Waivers and State Plan Amendments

What is Medicaid?

- Joint Federal-State Partnership
- Established by the Social Security Act of 1965

"Traditional" Medicaid

- Non-Disabled Adults
  - non-elderly low-income parents
  - other caretaker relatives, pregnant women
  - and other non-disabled adults
  - parents/caretaker relatives who are in mandatory eligibility groups and optional eligibility groups
- Pregnant Women
- Individuals with Disabilities
- Seniors &Medicare and Medicaid Enrollees

Medicaid Expansion

- As part of the ACA, the option was given to the states to expand Medicaid to single adults

States Can Propose Changes to Medicaid Program

- Must be done through Centers for Medicare and Medicaid Services (CMS), a division of the federal Department of Health and Human Services (HHS)
- Two methods for “reform”
  - Waivers
  - State Plan Amendments

What is a State Plan Amendment?

- Agreement between a state and the Federal government
- Describes how that state administers its Medicaid and CHIP programs
- an assurance that a state will abide by Federal rules
- may claim Federal matching funds for its program activities

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What can a SPA change?

- Eligibility
- Benefits
- Services
- Provider payments

Process for a SPA

- Approved by CMS in 180 days or less
- Once CMS receives a SPA, it has 90 days to approve or deny the change
  - Or ask the state for more information.
  - A request from CMS for more information stops the 90-day clock.
- New 90-day clock begins
- once approved it becomes a permanent
- part of a Medicaid state plan unless changed by a future SPA.

More on SPAs

- SPA reform has no time limit
- once approved it becomes a permanent Part of a Medicaid state plan unless changed by a future SPA.

What's in it?

- groups of individuals to be covered
- services to be provided
- methodologies for providers to be reimbursed
- and the administrative activities that are underway in the state.

Thinking of a change?

- When a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) for review and approval

Why submit a SPA?

- To request permissible program changes
- Make corrections
- Update their Medicaid or CHIP state plan with new information

Waivers

- 1115 – Research and Demonstration Projects
- 1915(b) – Managed Care Waiver
- 1915 (c) – Home and Community Based Services Waiver

Waiver Process

- Undefined Timeline
- Three to Five-year period
- Renewable, typically for an additional three years
- Can cover everyone in a state or a specific group or region
- Demonstrations must be "budget neutral" to the Federal government
- Process must allow for Public Input

Waivers

- Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Section 1915(b) Managed Care Waivers

- States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

Types of 1915(b) Waivers

- [1915(b)(1)] - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- [1915(b)(2)] - Allow a county or local government to act as a choice counselor or enrollment broker) in order to help people pick a managed care plan
- [1915(b)(3)] - Use the savings that the state gets from a managed care delivery system to provide additional services
- [1915(b)(4)] - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation)

CMS Streamlining of Application Process

- CMS has begun the process of "modularizing" its current 1915(b) waiver application to separate the various statutory authorities.
- A streamlined application for States to selectively contract with providers under their fee-for-service delivery system

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

- States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- States can provide traditional long-term care benefits
- Non-traditional home and community-based "1915(c)-like" services
- Using a managed care delivery system, rather than fee-for-service.

Current 1115 Waiver – Bridge to Health Care Reform

- Strengthen California's health care safety net
- Maximize opportunities to reduce the number of uninsured individuals
- Optimize opportunities to increase federal financial participation and maximize financial resources
- to address uncompensated care
- Promote long-term, efficient, and effective use of state and local funds
- Improve health care quality and outcomes
- Promote home-and community-based care

Four Initiatives of "Bridge to Healthcare Reform"

- Phase in coverage in individual counties for adults aged 19-64 with incomes up to 200% of the Federal poverty level through the Low Income Health Program (LIHP)
- Improve care coordination for vulnerable populations by mandatorily enrolling Seniors and Persons with Disabilities (SPDs) into Medi-Cal Managed Care
- Pilot coordinated systems of care through California Children's Services (CCS) Demonstrations
- Supports the ability of California's public hospitals to enhance quality of care through payment incentives through the Delivery System Reform Incentive Pool (DSRIP) Program for projects that support infrastructure development, innovation and redesign of the delivery system, population-focused improvements, and urgent improvement in care.

Amendments to the "Bridge to Healthcare Reform"

- CCI Duals Amendment
- Medi-Cal Managed Care Rural County Expansion Amendment
- Healthy Families Program Transition Amendment
- Non-Designated Public Hospitals (NDPHs) Safety Net Care Pool (SNCP) Uncompensated Care and Delivery System Reform Incentive Pool (DSRIP)
- HCCI Reallocation of Unspent DY 8 Funds Amendment
- DSRIP Category 5 – HIV Transition Projects / HCCI Reallocation of unspent DY 7 Funds
- 2014 Optional Expansion/ Mental Health Integration/ IHS Uncompensated Care Amendment
- IHS Facilities and Tribal Facilities Uncompensated Care Claiming Amendment
- CBAS Amendment

Next 1115 Waiver Proposal by DHCS

- Federal/State shared savings initiative
- Payment/Delivery Reform Incentive Payment Programs
- Safety net payment reforms that support coordinated and cost effective care for the remaining uninsured
- FQHC Payment/Delivery Reform
- Successor Delivery System Reform Incentive Payment program
- California Children's Services (CCS) Program Improvements
- Medicaid funded Shelter for Vulnerable Populations
- Workforce Development

Summary

COMPARING PATIENT-CENTERED MEDICAID REFORM OPTIONS

	Waiver	State Plan Amendment
Approval Process	Undefined	180 days or less
Duration of Reform	3-5 years, with optional extension	Permanent
Reporting Requirements	Federal reports required every quarter during the life of the waiver	No federal reporting requirement; state decides what and how to measure
Populations Covered	Can cover everyone in the state	Must exclude special-needs children, dual-eligibles, and Indian tribes, but may auto-enroll them into the reform with an opt-out provision

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