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Shaping Medicaid and SCHIP Through Waivers: The Fundamentals

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OVERVIEW — *The use of waivers has become one of the key vehicles for innovation in Medicaid and the State Children's Health Insurance Program (SCHIP). This background paper examines the use of research, demonstration, and program waiver authorities to test new approaches to the delivery of and payment for health care and long-term care services. The paper reviews the statutory basis and mechanics of demonstrations and program waivers, as well as their history and political context in shaping Medicaid and SCHIP. It also explores the ways the changing state-federal relationship and the ever-growing demand for state flexibility have driven waiver policy. Finally, the paper examines the impact of the Deficit Reduction Act of 2005 on the need for or desirability of waivers.*

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Shaping Medicaid and SCHIP through Waivers: The Fundamentals

Research, demonstration, and program waiver authorities are important vehicles for testing innovative strategies in public programs. The Centers for Medicare & Medicaid Services (CMS) Web site lists 469 demonstration projects and program waivers in Medicaid and the State Children's Health Insurance Program (SCHIP) that are either active or pending approval. CMS has estimated that over $100 billion (approximately one-third) of total Medicaid expenditures are for services delivered through program waivers and demonstrations.[1] The sheer number of these projects and the amount of funding dedicated to them are indications of their importance in shaping and evaluating the way Medicaid and SCHIP services are delivered.

AN INTRODUCTION TO WAIVERS

The Social Security Act (SSA) provides the authority to waive certain provisions of the Medicaid, Medicare, and SCHIP statutes in order to explore new approaches to the delivery of and payment for health care and long-term care services. *(For more information on Medicare demonstrations, see Amanda Cassidy, "The Fundamentals of Medicare Demonstrations," National Health Policy Forum, Background Paper 63, July 22, 2008, available at www.nhpf.org/pdfs_bp/BP63_MedicareDemos_07-22-08.pdf.)* Waiver authority plays several roles: it enables states and the federal government to test new, innovative, and more cost-effective approaches to delivering and financing health care services; it can be a vehicle for advancing an administration's policy and political priorities; and it gives Congress an opportunity to direct the Department of Health and Human Services (HHS) to test promising new payment and delivery mechanisms. The flexibility provided through demonstration and program waiver authority has enabled many states to fundamentally reshape their Medicaid programs, to the point that the demonstrations have effectively become the Medicaid program in some states. Congress has also mandated a number of specific research and demonstration projects, for example, the Money Follows the Person Rebalancing Demonstrations enacted in the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171). While there are many provisions of the statute that cannot be waived (such as the rate at which the federal government matches state health care expenditures for Medicaid and SCHIP), use of these authorities over the years has changed the face of the Medicaid program by permitting and, in some cases, encouraging innovation.

Medicaid: The Basics

The Medicaid program uses waiver authority to alter provisions of the statute that otherwise prevent states from implementing certain types of programs. While Medicaid rules generally provide a great deal of flexibility, the program is structured around several fundamental statutory provisions that act as guidelines for states and ensure certain protections for Medicaid beneficiaries. These provisions are known, in policy shorthand, as "amount, duration, and scope"; "comparability"; and "statewideness."

- **Amount, duration, and scope**—the statute requires that each Medicaid service category must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." States may vary the amount, duration, and scope of services they cover, within general limits. For example, although the law permits states to impose limits on the number of days services can be provided, a state would not be permitted to limit coverage for inpatient hospital care to only one day per year.
- **Comparability**—Medicaid benefits must also be comparable across the eligible population, meaning that states may not discriminate by providing different services to individuals within specific eligibility groups or limit services based on diagnosis, type of illness, or condition.
- **Statewideness**—States are generally required to make Medicaid benefits available to all eligible individuals, regardless of where in the state they live. For example, a state that covers prescription drugs must make that coverage available in both its rural and urban areas.[2]

In addition, the statute contains provisions requiring states to ensure that beneficiaries have freedom of choice of providers and delineating both mandatory benefits and eligibility groups that states must cover, as well as optional benefits and eligibility groups that states may choose to cover. While these provisions are a key aspect of the Medicaid program structure, the federal government is authorized to waive these and other statutory provisions for purposes of research and demonstration in order to permit states to test new and innovative service delivery and financing strategies. Medicaid waivers can be divided into two categories: research and demonstration projects and program waivers.

Research and demonstration projects — These projects are authorized under section 1115 of the SSA. Section 1115, enacted in 1962 (a few years before Medicaid itself was enacted), gives broad authority to the Secretary of HHS to authorize "any experimental, pilot or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of the programs covered by the SSA. These projects are usually innovative, and their designs require greater flexibility from the federal government, in terms of the types and numbers of rules that are altered, than program waivers. Since the early 1990s, they have tended to be broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state. In addition, section 1115 research and demonstration projects

are required by policy to include a research or evaluation component, at least for the initial approval period.[3] While section 1115 authority today is primarily associated with Medicaid and SCHIP, it also applies to several other titles of the SSA, including Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF, formerly Aid to Families with Dependent Children, or AFDC).[4] Indeed, it was the perceived success of section 1115 welfare reform demonstrations in the early 1990s that led Congress to enact and President Clinton to sign comprehensive welfare reform legislation in 1996.

Medicaid program waivers — Intended to modify Medicaid in a more controlled way than research and demonstration projects, Medicaid program waivers are limited in the types of projects that can be implemented, are focused in specific areas, and are not required to include an evaluation component. Two types of program waivers were enacted in 1981 and are currently in use. Section 1915(b)—often referred to as the "freedom of choice waiver"—authorizes states to implement delivery models, such as mandatory enrollment in managed care, that require eligible beneficiaries to use certain providers to receive services.[5] Section 1915(c) authorizes states to provide home and community-based services (HCBS) as an alternative to institutional care in hospitals, nursing homes, and intermediate care facilities for persons with mental retardation, or ICFs/MR.[6]

SECTION 1115 DEMONSTRATIONS IN DEPTH

Although section 1115 applies to several titles of the SSA, it has been used most extensively to alter Medicaid and, prior to welfare reform in 1996, the AFDC program. Section 1115 authority also applies to SCHIP, which was enacted as part of the Balanced Budget Act (BBA) of 1997, and demonstration projects are under way in several states.[7] Approval of a proposed section 1115 waiver is entirely at the discretion of the Secretary.

Statutory Provisions

Section 1115(a)(1) allows the Secretary to waive provisions of section 1902 of the Medicaid statute, the key section that contains the Medicaid state plan requirements. Each state operates its Medicaid program under a plan that is approved by CMS. Section 1902 outlines the information that must be included in the state plan and sets the federal parameters within which states must operate. The state plan describes the states' Medicaid eligibility criteria and the services that will be offered, as well as the service delivery and payment methodologies the state uses in administering Medicaid. Under an 1115 demonstration proposal, a state might propose, for example, to use income as the sole criterion in determining eligibility.[8] States have also proposed modifying the benefit package to provide certain benefits to one group, such as pregnant substance abusers, and not to others. Another common use has been to waive freedom of choice in order to require beneficiaries to receive services through a managed care organization.

More significantly, section 1115(a)(2) permits the Secretary to provide federal matching payments for state costs that would not otherwise be matched under section 1903, the section that contains funding requirements. It is this "costs-not-otherwise-matchable" authority that has been widely used for statewide health care reform demonstrations that expand coverage to new populations and services that Medicaid does not normally cover. Another common use, before enactment of the BBA of 1997, was to permit states to contract with health maintenance organizations (HMOs) that did not meet the Medicaid participation requirements and, therefore, would not usually be eligible to receive Medicaid reimbursement.[9]

Section 1115 research and demonstration projects are, theoretically, approved for a limited period of time—generally five years. In practice, however, because the Secretary has discretionary authority to renew these projects, many have operated for far longer and, to date, demonstrations have been terminated only at a state's request. For example, Arizona's Medicaid program has operated under section 1115 authority since its initial approval in 1982. When some analysts began to question the Secretary's authority to grant extensions, Congress clarified the matter in the BBA of 1997, which included a provision for one three-year extension after the first five years of operation. The ability to extend approvals for these demonstrations was further affirmed in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or BIPA, which permitted the Secretary to continue granting three-year extensions to existing section 1115 demonstration projects.

To date, demonstrations have been terminated only at a state's request.

Budget Neutrality and Financing Options

States have always had the ability to provide health coverage to any and all of their residents, above and beyond the federal Medicaid guidelines. However, if states choose to cover populations that are not eligible for Medicaid services under federal rules (such as nondisabled adults without children), they must do so with state-only funds, unless they are granted demonstration authority that allows them to receive federal Medicaid matching funds (known as federal financial participation, or FFP) for these populations. The financing of these types of expansions is often the most complex part of the application process because of the requirement for budget neutrality, that is, that federal expenditures over the life of a demonstration must be no greater than they would have been without the demonstration.

