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FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS

EXECUTIVE SUMMARY

For many years, Section 1115 waivers have been used in the Medicaid program to provide states an avenue to test and implement coverage approaches that do not meet federal program rules, but have also raised policy issues. Following are five key questions and answers about Section 1115 waivers:

What is a Section 1115 Medicaid demonstration waiver?

- Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and welfare programs authorized under the Act, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The authority is provided at the Secretary's discretion for demonstration projects that the Secretary determines promote Medicaid program objectives.
- There are comprehensive Section 1115 Medicaid waivers that allow broad changes in eligibility, benefits, cost sharing, and provider payments. There also are more narrowly drawn Section 1115 waivers as well as Section 1915 Medicaid waivers that focus on specific services and populations.

How are Section 1115 Medicaid demonstration waivers approved and renewed?

- Section 1115 waivers are approved at the discretion of the Secretary of HHS through negotiations between a state and the Centers for Medicare & Medicaid Services (CMS).
- Section 1115 waivers generally are approved for a five-year period and then must be renewed.

How are Section 1115 Medicaid demonstration waivers financed?

- Although not required by statute or regulation, longstanding administrative policy has required waivers to be budget neutral for the federal government, meaning that federal spending under a waiver must not be more than projected federal spending in the state without the waiver.
- The federal government enforces budget neutrality by establishing a cap on federal funds over the life of the waiver, placing a state at risk for all waiver costs above the cap. Most comprehensive Section 1115 waivers have relied on per capita caps; two states (Rhode Island and Vermont) have waivers with aggregate or global caps.

How are states currently using Section 1115 Medicaid demonstration waivers?

- 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.
- Currently, 30 states and the District of Columbia operate one or more comprehensive Section 1115 Medicaid waivers that involved an estimated $54.6 billion in federal outlays in 2011. These waivers generally fall into several categories, including waivers to implement managed care, to expand coverage with limited benefits, to restructure federal financing, and to expand coverage to low-income adults in preparation for the Medicaid expansion in 2014.

How does the Affordable Care Act (ACA) impact Section 1115 waivers?

- The ACA does not change the key provisions of Section 1115, but it does require new regulations to increase the transparency of the waiver approval process and creates new waiver authorities.
- Since the passage of the ACA, several states have obtained Section 1115 waivers to expand coverage to low-income adults in preparation for the coverage expansions under reform. Other states have expressed interest in pursuing waivers focused on reducing costs to address budget shortfalls.

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1. WHAT IS A SECTION 1115 MEDICAID DEMONSTRATION WAIVER?

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to waive provisions of major health and welfare programs authorized under the Act, including certain requirements in Medicaid. The Medicaid program is a jointly financed partnership between the federal government and states. The federal government provides open-ended federal matching dollars for allowable state spending on Medicaid, and states administer the program on a day-to-day basis. To receive federal Medicaid matching funds, states are required to meet federal core requirements, which include covering a specific set of eligibility groups and benefits. States also can choose to cover optional groups and benefits with federal Medicaid matching funds and have substantial discretion to determine how care is delivered as well as how and what providers are paid. Under Section 1115 of the Social Security Act, the Secretary of HHS can allow a state to receive federal Medicaid matching funds to operate its Medicaid program in ways not otherwise allowed under federal rules as long as the Secretary determines the initiative is a demonstration project that promotes the objectives of the program. The Secretary's waiver authority is broad, but it is not unlimited. There are some program elements the Secretary does not have authority to waive, such as the federal matching payment formula.

There are comprehensive Section 1115 waivers and more narrowly drawn waivers. States can obtain "comprehensive" Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost sharing, and provider payments. There also are more narrow Section 1115 waivers that focus on specific services, such as family planning services, or populations, such as people with HIV. The ACA creates an additional Section 1115A waiver authority that establishes the Center for Medicare and Medicaid Innovation (CMMI) to test, evaluate, and expand different service delivery and payment methodologies to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid, and CHIP.[1] Other Medicaid waivers authorized under Section 1915 of the Social Security Act permit states to enroll Medicaid beneficiaries in mandatory managed care or provide home and community based services to people who would otherwise need nursing home care.

