Medi-Cal *Policy Institute*

Medicaid Waivers: California's Use of a Federal Option

Report

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I. The Relevance of Medicaid Waivers for California Policymakers

Many policymakers in California are looking to federal Medicaid waivers as a tool to create changes in the state's health care system. Examples of policy changes that may require a Medicaid waiver include: redirecting indigent care funds; expanding Medi-Cal eligibility; restructuring models of care delivery; changing the Medi-Cal benefits package; and simplifying the current Medi-Cal program.

Several events and trends have precipitated renewed interest in waivers for California, including:

- Increases in the number of uninsured in California
- Interest in simplifying the administration of the Medi-Cal program
- Unspent CHIP and welfare-related funds available to states
- Creation of a new waiver for the Family P.A.C.T. program
- Recent and proposed renewals of California's managed care waivers
- A proposed extension of the Los Angeles County waiver
- Passage and implementation of the federal Balanced Budget Act of 1997
- Recent U.S. Supreme Court decisions impacting Medicaid, particularly *Olmstead v. L.C.*

The development of new Medicaid waivers for California raises several policy issues and requires an understanding of the impact—intended and unintended—of past waiver programs

in California. This document is intended to provide a background on the Medicaid waiver system and describe California's options for using waivers to modify the Medi-Cal program. This report examines the following:

- History and purpose of Medicaid waivers
- Different types of Medicaid waivers
- California's Medicaid waivers
- Waiver approval process
- Impact of the Balanced Budget Act of 1997 on California's need for waivers
- Additional waiver opportunities for California
- Key policy and research questions
- Implications for policymakers

II. The History and Purpose of Medicaid Waivers

Guidelines for Medi-Cal, California's Medicaid program, are based on laws and regulations created by the federal government. It is no small task for an individual state to modify its Medicaid program.

Specifically, when a state wants to make significant changes to its Medicaid program, it must take one of two steps: either (1) amend its State Medicaid Plan—the state's contract with the federal government; or (2) receive an exemption or "Medicaid waiver" from portions of Title XIX of the Social Security Act by the U.S. Department of Health and Human Services (DHHS).

The route a state must take depends upon the type of changes it seeks to make to its Medicaid program. If proposed changes are in alignment with existing federal Medicaid law, a state can change the program by filing a State Medicaid Plan amendment with the Health Care Financing Administration (HCFA) or DHHS. If the state proposes to change its program in a way that does not meet existing law, a federal waiver is required in order for the state to continue receiving federal matching funds for its Medicaid program.

In the past five years more than forty states, including California, have received waivers to adapt their Medicaid programs in a variety of ways. Currently California has twenty-nine active Medicaid waivers and more than half of the state's Medi-Cal recipients receive services in a delivery system created under a waiver.

Section 1902 of the Social Security Act lays out many of the basic requirements for state Medicaid programs. For example, with few exceptions, benefits offered to any Medicaid beneficiary must be offered to all beneficiaries (also called "statewideness"); state payment rates to providers must not exceed federal limits (the Upper Payment Limit); and each beneficiary must have a choice of providers.

Two sections of the Social Security Act, Sections 1915 and 1115, allow states to apply to the federal government to obtain an exemption from particular Medicaid statutes. These two sections prescribe two types of Medicaid waivers:

1. *Program Waivers:* These waivers, authorized under Section **1915(b)** or **(c)** of the Social Security Act, allow exemptions from parts of Section 1902 of the Social Security Act relating to managed care or home and community-based care.
2. *Research and Demonstration Waivers:* Section **1115** allows the waiver of a broader scope of Medicaid laws in Section 1902 for the purpose of experimentation or testing pilot programs.

This report explores the differences between these waivers (as summarized in the chart below) and their current and potential applications.

Waivers at a Glance

	1915(b) Freedom of Choice Waivers	**1915(c)** Home & Community-Based Waivers	**1115** Research & Demonstration Waivers
Federal Requirements Waived	Statewideness Comparability of services Choice of provider	Statewideness Comparability of services Income and resource standards	Broad scope of Medicaid rules
Approval Process	From HCFA with strict review timeline	From HCFA with strict review timeline	From DHHS with no specific review timeline
Time Period	Two years for initial waiver Two-year extensions	Three years for initial waiver Five-year extensions	Five years for initial waiver Three-year extensions for statewide programs, one-year extensions for other programs
Examples of Use	Managed care	Alternatives to institutional care for elderly and disabled	Expansion of eligibility Managed care

III. 1915 Program Waivers

Section 1915 was added to the Social Security Act in 1981 as part of the Omnibus Budget Reconciliation Act to allow states flexibility in two areas of the Medicaid program: managed care enrollment (part b) and eligibility for home and community-based alternatives to institutional care (part c). Section 1915 was originally intended by federal lawmakers to provide states with mechanisms to control Medicaid spending without increasing costs to the federal government. The federal rules for 1915 Medicaid waivers are found in Title 42 of the Code of Federal Regulations (CFR).

