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Medicaid and SCHIP Section 1115 Research and Demonstration Waivers

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Summary

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to conduct research and demonstration projects under several programs authorized by the Social Security Act. Two such programs are Medicaid and the State Children's Health Insurance Program (SCHIP).

Unlike many federal programs that operate demonstration waivers under tightly prescribed rules, Section 1115 gives the Secretary broad authority to modify virtually all aspects of programs without congressional review. Under this authority, states may test major restructuring of their Medicaid and SCHIP programs by experimenting with different approaches for the delivery of health care services, or adapting their programs to the special needs of particular geographic areas or groups of recipients.

On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Initiative. Using Section 1115 waiver authority, this initiative is designed to encourage states to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target population with incomes below 200% of the federal poverty line (FPL).

Background

Medicaid, authorized under Title XIX of the Social Security Act, is a joint federal-state entitlement program that pays for medical assistance primarily for low-income persons who are aged, blind, disabled, members of families with dependent children, as well as certain other pregnant women and children. The Balanced Budget Act of 1997 established SCHIP under a new Title XXI of the Social Security Act. SCHIP is intended to provide health insurance coverage to "targeted" low-income children — those whose family income exceeds Medicaid eligibility thresholds and who do not have private health insurance coverage. States may choose from three options when designing their SCHIP programs. They may expand their current Medicaid program, create a new, separate state

insurance program, or devise a combination of both approaches. Medicaid and SCHIP are administered by the states under broad federal guidelines.

Section 1115 Waiver Authority

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to conduct research and demonstration projects under several programs authorized by the Social Security Act. Two of these programs are Medicaid and SCHIP. Section 1115 also authorizes the Secretary to waive certain statutory requirements for conducting these projects. For this reason, the research and demonstration projects are often referred to as Section 1115 "waiver" projects. Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902 (usually, freedom of choice of provider, comparability of services, and state-wide access).[1] For SCHIP, no specific sections or requirements are cited as "waiveable." Section 2107(e)(2)(A) of the Social Security Act states that Section 1115 of the Act, pertaining to research and demonstration waivers, applies to SCHIP.

Unlike many federal programs that must operate demonstration waivers within a tightly prescribed set of rules, Section 1115 gives the Secretary broad authority to modify virtually all aspects of programs without prior congressional review. Under this authority, states have the flexibility to test a major restructuring of their Medicaid and SCHIP programs by experimenting with different approaches for the delivery of health care services, or adapting their programs to the special needs of particular geographic areas or groups of recipients.

On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Initiative. Using Section 1115 waiver authority, this initiative is designed to encourage states to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target population with incomes below 200% of the federal poverty line (FPL).

In the Medicaid program, Section 1115 waivers are often used to allow states to cover non-Medicaid services, offer different service packages in different parts of the state, test new reimbursement methods, change eligibility criteria in order to offer coverage to new or expanded groups, or to contract with a greater variety of managed care plans. As of January 16, 2004, the CMS had approved 19 Medicaid comprehensive state reform waivers.[2] In addition, six Medicaid waivers had been approved under the HIFA initiative. Five of the six HIFA approvals (Illinois, New Jersey, New Mexico, New York, and Oregon) were Medicaid/SCHIP combined waivers. A combined HIFA waiver

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[1] Freedom of choice refers to a requirement that Medicaid beneficiaries have the freedom to choose a provider. Comparability refers to a requirement that services be comparable in amount, duration, and scope for persons in particular eligibility groups. A waiver of the statewideness requirement allows states to provide services in only a portion of the state, rather than in all geographic jurisdictions.

[2] CMS's website, [http://www.cms.gov/medicaid/1115/statesum.pdf], lists comprehensive state health reform demonstration waivers and shows their approval and implementation status.

generally means that the state will finance changes to its Medicaid program using SCHIP funds.

In 1994, the Secretary issued a public notice,[3] describing the principles under which HHS would evaluate and approve (or disapprove) applications for Section 1115 waivers, and the procedures states were expected to follow for public involvement in the development of the demonstration project. In this notice the Secretary described a budget neutrality requirement for Section 1115 waivers, general requirements for waiver evaluations by states, and other policies and procedures. The budget neutrality requirement means that estimates of spending under the waiver can not exceed amounts that would otherwise have been spent under the program without the waiver. For both the Medicaid and SCHIP programs, Section 1115 waivers are typically authorized for a period of up to five years.[4] CMS is responsible for evaluations and reporting requirements associated with the waiver programs for the protection of recipients as well as program integrity.