Section 1115 waivers are intended to be research and demonstration projects to test and learn about new approaches to program design and administration. Because waivers are intended to be research and demonstration projects, federal law requires that they be formally evaluated. However, for many years, there has been a limited focus on waiver evaluations. In the early- to mid-1990s there was some formal waiver evaluation, including several federally-funded, multi-state evaluations conducted by independent contractors.[2] However, as the volume of waivers increased and research budgets became more constrained, the focus turned away from multi-state, federally-funded evaluations to more state-specific, state-funded evaluations.[3] Although all states have been required to complete evaluations of their waivers, not all evaluations are publicly available and no comprehensive summary of evaluation findings is available. The diminished focus on evaluation and limited availability of evaluation findings restricts the ability for researchers, policymakers, and other stakeholders to identify the impacts of and lessons learned from Section 1115 waivers to date. The ACA requires the Secretary of HHS to issue regulations that provide a process for the periodic evaluation of each Section 1115 waiver as part of regulations designed to increase the transparency of the waiver approval and renewal process.[4]

2. HOW ARE SECTION 1115 MEDICAID DEMONSTRATION WAIVERS APPROVED?

Waivers are approved and renewed through negotiations between a state and HHS. The process for obtaining a Section 1115 waiver begins with a state submitting an application to the Centers for Medicare & Medicaid Services (CMS), although states often discuss waiver ideas with CMS or submit concept papers before submitting an application. Staff members from CMS review the waiver application usually with the involvement of other HHS agencies and the Office of Management and Budget. During this time, significant negotiation may occur between the state and HHS. If a waiver is approved, CMS issues an award letter to the state, along with attachments listing the specific sections of the Social Security Act and applicable regulations that are being waived or modified and the types of expenditures allowed as well as the terms and conditions of approval, including a budget neutrality agreement. There has been significant variation in the length of time it takes to get final approval of a waiver. There also is variation across states in the role of state legislatures in the waiver approval process with many states requiring authorizing legislation for waivers and others having little or no involvement of the state legislature.[5]

Section 1115 waivers generally are approved for an initial five-year period and must be renewed to continue operations past that period. In general, Section 1115 waivers are approved for an initial five-year period.[6] At the end of the initial approval period, a state must obtain a renewal of the waiver to continue operations under it. Waiver renewals typically are for a three-year period. Some waivers have been continually renewed over many periods, allowing waiver operations to continue for many years.[7] The ACA gives the Secretary discretion to extend five-year renewals for waivers that include a focus on dual eligibles who receive assistance from both Medicaid and Medicare.[8]

Given the significant program changes that can occur under waivers, the transparency of the waiver approval and renewal process is important. In the mid-1990s, efforts were made to establish public process policies at the federal and state level by providing regular notice of waivers in the Federal Register with a comment period and requiring states to describe processes used to obtain public input as part of their waiver proposals.[9] However, commitment to these practices faded. Analyses by the Government Accountability Office (GAO) in 2002 and 2007 concluded that the public did not have sufficient opportunity to learn about and comment on pending waivers at the federal level and that there was significant variation in public input opportunities at the state level.[10] The ACA directed HHS to issue regulations to increase the transparency of the Section 1115 waiver approval and renewal process and to allow for public input at both the state and federal level. Proposed regulations were released in September 2010, which include specific requirements related to public notice and input processes at both the state and federal level.[11]

3. HOW ARE SECTION 1115 MEDICAID DEMONSTRATION WAIVERS FINANCED?

Although not required by statute or regulation, under longstanding administrative policy Section 1115 Medicaid waivers have been required to be budget neutral for the federal government. This means that federal spending under a waiver must not be more than projected federal spending would have been for that state without the waiver. The projection of federal costs without the waiver is among the issues subject to negotiation between the state and CMS during the waiver approval process.

