National Association of Medicaid Directors

New Administration, New Approach to Medicaid Waivers?

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Medicaid Waivers: Background and Context

- Enacted in 1965, Medicaid is the nation’s main public health insurance program for people with low income. As of June 2017, it was responsible for the care of **74.4 million individuals**.

- There is a widespread desire among Medicaid Directors to reorient the health care system to achieve better care lower costs, rendering Medicaid programs an indispensable platform for innovation and system-wide improvement. **Yet, the underlying Medicaid statute (now more than 50 years old) is not structured to meet this need.** It reflects a health care reality that no longer exists, overlooking the tremendous diversity defining state and territorial Medicaid programs.

“If you’ve seen one Medicaid program...you’ve seen one Medicaid program.”
In Come Medicaid Waivers…!

- One mechanism states can leverage to build programs that comply with federal authority while best meeting the distinctive needs of their beneficiaries is a waiver. States can use waivers to:
  - Offer a specialized benefit package to a subset of Medicaid beneficiaries;
  - Restrict enrollees to a specific network of providers; and/or
  - Extend coverage to groups beyond those defined in Medicaid law.

- Waivers should be budget neutral to the federal government and should further the goals of the Medicaid program.

- All states use them, and most states use MANY of them.
Some Examples of Waivers

- **Section 1115 Research and Demonstration Projects**, which give states broad authority to pursue “any experimental, pilot or demonstration project likely to assist in promoting the objectives” of the program.

- **Section 1915(c) waivers**, which give states authority to provide HCBS as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with intellectual disabilities, and hospitals.

- **Section 1915(b) waivers**, which permit states to implement service delivery models (e.g., those involving managed care plans) that restrict choice of providers other than in emergency circumstances.

- The **big reform waivers** are complex state-federal negotiations that often directly involve the highest pay grades (Governor, HHS Secretary, White House, etc.).
Waivers in Recent Years

- During the Obama administration, states as politically and geographically diverse as Texas, California and New York pursued 1115 waivers to craft Delivery System Reform Incentive Payment (DSRIP) models.

- States also used waivers to pursue alternate approaches to the ACA's Medicaid expansion:
  - Under an 1115 waiver, Indiana employs Medicaid funds to administer a benefit package modeled after a high-deductible health plan and health savings account.
  - Arkansas, also under an 1115 waiver, uses Medicaid funds to purchase private health plans on the Marketplace for low-income residents who fall in a coverage gap.

- Many waiver approaches were rejected by the Obama administration, such as those involving:
  - Work requirements
  - Lifetime limits
  - Personal responsibility, etc.
What Types of Waivers Are Being Proposed Today?

➢ Work requirements
  o **Indiana** is requesting an amendment to its January 2017 waiver application (HIP 2.0) to further tailor its HIP program, mandating participation in the 'Gateway to Work' program for all qualified able-bodied adults.
  o Other states that have proposed waivers for work requirements: Wisconsin, Arkansas, Kentucky, Indiana, Maine

➢ University funding
  o **Oklahoma** is seeking expenditure authority for payments made to four-year public universities in order to provide the universities funding for students enrolled in academic programs that license healthcare workers.

➢ Foster care
  o **Wisconsin** wishes to provide Medicaid coverage to former foster care youth who currently reside in Wisconsin but were in foster care and enrolled in Medicaid at age 18 or older in a different state.
Looking to the Future for Waivers

- NAMD has long called for **waiver reform**, backing policies that would:
  - Streamline CMS approval of waivers, perhaps by developing a functional clock similar to the state plan amendment process;
  - Create an efficient system of evaluation and reporting;
  - Build safeguards around budget neutrality;
  - Make the commonplace waivers a part of the underlying statute and grandfather waivers that have been approved and renewed; and
  - Create a pathway to permanency, eliminating requirements to continually adapt models and unnecessarily reinvent the wheel.

- Above all, NAMD believes that the federal-state partnership must be improved to ensure focus on coordination, health outcomes, program integrity, and efficiency, not on process measures or antiquated notions of program design. **States should not be limited by yesterday’s standards, and every development in program improvement should be able to be brought forward to employ by others as they become ready.**
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Fall Meeting (November 6th-8th):
http://events.medicaiddirectors.org/attendee-information/

Early bird registration ends October 6th!