Covering new populations and services has the potential to greatly increase state and federal costs of the program. As a result, budget neutrality is often a major point of contention in negotiations between CMS and states. Budget neutrality has been mandated by federal policy (rather than statute) since 1983. During the 1970s and early 1980s, the only budgetary restriction placed on projects was that the overall operating budget for research and demonstration activities—the funds apportioned to the Health Care Financing Administration (HCFA)[10] to staff and evaluate projects—could

not exceed the amount specified in the president's budget. Over a period of several years, the Office of Management and Budget (OMB) became increasingly concerned about the large amount of program service costs that were tied to research and demonstration projects.[11] In 1983, an agreement between the OMB and HHS gave the OMB clearance authority for demonstrations and established the budget neutrality policy. As discussed later, the budget neutrality requirements for Medicaid section 1115 demonstrations have led states to pursue a number of creative financing approaches in order to expand coverage or services that would not usually be eligible for federal matching funds.

Budget neutrality requires states to identify sources of savings that will offset the cost of any program expansion.

In order to maintain budget neutrality, states need to identify savings in their proposed section 1115 demonstrations that will offset the cost of any program expansion over the life of the demonstration approval period. States have used several key sources of savings to fund Medicaid program expansions:

Managed care savings — Statewide section 1115 demonstrations implemented during the 1990s most commonly projected savings through the use of managed care. Requiring Medicaid beneficiaries to enroll in managed care plans has been an effective strategy to limit federal and state expenditures. However, use of this source of savings is more limited now than in early demonstrations as a result of rising premium costs and because most states are already using managed care to the maximum extent feasible for the majority of their Medicaid populations. Still remaining largely outside managed care are elderly individuals and people with disabilities. States continue to explore whether to serve these populations through managed care, as large savings could potentially be achieved for these costly groups, which together comprise 24 percent of the Medicaid population but consume approximately 70 percent of program expenditures.

Redirecting Medicaid DSH payments[12] **—** States have proposed the use of allotted disproportionate share hospital (DSH) funding, on the premise that the need to pay hospitals for services to indigent patients is reduced when health insurance is provided for expansion populations. Some states have successfully used DSH as a financing mechanism, but others have been deterred by concerns from the provider community about reduced DSH funding. In addition, states' proposals may not have a clear impact on hospital uncompensated care costs, so DSH is not always a logical funding source.

Benefit and cost-sharing savings — To the extent a state offers more limited benefits than would normally be provided under Medicaid or increases cost sharing to existing populations, the projected savings can be used to finance the expansion of services to new populations. For example, Oregon's demonstration, approved in 1993, established a priority list of health services, which replaced the Medicaid benefit package for all beneficiaries in the state. The resulting reduction in benefit costs, combined with cost sharing and the use of managed care, permitted the state to cover many uninsured individuals who had not previously been eligible for Medicaid,

while maintaining budget neutrality. This financing strategy has also been used more recently under the Health Insurance Flexibility and Accountability (HIFA) initiative (see discussion below).

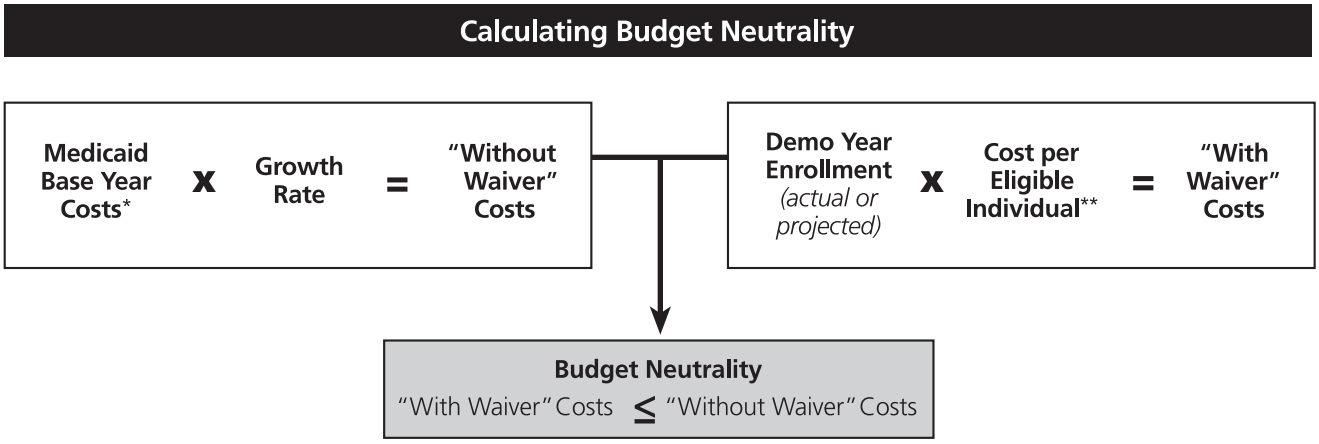
Calculating Budget Neutrality

The expenditure limit, or budget neutrality cap, for research and demonstration projects is based on projections of what federal costs would have been had there been no demonstration—sometimes called the "without waiver costs." The budget neutrality cap may apply to some or all of the project's service expenditures and may also include DSH expenditures.

Budget neutrality is calculated by first determining a state's Medicaid costs in a base year. The base year is usually the 12-month period for which the most recent, complete program data are available. Growth rates are then applied to the base year data to project future expenditures to create the without waiver baseline. The growth rates are determined by using historical caseload and expenditure data over the prior five-year period. The lower of either this historical growth rate or the Medicaid growth rate in the President's budget is used to set the budget-neutral expenditure limit for the demonstration. The "with waiver costs," including any new populations or services, are then compared to the without waiver costs to establish that the project is budget neutral. (See Figure 1 for a simplified illustration of how the budget neutrality cap may be calculated.)

The budget neutrality cap is usually calculated on a per member per month, or per capita, basis, eliminating financial exposure should enrollment growth exceed projections. However, aggregate caps have occasionally been used.[13] In a budget neutrality agreement with a per capita cap, the

FIGURE 1



** Base year costs include the number of enrollees (in member months) and costs per eligible individual for a given year.*

*** The cost per eligible individual is fixed based on the base-year costs and growth rate that have been negotiated for the "without waiver" costs.*

cost per eligible individual is fixed during negotiations; however, total expenditures over the life of the demonstration will vary based on actual enrollment. In a budget neutrality agreement with an aggregate cap, the total expenditures as determined during negotiations form an overall cap on expenditures for the demonstration, usually in return for greater state flexibility to operate its program. Once established through negotiations between the state and HHS, the cap on demonstration costs generally is not changed during the approval period of the demonstration. Negotiations around budget neutrality are often lengthy and contentious, since the outcome is critical to a state's ability to fully fund the demonstration and receive federal matching payments, as well as to the federal government's ability to contain its costs.

Hypothetical expansions — Since the mid-1990s, HCFA/CMS and the OMB have permitted hypothetical program expansions to be included in the without waiver baseline. These hypothetical expansions are program elements that states have the authority to adopt without a waiver but which are not currently part of the state's Medicaid program. For example, a state may propose to provide health coverage to children up to 185 percent of the federal poverty level, which is above the mandated Medicaid eligibility levels and can be accomplished through the use of existing law. In a demonstration proposal, the hypothetical expenditures for these as yet uncovered children may be included in the base-year calculations, effectively raising the expenditure limit for the demonstration. Many states used this creative method of calculating budget neutrality expenditure limits to pursue their program expansions during the mid-to-late-1990s. This approach to financing has been repeatedly criticized by the Government Accountability Office (GAO, formerly known as the General Accounting Office) almost from the moment of its inception, because the GAO believes that this methodology artificially inflates the amount the federal government would pay in the absence of the waiver.[14]

When SCHIP funds are used, allotment neutrality rather than budget neutrality applies.

SCHIP and Allotment Neutrality

As mentioned earlier, section 1115 demonstration authority also applies to the SCHIP program. Because of SCHIP's unique funding formula, which provides a higher federal matching rate than Medicaid, states have shown great interest in utilizing demonstration authority to shape SCHIP programs in ways that better meet states' needs and maximize the use of available federal funds. As a result, some states sought to use SCHIP allotment funds to expand coverage, especially in the early years of the program, when enrollment was low and excess funds were available.[15]

The advent of SCHIP and the ability to use funds from the state's SCHIP allotment for demonstration expansions has altered the budget neutrality equation. When SCHIP funds are used, allotment neutrality rather than budget neutrality applies. Instead of obtaining savings to finance

coverage expansions, a state may use the unspent portion of its SCHIP allotments up to the annual allotment cap, as well as currently redistributed funds.[16] One advantage to this interpretation is that states can receive the SCHIP enhanced federal matching payments for covering expansion populations—including parents and pregnant women—using the SCHIP allotment, rather than the state's usual Medicaid matching rate.[17]

However, the statutory funding formula included a reduction in allotments to states, known as "the SCHIP dip," for fiscal years 2003 through 2004. That decrease, in combination with the fiscal crises that most states experienced during those years and the continued increases in SCHIP enrollment, has significantly compromised the viability of SCHIP allotments as a funding source for states' expansion efforts. Further, given the Bush administration's recent position that limited SCHIP funds should be used exclusively to cover low-income children, it appears unlikely that future demonstration approvals will continue to permit the use of SCHIP funds for adult or other expansion populations, at least in the short term.

