Medicaid Topics

State by State Comparisons
Impact of Medicaid Waivers

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Issue Summary

The Medicaid law permits states to seek approval from the Center for Medicaid and Medicare Services in the Department of Health and Human Services for waivers from certain requirements to the federal regulations that implement the Medicaid program. The two most common types of waivers available to states are Section 1915 and Section 1115. These sections refer to the sections of the Social Security Act through which the Medicaid program was enacted. The intent of the waivers is for states to be able to demonstrate new ways to provide coverage and deliver services to the Medicaid eligible population. The increased flexibility available through waivers has been promoted as a way for states to cover more people without increasing program costs.

- ***Section 1915(b) Freedom of Choice waivers*** are the most targeted and permit states to enroll Medicaid beneficiaries in mandatory managed care. Eligibility for Medicaid can not be expanded under this authority. A Section 1915(b) waiver cannot negatively impact beneficiary access, quality of care of services and can not cost more than what the Medicaid program would have cost without the waiver. States also would seek a 1915(b) waiver in order to "carve out" a delivery system for specialty care such as a managed behavioral healthcare plan, create programs that are not available statewide or provide additional services via savings from a managed care plan.
- ***Section 1915(c) waivers*** allow States to offer services not otherwise available through their Medicaid programs to serve people in their own homes and communities. States may request approval for homemaker/home health aide services, personal care services, adult day health, habilitation, case management, respite care and "other" services requested by the State that the Secretary of HHS may approve. The initial legislation offered home and community-based services to individuals who, absent the waiver would require skilled nursing facility or intermediate care facility services. Subsequent legislation expanded the waiver authority to cover individuals who would require hospital level of care, prevocational educational and supported employment to rehabilitation services and day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals with chronic mental illness. This waiver authority recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than institutional care.

Increasingly, States are expressing an interest in providing long-term care services in a managed care environment or using a limited pool of providers. Many States are proposing to include non-traditional home and community-based services in their managed care programs. In order to do this, States use a combined 1915(b) and 1915(c) authority. The 1915(b) waiver is used to limit the freedom of choice component of managed care and the 1915(c) waiver is used to provide the home and community-based services and to expand Medicaid eligibility for

persons who are otherwise categorically eligible. States can implement these concurrent waivers as long as all Federal requirements for both waiver programs are met.

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs, including Medicaid and SCHIP, without a statutory change. Section 1115 waivers can permit changes in eligibility, benefits or cost-sharing in Medicaid. Currently, twenty-seven states and the District of Columbia have approved comprehensive Section 1115 waivers. Many waivers were adopted primarily to move Medicaid beneficiaries to mandatory managed care while others made more fundamental program changes.

Section 1115 of the Social Security Act specifies that waivers are to be used for "research and demonstration" projects that "further the objectives" of the program. In the 1990's, states used waivers to test whether managed care worked well for Medicaid enrollees and led to cost savings. Some states used the savings to expand coverage. The evaluations of these waivers resulted in legislative changes that gave states the options to implement managed care without seeking waivers. This new flexibility along with state fiscal pressures since 2001 has led some states to use waivers to reduce program spending rather than to expand coverage. A state does not need a waiver to expand Medicaid to children, parents of dependent children, pregnant women or elderly or disabled people. Waivers are needed, however, to:

- Cap Medicaid enrollment
- Reduce benefits or increase cost-sharing beyond federal standards
- Cover adults without dependent children and are otherwise not elderly, disabled or pregnant
- Cover groups other than uninsured children using SCHIP funds

The federal cost share for Medicaid under a waiver cannot be more than it would be without a waiver. States that use waivers to expand coverage must create offsetting savings or redirect existing federal funds to finance the expansion. Federal funds for services financed under the waiver are capped for the period of the waiver. If costs exceed the cap the states are responsible.

More recent waivers have resulted in very small expansions. As of fall 2003, recent waivers had resulted in a net gain in coverage of about 200,000 people. States have increasingly used waivers to reduce coverage and relieve state fiscal pressures. Waivers permit states to impose enrollment caps and to provide more limited benefits with higher out-of-pocket costs than allowed under regular federal rules. Limited benefits and higher cost sharing requirements have made it difficult for some beneficiaries, particularly the lowest income beneficiaries, to obtain care and, in some cases, have shifted costs onto health care providers.

