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3 Key Questions: Section 1115 Medicaid Demonstration Waivers

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Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid that differ from federal program rules. Waivers can provide states considerable flexibility in how they operate their programs, beyond what is available under current law, and can have a significant impact on program financing. As such, waivers have important implications for beneficiaries, providers, and states. While there is great diversity in how states have used waivers over time, waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services (CMS). Looking ahead, states are likely to continue to request waivers to implement provisions not allowed under current law; however, it is not yet clear what role Section 1115 waivers will play as the new administration and Congress move to repeal the ACA and debate possible broader changes to Medicaid financing. This brief answers key questions about Section 1115 waiver authority, the current landscape of demonstration waivers and what to watch going forward.

Key Takeaways

- Section 1115 Medicaid demonstration waivers have been used throughout the history of the program to allow the Secretary of the Department of Health and Human Services (HHS) to authorize demonstration projects that further the purposes of the Medicaid program. This provides states an avenue to test new approaches in Medicaid that differ from federal program rules; states must meet requirements related to budget neutrality, transparency, and evaluation.
- As of February 2017, 33 states had 41 approved Section 1115 waivers. These waivers fall into 5 categories: delivery system reform; alternative ACA Medicaid expansion models; managed long-term services and supports (MLTSS) through capitated managed care; behavioral health, and other targeted waivers.
- Even without changes in legislation, the new administration can make certain changes to the Medicaid program through waivers. Looking ahead, key questions to consider about waivers include:
  Questions about ACA Expansion Waivers: Will the new administration approve waivers that have been approved in other states in advance of completed waiver evaluations? Will waivers be approved that limit coverage or access, use ACA Medicaid funds for a partial coverage expansion, impose a work requirement as condition of eligibility, impose a lock-out for failure to pay monthly payments, or set a time limit for coverage?
  Broader Waiver Questions*:* Will CMS authorize joint Section 1115/Section 1332 waivers allowing Medicaid funds to subsidize Marketplace initiatives? Will requirements for transparency, public input and budget neutrality be maintained? What other types of waivers will the Secretary deem "likely to assist in promoting the objectives of the [Medicaid] program"?

What are Section 1115 Medicaid waivers and how do they Work?

Authority and Purpose. Under Section 1115 of the Social Security Act, the Secretary of HHS can waive specific provisions of major health and welfare programs, including certain requirements of Medicaid and CHIP. This authority permits the Secretary to allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under the federal rules, as long as the Secretary determines that the initiative is a "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of the program." States can obtain "comprehensive" Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs. There also are narrower Section 1115 waivers that focus on specific services or populations. While the Secretary's waiver authority is very broad, there are some elements of the program that the Secretary does not have authority to waive, such as the federal matching payment system for states, or requirements that are rooted in the Constitution such as the right to a fair hearing. Waivers are typically approved for a five-year period and can be extended, typically for three years.

Financing. While not set in statute or regulation, a longstanding component of Section 1115 waiver policy is that waivers must be budget neutral for the federal government. This means that federal costs under a waiver must not exceed what federal costs would have been for that state without the waiver, as calculated by the administration. The federal government enforces budget neutrality by establishing a cap on federal funds under the waiver, putting the state at risk for any costs beyond the cap.

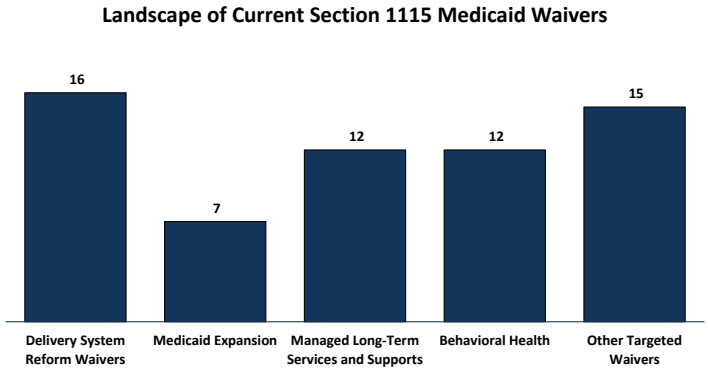
Transparency, Public Input and Evaluation. The Affordable Care Act (ACA) made Section 1115 waivers subject to new rules about transparency, public input and evaluation. In February 2012, HHS issued new regulations that require public notice and comment periods at the state and federal levels before new Section 1115 waivers and extensions of existing waivers are approved by CMS.[1] [2] The ACA also implemented new evaluation requirements for these waivers, including that states must have a publicly available, approved evaluation strategy. States also must submit an annual report to HHS that describes the changes occurring under the waiver and their impact on access, quality, and outcomes.[3]

What is the Current Landscape of Section 1115 Medicaid waivers?

