Research

Breaking Down Barriers to Medicaid Innovation: Rethinking Medicaid Waiver Approval

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EXECUTIVE SUMMARY

All fifty states use Medicaid waivers–exempting the programs' statutory and regulatory requirements–to one degree or another. These waivers allow states to tailor their program to their state's individual needs and circumstances. Further these waivers create an avenue for ongoing innovation throughout the Medicaid program, with successful policies undertaken by one state quickly being adopted by others.

The approval process to obtain waivers, however, is a lengthy one. The American Action Forum (AAF) found that the waiver approval process is a barrier to innovation in Medicaid–averaging 190 days for all types of waivers. To make matters worse, the average number of days for a state to gain approval for an entirely new Medicaid waiver is 337 days– almost an entire year. In order to reach a growing number of beneficiaries, states must be able to make changes efficiently and effectively to their Medicaid programs. This paper examines the existing data on the Medicaid waiver approval process between federal and state governments, highlighting the need for a faster, more nimble and open pathway to creative Medicaid solutions, and greater transparency around how those solutions are evaluated.

BACKGROUND

Established in 1965 as an amendment to the Social Security Act (SSA), the Medicaid program was developed to provide a medical safety net to the nation's poorest and most vulnerable citizens. As a joint federal-state program, the funding and design of Medicaid is tailored to each state, within the guidelines of statutory and federal regulatory requirements. States have choices in designing some program eligibility levels, reimbursement methodologies and expanding coverage to populations beyond those required by statute.

As part of this federal-state partnership, states have two ways to make alterations to the Medicaid program, the state plan amendment (SPA) process and federally approved waivers.[1] The Medicaid State Plan is the federal-state contract for the administration of a state's Medicaid program.[2] A SPA usually focuses on technical changes to the state plan that do not conflict with statutory or regulatory requirements. The SPA is drafted by the state and approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency governing the Medicaid program.

Program design changes that depart from either statutory or regulatory requirements result in the withdrawal of the federal portion of a state's Medicaid funding unless they are approved by CMS using the agency's Medicaid waiver authorities.[3]

MEDICAID WAIVERS

CMS' waiver authority provides an avenue for states to be more creative and innovative with the design of their individual Medicaid programs. Waiver authority takes what would otherwise be a static federal program, and allows states to tailor how they pay for services, the populations they serve, and the way care is delivered to their particular populations. The statute provides multiple authorities under which specific Medicaid requirements can be waived.[4] The three primary[5] waiver authorities are Section 1915 (b), Section 1915(c), and Section 1115 Demonstration waivers.[6]

- Section 1115 waivers allow states to waive certain requirements of the Medicaid program, including: state-wideness (uniformity of plan design across a state), provider choice, and comparability of services in Medicaid.[7] By waiving these requirements, states can create Medicaid initiatives that focus on a specific geographic region, tailor provider networks, establish enrollment caps, and provide additional services (or in some cases remove otherwise required services).[8]
- Section 1915(b) waivers allow states to create managed care programs and the waiver authority allows states to remove limitations on Medicaid beneficiaries' choice of provider requirements.[9]
- Section 1915(c) waivers allow states to incorporate the use of Home and Community Based Services (HCBS), helping beneficiaries remain in their communities and prevent the move to institutional care.[10]

Most states implement multiple waiver programs. Some states use waivers that encompass the state's entire Medicaid program, while others use them to serve one facet of their Medicaid population through a change in benefit design or the way that health care is delivered and managed for beneficiaries.

In Rhode Island for example, the state uses a waiver to administer the state's entire Medicaid program. Under the waiver the state capped Medicaid spending from 2009-2013 with a budget of $12.075 billion. Through the waiver, Rhode Island has created greater beneficiary involvement in their health care and saved $100 million from 2009-2011.[11]

In contrast to a comprehensive waiver, the state of Alabama uses waiver authority to allow for the continuation of Medicaid coverage for women that would otherwise only receive coverage while pregnant.[12]

Further, Medicaid waivers can be utilized to develop pilot care delivery programs. Oregon utilizes a section 1115 waiver to establish sixteen coordinated care organizations (CCOs) that work towards a more patient centered model of care.

Each of the examples demonstrates a state's ability to create additional value in the Medicaid program through waivers. However, in order to enact these improvements within the Medicaid program, states must draft and submit waiver proposals for approval by CMS.

MEDICAID WAIVER APPROVAL PROCESS

For each of the waivers approved, states must complete a CMS review process so that the agency can consider the details and financing of the proposal.. The stages of the Medicaid waiver process can be outlined as follows: [13]

1. The State submits a Medicaid waiver proposal to CMS.

2. CMS and the State enter into negotiations regarding the details of the waiver.
3. CMS provides written notification of waiver program approval.