At the start of the SCHIP program, the Secretary released guidance stating that CMS would not entertain Section 1115 waiver applications for SCHIP until states had a chance to get their programs up and running. On July 31, 2000, the Secretary sent a letter to state health officials outlining the circumstances under which the Secretary would grant a Section 1115 waiver under SCHIP.[5] The first SCHIP waivers were approved in January of 2001. As of January 16, 2004, CMS had approved 14 SCHIP waivers. Three of the 14 are SCHIP-only, HIFA waivers, and (as listed above) five of the 14 are Medicaid/SCHIP combined waivers.[6] Most of the states with approved SCHIP waivers will extend coverage to include one or more categories of adults, typically parents of Medicaid /SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. Four states, (Arizona, Illinois, New Mexico and Oregon) have approval to use SCHIP funds to cover childless adults under their HIFA demonstrations.[7] Michigan's SCHIP Section 1115 waiver also allows for such coverage.

Medicaid Provisions on Demonstration Waivers

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, other provisions in Medicaid specify limitations or restrictions on how a state may operate a waiver program. Some of these additional waiver-related provisions are:

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[3] Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures, 59 *Federal Register* 49249, Sept. 27, 1994.

[4] Guidance on Section 1115 waivers at [http://www.cms.hhs.gov/medicaid/1115/default.asp].

[5] Health Care Financing Administration, *Letter to State Health Officials*, July 31, 2000.

[6] CMS's website, [http://www.cms.hhs.gov/medicaid/1115/statesum.pdf], lists comprehensive state health reform demonstration waivers and shows their approval and implementation status.

[7] Letter to Senators Grassley and Baucus, U.S. General Accounting Office, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals,* Jan. 5, 2004, and project descriptions as listed on CMS' website at http://www.cms.gov/schip/1115waiv.pdf.

- *Services for Pregnant Women and Children*: Section 1902(l)(4)(A) requires that states with Section 1115 waivers provide medical assistance for the mandatory poverty-related groups of pregnant women and children.[8] States may *not* establish waivers that fail to provide all of mandatory services or that drop coverage to these groups.
- *Co-payment and Other Cost Sharing Requirements:* Section 1916 describes circumstances under which cost-sharing charges (premiums, coinsurance, deductibles) may be imposed on Medicaid enrollees. This section prohibits cost-sharing for certain enrollees and allows only nominal amounts for others. Section 1916(f) specifies the restricted circumstances under which cost-sharing may be imposed under waiver demonstrations. These include:
  - the waiver tests a unique and previously untested use of co-payments;
  - the waiver is limited to a maximum of two years;
  - the waiver provides benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;
  - the waiver is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and
  - participation in the project is voluntary.

In practice, states have not sought waivers to implement greater than nominal cost-sharing for groups traditionally covered by Medicaid. Rather, they have used waivers to impose higher cost-sharing for new population groups that would not otherwise be eligible for Medicaid in the absence of a waiver — often new groups with higher income than traditional groups. Technically, Section 1115 waivers that extend eligibility to new groups are not subject to Section 1916. However, restrictions on cost-sharing for new populations may be delineated in the contractual terms and conditions specified by CMS for such waivers.

Relationship of Medicaid/SCHIP Demonstration Waivers to Other Statutes

Section 1115 waiver projects may interact with other program rules outside of the Social Security Act; for example, employer sponsored health insurance as described by Employee Retirement Income Security Act (ERISA), or alien eligibility as contained in immigration law. In cases like these, the Secretary does not have the authority to waive

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[8] There are three poverty-related eligibility pathways into the Medicaid program. Two of these are mandatory and the third is an optional group. The mandatory poverty-related groups for children and families include: (1) children under age six and pregnant women in families with incomes below 133% of the federal poverty level, and (2) children born after Sept. 30, 1983 living in families with incomes below poverty (children in this group are being phased-in one year at a time so that by FY2002 all children under age 19 living in poverty will be eligible for Medicaid). The optional poverty-related group includes infants (under age one) and pregnant women who are in families with income between 133% and 185% of the federal poverty level.

provisions in these other statutes. For example, states may not provide benefits to qualified aliens as a part of a Section 1115 eligibility expansion without adhering to the 5-year ban on alien access to federal assistance as required by the *Personal Responsibility and Work Opportunity Reconciliation Act*, P.L. 104-193.