1915(b) Waivers

The 1915(b) waiver is often referred to as the "freedom of choice waiver" because one component of this waiver exempts states from the mandate that recipients have a choice of providers. Many states, including California with its Two-Plan Model waiver, have used this mechanism to require recipients to enroll in managed care plans. The provisions in Section 1902 to which a 1915(b) waiver typically applies are:

1. *Statewideness* [Section 1902(a)(1)]: Requires that the same Medicaid program be available to all recipients throughout the state. A waiver of this section allows a state to offer managed care models in specific regions of the state only.
2. *Comparability of Services* [Section 1902(a)(10)(B)]: Requires "all services for categorically needy individuals to be equal in amount, duration and scope." A waiver of this section allows a state to add services to the benefits package for certain populations, for example case management for managed care enrollees; it cannot be used to limit services.

3. *Choice of Provider* [Section 1902(a)(23)]: Requires that all recipients be allowed to select from "any qualified provider." ("Provider" is interpreted to mean health plan.) However, even under this waiver recipients must be offered a choice of at least two health plans.

4. *Upper Payment Limit* [Section 1902(a)(30)]: Requires that state payments to providers in managed care not exceed the cost of providing the same services on a fee-for-service basis. This section applies to state payments to individual and institutional providers as well as health plans.

There are more than eighty 1915(b) waivers currently in place in thirty-five states. The vast majority of these waivers are for the development of managed care models, many of which are for large numbers of Medicaid recipients. For example, Massachusetts, Colorado, and Indiana use 1915(b) waivers to enroll most of their Medicaid recipients in statewide Medicaid managed care programs.

California's 1915(b) Waivers

More than two million of California's five million Medi-Cal recipients are enrolled in programs under one of California's 1915(b) waivers. One waiver, approved in 1996 for the Two-Plan Model, covers twelve counties within the state. There also is a separate waiver for each of the five County Organized Health Systems (COHS) as well as the two Geographic Managed Care (GMC) counties. Section 1902(a)(5) of the Social Security Act requires that the Medicaid program be administered by a single state agency; however, California received waivers for implementation of COHS and GMC models to allow the California Medical Assistance Commission (CMAC) to negotiate contract provisions and capitation rates with participating contractors under these models. In addition, there are waivers for California's primary care case management model (considered a prepaid health plan under federal waiver definitions) and fee-for-service managed care.

Medi-Cal's mental health system also operates under 1915(b) waivers. The main mental health waiver, originally approved in 1995 and modified in 1997, allowed the state to consolidate the financing and organization of inpatient and outpatient mental health services in California by developing local managed care organizations in almost every county for all Medi-Cal recipients.

California also has two 1915(b) waivers relating to provider contracting and payment. The first, a selective provider contracting waiver, was originally approved in 1982 and allows California to negotiate Medi-Cal rates with hospitals and to contract with a select number of hospitals. The second, the Hudman waiver, was approved in 1992 and permits the state to use negotiated rates in contracting with skilled-nursing facilities.

1915(c) Waivers

The 1915(c) waiver is known as the "home and community-based services waiver" (HCBS) because it allows states to treat certain Medicaid populations in home or other community-based settings rather than in institutional or long-term care facilities such as hospitals or nursing homes. The opportunity for states to apply for HCBS waivers was created in 1981 under the federal Omnibus Budget Reconciliation Act (OBRA). OBRA created Section 1915(c) of the Social Security Act to allow states to develop specific Medicaid programs waiver for individuals who would be Medicaid-eligible if they were in a long-term care facility, typically a nursing home or institutional care facility. The categories of eligible populations include certain groups of people (for example the elderly, disabled, mentally ill, and developmentally disabled or mentally retarded) and people with certain illnesses or conditions (such as people with AIDS or technology-dependent children).

The HCBS waiver allows states to cover services beyond the scope of traditional Medicaid benefits to cover additional medical and non-medical services. The Social Security Act specifies seven services that may be provided under a 1915(c) waiver: home health, case management, personal care, homemaker, adult day health, habilitation, and respite care. Other services such as in-home support, transportation, and environmental modifications also may be included if the state can demonstrate that these services are necessary to prevent individuals from requiring institutionalization. In addition, certain psychosocial and treatment services also may be included in the waiver program for chronically mentally ill populations.

The provisions in Section 1902 that a 1915(c) waiver typically addresses are similar to a 1915(b) in terms of statewideness and comparability. In addition, a 1915(c) waiver often includes an exemption from the Income and Resource Standards [Section 1902(a)(10)(C)(i)(III)] which requires states to apply the same financial eligibility standards for a designated population equally throughout the state. Some states seek a waiver from this section to broaden or lower the eligibility requirements that allow a recipient to qualify for Medicaid or to equalize the eligibility criteria for institutional and non-institutional care.

A state's 1915(c) waiver must specify a limit or cap on the number of recipients eligible for the HCBS program. Typically, each HCBS program is for a particular population such as individuals with developmental disabilities, physical disabilities, or seniors. In many states there are waiting lists for access to the programs, and demand for alternatives to institutionalized care exceeds current state capacity under existing waiver programs.

There are more than two-hundred 1915(c) waiver programs in operation today, with at least one in every state in the country.[1] Many states have utilized 1915(c) waivers to a greater extent than California. For example, New Jersey, New York, and Missouri use these waivers for services such as case management and private nursing for blind and disabled children and adults, and case management and social services for children with developmental disabilities.

