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# How Medicaid Section 1115 Waivers Are Evolving: Early Insights About What to Watch

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While [efforts to pass major federal legislation](#) to repeal and replace the Affordable Care Act (ACA) and [restructure and reduce federal Medicaid financing](#) may be on hold temporarily, the focus of the Centers for Medicare and Medicaid Services (CMS) and states is expected to turn to achieving significant Medicaid program changes through Section 1115 demonstration waivers. Going back to the mid-1990s, each new administration has used discretion to approve and promote different types of demonstration waivers. Although few waivers have been approved recently, the Trump Administration has signaled its openness to allowing states to test policies that have never before been approved in Medicaid and is considering waivers that seek to impose [work requirements](#), drug screening and testing, eligibility time limits, enforceable premiums, and other eligibility and enrollment restrictions on existing [expansion adults](#) and/or [traditional Medicaid populations](#). The limited waiver activity that has occurred so far in 2017 provides some insights into how the purpose of waivers and their approval process, implementation, and oversight may be evolving. [As of September 2017, there were 33 states with 41 approved waivers and 18 states with 21 pending waivers](#). This issue brief presents three questions to help analyze the evolution of federal waiver policy as new waiver proposals and decisions emerge.

## 1. HOW ARE WAIVER APPROVAL CRITERIA CHANGING?

**Each administration has some discretion to approve demonstration waivers that will further Medicaid program objectives.** Different administrations have each used waivers to further their particular policy priorities. For example, the Obama Administration used federal Medicaid funding to promote [Delivery System Reform Incentive Payment \(DSRIP\) waivers](#), while the Bush Administration introduced Health Insurance Flexibility and Accountability (HIFA) waivers that sought to expand coverage within “current-level” resources and offered states increased flexibility to reduce benefits and charge cost-sharing to offset expansion costs.

**However, discretion around waivers has limits.** For example, the HHS Secretary’s Medicaid waiver authority is limited to certain provisions in Section 1902 of the Social Security Act. Section 1902 sets out the requirements for state Medicaid plans, such as provisions related to eligibility and benefits. However, many parts of the law are contained in other sections of the Social Security Act and therefore cannot be waived under Section 1115. For example, the [formula that establishes federal Medicaid matching rates for states](#) is outside Section 1902. In addition, the Secretary must determine that a waiver request will be an experimental, pilot or demonstration project that will further program objectives. In response to criticism from the General Accounting Office (GAO) about the lack of standards used to make this determination in the past, CMS posted [a set of criteria](#) to evaluate waiver requests in 2015.<sup>1</sup> These criteria focus on serving Medicaid eligible and low-

income state residents and include whether the waiver would increase coverage; increase access to providers; improve health outcomes; or increase the efficiency and quality of care through delivery system reform initiatives.

## EARLY INSIGHTS: WHAT TO WATCH

**The March 2017 letter to state governors signals that the Trump Administration may change the criteria for waiver approval to impose welfare-like standards that could result in reduced rather than expanded coverage.** While the 2015 waiver approval criteria have not been formally revised or rescinded to date, the Trump Administration’s [March 2017 letter to state governors](#) shows some movement toward a different interpretation of Medicaid program objectives. That letter describes the ACA’s Medicaid expansion as a “clear departure from the core, historical mission of the program” and distinguishes “the truly vulnerable.” The letter also invites state waiver requests to “support innovative approaches to increase employment and community engagement” and “align Medicaid and private insurance policies for non-disabled adults.” Some pending state waiver requests that seek policies like work requirements and time limits, such as those in [Kentucky](#), [Indiana](#), [Maine, and Wisconsin](#), estimate that these waivers will result in reduced coverage. Additionally, a [long-standing body of research](#) demonstrates that premiums and cost-sharing result in decreased enrollment and barriers to care for low-income populations. To change policy that is not in formal regulations, the administration could issue a letter to State Medicaid Directors or other guidance; however, such policy changes could face litigation challenges.

## 2. WHAT ARE POTENTIAL CHANGES TO PUBLIC INPUT AND WAIVER POLICY DEVELOPMENT?

**The ACA included requirements to allow for public input on waivers at the state and federal level.** While there are no set timeframes for CMS to approve or deny a waiver, the ACA included new [transparency rules](#) that require public comment periods at the state level before the waiver is submitted to CMS and a federal comment period after the waiver is submitted. The intent of this requirement is for states to address public comments and modify their waiver requests to reflect issues raised.

**Waivers are generally approved with a detailed set of terms and conditions, although some provisions may be conditionally approved subject to the development of additional protocols or meeting other requirements.** A waiver approval results in a list of specific waiver and expenditure authorities granted by CMS and a detailed set of waiver terms and conditions that includes key implementation dates and reporting and evaluation requirements, posted on [Medicaid.gov](#). Some waivers may be approved subject to certain conditions that may seek to ensure that certain readiness standards are met or certain beneficiary rights are protected. Often, details about the implementation of more administratively complex waiver policies, such as [premiums, health accounts, or healthy behavior incentives](#), are specified in protocols that are developed by the state and submitted to CMS after the waiver approval. Waiver implementation plans include a process to receive public input on implementation within the first six months for new waivers and then annually thereafter. These procedural elements are ways for stakeholders such as enrollees, providers, and health plans to understand and offer input into the implementation of policies that could significantly change the Medicaid program.