Funny Money?

The GAO has criticized the use of SCHIP allotments to provide coverage to adult populations, particularly with regard to program expansions that cover childless adults.[18] The GAO argues that the use of SCHIP funding in this manner does nothing to advance the primary objective of the program—providing health coverage for children—and Congress prohibited this practice for demonstrations approved after the enactment of the DRA. In January 2003, the GAO placed Medicaid for the first time on its list of programs at high risk for fraud, waste, abuse, or mismanagement, and Congress launched an investigation of state program integrity practices.[19] In addition to CMS's use of its waiver authority, the GAO report also identifies several financing strategies used by states (sometimes with either the explicit or implicit approval of HCFA/CMS) to artificially inflate the amount of federal matching funds that they receive while their own share of costs remains unchanged or decreases.[20]

Recent CMS initiatives to eliminate these Medicaid and SCHIP financing strategies have had an impact on the development and negotiation of section 1115 demonstration projects. In return for phasing out financing practices that CMS believes are unacceptable, several projects approved over the last five years establish pools of funds that are to be used for coverage of the uninsured and payments to safety net providers.[21] The pools permit states to retain a portion of federal funding that would have otherwise become unavailable to them as CMS has tightened its oversight of state financing practices.[22]

The money in the pools comes in some cases from the redirected DSH payments described above, but it is also derived from federal matching funds that states had previously generated through intergovernmental transfers and upper payment limit financing mechanisms.[23] In some

cases, demonstration terms and conditions require the states to meet certain milestones related to implementation of and improvements to the health care delivery system in order to access portions of these funds. For example, Florida's demonstration establishes a "low-income pool" funded with $600 million in payments that were formerly made to hospitals and would have been lost because of increased enrollment in managed care under the demonstration. The funds are to be used for payments to safety net providers and improving the health delivery system for the uninsured. Availability of half of the funds ($300 million) is contingent on the state's meeting milestones related to timeframes and deliverables specified in the waiver terms and conditions. Similarly, the Iowa demonstration and Massachusetts waiver extension shift resources previously funneled through hospitals to programs aimed at decreasing the number of uninsured.

Some GAO analysts argue that all publicly financed health programs should be placed permanently on the high-risk list because their complexity and high costs require constant vigilance. Although CMS's use of its waiver authority is only one of several reasons for the GAO designation of Medicaid as a high-risk program, it also reflects a tension that exists between the executive branch (including HHS, the OMB, and the White House) and the legislative branch (of which the GAO is an investigative arm). At issue is the appropriate locus of control for program changes. Demonstration projects are viewed by some as a mechanism for states to make changes that are intended to be a permanent part of their programs, thereby circumventing the federal legislative process and, arguably, increasing Medicaid outlays outside of the federal budget process. On the other hand, states do not wish to remain static as the private sector makes advances in health care financing and delivery that could be applied to their programs. In fact, many of the advances in knowledge about publicly financed health care delivery and payment over the years may not have occurred without the existence of innovative research and demonstration projects in Medicare and Medicaid.

CMS's use of its waiver authority reflects a tension between the executive and the legislative branches over the locus of control for program changes.

Evaluation

Most research and demonstration projects are evaluated to determine the success of the project in achieving its research and policy objectives. To accomplish this evaluation, HHS may contract with independent research organizations. In recent years, as its research budget has decreased, HHS has placed its priority on evaluating Medicare demonstrations and has required some Medicaid and SCHIP agencies to produce their own evaluations. Because these evaluation efforts are sometimes hampered by a lack of adequate data, their effectiveness in producing valid findings that substantiate how well a project is working has been questioned. In addition, demonstrations that have been widely replicated have been criticized for moving away from the original, more limited experimental

design.[24] However, some analysts argue that the experience gained from the more liberal use of demonstrations and program waivers has permitted the Medicaid program to evolve at a much more rapid pace than would otherwise have been possible.

Theoretically, successful programs can be adopted by Congress and made permanent. In practice, however, the interaction between the legislative and executive branches has not always been smooth. Congress has acted in some instances before HHS has fully evaluated a project's results, as was the case with the DRA legislation, which permits use of alternative benefit packages for some low-income populations. Time lags in completing evaluations have also been an issue. At other times, Congress has been slow to legislate changes for seemingly successful programs. For example, the Program of All-Inclusive Care for the Elderly, or PACE, operated under demonstration status for 11 years before Congress acted to make it a permanent part of the Medicare and Medicaid statutes. Similarly, the Cash and Counseling demonstrations that permit individuals to manage their personal assistance services operated for ten years before Congress authorized these programs as part of Medicaid in the DRA.

MEDICAID PROGRAM WAIVERS IN DEPTH

After protracted debate over ways to reform Medicaid early in the Reagan administration, the Omnibus Budget Reconciliation Act (OBRA) of 1981 enacted a new type of waiver authority in the Medicaid program. The authority for Medicaid program waivers, found at sections 1915(b) and 1915(c) of the SSA, was intended to control costs and give states more administrative flexibility to operate their programs based on experience that had been gained from research and demonstration projects in the areas of managed care and long-term care. At the same time, the federal government retained some additional control over states' use of these new programs and subjected them to greater scrutiny by requiring that they be approved through a waiver process rather than through the usual state plan amendment process.

Freedom of Choice Waivers

The Medicaid statute guarantees enrollees freedom of choice of providers in order to ensure access to services. Before the addition of section 1915(b) to the statute, beneficiaries could be enrolled in managed care organizations only on a voluntary basis. In June 1980, 16 states and the District of Columbia had contracted with HMOs or other types of prepaid health plans, covering approximately 1 percent of all Medicaid recipients.[25] At that time, encouraging more extensive use of managed care was seen as a way to help contain costs. As part of the following legislative session, Congress agreed that mandatory enrollment in managed care should be an optional service delivery mechanism for states. Although some stakeholders were (and continue to be) concerned that beneficiaries sacrifice freedom of choice

and the access to services that is presumed to be guaranteed by that choice, managed care arrangements soon flourished. Later, in the BBA of 1997, Congress authorized states to adopt mandatory managed care as a state plan option without a waiver, although the majority of states still rely on waivers to implement these programs (see below). Today more than 65 percent of the Medicaid population is served through some type of managed care arrangement—either through a traditional managed care organization or through a primary care case management model[26]—primarily through section 1915(b) waivers or section 1115 demonstrations.[27] As of June 2006, 29 states had more than 70 approved section 1915(b) program waivers.[28]

Section 1915(b) of the SSA permits states to use primary care case management systems or managed care organizations that restrict provider choice other than in emergency circumstances. This section of the statute also gives the Secretary authority to waive certain provisions of section 1902 as necessary. In addition to freedom of choice, the provisions that are most commonly waived are those that require statewide implementation (statewideness) and comparable services for all beneficiaries (comparability). The Secretary is specifically precluded, however, from waiving the provisions that establish payments to rural health clinics and federally qualified health centers, or FQHCs,[29] and payments to DSH hospitals for infants and young children. Neither may the Secretary restrict freedom of choice for Medicaid family planning services. In addition, section 1915(b) does not include an authority to expand eligibility, which is the reason that many states instead pursued section 1115 waivers in the 1990s. By law, approvals of 1915(b) waivers are for two years, with two-year renewals, and these programs must be "cost-effective and efficient." States may also provide additional services under these programs, using managed care savings.

Today more than 65 percent of the Medicaid population is served through some type of managed care arrangement.

The types of managed care programs established may provide either comprehensive medical services or may be a "carve out" to manage specialty services such as behavioral health or dental care. As a result, many states have more than one waiver program. For example, a state may provide managed primary and acute care services to families and children, as well as providing specialty managed care services to other targeted populations. Selected provider arrangements in which beneficiaries are restricted to receiving covered services from only a contracted facility, such as a hospital, have also been approved under section 1915(b) authority.

