

# medicaid and the uninsured

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## An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity

### EXECUTIVE SUMMARY

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 significant flexibility in how they operate their programs and can have a significant impact on program financing. As such, waivers have important implications for beneficiaries, providers, and states. This brief provides an overview of Section 1115 waiver authority, the waiver approval process, and recent Section 1115 Medicaid waiver activity and discusses the implications of this activity.

#### *Recent Section 1115 Waivers and Waiver Proposals*

There has been a recent increase in Section 1115 waiver activity, with the Centers for Medicare and Medicaid Services (CMS) making several waiver decisions and a number of states submitting new waiver proposals. The waivers and waiver proposals vary in their specific goals and approaches, but some key themes are apparent, including the following.

**Preparing for 2014 by expanding coverage early and simplifying enrollment processes.** Since the enactment of the ACA, seven states (CA, CO, DC, MN, MO, NJ, and WA) have obtained Section 1115 waivers to expand Medicaid early to adults in preparation for 2014. Two states (MA and NY) also have received waivers to streamline enrollment and renewal processes for adults, laying important groundwork for 2014.

**Seeking eligibility and enrollment restrictions and premium and cost sharing increases to address ongoing budget pressures.** Current federal rules generally prohibit states from implementing eligibility and enrollment restrictions. However, four states (AZ, HI, NV, WI) received approval to implement restrictions when their waivers expired or under a limited exception to the federal rule. Other proposed eligibility and enrollment restrictions have not been approved, and the Secretary of Health and Human Services has indicated that she will not waive the requirement to maintain eligibility and enrollment. In addition, several states have sought waiver authority to charge higher premiums and cost sharing than otherwise allowed. These requests have not been approved with the exception of higher costs for some adults in Arizona and Wisconsin who were otherwise at risk for having their coverage eliminated.

**Expanding managed care to include high-need populations and additional services.** California, Delaware, New York, and Texas have all received waiver approval to newly require some high-need individuals to enroll in managed care. Several other states (FL, KS, NJ, and NM) have waiver proposals to move elderly and disabled enrollees into managed care. Moreover, the waiver approval in Delaware and several other pending waiver proposals would expand managed care to more services, including long-term services and supports.

**Utilizing Section 1115 waiver authority to support safety-net delivery system improvements.**

Approved waiver initiatives in several states (CA, FL, MA, and TX) make federal matching funds available for safety-net pools that will be used to cover both uncompensated care costs and hospital delivery system improvement initiatives. These initiatives include infrastructure development, new care delivery models (e.g., medical homes, chronic disease management), and quality improvement projects.

**Other restructuring of payment and delivery systems.** A number of pending waivers propose other payment and delivery system changes that include a focus on connecting individuals to a medical or health home and providing case management and care coordination services, particularly for high-need populations (AZ, NJ, NV, NM, and OR). In addition, several pending waivers propose to establish coordinated sets of providers and make them accountable for care and outcomes of enrollees (NJ, NV, and OR) and to change payments for providers and plans to focus on episodes of care or outcomes (KS, NJ, NM, and OR).

**Focus on individuals who are dually eligible for both Medicaid and Medicare.** The approved managed care expansions in Delaware and Texas as well as waiver proposals in several states would newly require dual eligibles to enroll in managed care plans. In addition, some of the other proposed delivery and payment system changes would include dual eligibles.

### ***Implications of Recent Waiver Activity***

**Some states are using Section 1115 waiver authority to lay important groundwork for reform.** State actions to expand coverage early and streamline enrollment can provide key lessons for these and other states to help prepare for implementation of the 2014 coverage expansions. Moreover, initiatives to support safety-net delivery system improvements can help prepare these delivery systems for the increased demand for care when coverage expands in 2014.

**As states expand managed care to high-need populations and pursue other delivery and payment system changes, it will be important to closely monitor impacts on care and for there to be strong state oversight and beneficiary protections in place.** States are pursuing these changes with goals of improving the coordination of care and achieving cost savings. However, the extent to which these goals will be achieved remains to be seen. To date, there is limited evidence of savings and states have very limited experience with managed care for people with disabilities and managed long-term services and supports. As initiatives are implemented, it will be important to assess the adequacy of provider networks and beneficiaries' ability to access needed services. Moreover, as changes in delivery and payment systems shift risks and responsibilities from the state to plans and providers, strong state oversight and beneficiary protections will be increasingly important.

**As more Section 1115 waivers include high-need and high-cost beneficiaries, the share of Medicaid program enrollees and expenditures under Section 1115 waiver authority will increase.** An expansion in the role of waivers could increase state program variation and raises considerations related to the balance of federal standards and state flexibility. Moreover, to ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their impacts and for evaluation findings to be made publicly available.

**States are pursuing significant Medicaid program changes at the same time they are preparing for implementation of reform.** Both of these sets of changes require significant administrative time and resources. While these efforts may be complementary and mutually reinforcing, states will likely face the need to balance and coordinate resources across their efforts.

