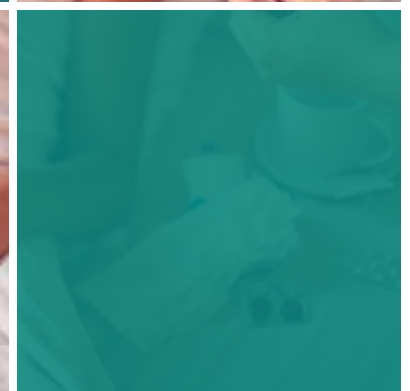
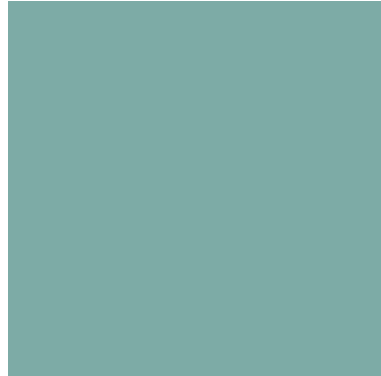




# Understanding Medicaid **Section 1115 Waivers:** **A Primer for State Legislators**

NATIONAL CONFERENCE *of* STATE LEGISLATURES





# Introduction

While the national health care debate continues, states continue to design and improve their Medicaid programs working within the flexibility allowed under existing federal Medicaid law, using longstanding tools such as Section 1115 waivers to best meet their state’s unique needs. This primer is designed to make that job easier by answering the eight most common and consequential questions about Medicaid Section 1115 waivers. In this booklet, we review some of the most important recent and proposed changes. We conclude with information about where to find information about the changing status of waiver applications, and offer resources and tools that can help state policymakers understand and engage in the waiver process.

## Top Eight Questions Regarding Section 1115 Waivers:

- 1. What are Section 1115 waivers? ..... 4
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# Background

Although federal law sets Medicaid minimum standards related to eligible groups and required benefits, states have significant latitude to make decisions about program eligibility, optional benefits, premiums and cost sharing, delivery system and provider payments. This is done either through a state plan and amendment process or through a Medicaid waiver process.

- A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program (and also its Children’s Health Insurance Program in states that administer their CHIP programs through Medicaid).
- A Medicaid waiver is a written approval from the federal government (reviewed and determined by the Centers for Medicare & Medicaid Services) that allows states to differ from the rules of the standard federal program. In other words, the state is allowed a “waiver” from some of the requirements of the federal program. This means that they can test and develop how to deliver services in their state-based program in a way that differs from federal guidelines.

States can make many changes to their Medicaid programs without a federal waiver. They can choose to cover optional benefits, expand eligibility to individuals with higher incomes, require nominal cost sharing, or make certain changes to their program’s delivery system without obtaining a waiver. Beyond this existing flexibility, states can apply for Section 1115 waivers to make certain types of changes to their Medicaid programs that otherwise would not be allowed under law.

For example, states can require enrollees to use a specified provider network, extend coverage to additional populations not defined in law, use healthy behavior incentives to reduce cost-sharing obligations, require some cost-sharing, establish work requirements for certain enrollees, or deliver Medicaid long-term services and supports through capitated managed care.

