OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

Medicaid State Plan Amendments and Waivers

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Issue

This report discusses Medicaid state plan amendments (SPA) and waivers and related legislative requirements.

Summary

Medicaid is administered jointly by state and federal governments. To make program changes, states must generally submit SPAs to the federal Centers for Medicare and Medicaid Services (CMS) for review and approval. Connecticut amends its state plan frequently and state law does not generally require legislative approval for SPAs.

Federal law authorizes various types of waivers that states may use to request that certain federal Medicaid requirements be waived. Connecticut currently has 10 home- and community-based services waivers, two demonstration waivers, and three freedom-of-choice waivers.

When the Department of Social Services (DSS) applies to CMS to request a new waiver or amend or renew an existing waiver, state law generally requires the department to submit waiver applications to the Appropriations and Human Services committees before submitting them to CMS. The committees must hold a public hearing within 30 days of receiving the application and approve, deny, or modify the application.

State Plan Amendments

Each state operates its Medicaid program in accordance with a state plan approved by CMS. As described by CMS, the plan sets out coverage groups, provided services, provider reimbursement methodologies, and the state's administrative activities.

To make a change in its Medicaid program, the state must send a SPA to CMS for review and approval. In Connecticut, the law does not require legislative approval for SPAs, except in certain narrow cases (e.g., certain program changes allowed under the Affordable Care Act (CGS § 17b-8)). However, several laws require the DSS commissioner to amend the state plan if needed to effectuate the law's purpose (e.g., CGS § 17b-28e on hospice, podiatry, behavioral health clinicians, and naturopath services).

CMS maintains a SPA database. Table 1 shows the SPAs most recently posted for Connecticut. The effective dates are routinely retroactive, sometimes reflecting a policy change the state has already put in place.

Table 1: Recent SPA Examples in Connecticut

Transmittal Number	*Subject*	*Approval Date*	*Effective Date*
CT-23-0011	Clinic services rates and methodology	09/20/2023	04/01/2023
CT-23-0013	One-time supplemental payment for intermediate care facilities for individuals with intellectual disabilities	09/18/2023	06/14/2023
CT-23-0007	Increases per diem rate for private psychiatric residential treatment facilities	06/15/2023	01/01/2023
CT-23-0010	Reimbursement methodology for continuous glucose monitors provided by a pharmacy	06/12/2023	03/01/2023
CT-23-0008	Increases rates for self-directed personal care attendant services under the Community First Choice benefit	06/12/2023	01/01/2023

Source: CMS

Waivers

Federal law authorizes several different types of waivers states may use to waive certain federal Medicaid requirements that would otherwise apply. For Connecticut, CMS has approved 1915(c) waivers, 1115 waivers, and 1915(b) waivers.

1915(c) Home- and Community-Based Waivers

1915(c) waivers allow states to establish Medicaid-funded programs to provide home- and community-based services to eligible individuals who would, without the benefit of such services,

otherwise be institutionalized (e.g., placed in a nursing home or other facility). A waiver allows the state to waive certain federal Medicaid requirements in order to (1) provide services not typically provided under Medicaid and (2) limit waiver enrollment. Separate waivers are generally required for each eligible population and states typically operate multiple waivers. Connecticut has 10 1915(c) waivers.

Federal law requires states to provide assurances that their waivers are "cost neutral," meaning the average cost per capita expenditures for covered services will not exceed those for institutionalized care (42 U.S.C. 1396n(c)(2)(D)). Waivers may also have individual cost caps established by the state and approved by CMS that limit the total cost of a person's care plan to some percentage of what it would cost to care for that person in an institution or a dollar amount.

CMS maintains a waiver database. Connecticut has 10 approved 1915(c) waivers (also described in this CMS factsheet);

1. Acquired Brain Injury I,
2. Acquired Brain Injury II,
3. Comprehensive Supports,
4. Employment and Day Supports,
5. Home- and Community-Based Services for Elders,
6. Home- and Community-Based Services for Persons with Autism,
7. Individual and Family Supports,
8. Katie Beckett,
9. Mental Health, and
10. Personal Care Assistance.

1115 Demonstration Waivers

Section 1115 of the Social Security Act (42 U.S.C. § 1315) allows the U.S. Department of Health and Human Services to waive federal requirements in public assistance programs for states seeking to test new approaches while maintaining federal funding. In practice, states generally use 1115 waivers in their Medicaid programs, rather than other assistance programs.

The Medicaid and CHIP Payment and Access Commission (MACPAC) notes that these waivers "are by their nature open-ended and subject to a great deal of secretarial discretion, so states seeking Section 1115 waivers must engage in lengthy negotiation processes with CMS."

Among other things, states seeking 1115 waivers must:

1. demonstrate that their demonstration project is "budget neutral" (CMS guidance, 2018);
2. comply with certain public process and transparency requirements (CMS guidance, 2012); and
3. contract with independent entities to evaluate and monitor their demonstration projects (CMS website, 2019).

Connecticut has two approved 1115 waivers: (1) Connecticut Substance Use Disorder Demonstration and (2) Covered Connecticut. According to DSS, the state is currently working on a third 1115 waiver to address justice-involved populations (see slides 39-41).

1915(b) Freedom-of-Choice Waivers

Section 1915(b) of the Social Security Act allows CMS to waive statutory requirements for comparability, statewideness, and freedom of choice in service delivery. As described by MACPAC, section 1915(b)(4) allows states to apply for waivers to limit the number or type of providers who may provide specific services.

According to CMS, Connecticut has three 1915(b)(4) waivers: (1) Connecticut Housing Engagement and Support Services (CHESS); (2) Connecticut Home Care Program for Elders Case Management Freedom of Choice Waiver; and (3) Early and Periodic Screening, Diagnostic and Treatment Services Early Intervention Services Program Waiver.

Legislative Approval in Connecticut

State law requires the DSS commissioner to submit federal waiver applications, renewals, and amendments to the Appropriations and Human Services committees before submitting them to CMS (CGS § 17b-8). She must also post notice of the intention to submit the waiver on the DSS website and in the Connecticut Law Journal, allow 30 days for written comments, and include the comments when submitting the waiver application to the committees.

The committees must:

1. hold a public hearing within 30 days of receiving the application;

2. approve, deny, or modify a waiver application; and
3. appoint a conference committee if the committees do not concur on the decision.

For waivers pertaining to Covered Connecticut, the Insurance and Real Estate Committee also participates in this process. These legislative approval requirements do not apply to applications addressing routine operational issues.

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