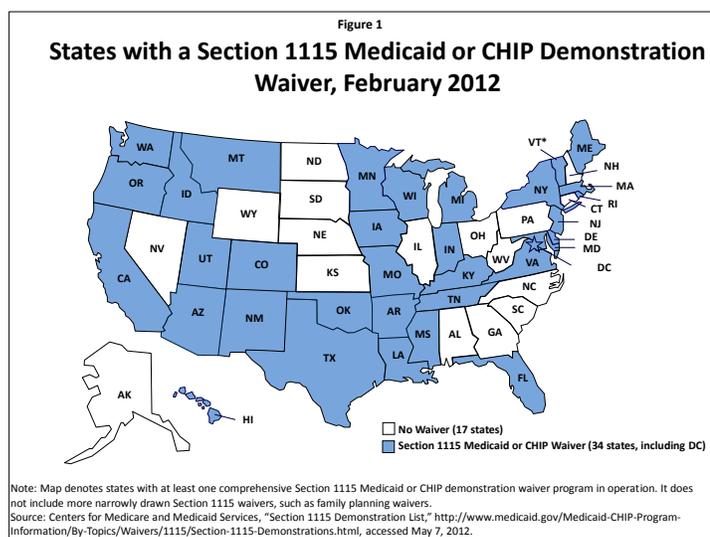
In conclusion, a number of states have recently received new Section 1115 waivers or have pending waiver proposals. While the specifics of each waiver initiative vary, some key themes have emerged, including using Section 1115 waiver authority to get a jump start on the 2014 Medicaid expansion; seeking eligibility and enrollment restrictions and premium and cost sharing increases to achieve cost savings; expanding managed care to include high need populations and more services; and restructuring delivery and payment systems. These approaches have important implications for beneficiaries, providers, and states as well as the balance between federal standards and state flexibility.

## INTRODUCTION

Section 1115 Medicaid waivers provide states an avenue to test new approaches in Medicaid that differ from federal program rules. Waivers can provide states significant flexibility in how they operate their programs and can have a significant impact on program financing. As such, waivers have important implications for beneficiaries, providers, and states.

Today, Section 1115 waivers play a significant role in the Medicaid program. As of May 2012, 34 states were operating at least one comprehensive Section 1115 Medicaid waiver (Figure 1).<sup>1</sup> In addition, according to data from the Office of Management and Budget (OMB), federal funds flowing through Section 1115 waivers will account for a third of total federal Medicaid expenditures in 2012.<sup>2</sup>

There has been a recent increase in Section 1115 waiver activity, with the Centers for Medicare and Medicaid Services (CMS) making several waiver decisions and a number of states submitting new waiver proposals that would make significant program changes. This brief provides an overview of Section 1115 waiver authority, the waiver approval process, and recent Section 1115 Medicaid waiver activity and discusses the implications of this activity.



## BACKGROUND

### *Waiver Authority in Medicaid*

Section 1115 of the Social Security Act (SSA) 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 Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. This authority is provided for "experimental, pilot, or demonstration" projects which, in the view of the Secretary, are "likely to assist in promoting the objectives of" the program. Although the Secretary's waiver authority is broad, it is not unlimited. There are some program elements the Secretary does not have authority to waive, such as the federal matching payment formula.<sup>3</sup>

<sup>1</sup> This does not include more narrowly focused Section 1115 waivers, such as family planning waivers. Centers for Medicare and Medicaid Services, "Section 1115 Demonstration List," <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>, accessed May 8, 2012 .

<sup>2</sup> Office of Management and Budget, Table 27-5: "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," Analytical Perspectives, Budget of the United States Government, Fiscal Year 2013, [http://www.whitehouse.gov/omb/budget/Analytical\\_Perspectives](http://www.whitehouse.gov/omb/budget/Analytical_Perspectives) .

<sup>3</sup> Specifically, Section 1115 provides authority for the Secretary to waive solely those provisions included in Section 1902 of the Medicaid Act. Moreover, the Secretary cannot waive provisions of Section 1902 that are governed by independent provisions outside of Section 1902 that bar their waiver.

States can obtain “comprehensive” Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost sharing, and provider payments. There also are narrower Section 1115 waivers that focus on specific services, such as family planning services, or populations, such as people with HIV.

There are additional Medicaid waiver authorities outside of Section 1115. The Affordable Care Act (ACA) created a new Center for Medicare and Medicaid Innovation (CMMI) which is provided waiver authority under Section 1115A 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. Further, Medicaid waivers may be authorized under Section 1915(b) authority to permit states to enroll most Medicaid beneficiaries in mandatory managed care and under Section 1915(c) authority to provide home and community-based services to people who would otherwise need institutional care. In addition, Section 1916(f) provides authority for the Secretary to approve higher cost sharing than otherwise allowed if a demonstration meets specified requirements and criteria.

#### KEY ELEMENTS OF A SECTION 1115 WAIVER

**Section 1115 waiver authority is provided for “experimental, pilot, or demonstration projects,” which are “likely to assist in promoting the objectives of” the program.** Section 1115 provides the Secretary of HHS authority to:

- Waive compliance with certain federal Medicaid requirements; and
- Provide federal matching funds for costs that would not otherwise be included as Medicaid expenditures.

**Section 1115 waivers are required to be budget neutral for the federal government.**

- Federal spending under a state’s waiver must not be more than projected federal spending would have been for the state without the waiver.
- Budget neutrality is enforced through a cap on federal matching funds over the life of the waiver.

**Waivers are approved through a series of negotiations between a state and HHS.**

- The approval process officially begins when a state submits a waiver application to CMS, which is subject to state and federal public notice and comment requirements.
- If a waiver is approved, CMS issues an award letter to the state along with attachments listing the specific sections of the SSA and applicable regulations that are being waived or modified and the types of expenditures allowed as well as the “terms and conditions” of approval.
- Waivers are typically approved for a five-year period and can be extended, typically for three years.