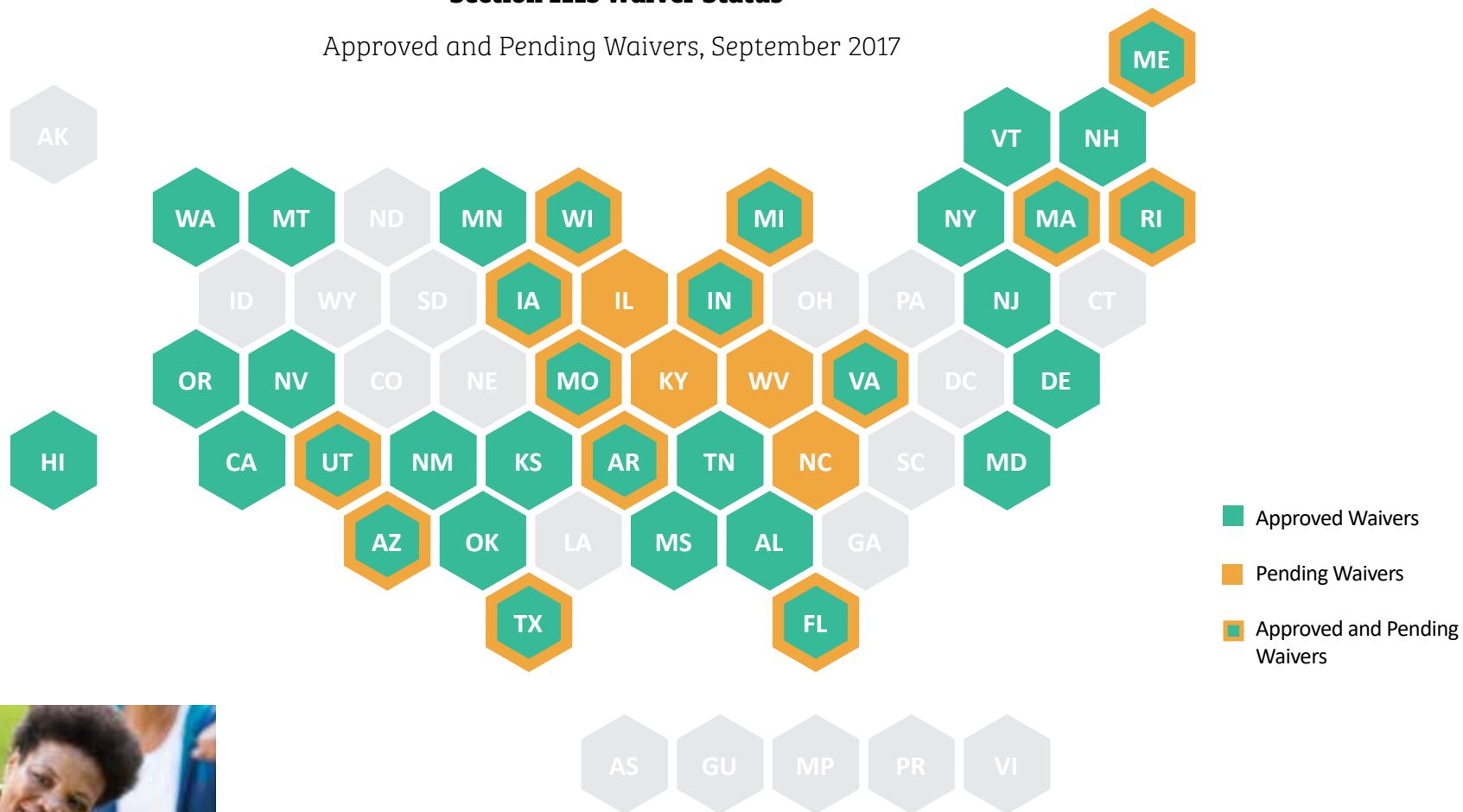
The flexibility and state options create significant variation among states, reflecting how states implement state plan options and use waivers to design programs that meet their needs and priorities. “The extensive use of waivers ... has contributed to wide variations in program design, covered services, and eligible populations among states and even within states,” noted the [Medicaid and CHIP Payment and Access Commission](#).<sup>1</sup> As shown in the map on facing page, use of Section 1115 waivers among states is common. As of September 2017, 33 states had at least one approved 1115 waiver and 18 states had one or more waivers pending approval by the Centers for Medicare & Medicaid Services (CMS), according to a 2017 Kaiser Family Foundation report.<sup>2</sup>

Legislative actions and the status of Section 1115 waivers are often in flux as waivers are approved or amended, or as states modify their approach; as a result, the examples contained in this brief are intended to provide options and approaches at the time of publication. NCSL will continue to update state waiver developments on the [NCSL web site](#).



## Section 1115 Waiver Status

Approved and Pending Waivers, September 2017



Source: Kaiser Family Foundation's State Health Facts.

### More at [ncsl.org](https://www.ncsl.org)

This [map](#) on the NCSL website also provides detailed, state-by-state information on approved and pending 1115 Waivers.