Enrollment caps enable states to predict expansion expenditures and limit program spending, thereby eliminating coverage to otherwise eligible people. Enrollment becomes on a "first come, first served" basis rather an entitlement based on income or need. In two states, Oregon and Tennessee, changes made through waivers led to net coverage reductions.

Waivers can increase the complexity in the Medicaid program by establishing different benefits and cost sharing for different groups of beneficiaries. They become more difficult for states to administer and can lead to lessened provider participation due to increased program complexity and individuals not seeking care because of confusion surrounding their coverage.

States continue to face challenges financing and operating their Medicaid programs due to a combination of increasing healthcare costs, slow state revenue growth and an increasingly aging population. The recent experience with waivers demonstrates that the savings that can be gleaned through waivers without reducing coverage is very limited. Without new federal spending, recent waivers have not been particularly effective in reducing the number of uninsured. State waiver applications should be carefully evaluated to determine the impact on both providers and the low-income, elderly and disabled populations.

Importance to Family Physicians

States are using waivers increasingly to:

- reduce benefits
- impose enrollment caps thereby eliminating coverage to otherwise eligible people
- establishing different benefits for different groups of beneficiaries
- increasing cost sharing and co-payments
- enroll beneficiaries in mandatory managed care

Family physicians could find that currently covered Medicaid patients are no longer eligible as a result of waivers or benefits have been eliminated for certain patients.

Managed care is not necessarily synonymous with HMO's. States are finding that primary care case management and disease management may be as or more effective in containing unnecessary costs for certain populations. A monthly case management fee is usually paid by Medicaid (or the Medicaid contractor) for performing this service. Family physicians have an opportunity to engage in dialogue with the state Medicaid program to shape such programs.

State-by-State Tables

Table 1
Medicaid Cost Containment Actions Taken by States, FY2005

	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	Disease/Case Management	Fraud and Abuse	LTC
United States	47 Yes	43 Yes	9 Yes	15 Yes	9 Yes	14 Yes	28 Yes	21 Yes	17 Yes
Alabama	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
Alaska	Yes	Yes	No	Yes	No	No	No	No	Yes
Arizona	Yes	Yes	No	Yes	Yes	No	Yes	No	No
Arkansas	Yes	Yes	No	No	No	No	No	No	No
California	Yes	Yes	No	No	No	No	Yes	Yes	No
Colorado	Yes	No	Yes	Yes	No	No	No	No	Yes
Connecticut	Yes	Yes	No	No	No	No	No	Yes	No
Delaware	Yes	Yes	No	No	No	No	No	No	No
District of Columbia	Yes	No	No	No	No	No	No	No	No
Florida	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes
Georgia	Yes	Yes	Yes	Yes	No	No	No	No	No
Hawaii	Yes	Yes	No	No	No	No	No	No	No
Idaho	Yes	Yes	No	No	No	Yes	Yes	No	Yes
Illinois	Yes	Yes	No	No	No	No	No	No	No
Indiana	Yes	Yes	No	No	No	Yes	Yes	No	Yes
Iowa	Yes	Yes	No	Yes	No	No	No	Yes	Yes
Kansas	Yes	Yes	No	No	No	No	Yes	Yes	No
Kentucky	Yes	No	No	No	No	No	No	No	No
Louisiana	Yes	Yes	No	Yes	No	No	Yes	No	No

Maine	Yes	Yes	Yes	Yes	No	No	Yes	No	No
Maryland	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes
Massachusetts	No	Yes	No	No	No	No	No	No	No
Michigan	Yes	Yes	No	No	No	Yes	Yes	No	Yes
Minnesota	Yes	Yes	No	Yes	No	No	No	No	No
Mississippi	No	Yes	No	Yes	Yes	No	Yes	No	No
Missouri	Yes	Yes	No	Yes	No	No	Yes	Yes	No
Montana	Yes	Yes	No	No	No	No	No	No	No
Nebraska	Yes	No	No	No	No	Yes	No	Yes	Yes
Nevada	Yes	Yes	No	Yes	No	No	No	No	No
New Hampshire	Yes	Yes	No	No	No	No	Yes	No	No
New Jersey	Yes	No	No	No	No	No	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
New York	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina	No	Yes	No	No	No	No	Yes	Yes	Yes
North Dakota	Yes	Yes	No	No	Yes	No	No	No	No
Ohio	Yes	Yes	No	No	No	No	Yes	Yes	Yes
Oklahoma	Yes	Yes	No	No	No	No	Yes	No	No
Oregon	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
Pennsylvania	Yes	No	No	No	No	Yes	Yes	No	No
Rhode Island	Yes	No	No	No	No	No	No	Yes	No
South Carolina	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes
South Dakota	Yes	Yes	No	No	Yes	No	Yes	Yes	No
Tennessee	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No