#### ***Section 1115 Waiver Financing***

Although not required by statute or regulation, under longstanding administrative policy, Section 1115 waivers have been required to be budget neutral to the federal government. This means that federal spending under a state’s waiver must not be more than projected federal spending would have been for that state without the waiver. The federal government enforces budget neutrality by establishing a cap on federal matching funds over the life of a waiver, placing the state at risk for all waiver costs that exceed the cap. To date, most Section 1115 waivers have utilized a per capita cap for groups covered under the waiver, which puts the state at risk for higher than anticipated per person costs but not higher than expected enrollment.

Section 1115 waivers do not change the federal Medicaid matching payment structure. A state must pay its share of costs for services and populations allowable under the waiver, as determined by the Medicaid matching rate formula in federal law. The federal government then matches the state's expenditures up to the established budget neutrality cap.

### ***Section 1115 Waiver Approval Process***

Waivers are subject to approval by the Secretary. The process of seeking a Section 1115 waiver officially begins when a state submits an application to the CMS, although states generally discuss waiver ideas with CMS or submit concept papers before submitting an official application. CMS staff reviews the waiver application often also with involvement of staff of other HHS agencies and OMB. Significant negotiation about aspects of the waiver may take place between the state and HHS over the course of the waiver approval process, including the waiver's financing and budget neutrality limit. OMB typically plays a key role in the negotiations related to financing and budget neutrality.

If a waiver is approved, CMS issues an award letter to the state, along with attachments listing the specific sections of the SSA and applicable regulations that are being waived or modified and the types of expenditures allowed as well as the "terms and conditions" of approval. The length of time associated with obtaining a final waiver approval varies widely and is affected by a number of factors including the scope and complexity of the waiver as well as the extent to which a state engages in discussions with CMS prior to submitting an official waiver application. There is also variation across states in the role of state legislatures in the waiver approval process, with some states requiring authorizing legislation for waivers and others having little or no involvement of the state legislature.<sup>4</sup>

Section 1115 waivers generally are approved for an initial five-year period, although some recent waivers have been approved for shorter periods of time because they will transition to the Medicaid expansion in 2014. At the end of the initial approval period, a state must obtain an extension to continue waiver operations. Waiver extensions are typically for a three-year period. Some waivers have been extended repeatedly, allowing them to remain in place for many years.

If a state wants to make changes to its waiver program outside of what is specified as allowed under its waiver terms and conditions, it must obtain approval for a waiver amendment from CMS. A state can seek a waiver amendment in the middle of their waiver approval period. A state can also seek an amendment to its waiver at the time it applies to extend a waiver.

In the past, concern has been expressed about the lack of public input and transparency in the Section 1115 waiver approval process at both the state and federal level. As a result, the ACA required HHS to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver process. Effective April 27, 2012, these regulations establish a state and federal public notice and comment process for Section 1115 waiver applications and extensions as well as reporting, compliance, and evaluation requirements for operating waivers.<sup>5</sup> The regulations apply to all new Section 1115 Medicaid and CHIP waiver proposals as well as extensions of existing waivers. CMS also is aligning the process requirements with Section 1115A waivers authorized by CMMI for dually

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<sup>4</sup> National Health Law Program and National Association of Community Health Centers, "Role of State Law in Limiting Medicaid Changes," April 13, 2006.

<sup>5</sup> Alker, J. and S. Artiga, "The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers," Kaiser Commission on Medicaid and the Uninsured, March 2012.

eligible beneficiaries.<sup>6</sup> The regulations do not apply to amendments to existing Section 1115 waivers or Section 1915 waivers.

Although the regulations do not apply to waiver amendments, in guidance, CMS has encouraged states to comply with the state public notice and comment process for waiver amendment requests. In addition, effective April 27, 2012, CMS will provide an opportunity for public comment on waiver amendments at the federal level by posting all amendment requests on its website and accepting comments. CMS plans to issue further guidance on how the notice and comment provisions would best be applied at the state and federal levels to waiver amendments.<sup>7</sup>

## PREVIOUS SECTION 1115 WAIVER ACTIVITY

Over the years, Section 1115 waivers have provided important opportunities for states to test new coverage approaches in Medicaid, but they have also raised important issues related to impacts on beneficiaries and providers and the balance between federal standards and state flexibility. Several key themes in waiver activity emerged during the 1990s and through the early 2000s.

**Expansions to adults and mandatory managed care.** In the mid-1990s through the early part of 2000, most waivers focused on expanding coverage, often to low-income adults without dependent children who were largely excluded from Medicaid under federal rules prior to the ACA, and implementing broader managed care systems than were permitted under federal Medicaid law. Supported by a flush economy, states used savings from mandatory managed care or redirected Disproportionate Share Hospital funds to help finance expanded coverage. These waivers provided important experience and lessons about the impact of managed care on Medicaid beneficiaries, paving the way for changes in the Balanced Budget Act of 1997 that provided a new state plan option to implement managed care arrangements without a waiver, subject to a framework of federal standards and requirements.