# What are Section 1115 Waivers?

Federal Section 1115 law permits the secretary of the Department of Health and Human Services (HHS) to approve experimental, pilot or demonstration projects that test and evaluate state-specific policy changes in Medicaid and CHIP programs to improve care, increase efficiency and reduce costs without increasing federal Medicaid expenditures. According to CMS, “Section 1115 demonstration projects present an opportunity for states to institute reforms that go beyond just routine medical care, and focus on evidence-based interventions that drive better health outcomes and quality of life improvements.”<sup>3</sup>

Under the waivers, states have considerable flexibility to:

- Expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Provide services not typically covered by Medicaid; and
- Use innovative service delivery systems that improve care, increase efficiency and reduce costs.

Section 1115 waiver authority has been available to states for decades. In the 1960s, Section 1115 was added to the Social Security Act and the Medicaid law was passed, providing a mechanism for states to waive certain federal rules as part of a demonstration project. Waivers vary considerably across states, from broad approaches to narrow ones. Examples of broad approaches include waivers that expand coverage to otherwise ineligible populations, such as people with higher incomes than specified in the law, or that provide benefit packages more

similar to commercial or employer insurance plans. More narrow approaches include waivers that focus on specific populations and services, such as allowing otherwise ineligible adults to access family planning services.

Each waiver application is unique, and states use them for different purposes. As of September 2017, 33 states had at least one approved Section 1115 waiver and 18 states had one or more waivers pending approval by the Centers for Medicare & Medicaid Services, according to a 2017 Kaiser Family Foundation report.

Before passage of the Affordable Care Act, states typically used Section 1115 waivers to expand coverage to childless adults who, prior to the law, were not eligible for coverage under federal rules. The ACA enabled states to cover this population with incomes up to 133 percent of the poverty level without a waiver. As of March 2017, 31 states and the District of Columbia expanded their Medicaid programs under the law’s provisions (see map at right).<sup>4</sup> Seven states—Arizona, Arkansas, Indiana, Iowa, Michigan, Montana and New Hampshire—used a Section 1115 waiver to implement their Medicaid expansions, which allowed them to modify the usual federal requirements, such as charging premiums beyond what is allowed in federal law. Utah was recently granted approval for a targeted expansion through a 1115 waiver process.

## Key Facts: Section 1115 Waivers

Allow states flexibility to design and improve their Medicaid and CHIP programs.

State demonstrations are likely to promote Medicaid program objectives and remain budget neutral to the federal government.

Thirty-three states currently operate at least one Section 1115 waiver.

