NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
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UNDER THE MICROSCOPE

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MEDICAID SECTION 1115 WAIVERS AND THE ACA: CAVEAT EMPTOR

ISSUE.

Even before the Affordable Care Act (ACA) became law, Medicaid's waiver programs have enabled states to test and implement unique approaches to coverage and care that are beyond the scope of Medicaid law and regulation. The waivers give states considerable flexibility in how they structure and operate their Medicaid programs. For example, Section 1915(c) waivers enable states to test and evaluate a broad array of home and community-based care options, (e.g., the "money follows the person" initiative), many of which can benefit people with behavioral disorders or intellectual/developmental disabilities (I/DDs).

Medicaid's Section 1115 waiver program, the focus of this edition of *Under the Microscope*, is exceptionally broad in scope. The Secretary of the U.S. Department of Health and Human Services' (HHS) Section 1115 waiver authority grants states the ability to undertake a wide array "experimental, pilot, or demonstration" projects designed to advance Medicaid's overall objectives.

According to the federal Centers for Medicare and Medicaid Services (CMS), after a lull in waiver requests, some 34 states had at least one Section 1115 waiver in place by mid-2012. Other requests are pending HHS approval. An approved waiver enables a state to gain federal Medicaid funds that otherwise would not have been available, thereby saving state expenditures. In fact, by the end of 2012, according to the Federal Office of Management and Budget, federal funds flowing to states as a result of these waivers will represent a third of all Medicaid spending.

Section 1115 waivers are separate from the ACA. Yet, they can be used to advance or thwart the intent of the ACA, to extend or reduce coverage to vulnerable populations, and to use federal funds to supplement or supplant local resources. Thus, it is wise to be aware and knowledgeable about your state's current and planned 1115 waivers. That is why we take a closer look at the Section 1115 Medicaid waiver and the role it plays—or may not play—in care for people with I/DDs or behavioral disorders as the ACA moves forward.

ANALYSIS.

What exactly are Section 1115 waivers? Working through the federal Centers for Medicare and Medicaid Services (CMS), the HHS Secretary may grant "comprehensive" Section 1115 waivers to states in areas related to Medicaid eligibility, benefits, provider payments and cost-sharing, as well as for particular populations and services, including for persons with behavioral disorders or I/DDs. In addition, under the ACA-established Center for Medicare and Medicaid Innovation, states may seek a Section 1115 specifically to test and evaluate different service and payment options and methods, including expansions, to foster quality improvement, patient-centered care, and lower costs of care for Medicaid, CHIP and Medicare services, all aims of the ACA.

State waiver approval is negotiated with HHS and must comply with particular limitations, including the stipulations of budget neutrality and the requirement that Federal spending under the waiver be no greater than otherwise would have been spent by the state. Moreover, thanks to the ACA, states are required to undertake a more transparent waiver approval process, with mandated ongoing opportunities

for stakeholder and public input. Further, once approved, waiver programs are now required to undergo more thorough periodic evaluations than at any time in the past. Waivers generally are granted for 5 years, with an option for an additional 3-year extension.

To what purpose are waivers being put? Section 1115 waivers have served various purposes throughout the history of the program. Waivers have and continue to enable states to test and evaluate new service delivery mechanisms (e.g., home- and community-based care), service structures (e.g., integrated care, health homes) and quality and cost balancing efforts (e.g., managed care systems, payment incentives, etc.). Over time, the types of waiver requests sought by states have waxed and waned as state economies have turned up or down. Also, over time, waivers have resulted in significant state-to-state variation in Medicaid eligibility thresholds, in services covered, and in structure of the care delivery system itself, with resulting effects for better or worse on poor and near-poor individuals and families.

After a lull of a few years, Section 1115 waivers have been on the rise again; waivers are in place in over 1/3 of the states today, with more coming. Credit both the ACA and hard-pressed state budgets that would benefit from federal waiver funds for the uptick.

Some states are using or plan to use the waivers to prepare for ACA implementation, such as broadening the beneficiary population beyond current levels (i.e., early Medicaid Expansion prior to 2014) or simplifying Medicaid enrollment. Others are emphasizing integrated care, prevention and early intervention, and safety-net service delivery. However, the vast majority of current waivers and waiver requests have two specific goals:

- To lower state contributions to Medicaid through payment and delivery system changes (e.g., patient cost-sharing, eligibility changes, etc.); and
- To bring all current Medicaid beneficiaries under managed care.