The waiver approval process depends on the type of waiver authority that a state is seeking to use. Regardless of authority type, waivers are required to be time limited, not increase program costs, and align with the purpose of the Medicaid program.[14] Waivers for managed care and HCBS (1915 (b) and (c)) do not have detailed transparency requirements. However, the section 1115 waiver process transparency requirements are much more involved – particularly since they were updated in the Affordable Care Act. It is important to note that, regardless of the type of waiver, there is a wait time before approval where CMS and states negotiate the details of the waiver program.

MEDICAID WAIVER APPROVAL WAIT TIMES

The Medicaid waiver approval process is murky at best. It is often a back and forth between states and CMS on the particulars of a certain piece of the waiver or a benefit offered. CMS posts some waiver applications and other waiver documents that have been submitted by states, are pending approval, have been approved, or are expired to a Medicaid Waiver website. However, these forms are not aggregated in a database format and are far from complete. The length of time needed for the approval of a waiver may depend on the complexity, originality, or current status of the issues/services covered in the waiver. The following data indicates the need for additional transparency, accountability, and state level control over the Medicaid waiver approval process.

Methodology

Data was collected from the submission and approval dates listed as part of the supporting documents on the CMS Waiver webpage. The data was aggregated and average approval times were estimated based on the difference between the date of the official state submission of the waiver proposal to CMS and the date CMS officially sent an approval notice to the state. Some waiver data indicated negative wait times for approval, and the data from these occurrences were set to zero. If a waiver did not have a submission and approval date, it was not included in this report's calculations.

LIMITATIONS

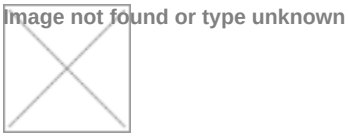
The data gathered from the CMS Medicaid waiver website lists most waivers that are currently approved, pending approval or expired. However, the supplemental documents providing information on each of the waivers' negotiation processes and CMS correspondence with each state is lacking. Approval timing data was not available for some states and other state data on the CMS website did not provide any supplemental documentation, limiting researchers' abilities to assess the approval process as a whole or determine the amendment and renewal proceedings for particular waivers. The posting of additional waiver details would allow for greater transparency of the negotiations between CMS and States, and would improve understanding of the negotiations aspect of the waiver approval process.

ANALYSIS

AAF looked into the waiver approval process using available data in order to gain an initial picture of the Medicaid waiver approval process as it stands today. Using CMS data, one can examine the amount of time it takes for CMS to approve state Medicaid waivers as a whole as well as some specific characteristics. We found

that, on average, CMS takes 190 days, or just over 6 months to approve a Medicaid waiver. Figure 1 shows the amount of time it takes for a Medicaid waiver to gain approval according to its status as an original waiver, a waiver renewal, or an amendment to an existing waiver. An original waiver is the term used throughout this paper to indicate the initial submission of a new waiver program. A waiver renewal or extension refers to secondary approval of a waiver that is already in existence but set to expire. A waiver amendment makes a change to an existing, active waiver. Data also includes waivers that have expired.

FIGURE 1: THE AVERAGE NUMBER OF DAYS FOR WAIVER APPROVAL BASED ON TYPE OF APPROVAL NEEDED

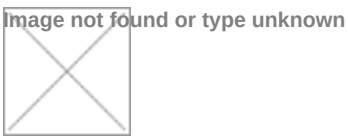


The data shows that original waivers have the longest wait time for approval at 337 days, followed by renewals/extensions at 199 days, and amendments at 177 days. This is most likely due to the level of complexity and burden of reviewing a new waiver. For an original waiver, CMS must review the entire program, weighing costs and benefits, whereas with renewal and amendments the agency is more likely to be familiar with the existing program. These wait times raise questions regarding the efficiency and effectiveness of the current waiver approval process. The range of days is very broad, varying from 0-1637 days for approval.

The ability of a federal agency to approve some waiver requests immediately while others take up to four years deserves explanation. While some states may submit waiver approvals that require a more thorough review process than others, the current range can create much uncertainty among waiver applicants. Since most waivers have three to five year limitations and must go through the CMS approval process again in order to be renewed or extended for another three or five year period.

As mentioned above, much more transparency is required for section 1115 demonstration waivers than for waivers approved under section 1915. Therefore, the data available for 1915 waiver approvals is extremely limited. The following chart shows the difference in the average amount of time taken to approve a waiver based on the authority used.

FIGURE 2: WAIVER APPROVAL AVERAGES ACCORDING TO THE WAIVER AUTHORITY UTILIZED

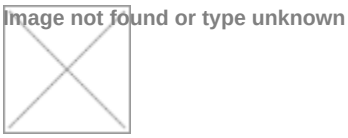


The approval time for section 1115 demonstration waivers is much higher than for 1915 (b) and 1915 (c) authorities. This could be due to the variation among section 1115 demonstrations, meaning that section 1115 waivers cover a larger number of services and care delivery models, taking longer for review.