Cost-effectiveness — Cost-effectiveness review for these programs traditionally has been based on comparison with what fee-for-service costs would have been in the absence of the waiver. However, CMS has implemented an alternative method as a result of erosion of the fee-for-service base in areas where the use of managed care has been widespread for a number of years. Under this methodology, renewals of section 1915(b) waivers use expenditures in the previous two-year period as the base costs. These costs are then projected using adjustments (such

as for inflation) to determine the cost-effective amount for the current two-year approval period. This methodology is intended to reduce the amount of negotiation needed for CMS to determine cost-effectiveness in order to approve the waivers.[30]

HCBS Waivers

OBRA 1981 also enacted section 1915(c), which permits states to provide a set of home and community-based services to individuals who would otherwise be institutionalized in hospitals, nursing homes, or ICFs/MR. Before enactment of section 1915(c), comprehensive long-term care services were available only in institutional settings. Although mandatory home health services and optional personal care services were and are available Medicaid benefits, states had largely restricted their use, allowing only medically oriented types of services, such as skilled nursing care, to be provided in the home. States also placed limits on the amount of services furnished. In enacting legislation for HCBS waivers, Congress intended to contain long-term care costs by permitting states to provide services in settings (such as the home or community) that are less expensive than institutions; Congress stipulated this with a cost neutrality provision (see below).

States have used HCBS to serve a wide variety of populations, including seniors, people with physical disabilities or HIV/AIDS, individuals with mental retardation and developmental disabilities, and people with traumatic brain injury. By 1999, every state except Arizona (which offers similar services in its statewide section 1115 demonstration) had at least one HCBS waiver serving persons with mental retardation or developmental disabilities and one HCBS waiver for seniors or people with physical disabilities. As of June 2008, there were approximately 287 HCBS waiver programs in operation.[31] Because of the diversity of the populations served, as well as other factors such as unique state delivery systems, payment structures, and consumer-driven service models, it is difficult to generalize about the programs that have been implemented under the authority of section 1915(c). They represent a diverse group of programs that are loosely connected by the same statutory waiver authority.

As with other waivers, while the Medicaid statute usually requires that comparable services be provided to all enrollees statewide, the Secretary may waive Medicaid requirements for statewideness and comparability. The Secretary may also waive certain Medicaid income and resource rules under section 1915(c). This permits states to use more liberal income criteria for determining eligibility for these programs than they would use in regular Medicaid. However, section 1915(c) also permits states to limit the number of individuals who may enroll in the waiver. The statute identifies services that may be made available as HCBS, including case management, homemaker/home health aide services, personal care services, adult day health, habilitation services, and respite care. It also permits the

Secretary to approve other services that are cost-effective and needed to avoid institutionalization, which has also led to greater diversity among the states' programs. Waivers under section 1915(c) are approved for three years, with an unlimited number of five-year extensions. The DRA of 2005 included a provision to enable states to convert their HCBS waivers into a state plan option.

Cost neutrality — The statute requires that section 1915(c) waivers be cost-neutral. Cost neutrality is determined by comparing the average per capita HCBS costs to average per capita costs under the state plan without the waiver. In addition, states use enrollment caps, made possible through waivers of statewideness and comparability requirements, to help limit expenditure growth in HCBS waiver programs. Enrollment caps help guard against the "woodwork effect," which occurs because some eligible individuals prefer not to apply for Medicaid institutional services but are more interested in applying for and using community-based services, in some cases substituting for care that was previously provided by family members.

WAIVERS DRIVING POLICY CHANGE

The ability to waive certain aspects of the SSA has given states significant flexibility to experiment with new and innovative approaches to program operation, service delivery, and financing. The outgrowth of these demonstrations and program waivers, in several cases, has been major legislative and policy change that has altered the face of the programs forever. In the early days of the Medicaid program, for example, research and demonstrations projects (done in conjunction with Medicare) resulted in the development of the prospective payment system that is widely used today to reimburse hospitals. As discussed above, demonstration initiatives have also led to coverage expansions and widespread use of managed care models in Medicaid.

Medicaid in the 1990s: Statewide Health Care Reform

The use of the section 1115 demonstration authority to alter the Medicaid program has grown dramatically since the mid-1990s. Although many demonstrations had been approved before that time, they tended to be small in scope, have a limited number of participants, or take place only in limited geographic areas. The waiver movement gained momentum when the Clinton administration signaled its willingness to provide states with more flexibility to design and operate public programs. Through negotiations with the National Governors Association, the Clinton administration publicly indicated its intent to provide more flexibility in designing and financing section 1115 demonstrations shortly after the presidential inauguration in 1993. Then, on September 27, 1994, HHS published a Federal Register notice outlining its policy with regard to section 1115 research

and demonstration projects.[32] This notice was significant because HHS articulated its intent to grant similar waivers to multiple states and to allow projects to be carried out on a statewide basis. It also allowed budget neutrality to be calculated over the life of the demonstration rather than on an annual basis. The ability to conduct such large-scale projects in multiple states, combined with states' desire to contain what were viewed as unsustainable increases in health care costs and significant levels of uninsurance, generated a new outpouring of health system reform efforts.

The demonstrations that were approved in the 1990s effectively became the vehicle for statewide health care reform in the absence of national health reform. Perhaps the most significant mechanism for statewide reform was the shift toward managed care as a delivery system for the Medicaid population of families and children and the associated capitation payment methodologies that were used to pay managed care organizations.[33] Concerns about rising health care costs are not a new phenomenon: just like employers in the commercial insurance market, states had begun looking to managed care as a means to control spiraling health care costs in the early 1980s, but with limited success. In the 1990s, many states began to turn to managed care on a large-scale basis as a means of improving access to care, decreasing health care costs, and using the savings to expand coverage. Through section 1115, states were able to obtain waivers of Medicaid requirements relative to freedom of choice of provider, statewide program implementation, and comparable services for all recipients. These waivers permitted states to require Medicaid-eligible individuals to enroll in managed care networks that operated in limited geographical areas of the state and in which enhanced benefits were often offered. Although these requirements could also be waived under section 1915(b), an important advantage of section 1115 was the ability to expand coverage to new populations and to alter payment mechanisms to certain providers such as federally qualified health centers.[34]

By 1997, CMS had approved 14 statewide health care reform demonstrations using some form of mandatory managed care, 9 of which included expansions to previously uninsured populations.[35] By 2002, these demonstrations were estimated to cover more than 8 million enrollees and account for about one-fifth of Medicaid spending.[36] In fact, the popularity and perceived success of mandatory managed care, both under section 1115 authority and under section 1915(b), led to legislation in 1997 allowing states to mandate enrollment in managed care by amending the state Medicaid plan rather than going through the waiver process. Today, 16 statewide managed care demonstration projects continue to operate (Table 1).

SCHIP: A New Era of Expansion

Almost from the date of the enactment of SCHIP in 1997, states were interested in obtaining waivers to operate their programs, either to cover groups of individuals that the statute excluded or to change other features

TABLE 1
Section 1115 Statewide Health Care Reform Demonstrations Operating in 2007

STATE	Date Awarded
Arizona	07/13/1982
Arkansas	09/01/1997
Delaware	05/17/1995
Hawaii	07/16/1993
Kentucky*	10/06/1995
Maryland	10/30/1996
Massachusetts	04/24/1995
Minnesota	04/27/1995
Missouri	04/29/1998
New York	07/15/1997
Oklahoma	04/01/1996
Oregon	03/19/1993
Rhode Island	11/01/1993
Tennessee	11/18/1993
Vermont	07/28/1995
Wisconsin	01/22/1999

** Kentucky's demonstration was originally approved as a statewide project; however it has been implemented only in selected areas of the state.*

Source: Centers for Medicare & Medicaid Services.

of the program, such as benefits and cost sharing. HHS initially delayed approval of SCHIP waivers because the department believed that it could not determine what types of projects were appropriate without first having experience with the new program. However, three states—Missouri, New Mexico, and Wisconsin—received approval for section 1115 demonstrations to permit additional cost sharing and, in the case of Missouri, a slight alteration of the benefit package.[37] The rationale was that these SCHIP programs were actually expansions of Medicaid, a program with which HCFA did have experience.

In July 2000, HCFA issued long-awaited guidance on SCHIP demonstration projects that signaled additional flexibility for both Medicaid expansion states and states with separate child health programs. This guidance indicated that HCFA would consider projects that expanded coverage to parents of children being served under SCHIP and pregnant women. It was believed that expansions of this nature would assist in improving enrollment of children, as well as providing much needed coverage for uninsured adults. The guidance also outlined that the principle of allotment neutrality, rather than budget neutrality, would apply. States were particularly interested in this feature because it enabled them to use more of their annual SCHIP allotments and receive the higher SCHIP matching rate for their expansions. In 2001, only Minnesota, Wisconsin, Rhode Island, and New Jersey were approved to use SCHIP funds to cover parents; today a total of 15 states have expanded coverage to adult populations (including parents and other adult caretakers, pregnant women and childless adults) and use SCHIP allotments to finance the expansions. The GAO has estimated that over 638,000 adults were covered through these demonstration projects in 2005.[38]

To date, 15 states have received approval to use SCHIP funds to cover additional populations.

