

What is a Medicaid Waiver?

The *LTC Fundamentals* series is produced by The SCAN Foundation to highlight and describe the organization and financing of long-term care (LTC) in California. This *LTC Fundamentals* brief describes Medicaid waivers and how they are generally used by states. It also describes current waivers in California.

Introduction

Medicaid is the federal-state jointly funded program that provides medical and long-term care (LTC) services for low-income Americans. Under this program, states are permitted to provide Medicaid-funded services outside of the established rules and requirements of the Medicaid program through waivers. In general, a waiver is a tool available to states through provisions in the Social Security Act (SSA) that grants authority to modify certain requirements of publicly funded programs to allow for the exploration of new approaches in service delivery. Medicaid waivers permit states to provide additional services to targeted groups of individuals, limit services to specific geographic areas, limit beneficiaries' choice of providers, and provide coverage to individuals who may not otherwise be eligible under existing Medicaid rules. This brief focuses on the various types of waivers available to states under Medicaid, as well as those Medicaid waivers that are currently operational in California.

Medicaid Waivers

The SSA specifies the statutory provisions that govern how the Medicaid program is structured, ensuring certain protections for its beneficiaries. Each state operates a Medicaid program under a state plan, which describes the nature and scope of a state's program. As required under Section 1902 of the SSA, a state develops its state plan and submits it for approval to the Centers for Medicare and Medicaid Services (CMS), the federal agency within the U.S. Department of Health and Human Services (HHS) that oversees Medicaid. The state plan is a state's agreement that it will conform to the requirements of the SSA and the official Medicaid-related issuances from CMS. As part of this agreement, a state receives federal matching payments for its Medicaid expenditures.¹

Federal Medicaid requirements can be waived to allow the federal government and states to achieve different goals in providing services

“...Medicaid provisions that states can waive... are: Comparability, Statewideness, and Freedom of Choice...”

to target populations. To obtain a waiver, a state’s Medicaid agency must apply to and receive approval from CMS. In some cases, states must also obtain approval from other agencies within HHS, as well as the Office of Management and Budget (OMB). During the approval process, the elements of a waiver are negotiated between CMS and the state. In general, CMS bases waiver approval upon two factors. The first is the interpretation and application of Medicaid law and regulations. The second is whether a state can demonstrate that the cost of activities under the waiver will be no greater than they would have been in the absence of the waiver, often referred to as “budget neutrality”, “cost neutrality”, or “cost-effectiveness” depending on the type of waiver considered.^{1,2}

Medicaid waivers can be divided into two types: 1) research and demonstration projects and 2) program waivers. Each of these types of waivers is described below (see also Table 1). Among the Medicaid provisions that states can waive through these mechanisms are:¹

- **Comparability:** Medicaid benefits must be comparable across the entire eligible population. This provision prohibits states from offering different services to individuals within specific eligibility groups or limiting 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 their geographic location within the state.
- **Freedom of Choice:** Medicaid beneficiaries are guaranteed the freedom of choice of providers to ensure access to services.

Additionally, the SSA specifies benefits and eligibility criteria for groups that states must cover, as well as optional benefits and eligibility criteria for groups that states may choose to cover. These requirements can be modified by waivers.

Research and Demonstration Projects—Section 1115 Waivers

Research and demonstration projects are authorized under Section 1115 of the SSA and are intended to demonstrate and evaluate a policy or an approach to providing coverage for medical or LTC services on a widespread basis.³

Section 1115 research and demonstration projects offer the broadest form of waiver authority that exists. These waivers permit the HHS Secretary to authorize experimental, pilot, or demonstration projects likely

to assist in promoting the objectives of the Medicaid program by allowing states to operate outside of the federal parameters within which they must design and operate their programs. Section 1115 waivers allow the HHS Secretary to: (1) waive federal rules governing the broad scope of the Medicaid program including eligibility criteria, benefit packages, as well as delivery and payment methods; and (2) permit federal matching funds for state costs that are not matched under standard program rules. By waiving these provisions, states can extend coverage to populations who would otherwise not qualify for Medicaid coverage (also known as “expansion populations”) or expand services beyond what is generally covered under the program.³ States can also use these waivers to provide a more narrowly focused package of services rather than the full scope of Medicaid to a targeted expansion population, such as non-disabled HIV-positive individuals.⁴

Section 1115 waivers must be budget neutral over the term of the project. To demonstrate this, states must identify savings through mechanisms such as managed care for high-cost eligibility groups or increased out-of-pocket payments for existing Medicaid beneficiaries, to offset the costs to expand coverage or services. Additionally, states must include a research or evaluation component to assess the waiver project’s success in achieving its goals and objectives.