Federal Matching Payments for Section 1115 Demonstrations

Medicaid and SCHIP are federal-state matching programs. The federal share of expenditures for Medicaid is paid to states based on a formula set in statute. This formula is designed to provide a higher federal matching percentage to states with lower per capita incomes. The law establishes a minimum federal medical assistance percentage (FMAP) of 50% and a maximum of 83%. The federal share of payments for SCHIP is based on a modified version of the Medicaid formula called the enhanced FMAP, and ranges from a minimum of 65% to a maximum of 85%.

Approved Section 1115 waivers are deemed to be part of a state's Medicaid state plan. Section 1115 requires that the project's costs be regarded as expenditures under the state's Medicaid plan and thus by default all related expenditures for such waivers are subject to that state's FMAP. Section 1903 describes the conditions under which federal financial participation is available. Section 1115(a)(2) stipulates that expenditures under a waiver are eligible for matching under Section 1903. The same federal matching rules apply for the SCHIP waiver projects. SCHIP Section 1115 demonstration programs are matched at an enhanced federal matching rate.

Waivers for Managed Care Enrollment

Prior to the passage of the *Balanced Budget Act of 1997* (BBA 97), a state had to obtain a Section 1115 or a Section 1915(b)[9] waiver from HHS if it wanted to require Medicaid recipients to enroll in a managed care program. BBA 97 granted states the flexibility to require enrollment of most Medicaid recipients into mandatory Medicaid managed care without a waiver so long as they offered beneficiaries a choice between at least two managed care organizations or two primary care case managers. A waiver, however, is still necessary when a state wishes to make enrollment in managed care mandatory for certain groups.[10] These groups are:

Children with special needs, including:

- Those who meet the definition of disability under the Supplemental Security Income (SSI) program;
- Disabled individuals who are 18 years of age or younger and who require a level of care provided in an institution but are receiving equally cost-effective care outside the institution (Katie Beckett Children);

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[9] The *Omnibus Budget Reconciliation Act of 1981* (P.L. 97-35) added Section 1915(b) to the Social Security Act. Section 1915(b) waivers, often referred to as "freedom-of-choice" waivers, allow states to establish mandatory managed care programs that restrict the providers from whom a beneficiary may obtain covered services.

[10] Parallel requirements under SCHIP have not been explicitly stated in CMS guidance or the final program rules.

- Children identified as having special health care needs through the Maternal and Child Health Services Block Grant (Title V); and
- Children in foster care or other out-of-home placement.

Persons who are eligible for both Medicare and Medicaid (dual eligibles), and

Members of federally recognized American Indian tribes.

Provisions for assuring appropriate access to care and quality of care in managed care and quality assurance monitoring responsibilities are found in Section 1903(m) and Section 1932. In general, the Secretary has authority to waive program rules when a waiver project will further the goals of Title XIX. In communications with CMS officials, program specialists pointed out that the Secretary in all likelihood would not waive such assurances or approvals, since doing so would make it difficult to show that a demonstration furthers the goals of the Medicaid program.

Financing Medicaid, SCHIP, and HIFA Section 1115 Demonstration Projects

Waiver programs must be budget-neutral, which means estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program. Costs for an eligibility expansion must be offset by cost reductions elsewhere within the Medicaid program. Several methods have been used to generate cost savings including: (1) moving part of the Medicaid population into managed care; (2) redirecting DSH payments targeted at care for uninsured individuals to cover the costs of expansion eligibles under the demonstration project; (3) streamlining benefit packages for certain eligibility groups; (4) benefit-specific approaches that provide targeted services to certain individuals so as to divert them from full Medicaid eligibility; and (5) the use of enrollment caps and cost-sharing with beneficiaries to reduce the amounts states must pay.

Under the SCHIP program, a different budget neutrality standard applies. States must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels. In October 2001, President Bush pointed to unspent SCHIP funds and the HIFA initiative as immediate mechanisms through which states could provide health insurance coverage to the uninsured.[11] In three states, Wisconsin, Minnesota, and Rhode Island, the Administration approved a "buyout" of the state's existing Medicaid Section 1115 waiver. That is, in these states certain adult populations that were initially covered under the state's existing Medicaid Section 1115 demonstrations are now covered by SCHIP Section 1115 waiver programs. Approval of these projects as SCHIP demonstrations shifted the funding source from Medicaid funds matched at the regular FMAP to SCHIP allotments matched at the enhanced FMAP.

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[11] Department of Health and Human Services, CMS Services, *Report on the Health Insurance Flexibility and Accountability (HIFA) Initiative: State Accessibility to Funding for Coverage Expansions*, Oct. 4, 2001.