Whatever their focus, Section 1115 waivers can affect beneficiaries and providers for good or ill; they can provide flexibility or a way around federal standards of care, eligibility and quality. Given the recent history of Section 1115 waiver requests since ACA enactment, the waiver process can help or hinder progress in meeting the needs of millions of people currently lacking health insurance – many of whom are those with behavioral disorders or I/DDs.

Promise and pitfalls for the I/DD and behavioral health communities.

Clearly, Medicaid is evolving in the wake of the ACA and the new directions in Section 1115 waivers. Over time, it is likely that managed care, whether centered on capitation or case rate models, will become the expectation. At the same time, integrated care—extending into social support and services—also will become the norm. The underlying model of care, too, will change from its current emphasis on acute care and treatment to an arc of care focused on prevention and promotion, treatment and sustained recovery.

These changes in Medicaid hold both promise and concern for persons with behavioral disorders or I/DDs and the professionals who serve them. Focusing on the Section 1115 waivers that support innovations of care, the promise is evident in such benefits as earlier intervention and reduced disability, in care and services that consider the whole person's heath and supportive needs. But there are also pitfalls, particularly when it comes to managed care and cost savings measures.

In and of itself, a state's drive toward omnibus Medicaid managed care or cost savings through a Section 1115 waiver is not necessarily a bad thing for the people we serve. *How managed care is structured and how cost savings are accomplished,* however, may pose a serious problem unless the system includes protections that safeguard the care and supportive services for people with these disorders. Appropriate, required performance measures may help to insure these safeguards.

For example, an *omnibus Section 1115 waiver* for a managed integrated care system, such as proposed by Pennsylvania, Kansas, and a number of other states, is a relatively new phenomenon, but not a unique approach today. In the absence of experience and expertise in blending all Medicaid services and providers together in a way that provides equitable access to care across beneficiary populations, such an approach could adversely affect behavioral health and I/DD services. Questions abound: Who determines

if behavioral health services are needed? Who controls or limits access to or the duration of those services? By managing care, will limited Medicaid dollars extend to behavioral health and I/DD services, providers and consumers?

The speed with which a state undertakes this kind of managed care integration through a Section 1115 waiver (such as proposed by Kansas) may also affect care for people with I/DDs and behavioral disorders. While such a waiver could provide incentives for better individualized care, including health homes, integrated care, and wrap-around services, too rapid a transition could lead to management of *costs*, rather than care. In Kansas, for example, one of the cited aims of the waiver to move Medicaid to managed care has been to save the state nearly a billion dollars over 5 years. Such a rapid shift from current service systems, particularly when the intent is to save dollars rather than manage care, could dislocate care for a highly vulnerable population, such as persons with I/DDs. Among the concerns raised by the I/DD community about too-rapid deployment of an overarching managed care approach were the loss of protections for people with disabilities and chronic conditions (e.g., choice of care, person-centered services); the potential for insufficient access to appropriate specialized care and providers; and the loss of other needed care provided in the most integrated setting appropriate to the needs of the individual. At present, it appears the process has been slowed as the result of stakeholder engagement, with the hope that some of the potential problems can be resolved in advance.

In examples such as these (and likely in other waivers with similarly sweeping approaches to managing Medicaid and its costs), due diligence is warranted, particularly until the best means of assuring equity and quality in access to and service availability through managed, integrated care are both established and set in place. The Kaiser Commission on Medicaid and the Uninsured has pointed out that "given the significant health care needs of these [high-need] individuals and states' limited experience covering these populations and services through managed care, it will be important to closely monitor the effects of these changes on their care, including the adequacy of their provider networks and their ability to access necessary services…". We suggest that these and other similar waiver programs set in place a full range of performance measures that reflect access to care, and both appropriate levels and quality of care—from prevention through recovery support—to better protect services for Medicaid beneficiaries with behavioral disorders or I/DDs.

Other new and pending state Medicaid Section 1115 waivers focus on omnibus managed care in ways that may better protect the service needs of beneficiaries with behavioral disorders or I/DDs. For example, Virginia's new 1115 waiver request integrates behavioral health and primary care, but retains a funding carve-out for those services. While silos aren't always the best practice, in this case, a carve-out silo better safeguards funds for behavioral health care and services that otherwise might disappear in a state's haste to manage dollars rather than care. From the perspective of the ACA, which emphasizes a person focus over a medical encounter focus, that's a good thing. Managed care, too, increasingly is managing the person using case rate systems that "bundle" and manage each individual's annual health needs and costs. As a result, traditional external managed care firms are less needed now. Providers become the managers with fiduciary incentives to provide the most appropriate, person-centered care.

