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IssueBrief

State Plan Amendments and Waivers:
How States Can Change Their Medicaid Programs

States have a tremendous amount of flexibility in designing their Medicaid programs, and they can change aspects of their existing programs at any time. But before they can do so, they must apply for and receive approval from the Centers for Medicare and Medicaid Services (CMS).

Federal approval is not only legally required, but it makes sense because of the role the federal government plays in Medicaid funding. Medicaid is jointly funded by the states and the federal government, and the federal government pays for at least half of all Medicaid costs in every state.

The Medicaid statute is part of the Social Security Act, and it includes some basic requirements that every state Medicaid program must follow.[1] The federal government has an interest in making sure that those requirements are met.

There are two ways that states can go about changing their Medicaid program:

1. A State Plan Amendment, or SPA
2. A Waiver

These two options are referred to as the legal authorities that states can use. Each has different requirements and different approval processes, and each one allows states to do different things. Among waivers, there are further differences depending on the type of waiver a state is applying for. See Table 1, "State Plan Amendments and Waivers at a Glance," on page 2 for a brief summary of the differences between State Plan Amendments and waivers.

Table 1.

State Plan Amendments and Waivers at a Glance

	State Plan Amendments	Waivers
Submission to CMS	Proposed change to Medicaid plan	Formal request to have certain federal Medicaid requirements waived
What States Can Ask For	Can address any aspect of Medicaid program administration (eligibility, benefits, services, provider payments, etc.); must comply with federal Medicaid requirements	Must relate to an area specified in the Medicaid statute Main waiver types: ■ 1915(b) Managed Care Waivers ■ 1915(c) Home- and Community-Based Care Waivers ■ Combined 1915(b) and (c) Waivers ■ 1115 Demonstrations
Budget Requirements	No cost or budget requirement	Must be cost effective or cost neutral; calculations depend on the waiver type
Approval Process	90-day clock that can be suspended if CMS submits information requests to the state	Process for 1115 waivers must be transparent; other waivers posted on Medicaid.gov but not subject to transparency requirements
Duration of Approval	Permanent	Time limited depending on waiver type; can be renewed

It is helpful for advocates to understand the basics of both State Plan Amendments and waivers because the best plan of action will depend on which process their state is pursuing.

This brief gives an overview of both State Plan Amendments and waivers and explains what each can mean from an advocacy perspective.

State Plan Amendments

What Are State Plan Amendments?

Every state has a Medicaid State Plan that outlines the details of its Medicaid program. Each state plan is different, reflecting the level of flexibility that states have in their Medicaid programs. If a state wants to change its Medicaid program, one option is to file a State Plan Amendment with the state's CMS Regional Office. A state can file a State Plan Amendment at any time. In most cases, it is much easier from an administrative perspective for a state to make a change by filing a State Plan Amendment than by filing a waiver.

When Can States Use a State Plan Amendment?

States use this process to change administrative aspects of their Medicaid plan. This includes changing provider payment rates, adding or cutting optional services, adding managed care, and changing benefit structures like prescription limits or cost-sharing.

The changes proposed in a State Plan Amendment must comply with federal Medicaid regulations. For example, states can use this process to change optional services but not mandatory services, and cost-sharing changes must comply with federal rules. (See text box on page 9 for information on limitations to states' authority to reduce eligibility).

The following federal requirements also apply to most State Plan Amendments:

- Statewideness: The changes must apply to Medicaid enrollees throughout the state, not just in certain areas.
- Comparability: Comparable services must be available to all people eligible for Medicaid, regardless of their eligibility category, so a state cannot change services for just one group of Medicaid enrollees. For example, it would violate the comparability provision if a state said that pregnant women in its Medicaid program would have a physician benefit, but people with disabilities would not.
- Choice of Providers: Medicaid enrollees must be free to choose among health care providers.

The only exceptions are those that are stated in the federal Medicaid statute. For example, the statute specifically exempts State Plan Amendment applications to provide managed care from the need to meet certain requirements. (See Table 2, "Managed Care, Waivers, and State Plan Amendments," on page 10 for a comparison of ways that states can pursue Medicaid managed care.)

If a state wishes to change its Medicaid program in ways that deviate from federal regulations, it must file a waiver.

