

*The National Association of Community Health Centers, Inc.*

**MODEL State Legislation to Implement State Flexibility in Medicaid**

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**Introduction**

The Deficit Reduction Act (DRA), signed by the President on February 8, 2006, contains broad new flexibility for States, enabling them to make extensive changes in their Medicaid benefits packages in order to reduce state spending. These changes could include reductions in the types of services covered, increases in patient cost-sharing with respect to particular services, or both. In addition, the Act authorizes the granting of waivers to enable States to fund health opportunity accounts in place of standard Medicaid benefits packages for certain populations.

Because this new flexibility presents States with more options than ever, it makes the role of State Legislatures in Medicaid policymaking even more critical than it has been. Some of these new flexibilities can be implemented through amendments to the State Medicaid plan, while others require waivers from the Secretary of Health and Human Services. In either case, it is up to each State to decide whether the Governor, the State Legislature, or both will design the new Medicaid benefits package.

The stakes are high. Medicaid is the largest single purchaser of health care services in almost every State. Changes to a State's Medicaid benefits package, including the types of services covered and the cost-sharing requirements that apply to each service, will directly affect hospitals, physicians, community clinics, pharmacies, and other providers that furnish services to Medicaid patients covered under the existing package, as well as the patients themselves. In legislative districts with significant Medicaid enrollment, many jobs as well as large amounts of federal and state dollars are potentially in play.

The purpose of this Model legislation is to ensure that the State Legislature has a role in designing and implementing any changes to the benefits package offered by the Medicaid program that it funds. In addition to protecting the State Legislature's constitutional prerogatives, this Model legislation would promote transparency in Medicaid policymaking by ensuring that all stakeholders have an opportunity to review the proposed policy changes and express their views.

**Commentary**

The Model legislative language addresses two areas of Medicaid policymaking: State Plan Amendments (SPAs) and demonstration waivers. State Medicaid programs operate under the terms of a State Medicaid Plan that is approved as being consistent with federal Medicaid law by the Secretary of Health and Human Services acting through the Centers for Medicare & Medicaid Services (CMS). A State's Medicaid Plan sets forth the State's policy with respect to eligibility, benefits, provider reimbursement, and other aspects of

its Medicaid program. States can change their Medicaid programs, but to do so without losing federal Medicaid matching funds they generally must either amend their State Plans or seek a waiver of federal requirements. In each case, federal approval is required. The following sections of this commentary describe how the Model language provides for State Legislative approval as well.

**Section 1. Prior Review and Approval of State Plan Amendments Affecting Medicaid Benefits Design.** Under sections 6041 and 6044 of DRA, States have the option of changing the design of their Medicaid benefits package, either by imposing cost sharing on certain eligibility groups, reducing benefits for certain eligibility groups, or both. In addition, section 6041 authorizes States to impose premiums or enrollment fees on certain groups. Finally, sections 6042 and 6043 give states new authority to impose higher cost-sharing on prescription drugs and non-emergency services in emergency rooms. In all cases, the States may implement these options by submitting a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) for approval. States do not have to obtain a waiver of federal statutory or regulatory requirements from the Secretary, and they do not have to demonstrate that the SPA is budget neutral to the federal government.

In some States, the State Medicaid Plan is incorporated directly into State statute, and amendments to the State Plan must therefore be approved by the State Legislature if they are to take effect. In other States, the State Medicaid Plan and SPAs are not approved by the State Legislature, but rather are set forth in regulations issued by the State Medicaid Agency or in an administrative transmittal, such as a state Medicaid manual, that has not gone through a formal notice-and-comment procedure to ensure public input. The model language in section 1 is relevant only in the latter States, where the State Legislature does not currently have a role in Medicaid policymaking.

The model language would give State Legislatures a policymaking role in Medicaid benefits design by requiring review and approval of all SPAs relating to Medicaid benefits or cost-sharing by the committees of jurisdiction in the State Legislature prior to the submission of the SPA to CMS. (The model language would not apply to SPAs that do not affect benefits design, however, it could be altered to include additional SPAs that cover other aspects of the Medicaid program, such as the groups of optional eligibles that the state covers in its program). To ensure that the State Legislature is involved in any Medicaid benefits redesign from the beginning, the model legislation requires the Governor or the State Medicaid Agency to notify the Legislature of its intent to submit an SPA affecting benefits. To assist State Legislators in understanding the SPA and its implications, the model language would require the State Medicaid Agency to provide background information about the SPA. This information would include estimates of the SPA's effect on state and federal Medicaid spending; its impact on providers; and its impact on access to health care by beneficiaries and the quality of the care they receive; and its impact on the private insurance market, including the premiums for coverage available to small businesses.

