September 2018 | Issue Brief

Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending 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. Waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services (CMS). In November 2017, CMS posted revised criteria for Section 1115 waivers that no longer include the goal of increasing coverage. On January 11, 2018, CMS posted new guidance for state Section 1115 waiver proposals to condition Medicaid on meeting a work requirement and subsequently has approved the first waivers of that type in the history of the Medicaid program. Each administration has some discretion over which waivers to approve and encourage (see Appendix A) but that discretion is not unlimited. For example, in June 2018, the DC federal district court set aside the work requirement and other provisions that restrict eligibility and enrollment in the Kentucky HEALTH waiver approval and sent it back to HHS to reconsider.

Section 1115 waiver activity is expected to continue both through administrative decisions and the courts. This brief provides basic information about the purpose and function of Section 1115 waivers, describes the current administration's waiver priorities, and discusses trends in recent state waiver requests and waiver decisions made by the Trump administration. The most current activity is contained in our Medicaid waiver tracker,[1] which shows approved and pending waivers.

What are Section 1115 Medicaid waivers?

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 an "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.[2,3] There also are narrower Section 1115 waivers that focus on specific services or populations. While the Secretary's waiver authority is broad, it is not unlimited. 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. However, according to a CMCS Informational Bulletin released on November 6, 2017, CMS will consider approving "routine,

successful, non-complex" Section 1115 waiver extension requests for up to 10 years.[4] On December 28, 2017, CMS approved the Mississippi Family Planning Medicaid Waiver extension for a 10-year period. Mississippi is the first state to receive a 10-year Section 1115 waiver extension under the new policy.[5]

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.[6]

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.[7,8] 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. The ACA also implemented new evaluation requirements for these waivers, including that states must have a publicly available, approved evaluation strategy.[9] States have traditionally been required to submit quarterly reports and must submit an annual report to HHS that describes the changes occurring under the waiver and their impact on access, quality, and outcomes.[10,11] CMS's August 2017 renewal of Florida's Managed Medical Assistance Section 1115 waiver allows the state to submit annual reports (and semi-annual reports at CMS's request) instead of quarterly reports.

What waiver priorities have been identified by the Trump administration?

Marking a new direction for Medicaid waivers, on November 7, 2017, CMS posted revised criteria for evaluating whether Section 1115 waiver applications further Medicaid program objectives (see Appendix B).[12] The revised criteria no longer include expanding coverage among the stated objectives. Instead, the revised waiver criteria focus on positive health outcomes, efficiencies to ensure program sustainability, coordinated strategies to promote upward mobility and independence, incentives that promote responsible beneficiary decision-making, alignment with commercial health products, and innovative payment and delivery system reforms.

CMS also has issued new guidance identifying waiver policy priority areas and inviting applications from states. On January 11, 2018, CMS issued new guidance for Section 1115 waiver proposals that impose work requirements (referred to as community engagement) in Medicaid as a condition of eligibility. This action reverses previous Democratic and Republican administrations, which had not approved such waiver requests on the basis that such provisions would not further the program's purposes of promoting health coverage and access. The guidance asserts that such provisions would promote program objectives by helping states "in their efforts to improve Medicaid enrollee health and well-being through

incentivizing work and community engagement" and invites proposals that are "designed to promote better mental, physical, and emotional health. . . [or] separately. . . help individuals and families rise out of poverty and attain independence."

CMS also continues to use waivers to help states address the opioid epidemic. On November 1, 2017, CMS issued a state Medicaid director letter revising guidance issued by the Obama administration in July 2015. The revised guidance continues to allow states to use Section 1115 waivers to pay for substance use treatment services in "institutions for mental disease" (IMDs).

What waiver themes are emerging under the Trump administration?

WAIVER PROVISIONS APPROVED

Work Requirements and Other Eligibility and Enrollment Restrictions. Under the previous administration, CMS approved certain eligibility- and enrollment-related waiver provisions as part of ACA Medicaid expansion waivers (e.g., charging premiums beyond what is allowed under federal law, eliminating retroactive eligibility, making coverage effective on the date of the first premium payment (instead of the date of application), and locking out certain expansion adults who are dis-enrolled for unpaid premiums). Under the Trump administration, states are seeking to apply these previously approved provisions as well as new restrictions to both expansion and traditional Medicaid populations.