**Health Insurance Flexibility and Accountability waiver initiative.** In 2001, the Bush Administration released a new Health Insurance Flexibility and Accountability (HIFA) waiver initiative, which promoted a streamlined approval process for states using waivers to expand coverage within “current-level” resources and offered states increased flexibility to reduce benefits and charge cost sharing to help finance the expansions. 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.<sup>8</sup>

**Restructuring with a focus on cost control.** Several years later, a few waivers emerged that restructured Medicaid financing as well as other key elements of the program. These waivers stemmed from continued federal emphasis on and interest among some states in controlling and increasing the predictability of program costs as well as broader ideas about reshaping Medicaid coverage to promote personal responsibility and reflect private market trends. Increasingly focused on cost control and

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<sup>6</sup> CMS Fact Sheet, “Improved Review and Approval Process for Section 1115 Medicaid Demonstration Projects,” February 22, 2012, <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4284>.

<sup>7</sup> Centers for Medicare and Medicaid Services, “Revised Review and Approval Process for Section 1115 Demonstrations,” SHO# 12-001, April 27, 2012.

<sup>8</sup> Artiga, S. and C. Mann, “New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity,” Kaiser Commission on Medicaid and the Uninsured, March 2005.

restructuring, some waivers led to losses of coverage and/or created new challenges for beneficiaries.<sup>9</sup> However, during the same period, Massachusetts obtained a waiver that enabled it to preserve a key stream of federal financing and supported its broad universal coverage effort without significantly restructuring its Medicaid program.

## **RECENT SECTION 1115 MEDICAID WAIVER ACTIVITY**

Following a relative lull in new Section 1115 waiver activity between 2009 and early 2010, when the Obama Administration first entered office and the focus shifted to health reform, there has been a recent resurgence in Section 1115 waiver activity. While the Administration has not promoted any specific Section 1115 waiver initiatives, a growing number of states have developed new waivers and waiver proposals, reflecting both new opportunities and priorities established by the ACA and continued state focus on limiting costs due to ongoing state budget pressures.

The waivers and waiver proposals vary in their specific goals and approaches, but some key themes are apparent. Following is a summary of these themes based on an analysis of Section 1115 waiver decisions and submitted waiver proposals between January 2010 and April 2012. The analysis focuses on key themes and is not an exhaustive review of all Section 1115 waiver activity over this period. It is notable that many new waiver programs and proposals include changes reflective of several of the key themes identified here (see Appendix A), and, as such, entail significant and broad Medicaid restructuring in these states.

### ***Coverage Expansions and Enrollment Simplifications to Prepare for the 2014 Medicaid Expansion***

#### **Some states are using Section 1115 waivers to get an early start on the 2014 Medicaid expansion.**

Prior to the ACA, states could not receive federal Medicaid matching funds to cover non-disabled adults without dependent children, regardless of their income, unless they received a Section 1115 waiver. Moreover, because of budget neutrality requirements, if a state obtained a Section 1115 waiver to expand eligibility to these adults, it could not receive additional federal Medicaid funds for this coverage. Instead, the state had to finance the new coverage by redirecting existing Medicaid funds or from program savings from other sources.

Under the ACA, beginning in 2014, Medicaid eligibility will expand to a national floor of 133% of the federal poverty level (FPL) for nearly all individuals (\$30,657 for a family of four in 2012). The ACA also provided states an option, effective April 2010, to get an early start on this expansion and receive federal Medicaid matching funds to cover adults with incomes up to 133% FPL. In addition, subject to federal approval, states may still expand coverage to adults through a Section 1115 waiver and are no longer restricted from receiving additional federal funds to finance the expanded coverage.<sup>10</sup>

Since the enactment of the ACA, seven states (CA, CO, DC, MN, MO, NJ, and WA) have obtained Section 1115 waivers to expand Medicaid to adults in preparation for the 2014 coverage expansion. Nearly all of these states previously covered some low-income adults through solely state- or county-funded

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<sup>9</sup> 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.

<sup>10</sup> Under longstanding policy, waiver expansions that cover groups that could be covered under Medicaid without a waiver are considered "pass throughs." States do not have to find offsetting savings to cover such groups, but their waiver payments still are brought under the budget neutrality cap.

programs. By moving this coverage to Medicaid and securing federal financing, the states were able to preserve and, in some cases, expand and strengthen coverage for low-income adults. In addition, they are gaining key experience reaching, enrolling, and providing care to low-income adults that will help inform their and other states' outreach and enrollment efforts for 2014.

These states are implementing their expansions through Section 1115 waiver authority rather than through the new ACA state plan option because they are expanding in ways that do not meet the federal rules for the new option, for example, by providing coverage to adults above 133% FPL (CA, DC, MN), implementing the expansion on a county rather than statewide basis (CA, MO), providing more limited benefits and/or charging higher cost sharing than otherwise allowed (CA, MN), and/or limiting enrollment of eligible individuals (CA, CO, MN, NJ, WA). Several other states (AR, IL, and OH) have pending waiver proposals for similar expansions.

**States have also recently obtained waiver authority to simplify enrollment and renewal processes.**

Many states are using existing state plan options that do not require a waiver to streamline their Medicaid and CHIP eligibility and enrollment processes in order to gain efficiencies and reduce burdens on families and administrative staff.<sup>11</sup> These changes also lay the groundwork for 2014, when states will provide new streamlined and technology-driven enrollment and renewal processes for Medicaid, CHIP, and other insurance affordability programs.