The federal government enforces budget neutrality by establishing a cap on federal funds over the life of the waiver, placing a state at risk for all waiver costs that exceed the cap over the life of the waiver. Budget neutrality caps are established based on the projection of what state spending would be in the absence of the waiver and can be set on a per capita or global basis. As noted, the projection of state spending is among the issues subject to negotiation between a state and CMS as part of the waiver approval process. Analyses by the GAO have identified problems with methods used to establish budget neutrality caps in some waivers and concluded that the caps in these waivers were set above the levels of what federal spending would be without the waiver.[12]

Most comprehensive Section 1115 waivers have relied on per capita caps. These caps limit the amount of federal funds a state can receive for persons covered under the waiver based on pre-set per person costs. Under a per capita cap, federal matching funds automatically adjust for enrollment levels but not for higher than projected per person costs.

Two states (Vermont and Rhode Island) currently have waivers that operate under aggregate caps. These aggregate or global caps place a total limit on federal funding for waiver-related expenditures and do not adjust for higher than projected enrollment or per person cost increases. While these waivers place a total limit on federal Medicaid matching funds for activities covered by the waivers, they do not serve as models to assess the potential impacts of current proposals to turn Medicaid into a block grant program. Although these waivers were intended to be budget neutral, analyses suggest that the caps for these waivers were set at a generous level, allowing for increased federal funding than the states would have received without the waivers.[13] In contrast, current discussions of turning Medicaid into a block grant program are focused on federal deficit reduction and would significantly reduce federal funding provided to states.[14]

Federal funds made available under Section 1115 Medicaid demonstration waivers are Medicaid matching funds. They match state expenditures for services and populations that are allowable under the waiver up to the established budget neutrality cap. The state must pay its share of these costs as determined by the Medicaid matching rate formula, which, as previously noted, is not subject to waiver.

4. HOW ARE STATES CURRENTLY USING SECTION 1115 MEDICAID DEMONSTRATION WAIVERS?

From Medicaid's beginning in 1965 through the early 1990s, there were many Section 1115 Medicaid waivers but most were small in scope. In the 1990s, there was a significant spurt in waiver activity, and, since then waivers have become more numerous and broader in scope. 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. As of April 2011, 30 states and DC were operating one or more Section 1115 Medicaid waivers, which involved an estimated $54.6 billion in federal outlays in 2011 and accounted for nearly 20% of federal Medicaid spending.[15] Most of these waivers fall into the following categories. (See also Appendix A.)

Ten are primarily managed care waivers, most of which also expanded coverage and were originally approved in the mid-1990s. These waivers generally allowed states to implement broader managed care systems than were permitted under federal law at the time and many used the savings from managed care to offset the costs of expanding coverage to additional groups. The flush economy in the mid- to late-90s helped support expansions, and some of these waivers resulted in significant coverage gains.[16] The experiences of these waivers also paved the way for changes in the Balanced Budget Act of 1997 that gave states new authority to implement managed care arrangements without a waiver. More recently, Florida received approval for a waiver in 2005 that allowed the state to make a number of program changes including implementing managed care. However, the state's approach to managed care is distinctly different from arrangements in other states in that it shifts new authority from the state to private managed care plans to make certain determinations regarding covered benefits and cost sharing requirements.[17]

An additional ten waivers primarily expand coverage to non-disabled parents and/or other adults, but with a more limited benefit package than the state otherwise provides in Medicaid. In a number of cases, the benefit package is also more limited than allowed under the core federal Medicaid benefit requirements, for example, limited solely to primary care services or a premium subsidy for the purchase of private coverage. These waivers were originally approved between 2002 and 2009, with many being approved under the Health Insurance Flexibility and Accountability (HIFA) waiver initiative released by the Bush Administration in 2001. HIFA encouraged states to use waivers to expand coverage within "current level resources" and offered new authority to reduce benefits and increase cost sharing for existing beneficiaries to offset expansion costs. The size of expansions varies across these waivers, but, overall, the coverage gain under them has been relatively limited.[18] Oregon and Utah also used the HIFA authority to reduce benefits and increase cost sharing for some previously eligible groups under their waivers. Oregon's waiver (Oregon Health Plan 2) replaced an earlier managed care waiver (Oregon Health Plan), and primarily resulted in coverage losses rather than gains.[19] Further, separate from the ten waivers that expanded limited benefits, during this same period, Tennessee replaced a managed care waiver (TennCare), with a new waiver (TennCare II) that focused on reducing coverage and costs.[20]