**Section 2. Prior Review and Approval of Demonstration Waiver Proposals.** Under section 1115 of the Social Security Act, states may seek waivers of federal Medicaid statutory requirements in order to conduct demonstrations of policy changes, including changes in Medicaid benefits design, with federal financial participation in the costs. A number of states have received section 1115 demonstration waivers to make major changes in their Medicaid benefits packages for expansion populations (e.g., Utah), traditional populations (e.g., Florida), or both (e.g. Oregon).<sup>1</sup>

Under the new section 1938 of the Social Security Act, as added by section 6082 of DRA, the Secretary of HHS is required to establish an additional, 10-state demonstration program for the provision of alternative benefits to certain groups of Medicaid beneficiaries. The alternative benefits must take the form of high-deductible health coverage combined with a contribution into a “health opportunity account” for each beneficiary. The contribution into the health opportunity account may not exceed \$1,000 per child or \$2,500 per adult, indexed annually for medical care inflation. The deductible for the health coverage must be between 100% and 110% of the contribution to the health opportunity account (for example, if a child had a health opportunity account of \$1,000, the deductible for Medicaid coverage for a child could be \$1,100, with the child paying the \$100 difference out of pocket before the Medicaid coverage triggers in). States may limit the demonstration to particular counties or regions. Certain groups of beneficiaries—the elderly, the disabled, and pregnant women—are exempt from the demonstration, which is targeted at low-income families with children. Enrollment by individual beneficiaries is voluntary.

A state that is currently operating a section 1115 demonstration waiver may also obtain a section 1938 waiver. Thus a state may simultaneously alter its benefits designs for different populations in different parts of the state through both a section 1115 demonstration waiver and a section 1938 demonstration waiver.

In some States, the Governor or State Medicaid Agency is required to consult with the State Legislature prior to negotiating a section 1115 demonstration waiver with CMS and, in some instances, prior to implementing an approved waiver. . In other States, the negotiation of a section 1115 waiver with CMS, and the implementation of an approved waiver, is left to the sole discretion of the Executive Branch. The model language in section 2 would apply in the latter States with respect to section 1115 waivers, and in all States with respect to section 1938 waivers.

The model language would ensure a policymaking role for State Legislatures in the design and implementation of Medicaid demonstration waivers by requiring review and approval of all section 1115 and section 1938 waiver applications relating to Medicaid benefits design by the committees of jurisdiction in the State Legislature prior to the

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<sup>1</sup> The National Conference of State Legislatures explains Section 1115 waivers at [www.ncsl.org/programs/health/hifa.htm#f](http://www.ncsl.org/programs/health/hifa.htm#f). Waiver documents for each state are posted at [www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage)

submission of the waiver application to CMS. (The model language would not apply to other waivers, such as home and community-based services waivers under section 1915(c)). To ensure that the State Legislature is involved in any policy changes from the beginning, the model legislation requires the Governor or the State Medicaid Agency to notify the Legislature of its intent to submit a demonstration waiver application. Because the scope and content of waivers often changes significantly between the submission of a waiver application to CMS and final approval by the federal agency, the model language would also require review and approval of all section 1115 and section 1938 waivers (including the renewal of these waivers) affecting Medicaid benefits approved by CMS prior to actual implementation.

To assist State Legislators in understanding the proposed waivers and their implications, the model language would require the State Medicaid Agency to provide background information about the waiver and its impact. This information would include estimates of the effect of the waiver on state and federal Medicaid spending; its impact on providers; its impact on access to health care by beneficiaries and the quality of the care they receive; and its impact on the private insurance market, including the premiums for coverage available to small businesses.

### **Model Legislative Language**

Because each State has its own conventions for statutory drafting, the legislative language presented below is necessarily generic. The structure of each section is designed to enable State policymakers to customize the language to their unique circumstances and procedures. For example, the model language would require the submission of information to, and action by, the “[Committees of jurisdiction].” This is a placeholder for the locus of Medicaid policymaking in each State Legislature. In some States, this will be the fiscal committee(s), in others the House or Senate leadership. Each State will have to modify “[Committees of jurisdiction]” to fit its own circumstances.

## **§ 1. Prior Review and Approval of State Plan Amendments Affecting Medicaid Benefits Design**

- (a) **Prohibition Against Submission without Prior Review and Approval.**— The [State Medicaid Agency] shall not submit to the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services any amendment to the [State Medicaid Plan] described in subsection (b) unless each of the requirements of subsections (c) and (d) have been met.
  
- (b) **State Plan Amendments Subject to Prior Review and Approval.**— An amendment to the [State Medicaid Plan] described in this subsection is an amendment that modifies, directly or indirectly:
  - (1) the items and services covered;
  - (2) deductibles, copayments, or other cost-sharing requirements;
  - or
  - (3) the premiums or enrollment fees applicable

under the [State Medicaid Plan] in effect as of [INSERT date of enactment].

