Medicaid requirements (statewide, comparability of services, and freedom of choice of provider.) There are four types of authorities under Section 1915(b) that states may request:

- (b)(1) mandates Medicaid Enrollment into managed care
- (b)(2) utilize a "central broker"
- (b)(3) uses cost savings to provide additional services
- (b)(4) limits number of providers for services

PROGRAM REQUIREMENTS:
A Section 1915(b) waiver program cannot negatively impact beneficiary access, quality of care of services, and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver). Section 1915(b) waivers do not carry the evaluation requirements necessary for Section 1115 waivers, but an independent assessment is due for the first two waiver periods. More information is available about this requirement in the Independent Assessment Guidelines, published by the Centers for Medicare & Medicaid Services (CMS) in 1998 that may be downloaded below.

APPLICATION PROCESS
The application must be submitted to CMS by the Single State Medicaid Agency for review. Upon receiving the application, CMS has 90 days to approve, disapprove, or request additional information on the proposal. If CMS does not act within 90 days, the application is deemed approved. Section 1915(b) waiver programs are approved for 2-year periods, and states may submit renewal applications to continue these programs ongoing.

Home and Community-Based Services (HCBS) Waivers Section 1915 (c):

States may offer a variety of services to consumers under an HCBS waiver program and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, environmental modifications). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general spouses and parents of minor children cannot be paid providers of waiver services.

States have the discretion to choose the number of consumers to serve in a HCBS waiver program. Once approved by CMS, a state is held to the number of persons estimated in its application but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment to CMS for approval.

APPLICATION & APPROVAL PROCESS

The State Medicaid agency must submit to CMS for review and approval an application for an HCBS waiver, and the State Medicaid Agency has the ultimate responsibility for an HCBS waiver program, although it may delegate the day-to-day operation of the program to another entity. Initial HCBS waivers are approved for a three-year period, and waivers are renewed for five-year intervals.

PROVISIONS WAIVED

Section 1902(a)(1), regarding statewideness. This allows states to target waivers to particular areas of the state where the need is greatest, or perhaps where certain types of providers are available.

Section 1902(a)(10)(B), regarding comparability of services. This allows states to make waiver services available to people at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups, such as elderly individuals, technology-dependent children, or persons with mental retardation or developmental disabilities. States may also target services on the basis of disease or condition, such as Acquired Immune Deficiency Syndrome.

Section 1902(a)(10)(C)(i)(III), regarding income and resource rules applicable in the community. This allows states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States may also use spousal impoverishment rules to determine financial eligibility for waiver services.

PROGRAM REQUIREMENTS

Within the parameters of broad Federal guidelines, States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement an HCBS waiver program include:

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care.

OLMSTEAD & HCBS WAIVERS

In the 1999 Olmstead v. L.C. decision, the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Olmstead v. L.C. decision interpreted Title II of the American with Disabilities Act (ADA) and its implementing regulations. Medicaid can be an important resource to assist states in fulfilling their obligations under ADA. The HCBS waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients.

CURRENT STATUS
Forty-nine States and the District of Columbia offer services through HCBS waivers, and Arizona operate a similar program under section 1115 research and demonstration authority. There is no federal requirement limiting the number of HCBS waiver programs a state may operate at any given time, and there are currently approximately 290 active HCBS waiver programs in operation throughout the country.

Combined 1915 (b)/(c) Waivers:

States may opt to simultaneously utilized section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. In essence, states use the 1915(b) authority to limit freedom of choice, and 1915(c) authority to target eligibility for the program and provide home and community-based services. By doing this, states can provide long-term care services in a managed care environment or use a limited pool of providers.

In addition to providing traditional long-term care state plan services (such as home health, personal care, and institutional services,) states may propose to include non-traditional home and community-based "1915(c)-like" services (such as homemaker services, adult day health services, and respite care) in their managed care programs.

States can implement 1915(b) and 1915(c) concurrent waivers **as long as all Federal requirements for both programs are met**. Therefore, when submitting application for concurrent 1915(b)/(c) programs, states must submit a separate application for each waiver type and satisfy all of the applicable requirements. For example, states must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver. States must also comply with the separate reporting requirements for each waiver. Because the waivers are approved for different time periods, renewal requests must be prepared separately and submitted at different points in time. Meeting these separate requirements can be a potential barrier for states that are considering going forward with such a program. However, the ability to develop an innovative managed care program that integrates home and community-based services with traditional state plan services is appealing enough to some states to outweigh the potential barriers.

Current State Initiatives
The Texas STAR+PLUS program, approved in January 1998, was the first concurrent 1915(b)/(c) program to be implemented. This mandatory program serves disabled and elderly beneficiaries in Harris County (Houston) and integrates acute and long-term care services through a managed care delivery system, consisting of three managed care organizations (MCOs) and a primary care case management system (PCCM.) The majority of STAR+PLUS enrollees are dually eligible for Medicaid and Medicare. Although STAR+PLUS does not restrict Medicare freedom of choice, an enhanced drug benefit is provided as an incentive to dual eligibles that elect to enroll in the same MCO for their Medicaid and Medicare services. Care coordination is an essential component of the STAR+PLUS model.

Michigan's Medicaid Prepaid Specialty Mental Health and Substance Abuse Services and Combination 1915(b)/(c) Medicaid Prepaid Specialty Services and Supports for Persons with Developmental Disabilities program were approved in June 1998. Unlike the STAR+PLUS program, which integrates acute and long-term care, Michigan's program "carves out" specialty mental health, substance abuse, and developmental disabilities services and supports and provides these services under a prepaid shared risk arrangement. The purpose of this program is to provide beneficiaries an opportunity to experience "person-centered" assessment and planning approaches that provide a wider, more flexible, and mutually negotiated set of supports and services, thus enabling such individuals to exercise and experience greater choice and control.

Katrina Waiver Summary Information:

The demonstration waivers and expenditure authorities designated as 1115 Katrina Waivers and accompanying state specific Special Terms and Conditions will assist each state in providing Medicaid and SCHIP coverage for evacuees who have been displaced as a result of Hurricane Katrina. Additionally, these demonstrations allow the establishment of expedited Medicaid/SCHIP eligibility for new applicants in the time of a natural disaster who would now meet certain income eligibility standards as described in the simplified eligibility chart. A period of eligibility for up to 5 months is provided for these eligibility groups, which are designated as evacuees under these demonstrations.

The demonstration populations consist of evacuees. “Evacuee” refers to an individual who is a resident of the emergency area affected by a national disaster as declared by the President of the United States pursuant to the National Emergencies Act or by the Robert T. Stafford Disaster Relief and Emergency Assistance Act, and has been displaced from or within his or her home State, and is not a non-qualified alien.

Under these demonstrations, each state will provide services through its programs to evacuees who fit into the demonstration population consisting of parents, pregnant women, children under age 19, individuals with disabilities, low-income Medicare recipient, and low-income individuals in need of long-term care with incomes up to and including the levels listed on the simplified eligibility chart.

[i] All of the information contained in this documents was copied from the CMS website at http://www.cms.hhs.gov/pf/printpage.asp?ref=http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp#.