California's 1915(c) Waivers

California has six home and community-based service waivers. These waivers are statewide and serve specified subgroups of aged, developmentally disabled and mentally retarded, physically disabled, and HIV/AIDS Medi-Cal eligible populations. In 1997, more than 46,000 Medi-Cal recipients received services through an HCBS waiver program.[2] The waiver for technology-dependent individuals with mental retardation or developmental disabilities is the largest of California's six programs, as measured by clients served per year (approximately 35,000) and expenditures per year (roughly $385 million of $448.5 million).[3]

The recent U.S. Supreme Court decision of *Olmstead v. L.C.* may spark renewed interest in the need for additional 1915(c) waivers for California.[4] This decision requires states to provide community-based alternatives to institutionalization for developmentally disabled populations with long-term care needs. While the decision does limit states' obligations "to resist modifications that entail a 'fundamental alteration'" of services, further legal and federal administrative interpretation regarding issues such as the "reasonable pace" at which states' waiting lists for programs must move and the populations that qualify under this lawsuit will likely be necessary to clarify the Supreme Court's ruling. While the case was not specifically about Medicaid, the ruling does have significant implications for Medicaid programs throughout the country, particularly for a state like California in which Medi-Cal is a major purchaser of long-term care services. All states are required to develop a plan for meeting the needs of developmentally disabled populations in community settings rather than in institutions and to demonstrate progress toward this goal. To date, California's Health and Human Services Agency has not publicly discussed plans for responding to the ruling.

IV. 1115 Research and Demonstration Waivers

1115 waivers, known as Research and Demonstration Waivers, provide exemptions from a wider set of Medicaid regulations than those provided by 1915 waivers. Section 1115(a) was added to the Social Security Act in 1962—prior to the enactment of Medicaid in 1965—and was originally intended for states' use of welfare demonstration projects. It granted the secretary of DHHS authority to waive federal grant rules such as the rules governing Aid to Families with Dependent Children and came to include Medicaid when it began in 1965. The purpose of this type of waiver is "to experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid status." With a few exceptions, such as the Los Angeles County waiver, 1115 waivers are used for statewide programs. The first Section 1115 waiver relating to broad changes in a state Medicaid program was granted in 1982 to Arizona for the implementation of Medicaid managed care, the first ever Medicaid program in that state.

Most states have used 1115 waivers to implement Medicaid managed care. However, there are other uses for 1115 waivers; twelve states extend family planning coverage or eligibility periods with an 1115 waiver.

The 1115 waivers can be used to waive a much broader set of federal Medicaid provisions than 1915 waivers as long as program changes do not create additional federal costs or are budget neutral. These waivers can create opportunities for states to expand eligibility or benefit packages by generating savings and reinvesting these savings into such expansions. To date, Oregon is the only state to use an 1115 waiver to significantly alter the Medicaid benefits package. Some states have used an 1115 waiver to extend coverage to new populations such as medically indigent adults, generally using managed care to demonstrate cost-efficiencies that allow for coverage of additional recipients. Tennessee, Hawaii, and Florida are among the states that have financed eligibility expansions through changes to other aspects of their Medicaid programs such as redirecting disproportionate-share hospital (DSH) funds.

Some states, such as Wisconsin, are also using 1115 waivers to create "enrollment thresholds" that cap program participation (for non-mandatory populations only), which is otherwise not allowed due to Medicaid's status as an entitlement program. Tennessee capped enrollment in Medicaid as part of its TennCare program and Wisconsin has capped enrollment in its new BadgerCare program. States are also using 1115 waivers to develop programs that include cost-sharing requirements, typically in the form of premiums. Minnesota, Florida, Hawaii, and Rhode Island have implemented premiums ranging from $14.50 to $140 per person per month depending upon the state, eligibility criteria, and family size.

Prior to the passage of the Balanced Budget Act of 1997, many states used 1115 waivers to implement managed care lock-in periods, which mandate a recipient remain in the same health plan for a set period of time (typically twelve months) or to obtain an exemption from the "75/25 rule" (requiring a health plan to have no more than 75% of its members enrolled in Medicaid or Medicare). Since the enactment of the BBA, states can create lock-in periods under a State Medicaid Plan amendment and there are no requirements regarding the proportion of publicly insured in authorized health plans.

Certain changes to Medicaid programs are generally not permitted, even under an 1115 waiver. These include limiting services for pregnant women and children; imposing certain types of cost-sharing for current eligibles; changing the federal match rates; exemptions from Employees Retirement Income Security Act (ERISA) rules; and exemptions from HCFA approval of all state contracts with managed care organizations.

California's 1115 Waivers

Historically, California has used Section 1115 waivers in a fairly narrow way given the potential breadth of this type of waiver. Two examples of programs for which California has received an 1115 waiver are the Program for All-Inclusive Care for the Elderly (PACE), community care for dual-eligibles (recipients of Medicaid and Medicare) who would otherwise be institutionalized, and the Direct Purchase Vaccine Program, which allowed states to buy discounted vaccines directly from (and was eventually superseded by) the federal Vaccines for Children programs.[5] In recent years, however, California has applied for and received two 1115 waivers that are unique in structure and breadth: the Los Angeles County waiver and the Family P.A.C.T. waiver.

The Los Angeles 1115 Waiver

The Los Angeles County waiver, first approved in 1996, is an unusual 1115 waiver in many ways. It was created to financially stabilize the Los Angeles County public health care system by expanding the expenditures—such as out outpatient care for the uninsured—that qualify for federal matching dollars under Medicaid. Under this waiver Los Angeles has received more than $925 million in additional federal funds. The waiver program was also intended to increase access for the uninsured in Los Angeles County by re-engineering the county's delivery

of care to both the indigent and Medi-Cal populations and reduce inappropriate hospital inpatient utilization. The waiver is set to expire in June 2000. Los Angeles County is currently pursuing an extension for an additional five years. Included in the request for an extension are program amendments, many of which relate to disproportionate-share hospital funds.