Texas	Yes	Yes	No	No	Yes	Yes	Yes	No	No
Utah	Yes	No	Yes	No	No	No	No	No	No
Vermont	Yes	Yes	No	No	No	No	No	Yes	Yes
Virginia	No	Yes	No	No	No	No	Yes	No	No
Washington	Yes	Yes	No	No	Yes	No	Yes	Yes	No
West Virginia	Yes	Yes	No	No	No	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	No	No	Yes	Yes	No	Yes
Wyoming	Yes	Yes	No	No	No	No	Yes	No	No

Definitions: Provider Payments: Provider payment rate change, which may involve a payment rate freeze or cut. Providers include physicians, inpatient hospitals, nursing homes and managed care organizations.
Pharmacy Controls: Pharmacy utilization or cost control initiatives.
Benefit Reductions: Benefits restrictions, reductions or eliminations.
Eligibility Cuts: Eligibility reductions or restrictions. This may involve changes to eligibility standards, application and renewal process, or premiums.
Copays: New or higher copayments for services. In imposing copayments, states must comply with Federal Medicaid law, which specifies that copayments must be "nominal", generally defined as $3.00 or less per service. The law also provides exemptions so copayments cannot apply to certain services or certain eligibility groups such as children or pregnant women. Federal law requires that a provider must render a service regardless of whether the copayment is collected.
Managed Care Expansion: Increase managed care enrollment, or expand primary care case management or risk based managed care into additional service areas.
Disease/Case Management: New or expanded disease or case management programs.
Fraud and Abuse: New or enhanced fraud and abuse detection or prevention activities including recipient lock-in, establishment of a new Medicaid fraud unit within the state Office of Inspector General, and greater focus on third party liability recoveries.
LTC: Cost containment initiatives for long term care and home and community based services programs.

Sources: The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005. Results from a 50-State Survey, Appendix B. Kaiser Commission on Medicaid and the Uninsured, October 2004. Available at: http://www.kff.org/medicaid/7190.cfm.

SECTION 1115 HEALTH CARE REFORM DEMONSTRATIONS (8/28/03)			
STATE	**KEY DATES**	**PROJECT OFFICER**	**TEAM LEADER**
APPROVED - IMPLEMENTED (19)			
Arizona	Proposal Submitted: 5/22/82 Awarded: 7/13/82 Implemented: 10/1/82 Extension Submitted: 10/17/01 Extension Approved: 12/12/01 Extension Expires: 9/30/06 **Amendment Under Review**	Joan Peterson (410) 786-0621	Sidney Trieger
Arkansas	Outline Submitted: 1/97 Concept Paper Submitted: 2/21/97 Draft Proposal Submitted: 4/24/97 Proposal Submitted: 5/13/97 Awarded: 8/19/97 Implemented: 9/1/97 Original Expiration Date: 8/31/02 Extension Submitted: 8/30/01 Extension Approved: 2/26/02 Extension Expires: 9/30/05	Joan Peterson (410) 786-0621	Sidney Trieger
***California (LA County)**	Working draft Submitted: 11/21/95 Proposal Submitted: 2/29/96 Approved: 4/15/96 Implemented: 7/1/95 Extension Submitted: 10/13/99 Extension Approved: 1/17/01 Extension Expires: 6/30/05 **Amendment Under Review**	Cheryl Tarver-Eaton (410) 786-5451	Sidney Trieger
Delaware	Submitted: 7/27/94 Awarded: 5/17/95 Implemented: 1/1/96 Expiration Date: 12/31/00 Extension Submitted: 12/29/99 Extension Approved: 6/29/00 Extension Expires: 12/31/03 Extension Submitted: 8/28/03	Alisa Adamo (410) 786-6618	Sidney Trieger
District of Columbia	Concept Paper Submitted: 11/18/97 Revised Concept Paper Submitted: 4/6/98 Proposal Submitted: 10/23/98 Revised Proposal Submitted: 11/3/99 Awarded: 3/6/02 Implemented: 2/3/03 Expiration Date: 2/2/08	Juli Harkins (410) 786-1028	Sidney Trieger
Hawaii	Submitted: 4/19/93 Awarded: 7/16/93 Implemented: 8/1/94 Extension Submitted: 4/1/98 Extension Approved: 9/30/98 Extension Expired: 3/31/02 Extension Submitted: 11/14/01 Extension Approved: 3/18/02 Extension Expires: 3/31/05	Maria Sotirelis (410) 786-0552	Sidney Trieger
Kentucky (sub state)	Submitted: 5/26/93 Awarded: 12/9/93 Revised Proposal Submited: 6/22/95 Revised Proposal Approved: 10/6/95 Implemented: 11/1/97 Expiration Date: 10/31/02 Extension Submitted: 3/4/02 Extension Approved: 10/31/02 Extension Expires: 10/31/05	Maria Sotirelis (410) 786-0552	Sidney Trieger