Submission and Approval

A state can easily file a State Plan Amendment by submitting the pages from the existing state plan that are going to be changed to CMS. Within 90 days of receiving it, CMS will review the submitted changes as well as other aspects of the state's Medicaid program. If CMS has questions or concerns—for example, if CMS thinks that a proposed State Plan Amendment does not meet federal requirements—CMS will issue a request for information and start a process of working with the state to change the proposal so that it can be approved. If CMS sends an inquiry to a state, the 90-day approval clock stops and does not resume again until CMS receives the state's reply. Depending on the issue in question, the state may be able to move forward with its proposed change while it is working through issues with CMS.[2]

Effective Date, Duration, and Administration

Once CMS approves a State Plan Amendment, the changes can take effect retroactively to the first day of the quarter in which the state submitted the amendment. Once approved, a State Plan Amendment does not expire, but a state can change it through a subsequent State Plan Amendment.

Changes made through this process become part of the Medicaid program and operate like all other aspects of Medicaid. There is not a federal requirement that the change meet any budget requirements. This is different from waivers, which generally do have budget requirements.

Waivers

What are waivers?

A waiver is a request that the Secretary of Health and Human Services (HHS) waive certain Medicaid program requirements in a state. The Medicaid statute gives the Secretary the authority to waive certain Medicaid requirements in order to test new ways to deliver or pay for care in Medicaid.

There are multiple types of waivers. Each is designated by the section of the Medicaid statute that gives the Secretary of HHS the legal authority to waive Medicaid requirements. While each type of waiver addresses different elements of Medicaid and has different requirements, all waivers have the following in common:

- They are time-limited, are generally approved for three to five years, and can be renewed.
- They must not increase costs to the Medicaid program. The exact budget impact is measured differently depending on the type of waiver.[3]
- They must be consistent with the purpose of the Medicaid program, which is to provide meaningful health insurance to qualifying low-income people.

Types of Waivers

The main types of waivers are listed below, with a brief description of what each type allows a state to do. States can have multiple waiver programs, and even multiple waivers of the same type, in operation at the same time.

- **1915(a) Managed Care Contract**: This provision of the Social Security Act allows states to set up a voluntary managed care program by executing contracts with managed care plans. The state has to go through a competitive bidding process to select the managed care plans, and CMS must approve the program in order for the state to make payments to the plans. This waives Medicaid requirements related to provider choice for individuals who elect to enroll in the managed care program.

  Requirements, duration, and prevalence:

  - Enrollment must be voluntary.
  - The law does not set a time limit for this type of waiver. In practice however, managed care contracts are usually limited, typically lasting from one to three years.
  - Curently, 13 of these waivers are in effect in states.

- **1915(b) Managed Care Waiver**: This allows CMS to approve managed care programs that do one or more of the following: restrict Medicaid beneficiaries' choice of health care providers; allow a county or local government to act as a broker to help people in Medicaid select a managed care plan; restrict the number and type of providers for specific Medicaid services, such as the number of companies providing transportation services; or allow the state to use the savings achieved through the managed care system to provide additional services to people in Medicaid. With this authority, a state can also require that all Medicaid enrollees in the state or a particular area enroll in managed care.

  Requirements, duration, and prevalence:

  - The waiver must be cost effective, meaning the managed care plan cannot cost Medicaid more than traditional fee-for-service Medicaid.
  - Programs cannot have a negative effect on access to or quality of care.
  - These waivers are approved for a specified amount of time up to five years. They can be renewed.
  - Currently, 48 of these waivers are in effect in states.[4]

- **1915(c) Home- and Community-Based Care Waiver**: This is one of several ways a state can provide home- and community-based services in its Medicaid program.[5] This waiver option gives states flexibility to provide additional services that are not typically covered by Medicaid if those services will help an individual remain in the community rather than be placed in a nursing home. States can limit the number of individuals the waiver will serve. They can also target certain groups. For example, a 1915(c) waiver program might be open only to seniors with dementia, adults with traumatic brain injury, or children with developmental disabilities.

  Requirements, duration, and prevalence:

  - Programs are limited to individuals who would need institutional care if the waiver services were not available.
  - Services must be provided following a plan of care.
  - The programs must be cost neutral. This is determined by comparing average per-person waiver service costs to average per-person nursing home costs and estimating how many people would have been institutionalized without the waiver.
  - Initial program approval is for three years. Upon expiration, the waiver can be renewed for up to five years.
  - There are 264 currently approved 1915(c) waivers in operation. Most states have at least one of these waiver programs.

- **Combined 1915(b) and (c) Waivers**: States can combine these two waivers to provide long-term services in a managed care setting or through a limited pool of service providers. Through the 1915(b) managed care waiver, a state could provide long-term care that is part of its state plan through a managed care program. That could include nursing home, home health, or personal care services. The 1915(c) waiver would allow the state to expand the services offered beyond what is available through the state plan.