To date, many of these simplifications have focused on children, in part, reflecting greater flexibility under federal rules to simplify processes for children relative to their parents and other adults covered by Medicaid. However, two states recently obtained Section 1115 waiver authority to apply simplifications that are only available to children under current federal rules to some adults. Specifically, Massachusetts received waiver approval to renew Medicaid coverage for parents using express lane eligibility (ELE). ELE allows a state to conduct Medicaid enrollments or renewals using eligibility information from other public programs or the state tax or revenue department, eliminating the need for families to provide the same information to multiple agencies. In addition, New York received waiver approval to provide 12-months continuous eligibility to parents, pregnant women, and certain other adults in Medicaid. Continuous eligibility enables individuals to maintain coverage for a 12-month period regardless of fluctuations in their income, helping to reduce churning into and out of coverage and promoting more reliable access to care.

Moreover, in the preamble to the release of the final regulations to implement the ACA provisions related to Medicaid eligibility and enrollment, CMS identified ELE and 12-month continuous eligibility for adults as enrollment simplifications that states could pursue under Section 1115 authority.<sup>12</sup> CMS also indicated a willingness to work with states on developing waivers that would allow them to apply new

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<sup>11</sup> Heberlein, M., et al., "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012," Kaiser Commission on Medicaid and the Uninsured, January 2012.

<sup>12</sup> ELE authority for children extends through the timeframe that CHIP has been reauthorized, until September 30, 2013. The preamble indicates that the ACA does not provide authority to extend ELE to adults or beyond the sunset date of September 30, 2013, but that states may be able to develop similar processes through a Section 1115 waiver. "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 (Final rule; Interim final rule)." 77 Fed. Reg. 17157, 17171 (March 23, 2012) .

income determination methods that will be implemented for most Medicaid enrollees in 2014 to groups that are otherwise excluded from the new methods.<sup>13</sup>

### ***Eligibility and Enrollment Restrictions***

**Current federal rules require states to maintain eligibility levels and enrollment processes that were in place at the time the ACA was enacted, until 2014 for adults and until 2019 for children.** This requirement is designed to preserve the base of coverage upon which the coverage expansions in the ACA will build. There is a limited exception to this requirement that allows a state to eliminate coverage for parents and other non-disabled adults with incomes above 133% FPL if the state is facing a documented budget deficit. In addition, a state is not required to extend coverage provided through an existing waiver when the waiver expires. Because of this requirement, a state would need a waiver to roll back eligibility or enrollment or renewal policies outside of restricting coverage under the budget deficit exception or when a waiver expires.

**Four states received approval to implement eligibility restrictions when their waivers expired or under the budget deficit exception for adults with incomes above 133% FPL.** When Arizona's previous Section 1115 waiver program expired (and it negotiated a new waiver), the state ended its Medically Needy program and closed enrollment for adults who were solely covered under waiver authority. In addition, Nevada eliminated coverage for a small number of pregnant women and parents when its waiver expired. Further, Hawaii received approval to eliminate coverage for adults above 133% FPL covered through its waiver program, and Wisconsin received approval to implement eligibility and enrollment restrictions for adults above 133% FPL covered under its waiver since these adults could otherwise have their coverage eliminated. These restrictions include denying Medicaid eligibility for some adults who have access to "affordable" employer sponsored insurance, increasing premiums, and extending the lock-out period from six to twelve months for adults who lose coverage due to unpaid premiums.

**Other proposed eligibility and enrollment restrictions have not been approved, and the Secretary of HHS has indicated that she will not waive the requirement to maintain eligibility and enrollment.**<sup>14</sup> As part of negotiations for its new waiver, Arizona also proposed closing enrollment to some poor parents, further reducing enrollment for childless adults, eliminating Emergency Medicaid coverage for non-citizens, and moving from a 12-month to a 6-month renewal period for parents and childless adults. These proposed changes were not allowed as part of the new waiver approval. In addition, Wisconsin sought to apply its eligibility and enrollment restrictions to additional populations beyond adults with incomes over 133% FPL, including children, but CMS indicated that it would only approve changes for the adults over 133% FPL whose coverage could be eliminated under the budget deficit exception.

### ***Premium and Cost Sharing Increases***

**States also have been seeking Section 1115 waiver authority to charge higher premiums and cost sharing.** These changes are being pursued with goals of both reducing program costs and increasing "personal responsibility" among enrollees. Under federal rules, states may impose some premiums and

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<sup>13</sup> "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 (Final rule; Interim final rule)." 77 Fed. Reg. 17150-51 (March 23, 2012) .

<sup>14</sup> "Sebelius: HHS will not waive maintenance of effort requirements for any state," Wisconsin Health News, April 12, 2012, <http://wisconsinhealthnews.com/topstories/sebelius-hhs-will-not-waive-maintenance-of-effort-requirements-for-any-state>.

cost-sharing on specified populations. However, the amounts states are permitted to charge and the groups whom they may charge are limited to help assure individuals' ability to access needed care. Further, under the current requirement to maintain eligibility and enrollment policies, states generally cannot increase premiums above the levels that were in place at the time the ACA was enacted. States do, however, have the option to increase cost-sharing up to the federally allowable amounts without a waiver.

