

SB05-221 Bill Analysis

For the Health District of Northern Larimer County Board of Directors

April 20, 2005

Bill Title: Concerning a requirement that the state seek a waiver under the health insurance flexibility and accountability demonstration program

Sponsors: Senate: Hagedorn; House: Buescher

Committees: Senate: HHS, Appropriations

History: 04/14/2005 Senate Committee on Health and Human Services Refer Amended to Appropriations

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Background

Waiver Authority

The Social Security Act (SSA) provides the authority to waive certain provisions of the Medicare, Medicaid and SCHIP statutes, enabling states and the federal government to implement innovative measures for providing health care services.¹ Waiver authority, established under the SSA, is used to modify program provisions that inhibit states from implementing certain types of programs.

Waivers are not new to the Medicaid program. In 1962, prior to the establishment of Medicaid, Section 1115 of the SSA was enacted.² Specifically, Section 1115 allows the Secretary of the Department of Health and Human Services (DHHS) to authorize, “any experimental, pilot or demonstration project, which, in the judgment of the Secretary, is likely to assist in promoting the objectives” of the programs covered by the SSA.³ Although Section 1115 waivers preceded Medicaid, it was not until the early 1980s that these types of waivers were used to employ broad reforms to state Medicaid programs. Specifically, Arizona was the first state to be approved for a Section 1115 proposal for comprehensive and statewide Medicaid reform in 1982.⁴

Notably, Section 1115 waivers are not the only types of waivers offered to states. In 1981, two types of program waivers under Section 1915 were enacted. Section 1915(b) waivers authorize states to implement delivery models (for example, mandatory enrollment in managed care) that compel eligible beneficiaries to use specific providers to receive services.⁵ Section 1915(c) waivers authorize states to offer home and community-based services as alternatives to institutional care in “hospitals, nursing homes, and intermediate care facilities for persons with mental retardation.”⁶

Overall, waiver authority allows federal and state governments to redefine their roles in several ways. First, waivers allow states and the federal government to test innovative and cost-effective approaches for financing and delivering health care. Second, waivers can be used to promote an administration’s political or policy objectives. Third, waivers allow Congress to direct the DHHS to test new payment and delivery methods. Finally, waivers permit state flexibility and reshaping of Medicaid programs at the state level.⁷

Waiver Financing: Budget Neutrality

All Section 1115 research and demonstration projects and program waivers are required to demonstrate budget or cost neutrality. Specifically, programs conducted under a demonstration project should not cost the federal government more than would have been spent under program rules without the demonstration. In order to demonstrate budget neutrality,

¹ Cynthia Shirk, “Shaping Public Programs through Medicare, Medicaid, and SCHIP Waivers: the Fundamentals,” National Health Policy Forum Background Paper (September 15, 2003)

² “Section 1115 Waivers in Medicaid and the State Children’s Health Insurance Program: An Overview,” Policy Brief for the Kaiser Commission on Medicaid and the Uninsured (July 20, 2001)

³ Shirk, p. 3

⁴ Richard Teske, “How States Can Use Federal Waivers to Help the Poor and Test Health Reforms,” for the Heritage Foundation (November 2, 1999)

⁵ Shirk

⁶ Shirk, p. 4

⁷ Shirk

states must compare the ‘with waiver’ costs against the ‘without waiver’ or status quo costs over the proposed 5-year waiver period. For this reason, states must estimate both types of costs (with and without waiver), and defend the credibility of their assumptions and methods (which are actively negotiated by the state and the Health Care Financing Administration (HCFA) during the waiver review process). The Office of Management and Budget (OMB) and HCFA Office of the Actuary test these expenditures and must certify that the 1115 waiver is budget neutral for the federal government over the aggregate 5-year period. However, budget neutrality is not necessary for individual years.⁸

HIFA Waivers

Beginning on August 4, 2001, the US Department of Health and Human Services reworked the existing Section 1115 Medicaid waiver by calling states to participate in the Health Insurance Flexibility and Accountability Initiative of 2001 (HIFA). The purpose of HIFA is to expand health insurance coverage to the uninsured within available Medicaid and State Children’s Health Insurance Program (SCHIP) resources by targeting individuals below 200% FPL and offering states new flexibility to implement changes.⁹

Application Process & Benefits Packages

Like all Section 1115 waivers, an electronic application template is available for HIFA waivers, which are initially granted for 5-years (please see **Appendix A** for application requirements). Thereafter, HHS can approve extensions if a state meets data reporting requirements and demonstrates a decline in the rate of uninsured individuals. Overall, state demonstrations must be statewide, include public and private insurance options, and target individuals under 200% FPL. Finally, like all Section 1115 waivers, HIFA demonstrations must demonstrate budget neutrality.