The Trump administration has approved eligibility and enrollment restrictions that have never been approved before (see waiver tracker for details). In some states, these provisions apply to both expansion adults and traditional Medicaid populations (e.g., low-income parent/caretakers). Waiver provisions approved by CMS for the first time under the Trump administration include:

- conditioning eligibility on meeting work requirements;
- coverage lock-outs for failure to timely renew coverage or report changes affecting eligibility;
- approval to charge premiums up to 4% of family income;
- a premium surcharge for tobacco users;
- fees for missed appointments; and
- eliminating retroactive coverage for nearly all Medicaid enrollees, including seniors and people with disabilities.[13]

Healthy Behavior Incentives and Benefit Restrictions. The current administration has also approved waivers that eliminate non-emergency medical transportation (NEMT) and implement healthy behavior incentives (tied to premium or cost-sharing reductions) – provisions approved by previous administrations as part of ACA expansion waivers.

Uncompensated Care Pools. Several states use Section 1115 authority to operate Uncompensated Care Pools (also called "Low Income Pools" in some states) to help defray the cost of uncompensated hospital care. The Trump administration approved Florida's Section 1115 waiver extension request in December 2017, which included an increase in funding for the state's low income pool to $1.5 billion annually, reversing the trend toward reducing these funds.[14,15,16] CMS also approved an increase in funding for Texas' uncompensated care pool ($3.1 billion per year in the first two years, remaining years subject to new formula) as part of its December 2017 approval of Texas' Healthcare Transformation and Quality Improvement Program waiver renewal.[17]

Behavioral Health. State interest in Medicaid Section 1115 behavioral health waivers, including mental health and substance use disorders, remains high. Current and pending Section 1115 behavioral health waivers address four main areas:

- using Medicaid funds to pay for substance use and/or mental health services in "institutions for mental disease" (IMDs);[18]
- expanding community-based behavioral health benefits;
- expanding Medicaid eligibility to cover additional people with behavioral health needs; and
- financing delivery system reforms, such as physical and behavioral health integration or alternative payment models.

IMD substance use disorder (SUD) payment waivers approved under the Trump administration differ from those approved under the Obama administration in some ways. For example, waivers approved under the Obama guidance specified numeric day limits on IMD stays eligible for federal Medicaid funds. By contrast, most waivers approved under the Trump Administration do not have an explicit day limit. In addition, waivers approved under the 2015 guidance were contingent on states covering community-based services along with short-term institutional services that "supplement and coordinate with, but do not supplant, community-based services." While the 2017 guidance notes that "states should indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state" and directs states to "demonstrate how they are implementing evidence-based treatment guidelines," most of those waivers generally do not detail the state's coverage of SUD services across the care continuum as the earlier waivers do.

WAIVER PROVISIONS NOT APPROVED OR BEING PHASED OUT

The Trump administration has signaled some of its policy directions by not approving some state waiver proposals. For example, the current administration did not approve requests in Arkansas or Massachusetts to limit ACA expansion eligibility to 100% FPL with the enhanced match. [19,20,21] In a CMS administrator letter to Kansas on May 7, 2018, CMS rejected Kansas' proposal to impose a lifetime limit on Medicaid benefits for eligible beneficiaries. In June 2018, CMS rejected a provision in Massachusetts' proposed waiver amendment that requested permission to adopt a closed prescription drug formulary.[22]

The current administration also has decided to phase-out some waiver programs. Delivery System Reform Incentive Payment (DSRIP) initiatives, which emerged under the Obama administration, provided states with significant federal funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.[23] In December 2017, CMS approved a five-year renewal of Texas' Healthcare Transformation and Quality Improvement Program Section 1115 waiver. The waiver renewal decreases federal matching funds for the state's DSRIP program between year one and year four, eliminating federal funding for DSRIP in the fifth year.[24] Although some states may be interested in developing new DSRIP initiatives, DSRIP does not appear to be a tool the Trump administration will use to advance delivery system reform.

WAIVER PROVISIONS PENDING BUT NOT APPROVED BY CMS TO DATE

Currently, there are pending state Section 1115 waivers at CMS that include provisions never approved to date including (for the latest updates, check our Medicaid waiver tracker):

- conditioning eligibility on meeting work requirements in states without an ACA Medicaid expansion;
- time limits on coverage;
- drug screening and testing;
- disenrollment and lock-out for non-payment of premiums for enrollees below 100% FPL;
- waiving beneficiary freedom of choice for family planning services; and
- waiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement for 19 and 20 year old expansion adults.