**In the past, some states have obtained Section 1115 waiver authority to charge premiums and cost sharing in ways not otherwise allowed under federal rules, but the Secretary's authority to approve higher cost-sharing under Section 1115 has been the subject of recent litigation.** Specifically, the August 2011 Ninth Circuit Court of Appeals decision in *Newton-Nations et al. v. Bethlach and Sebelius*, reversed the HHS Secretary's 2003 decision to allow Arizona to charge higher copayments for certain groups under its Section 1115 waiver. Moreover, in its analysis, the court asserted that the Secretary must determine that a cost-sharing proposal under a Section 1115 waiver has value as a demonstration, experimental, or pilot project and that a simple benefits cut that may save money but has no research or experimental goal is not sufficient. The court also determined that Section 1115 obligates the Secretary to evaluate the potential impact of the cost sharing proposal on enrollees. Finally, the court questioned whether Arizona's project could have experimental, pilot, or demonstration value given the longstanding and significant body of research that has consistently concluded that copayments cause low-income people to forego medically necessary care.<sup>15</sup>

**Since the court ruling, there have been several Section 1115 waiver decisions related to premium and cost-sharing increases.** The new Arizona waiver approved in 2011 allows the state to charge some higher cost sharing for adults, but the waiver approval noted that the cost sharing was necessary to prevent the state from implementing other actions such as reducing coverage for the population. Moreover, several hypotheses related to the impact of the copayments were identified that will be tested as part of the waiver.<sup>16</sup> In addition, as noted, Wisconsin received approval to increase premiums for some adults with incomes above 133% of poverty who could otherwise have their coverage eliminated.

Other Section 1115 waiver proposals to charge higher premiums and cost sharing than otherwise allowed under federal rules have not been approved, including cost sharing increases for children, pregnant women, and parents that were included in the Arizona waiver proposal, a waiver amendment request from California to charge copayments for the vast majority of Medicaid beneficiaries, and a proposal from Florida to charge a \$10 monthly premium and a \$100 copayment for non-emergent use of the emergency room for most Medicaid beneficiaries. In addition, CMS officials indicated to Utah that it would not approve higher cost sharing amounts included in a broad Section 1115 waiver proposal.<sup>17</sup>

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<sup>15</sup> National Health Law Program, "Q&A: Limiting the Cost Sharing in Medicaid-Funded Programs," October 2011.

<sup>16</sup> These include: how utilization of needed preventive, primary care, and treatment services will be affected; to what extent the imposition of pharmacy copayments and copayments related to non-emergent use of emergency rooms ensure appropriate utilization of emergency room care and appropriate utilization of cost and clinically effective generic and brand name drugs; whether the mandatory copayments affect per capita state and federal expenditures in the short and long-term; and whether there is any impact on physician participation or physician willingness to accept appointments.

<sup>17</sup> Utah's waiver proposal is no longer active; however, the state is now pursuing other changes originally proposed in the waiver through other authorities.

In denying these proposals, CMS indicated that the proposed premium and cost sharing amounts were not consistent with federal premium and cost sharing rules. Moreover, CMS noted that to impose higher cost sharing than otherwise allowed a state would need to meet the separate cost sharing waiver requirements under Section 1916(f). As noted, under Section 1916(f), a state may seek a demonstration waiver to charge cost sharing above allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years. However, to date, states have not pursued these waivers.

### ***Payment and Delivery System Restructuring***

**Over the past several decades, states have increasingly utilized managed care models in Medicaid through a combination of state plan options, Section 1115 waivers, and Section 1915 waivers.** Use of managed care has largely focused on low-income families and children and certain services, such as mental health or long-term services and supports, have often been carved out of managed care and provided on a fee-for-service basis, or, in some cases, through a separate managed long-term care arrangement.<sup>18</sup>

**A number of states are now seeking to expand managed care to high-need populations and to move additional services into managed care plans under Section 1115 waiver authority.** For example, under approved Section 1115 waivers, California and Texas are both expanding managed care to elderly and disabled enrollees. In addition, Delaware and New York obtained waiver amendments to require some previously exempt high-need individuals to enroll in managed care. Further, Florida, Kansas, New Jersey, New Mexico, and Oregon all have waiver proposals that would move elderly and disabled enrollees into managed care. In addition the approved amendment in Delaware and several other pending waiver proposals (KS, NJ, NY, NM, and OR) expand managed care to more services, including long-term services and supports. States are pursuing these changes with goals of improving the coordination and integration of care and achieving cost savings. However, the extent to which these goals will be achieved remains to be seen. To date, there is very limited evidence of savings and states have very limited experience with managed care for people with disabilities and managed long-term services and supports.<sup>19</sup>

**States are also utilizing Section 1115 waiver authority to support safety-net delivery system improvements.** Approved waiver initiatives in California, Texas, Massachusetts, and Florida make federal matching funds available for safety-net pools that will be used to cover both uncompensated care costs and hospital delivery system improvement initiatives. These improvement initiatives include infrastructure development, new care delivery models (e.g., medical homes, chronic disease management), and quality improvement projects. New Mexico also has proposed a similar initiative in its pending waiver application.

**In addition, states are seeking other restructuring of payment and delivery systems focused on coordinating care and changing financial incentives for plans and providers.** A number of pending waiver proposals include a focus on connecting individuals to a medical or health home and providing

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<sup>18</sup> Gifford, K., et al., “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,” Kaiser Commission on Medicaid and the Uninsured, September 2011.