HIFA demonstrations may address three types of populations: *mandatory populations* whose coverage is required by the state Medicaid plan; *optional populations* that can be covered under Medicaid or SCHIP without a Section 1115 waiver, regardless or whether or not the state currently covers those populations; and *expansion populations* that are not eligible for Medicaid or SCHIP without the 1115 waiver.¹⁰ **Table 1 below** lists the benefits package requirements for HIFA populations. Currently, 65% of Medicaid spending is for optional eligibility groups and optional benefits, while 35% is used for mandatory services for mandatory populations.¹¹

Table 1: Requirements for Benefit Packages under HIFA¹²

ELIGIBLE POPULATION	RECOMMENDED BENEFIT PACKAGE UNDER HIFA
Mandatory	<ul style="list-style-type: none"> • Cannot change benefits package • Cost sharing limited to nominal amounts by the federal government
Optional	<ul style="list-style-type: none"> • Choose one of the approved SCHIP benefit packages, which at minimum must include: <ul style="list-style-type: none"> ◊ Inpatient & Outpatient hospital services ◊ Physicians surgical and medical services ◊ Lab & X-ray services ◊ Well-baby and well-child care ◊ Age appropriate immunizations • Cost sharing is defined by the state but not to exceed 5% of the family’s income • States can alter the benefit package by placing upper use-limits on or eliminating certain optional services (for example, prescription drug services, chiropractic services, prosthetic services, hospice or home health care services for individuals who do not require nursing home care).
Expansion	<ul style="list-style-type: none"> • Basic Primary care (for example health care services provided by a primary care physician, OB/GYN, pediatrician or internal medicine physician) • Cost sharing is defined by the state

⁸ Charles Milligan, “Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage,” Issue Brief, Robert Wood Johnson Foundation (May, 2001)

⁹ Laura Tobler, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative” for the National Conference of State Legislatures (March 2003)

¹⁰ Ibid

¹¹ Ibid

¹² Ibid

HIFA Waivers & Colorado

The Colorado Department of Health Care Planning and Finance (HCPF) has been working on the HIFA process for over two years and has contracted with private, grant-funded consultants to gather the required information for the HIFA process. HCPF has identified several goals to be pursued via the HIFA demonstration:

- (1) Reduction in the number of uninsured in Colorado
- (2) Creation of a seamless healthcare system
- (3) Increased access to primary and preventive care in the State
- (4) Efficient purchasing
- (5) Targeting Medicaid children and families, Baby/Kid Care, CHP+ children and pregnant women

To achieve these goals, HCPF intends to pursue a program that is efficient, effective, user-friendly, administratively simple, quality driven, consistent with managed-care practices, and accountable to consumers. Generally, there will be one program for CHP+ and Medicaid designed to increase access to healthcare as well as facilitate an acceptable network of providers. In order to pursue these goals and objectives, HCPF has identified several key components for the HIFA demonstration:

- ❖ Administratively streamlined program for CHP+ and Medicaid with separate financing that will deliver appropriate, cost-effective services to all children
- ❖ Underlying financing arrangements and federal match rates that remain unchanged
- ❖ Inclusion of income-eligible Medicaid clients (excluding SSI children and Foster kids)
- ❖ Maintaining (not waiving) definitions of Medical Necessity for Medicaid consumers¹³
- ❖ Budget neutrality and/or cost-effectiveness analysis of proposed recommendations

In order to meet federal application requirements, the demonstration application submitted by HCPF must include several informational elements in addition to the standard application requirements listed in Appendix A. **Table 2 below** lists these requirements.

