JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

# Overview of 1115 Waivers


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# State Tools for Modifying Medicaid Program

- Three primary tools for modifying a state Medicaid program:
  - State Plan Amendments (SPA) – used to change administrative aspects of a state's Medicaid program like covered benefits and provider payments
    - Usually covers a single discrete topic
    - Remains in effect until it is withdrawn and can be granted retroactively
  - 1915 Waivers – used for particular narrow functions like coverage of home and community based services and, in other states, case management
  - 1115 Waivers – broad authority for states to pursue "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of Medicaid, but must be budget neutral for the federal government
    - Generally used for large initiatives
    - Granted for 5 year terms and can be renewed

# DHHS Preparation for 1115 Amendment

- 1115 waiver submission covers only the components of a state proposal that require special federal authority; not a holistic picture of any Medicaid reform initiative
- Prior to submitting the amended waiver, DHHS held public hearings and released 80-page program design
  - End-to-end view of vision for all components of the managed care transition, including those not requiring waiver authority
  - Detailed discussion of covered populations and timelines
- Also releasing concept papers on specific topics
  - BH IDD Tailored Plans
  - Network Adequacy
  - Other topics to be released in coming months

# 1115 Process

- State submits an application to CMS:
  - Defining the proposed demonstration project and how it meets the objectives of Medicaid
  - Asking for federal waiver of particular aspects of the Medicaid statute:
    - Programmatic authority, e.g. allowing DHHS to make managed care enrollment mandatory
    - Expenditure authority, which allows DHHS to claim a federal Medicaid match for activities that may be conducted in the future
  - Demonstrating how the waiver (including any proposed expenditure authority) is budget neutral for the federal government
- CMS and the state negotiate Special Terms and Conditions (STCs) that govern how the waiver will operate and the circumstances under which the state can claim federal match
- Waivers are granted for 5 year terms
- Waivers only cover items that require programmatic or expenditure authority

# 1115 Budget Neutrality

- Application serves as starting point for discussions with CMS
- CMS and the state agree on an amount of "savings" for the federal government compared to federal spending in the absence of the waiver
  - Specific formulas CMS prescribes for budget neutrality projections, which are very different from how DHHS projects the Medicaid budget
- Based on those "savings," state secures agreement that CMS will provide matching funds up to certain amounts for certain activities not typically covered by Medicaid if the state conducts those activities in the future
  - State share must still be provided at match rate appropriate for the activity (e.g. 50% for administrative activities or FMAP for medical services) under normal matching rules
  - State is under no obligation to conduct particular activities
- Budget neutrality cannot be renegotiated except under exceptional circumstances

# DHHS 1115 Waiver Application

- Some components of the waiver require additional legislative authority to implement, which is made clear throughout the submission to CMS:
  - Integration of behavioral health into PHP contracts
  - Creation of Tailored Plans for those with significant needs and delayed enrollment of Tailored Plan population
  - Exclusion of certain populations with limited coverage from managed care (inmates of prisons, family planning enrollees)
  - Delayed enrollment of special populations (foster children, CAP-C and CAP-DA waiver enrollees, non-dual long-stay nursing home enrollees), coordinated with launch of specialized products to meet needs and manage budget
  - Minor changes to managed care coverage related to eyeglasses
  - Imposition of work requirements and premiums for potential future populations
  - Supplemental payment reform
  - MCO tax and revenue

# DHHS 1115 Waiver Application

- *Any* spending under the waiver requires enactment of future year budgets
  - DHHS does not currently have funds to expend state share on any waiver activities, including even making capitation payments to PHPs at managed care launch
  - Future enacted budgets will define how Medicaid spends money
  - This may include items for which CMS has granted expenditure authority, if state funding is appropriated
  - Examples of these potential future "expenditure authority" activities include:
    - Initiatives to develop the NC health care workforce
    - Initiatives to improve access to, use of, and efficiency of telemedicine services
    - Public/private partnerships

# Discussions with CMS

- DHHS has had ongoing weekly meetings with CMS subject matter experts since September to discuss waiver components
- Major areas of CMS feedback:
  - Changes have been made to the process for cost-settling local health departments and other safety net providers in managed care (now using state plan authority, not waiver authority)
  - We continue to discuss the scope of an Institution for Mental Disease (IMD) waiver based on guidance provided by CMS after the waiver was submitted
  - Budget neutrality conversations are ongoing; recent discussions have unearthed potential areas of disagreement
- Continue to work with federal partners