Understanding the landscape of current waiver activity can serve as a useful baseline for analyzing potential changes under a new administration. States have used waivers for many purposes, including to expand coverage, change delivery systems, alter benefits and cost-sharing, modify provider payments, and quickly extend coverage during an emergency. Increasingly, states are using Section 1115 waivers to combine programs (e.g., including authorities otherwise available under Section 1915 (b) managed care waivers and/or Section 1915 (c) home and community based services waivers,

Figure 1

States with Section 1115 Medicaid demonstration waivers in place, February 2017



along with Section 1115 authority for other eligibility, benefits, delivery system and payment reforms) under one single authority.

As of February 2017, 33 states had approved Section 1115 waivers (not including family planning or CHIP-only waivers). Some states have multiple waivers, and many waivers are comprehensive and may fall into a few different areas. Major areas of focus of current state Section 1115 waivers include delivery system reform initiatives, especially efforts that tie provider incentive payments to performance goals; implementation of alternative ACA Medicaid expansion models; authorizing the delivery of Medicaid long-term services and supports (LTSS) through capitated managed care; integrating physical and behavioral health or providing enhanced behavioral health services to targeted populations, and responding to public health emergencies and providing coverage for other targeted groups (Figure 1). These themes are discussed in more detail below (also see Appendix A).

Delivery System Reform Waivers. Sixteen states have approved waivers that focus on delivery system reform initiatives, especially efforts that tie provider incentive payments to performance goals. These states are using Section 1115 expenditure authority to authorize spending of federal dollars on delivery system reforms that otherwise would not be available under current law.[4] Ten of these states are using Section 1115 waivers to implement Delivery System Reform Incentive Payment (DSRIP) initiatives.[5] [6] DSRIP initiatives have emerged as part of broader Section 1115 waiver programs and provide states with significant federal funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals and often grew out of negotiations between states and HHS over the appropriate way to finance hospital care. Now, however, they increasingly are being used to promote a far more sweeping set of payment and delivery system reforms. Under DSRIP initiatives, incentive funds to providers are tied to meeting performance metrics. A few other states have approved Section 1115 waivers for federal investment in delivery system reform initiatives other than DSRIP including Alabama's provider-based Regional Care Organizations (RCOs), Arizona's initiative to integrate physical and behavioral health care, Oregon's Coordinated Care Organizations (CCOs), and Vermont's all-payer ACO model. Florida and Tennessee as well as several states with other delivery system reform initiatives (Arizona, California, Kansas, Massachusetts, New Mexico, and Texas) also use Section 1115 authority to operate Uncompensated Care Pools, to help defray the cost of uncompensated hospital care.

ACA Expansion Waivers. A few states have sought Section 1115 waivers to implement the ACA's Medicaid expansion, in part because they could not otherwise secure political support to expand coverage. As of February 2017, seven states (Arizona, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire) have approved waivers to implement the ACA Medicaid expansion in ways that extend beyond the flexibility provided by the law. While the waivers are each unique, they include some common provisions including: implementing the Medicaid expansion through a premium assistance model; charging premiums beyond what is authorized in federal law; eliminating non-emergency medical transportation, an otherwise required benefit; and using healthy behavior incentives to reduce premiums and/or co-payments (Table 1). Indiana's waiver included provisions that had not been approved in other states including allowing the state to waive retroactive eligibility (later approved in New Hampshire and Arkansas); making coverage effective on the

date of the first premium payment instead of the date of application; and barring certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums (a lock-out of up to three months for certain expansion adults was later approved in Montana).[7]

Table 1: Themes in Approved ACA Expansion Waivers

	AR[i]	AZ	IA	IN	MI	MT	NH
Premium Assistance	QHP & ESI		ESI	ESI	QHP		QHP
Premiums / Monthly Contributions	X	X	X	X	X	X	
Healthy Behavior Incentives		X	X	X	X		
Waive Required Benefits (NEMT)			X	X			
Reasonable Promptness				X			
Waive Retroactive Eligibility	X[ii]			X			X
Co-payments Above Statutory Limits				X[iii]			
12-Month Continuous Eligibility						X	

Notes: "QHP" refers to Qualified Health Plans. "ESI" refers to employer-sponsored health insurance. i-AR waiver provides authority for state to not offer NEMT for individuals covered through ESI who do not demonstrate need for services. ii-AR waiver includes conditional waiver of retroactive coverage, contingent upon state coming into compliance with statutory and regulatory requirements related to eligibility determinations. iii-Cost-sharing waiver approved in IN under Section 1916(f), not Section 1115.

