

The Basics

Medicaid and SCHIP Waivers

Medicaid and the State Children’s Health Insurance Program (SCHIP) are state-administered programs that operate under federal guidelines using a combination of state and federal funds. States receive federal matching funds for these health coverage programs, provided they meet certain requirements with respect to eligibility, benefits, and financing mechanisms. The statute permits some of these requirements to be modified—or waived—so that the federal government and states may explore new approaches to the delivery of and payment for health care services. These program modifications are known as “waivers.” The flexibility provided through waivers has enabled some states to fundamentally reshape their Medicaid programs. Medicaid waivers can be divided into two categories: **research and demonstration projects** (section 1115 waivers) and **program waivers** [sections 1915(b) and 1915(c)].

RESEARCH AND DEMONSTRATION PROJECTS

Research and demonstration projects are conducted under the authority of section 1115 of the Social Security Act (SSA). These “section 1115 waivers” have generally become broad in scope, operate across a state, and affect a large portion of the Medicaid population within a state. Section 1115 waivers cover an estimated 8 million enrollees and account for about one-fifth of Medicaid spending.¹

Under section 1115, the Secretary of Health and Human Services may waive certain provisions of the Medicaid statute that outline the federal parameters within which states must design and operate their programs.² Provisions that may be waived include Medicaid eligibility criteria, the services that will be offered, and the service delivery and payment methods the state uses in administering the program. For example, a state may propose modifying the benefit package to provide certain benefits to one group, such as pregnant women with substance abuse issues, and not to others. A common use has been to require beneficiaries to receive Medicaid services through a managed care organization.³ Waivers can permit provision of federal matching payments for state costs that would not otherwise be matched under existing Medicaid or SCHIP rules, enabling states to expand coverage to new populations and provide services that the programs do not normally cover.

Section 1115 waivers are required to include a research or evaluation component and generally are approved for a five-year period (with a three-year renewal period after the first five years). All types of waivers are required

to be budget neutral, meaning programs conducted under a waiver should generally not cost the federal government more than would have been spent under existing program rules.

The Evolution of Waivers

The use of section 1115 research and demonstration waiver authority has evolved over the years. The demonstration projects approved in the 1980s tended to be small in scope, have a limited number of participants or take place in limited geographic areas. In the 1990s, demonstrations became more expansive and ultimately served as a vehicle for statewide health care reform in the absence of national health reform. The most significant mechanism for statewide Medicaid reform was the shift toward mandatory managed care as a delivery system for families and children. States were able to use the savings generated by shifting to managed care to expand coverage to populations that would not otherwise be eligible for Medicaid. By 1997, the Health Care Financing Administration [now called the Centers for Medicare & Medicaid Services (CMS)] had approved 14 statewide health care reform waivers, 9 of which included expansions to previously uninsured populations—all using some form of mandatory managed care.⁴

The SCHIP program was enacted in 1997, but the federal government did not initially allow states to use the section 1115 waiver authority, based on the argument that it was not appropriate to make major changes so early on in the development of the program. In 2000, HCFA issued guidance on SCHIP demonstration projects that provided flexibility for states to provide coverage for pregnant women and parents of children being served under SCHIP. Fifteen states have received approval to use SCHIP funds to pay for expanded coverage to adult populations (including parents and other adult caretakers, pregnant women and childless adults). However, the use of SCHIP funding for populations other than children has been extremely controversial. In 2005, Congress explicitly precluded states from using SCHIP funds for coverage of childless adults, and phasing out SCHIP coverage for parents has also been debated. An estimated 638,000 adults were covered through SCHIP demonstration projects in 2005.⁵

CMS announced the Health Insurance Flexibility and Accountability (HIFA) initiative in August 2001. HIFA permitted states to expand health insurance coverage to more individuals and encouraged the use of premium assistance to help families and individuals purchase private insurance through their employers. It also provided new flexibility for states to design their programs by altering benefit packages and cost-sharing requirements for certain optional and expansion populations. Eleven states have received approval for HIFA demonstrations.⁶

PROGRAM WAIVERS

Program waivers were enacted by Congress in the Omnibus Reconciliation Act (OBRA) of 1981 to provide targeted mechanisms for testing new service

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delivery approaches while controlling Medicaid expenditures. These two new provisions—section 1915(b) and section 1915(c)—are known as “program waiver” authorities because they are specific to Medicaid, whereas section 1115 can be used for other programs authorized by the Social Security Act. Freedom of Choice Waivers [section 1915(b)] and Home- and Community-Based Services (HCBS) Waivers [section 1915(c)] must generally be cost neutral, but are not as expansive as section 1115 waivers and are not required to include an evaluation component.