Preparing for ACA implementation, particularly the 2014 Medicaid Expansion, has been the centerpiece of still other waivers, such as California's now ongoing "Bridge to Reform" waiver. That waiver's focus on patient-focused, coordinated care makes it of particular import for persons with behavioral disorders or I/DDs and for services that start with the person, not the illness. Specifically, the waiver enables the State to broaden access to care in the form of medical homes for as many as 500,000 impoverished adults (ages 19-64) who do not qualify for Medi-Cal, a significant number of whom are living with untreated, chronic behavioral disorders. A delivery system reform incentive pool—with payments tied to performance—is encouraging county and state facilities to invest in innovative care models, like medical homes for individuals with disabilities. In addition, the waiver is enabling the state to test ACOs, enhanced primary care case management, health homes, managed care and specialty health plans as delivery systems for children with special health care needs.

In most cases, the Section 1115 waivers and the ACA are on completely different tracks in the states.

A significant number of states that have opted out of features of the ACA, such as the Medicaid Expansion and the State Health Insurance Exchange, continue to press forward with Section 1115 waiver requests, most often centered on omnibus managed care, primarily to hold down state Medicaid costs and reap the federal match for waiver programs. Whether these broad managed care waivers, if approved by HHS, actually get evaluated and yield information about what works and doesn't work for Medicaid beneficiaries under each state's managed care scenario remains to be seen. What is clear today, however, is that to safeguard the services and supports needed by people with behavioral disorders or I/DDs, attention must be paid not only to the ACA, but also to every state's Section 1115 waiver proposals.

ACTION STEPS.

Clearly, Section 1115 waivers alone cannot solve a state's economic ills or the healthcare needs of its citizens. Rather, they are intended as time-limited ways that states may test and assess method, practices, or structures that otherwise are beyond the scope of Medicaid' regulations. However, with the growing emphasis on these waivers as a means of controlling state expenditures and implementing managed care systems, the implications of any state's Section 1115 waiver potentially is significant for people with behavioral disorders or I/DDs.

Our job as behavioral health care providers and county behavioral health and I/DD administrators is to ensure that ANY waiver is in the best interest of our clients and patients. It begins with an awareness of and attentiveness to YOUR state's activities and plans with regard to Medicaid Section 1115 waivers.

Remember, 1115 waivers do not and will not apply to people newly eligible for Medicaid under the ACA's 2014 Medicaid Expansion provisions, many of whom are people with behavioral disorders or I/DDs. Any benefits from the waivers will be limited solely to those currently under the Medicaid program.

And remember that the 1115 waiver is intended as a demonstration not a permanent feature of a state's Medicaid program. And, while it may reduce costs or otherwise save limited resources, its purpose is to give states flexibility in program operation.

You can engage early in the waiver process, since the ACA now requires 1115 waivers to be subject to public input as well as HHS approval before they may be set in place in a state.

Analyze the plans, and take action, with the following "dos" and "don'ts" as a starting point:

Do—

- Recognize that some states are using Section 1115 waivers to lay important groundwork for the ACA by preserving and strengthening coverage for low-income adults today
- Advocate for integrated behavioral health and primary care that retains a carve-out to preserve separate funding.
- Support waivers that promote early adoption of the ACA's 2014 Medicaid Expansion.
- Urge that due diligence, time and care be taken to adopt integrated care, particularly for I/DD services.
- Advocate for ongoing evaluation of the impact of waiver programs, not only on costs, but also on access to and quality of care.

Don't—

- Promote an omnibus waiver; our services and consumers could well get lost.
- Support managed behavioral benefits that rely solely on managed behavioral health companies.
- Assume that the ACA will supersede the Section 1115 waiver. It may not do so, depending on your state's stance on implementing the Essential Health Benefit, the Medicaid Expansion, and the State Health Insurance Exchange.

Above all, you should recognize that, given where Medicaid is headed as a result of the ACA, the wavier process can be used to help or to hurt progress in our field. The local behavioral health and I/DD communities need to be vigilant in communicating with states and both CMS and HHS what will help or hurt when it comes to Section 1115 waiver requests. Together, the best of the waiver process must be

advanced; and new knowledge gleaned from the waiver experiments must become the basis for ever more effective, cost responsible Medicaid services, programs and systems.

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