MLTSS. Twelve states are using Section 1115 waivers to authorize the delivery of Medicaid long- term services and supports (LTSS) through capitated managed care. While various Medicaid state plan authorities enable states to expand beneficiary access to home and community-based services (HCBS), states are using Section 1115 waivers to streamline program administration, improve care coordination, and expand beneficiary access to home and community-based services (HCBS). These states need waiver authority to require seniors and people with disabilities to enroll in managed care. Most Section 1115 MLTSS waivers include provisions designed to expand HCBS financial eligibility. Over half of states with Section 1115 MLTSS waivers expand HCBS eligibility to people with functional needs who are "at risk" of institutionalization.

Behavioral Health. Twelve states are using Section 1115 waivers to provide enhanced behavioral health services (mental health and/or substance use disorder services) to targeted populations or to integrate the delivery of physical and behavioral health services. This includes states responding to CMS guidance issued in 2015, which describes a new Section 1115 waiver opportunity that supports states' ability to provide more effective care to Medicaid beneficiaries with a substance use disorder (SUD), including the provision of treatment services not otherwise covered under Medicaid. For example, states may receive federal matching funds for costs (otherwise not matchable) to provide coverage for services provided to individuals residing in institutions for mental disease (IMDs) for short-term acute SUD treatment.

Other Targeted Waivers. Section 1115 waivers have also historically helped states quickly provide Medicaid support during emergency situations. Currently, Michigan is operating a Section 1115 waiver to expand eligibility and provide additional services targeted to pregnant women and children affected by the Flint water supply crisis. Fourteen other states also operate narrow Section 1115 waivers that affect targeted populations

(e.g., persons with HIV/AIDS, seniors and people with disabilities, uninsured nonelderly adults in non-expansion states). These targeted waivers may provide limited benefit coverage and/or include cost-sharing.

What to Watch in Waivers Going Forward?

Without changes in legislation, the new administration can make changes to Medicaid by reinterpreting current law through new regulations or sub-regulatory guidance and through approval (or denial) of Section 1115 Medicaid demonstration waivers. The role of waivers is not clear as Congress moves to repeal the ACA and also debates broader changes to Medicaid financing; however, legislative changes are likely to take time to enact and implement, while state specific waivers could be approved and implemented more quickly. Key questions about what types of waivers might be considered include:

- **Questions about ACA Expansion Waivers:** Will the new administration approve waivers that have been approved in other states in advance of completed waiver evaluations? Will waiver provisions, not approved to date, be approved that limit coverage or access, use ACA Medicaid funds for a partial coverage expansion, impose a work requirement as condition of eligibility, impose a lock-out for failure to pay monthly payments, or set a time limit for coverage?
- **Broader Waiver Questions:** Will requirements for transparency, public input and budget neutrality be maintained? What other types of waivers will the HHS Secretary deem to "assist in furthering the objectives of the [Medicaid] program"? Will the new administration identify and invite state waiver applications for certain types of waivers to further their policy priorities? Will CMS authorize joint Section 1115/Section 1332 waivers allowing Medicaid funds to subsidize Marketplace initiatives?

Looking ahead, more states may move forward with Medicaid demonstration waiver requests. Kentucky has a waiver pending at CMS to make changes to its traditional ACA Medicaid expansion, Indiana has submitted a proposal to extend their current HIP 2.0 Medicaid expansion waiver with some changes, and Arizona has a waiver pending that would impose a work requirement and a lifetime limit on Medicaid benefits for "able-bodied" adults. Beyond ACA expansion waivers, waivers in Texas and Florida will be up for renewal. Action on these and other waivers could provide insights as to what might be approved by the current administration.