HIFA: Continuing Expansion and Cost Containment

The Health Insurance Flexibility and Accountability demonstration initiative was announced by the Secretary of HHS in August 2001.[39] HIFA provides states with an opportunity to expand health insurance coverage to more individuals, encourages the use of premium assistance to help families and individuals purchase private insurance through their employers, and provides new flexibility for states to design their programs through the use of section 1115 authority. Eleven states have received approval for HIFA demonstrations and three additional states have received HIFA amendments to previously existing section 1115 demonstration projects.[40]

HIFA continued many of the features from previous statewide health care reform and SCHIP demonstrations: budget neutrality is calculated in much the same way and states may use excess SCHIP allotment dollars to fund eligibility expansions. However, HIFA set a precedent for expanding coverage to additional populations by permitting reduced benefits and increased cost sharing for populations that states were already covering under their Medicaid programs. This approach had been previously permitted

in a limited number of projects on a case-by-case basis. However, HIFA signaled the Bush administration's willingness to consider proposals to limit benefits and increase cost sharing on a wide scale.

This approach has aroused controversy around appropriate minimum federal standards, with some analysts fearing that states would reduce services to current beneficiaries. A study on the early experiences of ten HIFA waivers found that the principal motivation of most HIFA projects was to expand coverage and that eight of the ten states made no changes in benefits and cost sharing for current Medicaid and SCHIP enrollees.[41] However, during the fiscal crisis of the early 2000s, some states with HIFA waivers did take advantage of waiver flexibility to contain costs of populations eligible under the demonstration. CMS, during that same time period, also approved several new demonstration projects and amendments to existing projects not classified as HIFA that included features directed at cost containment. (See Table 2, next page, for a list of states approved, beginning in 2001.) Steps taken by states to contain costs have included delaying full implementation of their projects, rolling back eligibility for waiver populations, closing enrollment or imposing enrollment caps on waiver populations, modifying benefit packages, and imposing new cost sharing. In addition, four states—Florida, Montana, Mississippi, and Utah—did reduce benefits for some eligibility groups previously covered under their Medicaid state plans and, with the exception of Utah, did so without using the resulting savings to expand coverage to the uninsured.

A key policy question is whether it is better to provide more limited coverage to a larger number of individuals or to provide more comprehensive coverage to fewer people.

Undeniably, the fiscal crisis experienced in most states from 2002 to 2004 was the worst in recent history. Without the flexibility provided through waivers, more states may have needed to eliminate eligibility expansions that they had previously accomplished or do away with certain optional benefits. Proponents of waivers point out that these projects provide health care coverage to many individuals who cannot normally be covered by Medicaid and SCHIP and would otherwise be uninsured. A key policy question is whether it is better to provide more limited coverage to a larger number of individuals or to provide more comprehensive coverage to fewer people. For example, Utah's demonstration, approved in 2002, covers more people by providing a set of preventive and primary care services to an expansion population of up to 25,000 parents, caretaker relatives, and childless adults with incomes up to 150 percent of the federal poverty level (FPL). This expansion is financed by savings obtained from reducing benefits and increasing cost sharing for a state plan population of able-bodied parents and caretaker relatives. The reduced benefit package eliminates certain services, such as eyeglasses, occupational therapy, private duty nursing, medical supplies and equipment, and long-term care, and places tighter limits on other services, such as physical therapy, speech therapy, mental health/substance abuse treatment, organ transplants, and transportation. While these services are mostly ones that are not needed or heavily used by

an able-bodied population, questions remain about whether covering more people is worth the trade-off of potentially unmet need for lower-income populations and whether different segments of society are and should be treated equitably in new approaches to health insurance coverage.

Despite the tight fiscal situation during the early 2000s, it has been estimated that approximately 300,000 expansion population individuals were covered by ten HIFA demonstrations by the end of 2005.[42] In addition, the emphasis of HIFA on coordinating coverage with the private market has

TABLE 2
Section 1115 Demonstrations Approved Since August 2001

STATE*	HIFA	Includes Expansion Population	Date Approved
Arizona	Y	Y	12/12/2001
Arkansas	Y	Y	03/03/2006
California			
Parental Coverage†	Y	Y	01/25/2002
Hospital Uninsured Care	N	Y	08/24/2005
Colorado	Y	Y	09/27/2002
District of Columbia	N	Y	03/07/2002
Florida‡	N	N	10/19/2005
Idaho	Y	Y	11/04/2004
Indiana	N	Y	12/14/2007
Iowa	N	Y	06/30/2005
Illinois	Y	Y	10/13/2002
Maine	Y	Y	09/13/2002
Michigan	Y	Y	01/16/2004
Mississippi	N	N	09/10/2004
Montana	N	N	01/29/2004
New Mexico	Y	Y	08/23/2002
New York – FSHRP§	N	N	09/29/2006
Nevada	Y	Y	11/02/2006
Texas	N	N	03/05/2007
Utah	N	Y	02/08/2002
Vermont – GCHC§	N	Y	09/27/2005
Virginia	Y	Y	06/30/2005
Washington	N	N	02/13/2004

* *Some states have more than one demonstration. The Arizona, Arkansas, New York, and Vermont projects listed here were approved separately from their comprehensive managed care demonstrations.*

† *The California parental coverage waiver has not been implemented.*

‡ *Although Florida's demonstration does not technically include an expansion population, it does establish a low-income pool to provide coverage to the uninsured.*

§ *FSHRP = Federal-State Health Reform Partnership*

GCHC = Global Commitment to Healthcare

Note: This table includes only comprehensive demonstrations initially approved after the announcement of the HIFA initiative. Several previously existing demonstrations were also amended during this period.

provided some impetus for developing premium assistance programs, although state experience with these programs has been mixed at best. The full impact of HIFA and other recently implemented demonstrations on the health care system and beneficiaries is unknown at this time. Summary results from the first stage of an evaluation of HIFA funded by CMS—mostly descriptive of state initiatives—were published in Health Affairs in 2006, with a more in-depth evaluation scheduled to be completed in 2008. Other demonstrations, such as the one in Florida, have been implemented only recently and have not yet been studied in depth.

Independence Plus

Before enactment of the DRA, CMS promoted greater consumer choice in the area of long-term care through the Independence Plus initiative. The initiative was based on Cash and Counseling demonstrations that were awarded to Arkansas, Florida, and New Jersey in 1997. The projects tested direct payment of cash benefits to individuals with disabilities to allow them to purchase their own personal assistance services. The Oregon Independent Choices demonstration approved in November 2000 followed a similar model.[43] These demonstrations were significant in that they marked the first time that the Medicaid program permitted cash allowances to be paid directly to beneficiaries rather than providers. By 2007, there were 11 approved Independence Plus waivers in ten states.[44] Concerns about the total costs of community-based programs to states' Medicaid programs, however, led most states to continue these programs with capped enrollments. Experience with Independence Plus led to provisions in the DRA that permit states to offer self-directed services as a state plan option (see below). Since passage of the DRA, CMS is no longer promoting Independence Plus, and some states have begun converting their programs to the state plan option. (See DRA text box below.)

The Deficit Reduction Act (DRA) of 2005

The DRA of 2005 made some of the most significant changes to the Medicaid statute in decades. Building on experience gained with section 1915(b), 1915(c) and 1115 waivers, the DRA provides states with greater flexibility to operate their programs by amending their Medicaid state plans rather than through waivers. Key provisions of the DRA include the following options:

- Alter benefit packages and cost sharing for certain Medicaid populations through the Medicaid state plan
- Offer home and community-based services through the Medicaid state plan
- Provide self-directed personal assistance services through the Medicaid state plan

CURRENT TRENDS, FUTURE DIRECTIONS

Current initiatives in research, demonstration, and program waivers are driven by many of the same forces that have driven the use of waivers since the early 1980s. Health care costs continue to increase at rates considered to be unsustainable. A substantial portion of the population remains uninsured, and quality of care continues to be a challenging issue. As the factors contributing to these problems have evolved over the years, research and demonstration projects and program waiver initiatives also have changed. For example, several recent initiatives attempt to address the increasingly larger share of state budgets devoted to Medicaid by implementing benefit packages that are targeted to specific populations and focus on prevention. Others are seeking new ways to pay for services that increase value while containing costs.