Table 2: Federal Application/Information Requirements for State HIFA Demonstrations

REQUIREMENT	CURRENT STATUS OF HCPF IN MEETING REQUIREMENT
Assessment of the current uninsured rate within the state for all groups under 200% and for any group the state is proposing to cover under the HIFA and projection of future uninsured rates.	Yes
Assessment of insurance coverage levels in the state categorized by sources.	Yes
Colorado's coverage goal and comprehensive strategy to address the uninsured.	Unknown
Plan to address changes in the uninsured rate	Unknown
Performance measures for evaluating the effectiveness. Should include: access to care, quality of care, and outcomes	Unknown

Overview of SB05-221

SB05-221 requires HCPF to prepare a waiver under the HIFA demonstration program to allow the department to create a new service delivery or purchasing system in order to better serve children and adults under the Medicaid program or CHP+. This legislation mandates that HCPF submit the waiver to the Health and Human Services (HHS) Committees of

¹³ The definition of "medical necessity" under the Medicaid program requires states to cover all treatments, regardless of whether treatments are necessary to restore normal functioning following an illness or injury. Furthermore, federal law requires the provision of broad, preventative care for children covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) regulations. In sum, "medical necessity" for children is defined as a preventative standard of care and is applied in individual cases. The Medicaid definition of medical necessity extends to SCHIP programs that are Medicaid expansions. Under separately administered SCHIP programs, states have discretion in defining "medical necessity." For separately administered SCHIP programs, there are no federal standards relating to coverage plans. Federal regulations require a design based on a "benchmark" plan, which usually follows a commercial orientation toward "medical necessity"; however, states may apply Medicaid principles in their coverage design. The commercial standard for "medical necessity" is to normally provide coverage to diagnose and treat an illness or injury, specifically to restore normal functioning. See Meryl Price and Prema Popat, MDF Associates, "Design of a Streamlined Program for CHP+ and Medicaid," Commissioned by the State of Colorado Department of Health Care Policy and Financing (February 2004).

the General Assembly in addition to specified information that may not be included in the waiver. No waiver shall be finalized by HCPF that reduces federal financial participation.

Within 60 days of submission of the waiver, joint HHS committees must conduct at least four public hearings on the waiver across the State (Denver Metro Area, West of the Continental Divide, Northern Colorado and Southern Colorado). Following the joint hearings, but within those 60 days, the joint HHS committees shall approve or reject the waiver. Within 15 days after the approval of the waiver by the joint committees, the Joint Budget Committee (JBC) shall either approve or reject the waiver as submitted by the department. If the JBC approves the waiver, HCPF shall submit the waiver to the federal government.

If the federal government returns the waiver with suggested or required amendments, HCPF shall submit an amended waiver to the joint HHS committees, who will then hold a joint hearing during which public testimony on the amended waiver may be heard. Thereafter, the amended waiver will be considered by the JBC. If the JBC approves the amended waiver, it will be submitted to the federal government. If the waiver is implemented, the State Auditor’s Office will oversee an evaluation of the waiver.

Why is this issue important to the Health District?

The HIFA waiver proposed in SB05-221 would substantially alter the Medicaid and CHP+ programs by streamlining the two. This combination may work to include in these programs more children and adults currently ineligible for coverage. However, for those already covered – especially optional and expansion populations – the types of healthcare services offered may change, and it is possible that reduction in benefits could occur. Health District residents enrolled in Medicaid and CHP+ programs will be directly affected by any program changes implemented via the HIFA waiver.