Even within one waiver authority, the timeframe for approval is questionable. Due to requirements for greater transparency in demonstration waivers, more data is available on the approval process and timeline. The

following graph shows the average length of time for CMS to approve all section 1115 demonstration waivers, family planning (section 1115 FP) waivers, original demonstration waivers, section 1115 waiver renewal/extensions and section 1115 waiver amendments.

FIGURE 3: SECTION 1115 DEMONSTRATION WAIVER APPROVAL TIME AVERAGES



As seen in Figure 3, a section 1115 demonstration waiver approval process averages 234 days, over seven months. Once a waiver is approved, usually for a three to five year period, any amendments to the active waiver average an approval time of 216 days, and the renewal of an existing waiver set to expire averages approval time of 276 days. As seen in the graph below, it takes a month longer to approve a program renewal – on average- that it does to approve an original demonstration program. The section 1115 FP approval is a separate case because section 1115 FP or Family Planning waivers are similar in nature in that they each offer a set of family planning benefits. However, according to CMS data, approval time for a section 1115 FP waiver averages almost one year – 361 days.

FIGURE 4: MEDICAID WAIVER APPROVAL TIME BY STATE

Each state manages a unique Medicaid program, operating under specific sets of waivers, SPAs and care delivery models. While each state has a distinct program, every state operates at least one Medicaid waiver.[15] Often, once one state develops a new process, other states may follow with similar programs,[16] and it could be expected of CMS to provide more timely responses to states following suit, as they are more familiar with the proposed waiver program details. Despite similar programs across many states, the average approval waiting periods vary vastly across the country. This variation prevents states from estimating the length of time necessary for CMS to approve a waiver proposal. Uncertainty in approval times creates difficulty in making policy and planning decisions at the state level. Figure 4 depicts this range of approvals and the need for more certainty in approval times across states.

DISCUSSION

The amount of time taken to approve a Medicaid waiver is a direct indicator of the complexity of the process. The waiver approval process should be reformed to include more state autonomy, an official timeframe and efficient evaluation.

An average approval timeframe of six months from state submission to approval only describes one piece of the complicated process – it does not include the countless hours spent at the state level weighing options for the waiver, gathering stakeholder input and drafting a proposal that then enters into the approval process. The continual interruption for approval and compliance updates costs states time and Medicaid funding. For example, the Arizona Cost Containment System (AZCCS) is a comprehensive waiver that has been subject to federal review for 30 years. In 1982, the waiver was less than 20 pages, by 2006 the waiver reached a length of 60 pages, and today the waiver is approaching 200 pages in length.[17] In meetings with the Medicaid and CHIP Payment and Access Commission (MACPAC), state Medicaid Directors indicated the need for a less complex process freeing up resources to develop new and innovative approaches to delivering Medicaid

services to beneficiaries.[18]

Once the state has completed the waiver approval process, the waiver is then up for renewal in three to five years. Even waivers with a track record of success may need to be updated with an amendment—averaging 177 days for approved changes—and will experience renewal or extension, jeopardizing coverage for some of their poorest citizens. The section 1115 demonstration waiver timeline illustrated in Figure 3 shows approvals and amendments with even lengthier timeframes. Instituting a required timeframe on the part of CMS could work to ease the uncertainty around funding and design changes states are required to make in waiver approvals, amendments and renewals.

A set time clock for waiver approval would allow for states to plan with certainty, and for a more efficient evaluation process. As waivers are vetted for budget neutrality and other CMS requirements, the decision date will serve as way to streamline the federal assessment, both at the regional and headquarters levels.

CONCLUSION

Waivers usually involve millions or billions of dollars in federal and state funding, and therefore the process must be rigorous. As states are looking for ways to contain costs in their Medicaid programs, the waiver process should be designed in such a way that is not an obstacle to innovative reform. An average wait time of over six months is unacceptable, and does not allow for a Medicaid program that meets the needs of the poor while providing the most appropriate care.

Though the Medicaid expansion approval process has been documented for months, many other waiver approval processes do not gain national attention. As most waiver approval processes do not have such a high profile, the methods through which the waivers are approved are not highlighted. Additional transparency is needed. There is significant variation in the amount of time taken during the CMS-state negotiation process to approve a Medicaid waiver.[19] CMS is not accountable for the length of time taken to approve a waiver often leaving states in limbo as they await approval.

As health care expenditures continue to rise, states will be searching for ways to provide more care with less budgetary impact. The coming pressures should be eased by making pathways for innovative and alternative approaches more efficient and dependable.

[1] http://familiesusa.org/product/state-plan-amendments-and-waivers-how-states-can-change-their-medicaid-programs