Other counties and states have been discouraged by HCFA from applying for a waiver similar in structure to Los Angeles'. In 1997, HCFA disseminated guidelines to California counties outlining the specific criteria for HCFA approval of new 1115 county-based programs. The guidelines specify the "matchable" Medicaid expenditures for counties such as uncompensated care in ambulatory care centers and public health clinics and certain DSH payments made by the county to private facilities. Some counties, such as Alameda and San Francisco, have taken exploratory steps toward developing their own programs to cover indigent populations with an 1115 waiver.

The Family Planning Waiver

California recently received approval for an 1115 waiver to cover reproductive health services for medically indigent females with incomes between 100% and 200% of the federal poverty level. This waiver proposal was originally included in Governor Davis' 1999-2000 budget. Rather than signal a new direction in policy, this waiver shifts the state's Family P.A.C.T. (Planning Access Care and Treatment) program to Medi-Cal in order to receive federal matching funds. Family P.A.C.T. was originally implemented in 1996 and funded by the state's General Fund. The state projects this waiver will result in an estimated $144 million in annual savings for California by expanding the services eligible for federal matching Medicaid funds. Medicaid funds for family planning services are matched by the federal government at 90% versus the 51% match for other services.

Current California Medicaid Waivers

1915(b) Waivers: Freedom of Choice Waivers		First Approved	Geographic Area
County Organized Health Systems (COHS)	*Allows the county to operate a comprehensive full-risk countywide health initiative program for Medi-Cal beneficiaries (requires explicit federal statute for program).*		
	CalOPTIMA	Oct.1, 1995	Orange County
	Central Coast Alliance for Health	Jan. 1, 1996	Santa Cruz, Monterey Counties
	Health Plan of San Mateo	Dec.1, 1987	San Mateo County
	Partnership Health Plan	April 1, 1994	Solano, Napa Counties
	Santa Barbara Health Initiative	Sept. 1, 1987	Santa Barbara Counties
Geographic Managed Care (GMC)	*Allows for the mandatory enrollment of AFDC-linked Medi-Cal beneficiaries in multiple full-risk plans in a single county.*		
	Healthy San Diego	Oct. 17, 1998	San Diego County
	Sacramento	Jan. 1, 1994	Sacramento County
Fee-for-Service (FFS) Managed Care Network	Allows the operation of an enhanced fee-for-service managed care delivery system for a mandatorily enrolled beneficiary population in multiple counties (similar to federal PCCM program).	Feb. 28, 1997	Placer, Sonoma Counties
Hudman Waiver	Allows selective contracting with skilled nursing facilities to provide services to Medi-Cal beneficiaries and to negotiate rates.	April 24, 1992	Statewide
Mental Health Care Field Test	Allows fee-for-service payments and coordination for mental health services.	Feb. 13, 1995	San Mateo County
Mental Health Services Consolidation	Allows fee-for-service payments for mental health services statewide.	March 15, 1995	Statewide, excluding San Mateo and Solano Counties
Primary Care Case Management Program (PCCM)	Allows the state to award partial risk contracts to selected providers for all outpatient services (similar to federal PHP program).	Dec. 20, 1982	Statewide
Selective Provider Contracting Program (SPCP)	Allows selective contracting with hospitals to provide services to Medi-Cal beneficiaries and to negotiate rates.	Sept. 21, 1982	Statewide
Two-Plan Model	Allows for the mandatory enrollment of AFDC-linked Medi-Cal beneficiaries in one of two full-risk managed care plans in a specific county. This waiver is used in 12 counties.	Jan. 23, 1996	Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare Counties

Current California Medicaid Waivers *(continued)*

1915(c) Waivers: Home and Community-Based Waivers		First Approved	Geographic Area
Allows the state to treat certain Medi-Cal populations in the home or other community-based settings rather than in institutional or long-term care facilities such as hospitals or nursing homes.			
AIDS	AIDS and HIV+	May 9, 1996	Statewide*
IHMC	In-Home Medical Care	Aug. 11, 1994	Statewide*
MODEL	Medically fragile children	June 12, 1987	Statewide*
MR/DD	Mentally Retarded and Developmentally Disabled	Sept. 28, 1998	Statewide*
MSSP	Multi-Services for Seniors Program	Jan. 8, 1996	Statewide*
NFLOC	Nursing Facility and Level of Care Program	Nov. 14, 1996	Statewide*

1115 Waivers: Research and Demonstration Waivers		First Approved	Geographic Area
Family Mosaic Project	Provides intensive case management with coordination of mental health treatment and other services for children and their families.	Feb. 1, 1993	San Francisco County
Family Planning Access Care and Treatment (Family P.A.C.T.)	Allows for federally matched funds to be used for reproductive health services for medically indigent females.	Dec. 1, 1999	Statewide
Los Angeles County	Allows for an increase in expenditures that qualify for federal matching to financially stabilize the county's public health care system and to increase access for the uninsured.	April 15, 1996	Los Angeles County
Senior Care Action Network (SCAN)	Allows for the operation of an innovative service delivery system for the elderly, providing a broad array of social and health services, to an enrolled elderly population on a prepaid capitation basis.	Aug. 17, 1984	Los Angeles, Riverside, San Bernardino Counties

*Although these waivers are approved statewide, they currently are being implemented only in limited geographic regions.