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STATE	**KEY DATES**	**PROJECT OFFICER**	**TEAM LEADER**
Maryland	Submitted: 5/3/96 Awarded: 10/30/96 Implemented: 6/2/97 Expiration Date: 6/1/02 Extension Submitted: 6/1/01 Extension Approved: 11/27/01 Extension Expires: 5/31/05	Tim Roe (410) 786-2006	
Massachusetts	Submitted: 4/15/94 Awarded: 4/24/95 Implemented: 7/1/97 Expiration Date: 6/30/02 Extension Submitted: 6/28/01 Extension Approved: 12/21/01 Extension Expires: 6/30/05 **Amendment Under Review**	Sharon Donovan (410) 786-2561	Sidney Trieger
Minnesota	Submitted: 7/27/94 Awarded: 4/27/95 Implemented: 7/1/95 Extension Submitted: 5/12/99 Extension Approved: 12/23/99 Extension Expired: 6/30/02 Extension Submitted: 4/3/01 Extension Approved: 10/2/01 T&C`s rejected by state: 10/24/01 Revised Extension Approved: 3/26/02 Extension Expires: 6/30/05	Joe Millstone (410) 786-2976	Sidney Trieger
****Missouri**	Submitted: 6/30/94 Revised Proposal Submitted: 3/24/95 Concept Paper for Revised Proposal Submitted: 4/21/97 Revised Proposal Submitted: 9/2/97 Proposal Revised/Resubmitted: 2/13/98 Awarded: 4/29/98 Implemented: 2/1/99 Expiration Date: 3/1/04 Extension Submitted: 2/28/03 **Amendment Under Review**	Candice Hall (410) 786-4453	Sidney Trieger
New York	Submitted: 3/20/95 Awarded: 7/15/97 Implemented: 10/1/97 Expiration Date: 3/31/03 Extension Submitted: 3/29/02 Extension Approved: 9/27/02 Conditional Acceptance: 10/25/02 Revised extension approved: 2/3/03 Extension Expires: 3/31/06 Extension Effective: 4/1/03	Cheryl Tarver-Eaton (410) 786-5451 Maria Sotirelis (410) 786-0552	Sidney Trieger
Oklahoma	Submitted: 12/94 Awarded: 10/12/95 Implemented: 4/1/96 Extension Submitted: 6/30/99 Extension Approved: 12/30/99 Extension Expires: 12/31/03	Donna Schmidt (410) 786-5532	Sidney Trieger
Oregon (expand coverage) OHPII	Submitted: 6/6/02 Approved: 10/15/02 Expires: 10/31/07 Implemented: 11/1/02 **Amendment Under Review**	Donna Schmidt (410) 786-5532	Sidney Trieger