Evaluations may be conducted by independent research organizations that have contracted with HHS or by state Medicaid agencies. Based on their outcomes, Section 1115 waiver projects may become incorporated as Medicaid state plan services at the completion of the waiver term.¹

Section 1115 waivers are generally approved to operate for a five-year period, which can be renewed for additional lengths of time (two years for statewide programs and one year for all others).⁵ The approval process for these waivers is not held to a specific timeframe and can often last for several months or longer. Section 1115 waivers are subject to the approval of CMS, other HHS agencies, and OMB.³ Currently, 30 states and the District of Columbia operate at least one Section 1115 waiver.⁴

Program Waivers— Section 1915(b) and 1915(c) Waivers

Program waivers are authorized by sections 1915(b) and 1915(c) of the SSA and are intended to control costs, while allowing states administrative flexibility to operate their programs. Compared to Section 1115 waivers that provide the authority to waive requirements related to the broader scope of the Medicaid program, Section 1915(b) and 1915(c) waivers are targeted to a narrower set of Medicaid requirements.

Section 1915(b) “Freedom of Choice” Waivers

Section 1915(b) waivers permit states to waive the freedom of choice provision and require eligible beneficiaries to receive services from a limited set of providers. This is often implemented using managed care models. Section 1915(b) waivers also allow states to waive comparability and statewideness provisions, affording states the ability to target specific populations in certain parts of the state. Managed care programs established under these waivers can either provide a comprehensive set of services or manage a particular type of service, such as behavioral health care. For Section 1915(b) waivers, states are required to demonstrate cost-effectiveness, meaning that per-beneficiary costs under the waiver program are no greater than what they would have been under fee-for-service in the absence of the waiver. States cannot use 1915(b) waivers to extend Medicaid coverage to new populations but can, however, expand services using program savings.¹

In general, Section 1915(b) waivers are initially approved for a two-year period and can be renewed in two-year increments. Section 1915(b) waivers are subject to the approval of CMS. The approval process for 1915(b) waivers consists of a 90-day review

period that can be restarted if CMS requires additional information.^{1,3} In 2009, Section 1915(b) waivers were in operation across 25 states.⁶

Section 1915(c) Home- and Community-Based Services (HCBS) Waivers

Section 1915(c) authorizes states to provide home- and community-based services (HCBS) to individuals who would otherwise require care in an institutional setting, such as a nursing home.¹ HCBS can include personal care, homemaker services, case management, environmental modifications, and respite care. Section 1915(c) waivers allow the HHS Secretary to waive comparability and statewideness provisions, as well as certain income and asset rules. This permits states to use greater or lesser restrictive eligibility criteria for services and to target services to specific populations. States may also use enrollment caps to limit the number of beneficiaries that can be served through a Section 1915(c) waiver program. States must demonstrate that 1915(c) waivers are cost neutral, meaning that average per capita HCBS costs do not exceed what average per capita institutional costs would have been under the state plan if the waiver had not been in operation.^{1,7}

Under current federal regulation, a Section 1915(c) waiver can only serve one of three target groups: 1) older adults, people with disabilities, or both, 2) people with mental retardation, developmental disabilities, or both, and 3) people with mental illness. To serve more than one of these groups, states must currently develop separate section 1915(c) waivers for each group. In April 2011, CMS issued a notice of proposed rulemaking to allow states to create coordinated waivers that serve more than one of these groups. This would allow states to better meet the needs of Medicaid beneficiaries and administer services more efficiently. The proposed rule was available for public comment until June 14, 2011.⁸

Section 1915(c) waivers are initially approved for a three-year period and can be renewed in five-year increments. As with Section 1915(b) waivers, Section 1915(c) waivers are subject to CMS approval and undergo a 90-day review period that can be restarted if CMS requires additional information. Section 1915(c) waivers are in operation across nearly every state (Arizona and Vermont are the only states that do not operate 1915(c) waivers and instead provide HCBS through Section 1115 waivers).⁹

Concurrent 1915(b)/(c) Waivers

States can combine 1915(b) and 1915(c) waivers to provide a continuum of services to older adults and people with disabilities. Under such a program, states use the 1915(b) authority to limit freedom of choice in accessing providers and the 1915(c) authority to target eligibility for the program and provide HCBS. This allows states to provide HCBS in a managed care environment.¹⁰