Appendix A

Themes in Approved Section 1115 Waivers, as of February 2017							
	Waiver Name	Waiver Expiration Date	Delivery System Reform	Medicaid Expansion	MLTSS*	BH	Other Targeted Populations
	Total active, approved waivers: 41 (across 33 states)		**16**	**7**	**12**	**12**	**15**
AL	Alabama Medicaid Transformation	3/31/2021	X				
AR	Arkansas Works	12/31/2021		X			
AR	Arkansas' Tax Equity and Fiscal Responsibility Act (TEFRA-like)	12/31/2017					expands eligibility for children with disabilities
AZ	Arizona Health Care Cost Containment System	9/30/2021	X	X	X	X	
CA	California Medi-Cal 2020	12/30/2020	X		X	X	
DE	Delaware Diamond State Health Plan	12/31/2018			X	X	
FL	Florida Managed Medical Assistance	06/30/2017	X				
FL	Florida MEDS-AD	2/27/2017					expands eligibility for seniors and people with disabilities
HI	Hawaii QUEST Integration	12/31/2018			X	X	
IA	Iowa Wellness Plan	12/31/2019		X			
IN	Healthy Indiana Plan (HIP) 2.0	1/31/2018		X			
IN	Indiana End Stage Renal Disease (ESRD)	12/31/2020					expands eligibility for Medicare-enrolled people with ESRD
KS	KanCare	12/31/2017	X		X**	X	
MA	MassHealth	6/30/2022	X			X	
MD	Maryland Health Choice	12/31/2021				X	
ME	Maine Section 1115 Demonstration for Individuals with HIV/AIDS	12/31/2017					expands eligibility and provides limited benefit package for people with HIV/AIDs
MI	Healthy Michigan	12/31/2018		X			
MI	Flint MI	2/28/2021					expands eligibility and provides additional services to pregnant women & children
MN	Minnesota Reform 2020: Pathways to Independence	6/30/2018					expands eligibility for HCBS
MN	Minnesota Prepaid Medical Assistance Project Plus	12/31/2020					expands eligibility for one-year-old children
MO	Missouri Gateway to Better Health	12/31/2017					expands eligibility and provides limited benefits to nonelderly adults in St. Louis area
MS	Healthier Mississippi	9/30/2018					expands eligibility and offers limited benefit package to capped number of seniors and people with disabilities
MT	Montana Health Economic Livelihood Partnership (HELP)	12/31/2020		X			
MT	Montana Additional Services and Populations	12/31/2017				X	
NH	New Hampshire Health Protection Program Premium Assistance Demonstration	12/31/2018		X			
NH	Building Capacity for Transformation	12/31/2020	X			X	
NJ	New Jersey Comprehensive Waiver	6/30/2017	X		X	X	
NM	Centennial Care	12/31/2018	X		X		

Themes in Approved Section 1115 Waivers, as of February 2017							
	Waiver Name	Waiver Expiration Date	Delivery System Reform	Medicaid Expansion	MLTSS*	BH	Other Targeted Populations
NV	Nevada Comprehensive Care	6/30/2018					provides primary care case management to high-cost/high-need people w/ certain chronic conditions
NY	New York Medicaid Redesign Team	3/31/2021	X		X	X	
OK	Oklahoma SoonerCare	12/31/2017					expands eligibility to certain populations (working people with disabilities, college students, working foster parents, nonprofit employees), varies benefits and cost-sharing, and authorizes federal funds for primary care case management
OR	Oregon Health Plan	6/30/2022	X				
RI	Rhode Island Comprehensive Demonstration	12/31/2018	X		X		
TN	TennCare II	6/30/2021	X		X		
TX	Texas Healthcare Transformation and Quality Improvement Program	12/31/2017	X		X		
UT	Primary Care Network	12/31/2017					expands eligibility and provides limited benefit package to nonelderly adults
VA	Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Demonstration	12/31/2019				X	
VT	Vermont Global Commitment to Health	12/31/2021	X		X		
WA	Washington Medicaid Transformation Project	12/31/2021	X				expands eligibility and offers limited HCBS benefit package targeted to seniors with unpaid family caregivers
WI	Badger Care Reform	12/31/2018					expands eligibility and establishes sliding scale premiums for nonelderly adults
WI	Wisconsin SeniorCare	12/31/2018					authorizes pharmacy benefits and cost-sharing for seniors

NOTES: "MLTSS" = Managed long-term services and support, "BH" = Behavioral health. Delivery system reform includes states with DSRIP initiatives (CA, KS, MA, NH, NJ, NM, NY, RI, TX, WA), and states that receive federal dollars for other (i.e., non-DSRIP), smaller delivery system reform initiatives (AL, AZ, OR, VT), and states with uncompensated care pools (AZ, CA, FL, KS, MA, NM, TN, and TX). Delivery System Reform does not include/capture states mandating managed care through Section 1115. Medicaid Expansion includes states implementing the ACA Medicaid expansion through alternative models. MLTSS includes only capitated MLTSS. Behavioral health includes states providing enhanced behavioral health services to targeted populations (e.g., SMI or SUD) and/or states implementing initiatives focused on the integration of physical and behavioral health care. Other targeted includes narrow waivers focused on specific populations and/or services. This table does NOT include family planning or CHIP-only waivers. *Four states (CA, NY, RI & TX) have concurrent Section 1115A authority for financial alignment demonstrations that integrate Medicare and Medicaid benefits for dual eligible beneficiaries in a single health plan. **Kansas administers MLTSS through concurrent Section 1115/1915 (c) waivers.