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Massachusetts	Submitted: 4/15/94 Awarded: 4/24/95 Implemented: 7/1/97 Expiration Date: 6/30/02 Extension Submitted: 6/28/01 Extension Approved: 12/21/01 Extension Expires: 6/30/05 **Amendment Under Review**	Sharon Donovan (410) 786-2561	Sidney Trieger
Minnesota	Submitted: 7/27/94 Awarded: 4/27/95 Implemented: 7/1/95 Extension Submitted: 5/12/99 Extension Approved: 12/23/99 Extension Expired: 6/30/02 Extension Submitted: 4/3/01 Extension Approved: 10/2/01 T&C's rejected by state: 10/24/01 Revised Extension Approved: 3/26/02 Extension Expires: 6/30/05	Joe Millstone (410) 786-2976	Sidney Trieger
****Missouri**	Submitted: 6/30/94 Revised Proposal Submitted: 3/24/95 Concept Paper for Revised Proposal Submitted: 4/21/97 Revised Proposal Submitted: 9/2/97 Proposal Revised/Resubmitted: 2/13/98 Awarded: 4/29/98 Implemented: 2/1/99 Expiration Date: 3/1/04 Extension Submitted: 2/28/03 **Amendment Under Review**	Candice Hall (410) 786-4453	Sidney Trieger
New York	Submitted: 3/20/95 Awarded: 7/15/97 Implemented: 10/1/97 Expiration Date: 3/31/03 Extension Submitted: 3/29/02 Extension Approved: 9/27/02 Conditional Acceptance: 10/25/02 Revised extension approved: 2/3/03 Extension Expires: 3/31/06 Extension Effective: 4/1/03	Cheryl Tarver-Eaton (410) 786-5451 Maria Sotirelis (410) 786-0552	Sidney Trieger
Oklahoma	Submitted: 12/94 Awarded: 10/12/95 Implemented: 4/1/96 Extension Submitted: 6/30/99 Extension Approved: 12/30/99 Extension Expires: 12/31/03	Donna Schmidt (410) 786-5532	Sidney Trieger
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Tennessee (Redesign) TENNCARE II	Submitted: 2/12/02 Awarded: 5/30/02 Implemented: 7/1/02 Expiration Date: 6/30/07 **Amendment Under Review**	Joe Millstone (410) 786-2976	Sidney Trieger
***Utah (Primary Care Network)**	Concept Paper Submitted: 5/2/01 Proposal Submitted: 11/15/01 Awarded: 2/8/02 Implemented: 7/1/02 Expiration Date: 6/30/07	Sharon Donovan (410) 786-2561	Sidney Trieger
Vermont	Submitted: 2/22/95 Awarded: 7/28/95 Implemented: 1/1/96 Extension Submitted: 12/7/99 Extension Approved: 6/5/00 Extension Expires: 12/31/03 **Amendment Under Review**	Joan Peterson (410) 786-0621	Sidney Trieger
****Wisconsin**	Submitted: 1/21/98 Awarded: 1/22/99 Implemented: 7/1/99 Expiration Date: 3/31/04 Extension Submitted: 3/31/03	Dianne Heffron (410) 786-3247	Sidney Trieger
APPROVED - PENDING IMPLEMENTATION (0			
Proposals Withdrawn (3)			
***Florida (Medicaid Funding for Healthy Start)**	Submitted: 1/12/99 Withdrawn: 12/1/99	-----	-----
Kansas	Submitted: 3/23/95 Withdrawn: 4/23/97	-----	-----
***Texas (Diabetes Care by Community Pharmacists)**	Submitted: 1/11/99 Withdrawn: 7/27/01	-----	-----
Waiver Terminated (1)			
***Alabama**	Submitted: 7/10/95 Awarded: 12/6/96 Implemented: 5/1/97 Expiration Date: 4/30/02 Terminated: 10/1/99	-----	-----
Waiver Expired (5)			
Illinois	Submitted: 9/14/94 Awarded: 7/12/96 Expiration Date: 7/12/01 This program was never implemented	-----	-----

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Tennessee (Redesign) TENNCARE II	Submitted: 2/12/02 Awarded: 5/30/02 Implemented: 7/1/02 Expiration Date: 6/30/07 **Amendment Under Review**	Joe Millstone (410) 786-2976	Sidney Trieger
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Vermont	Submitted: 2/22/95 Awarded: 7/28/95 Implemented: 1/1/96 Extension Submitted: 12/7/99 Extension Approved: 6/5/00 Extension Expires: 12/31/03 **Amendment Under Review**	Joan Peterson (410) 786-0621	Sidney Trieger
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Illinois	Submitted: 9/14/94 Awarded: 7/12/96 Expiration Date: 7/12/01 This program was never implemented	-----	-----