## EARLY INSIGHTS: WHAT TO WATCH

**While the March 2017 letter affirms “reasonable public input processes and transparency guidelines” for waiver applications and renewals, some deviation from the ACA’s public notice and comment process is occurring.** For example, [Kentucky](#) did not hold a state-level public comment period before submitting an amendment to its pending new waiver application to CMS, instead indicating that it would “accept CMS’s offer” to hold a “voluntary” state-level public comment period, which will run concurrently with the federal public comment period.<sup>2</sup>

**CMS may consider removing some conditional approval requirements for existing waivers.** [Arkansas’](#) retroactive eligibility waiver was conditioned on the state completing an eligibility determination mitigation plan, providing benefits during a reasonable opportunity period, and implementing hospital presumptive eligibility. CMS is considering the state’s request to remove those conditions. Stakeholders may be interested in assessing whether the policy goals underlying these conditions have been achieved before the conditions are removed.

### 3. HOW WILL THE IMPACT OF SIGNIFICANT WAIVER CHANGES BE REPORTED AND MEASURED?

**Oversight of waiver implementation is important, particularly for waivers that seek to implement new or complex policies.** Waivers terms and conditions typically require states to report on waiver implementation and administration through both quarterly and annual reports to CMS. This reporting allows CMS and other stakeholders to oversee and understand waiver policy implementation and effects on beneficiaries. Even renewals of long-standing waivers often involve the addition of new or adjusted policies that may not have been previously implemented.

**Although not always addressed in the waiver approval, adequate administrative staff and funding are key to waiver implementation.** Experience with Medicaid expansion waivers involving premiums, health accounts, and healthy behavior incentives in [Michigan and Indiana](#) reveals that substantial resources for beneficiary and provider outreach and education and sophisticated information technology systems to track payments and exchange information among the state, health plans, and providers are key to successful implementation.

**Despite the challenges in conducting waiver evaluations, timely and publicly available results enable CMS, states, and stakeholders to learn from waivers.** Consistent with the statutory requirement that waivers further an experimental or demonstration goal, waiver terms and conditions include requirements for states to conduct independent [waiver evaluations](#). States may face challenges in waiver evaluations including access to timely data and isolating the effects of administratively complex waivers that evolve during implementation. The ACA reaffirmed the importance of waiver evaluations by newly requiring that states have a publicly available, approved evaluation strategy with [comprehensive research questions](#). Evaluation findings allow CMS, states, and stakeholders to make mid-course corrections as necessary, determine whether waiver policies had their intended effect, and if certain provisions could or should be replicated in other states.

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**CMS has removed some waiver reporting requirements in a recent extension approval.** [Florida's](#) recent waiver approval removes the requirement for the state to provide quarterly updates thereby limiting data available to CMS and other stakeholders to oversee implementation to annual reporting.

**Some waiver policies prove to be too costly or complex to implement as originally intended and are reshaped or dropped.** For example, [Indiana](#) is seeking to change its premiums to a tiered structure based on income bands instead of a flat 2% of income to improve administrative efficiency in tracking and recalculating premium amounts as enrollee income changes. Indiana also wants to discontinue its premium assistance program for people with access to employer-sponsored insurance due to low enrollment and high administrative costs. [Arkansas](#) has discontinued its health savings account model with monthly beneficiary contributions due to high administrative costs and administrative complexity. Although [Kentucky](#) has not yet received waiver approval, it already has amended its initial request to change its pending work requirement to a flat 20 hours per week instead of graduated hours increasing from 5 to 20 based on length of program enrollment due to concerns about administrative complexity. If waivers are not implemented according to the approval parameters, it is not possible to adequately measure the effects of specific policies.

**Policy makers and researchers will be watching to see if waiver evaluations are required, conducted and used to inform decisions on future waiver requests.** While there is not much evidence about how the new administration will proceed with waiver evaluations, CMS recently relieved [Montana](#) from the requirement to evaluate its expansion waiver based on its participation in a cross-state federal evaluation. There are also questions about what data will be available for researchers and analysts to assess the impact of waivers on program coverage and on beneficiaries, and how that data and experience will be applied to other state waiver requests.

## Endnotes

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<sup>1</sup> Medicaid.gov, About Section 1115 Demonstrations (last accessed Oct. 24, 2017), <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.

<sup>2</sup> Although the final regulations involving public notice do not require a state-level public comment period for amendments to existing/ongoing demonstrations, CMS has historically applied these regulations to amendments. CMS guidance also encourages states to comply with public notice regulations when making changes that affect benefits, cost sharing, eligibility, and delivery systems. CMS, SHO#12-001 (April 27, 2012), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf>.