



CDHP Issue Brief

Understanding Medicaid State Waivers and their Impact on Children's Dental Coverage

With Medicaid continuing to dominate many governors' agendas, many governors are looking to the federal government for options to contain state costs by significantly altering the basic structure of children's coverage. Medicaid waivers, particularly "1115 waivers," have become a primary method for some states to contain Medicaid expenditures. While these waivers were once a strategy for expanding Medicaid coverage, they have now become a battleground for maintaining fundamental pediatric services. In response to governors' efforts, Congress recently passed Medicaid provisions in the Deficit Reduction Act of 2005 (DRA) that include new options previously only available through state waivers. Additionally, the President has called for further waiver expansions. Both hold potential to threaten dental coverage for children by allowing states to limit services currently required by Medicaid's EPSDT benefit.

Medicaid Waivers

The Centers for Medicare and Medicaid Services (CMS), which regulates Medicaid, has the authority to allow states to use federal Medicaid and SCHIP funds for innovative strategies not otherwise allowed under Medicaid rules. This is known as a waiver. Of particular interest to retaining EPSDT services is the category called "1115 Waivers for Research and Demonstration Projects."ⁱ Waivers have been used in strong and weak economic times.ⁱⁱ Waivers are neither inherently "good" nor "bad" but merely ways for states to try new strategies not otherwise allowed by law. In the mid-1990's, 1115 waivers were used primarily to expand Medicaid coverage. However, today most states' interest in waivers is to limit coverage for children. Federal waivers require states to develop five-year plans that are budget neutral. 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. "Budget neutrality" is accomplished by placing dollar caps on federal spending during the waiver period. These caps may be either global (similar to a block grant) or per capita (per person).

Dental Benefits for Children

Comprehensive dental care coverage for children is mandatory for all Medicaid enrolled children from birth through age 20 under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. However, there is no dental benefit within Medicaid outside of EPSDT. It is currently unclear whether CMS would approve a waiver seeking to waive EPSDT benefits, thereby potentially limiting or eliminating low-income children's dental coverage. To look more closely at the potential for losing dental coverage, we examine the latest trends in Medicaid waivers, the motives for those changes, and what child advocates should be aware of to maintain dental care as an inherent Medicaid benefit for children.

Trends in Medicaid Waivers

Waivers have been a strategy for states to make changes ahead of Medicaid laws. Many of the most recent waiver ideas supported by the Administration have given states flexibility by shifting costs to individuals or by putting states at risk for excess costs. There is a growing trend for Medicaid to mirror commercial insurance plans and *defined contribution* plans (instead of *defined benefits*). Proposed changes include shifting Medicaid responsibilities out of state government and into private companies, providing personal health accounts for beneficiaries' use in paying for high-deductible health insurance – resulting in more cost-sharing by the beneficiary and less benefits covered by the plan, and creating health incentive accounts that would reward beneficiaries for healthy behaviors or penalize them for unhealthy behaviors.

In February, Congress endorsed the governors' call for greater flexibility *without* waivers. The Deficit Reduction Act of 2005 (DRA), which was passed in early February 2006, gives states the option to enroll children in a limited benefit package so long as the package meets one of four commercial benchmarks, none of which require a dental benefit. For children enrolled in these limited packages, states are also required to offer an "EPSDT wrap around" benefit. However, a definition of an "EPSDT wrap around" is not provided in the legislation and considerable controversy remains regarding the specific nature of this

requirement. Additionally DRA grants states options to enact cost sharing, charge premiums, and limit access to services for optional Medicaid beneficiaries.

Florida

The Florida waiver is a two county pilot scheduled for a July 1 start. It was enacted by the Florida legislature and approved by CMS. The waiver moves Medicaid into a competitive marketplace by providing Medicaid beneficiaries, the largest group being children, a risk adjusted premium. A beneficiary will only be eligible for full coverage after choosing a plan. The state has agreed to a per person financial growth cap of eight percent annually over the life of the five-year waiverⁱⁱⁱ. If the state is unable to keep expenses within the capped amount, it will have to make decisions on how to cut costs. The Florida waiver requires all plans to offer the full range of EPSDT benefits. However, the premium levels for children have not been released and questions remain about what limits Florida may have to create in order to both provide EPSDT services and stay within the new financial arrangement.

As a follow-up to Congress granting states greater flexibility without the need for waivers, the President's 2007 budget goes a step further by announcing a "new waiver initiative that emphasizes market-driven approaches to health careⁱⁱⁱ." Citing Florida (see text box) as an example, the Administration expresses support for "consumer-driven approaches to health care with access to affordable coverage while giving States more tools to offer better health coverage to some current beneficiaries, as well as to individuals who are currently uninsured."

Further describing the waiver program, the budget document calls for "broadening choices and encouraging competition in the private market" as an approach to Medicaid "modernization through state-level reforms."

What do DRA and waivers mean for children's oral health?

The only mandatory dental benefit for children exists in EPSDT but the continued definition and enforcement of EPSDT under the DRA's "wrap-around" provision is in question. Without an explicit EPSDT benefit or Congressional requirement for continued comprehensive dental coverage, children may lose access to the kinds of oral health coverage they now have. The majority of oral disease exists within Medicaid eligible low-income children. In fact, 80 percent of tooth decay is found in 25 percent of children – primarily low-income children. The loss of comprehensive, enforceable dental benefits through EPSDT could result in even less dental care and more disease progression resulting in detriment to a child's ability to eat, speak, sleep, and learn.

The budget neutrality requirement of the waivers allows states to predict their Medicaid costs, but may force them to make difficult decisions about benefits or provider payments if predictions are off. If a state were to exceed its global or per capita cap, it would be responsible for the additional cost – either through additional state funding or cuts to the program. Benefit cuts could include the reduction or elimination of dental coverage for children (as has been the case for adults) or reduced provider payments for dental services.

Looking to the future

DRA changes and waivers hold potential to both improve and to harm dental benefits for low-income children. Despite very stringent guarantees of coverage and access, Medicaid dental programs for the last 34 years have performed poorly in most states most of the time and many have become the subject of litigation. Programmatic change therefore holds promise of creative reform that can result in improved dental care for children with the greatest needs. On the other hand, Congressional and Administrative loosening of Medicaid requirements and allowing states to make changes outside of the public scrutiny of the CMS waiver approval process raises the possibility of erosion or even elimination of dental coverage.

Get active!

Pediatric oral health advocates need to respond to these changes in Medicaid by increasing their vigilance, engaging more directly with their state Medicaid authorities, and seeking to positively influence state decisions.

As it will be increasingly difficult to determine whether dental benefits will be targeted by "market-based reforms," now is a critical time to voice concern for children's oral health and call for state-by-state

commitment to comprehensive dental services so that dental benefits remain intact and access to care can improve.

ⁱ For more information on Medicaid waivers go to Centers for Medicare & Medicaid Services at

www.cms.hhs.gov/MedicaidStWaivProgDemoPGL/

ⁱⁱ Artiga, S and Mann, C. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, March 2005.

ⁱⁱⁱ Office of Management and Budget, Budget of the United States FY 2007, section on Department of Health and Human Services, <http://www.whitehouse.gov/omb/budget/fy2007/hhs.html>.

ⁱⁱⁱⁱ November 21, 2005 (updated January 4, 2006), *What will Florida's "Medicaid Choice" Waiver Proposal Mean for Children?*, Georgetown university Health Policy Institute Center for Children and Families, <http://ccf.georgetown.edu/pdfs/florida1105.pdf>