What to Watch in Waivers Going Forward

Each administration has some discretion to approve waivers, although that discretion is ultimately limited by the Medicaid program purposes set out by Congress in federal law. The direction of recent waivers has and may continue to test the bounds of administrative flexibility through waivers, as evidenced by recent litigation challenging certain waiver approvals. HHS reopened the public comment period[25] and will reconsider Kentucky's waiver, including work requirements, premiums, coverage lockouts, and other restrictive eligibility and enrollment provisions, after the DC federal district court set aside HHS's approval, noting that the Secretary failed to consider how the waiver would promote Medicaid's primary objective of providing affordable coverage, given the 95,000 people estimated to lose coverage under the waiver. In August 2018, three Medicaid enrollees filed a lawsuit challenging HHS's approval of Arkansas's waiver amendment, including a work requirement, mandatory online reporting, and reduction of retroactive coverage. As more waivers are submitted and approved, key questions include:

- What are the stated goals and objectives? What does research or experience in other states show about provisions in the waiver?

- What populations are affected by the proposal? What are the anticipated effects on enrollment?
- What is the implementation plan and timeline? What are the administrative costs and challenges? What new systems will be necessary to implement the waiver?
- What is the process to receive public input on new waivers, amendments and operational protocols?
- What are the requirements for reporting and evaluation? How often do states need to submit data?
- Will waiver evaluations be timely and adequate? What data and reporting will be available prior to the completion of formal evaluations?

Appendix A

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 pre-ACA mid-90s through the early part of this decade (before statutory authority/federal funds were directly authorized for coverage expansion to childless adults), most waivers focused on expanding coverage. 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 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. 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 emergencies, 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.

Appendix B

What are the CMS Criteria for Approving Section 1115 Medicaid Demonstration Waivers?

In response to criticism from the General Accounting Office (GAO) about the lack of standards used to determine whether proposed Section 1115 demonstrations further Medicaid program objectives, the CMS posted a set of criteria to use when considering waiver requests in 2015. These criteria were revised by the Trump Administration in November 2017. For comparison, both sets of criteria are listed below.

2015 CMS Waiver Approval Criteria:

1. Increase and strengthen overall coverage of low-income individuals in the state;
2. Increase access to, stabilize and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. Improve health outcomes for Medicaid and other low-income populations in the state; or
4. Increase the efficiency and quality of care for Medicaid and other low-income populations through invitations to transform service delivery networks.

November 2017 Revised CMS Waiver Approval Criteria:

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
2. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;
3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
4. Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Endnotes

[1] Major areas of focus of current approved state Section 1115 waivers include: the implementation of alternative ACA Medicaid expansion models; eligibility and enrollment restrictions; work requirements; benefit restrictions, copays and healthy behaviors; delivery system reform initiatives; integrating physical and behavioral health or providing enhanced behavioral health services to targeted populations; authorizing the delivery of Medicaid long-term services and supports (LTSS) through capitated managed care; and responding to public health emergencies and providing coverage for other targeted groups.

[2] Some states have multiple waivers, and many waivers are comprehensive and may fall into a few different areas.

[3] Increasingly, states are using Section 1115 waivers to combine programs under one single authority (e.g., including authorities otherwise available under Section 1915 (b) managed care waivers and/or Section 1915 (c) home and community based services waivers, along with Section 1115 authority for other eligibility, benefits, delivery system, and payment reforms).

[4] This CMCS Information Bulletin also outlines changes to the "fast track" federal review process for Section 1115 waiver extension requests, removing the requirement that states must have at least one full extension cycle without "substantial program changes" before they are eligible to be considered for the "fast track" review process. (The "fast track" process was designed to expedite the federal review of certain Section 1115 waiver extensions requests that meet specified criteria.)

[5] On December 28, 2017, CMS approved the Mississippi Family Planning Medicaid Waiver extension for a 10-year period. Mississippi is the first state to receive a 10-year Section 1115 waiver extension under the new policy.

[6] On August 22, 2018, CMS released a letter to state Medicaid directors describing current policies related to budget neutrality for Section 1115 Medicaid demonstration projects.

[7] 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/.