States can operate concurrent 1915(b) and 1915(c) waivers as long as federal requirements for both waivers are met. States must submit a separate application for each waiver and satisfy all of the applicable requirements, including cost-effectiveness for the 1915(b) waiver and cost neutrality for the 1915(c) waiver. Each waiver is approved for its respective time period and, as such, renewals must be requested at different points in time.¹⁰ In 2009, there were nine combined 1915(b)/(c) waivers in operation across eight states.⁶

TABLE 1 Summary of Medicaid Waivers

	Section 1115 Research and Demonstration Waivers	Section 1915 (b) Freedom of Choice Waivers	Section 1915 (c) Home & Community Based Services Waivers
Federal Requirements Waived	Broad scope of Medicaid rules, including: <ul style="list-style-type: none"> • eligibility criteria • benefit packages • service delivery and payment methods 	<ul style="list-style-type: none"> • Statewideness • Comparability of services • Choice of provider 	<ul style="list-style-type: none"> • Statewideness • Comparability of services • Income and resource standards
Approval Process	Subject to CMS review; no specific review timeline	Subject to CMS review lasting 90-days (or longer if additional information is requested)	Subject to CMS review lasting 90-days (or longer if additional information is requested)
Time Period for Waiver Operation	<ul style="list-style-type: none"> • Five years for initial waiver • Three-year extensions for statewide programs; one-year extensions for other programs 	<ul style="list-style-type: none"> • Two years for initial waiver • Two-year extensions 	<ul style="list-style-type: none"> • Three years for initial waiver • Five-year extensions
Examples of Use	<ul style="list-style-type: none"> • Expansion of eligibility • Managed care 	<ul style="list-style-type: none"> • Managed care 	<ul style="list-style-type: none"> • Service alternatives to institutional care for elderly and disabled

Source: California Department of Health Care Services. Waivers at a Glance. <http://www.dhcs.ca.gov/services/medi-cal/Pages/AuthorizedWaivers.aspx>. Accessed April 2, 2011.

Medi-Cal Waivers in California

In California, the Department of Health Care Services (the department that operates Medi-Cal, the state’s Medicaid program) assumes responsibility for submitting waiver applications to the federal government. In addition to federal approval, requests for new waivers in California typically require authorization by the State Legislature.¹¹

Table 2 below lists the waivers that are currently active in California, including a description of services provided, eligibility requirements, enrollment capacity (if applicable), and terms of operation for each.

TABLE 2 California Medi-Cal Waivers

Title	Description	Term
Section 1115 Research and Demonstration Waiver^a		
“Bridge to Reform” Demonstration	<p>Description: Provides federal matching funds for the following activities: (1) the Low-Income Health Program (LIHP), which will extend Medicaid coverage to 500,000 low-income uninsured adults through either the Coverage Expansion or Health Care Coverage initiatives; (2) the Delivery System Reform Incentive Pool (DSRIP), through which the state can make payments to safety-net hospitals to improve the quality of care they provide and the health of the populations they serve; and (3) system delivery reform for special populations, such as mandatory enrollment for Medi-Cal-only seniors and people with disabilities (SPDs) into managed care plans to achieve better care coordination and management and to offset costs of the LIHP and DSRIP initiatives.</p> <p>Eligibility: To be eligible for services under LIHP, individuals must: 1) be non-pregnant adults between the ages of 19 and 64, 2) not be enrolled in Medi-Cal or the Child Health Insurance Program, and 3) have family incomes at or below 133 percent of the Federal Poverty Level (Coverage Expansion initiative) or between 133 and 200 percent of the Federal Poverty Level (Health Care Coverage initiative). For the DSRIP program, hospitals will be required to meet certain process and outcome measures to receive federal funding. For the mandatory managed care initiative, Medi-Cal-only SPDs will be required to enroll in one of the Medi-Cal managed care plans available in the counties where they reside.</p> <p>Enrollment Capacity: Not applicable</p>	Nov. 1, 2010- Oct. 31, 2015
Section 1915 (b) Freedom Of Choice Waivers		
Specialty Mental Health Consolidation Program	<p>Description: Provides mental health services to Medi-Cal beneficiaries who require treatment by licensed mental health professionals through county mental health plans. Services include psychiatric health facility care, nursing facility care, adult residential treatment, and targeted case management.</p> <p>Eligibility: To receive services, individuals must: 1) be eligible for Medi-Cal, 2) meet specified diagnoses, impairment, and intervention criteria, and 3) require treatment by a licensed mental health professional.</p> <p>Enrollment Capacity: Not applicable</p>	Oct. 1, 2009- Jun. 30, 2011
Section 1915 (c) Home- and Community-Based Services (HCBS) Waivers		
Acquired Immune Deficiency Syndrome (AIDS)	<p>Description: Provides HCBS, including case management, home health aide/ personal attendant services, and home-delivered meals to Medi-Cal beneficiaries with mid- to late-stage HIV/AIDS disease as an alternative to nursing facility or hospital care.</p> <p>Eligibility: To receive services, an individual must: 1) meet Medi-Cal eligibility requirements, 2) be certified to require a nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale and 3) have a written diagnosis by an attending physician of HIV disease or AIDS with current signs, symptoms, or disabilities related to the disease or treatment.</p> <p>Enrollment Capacity: 4,250 individuals for the 2011 calendar year.</p>	Jan. 1, 2007- Dec. 31, 2011

