Legislative Council Staff
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Adding Benefits Under Medicaid

Medicaid is a joint federal and state program that provides health benefits and services to Coloradans who meet eligibility requirements. Each state administers its own Medicaid program, and the federal Centers for Medicare and Medicaid Services (CMS) set standards for the program to receive federal financial participation. The Department of Health Care Policy and Financing (HCPF) oversees Colorado's Medicaid. This issue brief summarizes the process to add benefits under Medicaid.

State approval process

The process to create or revise a Medicaid benefit may be initiated at any time. Changes to benefits can be initiated by HCPF, required by legislation, or requested by a client or provider.[1] *This flowchart* outlines the rulemaking process to make changes to Medicaid benefits. In summary:

1. HCPF researches and proposes specific changes or new benefits.
2. HCPF solicits stakeholder feedback on the proposed policy change, and makes revisions if necessary.
3. The policy is drafted into rule and presented to the Medical Services Board (board), which is responsible for adopting the rules that govern HCPF programs and consists of 11 appointed members.
4. The board holds a public meeting to hear feedback on the draft rule and approves further revisions to the draft rule if necessary.
5. The board holds a second meeting to formally vote on the rule.

If the proposed change to benefits requires additional funding or conflicts with current state law, legislation is required to enact it. Often legislation passes before a new rule is drafted and triggers the rulemaking process.

Federal approval process

State Plan

To continue receiving federal financial participation, all rules must be in compliance with the federal Social Security Act. HCPF ensures compliance through the state plan, which describes how the programs must be administered.

The federal Social Security Act details:

- which services can or must be available under the programs;
- which populations are eligible for enrollment in the programs;
- requirements to ensure all eligible people have equal access to services; and[2]
- many other requirements.

[1] 10 CCR 2505-10 (8.190).

[2] 42 U.S.C. § 1396a.

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The Colorado State Plan was first enacted in 1994, and has been amended hundreds of times. All of the amendments are *publicly available online*.

If a proposed rule conflicts with the state plan, HCPF must either submit a state plan amendment (SPA) or apply to the federal government for a waiver.

A recent example is *SPA CO-23-0005*, which allowed HCPF to cover a new form of transportation services, per *House Bill 21-1085* and the federal *assurance of transportation requirements*.

Waivers

Waivers waive the state plan requirements under defined circumstances for set trial periods. States submit waiver applications to the federal Secretary of Health and Human Services for approval. HCPF currently has *27 active waivers*. Waivers can also be amended through a similar process as that for enacting a new waiver.

The two types of waivers discussed below may be used to add services under Medicaid.

1115 Waivers. Section 1115 waivers are used for demonstration projects and are typically available statewide for five years. They aim to demonstrate the usefulness of new programs that may become incorporated into the state plan in the future.

To be approved, the waiver must not cause federal Medicaid costs in the state to exceed the five-year growth trend assumed in the federal budget, referred to as budget neutrality. *This issue brief* by a nonpartisan federal agency details the process for demonstrating budget neutrality.

One of two currently active 1115 waivers was initiated by *House Bill 18-1136* and allows HCPF to offer residential and inpatient Substance Use Disorder treatments to all Medicaid enrollees through December 2025.

1915(c) waivers. Section 1915(c) waivers are typically used to tailor a program to a population with special needs by offering services that may not be available to the general population. The waiver may also grant access to the program for people who are not otherwise eligible for Medicaid. Though approved for between two and five years at a time, renewals are typical.

To be approved, per capita expenditures must not exceed what they would otherwise be under the state plan, referred to as cost neutrality. Unlike for most programs, states may impose per capita expenditure and enrollment caps on 1915(c) waiver services to limit costs.

Most 1915(c) waivers are related to home- and community-based services (HCBS) for people with special needs so that they can remain in their homes with additional support, rather than be placed in a nursing home or other facility at a higher level of care. A full list of these waivers can be found *here*. For these waivers, several changes are currently in progress as a result of the Community First Choice bill, *Senate Bill 23-289*.