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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 what is required by federal statute. 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) and often reflect changing priorities from one administration to another. In November 2017, CMS, under the Trump administration, posted revised criteria for Section 1115 waivers that no longer include the goal of increasing coverage, as in prior administrations. In January 2018, CMS posted new guidance to allow 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. Litigation challenging waiver approvals in Kentucky and Arkansas is ongoing.[1]

Section 1115 waiver activity is expected to continue both through administrative actions 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. The most current activity is contained in our Medicaid waiver tracker,[2] 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."[3] States can obtain "comprehensive" Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs.[4,5] 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.[6] 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 generally enforces budget neutrality by establishing a per member per month cap on federal funds under the waiver, putting the state at risk for increases in per member per month costs but not for increased costs due to enrollment growth.[7]

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.[8,9] 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.[10] 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.[11,12]

What waiver priorities have been identified by the Trump administration?

New Waiver Approval Criteria. 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).[13] 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.

Work Requirements / Community Engagement. CMS also has issued new guidance identifying waiver policy priority areas and inviting applications from states. In January 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." In June 2018, a federal district court invalidated CMS's initial approval of Kentucky's waiver, which included a work requirement and other eligibility restrictions, finding that the Secretary failed to consider the waiver's impact on Medicaid's primary objective of providing affordable health coverage. Litigation challenging CMS's re-approval of Kentucky's waiver as well as CMS's approval of a work requirement waiver in Arkansas is ongoing.

Opioids / Behavioral Health. CMS continues to use waivers to help states address the opioid epidemic as well as broader behavioral health initiatives. 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 disorder (SUD) treatment services in "institutions for mental disease" (IMDs), and CMS continues to approve IMD SUD payment waivers.[14] On November 13, 2018, CMS also issued new guidance inviting states to apply for Section 1115 waivers of the federal IMD payment exclusion for services for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED). This guidance reverses prior CMS policy to not use Section 1115 waiver authority to allow Medicaid payments for non-elderly adults with a primary mental health diagnosis in IMDs[15] and could have implications for states' community integration obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision. As of early February 2019, CMS has not posted any state waiver applications under the new guidance. CMS notes that states may participate in the SUD demonstration opportunity and the SMI/SED demonstration at the same time.

Process and Evaluation. CMS released an Informational Bulletin in November 2017 indicating it will consider approving "routine, successful, non-complex" Section 1115 waiver extension requests for up to 10 years.[16] 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. In the same November 2017 guidance, CMS also signaled an interest in moving toward reducing the frequency of reporting required for states from quarterly to semi-annually or annually for certain demonstrations. 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.

Endnotes

[1] 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. In November 2018, CMS re-approved the Kentucky waiver. In January 2019, the plaintiffs filed an amended complaint challenging CMS's re-approval of the waiver, and briefing is underway.

[2] 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; behavioral health; 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.

[3] 42 U.S.C. § 1315.

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

[5] 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).

[6] The Secretary's waiver authority is limited to the provisions of 42 U.S.C. § 1396a, provided that waivers are demonstration projects that further Medicaid program objectives. 42 U.S.C. § 1315.

[7] 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.

[8] 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/.

[9] 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).

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

[11] 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/.

[12] 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.

[13] "About Section 1115 Demonstrations," CMS, last accessed Jan. 29, 2019, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[14] Federal law generally bars states from receiving "any such [federal Medicaid] payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an [IMD]." 42 U.S.C. § 1396d (a)(29)(B).

[15] One state, Vermont, currently has waiver authority for IMD mental health services, but those payments must be phased out between 2021 and 2025. Vermont had sought expanded waiver authority for IMD mental health services, and other states, including Illinois, Massachusetts, and North Carolina, had sought IMD mental health authority; all of these requests were denied by CMS. In the Vermont, Illinois, and North Carolina denials, CMS specifically cited its

policy to not allow Medicaid payments for individuals who receive only mental health treatment in IMDs. Maryland also indicated that CMS had denied its request for IMD mental health payment waiver authority.

[16] 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.)