<sup>19</sup> Connolly, J. and J. Paradise, “People with Disabilities and Medicaid Managed Care: Key Issues to Consider,” Kaiser Commission on Medicaid and the Uninsured, February 2012 and Summer, L. “Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider,” October 2011.

case management and care coordination services, particularly for high need populations (AZ, NJ, NV, NM, and OR). In addition, several proposed waivers seek to establish coordinated sets of providers and make them accountable for care and outcomes of enrollees (NJ, NV, and OR) and to change payments and/or create financial incentives for providers and plans to focus on episodes of care or outcomes (KS, NJ, NM, and OR). Many of these states are concurrently pursuing related initiatives through state plan options that do not require waiver authority, such as the new “health homes” option, and/or through the new duals integration initiative through the CMMI under Section 1115A authority.<sup>20</sup>

**Many of the managed care expansions and payment and delivery system changes include a focus on individuals who are dually eligible for both Medicaid and Medicare.** The approved managed care expansion in Delaware and Texas as well as proposals in several other states (FL, KS, NJ) would newly require dual eligibles to enroll in managed care plans. In addition, many of the other proposed delivery and payment system changes would include dual eligibles. As such there will likely be significant interactions between these Section 1115 waivers and the developing duals integration projects under Section 1115A authority through CMMI.

## IMPLICATIONS

These key themes in recent waiver activity have a number of important implications, including the following:

**Some states are using Section 1115 waiver authority to lay important groundwork for reform.** Several states are utilizing Section 1115 waiver authority to get a jump start on enrolling low-income adults into Medicaid prior to the broad Medicaid and exchange coverage expansions in 2014. These early Medicaid expansions have helped these states preserve and strengthen coverage options for low-income adults today and provide the opportunity to learn key lessons about reaching, enrolling, and providing care to low-income adults that will help inform these and other states’ efforts to implement the broad Medicaid expansion in 2014. Moreover, as noted, several states are implementing waiver initiatives to support safety-net delivery system improvements that include capacity building, infrastructure developments, and a focus on quality improvement. These initiatives will likely help prepare these delivery systems for the increased demand for care when coverage expands in 2014.

**Given the focus on high-need Medicaid enrollees in recent Section 1115 waivers, it will be important to closely monitor impacts on their access to and quality of care.** As noted, many recent waivers and waiver proposals seek to shift elderly and disabled individuals into managed care arrangements, as well as move more services, including long-term services and supports, into managed care contracts. Moreover, other payment and delivery changes proposed in many waivers would impact these groups. Given the significant health care needs of these individuals and states’ limited experiences covering these populations and services through managed care, it will be important to closely monitor the effects of these changes on their care, including the adequacy of their provider networks and their ability to access to necessary services, including home and community-based long-term services and supports. To ensure these individuals have appropriate access to the wide array of specialists and services necessary to meet their diverse needs, it will be important for states to establish capitation rates that are sufficient to enable plans to recruit the necessary provider networks. In addition, special outreach and assistance

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<sup>20</sup> Musumeci, MB.; Connolly, J.; Howard, J. and G. Jacobson, “Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS,” Kaiser Commission on Medicaid and the Uninsured, August 2011

will be necessary to ensure that beneficiaries understand managed care, select a plan well-suited to their needs, and can effectively access needed services.

Early experience from California's enrollment of seniors and people with disabilities into managed care points to some potential challenges in these areas. For example, between June 2011 and February 2012, about 60 percent of enrollees were automatically enrolled in a plan rather than affirmatively choosing a plan.<sup>21</sup> Moreover, although individuals can continue to receive services from out-of-network providers for 12 months, there have been reports of beneficiaries having difficulty accessing this care, even with assistance, which has led to significant disruptions in their care.<sup>22</sup>

**Many recent Section 1115 waivers and waiver proposals shift risks and responsibilities from the state to plans and providers, increasing the importance of strong state oversight and beneficiary protections.** The focus on moving more enrollees and services to managed care and changing delivery and payment arrangements, particularly for high-need individuals, shifts more risks and responsibilities to plans and providers. Accordingly it will be increasingly important for states to provide strong oversight of plans and providers. Core components of effective oversight include explicit contract language about plans' responsibilities, a focus on performance measurement, and mechanisms that provide for ongoing feedback from consumers and providers to help monitor program operations.<sup>23</sup> A key challenge to oversight is that, to date, few standardized access and quality measures tailored to capture the special needs of people with disabilities have been developed or tested. Nor have standard quality measures been developed for long-term services and supports.<sup>24</sup> Moreover, it also will be important for states to establish strong beneficiary protections as well as avenues of recourse that beneficiaries can utilize if they are experiencing problems.<sup>25</sup>

**Particularly as more Section 1115 waivers include high-need and high-cost beneficiaries, the share of Medicaid program enrollees and expenditures under Section 1115 waiver authority could significantly increase.** As a result, a larger share of states' Medicaid programs would be governed by the special terms and conditions and budget neutrality agreements of Section 1115 waivers rather than the statutory rules established by the Congress. An expansion in the role of waivers in the program could increase state program variation and raises important considerations related to the balance of federal standards and state flexibility in the program. Moreover, given the scope and scale of many recent waivers and waiver proposals, it is important to consider whether some aspects of waivers could be implemented through other program authorities, such as state plan options or other waivers, and the implications of making such changes under Section 1115 versus through an alternative authority. For example, the type of authority under which a program change is made can impact the approval process, public notice and input requirements, and beneficiary rights and protections.