[8] Indiana filed an amendment to its pending extension on May 25, 2017 and Kentucky filed an amendment to its pending application on July 3, 2017. Neither state held a state-level public comment period before submission to CMS. 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. However, these amendments were not to ongoing demonstrations but to a new waiver request (KY) and extension request (IN).

[9] However, CMS recently relieved Montana from the requirement to evaluate its expansion waiver based on its participation in a cross-state federal evaluation.

[10] 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/.

[11] The November 6, 2017 CMCS Information Bulletin (found at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617-2.pdf) on Section 1115 demonstration process improvements also signaled CMS's interest in moving toward reducing the frequency of reporting required for states to semi-annually or annually for certain demonstrations.

[12] "About Section 1115 Demonstrations," CMS, accessed December 6, 2017, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[13] In October 2017, CMS approved an amendment to Iowa's eliminating 3-month retroactive coverage for nearly all new Medicaid applicants. The new retroactive coverage waiver applies to all other state plan populations, including low-income parents, children over age 1, ACA expansion adults, seniors, and people with disabilities. Pregnant women and infants under age 1 still qualify for retroactive coverage in Iowa.

[14] Uncompensated Care Pool funding was being phased down according to post-ACA guidelines established by the Obama Administration. These guidelines established that 1) uncompensated care pool funding should not pay for

costs that would be covered in a Medicaid expansion, 2) Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals, and 3) provider payment should promote provider participation and access, and should support plans in managing and coordinating care.

[15] Florida Managed Medical Assistance Program (MMA), Special Terms and Conditions, #11-W-00206/4, approved August 3, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf.

[16] Under Florida's LIP, funding was set at $1 billion in SFY 2016 and $608 million in SFY 2017. CMS indicated the new LIP funding amount approved as part of the state's extension request reflects "the most recent available data on hospitals' charity care costs." Florida's LIP funds may be used for health care costs incurred by the state or by providers (hospitals, medical school physician practices, and federally qualified health centers (FQHCs)/rural health centers (RHCs)) to furnish uncompensated medical care for uninsured low-income individuals up to 200% FPL.

[17] Texas Healthcare Transformation and Quality Improvement Program, Special Terms and Conditions, # 11-W-00278/6, approved January 1, 2018 through September 30, 2022, https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf.

[18] On November 1, 2017, CMS issued a state Medicaid director letter revising the July 2015 guidance. The revised guidance continues to allow states to use Section 1115 waivers to pay for IMD substance use treatment services and affirms many components of the earlier guidance. For example, it notes that "states should indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state" and directs states to "demonstrate how they are implementing evidence-based treatment guidelines." The revised guidance requires certain demonstration components, such as residential treatment provider qualifications and capacity, opioid prescribing guidelines, access to naloxone, prescription drug monitoring programs, and care coordination between residential and community settings. States must report on core and state-specific quality measures, perform waiver evaluations, and are subject to a $5 million deferral per item for failure to comply with evaluation and reporting requirements.

[19] The Trump administration rejected Massachusetts' request for partial expansion to 100% of the FPL using the ACA enhanced match on June 27, 2018. The current administration did not make a decision on Arkansas' partial expansion request in its March 5, 2018 approval of the Arkansas Works waiver amendment request.

[20] Utah's pending waiver amendment (submitted in June 2018) requests authority for a partial expansion to 100% FPL using the ACA enhanced match, as well as authority to cap expansion enrollment if the state determines there are insufficient funds for program continuation.

[21] The Obama Administration issued policy guidance, consistent with its legal interpretation of the ACA, indicating that states cannot receive enhanced federal ACA expansion funding unless they cover all newly eligible adults through 138% FPL.

[22] In its rejection of Massachusetts' prescription drug formulary proposal, CMS said it would be willing to consider a closed formulary proposal under which the state agrees to negotiate directly with manufacturers and forgo all manufacturer rebates available under the federal Medicaid Drug Rebate Program.

[23] 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.

[24] Texas Healthcare Transformation and Quality Improvement Program, Special Terms and Conditions, # 11-W-00278/6, approved January 1, 2018 through September 30, 2022, https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf.

[25] Following the federal district court's decision in *Stewart v. Azar*, CMS reopened the 30-day federal public comment period to accept comment's on: 1) the state's original KY HEALTH demonstration proposal (submitted August 24, 2016), 2) Kentucky's revised KY HEALTH demonstration application (submitted July 3, 2017), and CMS's approved KY HEALTH special terms and conditions (approved on January 12, 2018).