Defined Contributions

Florida's demonstration project is the first to test a defined contribution approach to the delivery of health care services. Traditional Medicaid is a defined benefit program; that is, eligible beneficiaries are entitled to a set of mandatory benefits (that states must offer) and optional benefits (that states may choose to offer). The Florida demonstration instead sets a specific level of funding—in the form of a risk-adjusted premium—for each beneficiary. Beneficiaries then are expected to choose the plan best suited for their needs from a variety of state-approved managed care options in which the benefit packages vary, or they may opt out of Medicaid and use their annual premiums to purchase employer-sponsored insurance.

Florida's program has been in operation in a five-county area for just over one year, so outcome information is limited thus far. However, a recent report by the Florida Medicaid inspector general has recommended that the state delay expansion to other counties until certain problems with the program are resolved: primarily the difficulty beneficiaries have had in selecting benefit plans and finding specialists when needed.[45] The report also found that some beneficiaries with complex illnesses used the maximum allowed drug coverage and were left uncovered.

Tiered Benefit Packages

Several states have received approval to provide different levels of benefits and cost sharing to different populations. While traditional Medicaid requires that comparable benefits are provided to all Medicaid-eligible individuals, these projects are predicated on the idea that benefit packages should be designed to meet the varying health needs of diverse populations. In most cases, the new benefit packages are more similar to commercial benefit packages, which usually do not cover all the same benefits and impose more limitations than traditional Medicaid. Some analysts also believe that making the benefit package look more like commercial

insurance will help to prevent people from dropping private coverage to enroll in Medicaid—a problem that has been a major concern for some states. These benefit changes have primarily been used for relatively healthy adults as opposed to individuals with disabilities or long-term care needs. For example, Iowa provides a limited set of Medicaid benefits to an expansion population of adults, ages 19 through 64, who have family incomes between 100 percent and 200 percent of the FPL and who are not otherwise Medicaid-eligible. Enrollees pay monthly premiums of up to five percent of annual family income. The benefits are limited to inpatient and outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, and transportation services and medical equipment and supplies as covered by the Medicaid state plan.

Rewarding Healthy Behavior

Another new feature being tested in some states, under both demonstrations and the flexibility offered by the DRA, is influencing beneficiary behavior by providing funds or credits that are earned through desirable behaviors. For example, the Florida demonstration establishes an "enhanced benefit account," in which enrollees who participate in state-defined activities, such as weight management, smoking cessation and diabetes management, accumulate funds that can be used for noncovered health-related needs such as over-the-counter medications.

Rebalancing Long-Term Care

Through the use of section 1915(c) HCBS waivers and section 1115 demonstrations, states are attempting to "rebalance," that is, achieve a more equitable balance between the proportion of total Medicaid long-term care expenditures used for institutional services and those used for community-based supports. For example, Vermont received approval in 2003 for a demonstration directed at managing nursing facility admissions by selectively contracting with facilities to reduce their bed capacity, assessing and counseling individuals seeking long-term care services, and increasing access to community-based options. Between 1991 and 2006, HCBS increased from about 14 percent to 39 percent of Medicaid long-term care spending.[46]

Managed Long-Term Care

States are seeking ways to use managed care to provide long-term care services or to designate a limited pool of providers to deliver certain services in order to better coordinate services for people with complex medical conditions while controlling costs. For example, Wisconsin's Family Care program manages Medicaid-financed long-term care services for older adults (over age 60) and people with developmental or physical disabilities in nine counties.

REDUCING THE NEED FOR WAIVERS?

Over the years, Congress has taken steps designed to reduce the need for waivers, providing statutory authority for states to make changes to their programs by amending their Medicaid state plans as an alternative to seeking demonstration or program waivers. The advantages of a state plan option are that it eliminates both the need to establish cost neutrality and a time limit on the approval, and (theoretically, at least) it allows for more expeditious approval of state plan amendments (see text box).[47] However, it is important to note that statutory changes often do not include all of the elements that are needed in order for a demonstration project or waiver program to operate without waivers. For example, section 1932 was enacted in the BBA of 1997 to permit states to offer mandatory managed care through the Medicaid state plan rather than through waivers. As of June 2006, 19 states had used the state plan option to implement mandatory managed care, while 29 states continue to operate more than 70 section 1915(b) programs.[48] Although section 1932 has been an effective means of avoiding the waiver process for some states, it has not worked for others. In part, this is due to the states' familiarity with section 1915(b) and the process for obtaining approval. In addition, the state plan option limits the populations that may be included, particularly children with special needs, which has discouraged many states from using section 1932. Consequently, the number of section 1915(b) waivers has remained fairly constant over time.

Similarly, the DRA of 2005 contains several provisions that potentially alter the need for Medicaid waivers by permitting amendments to the state plan. New options authorized in the DRA are perhaps the most significant changes to the Medicaid statute in decades. The DRA includes provisions that affect Medicaid coverage for seniors and people with disabilities in need of long-term care services, as well as for low-income parents and children. (See DRA text box, page 21.)

HCBS State Plan Option

In the area of long-term care, the DRA built on experience gained though the HCBS waiver program by adding a new option to section

State Plan Amendment (SPA)
vs. Waiver Approval Process

Amending the Medicaid state plan is usually less complicated than applying for and negotiating a waiver. Main differences between the two processes include:

SPA	Waivers
90-day review period, restarted if CMS requests additional information.	Demonstrations: No set time frame— often can take several months or longer. Sections 1915(b) and (c): Same as SPA.
No budget or cost neutrality requirement, but CMS may scrutinize source of state share.	Budget or cost neutrality negotiated by state and federal government.
Most program requirements specified in law and regulation.	Many program requirements negotiated by state and federal government.
No renewal needed.	Must be periodically renewed.
Secretary must approve if proposed amendment complies with law.	Secretary may approve if proposed project is consistent with DHHS policy priorities.

1915 which permits states to offer HCBS through an amendment to the Medicaid state plan. Unlike section 1915(c) waivers, the new provision at section 1915(i) does not require that individuals served by the program need an institutional level of care in order to qualify for services. Instead, states must establish needs-based criteria for eligibility, in addition to the financial eligibility criteria described in the statute. At a state's option, eligible individuals may also choose to self-direct some or all of the covered services.

A recent report indicates that only one state (Iowa) adopted the HCBS state plan option in fiscal year 2007 and that five additional states report plans to do so in 2008.[49] However, the full extent to which states will adopt the HCBS state plan option remains to be seen. Many states are still evaluating its potential, while others have indicated that the state plan option does not provide enough flexibility to meet the needs of their programs. For example, the state plan option does not permit states to waive comparability, which may restrict its use in states that want to offer different benefits to different populations. In addition, the scope of services under the state plan option is limited to the services listed in statute, while states offer many others under waiver authority. The option is also restricted to individuals with incomes below 150 percent of the FPL, while many states already cover individuals with higher incomes under their waivers.

Self-Directed Services Option

Building on the Independence Plus model, the DRA also added a new subsection to section 1915, entitled "Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling)." This provision, now known as 1915(j), permits states to provide self-directed personal assistance services through the Medicaid state plan instead of through waiver or demonstration authorities. States offering this new option may choose to make the option available only in certain geographic areas of the state and may also limit the number of people eligible to self-direct. As of May 2008, four states (Alabama, Arkansas, Florida and Oregon) have approved state plan amendments to utilize this service delivery model.[50]

Benefit and Cost-Sharing Options

The DRA made even more substantial changes for low-income families by providing new flexibility for states to alter benefit packages and cost sharing for some Medicaid populations through the state plan amendment process.[51] The benefit and cost-sharing structures permitted by the DRA are modeled after SCHIP and, like SCHIP, permit states to provide "benchmark" or benchmark-equivalent benefit packages that are similar to commercial insurance products. The law also provides additional flexibility by permitting states to request "secretary-approved coverage" when the design of the benefit package does not meet one of the benchmark

standards. This would be necessary, for example, if a state proposed to provide only primary care services, since all benchmark packages include hospital services. Under DRA provisions, states may also set premiums and cost sharing for families in certain income categories at levels that are higher than nominal, as long as these charges do not exceed five percent of family income.[52] The DRA alternative benefit and cost-sharing provisions apply only to certain Medicaid state plan populations: primarily adults not covered by TANF and nondisabled children in optional eligibility groups. Similar flexibility has been permitted under some section 1115 demonstration projects approved over the last six years.