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<sup>21</sup> California Department of Health Care Services, "Managed Care Implementation for Seniors and Persons with Disabilities Monitoring Dashboard," May 2012, 1.1 Enrollment Summary, p. 1  
[http://www.dhcs.ca.gov/individuals/Documents/MMCD\\_SPD/ChartsRptsData/SPD\\_Dashboard.pdf](http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf).

<sup>22</sup> Gorn, D., "Clashing View of Transition for Seniors, Disabled," California Healthline, December 12, 2011,  
<http://www.californiahealthline.org/capitol-desk/2011/12/accusations-anger-spill-over-at-hearing.aspx>.

<sup>23</sup> Connolly, J. and J. Paradise, "People with Disabilities and Medicaid Managed Care: Key Issues to Consider," Kaiser Commission on Medicaid and the Uninsured, February 2012.

<sup>24</sup> Summer, L., "Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider," Kaiser Commission on Medicaid and the Uninsured, October 2011.

<sup>25</sup> Musumeci, MB., "A Guide to the Medicaid Appeals Process," Kaiser Commission on Medicaid and the Uninsured, March 2012.

**To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their impacts.** Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated. In the early- to mid-1990s, when an increasing number of states sought waivers, there was some formal evaluation, including several federally-funded multi-state evaluations conducted by independent contractors. However, as the volume of waivers increased and research budgets became more constrained, focus turned away from federally-funded, multi-state waiver evaluations toward state-specific, state-funded evaluations. Looking ahead, evaluations of new waivers will be important for understanding their impacts and the extent to which they achieve their intended goals. Consistent with earlier practices and federal law, recent waivers include requirements for the states to conduct evaluations, but to date, there has been no indication of plans for federally-funded evaluations. Ensuring that evaluations occur and making evaluation findings publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

**States are pursuing significant Medicaid program changes at the same time they are preparing for implementation of reform.** A number of states are seeking Section 1115 waiver authority to implement significant Medicaid program changes, particularly related to delivery of and payment for care. At the same time, many states are also preparing for implementation of health reform, for example, by upgrading Medicaid eligibility and enrollment systems and developing new health insurance exchanges. Both of these sets of changes will require significant administrative time and resources, as well as efforts by key stakeholders related to planning and implementation. While these efforts may often be complementary and mutually reinforcing, states pursuing multiple initiatives simultaneously will likely face the need to balance and coordinate resources across their efforts.

## **Conclusion**

In conclusion, a number of states have recently received new Section 1115 waivers or waiver amendments or have pending waiver proposals. While the specifics of each waiver initiative vary, there are some key themes emerging. Recent Section 1115 waiver decisions indicate the Secretary's willingness to approve early expansion and enrollment simplification initiatives as well as managed care expansions, safety-net delivery system improvement initiatives, and other delivery and payment reforms under Section 1115 authority. In contrast, several recent waiver proposals to reduce costs by restricting eligibility and enrollment and increasing premiums and cost sharing have not been approved.

Waivers can provide states significant flexibility in how they operate their programs and can have a significant impact on program financing. As waiver activity continues, it will be important to monitor the potential impacts on enrollees, particularly high need enrollees who are the focus of many emerging initiatives. In addition, it will be important to consider how the waiver changes affect the state role in administering the Medicaid program and the balance between state flexibility and federal standards.

This brief was prepared by Samantha Artiga of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The author extends thanks to Joan Alker of the Georgetown University Center for Children and Families; Judy Solomon of the Center on Budget and Policy Priorities; and Andy Schneider, consultant to the Commission for their helpful comments.

**Appendix A:**  
**Key Themes in Section 1115 Waiver Decisions and Submitted Waiver Proposals, January 2010-April 2012**

	Early Expansion to Adults	Eligibility and/or Enrollment Restrictions	Premium and/or Cost Sharing Increases	Expansion of Managed Care to:		Pool to Support Safety-Net Delivery System Improvement	Other Delivery and Payment System Restructuring
				High Need Populations	Long-Term Services and Supports		
Arkansas	Proposed						
Arizona		Some Approved Some Denied	Some Approved Some Denied				Proposed
California	Approved		Denied	Approved		Approved	
Colorado	Approved						
District of Columbia	Approved						
Delaware				Approved	Approved		
Florida			Denied	Proposed	*	Approved	
Hawaii		Approved					
Illinois	Proposed**						
Kansas				Proposed	Proposed		Proposed
Massachusetts						Approved	
Minnesota	Approved						
Missouri	Approved**						
Nevada							Proposed
New Jersey	Approved		Proposed	Proposed	Proposed		Proposed
New York				Approved	Proposed		
New Mexico			Proposed	Proposed	Proposed	Proposed	Proposed
Ohio	Proposed**						
Oregon				Proposed	Proposed		Proposed
Texas				Approved		Approved	
Washington	Approved						
Wisconsin		Some Approved Some Denied	Some Approved Some Denied				

\*Florida has proposed to provide long-term services and supports through a managed care arrangement under separate § 1915 waiver authority.

\*\*The proposed and approved expansions in these states are only for adults in certain areas of each state (Cook County in Illinois, St. Louis area in Missouri, and Cuyahoga County in Ohio.)

Note: This list does not include more narrowly focused Section 1115 waivers, such as family planning waivers.

Source: Centers for Medicare and Medicaid Services, "Section 1115 Demonstration List," <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>, accessed May 8, 2012.

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