



Keeping Up with Medicaid Changes in States: A Guide for Child Oral Health Advocates

Medicaid and the State Children's Health Insurance Program (SCHIP) are the two publicly financed health insurance programs that provide dental benefits for children from low- and modest-income families. Medicaid requires dental coverage under its pediatric "EPSDT" benefit while SCHIP deems dental care optional. Recent Congressional changes have moved Medicaid closer to SCHIP by allowing states greater flexibility in program design and by making it easier for states to change their Medicaid programs.

The Deficit Reduction Act of 2005 (DRA) has made it easier for states to make changes in their Medicaid programs and has also reduced opportunities for public input when they make programmatic changes. This document provides an overview of both pre- and post-DRA State options for changing Medicaid. An understanding of these federal and state options is critical as dental and child advocates work to keep dental coverage available, accessible and affordable for vulnerable children.

Background

The basic purpose of Medicaid has remained unchanged since its creation in 1965 - to provide comprehensive, affordable, and quality health coverage to the most vulnerable members of society. Federal Medicaid standards are established by Congress and regulated by the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). Within these standards, states have considerable flexibility in determining specific criteria such as eligibility, benefits, co-payments, some contracting arrangements, and payments to providers.

States use these flexibilities to configure their Medicaid programs very differently across the country. CMS determines procedures for making changes within its rules and also establishes opportunities for waiving its rules so that states can experiment with unique and cost-saving strategies. Thus, states have an array of choices that reflect their structure, politics, and history.

Medicaid State Plans

Every state Medicaid program is required to have a Medicaid State Plan on file with the Secretary of Health and Human Services. This plan describes the scope and operation of the state's Medicaid programⁱ including details about the program administration, eligibility criteria, benefits, and provider reimbursement.ⁱⁱ

Options for Changing Medicaid

States have three primary options for changing their Medicaid programs. The first two, State Plan Amendments and Waivers/Demonstrations, require federal approval while the third, administrative rules changes, are accomplished by the state without federal oversight.

- 1. State plan amendments (SPA)** – There are two circumstances in which a state must amend its plan and seek CMS approval. The first is when it makes design changes in elements such as eligibility, benefit package or reimbursement rates. The second is when Congress or CMS changes the Medicaid program and requires a state response.ⁱⁱⁱ CMS determines the process and timeline for such approvals.
- 2. Waivers and Demonstration Projects** – CMS has the legal authority to allow states to develop innovative strategies or limitations not otherwise permitted under Medicaid rules by selectively "waiving" its rules. A demonstration project is a category of waivers that allows changes to Medicaid for innovations such as those that target only a subset of covered individuals (e.g. children of only a certain age) or individuals who live in only part of the state (e.g. a demonstration that is implemented in only one county).

States must submit applications to CMS to receive federal approval for a waiver. Federal waivers require states to develop multi-year plans that demonstrate “budget neutrality.” That is, states cannot propose changes that would result in federal funding greater than the amount the state would have received without the waiver during that same period.

Three broad categories of Medicaid waivers exist within CMS.^{ii, iv}

- **1115 Waivers for Research and Demonstration Projects** – states can seek approval to do such things as change the categories of eligible individuals or benefits they receive, not otherwise allowable in Medicaid. These waivers are approved initially for five years with the option to renew for additional years.
 - **Section 1915(b) Managed Care/Freedom of Choice Waivers** – states may limit Medicaid beneficiaries’ choice of providers, not otherwise allowable in Medicaid. Section 1915(b) waivers are approved for two-years with the option of renewal.
 - **Section 1915(c) Home and Community-Based Services Waivers** – states may ask to provide long-term care to beneficiaries in settings other than institutions, not otherwise available in Medicaid. Section 1915(c) waivers are approved for three years with the option to renew the plan for five-year intervals.
- 3. Administrative rules changes** – Many programmatic changes can be made by the state Medicaid agency without the need for federal approval as long as they don’t substantially change the State Plan. For example, policies and procedures governing choice of claim forms, frequencies of services, prior authorization procedures, choice of administrative agents, and eligibility verification procedures by providers do not typically require federal review. As such, they may have a profound effect on provider participation and satisfaction. In some states, these administrative changes require state legislative oversight.

Process for making changes

States differ in their approaches to generating an SPA or waiver *and* for making changes that do not require federal approval. The balance of power between the executive branch and legislative branch of government varies by state, as do the mechanisms that have evolved for administering Medicaid. In some states the legislature must initiate substantive programmatic changes while in others it may need only to approve changes (or may not be involved in the process altogether). Some states grant a great deal of authority to the Governor while others concentrate this authority in the Medicaid agency. Even within a given state, the locus of control may vary depending upon whether policy and procedural changes impact funding.

- 1. State legislative changes** – The state legislature may have oversight for any changes made to the Medicaid program – both those that require federal approval and those that do not. A recent survey of states^v reported that four states require legislative approval prior to submission of an SPA, not including two states that require the legislature be notified of the submission of an SPA. Aside from plan amendments, 13 states require legislative approval of waiver applications. Twenty states determine Medicaid benefits by statute. In these states, any benefit change requires legislative action.
- 2. Regulatory changes** – Changes created by legislatures are further refined by the development of regulations by the state’s Medicaid authority. These regulations interpret the legislature’s intent while also reflecting the executive branch preferences. Once regulations are developed and approved, they carry the same force of law as does legislation.
- 3. Administrative Policy and Procedures** – States may also make administrative changes that may not require federal or legislative approval, depending on the state. Many of these changes may be made through changes within the Medicaid agency by modifying the administrative policies or procedures. They are often allowed to shift money between categories of services and eligibility categories; change reimbursement rates, prior authorization, verification procedures, procedures covered – including frequencies of services; and modify the list of participating providers without legislative or gubernatorial approval.

Public Notice and Comment

Currently, there are no federal requirements for public notice or a public comment period for federally submitted Medicaid changes (SPAs or waivers). While all states have a mandate of public notice for any regulatory changes, the method and effort for carrying out that requirement varies. Without a requirement to report public comments as part of every SPA or waiver application it is difficult to know if the public is adequately informed about the process.

Recent Implications of Process of Medicaid Changes

Recent changes made by Congress through DRA have shifted many Medicaid options that previously would only have been available as a waiver to be an option through a State Plan Amendment. These changes provide less oversight by state legislatures, as many states require approval for a waiver application and fewer need legislature clearance for an SPA. This shift may also change the opportunity for public comment. Staying informed about the process for Medicaid changes and seeking out opportunities to comment on these changes is critical for dental providers to influence policy decisions that shape access to dental care for vulnerable children.

For more information on current Medicaid coverage for children's dental care, go to www.cdhp.org or call (202) 833-8288.

ⁱ National Health Law Program. *Medicaid Q&A: State Medicaid Plans*, prepared by Jane Perkins, April 25, 2006. www.healthlaw.org. Accessed June 22, 2006.

ⁱⁱ Centers for Medicaid and Medicare Services. *State Medicaid Plans and Plan Amendments* <http://www.cms.hhs.gov/medicaid/stateplans> Accessed June 20, 2006.

ⁱⁱⁱ The Kaiser Commission on Medicaid and the Uninsured. *The Medicaid Resource Book*. July 2002.

^{iv} For more information on Medicaid waivers go to Centers for Medicare & Medicaid Services at www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/

^v The National Health Law Program and the National Association of Community Health Centers. *Role of State Law in Limiting Medicaid Changes* April 2006. <http://www.healthlaw.org/library.cfm?fa=detail&id=103219&appView=folder>. Accessed June 27, 2006.