  Requirements, duration, and prevalence:

  - Programs must meet the requirements of both waiver programs.
  - States must renew each portion of the waiver separately, based on the approval time frames for each.
  - Because states must meet the requirements of two different waiver programs, few states have used this waiver authority. Currently, only Michigan is operating a program combining these waivers.

- **1115 Research and Demonstration Project**: Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to approve pilot or experimental projects that promote the objectives of the Medicaid program. This authority is designed to give states significant flexibility to try new health care delivery approaches or payment methods or to otherwise improve patient care in a cost effective way. States can use 1115 waivers for a wide range of program changes. Some of these changes are good for consumers, while some raise significant concerns.

  Requirements, duration, and prevalence:

  - Programs cannot cost Medicaid more than projected costs without the waiver. Because states can use these waivers to expand Medicaid to new populations or offer new services, the budget evaluations can be complicated and sometimes take multiple factors into consideration.
  - These waivers are generally approved for five years and can be renewed.
  - Currently, 43 of these waivers are operating in states.

Submission and Approval Process

The submission and approval process depends on the type of waiver. There are standard applications for 1915 waivers, but not for 1115 waivers. There can be a considerable amount of interaction and negotiation between the state and CMS during the review and approval process. That is particularly true for 1115 waivers, which sometimes encompass far-reaching changes to a state's program.

What This Means for Advocates

State Plan Amendments and waivers can help states expand their Medicaid programs or offer services that better meet the needs of Medicaid enrollees. However, State Plan Amendments and waivers can also be used to cut services or restructure the program in ways that could hurt consumers. As states continue to deal with budget shortfalls as a result of the recession, more will be looking at making changes to their Medicaid programs that cut critical services and would harm people who depend on Medicaid.

Advocates should look at each state proposal carefully to determine whether it might help or hurt consumers. For changes that look harmful, advocates should get engaged and make their concerns known at the state and federal levels

State Plan Amendments

In most cases, for State Plan Amendments that look harmful to consumers, advocates should focus their efforts at the state level. There, they will be able to mobilize coalitions to stop proposed cuts or service reductions. If a State Plan Amendment does not violate federal requirements, CMS is likely to approve it. Therefore, targeted state efforts will be most effective. However, if advocates believe that a proposed change violates federal Medicaid requirements, they should voice those concerns to CMS.

Unfortunately, it can be difficult for advocates to know when the state is filing a State Plan Amendment. There is no federal requirement that states post notices when they are changing their state Medicaid plan. State requirements for public notice vary. States also differ in their internal processes for approving a State Plan Amendment request. Some states require legislative approval for State Plan Amendments, while others do not. Some require legislative approval only when the change will have a budget impact. In some states, the governor has a great deal of authority over the Medicaid program, and in other states, the Medicaid agency has more authority. Some states post State Plan Amendments on their website, but generally only after they are filed with CMS.

Advocates should learn about the process in their state and cultivate relationships with people who would know when a State Plan Amendment is generated. Hopefully, that will provide an avenue for getting a bit of advance notice if a State Plan Amendment is forthcoming. Fortunately, if the proposed change is large—like discontinuation of an optional service—most states will provide some public notice, if only to minimize backlash.

Waivers

For waivers, advocates should work at both the state and federal level. By definition, waivers are requests to bypass certain federal Medicaid requirements. Approval is not guaranteed, particularly if there are real concerns that a waiver might hurt Medicaid enrollees or interfere with the goals of the Medicaid program.

CMS has recently made it much easier for advocates to be engaged. In April 2012, rules became effective that require greater transparency at both the state and federal level during the 1115 waiver approval process. These new rules give advocates more opportunities to weigh in if a proposed waiver looks harmful to consumers. (See Families USA's publication, "How the Affordable Care Act Makes the 1115 Waiver Process More Transparent," available online at http://familiesusa2.org/assets/pdfs/medicaid/Section-1115-Waiver-Process.pdf.)

Unfortunately, the new rules for 1115 waivers do not apply to other types of waivers. However, advocates can still communicate their concerns about all types of waivers to CMS. CMS posts waivers that are pending consideration at www.Medicaid.gov. Advocates should also push their states to adopt state publication and hearing processes similar to the new 1115 requirements for other types of waivers.

Remember, State Plan Amendments and waivers can be either good or bad. It's up to advocates to look at state proposals, evaluate the ramifications for people enrolled in Medicaid and for the future of the Medicaid program, and then decide the best course of action.

