INTRODUCTION

States may apply for waivers from the Centers for Medicare & Medicaid Services (CMS) to customize their Medicaid program. States can leverage waivers to design Medicaid programs that meet their unique needs and priorities. Waivers allow states to cover benefits that Medicaid state plans[1] do not or allow states to provide benefits that exceed what is in the state plan. In addition, federal authority requires states to demonstrate waivers are cost effective and efficient.[2]

While federal law requires that states adhere to certain requirements related to eligibility categories and required benefits, federal law also provides significant flexibility for states to make decisions about their specific program design, inclusive of eligibility, delivery system, premiums and cost sharing, and optional benefits.

All 50 states operate at least one waiver, which has led to considerable variability among states in terms of program design, eligible populations, covered services, and benefit limitations. Given this variability among states, UnitedHealthcare Community and State, in partnership with its independent National Advisory Board (Board), has undertaken a multi-year project to explore the research and available data to develop recommendations for benefit design to support the following populations in achieving improved health and wellness while affording them greater flexibility and control over these benefits and their lives:

- Individuals with Alzheimer's or related dementias
- Individuals with physical disabilities
- Individuals with intellectual disabilities and developmental disabilities (I/DD)
- Individuals with behavioral disabilities (e.g. Serious Mental Illness)

This phase of the project included researching and cataloging all of the waivers in all 50 states, Puerto Rico, and the District of Columbia.

Over the next year, UnitedHealthcare Community and State, in collaboration with the Board, will provide recommendations on the core set of benefits needed to ensure individuals along the care continuum have access to needed services at the right time and in the right setting. Additionally, research will continue on examining state and federal policies that create barriers to accessing coverage, as well as other factors that may impede an individual's path to wellness. The culmination of this project will include:

- Creating policy recommendations to improve the regulatory environment to support a culture of access; and
- Developing principles of person-centeredness and cultural competency that create a foundation upon which UnitedHealthcare Community and State staff can leverage in their interactions with members and each other.

[1] A Medicaid and CHIP state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that is underway in the state.

[2] Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/medicaid-101/waivers/

LEVERAGING WAIVERS TO SUPPORT STATE PRIORITIES

The number, type, and scope of Medicaid waivers vary considerably across states. There are several types of waivers providing services to Medicaid recipients, as shown by the figure below, that allow states to target certain objectives like reducing costs, expanding coverage, or improving care for specific populations. Given the targeted approach of our research, our focus was primarily on review and analysis of Section 1915 waivers. Most states use Section 1915 waivers to meet the needs of people in need of long-term care services and supports (LTSS) in their home or community instead of an institutional setting or long-term care facility. Some states (e.g., Rhode Island and Kansas), however, operate comprehensive Section 1115 Medicaid demonstration waivers, which include all of their covered populations.

Home and Community-Based Services (HCBS) Waiver Types

Section 1115 Research And Demonstration Projects	• Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid that differ from federal program rules. Waivers can provide states considerable flexibility in how they operate their programs beyond what is available under current law.
Section 1915 Waiver Programs	• States can apply for home and community-based services 1915 waivers to support certain Medicaid populations in home or other community-based settings instead of in institutional or long-term care facilities. States can apply for different 1915 waiver authority to provide a continuum of services to seniors and people with disabilities, so long as all federal requirements are met.

ACHIEVING ADMINISTRATIVE EFFICIENCY

Most states operate multiple waivers to support individuals in need of LTSS. Federal authority, however, provides states with the flexibility to serve individuals of different target groups under one waiver.[3] On January 16, 2014, CMS published a final rule (42 CFR 441.301 (b)(6)) that permits states to combine target groups within one waiver, removing a barrier for states that wish to design a waiver that meets the needs of more than one target population. The provision of the rule related to target groups provides an option to states to design services across populations, which may lead to improved integration and administrative efficiencies in state Medicaid agencies. To operate a waiver under this rule, the waiver must be limited to one or more of the following target groups or any subgroup thereof that the state may define:

- Aged or disabled, or both
- Individuals with Intellectual or Developmental Disabilities, or both
- Mentally ill

[3] A provision of the 2014 1915(c) HCBS Final Regulation permits states to serve multiple target groups under one 1915(c) waiver.