CMS has been heavily promoting the use of the state plan option rather than waivers for alternative benefit packages.[53] In fact, the number of comprehensive section 1115 demonstration approvals has fallen since the passage of the DRA, with only four approvals of new projects occurring since its enactment in early 2006. Several states have already taken advantage of the flexibility permitted under the DRA. Idaho, Kentucky, and West Virginia—which were in the process of planning section 1115 demonstrations at the time the DRA was enacted—have received approval for state plan amendments that are a comprehensive redesign of Medicaid benefits, and several other states are planning to do so in the future.[54]

Despite this shift, DRA flexibility probably will not negate the need for some states to seek waivers. The DRA does not permit benefit and cost-sharing changes for many Medicaid state plan populations and is available only for populations that were covered under the state plan at the time the law was enacted. CMS has indicated that alternative benefit packages may also be offered to other groups as an option—that is, beneficiaries may not be required to enroll on a mandatory basis—which may be a limiting factor for some states. In proposed rules, CMS has also indicated that states could potentially expand existing eligibility categories by modifying the income eligibility levels for those groups.[55] However, the extent to which such expansions would be permitted through a state plan amendment is unclear because CMS, in other contexts, has been working to limit the use of income disregards and deductions that effectively raise Medicaid eligibility limits.[56] Further, some populations—for example, childless adults—can not be covered by Medicaid under current law; therefore, a waiver would still be necessary if a state opted to cover any excluded populations. States may also wish to "bank" accrued savings over the life of a demonstration to allow enhanced coverage or expansion to non-Medicaid-eligible groups at some later date. Any cost savings achieved through state plan amendments likely could not be used to offset costs for further expanding coverage through a waiver. Other reforms, such as the defined contribution approach being taken in Florida, could not be accomplished through DRA authority. Therefore, states wishing to pursue certain eligibility or coverage expansions or make more sweeping changes to their Medicaid programs would still need to obtain a waiver to do so.

CONCLUSION

Program waivers and demonstration projects are prevalent features of almost all states' Medicaid programs. Taken as a whole, the combination of Medicaid section 1115 demonstration projects and section 1915(b) and 1915(c) waivers have dramatically altered the way in which eligibility is determined, services are delivered, and payment is made in the Medicaid program. Demonstrations have also expanded coverage to many people who would have been uninsured in the absence of these programs. And over time, demonstrations have made Medicaid programs look increasingly different from one state to the next.

The broadened use of research and demonstration authority during the Clinton and Bush administrations has created much controversy. In March and April 2001, as well as in June 2003, Congress sent inquiries to CMS asking for detailed information about Medicaid section 1115 demonstrations and expressing concerns about the approval process as well as quality, access, and the manner in which budget neutrality is calculated. As noted earlier, the GAO has questioned the Secretary's use of waiver authority for HIFA in particular for diverting SCHIP funds from children's coverage to adults, and sensitivity around these issues has resulted in HIFA initiative guidance being pulled from the CMS website. More recently, GAO has questioned whether CMS's use of its waiver authority in the Florida and Vermont demonstrations is consistent with federal law.[57] In addition, the CMS research budget for Medicaid demonstrations in recent years has been limited to such an extent that little is known about the impact of program changes in recent demonstrations, much less how that information might inform the future of the program.

These types of controversies have surrounded research and demonstration projects and program waivers over the last 20 years. The overarching question, however, seems to be, what is the appropriate role of research and demonstration projects? Changes to programs accomplished through these mechanisms can have a huge impact on beneficiaries, providers, and the health care system as a whole. To the extent that demonstrations change the states' entire Medicaid program without legislative backing, analysts have speculated that HHS may be overstepping its bounds. On the other hand, many features of public programs that are widely accepted today were controversial when they were first tested through research and demonstration projects. Legislative change can be slow to occur when states are facing immediate budget crises and costs are rising at alarming rates.

Recent developments, in particular, point out the need for a coherent federal policy regarding waivers. After first encouraging use of SCHIP funds to expand coverage to adults, the Bush Administration has now taken the position that limited SCHIP funds should be used to cover only low-income children and proposed federal legislation would phase out adult coverage. The DRA, while building on the tiered benefit approaches approved in demonstration projects over the last few years, did so in the

absence of evaluation results and experience that could have informed statutory changes. Further, the lack of a national evaluation strategy and decreased federal funding for independent evaluation of demonstrations in recent years have led to limited information about the outcomes of state reform efforts.

The evolutionary use of program waivers and demonstrations to provide greater and greater flexibility to states has changed the nature of the Medicaid and SCHIP programs. Projects are driven sometimes by administration policies, sometimes by statutory mandates, and often are implemented in response to rapidly escalating costs. Controversies surrounding waivers are not likely to be resolved any time in the near future. In the meantime, the experience gained from research and demonstration projects and program waiver initiatives has great potential to inform the debate about how to best address the challenges of uninsurance, cost containment, and quality of care facing the nation's health care system. To do so the federal government must commit itself to leadership in designing, evaluating and sharing the results of these experiments.

ENDNOTES

1. Centers for Medicare & Medicaid Services (CMS), "Roadmap to Medicaid Reform: New Options to Improve and Expand Insurance Coverage for Acute Care Needs," available at www.cms.hhs.gov/smdl/downloads/Rvacutecare.pdf.

2. Andy Schneider and Rachel Garfield, "Medicaid Benefits," in Andy Schneider *et al.*, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, January 2003, pp. 59–61; available at www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14260.

3. Statewide health care reform demonstrations, as discussed later in this paper, are initially approved for a five-year period and renewed for subsequent three-year periods. CMS has not required additional evaluations for the renewal periods.

4. Aid to Families with Dependent Children was the welfare program that provided cash payments to low-income women with dependent children. It was replaced by the Temporary Assistance for Needy Families block grant program in 1996.

5. Section 1902(a)(23) of the Medicaid statute allows eligible individuals to obtain services from any participating provider. This rule is referred to as "freedom of choice."

6. Intermediate care facilities for persons with mental retardation, or ICFs/MR, are defined as public or private facilities whose primary purpose is to provide health or rehabilitative services to individuals with mental retardation or related conditions (such as cerebral palsy). States have the option to cover services provided in these facilities. See Schneider *et al., Medicaid Resource Book,* p. 169.

7. Section 2107(e)(2)(A) of the Social Security Act states that section 1115 applies to the State Children's Health Insurance Program, or SCHIP, (Title XXI) in the same manner as it does to Medicaid (Title XIX).

8. Historically, states have considered an individual's assets or have disregarded certain types of income, such as deducting child care expenses, in calculating financial eligibility for the program.

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9. The participation requirements for Medicaid managed care organizations are found at section 1903(m) of the Social Security Act. The Balanced Budget Act of 1997 significantly altered these participation requirements, virtually eliminating the need for states to use demonstration authority for this purpose.

10. The Health Care Financing Administration (HCFA) is the former name of the Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). This paper uses the agency name in use at the time of the developments under discussion.

11. Allen Dobson, Donald Moran, and Gary Young, "The Role of Federal Waivers in the Health Policy Process," *Health Affairs,* 11, no. 4 (Winter 1992), pp. 72–94; available at http://content.healthaffairs.org/cgi/reprint/11/4/72?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Dobson&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.

12. Disproportionate share hospital payments are made by states' Medicaid programs to hospitals that are documented as serving a "disproportionate share" of low-income or uninsured patients. The federal matching funds that states can use to make these payments are capped as specified by the Medicaid statute.

13. For example, Tennessee's original section 1115 demonstration, TennCare, had an aggregate cap; however it was changed to a per member per month cap in more recent revisions to the program. Vermont's Global Commitment to Health also uses an aggregate cap on spending to finance its program.

14. U.S. General Accounting Office (GAO), *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs,* GAO/HEHS-96-44, November 1995; available at www.gao.gov/archive/1996/he96044.pdf.

15. States participating in SCHIP receive an annual allotment based on the Current Population Survey annual estimates of the number of uninsured children in each state. Each annual allotment remains available to the states for three fiscal years. For more information, see Judith D. Moore, "SCHIP in the Formative Years: An Update," National Health Policy Forum, Issue Brief No. 759, September 21, 2001, pp. 4–5; available at www.nhpf.org/pdfs_ib/IB759_SCHIPUpdate_9-21-00.pdf.

16. States that have spent all of their annual SCHIP allotments can receive additional funds that are "redistributed" from states that were not able to spend their full allotments.

17. Initially, states were also able to cover childless adults using unspent SCHIP allotment funds; however, the Deficit Reduction Act (DRA) of 2005 included a provision prohibiting use of SCHIP funds for this population for any state that had not yet implemented such a program.

18. GAO, *Medicaid and SCHIP: Recent Approvals of Demonstration Waiver Projects Raise Concerns,* GAO-02-817, July 2002; available at www.gao.gov/new.items/d02817.pdf.

19. GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services,* GAO-03-101, January 2003; available at www.gao.gov/pas/2003/d03101.pdf. On June 16, 2003, the House Energy and Commerce Committee issued a letter to all governors announcing an investigation as a result of this report.

20. For more information on state financing strategies, see Jennifer Ryan, "Medicaid in 2006: A Trip Down the Yellow Brick Road?" National Health Policy Forum, Issue Brief No. 810, March 29, 2006; available at www.nhpf.org/pdfs_ib/IB810_Medicaid2006_03-29-06.pdf.