Two waivers alter the Medicaid financing arrangement by establishing a global cap on federal Medicaid funds. These include a waiver in Vermont, approved in 2005, and a waiver in Rhode Island approved in 2009, which put the states at risk for all costs beyond their global caps.

Five waivers extend coverage to adults as part of broad efforts to expand coverage; most were recently approved to help states prepare for and transition to the broad coverage expansions under the ACA. During 2005, Massachusetts obtained an amendment to its longstanding managed care expansion waiver (MassHealth) that built on and strengthened Medicaid as part of its effort to provide universal coverage. Further, since 2010, four waivers (in California, the District of Columbia, New Jersey, and Washington) were approved to enable the states to begin expanding coverage early to low-income adults in preparation for the broad Medicaid expansion that will occur in 2014 under reform.

5. HOW DOES THE ACA IMPACT SECTION 1115 WAIVERS?

The ACA does not change the key provisions of Section 1115, but does require greater transparency in the Section 1115 Medicaid waiver approval and renewal process. The ACA amended the Section 1115 waiver authority, leaving its key provisions intact but requiring the Secretary of HHS to issue regulations that provide for a process to ensure a "meaningful level of public input" in the development and approval of waiver demonstrations.

The ACA also creates new Section 1115A and Section 1332 waiver authorities. Section 1115A authorizes the Secretary to waive provisions of Medicare, Medicaid, and CHIP law, establishes the Center for Medicare and Medicaid Innovation (CMMI), and provides $10 billion per year through FY2019 to test, evaluate, and expand different service delivery and payment models to slow cost growth while preserving or enhancing quality of care.[21] In addition, beginning in 2017, Section 1332 of the ACA provides authority for State Innovation Waivers of non-Medicaid provisions of the new law related to Exchanges, benefits, and cost-sharing protections and includes provisions to coordinate the Section 1115 and Section 1332 waiver processes.

The ACA's Maintenance of Effort (MOE) requirement applies to coverage under Section 1115 waivers with some limited exceptions. The ACA includes a MOE requirement designed to maintain coverage until the coverage expansions in Medicaid and Exchange coverage go into effect in 2014. Under the MOE requirement, as a condition of receiving federal Medicaid funding, states must maintain eligibility and enrollment policies that were in place when reform was enacted (March 23, 2010) until 2014 for adults in Medicaid and until 2019 for children in Medicaid and CHIP. One exception allows states facing a documented budget deficit to reduce eligibility for non-pregnant, non-disabled adults above 133% of the federal poverty level (FPL). The MOE requirement applies to coverage under Section 1115 waivers. However, under the MOE exception, a state facing a documented budget deficit can reduce waiver coverage for adults with income above 133% FPL.[22] Further, a state can make changes explicitly allowed under its waiver terms and conditions to stay within its budget neutrality limit (e.g., capping enrollment).[23] A state also can end or modify its waiver at the end of its approval period since the MOE provision does not require a state to continue a Section 1115 waiver beyond its expiration date.[24]

As noted, since the passage of the ACA, several states have obtained Section 1115 waivers to extend coverage to low-income adults in preparation for the broad coverage expansions under reform; however, other states have expressed interest in obtaining waivers focused on reducing costs to address budget shortfalls. It largely remains to be seen what types of specific changes states may seek through waivers to reduce program costs, although some states have expressed interest in waivers of the MOE requirement to reduce eligibility and impose new enrollment requirements as well as waivers to reduce benefits and increase costs imposed on enrollees. As is the case with all Section 1115 waivers, approval of waiver changes focused on reducing costs would be subject to the Secretary's discretion and determination as to whether the waiver is a demonstration project that furthers the objectives of the Medicaid program.[25]