(c) **Prior Review**— The requirements of this subsection are:

(1) No later than the date on which the Governor submits a budget for a state fiscal year, the [State Medicaid Agency] shall notify in writing the [Committees of jurisdiction] of any State Plan amendment described in subsection (b) that the Governor or the [State Medicaid Agency] has under consideration for submission to the Centers for Medicare & Medicaid Services during the State fiscal year to which the Governor's budget applies.

(2) No later than 60 working days prior to submission of the State Plan amendment described in subsection (b) to the Centers for Medicare & Medicaid Services, the [State Medicaid Agency] submits to the [Committees of jurisdiction] each of the following:

(A) a copy of the proposed State Plan amendment;

(B) a detailed estimate of the change in State and Federal Medicaid spending that would result from implementation of the proposed amendment during [the State fiscal year in which the amendment would first be effective];

(C) the capitation rates (by rate category) paid to Medicaid managed care organizations

(i) prior to implementation of the proposed amendment; and

(ii) subsequent to implementation of the proposed amendment;

(D) a written opinion of the [State Attorney General] that, if adopted, the proposed State Plan amendment will not subject the State to the loss of Federal Medicaid matching funds due to noncompliance with Federal laws and regulations;

(E) an estimate of the number of each type of provider participating in the State Medicaid program that is likely to be affected by the proposed amendment;

(F) a detailed estimate of the likely financial effect of the proposed amendment on each type of provider participating

in the State Medicaid program that is likely to be affected by the proposed amendment;

(G) an estimate of the number of Medicaid beneficiaries likely to be affected by the proposed amendment, by eligibility group; and

(H) a detailed estimate of the likely effect of the proposed amendment on utilization of needed primary care and preventive health services by Medicaid beneficiaries;

(I) a detailed estimate of the likely effect of the proposed amendment on the quality of primary care and preventive health services received by Medicaid beneficiaries;

(J) a detailed estimate of the likely effect of the proposed amendment on the utilization of hospital emergency rooms by Medicaid beneficiaries; and

(K) a detailed estimate of the likely effect of the proposed amendment on private health insurance premiums available to small businesses as the result of any shift of costs by health care providers serving Medicaid beneficiaries with respect to whom the proposed amendment would reduce benefits or increase cost-sharing requirements.

(3) Each of the [Committees of jurisdiction] conducts, at least 30 working days prior to submission of the State Plan amendment to the Centers for Medicare & Medicaid Services, no less than [one] public hearing at which representatives of providers participating in Medicaid and Medicaid beneficiaries are afforded, upon timely and sufficient public notice, an opportunity to present testimony with regard to the proposed amendment.

(d) **Prior Approval.**— The [State Medicaid Agency] shall not submit a State Plan amendment described in subsection (b) to the Centers for Medicare & Medicaid Services for approval unless each of the [Committees of jurisdiction], after reviewing the information required to be submitted under subsections (c)(1) and (c)(2) and conducting the hearings described in subsection (c)(3), has approved such amendment by a majority vote.

## **§ 2. Prior Review and Approval of Demonstration Waivers**

(a) **Prohibition Against Submission of Demonstration Waiver Application without Prior Review and Approval.**— The Governor or the [State Medicaid Agency] shall not submit to the Secretary of the U.S. Department of Health and

Human Services or to the Centers for Medicare & Medicaid Services any application for a demonstration waiver (including an application for renewal of a demonstration waiver) described in subsection (b) unless each of the requirements of subsections (c) and (d) have been met.

**(b) Demonstration Waiver Described.**— A demonstration waiver described in this subsection is a waiver granted by the Secretary of the U.S. Department of Health and Human Services under the authority of section 1115 or section 1938 of the Social Security Act that would modify, directly or indirectly:

- (1) the items and services covered;
  - (2) deductibles, copayments, or other cost-sharing requirements; or
  - (3) the premiums or enrollment fees applicable
- under the [State Medicaid Plan] in effect as of [INSERT date of enactment].

**(c) Review Prior to Submission of Application for Demonstration Waiver.**— The requirements of this subsection are:

(1) No later than the date on which the Governor or the [State Medicaid Agency] begins or contracts for the development of a concept paper or similar planning document for a demonstration waiver described in subsection (b), the Governor or the [State Medicaid Agency] notifies in writing the [Committees of jurisdiction] of the intent to develop a submission to the Centers for Medicare & Medicaid Services for such a waiver.