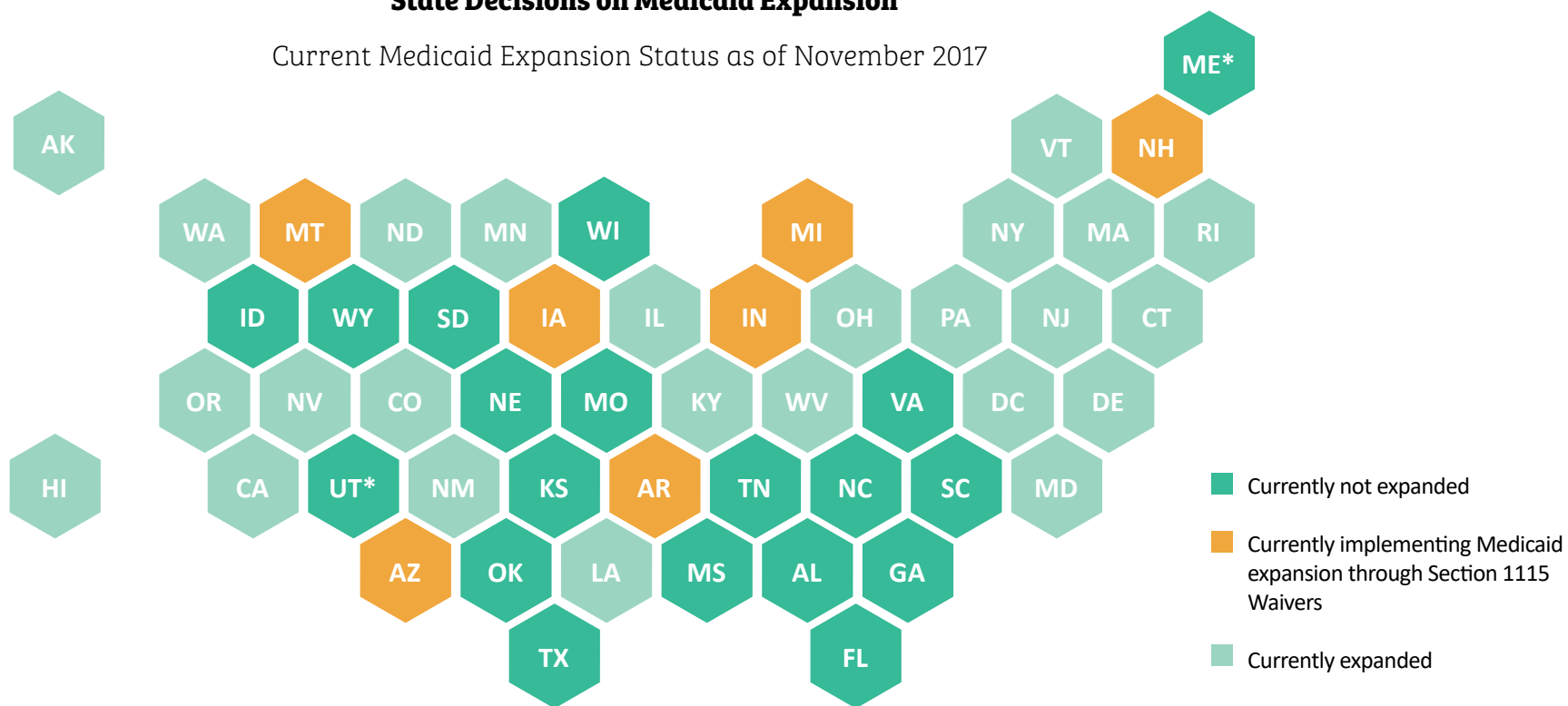
Proposals are subject to evaluation and typically receive approval for a three- to five-year period.

**Arkansas** was the first state to expand Medicaid under the ACA using a private insurance model to non-pregnant enrollees ages 19-64 by means of a waiver.

**Indiana** describes its demonstration as a “consumer-driven health plan,” which seeks to “reduce the number of uninsured, low-income Hoosiers and increase access to health care services; promote value-based decision-making and personal health responsibility; promote disease-prevention and health promotion to achieve better health outcomes; promote private market coverage ... and assure state fiscal responsibility and efficient management of the program.”

## State Decisions on Medicaid Expansion

Current Medicaid Expansion Status as of November 2017



\*In November 2017, Maine voters approved a ballot measure to allow more low-income residents to qualify for Medicaid coverage under the federal law.

\*Utah partially expanded Medicaid to a targeted population in November, 2017.

Source: Kaiser Family Foundation's State Health Facts.

### More at [nctl.org](http://nctl.org)

This [map](#) on the NCSL website also provides overview information on the breakdown of insurance coverage for each state's population. The categories include: percent of the population covered by Medicaid, Medicare, private insurance, and the percent uninsured.

# What is Currently Required for Section 1115 Approval?

The Centers for Medicare & Medicaid Services (CMS) evaluates Section 1115 waiver requests to assure that federal Medicaid expenditures will not exceed what would have occurred without the proposed demonstration, and that waivers will promote the objectives of the Medicaid program. A core objective of the Medicaid program, according to CMS, is “to serve the health and wellness needs of our nation’s vulnerable and low-income individuals and families.”<sup>5</sup> Currently, CMS uses the following criteria to determine whether each state’s proposed waiver meets Medicaid/CHIP objectives and will:

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

States are required to provide matching funds for the care and services available under their state’s Medicaid plan. They rely on a variety of sources to finance Medicaid expenditures, including general funds, intergovernmental transfers (e.g., from public hospitals or local governments), certified public expenditures (CPEs), and permissible taxes and provider donations or state-funded health programs.