V. The Waiver Process

Criteria for Waiver Approval

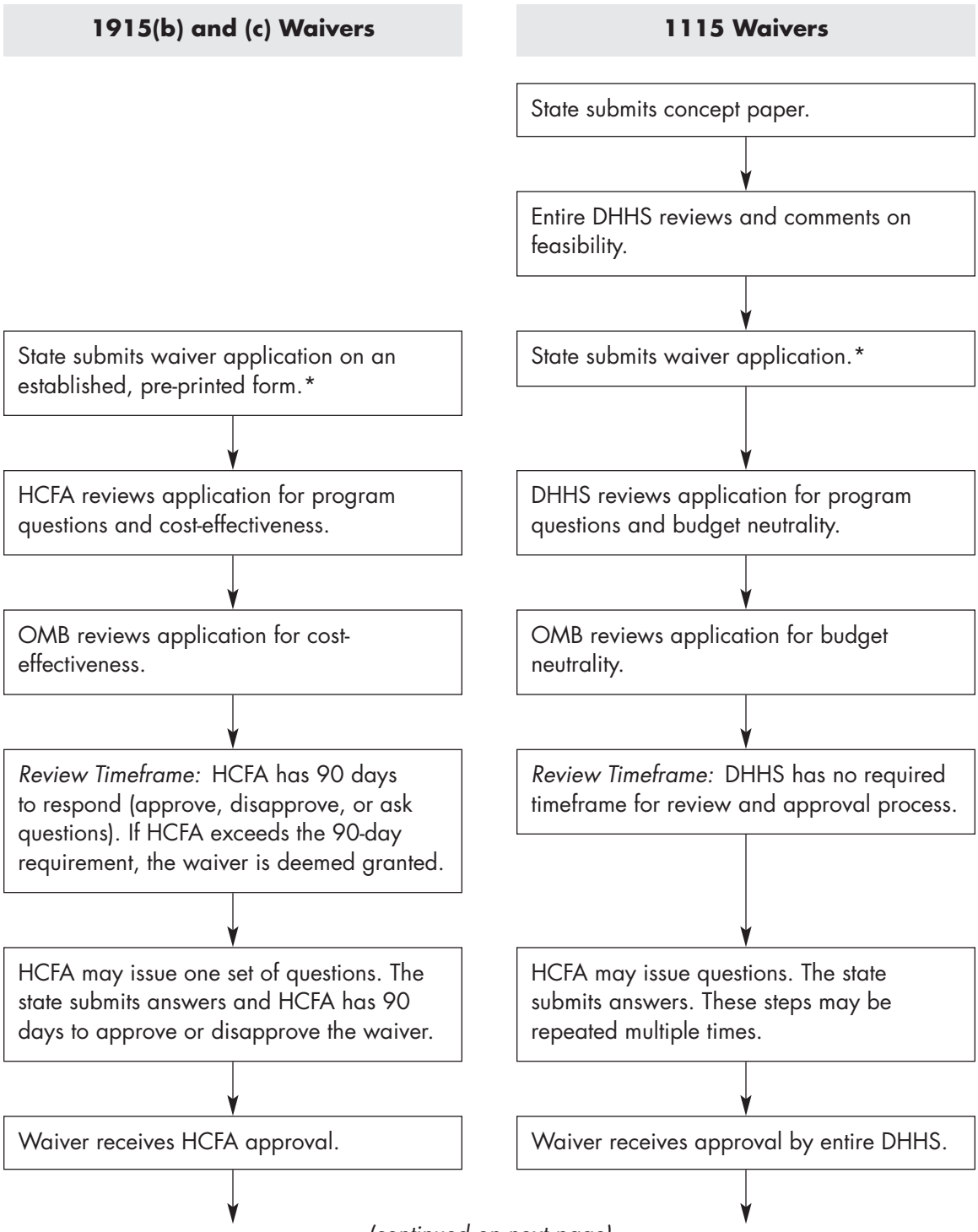
The criteria used by the federal government for approval of Medicaid waivers are generally based upon policy—DHHS's and particularly HCFA's interpretations and applications of Medicaid law and regulations—rather than solely on the law. The most significant requirement is that of cost-effectiveness or budget neutrality:

> *Cost-Effectiveness or Budget Neutrality*: A requirement that the proposed changes do not cost the federal government more than the *expected* Medicaid costs for the traditional Medicaid population under the same time period. For 1915 waivers the term for this requirement is "cost-effectiveness" and for 1115 waivers it is "budget neutrality." It is the responsibility of the Office of Management and Budget (OMB) to review waivers for cost-effectiveness or budget neutrality, respectively.

To be considered cost-effective, Section 1915 waivers must not exceed fee-for-service equivalent costs. These waivers do not need to *yield* cost savings to be cost-effective during the waiver period as long as costs do not *exceed* the federal fee-for-service equivalency. If there are savings under a 1915 waiver, these funds are considered savings to the state's General Fund.