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Appendix A: Overview of Active Comprehensive Section 1115 Medicaid Waivers

State	Program Name	Original Approval	Last Extension	Expiration
Managed Care				
AZ	Arizona Health Care Cost Containment System	7/13/1982	10/26/2006	9/30/2011
DE	Delaware Diamond State Health Plan	5/17/1995	1/31/2011	12/31/2013
FL	Florida Medicaid Reform	10/19/2005	N/A	6/30/2011
HI	Hawaii QUEST Expanded	7/16/1993	2/1/2008	6/30/2013
KY	Kentucky Health Care Partnership Program	12/9/1993	10/30/2008	10/31/2011
MD	Maryland HealthChoice	10/30/1996	8/29/2008	6/30/2011
MN	Minnesota Prepaid Medical Assistance Project Plus	4/27/1995	8/11/2008	6/30/2011
NY	New York Partnership Plan	7/15/1997	9/29/2006	4/30/2010
OK	Oklahoma SoonerCare Demonstration	10/12/1995	12/30/2009	12/31/2012
WI	Wisconsin BadgerCare	1/22/1999	12/30/2010	12/31/2013
Limited Benefit Expansion				
AR	Arkansas Safety Net Benefit Program	3/3/2006	N/A	9/30/2011
ID	Idaho Medicaid Non-Pregnant Childless Adult Waiver	12/23/2009	N/A	9/30/2014
IA	IowaCare	7/1/2005	9/1/2010	12/31/2013
IN	Healthy Indiana Plan	12/14/2007	N/A	12/31/2012
ME	Maine Care for Childless Adults	9/13/2002	9/27/2010	12/31/2013
MI	Michigan Medicaid Nonpregnant Childless Adults Waiver	12/22/2009	N/A	9/30/2014
NM	New Mexico State Coverage Insurance	12/30/2009	N/A	9/30/2014
OR	Oregon Health Plan 2	10/15/2002	3/17/2010	10/31/2013
UT	Utah Primary Care Network	2/8/2002	6/23/2010	6/30/2013
WI	Wisconsin BadgerCare Plus Health Insurance for Childless Adults	12/31/2008	N/A	12/31/2013
Restructuring of Federal Financing				
RI	Rhode Island Global Consumer Choice Demonstration	1/16/2009	N/A	12/31/2013
VT	Vermont Global Commitment to Health	9/27/2005	12/29/2010	12/31/2013
Expansions to Low-Income Adults in Preparation for Reform Expansion				
CA	California's Bridge to Reform	8/31/2005	11/2/2010	10/31/2015
DC	District of Columbia Childless Adults	10/28/2010	N/A	12/31/2013
MA	MassHealth	4/24/1995	12/22/2008	6/30/2011
NJ	Childless Adult Expansion	4/4/2011	N/A	12/31/2013
WA	Washington Transitional Bridge Demonstration	1/3/2011	N/A	12/31/2013
Other				
AR	ARKids B	8/19/1997	12/23/2010	12/31/2013
AR	Arkansas TEFRA-Like 1115	10/17/2002	12/14/2010	12/31/2013
FL	Florida MEDS-AD	12/15/2005	12/14/2010	12/31/2013
LA	Louisiana Greater New Orleans Community Health Connection	9/22/2010	N/A	12/31/2013
ME	Maine HIV/AIDS Program	2/24/2000	6/28/2010	12/31/2013
MO	Missouri Gateway to Better Health	7/28/2010	N/A	12/31/2013
MS	Healthier Mississippi	9/10/2004	10/29/2010	12/31/2013
MT	Montana Basic Medicaid for Able-Bodied Adults	1/29/2004	11/24/2010	12/31/2013
NY	New York Federal-State Health Reform Partnership	9/29/2006	N/A	3/31/2014
TN	TennCare II	5/30/2002	12/15/2009	6/30/2013

Note: Waivers solely under Title XXI CHIP authority are not included.
Sources: Centers for Medicare and Medicaid Services, "Status of CAHPG Comprehensive 1115 Demonstrations," http://www.cms.gov/apps/files/Section1115%20Demos-040111.pdf, updated to reflect approval of New Jersey waiver in April 2011. Categorization of waivers based on KCMU analysis of waiver provisions.