SUMMATION OF ARGUMENTS: SB05-221	
Arguments For	ARGUMENTS AGAINST
<ul style="list-style-type: none"> ❖ Streamlined Medicaid and CHP+ program entails continuity of care, less movement from program to program by consumers, and easier enrollment for Medicaid and CHP+ families.¹⁴ ❖ HIFA waiver could provide an opportunity to expand coverage to individuals currently uninsured. ❖ Specifically, more Medicaid funds enable states to serve more people. Although match rates vary by state, the federal government will pay at least 50% of expenditures and up to 80% for approved waivers, allowing states to increase access in ways that would be difficult if programs were solely state-funded.¹⁵ ❖ With the passage of enabling legislation for Amendment 35, a HIFA waiver would work to create multiple strategies for addressing healthcare needs in Colorado. ❖ Regarding budget neutrality, HCPF has stated that spending is about 50% more for Medicaid children compared to CHP children who receive the same services. Hospitalization costs under Medicaid contribute for the increased costs. With the HIFA waiver, costs would be reduced because both Medicaid and CHP children would receive services through primary care physicians. ❖ HCPF has stated publicly that they do not plan to include EPSDT children in the streamlined program. 	<ul style="list-style-type: none"> ❖ HIFA waivers do not require that services for optional groups be sustained. Other states have decreased services to optional groups in order to achieve savings to expand services to new populations. When children need services that are not covered, there is the risk that they may go without that service, or that the cost of the services will be displaced to hospitals and/or safety net providers. ❖ EPSDT law requires that services provided under Medicaid that are necessary to “treat or ameliorate a defect, physical or mental illness, or a condition identified by a screen, must be provided to EPSDT.” However, some states have attempted to limit EPSDT via HIFA demonstrations.¹⁶ ❖ Increased cost sharing in public programs sometimes reduces access to services.¹⁷ ❖ While Medicaid clients would be entitled to all medically necessary services, as defined under Medicaid, other children would be provided access to “appropriate” services. This would apply to access for CHP+ enrollees to all, some or none of the extended (Core Plus) benefit package, “depending on need and the State’s ability to provide additional benefits paid for by savings without spending additional funds.”¹⁸

Board Position

Preface

The issues surrounding the implementation of a HIFA demonstration in Colorado are not simple or clear-cut. On one hand, a HIFA waiver holds the potential to expand healthcare coverage to uninsured Coloradans. If services were maintained for all populations, the benefits of this type of expansion would be tremendous. On the other hand, if services were decreased for certain populations (for example, optional populations) the HIFA demonstration may have negative consequences for Coloradans already covered, as well as for safety net health care providers. Without full disclosure of the details of the waiver proposal, it is difficult to assess the potential outcomes of a HIFA waiver at this time.

Board Position

The Board recommends that the details of the waiver proposal be released well in advance of the required public hearings, allowing the public, providers and consumers time to analyze and respond to both the benefits and challenges that the proposed waiver will present.

The Board reserves its support or opposition for the particular waiver being proposed by HCPF until the details are released and staff can complete a detailed analysis for presentation to the Health District Board.

About this Update

This update was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. Updates are based on bills or issues at the time of their consideration by the Board and are accurate to the best of staff knowledge. It is suggested that people check to see whether a bill has changed during the course of a legislative session by visiting the Colorado General Assembly web page at www.state.co.us/gov_dir/stateleg.html. To see whether the Health District Board of Directors took a position on this or other policy issues, please visit www.healthdistrict.org/policy.

About the Health District

The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. Their mission is to improve the health of the community.

For more information about this analysis or the Health District, please contact Katherine Young, at kyoung@healthdistrict.org, or (970) 224-5209.

Appendix A

Applying for a HIFA Waiver

The purpose of the HIFA waiver is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and state Children's Health Insurance Plan resources.

Required information on the application:

- General description of program
- Definitions
- HIFA Demonstration Standards Features
- State Specific Elements
 - ◊ Upper Income Limits
 - ◊ Eligibility
 - ◊ Enrollment/Expenditure Cap
 - ◊ Phase-in
 - ◊ Benefits Package
 - ◊ Coverage Vehicle
 - ◊ Private health insurance coverage options
 - ◊ Cost Sharing
- Accountability and Monitoring
 - ◊ Insurance Coverage
 - ◊ State Coverage Goals and State Progress Reports
- Program Costs
- Waivers and Expenditure Authority Requested
 - ◊ Waivers
 - ◊ Expenditure Authority
- Attachments
 - ◊ How the State will ensure that using waiver will not induce individuals with private health coverage to drop their current coverage.
 - ◊ Description of expansion populations
 - ◊ Benefits package description.
 - ◊ Description of private health insurance coverage options
 - ◊ Discussion of cost sharing limits
 - ◊ Additional detail regarding measuring progress toward reducing the rate of the un-insurance.
 - ◊ Budget Work Sheet
 - ◊ Additional waivers or expenditure authority request and justification.

Please note that In addition to the application states should complete a Medicaid budget neutrality template and/or SCHIP allotment neutrality template.

Progress Reports

- 6 months after each demonstration year
- Should include: uninsured rates, effectiveness, impact employer coverage, other factors, and progress on performance measures.
- In addition, independent evaluations done by contractors.