Through the waiver process, states typically receive approval for a five-year period, after which they can request a three- or five-year extension. To extend a demonstration, states must show budget neutrality, provide an evaluation report on the factors they tested in the pilot and comply with public notice rules, among other requirements. CMS provides a “fast track” review process for extensions and renewals of certain demonstrations, such as for those that do not propose major changes, and that demonstrate positive evaluation results.<sup>6</sup> According to CMS, the approach “streamlines the extension process for those states with established demonstrations that are working successfully and who are not proposing to make major or complex policy changes to the demonstration.”<sup>7</sup>

Federal resources issued in late 2017 provide [additional guidance](#) about the Section 1115 review and approval process.<sup>8</sup>

- A recent letter from former HHS Secretary Tom Price and CMS Administrator Seema Verma signaled a “new era for the federal and state partnership,” one that grants states “more freedom” and flexibility to design approaches that meet the unique needs of their Medicaid population. According to the [March 2017 letter](#), “States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.”<sup>9</sup>
- In November 2017, CMS issued a letter to state Medicaid directors that outlined a more flexible, streamlined approach to “accelerate states’ ability to respond to the national opioid crisis.” The letter details flexibility for states to implement best practices and improve access to and quality of treatment for enrollees impacted by the opioid crisis.
- In November 2017, CMS issued an informational bulletin that outlined several Section 1115 process improvements, including changes to the review and approval process meant to reduce burden, increase efficiency, and promote transparency in the waiver reviews and approvals. Among the changes, CMS will revise and simplify the application template, work with states to develop an approval timeline, develop parameters for expedited approval of waivers that are similar to those approved in other states, allow states to request approval for certain demonstrations for up to 10 years, and remove the requirement that states have had at least one full extension before using the fast-track review approach.



# How are States Using Section 1115 Waivers Today?

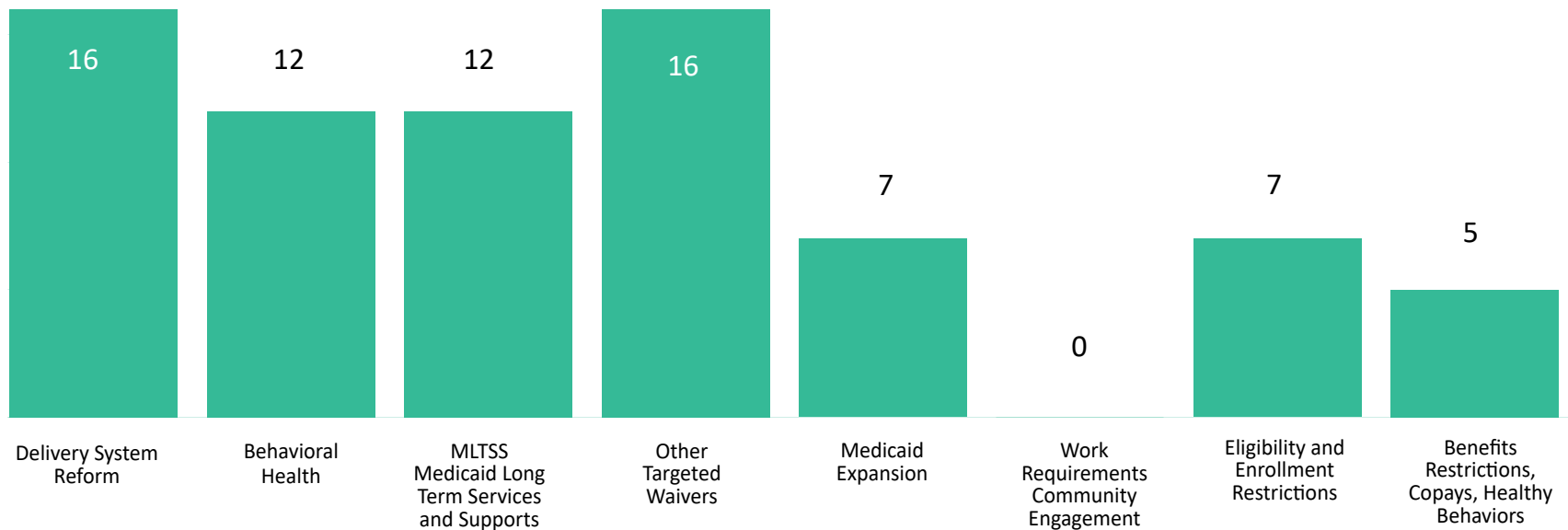
Approved waivers test a wide range of policy approaches, including reforming delivery systems, improving service systems for behavioral health care (which include mental health and substance use disorder services), authorizing mandatory managed care enrollment for Medicaid long-term services and supports, and expanding coverage to otherwise ineligible groups.