ENDNOTES

[1] Section 1115A of the Social Security Act, as added by section 3021(a) of the ACA, P.L. 111-148.
[2] Artiga, S., "The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward," Kaiser Commission on Medicaid and the Uninsured, March 2009.
[3] Ibid.
[4] Section 1115(d) of the Social Security Act, as added by section 10201(i) of the ACA, P.L. 111-148.
[5] National Health Law Program and National Association of Community Health Centers, "Role of State Law in Limiting Medicaid Changes," January 2007.
[6] Recent waivers approved for the District of Columbia and Washington State were approved for a shorter initial period since they are designed to phase out when the broad coverage expansions under health reform take effect in 2014. Centers for Medicare and Medicaid Services, "Status of CAHPG Comprehensive 1115 Demonstrations," http://www.cms.gov/apps/files/Section1115%20Demos-040111.pdf.
[7] Centers for Medicare and Medicaid Services, "Status of CAHPG Comprehensive 1115 Demonstrations," op. cit.
[8] Section 1915(h)(2) of the Social Security Act, as added by section 2601(a) of the ACA, P.L. 111-148.
[9] Artiga, S., "The Role of Section 1115 Waivers in Medicaid and CHIP," op. cit.
[10] Government Accountability Office, "Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern," GAO-07-694R, July 24, 2007 and Government Accountability Office, "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns, GAO-02-817, July 12, 2002.
[11] Section 1115(d) of the Social Security Act, as added by section 10201(i) of the ACA, P.L. 111-148.
[12] Government Accountability Office, "Medicaid Demonstration Waivers, Recent HHS Approvals Continue to Raise Cost and Oversight Concerns," January 31, 2008 and Government Accountability Office, "Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns, June 2004.
[13] Guyer, J., "Vermont's Global Commitment Waiver: Implications for the Medicaid Program," Kaiser Commission on Medicaid and the Uninsured, April 2006, Government Accountability Office, "Cost and Oversight Concerns," op. cit., and Cross-Call, J. and J. Solomon, "Rhode Island's Global Waiver Not a Model for How States Would Fare Under a Medicaid Block Grant," Center on Budget and Policy Priorities, March 22, 2011.
[14] Holahan, J., et al., "House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing," Kaiser Commission on Medicaid and the Uninsured, May 2011 and Cross-Call, J. and J. Solomon, "Rhode Island's Global Waiver," op. cit.
[15] Centers for Medicare and Medicaid Services, "Status of CAHPG Comprehensive 1115 Demonstrations," op. cit. and Analytical Perspectives, Budget of the United States Government, Fiscal Year 2012, Table 27-6, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/technical_analyses.pdf
[16] "Restructuring Medicaid: Key Elements and Issues in Section 1115 Demonstration Waivers," The Henry J. Kaiser Family Foundation, May 1997.
[17] "Florida Medicaid Reform Waiver: Early Findings and Current Status," Kaiser Commission on Medicaid and the Uninsured," October 2008.
[18] Artiga, S. and C. Mann, "Coverage gains Under Recent Section 1115 Waivers: A Data Update," Kaiser Commission on Medicaid and the Uninsured, August 2005.
[19] Ibid.
[20] Ibid.
[21] Section 1115A of the Social Security Act, as added by section 3021(a) of the ACA, P.L. 111-148.
[22] Centers for Medicare & Medicaid Services, State Medicaid Director Letter Re: Maintenance of Effort, SMDL # 11-001, February 2011.
[23] Ibid.
[24] Ibid.
[25] Congressional Research Service, "Authority of the Secretary of HHS to Waive the Maintenance of Effort Requirements in Section 2001(b) of the PPACA," March 3, 2011.

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