Medicaid State Plans

Medicaid Authority – Medicaid is a joint federal and state benefits program established by Title XIX amendments to the Social Security Act of 1935. The Medicaid program provides health care to low-income families and medically needy (aged, blind, or disabled) individuals.

What is a State Plan Amendment (SPA)?

A state plan for medical assistance is an agreement between a state and the federal government's Centers for Medicare and Medicaid Services (CMS) describing how the state will administer its Medicaid program.

1. The Social Security Act requires all states submit state plans for medical assistance to CMS, which are approved by the Secretary of Health and Human Services
2. Generally, states must comply with federal requirements of § 1902 of the Social Security Act in order to receive federal matching funds
3. The state plan specifies:
    a. Groups of individuals to be covered
    b. Services to be provided
    c. Methodologies for providers to be reimbursed
    d. Administrative activities that are underway in the state

When a state is planning to make a change to its Medicaid or Children's Health Insurance Program (CHIP) program policies or operational approach, states send state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) for review and approval. A SPA is the vehicle most often used by states seeking changes to their Medicaid programs. Virginia has, on average, 25 SPAs per year. When a state submits a SPA to CMS for approval, the Secretary of Health and Human Services has **90 days to make a decision;** otherwise, the proposed change automatically goes into effect. The State Plan for Medical Assistance is reflected in the Virginia Administrative Code (12 VAC 30 chapters 5-110).

Medicaid Waivers

What is a Medicaid Waiver?

States use a variety of different Medicaid waivers to test new or existing service delivery or payment models, in an effort to advance the state's Medicaid program.

Three common types of Medicaid waivers most often used to implement a variety of programs:

1. **The §1915(b) Waiver** is designed for establishing a managed care service delivery system.
2. **The §1915(c) Waiver** is a home and community based services waiver designed to transition long-term care services from institutional settings to the home and community.
3. **The §1115 Waiver** is a flexible waiver for testing research and demonstration projects

Of these three waivers, the experimental nature of the §1115 Waiver and its evolution have enabled it to become a tool for states interested in implementing alternative approaches to traditional Medicaid expansion.

To implement a program under a Medicaid Waiver, states must submit a waiver application to CMS and receive the approval of the Secretary of HHS. To obtain approval, proposed waiver projects must be (1) time-limited, (2) budget neutral (not increase federal deficit) or cost effective (depending on which waiver is used), and (3) promote the purposes of the Medicaid program.

What is a §1115 Waiver?

Waiving Federal Requirements While Receiving Federal Match

Section 1115 of the Social Security Act permits the Secretary of HHS to waive certain federal requirements within the Social Security Act regarding states' administration of the Medicaid program.

1. Specifically, § 1115 allows states to waive compliance with **§ 1902 of the Social Security Act**, which establishes federal requirements for state plans for medical assistance.
2. States may use a § 1115 Waiver to receive federal Medicaid funding for programs that would not typically be permitted under § 1902 for state plans for medical assistance.
3. The 50-50 Federal Match rate for Virginia would still apply to an §1115 Waiver.

Demonstration projects under a §1115 Waiver are by their nature open-ended and subject to a great deal of federal discretion. States seeking approval from CMS for a §1115 Waiver must therefore engage in a lengthy negotiation process with CMS and other federal partners, such as the Office of Management and Budget. There is no established deadline for CMS to approve a §1115 Waiver proposal and on average the negotiation process can take 18 to 24 months.

§ 1115 Waiver Proposals

States may waive these requirements by submitting a §1115 Waiver proposal to CMS and receiving approval for the demonstration project under the §1115 Waiver.

§1115 Waivers Are Available for "Experimental, Pilot, or Demonstration" Projects that are:

1. **Likely to assist in promoting the objectives of the Medicaid program:**
   The Secretary of HHS can only grant §1115 waivers if they are likely to further the objectives of the Medicaid program. §1115 Waivers are available for a variety of purposes, but states most often use §1115 Waivers to:
   - expand coverage
   - implement delivery system reform
   - advance behavioral health initiatives

2. **Budget Neutral to the Federal Government:**
   Longstanding HHS policy requires §1115 Waivers to be budget neutral for the federal government

a. CMS has defined "budget neutral to the federal government" to mean that Federal spending with the waiver program should not exceed federal spending without the waiver program.
b. This means that an application for a §1115 Waiver project will need to identify savings that can offset the costs of implementing the proposed project.
c. To ensure budget neutrality, the federal government places a cap on federal matching funds for the duration of the waiver period. **This puts the state at risk for all costs that exceed the waiver cap**.
d. Due to budget neutrality requirement, §1115 Waiver proposals require review and approval by the Office of Management and Budget as well as CMS.

§1332 State Innovation Waivers (non-Medicaid)

§1332 Waivers are Not Medicaid waivers

Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. These waivers are not for the Medicaid program or Medicaid enrollees.

1. Section 1332 Waivers **allow comprehensive changes to a state's healthcare delivery system** as well as small changes focused on a specific issue, such as reinsurance programs.
2. Section 1332 waivers permit states to apply for waivers of certain Affordable Care Act (ACA) requirements from the Department of Health and Human Services (HHS) and from the Department of the Treasury (Treasury).
3. **1332 Waivers are limited by the ACA's Guardrails.** §1332 Waiver programs must satisfy Guardrails established under the ACA, by:
    a. Providing coverage that is at least as **comprehensive** and **affordable** as would be provided absent the waiver
    b. Providing coverage to a **comparable** number of residents of the state as would be provided coverage absent the waiver
    c. **Not increasing the federal deficit** (i.e. budget neutral for the federal government)
4. Waivers are approved for **five-year periods** and can be renewed.

What is the Difference Between §1115 and §1332 Waivers?

§1332 Waivers are not Medicaid Waivers and cannot change Medicaid program requirements

States may submit applications for §1332 Innovation waivers with §1115 Medicaid Demonstration Project waivers to be evaluated independently, but §1332 waivers cannot be used to change Medicaid program requirements.