<p>Assisted Living</p>	<p>Description: Provides assisted living services, including personal care, health-related, recreational, and transitional care to a limited number of eligible seniors and persons with disabilities currently residing in Sacramento, San Joaquin, Los Angeles, San Bernardino and Riverside Counties. The Department of Health Care Services is currently expanding the program to Sonoma and Fresno Counties.</p> <p>Eligibility: To receive services, an individual must: 1) be eligible for Medi-Cal, 2) have a nursing home level of care need, and 3) reside in one of the designated counties.</p> <p>Enrollment Capacity: 2,260 for the 2011 waiver year.^b</p>	<p>Mar. 1, 2009- Feb. 29, 2014</p>
<p>HCBS Waiver for the Developmentally Disabled (HCBS-DD)</p>	<p>Description: Provides HCBS, such as home health aide services, habilitation, adult residential care, respite, and many other services to Regional Center consumers with developmental disabilities, enabling them to living in the community rather than in an intermediate care facility for the developmentally disabled (ICF/DD).</p> <p>Eligibility: To be eligible for services, individuals must: 1) be eligible for the full scope of Medi-Cal, 2) have a formal diagnosis of a developmental disability that originates before the age of 18, 3) be a Regional Center consumer, and 4) meet the level of care criteria for admission to a Federal intermediate care facility for the mentally retarded (ICF/MR), or in California, an ICF/DD.</p> <p>Enrollment Capacity: 95,000 for the 2010-11 waiver year.^b</p>	<p>Oct. 1, 2006- Sept. 30, 2011</p>
<p>Nursing Facility/Acute Hospital (NF/AH)</p>	<p>Description: Along with the In-Home Operations Waiver discussed below, the NF/AH Waiver consolidated three former waivers (Nursing Facility A/B Waiver, Nursing Facility Subacute Waiver, and the In-Home Medical Care Waiver). Provides services in the home to Medi-Cal beneficiaries who would otherwise receive care in an intermediate care facility, a skilled nursing facility, a subacute nursing facility, or an acute care hospital. Services include private duty nursing, case management, waiver personal care services, and other HCBS.</p> <p>Eligibility: The NF/AH Waiver is an umbrella for three levels of care (Nursing Facility A/B, Subacute, and Acute), each with distinct eligibility criteria. In general, individuals must: 1) be eligible for the full scope of Medi-Cal, 2) currently reside in an institution (e.g. acute hospital, adult or pediatric subacute nursing facility, distinct-part nursing facility, adult or pediatric skilled nursing facility or intermediate care facility) with the option of receiving care in a home-like setting or reside in the community and be at-risk for institutionalization within the next 30 days.</p> <p>Enrollment Capacity: 3,032 individuals for the 2011 calendar year, allocated across levels of care (Nursing Facility A/B, Subacute, and Acute).</p>	<p>Jan. 7, 2007- Dec. 31, 2011</p>
<p>In-Home Operations (IHO)</p>	<p>Description: Replaced components of the prior Nursing Facility A/B Waiver, Nursing Facility Subacute Waiver, and In-Home Medical Care Waiver. Services include private-duty nursing, personal care, home health aide services, habilitation, family training and community transition services.</p> <p>Eligibility: Grandfathered in Medi-Cal beneficiaries previously enrolled in these waivers who require direct care services provided primarily by a licensed nurse and needed services in excess of that available through the NF/AH Waiver.</p> <p>Enrollment Capacity: 162 individuals for the 2011 calendar year.</p>	<p>Jan. 1, 2010- Dec. 31, 2014</p>