For an 1115 waiver, the state must demonstrate that actual costs will be reduced or the rate of growth in spending will be slower over the period of the waiver than it would be without the waiver.[6] Savings from an 1115 program may be reinvested in the program for other purposes such as expanding eligibility. Under current federal policy, costs are calculated over the time period of the waiver using projected fee-for-service costs as the benchmark by which budget neutrality is determined. Thus, assumptions made about state expenditures in the absence of a waiver are critical in a state's program design and financing—a waiver program may use additional state expenditures but those expenditures cannot be more than projected expenditures

Flow Chart of Approval Processes



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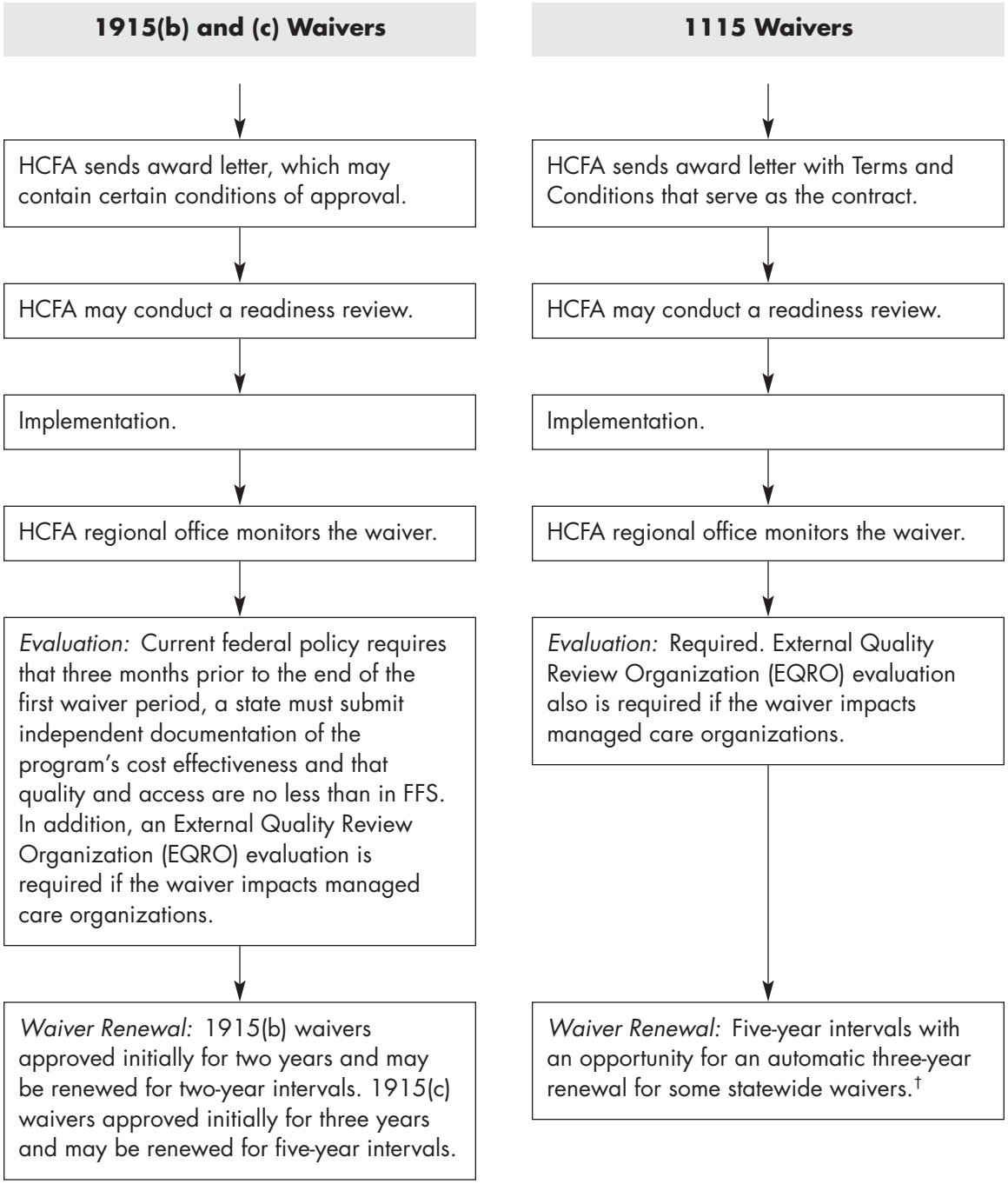
Flow Chart of Approval Processes *(continued)*



* State legislation may be necessary for implementation of program and may happen prior to or concurrent with federal approval process.

† Some of California's 1115 waivers have been approved for one-year periods, for example PACE.

of a Medicaid program without a waiver. Some states have based their benchmark expenditures on assumptions that their existing Medicaid program would, in fact, change significantly without a waiver (for example in the case of eligibility expansions) in order to allow their proposed waiver expenditures to be evaluated against higher Medicaid expenditures in determining budget neutrality.