Section 1115 waivers vary significantly across states, ranging from comprehensive reforms aimed at improving how health care services are delivered or paid for, to more targeted waivers used to expand coverage for specific population. For example, the Flint, Michigan Section 1115 demonstration enables the state to expand Medicaid coverage to all children up to age 21, and pregnant women with incomes up to 400 percent of the federal poverty level, who are served by the Flint water system until it has been deemed safe. Beneficiaries are not subject to any cost-sharing or premiums, regardless of eligibility group.

As of September 2017, states were using waivers for a variety of purposes, according to an analysis by the Kaiser Family Foundation. As shown below, a dozen or more states designed their waivers to reform their delivery system, expand coverage to targeted groups, integrate behavioral and physical health or otherwise improve behavioral health services, and deliver long-term services and supports through managed care organizations. A smaller number of states used their Section 1115 waiver to implement the ACA Medicaid expansion, restrict eligibility and enrollment, provide incentives (e.g., reduced co-payments) for healthy behaviors, and disincentives (e.g., higher copayments) for non-urgent emergency room visits.

## States with Approved Section 1115 Medicaid Demonstration Waivers, September 2017

Overview of Approved Section 1115 Medicaid Waivers



Source: Kaiser Commission on Medicaid and the Uninsured.

# What are Some Examples of Current Section 1115 Approved Waivers?

STATE	Section 1115 Waiver Summary
AZ	<p>Arizona’s Health Care Cost Containment System Section 1115 waiver provides health care services through a statewide, capitated managed care delivery system for both mandatory and optional Medicaid groups. CMS approved Arizona’s waiver in September 2016 to continue the state’s Medicaid managed care delivery system; integrate physical and behavioral health; cover adult dental benefits to Arizona Long Term Care Services beneficiaries up to \$1,000 annually; and create a new voluntary beneficiary engagement initiative for adults with incomes between 100 percent and 133 percent of the federal poverty guidelines. The initiative tests using incentives to build health literacy, achieve health targets and encourage appropriate care. The Choice Accountability Responsibility Engagement (CARE) account functions like a flexible savings account. Medicaid beneficiaries may be required to pay monthly contributions up to 2 percent of household income and copayment-like charges on a limited set of services, subject to Medicaid’s aggregate cap of 5 percent of household income.</p> <p>In January 2017, CMS approved an amendment to establish the Targeted Investments Program, which provides incentive payments to providers for increasing physical and behavioral health integration and coordination for enrollees with behavioral health needs.</p>
CA	<p>CMS approved California’s Section 1115 Medicaid waiver renewal in 2015, known as Medi-Cal 2020. According to the California Department of Health Care Services, Medi-Cal 2020 “will guide [the state] through the next five years as we work to transform and improve the quality of care, access, and efficiency of health care services for over 13 million Medi-Cal members.” The approval allows California to extend its safety net care pool for five years and support alternative payment methods and better integration of care.</p>