<p>Multipurpose Senior Services Program (MSSP)</p>	<p>Description: Provides HCBS, such as case management, adult day care, housing assistance, chore services and personal care services to Medi-Cal beneficiaries who are 65 and older and have a disability as an alternative to nursing home placement. There are 41 MSSP sites across counties in the state.</p> <p>Eligibility: Eligible individuals must: 1) be determined to need a nursing facility level of care in the absence of waiver services, 2) be enrolled in one HCBS waiver at a time, and 3) live in a county with an MSSP site.</p> <p>Enrollment Capacity: 16,335 individuals over the term of the waiver’s operation.</p>	<p>Jul. 1, 2009- Jun. 30, 2014</p>
<p>Developmentally Disabled Continuous Nursing Care (DD-CNC)</p>	<p>Description: Provides continuous nursing care to medically fragile Medi-Cal beneficiaries with developmental disabilities in a small home-like community setting. Services include 24-hour nursing, including personal care, developmental services and nursing supervision, as well as assistance with medication management, ventilator and tracheotomy care, and tube feeding.</p> <p>Eligibility: To be eligible for services, individuals must: 1) be eligible for Medi-Cal and not be enrolled in a managed care health plan, 2) be enrolled in a regional center and certified as developmentally disabled, 3) have a medical necessity for continuous skilled nursing care needs and 4) be free of clinically active communicable disease.</p> <p>Enrollment Capacity: 72 individuals for the 2010 waiver year.^b</p>	<p>Oct. 1, 2009- Sept. 30, 2012</p>
<p>Pediatric Palliative Care</p>	<p>Description: Provides children with life-limiting conditions a range of home-based hospice-like services with the option to continue receiving curative treatment. Services include pain and symptom management; care coordination; expressive therapies, such as creative art, music, massage and play therapy; family training; support counseling; and respite care.</p> <p>Eligibility: To receive services, an individual must: 1) be eligible for the full scope of Medicaid, 2) be 20 years of age or younger, 3) live in one of the 11 counties in which waiver services are offered, and 4) have one of 10 eligible medical conditions, including cancer, cystic fibrosis, and ventilator dependant muscular dystrophy.</p> <p>Enrollment Capacity: 1,300 individuals for the 2011-12 waiver year.^b</p>	<p>Apr. 1, 2009- Mar. 31, 2012</p>

Source: California Department of Health Care Services, Description of Medi-Cal Waivers, September 2010. <http://www.dhcs.ca.gov/services/medi-cal/Documents/MediCalWaiversSept10.pdf>. Accessed April 1, 2011; Kaiser Commission on Medicaid and the Uninsured. Key Facts on California’s “Bridge to Reform” Medicaid Demonstration Waiver. 2011; <http://www.kff.org/medicaid/upload/8197-FS.pdf>. Accessed June 7, 2011; California Department of Health Care Services Correspondence on April 7, 2011; Department of Health Care Services, State of California. Pediatric Palliative Care Waiver: Program History and Overview. <http://www.dhcs.ca.gov/services/ppc/Pages/ProgramOverview.aspx>. Accessed July 27, 2011.

^a Prior to November 2010, California operated four 1915(b) waivers that authorized the operation of managed care programs for Medi-Cal beneficiaries in certain counties. These were the Two-Plan/Geographic Managed Care Waiver, County Organized Health Systems Waiver, County Organized Health Systems: Santa Barbara-San Luis Obispo Regional Health Authority (SBSLORHA or CenCal) Waiver, and the Health Plan of San Mateo Waiver. The Section 1115 “Bridge to Reform” Waiver consolidated these four waivers to carry out the demonstration.¹²

^b “Waiver year” refers to the 12-month period for a waiver approved by CMS. It varies for each waiver and may at times correspond to a calendar year (January 1 through December 31).

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Conclusion

Medicaid waivers have proven to be useful tools in spurring innovation in the organization and delivery of the Medicaid benefit and ensuring that these services are provided to the populations that need them. As in other states, waivers have been particularly important in expanding the range of HCBS options available in California since, unlike nursing home care, these services are not mandatorily covered under Medicaid. States must choose to provide these additional services and waivers have provided the authority and federal funding to do so.

Yet, while waivers provide states a forum for innovation and service expansion, they have at the same time contributed to the fragmented way in which HCBS are administered as states operate within the limits of the federally established structure of the Medicaid program. Because states at this time are not permitted to create 1915(c) waivers that serve multiple target groups, they have had to

apply for and operate a number of individual waiver programs, which results in both administrative and financial inefficiencies.

The Patient Protection and Affordable Care Act (ACA; 111-148) and forthcoming federal regulations may provide opportunities to improve HCBS provision by allowing states to provide waivers services in a more coordinated way and by giving current waiver programs more permanence, allowing them to be delivered as optional state plan services through programs like Community First Choice. However, meaningful change will require California as well as other states to take steps to significantly transform their systems to reduce existing fragmentation and streamline service delivery.

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