Section 1915(b) “Freedom of Choice” Waivers — The Medicaid statute guarantees enrollees freedom of choice of providers in order to ensure access to services. Section 1915(b) waivers permit states to implement service delivery models, such as mandatory enrollment in managed care, that require eligible beneficiaries to receive services only from certain providers. However, unlike section 1115, section 1915(b) does not permit states to expand coverage to new populations. CMS also permits states to use section 1915(b) to waive the requirements for statewide implementation (statewideness) and for providing comparable services for all beneficiaries (comparability). Waiving these requirements would, for example, enable states to provide managed care in a limited geographic area of the state or to provide enhanced benefits to managed care enrollees.

Section 1915(b) waivers are approved for two years, with two-year renewals. The Balanced Budget Act of 1997 added a new provision to enable states to require mandatory managed care enrollment through a state plan amendment rather than a waiver. However, section 1915(b) continues to be widely used and, as of June 2006, there were more than 70 approved Freedom of Choice Waivers operating in 29 states.⁷

Section 1915(c) “HCBS” Waivers — Section 1915(c) of the Medicaid statute authorizes states to provide HCBS as an alternative to institutional care in nursing homes, intermediate care facilities for persons with mental retardation (ICFs/MR), and hospitals. HCBS Waivers are approved for three years with an unlimited number of five-year extensions. The statute identifies services that may be considered home- and community-based services, including case management, homemaker/home health aide services, personal care services, adult day health, habilitation services,⁸ and respite care. Section 1915(c) also permits the Secretary to approve other services needed to avoid institutionalization. HCBS Waiver programs are expected to be at least cost neutral, meaning that expenditures on behalf of beneficiaries enrolled in the waiver should generally be no greater than they would have been if the individual had resided in an institution.

HCBS Waivers permit states to provide a targeted set of services to specific populations. States may also impose enrollment caps that limit expenditure growth in HCBS Waiver programs. States have used HCBS Waiver programs 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 state-wide section 1115 demonstration) had at least one waiver serving persons with mental retardation or developmental disabilities and one waiver for seniors or people with physical disabilities. As of June 2008, there were 287 HCBS Waiver programs in operation. The Deficit Reduction Act (DRA) of 2005 included a provision allowing states to convert their HCBS Waivers into state plan options.

*For more detailed information on **Medicaid and SCHIP waivers**, see Cynthia Shirk, “Shaping Medicaid and SCHIP Through Waivers: The Fundamentals,” at www.nhpf.org/pdfs_bp/BP64_MedicaidSCHIP.Waivers_07-22-08.pdf.*

*For information on **Medicare demonstrations**, see Amanda Cassidy, “The Basics: Medicare Demonstrations,” at www.nhpf.org/pdfs_basics/Basic_Medicare-Demos_07-30-08.pdf; and Amanda Cassidy, “The Fundamentals of Medicare Demonstrations,” at www.nhpf.org/pdfs_bp/BP63_MedicareDemos_07-22-08.pdf.*

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ENDNOTES

1. Jennifer Ryan, “1115 Ways to Waive Medicaid and SCHIP Rules,” National Health Policy Forum, Issue Brief 777, June 13, 2002; available at www.nhpf.org/pdfs_ib/IB777_1115Waivers_6-13-02.pdf.
2. Each state operates its Medicaid program under a state plan that is reviewed and approved by the federal Centers for Medicare & Medicaid Services (CMS). States may only waive provisions of section 1902 of the Social Security Act related to the state plan design.
3. 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.”
4. Sub-state 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/MedicaidStWaivProgDemoPGL/03_Research&DemonstrationProjects-Section1115.asp.
5. Kathryn G. Allen, U.S. Government Accountability Office (GAO), “States’ SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization,” testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, March 1, 2007; available at www.gao.gov/new.items/d07558t.pdf.
6. For more information on HIFA approvals, see Cynthia Shirk, “Shaping Medicaid and SCHIP Through Waivers: The Fundamentals,” National Health Policy Forum, Background Paper 64, July 22, 2008; available at www.nhpf.org/pdfs_bp/BP64_MedicaidSCHIP.Waivers_07-22-08.pdf.
7. CMS, “2006 National Summary of State Medicaid Managed Care Programs: Program Descriptions as of June 30, 2006,” U.S. Department of Health and Human Services, June 2006; available at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/nationalsummreport06.pdf.
8. Habilitation services can include physical and occupational therapy, speech therapy, case management, life skill training, and medication management, among others.