(2) The Governor or the [State Medicaid Agency] submits to the [Committees of jurisdiction], at least 60 working days prior to submission to the Centers for Medicare & Medicaid Services of an application for a demonstration waiver described in subsection (b), each of the following:

(A) a copy of the proposed application;

(B) a detailed estimate of the change in State and Federal Medicaid spending that would result from implementation of the proposed demonstration waiver during each of the State fiscal years in which the waiver would be in effect;

(C) an estimate of the number of each type of provider participating in the State Medicaid program that is likely to be affected by the proposed demonstration waiver;

(D) a detailed estimate of the likely financial effect of the proposed amendment on each type of provider participating in the State Medicaid program that is likely to be affected by the proposed demonstration waiver;

(E) an estimate of the number of Medicaid beneficiaries, by eligibility group, that is likely to be affected by the proposed demonstration waiver;

(F) a detailed estimate of the likely effect of the proposed demonstration waiver on utilization of primary care and preventive health care services by Medicaid beneficiaries;

(G) a detailed estimate of the likely effect of the proposed demonstration waiver on the quality of primary care and preventive health services received by Medicaid beneficiaries;

(H) a detailed estimate of the likely effect of the proposed demonstration waiver on the utilization of hospital emergency rooms by Medicaid beneficiaries; and

(I) a detailed estimate of the likely effect of the proposed demonstration waiver on private health insurance premiums available to small businesses as the result of any shift of costs by health care providers serving Medicaid beneficiaries with respect to whom the proposed demonstration waiver would reduce benefits or increase cost-sharing requirements.

(3) Each of the [Committees of jurisdiction] conducts, at least 30 working days prior to submission of the demonstration waiver application to the Centers for Medicare & Medicaid Services, no less than [one] public hearing at which representatives of providers participating in Medicaid and Medicaid beneficiaries are afforded, upon timely and sufficient public notice, an opportunity to present testimony with regard to the proposed demonstration waiver application.

**(d) Approval Prior to Submission of Application for Demonstration Waiver.**— The Governor or the [State Medicaid Agency] shall not submit to the Secretary of the U.S. Department of Health and Human Services or to the Centers for Medicare & Medicaid an application for a demonstration waiver described in subsection (b) unless each of the [Committees of jurisdiction], after reviewing the information required to be submitted under subsections (c)(1) and (c)(2) and conducting the hearings described in subsection (c)(3), has approved such application by a majority vote.

**(e) Prohibition Against Implementation of Waiver without Prior Review and Approval.**— The [State Medicaid Agency] shall not implement a demonstration waiver described in subsection (b) and approved by the Secretary of the U.S.

Department of Health and Human Services or by the Centers for Medicare & Medicaid Services unless each of the following requirements have been met:

- (1) The [State Medicaid Agency] submits to the [Committees of jurisdiction], at least 60 working days prior to the approved date for implementation of the demonstration waiver, each of the following:
  - (A) a copy of the approved demonstration waiver and all related documents, including the standard terms and conditions, budget neutrality requirements, and operational protocol;
  - (B) a detailed explanation of the differences between the waiver application as approved by the [Committees of jurisdiction] under subsection (c)(3) and the demonstration waiver as approved by the Secretary or the Centers for Medicare & Medicaid Services;
  - (C) a detailed estimate of the change in State and Federal Medicaid spending that would result from implementation of the demonstration waiver as approved during each of the State fiscal years during the term of the waiver;
  - (D) a detailed estimate of the likely financial effect of the demonstration waiver as approved on each type of provider participating in the State Medicaid program that is likely to be affected by the approved waiver; and
  - (E) a detailed estimate of the likely effect of the demonstration waiver as approved on the utilization of primary care and preventive health services by Medicaid beneficiaries;
  - (F) a detailed estimate of the likely effect of the demonstration waiver as approved on the quality of primary care and preventive health services received by Medicaid beneficiaries;
  - (G) a detailed estimate of the likely effect of the demonstration waiver as approved on the utilization of hospital emergency rooms by Medicaid beneficiaries; and
  - (H) a detailed estimate of the likely effect of the proposed amendment on private health insurance premiums available to small businesses as the result of any shift of costs by

health care providers serving Medicaid beneficiaries whose benefits would be reduced or cost-sharing increased by the proposed amendment

(2) Each of the [Committees of jurisdiction] conducts, at least 30 working days prior to implementation of the demonstration waiver as approved, no less than [one] public hearing in each region of the State in which the demonstration waiver as approved would take effect at which representatives of providers participating in Medicaid and Medicaid beneficiaries are afforded, upon timely and sufficient public notice, an opportunity to present testimony with regard to the approved waiver; and

(3) Each of the [Committees of jurisdiction], after reviewing the information required to be submitted under paragraph (1) and conducting the hearings described in paragraph (2), have approved the implementation of the demonstration waiver as approved by a majority vote.