Through this guidance, CMS was attempting to create some standardization on key program elements related to policy objectives that are of importance to stakeholders, providers, and policymakers. The guidance was also intended to provide states with the flexibility needed to evolve their programs. Prior to this regulation, states were required to develop separate section 1915(c) waivers to serve more than one of the specified target groups; this resulted in states simultaneously operating numerous waivers, ranging anywhere from one to 11 waivers in one state. Despite this flexibility, many states still administer several waivers to provide services to a variety of populations. This approach is administratively burdensome for states and creates confusion for individuals in need of services.

Instead, states could consider leveraging this federal flexibility to streamline their Medicaid HCBS programs. In addition to creating a more efficient program by decreasing the administrative complexity inherent when operating multiple waivers, there are also several additional reasons why states may opt to streamline their Medicaid HCBS programs into a single waiver. These include the following:

- Allows states to serve individuals of different target groups who live together (e.g. an individual with an intellectual disability and his/her aging parent) seamlessly.
- Recognizes that individuals' needs may make them eligible under multiple eligibility groups.
- Offers an array of services to meet a wide range of needs, regardless of diagnostic category.
- Encourages administrative efficiencies for states that offer the same benefits to multiple target groups using multiple waivers.
- Decreases administrative complexity for states by moving away from a piecemeal approach, as they will not have to combine multiple authorities, administer different sets of eligibility rules, and oversee distinct quality measures.
- Improves consumer experience. The current Medicaid HCBS system creates confusion for individuals in need of services. Those seeking services for the first time are typically unfamiliar with the program's complexities and may have to navigate different sets of requirements and determine which pathway leads to the benefit package that best meets their needs. One benefit package may include supports such as personal care targeted to people with physical disabilities, while specialty behavioral health services may be available through a separate benefit package. If different services are offered through distinct programs, people with multiple needs may have to choose which services to pursue and which to forgo.[4]

While there are several advantages for states opting to leverage one waiver serving multiple target populations, policymakers must also ensure that their program design recommendations simultaneously contain costs and improve care. Additionally, states should also consider the following when designing their HCBS waiver programs to ensure programs are in alignment with federal guidelines:

[4] https://www.kff.org/report-section/streamlining-medicaid-home-and-community-based-services-key-policy-questions-issue-brief/

- Each individual within the waiver, regardless of target group, must have equal access to the services necessary to meet their unique needs as indicated in the person-centered plan.
- States may not limit services based on an individual's target group; for instance, states cannot mandate that Personal Emergency Response Systems (PERS) benefit is only for older adults or that only for individuals with I/DD can access habilitation services.

STATE TRENDS

Kaiser Family Foundation surveyed states considering waiver consolidation and released their findings in January 2018. They found:

- Sixteen states reported plans to consolidate multiple Section 1915(c) HCBS waivers or move those services to another Medicaid authority;
- Some states are planning to consolidate multiple Section 1915(c) waivers into a single Section 1115 waiver that would both authorize HCBS and require capitated managed care enrollment; and
- Other states are moving certain HCBS from Section 1915(c) waiver to Medicaid state plan authority. For example, South Carolina and Utah are phasing out their Section 1915(c) waivers that serve children with autism and instead offering those services as part of their state plan benefit package.[5]

CONSIDERATIONS

A significant number of states are considering consolidating waivers that provide home and community-based services. States must, however, consider a variety of factors including the fiscal, operational, and programmatic impacts of consolidating waivers in addition to the federal requirement that states must demonstrate cost neutrality. Cost neutrality requires that spending on waiver services cannot be greater than they would be in the absence of the waiver. States considering consolidating multiple HCBS waivers must carefully weigh cost neutrality requirements against the administrative efficiencies achieved through waiver consolidation.

ADDITIONAL RESOURCE

UnitedHealthcare Community and State's National Advisory Board's Recommended Benefits to Support Individuals with Complex Health Needs

[5] https://www.kff.org/report-section/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies-report/