Differences in Approval Processes

There are several differences among the waiver review and approval processes for 1915 and 1115 waivers. These differences may be of particular interest to policymakers because they may determine the type of waiver a state chooses to seek. For strategic purposes, the most significant differences are timing, scope of review, predictability of review process, and criteria. The process for a 1915 waiver is typically faster and more clearly defined, making it easier for a state to predict program implementation timelines. For an 1115 waiver there are no response time requirements for federal review. In addition, the approval of an 1115 waiver requires a more extensive review process than does that of the 1915 waiver. The entire DHHS reviews 1115 waivers rather than just HCFA. In the course of DHHS review, the 1115 waivers are subject to the following additional, though not necessarily codified, considerations:

> *Experimentation and Innovation*: The proposed program must be an experiment. This means that it must include research that provides new information on models that adapt the Medicaid program to meet states' needs.
>
> *Impact on Medicaid as an Entitlement*: The proposed benefit package must not set a precedent for less than full coverage of the current benefit package in that particular state.
>
> *Political Environment*: The current administration's policy direction and goals related to Medicaid and federal-state politics are arguably the most critical elements for approval of an 1115 waiver. This may make the predictability of waiver approval difficult for some states.

The flow chart on the two preceding pages outlines the different steps in the approval processes for Medicaid waivers.

VI. The Impact of the Balanced Budget Act of 1997

The federal Balanced Budget Act of 1997 (BBA) made significant changes to the need for and use of waiver authority on the part of states. States now have the authority to make changes to their Medicaid programs in ways that previously required a waiver, particularly in the development of Medicaid managed care systems. The purpose of such changes was to permit states greater flexibility in structuring their Medicaid programs.

Under the BBA, if a state wants to establish a new Medicaid managed care program, it does *not* need a 1915(b) waiver to enroll Medi-Cal recipients on a mandatory basis *unless* the program either:

- Enrolls special populations such as individuals eligible for Medi-Cal and Medicare, children with disabilities, children in foster care, or children with special health care needs (California's CCS population); or
- Does not offer the choice of at least two plans, with some exception for rural areas.

The effect of the BBA changes on existing waivers has been a source of some confusion for states. The BBA allows existing waivers to supersede changes in the BBA for the term of the waiver. However, states must be compliant with all BBA regulations within a certain time period after a waiver is expired or renewed (two years for 1915 waivers and three years for 1115 waivers). New contracts between the state and managed care organizations must reflect BBA requirements and need HCFA prior approval. Those 1115 or 1915 waivers approved after August 5, 1997 are subject to BBA requirements in effect at the time of the approval of the waiver. However, despite these requirements, BBA rules have not yet been finalized. Proposed rules were published in the fall of 1998, and it is expected that the final BBA rules will be published in early 2000.

Impact on California's Waivers

The BBA provides several options for California to implement program changes *without* a waiver, particularly as they relate to managed care enrollment:

- *Expansion:* Under the BBA, California no longer needs a waiver for Medi-Cal managed care implementation in the thirty-one counties that do not currently participate in mandatory managed care models. Instead of a waiver, the state would submit to HCFA an amendment to the State Medicaid Plan. However, HCFA will continue to require prior approval of California's contracts with managed care organizations enrolling Medi-Cal recipients.
- *Guaranteed Eligibility:* California no longer needs a waiver to guarantee and extend six months of eligibility to Medi-Cal recipients enrolled in managed care.
- *Lock-in:* California no longer needs a waiver to require managed care enrollees to remain in one health plan for up to twelve months, as long as the lock-in provision is applied statewide to all Medi-Cal managed care plans.

California is currently exploring the adoption of several of these options, and the Medi-Cal Policy Institute has commissioned The Lewin Group to conduct cost estimates of guaranteed eligibility and lock-in. Those studies are now available on the Institute's Web site at *www.medi-cal.org.*

VII. Additional Waiver Opportunities for California

The potential for using additional waivers to meet a variety of policy and programmatic goals is varied. Additional 1915(b) waivers will be needed if the state is to expand the populations required to enroll in managed care to include additional groups such as children with special health care needs. However, to expand managed care to existing eligible populations in additional geographic regions, a waiver would probably not be necessary for most managed care models.[7]

The opportunities for additional 1915(c) waivers are less clear and yet probably provide greater potential for the development of new programs for Medi-Cal beneficiaries. Further study on the barriers to implementing additional 1915(c) waivers is warranted, particularly in light of the recent Supreme Court ruling in *Olmstead*. In addition, California would be well served to examine successful models of 1915(c) programs in other states.

The use of the 1115 waiver for implementation of policies other than managed care is relatively untapped and heavily dependent on the political environment. However, the issue of budget neutrality is a significant challenge for this state because it has among the lowest Medicaid capitation and reimbursement rates in the country.

Options for new Medicaid waivers in California that policymakers and other Medi-Cal stakeholders have suggested or are considering include:

Additional 1915(b) Waivers

- To expand the dual-eligible population enrolled in Medi-Cal managed care to the Two-Plan or Geographic Managed Care models

- To create new models of Medi-Cal managed care for special populations such as children with special health care needs, dual-eligibles, or individuals with HIV/AIDS
- To change rate-setting methodologies for managed care payments

Additional 1915(c) Waivers

- To develop and implement alternatives to institutionalization for Medi-Cal populations and contain long-term care costs
- To better understand barriers to integrating long-term care services with other models of care

Additional 1115 Waivers

- To restructure and simplify the current Medi-Cal program for recipients
- To expand eligibility for particular populations, such as for medically indigent adults
- To facilitate the decategorization of Medi-Cal and other funding streams
- To combine different programs for low-income populations such as AIM, Healthy Families, and Medi-Cal
- To support county-based changes to Medi-Cal

California has numerous opportunities to expand and implement Medicaid waivers. Some opportunities can be identified by examining the use of Medicaid waivers in other states. However, policymakers can pursue and test new options and should not limit themselves to considering only those options that already have been employed using Medicaid waivers, particularly when considering a 1915(c) or 1115 waiver. Many states will probably test new applications of 1915(c) waivers to meet the demands of the *Olmstead* ruling and the very structure of the 1115 waiver offers opportunities for experimentation and innovation in program design.