The Affordable Care Act's Medicaid Maintenance of Effort Requirement

Starting in 2014, the Affordable Care Act expands Medicaid eligibility to all people under 65 with incomes below 133 percent of poverty.[6] Today, Medicaid requires states to cover certain groups of individuals—such as pregnant women, people with disabilities, seniors, and children—at certain income levels. However, for others—adults without dependent children—eligibility varies widely from state to state. Most states do not cover childless adults at all, no matter how poor they are. The Medicaid expansion will standardize eligibility across states and base it on income alone. As a result, Medicaid will cover many more people, but the federal government will pick up nearly all the costs of this expansion.[7]

To lay the foundation for the Medicaid expansion in 2014, the Affordable Care Act requires states to maintain Medicaid eligibility levels at least at the March 2010 level. Additionally, enrollment processes cannot be made more restrictive. States can, however, request a waiver from the maintenance of effort requirement.

Managed Care, Waivers, and State Plan Amendments

State Medicaid programs use managed care extensively. Today, more than 70 percent of Medicaid beneficiaries are in managed care for their medical care.[8] There are several mechanisms states can use to add managed care to their Medicaid program, including State Plan Amendments, 1915(a) waivers, and 1915(b) waivers. With each—even a managed care State Plan Amendment—states can bypass federal Medicaid requirements in the following ways:

- Statewideness: Managed care services do not have be available throughout a state. They can instead be limited to Medicaid enrollees in certain geographic areas.
- Comparability: States can offer people enrolled in managed care plans a different benefits package than traditional Medicaid.
- Choice of Providers: Medicaid managed care plans can limit enrollees' choice of providers.

Table 2 lists the different ways states can pursue managed care in Medicaid, and some distinguishing features of each option.

Table 2.

Managed Care, Waivers, and State Plan Amendments

Federal Authority (applicable section of the Social Security Act)	Features
Sec. 1932(a) State Plan Amendment 1932(a) of the Social Security Act outlines various provisions related to Medicaid managed care, including adding managed care through a State Plan Amendment	■ Managed care program becomes a permanent part of the state Medicaid plan with no expiration date. ■ States cannot require individuals eligible for both Medicare and Medicaid ("dual eligibles"), children with special needs, or Native Americans to enroll in managed care. ■ 21 states are operating managed care programs under 1932(a) State Plan Amendments.
Sec. 1915(a)	■ Allows states to implement a managed care program by executing a contract with one or more companies that have gone through a competitive bidding process. CMS must approve the process before the state can make a payment. ■ Enrollment must be voluntary. ■ 13 states are currently operating managed care programs under 1915(a) waivers. ■ The law does not set a time limit for this type of waiver. In practice, however, managed care contracts are usually limited, typically lasting from one to three years.
Sec. 1915(b)	■ Programs only approved for a specific amount of time, no longer than 5 years. They can be renewed. ■ States can require dual eligibles, children with special needs, and Native Americans to enroll. ■ The state must show that the managed care program is cost-effective, efficient, and consistent with the goals of the Medicaid program.

Source: Medicaid.gov, "Managed Care," available online at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html, accessed May 23, 2012.

Endnotes

[1] For more information on Medicaid requirements, see the "About Medicaid" section of Families USA's website, available online at http://www.familiesusa.org/issues/medicaid/about-medicaid.html.

[2] In October 2010, CMS streamlined the review process so that states could move forward more quickly with state plan amendments. The process is outlined in CMS's State Medicaid Director Letter #10-020, "Re: Revised State Plan Amendment Review Process," October 1, 2010, available online at https://www.cms.gov/smdl/downloads/SMD10020.pdf.

[3] For a more detailed discussion of Medicaid waivers and how budget neutrality is calculated for different types of waivers, see Cynthia Shirk, *The Basics: Medicaid Waivers and Budget Neutrality* (Washington: The National Health Policy Forum, 2006), available online at http://www.nhpf.org/library/the-basics/Basics_MedicaidBudgetNeut_08-26-09.pdf.

[4] All information on the number of states currently operating different kinds of waivers is from www.Medicaid.gov.

[5] There are also options for states to add home- and community-based services to their Medicaid programs using a State Plan Amendment.

[6] The law expands eligibility to people with incomes at or below 133 percent of poverty, but it disregards 5 percent of income when determining eligibility, making the actual income limit 138 percent of poverty.

[7] The federal government will pay the full cost of the Medicaid expansion for the first three years. After that, the federal share gradually declines to 90 percent in 2020 and remains at that level.

[8] Statehealthfacts.org, *Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of July 1, 2010* (Washington: Kaiser Family Foundation, 2010) available online at http://statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4, accessed May 23, 2012.

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