Appendix B

How Have States Used Section 1115 Demonstration Waivers in the Past?

From Medicaid's beginning in 1965 through the early 1990s, waivers were small in scope. Beginning in the 1990s, there was an increase in waiver activity, and waivers became broader in scope. General periods of waiver activity are discussed below:

Broad Expansion Waivers (Mid-1990s-2001). In the mid-90s through the early part of this decade most waivers focused on expanding coverage (this was pre-ACA – before statutory authority/federal funds directly authorized for coverage expansion to childless adults). Many began as state efforts to implement broader managed care systems than were permitted under federal law. States used savings from mandatory managed care or redirected disproportionate share hospital (DSH) funds to offset expansion costs, and flush economic times during the mid- to late-90s helped support expansion efforts. Two of the largest waivers approved during this time (Oregon Health Plan and Tenncare) also restructured coverage for existing beneficiaries in ways that were considered very controversial at the time.

HIFA Waivers (2001 Forward). In August 2001, under President Bush, the administration announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative, which promoted the use of waivers to expand coverage within "current-level" resources and offered states increased flexibility to reduce benefits and charge cost-sharing to offset expansion costs. However, states had limited interest and success in expanding coverage under HIFA, and waivers instead began to increasingly focus on cost control as the nation moved into an economic downturn. Expansions that did move forward under HIFA waivers were generally limited, particularly when compared to the larger expansions of the 1990s.

Reform Waivers (2005 Forward). Beginning in 2005, some broad waivers were approved that restructured Medicaid financing and other key program elements, for example, by setting a global cap on federal funds.[8] These waivers stemmed from continued federal emphasis on and interest by some states in controlling and increasing predictability of program costs as well as ideas about reshaping Medicaid to promote personal responsibility and reflect private market trends. However, during this same period, Massachusetts obtained a waiver that provided support for its efforts to provide universal coverage without significantly restructuring its Medicaid program.

Pre-ACA Expansion Waivers (2010-2013). Six states (California, Colorado, the District of Columbia, Minnesota, New Jersey, and Washington) used waivers to expand Medicaid coverage to adults after the enactment of the ACA to prepare for 2014.

Emergency Waivers (periodic over time in response to emergencies). Beyond these themes, waivers have also helped states quickly provide Medicaid support during emergency situations, for example, by enabling a vastly streamlined enrollment process in New York in the wake of the September 11th attacks, and by assisting states in providing temporary Medicaid coverage to certain groups of Hurricane Katrina survivors.

Endnotes

[1] Kaiser Commission on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2012), http://kff.org/health-reform/fact-sheet/the-new-review-and-approvalprocess-rule/.

[2] provisions have not been applied to waiver amendments

[3] Robin Rudowitz, MaryBeth Musumeci, and Alexandra Gates, *Medicaid Expansion Waivers: What Will We Learn?* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://kff.org/medicaid/issue-brief/medicaid-expansion-waivers-what-will-we-learn/.

[4] Some of these states have Section 1115 waivers that utilize managed care; however, many types of managed care delivery systems could be implemented without waiver authority (although states do need Section 1115 authority to mandate managed care for certain groups including children with special needs, foster care kids, and duals). A number of other states are engaged in delivery system reform efforts outside of this group, through Medicaid initiatives that do not receive funding under Section 1115.

[5] Centers for Medicare and Medicaid Services (CMS), *Medicaid & CHIP Strengthening Coverage, Improving Health,* (Baltimore, MD: Centers for Medicare and Medicaid Services, January 2017), https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

[6] DSRIP states: California, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Texas, and Washington

[7] IN renewal pending

[8] The State Health Access Data Assistance Center (SHADAC) (a program of the Robert Wood Johnson Foundation), *Medicaid Block Grants: Lessons from Rhode Island's Global Waiver*, (Minneapolis, MN: The State Health Access Data Assistance Center, June 2013) (*citing* "Rhode Island also purposefully built a cushion into its fiscal projections and the Global Waiver was much more generous than typical block grant proposals."), http://www.shadac.org/sites/default/files/publications/RI_Global_Waiver_Brief_FINAL.pdf.