VIII. Key Policy and Research Questions

The use of and opportunities for future waivers raise key questions about Medi-Cal and the direction the state wishes to take the Medi-Cal program. Current policy debates in California have focused around three goals for which waivers might be used: (1) generating savings; (2) expanding eligibility; and (3) meeting long-term care needs.

Specifically, policymakers need to consider the following issues and the questions each issue raises regarding the use of Medicaid waivers for California:

Generating Savings

- Should the state explore changing the role of indigent care funding sources in developing budget-neutral options to expand Medi-Cal coverage for the uninsured? What about the re-direction of DSH funds to generate savings as some other states have done? What about cost-sharing for new eligibles? If so, should cost-sharing be in the form of premiums? What level of premiums is appropriate?
- What impact would increases in Medi-Cal reimbursement rates have on opportunities available to California under Medicaid waivers? Would additional funds in the Medi-Cal system reduce the need for waivers by indirectly subsidizing additional indigent care? Or would rate increases give the state additional flexibility in designing program changes under an 1115 waiver by increasing benchmark expenditures?
- Is there a need to set state policy to guide how expected savings from 1115 waivers should be spent?

- Should the state encourage, and even partner with, counties that wish to pursue their own waivers? What if waivers are increasingly county-based rather than developed by state policymakers? Are there inequities or unintended impacts created by region-specific waivers on the state's health care system?

Eligibility Expansions

- Should waiver efforts be directed at restructuring the current program to improve access or expand eligibility to cover additional Californians?
- What unintended impacts—fiscal or otherwise—might be created in using waivers to increase the number of uninsured in California?
- What are the tradeoffs of using an 1115 waiver to expand eligibility rather than new options under the 1931(b) program? Which option is more likely to create administrative simplifications as well as expand eligibility? Is coverage for a group of low-income working parents preferable to broader expansions that require federal oversight and a demonstration of budget neutrality?
- What are the tradeoffs involved in using waivers to expand coverage under Medi-Cal versus expanding Healthy Families to cover portions of the uninsured? How might the currently uninsured be attracted to or deterred from public coverage in either program? Should waivers be used as a mechanism to create a buy-in option to Healthy Families?
- Are eligibility expansions via waivers a temporary or permanent solution for coverage of impacted populations?

Meeting California's Changing Long-Term Care Needs

- What barriers have prevented the creation of more home and community-based services programs in California? What can California learn from other states' use of 1915(c) waivers?
- Is the solution to create additional programs or to expand the number of "slots" or persons served under existing waivers?
- On what populations with long-term care needs should the state focus its policy changes?
- How do perceptions regarding the cost-effectiveness of HCBS programs differ from other states' experiences?
- What services should new HCBS models for California include? What legislative changes might be needed to change the definition and role of caregivers?

- How can 1915(c) waivers leverage changes that cut across payers in long-term care? Are Medicaid reimbursement methodologies compatible with community-based systems?
- What role will HCBS programs play in California's plan to meet standards set forth in *Olmstead v. L.C.?* How broadly will California interpret the populations included in the Supreme Court's decision in developing and amending its State Medicaid Plan?

Implications for Policymakers

The questions above and others require further research and public debate among California's federal, state, and county policymakers. While Medicaid waivers are not a magic bullet for the problems in California's health care systems, they are certainly an important tool for meeting policy goals such as increasing coverage for the uninsured, maximizing federal Medicaid revenues, and controlling growth in long-term care expenditures while increasing capacity in community settings.

Possible next steps for policymakers in California include:

- Evaluating the effectiveness of current and past California waivers
- Examining the unintended consequences of California's waivers
- Learning from the experiences of other states' waiver programs
- Improving collaboration between counties and the state in developing waiver programs
- Developing innovative uses for new waivers

There is no single answer to questions such as, "Is a Medicaid waiver the best approach to meet a certain policy goal?" or even "Can California get a waiver to do XYZ?" The answers are complex and require careful study on the part of policymakers and other Medi-Cal stakeholders. The Medi-Cal Policy Institute hopes that this paper will stimulate discussion among policymakers around these and related issues.

Notes

[1] Arizona's Medicaid program is included under its comprehensive 1115 waiver.

[2] Harrington, C., A. LeBlanc, V. Wellin, and H. Carrillo (1999). 1915(c) Waiver Data by State, 1992-1997 from HCFA Form 372. San Francisco, CA: University of California San Francisco, CA.

[3] Ibid.

[4] *Olmstead v. L.C.,* 138 F.3d 893 (1999).

[5] PACE was initially established in California through an 1115 waiver, but provisions in the Balanced Budget Act will allow the program to be continued through a State Medicaid Plan amendment in the future.

[6] Expected savings must be derived from Medicaid and not from other public programs, such as food stamps or welfare.

[7] With the exception of County Organized Health Systems which would require a waiver and additional changes in federal law.

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