21. For further description of demonstrations using safety net pools, see Theresa Sachs, Jenna Walls, and Isabel Friedenzohn, "Uncharted Territory: Current Trends in Section 1115 Demonstrations," *State Coverage Initiatives Issue Brief,* vi, no. 2 (March 2006); available at www.statecoverage.net/pdf/issuebrief306.pdf.

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22. The U.S. Government Accountability Office (before 2004 known as the General Accounting Office and also referred to here as GAO) recently issued a report which found that (i) HHS approvals of demonstrations in Florida and Vermont that use these funding mechanisms do not ensure budget neutrality because the spending limits approved by HHS are higher than both the states' historical growth rates and the national projected Medicaid growth rate and (ii) the reason for the higher spending limits is not fully supported by documentation. For further information, see GAO, *Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, GAO-08-87, January 2008; available at www.gao.gov/new.items/d0887.pdf.

23. Intergovernmental transfers are local funds that are transferred from a local public agency or provider (such as a county or municipal hospital or nursing facility) to the state Medicaid program to be used as the state share of Medicaid expenditures for purposes of claiming federal matching funds. States also have broad authority to set provider payment rates, as long as the payments, in total across all providers of a defined class, do not exceed an aggregate ceiling known as the upper payment limit, or UPL. This UPL is set at the estimated amount that would have been paid under Medicare payment principles.

24. Sara Rosenbaum *et al.,* "Section 1115 Medicaid Waivers: Charting a Path for Medicaid Managed Care Reform," in *Access to Health Care: Promises and Prospects for Low-Income Americans,* Marsha Lillie-Blanton *et al.,* Eds. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1999); available at www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13317.

25. Maren D. Anderson and Peter D. Fox, "Lessons Learned from Medicaid Managed Care Approaches," *Health Affairs,* 6, no. 1 (Spring 1987), pp. 71–86; available at http://content.healthaffairs.org/cgi/reprint/6/1/71?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Anderson&fulltext=managed+care&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.

26. Primary care case management systems usually involve the state's providing a capitated payment for medical case management (sometimes including preventive care) for each enrollee, with other services continuing to be paid on a fee-for-service basis.

27. CMS, "2006 Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2006"; available at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf.

28. CMS, "2006 National Summary of State Medicaid Managed Care Programs: Program Descriptions as of June 30, 2006"; available at www.cms.hhs.gov/MedicaidDataSourceGenInfo/Downloads/nationalsummreport06.pdf.

29. Federally qualified health centers are community health centers and migrant health centers funded under section 330 of the Public Health Service Act.

30. Mike Fiore, CMS, telephone interview with author, March 20, 2003.

31. For more information about section 1915(c) waivers, see CMS, "HCBS Waivers—Section 1915(c)," updated June 3, 2008; available at www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp.

32. HHS, "Medicaid Program: Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures," *Federal Register,* 59, no. 186 (September 27, 1994). For a fuller discussion of the *Federal Register* notice, see Jennifer M. Ryan, "1115 Ways to Waive Medicaid and SCHIP Rules," National Health Policy Forum Issue Brief No. 777, June 2002; available at www.nhpf.org/pdfs_ib/IB777_1115Waivers_6-13-02.pdf.

33. Capitation is a payment methodology in which managed care organizations (MCOs) are paid a set rate for each enrolled beneficiary. The rate may vary by group—for example, the rate may be higher for adults or people with chronic illnesses than for children—and the MCOs are usually responsible (at risk) for service costs that exceed the payment rate.

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34. States are required to include services provided by federally qualified health centers (FQHCs) in the Medicaid benefit package and to pay for those services on a cost-based reimbursement basis. Under some demonstrations, states were permitted to alter this payment method so that FQHCs were paid negotiated rates as providers within a managed care network. Waivers for this purpose became less common after the BBA of 1997 required FQHCs participating in Medicaid managed care to continue to receive cost-based reimbursement.

35. Substate demonstrations in Los Angeles County, California, and Alabama were approved during the same period. For more information, see CMS, "Research and Demonstration Projects—Section 1115"; available at www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp.

36. Ryan, "1115 Ways to Waive Medicaid and SCHIP Rules."

37. The Missouri and Wisconsin demonstrations also included expansions of Medicaid coverage, funded at the regular federal matching rate, to parents of children enrolled in SCHIP.

38. Kathryn G. Allen, GAO, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization," testimony Before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 1, 2007; available at www.gao.gov/new.items/d07558t.pdf.

39. For more information on the Health Insurance Flexibility and Accountability (HIFA) initiative, see Cindy Mann, "The New Medicaid and CHIP Waiver Initiatives," Kaiser Commission on Medicaid and the Uninsured, February 2002, available at www.kff.org/medicaid/upload/The-New-Medicaid-and-CHIP-Waiver-Initiatives-Background-Paper.pdf; Cindy Shirk, National Governors Association, "HIFA: Finding the Flexibility," National Governors Association, October 2001, available at www.nga.org/Files/pdf/102401HIFA.pdf; and Ryan, "1115 Ways to Waive Medicaid and SCHIP Rules."

40. The states with approved HIFA waivers are Arizona, Arkansas, California (not implemented), Colorado, Idaho, Illinois, Maine, Michigan, New Jersey (amendment), New Mexico, Nevada, Oklahoma (amendment), Oregon (amendment) and Virginia.

41. Teresa Coughlin, *et al.*, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs* Web Exclusive, April 25, 2006, pp. w204–w216; available (subscription required) at http://content.healthaffairs.org/cgi/reprint/25/3/w204?SEARCHID=1&hits=10&gca=healthaff%3B25%2F3%2Fw204&FIRSTINDEX=0&AUTHOR1=Coughlin&ck=nck&&ck=nck.

42. Coughlin, *et al.*, "An Early Look at Ten State HIFA Medicaid Waivers."

43. Oregon's demonstration has now been converted to a section 1915(j) state plan option. See section in this paper on "Reducing the Need for Waivers?"

44. The ten states were California, Connecticut, Delaware, Florida, Louisiana, Maryland, New Hampshire, New Jersey, North Carolina, and South Carolina. Florida's and New Jersey's earlier Cash and Counseling demonstrations were converted into Independence Plus demonstrations. In addition, Colorado operates a section 1115 self-direction demonstration that is similar to Independence Plus. For more information see CMS, "Independence Plus: Overview"; available at www.cms.hhs.gov/IndependencePlus/.

45. Kaiser Daily Health Policy Report, "Florida Should Delay Medicaid Pilot Project Expansion, Report Says," Henry J. Kaiser Family Foundation, October 18, 2007; available at www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=48293.

46. Brian Burwell, Kate Sredl, and Steve Eiken, "Medicaid Long-Term Care Expenditures in FY 2006," memorandum, Thomson Healthcare, August 10, 2007; available at www.hcbs.org/files/120/5958/memo.pdf.

47. State plan amendments are submitted to CMS for approval when the state wants to add a new component or revise an existing component in its Medicaid program. State plan amendments must be reviewed and approved (or disapproved) by CMS within 90 days.

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48. CMS, "2006 National Summary of State Medicaid Managed Care Programs."

49. Vernon Smith, *et al.*, "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008," Kaiser Commission on Medicaid and the Uninsured, October 2007; available at www.kff.org/medicaid/upload/7699.pdf.

50. Carrie Smith, CMS, email correspondence with author, May 30 2008.

51. For more information on DRA provisions see Ryan, "Medicaid in 2006: A Trip Down the Yellow Brick Road?"

52. Medicaid generally limits cost sharing to "nominal" levels (defined in regulation as no higher than $3 for most services) and does not permit premiums higher than $19, depending on family size and income. Most children and pregnant women are exempt from cost sharing.

53. Waiver authority is usually used only when there is not a viable way to accomplish a programmatic change through the usual state plan amendment process.

54. Vernon Smith *et al.*, "As Tough Times Wane, States Act."

55. HHS, "Medicaid Program; State Flexibility for Medicaid Benefit Packages," proposed rule, *Federal Register*, 73, no. 36 (February 22, 2008), pp. 9714–9727; available at http://frwebgate6.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=242624141964+13+1+0&WAISaction=retrieve.

56. For SCHIP, including both separate programs and Medicaid expansions, CMS issued a letter to state health officials that effectively limited expansions to no more than 250 percent of the FPL by placing what most analysts agree are unattainable requirements on states that wish to cover children at higher income levels. See CMS, Letter to State Health Officials, SHO #07-001, August 17, 2007; available at www.cms.hhs.gov/smdl/downloads/SHO081707.pdf.

57. GAO, Letter to Michael O. Levitt regarding "Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act," B-309734, July 24, 2007; available at www.gao.gov/decisions/appro/309734.pdf.