STATE	Section 1115 Waiver Summary
DE	<p>The Delaware Diamond State Health Plan (DSHP) demonstration, initially approved in 1995, enrolls most Medicaid recipients into managed care organizations (MCOs) to create efficiencies in the Medicaid program and expand coverage to certain individuals who would otherwise not be eligible for Medicaid. DSHP expanded eligibility for non-pregnant adults ages 19-64 with incomes up to and including 133 percent of the federal poverty guidelines through its state plan. The Section 1115 waiver allows the state to enroll this group, like most other Medicaid coverage groups, into managed care. The demonstration also provides long-term care services and supports (LTSS) to eligible individuals through a managed care delivery system, called DSHP-Plus. Beginning in 2015, the state implemented Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), a voluntary program that provides enhanced behavioral health services and supports for targeted Medicaid beneficiaries.</p>
FL	<p>Florida’s current Section 1115 demonstration allows the state to operate a capitated Medicaid managed care program. Participating enrollees have access to Healthy Behaviors Programs that provide incentives for healthy behaviors, such as losing weight or quitting tobacco use. The demonstration also establishes a low-income pool to support safety net entities that provide uncompensated care to the Medicaid, uninsured and underinsured populations. The renewal allows the state to continue operating the Managed Medical Assistance program while increasing the Low-Income Pool to \$1.5 billion annually.</p>
IN	<p>Indiana’s consumer-driven health care program for Medicaid-eligible low-income individuals uses Personal Wellness and Responsibility (POWER) accounts to promote the efficient use of health care, encourage preventive care and discourage unnecessary care. The three-year “Healthy Indiana Plan 2.0,” approved by CMS in January 2015, extends coverage to adults in Indiana with incomes up to 133 percent of the federal poverty guidelines. Described as the first consumer-driven health care program for Medicaid-eligible or low-income individuals, the plan was based on and was approved as an amendment to an existing waiver called the Healthy Indiana Plan (HIP).</p> <p>The Indiana Healthy Indiana Plan (HIP) 1.0 demonstration was extended on July 28, 2016, and renamed the “End Stage Renal Disease (ESRD)” demonstration. The ESRD Section 1115 demonstration provides Medicare-enrolled individuals with end stage renal disease, who are otherwise ineligible for Medicaid, with supplemental wrap-around coverage, including supplemental coverage for kidney transplant services.</p>

STATE	Section 1115 Waiver Summary
FLINT, MI	The Flint, Michigan Section 1115 demonstration enables Michigan to expand Medicaid coverage to all pregnant women and children up to age 21 with incomes up to and including 400 percent of the federal poverty guidelines. The coverage is for those who are currently served by the Flint water system or were served by the system between April 2014 and the date on which the Flint water system is determined safe by the appropriate state authorities. Flint beneficiaries will not be subject to any cost-sharing or premiums, regardless of eligibility group.
MT	Montana submitted the Montana Health Economic Livelihood Partnership (HELP) Section 1115 demonstration application in September 2015, which supports the Health Economic Livelihood Partnership (HELP) Act. The demonstration allows the state to charge premiums and copayments to some members of the new adult group with incomes between 50 percent and 133 percent of the federal poverty level. According to a 2016 progress report prepared for a Legislative Finance Committee meeting, Montana was the first state to use a private third-party administrator (Blue Cross and Blue Shield of Montana), which manages and reimburses a provider network, collects premiums and runs a wellness program. According to the same report, the HELP Act “invests in accountability and encourages personal responsibility—requiring enrollees to pay up to 5% of their incomes in out-of-pocket costs and providing them with job search and training opportunities.” The state’s HELP plan offers medical, behavioral health, dental, vision, prescription drug and other benefits. As of October 2017, Montana has a pending amendment that would eliminate the third-party administrator and return the program to fee-for-service.
NV	Nevada’s Comprehensive Care Medicaid Section 1115 demonstration implements mandatory care management services throughout the state for a subset of high-cost, high-need beneficiaries who are not eligible for the state’s existing care management options, including managed care organizations.

STATE	Section 1115 Waiver Summary
UT	In October 2017, CMS approved a five-year extension to Utah’s section 1115 Primary Care Network (PCN) demonstration. The extension will add covered benefits for, and continue providing health coverage to vulnerable populations, some of whom are not eligible for Medicaid under the state plan. The approval authorizes Utah to provide full state plan benefits to “targeted adults,” who are adults without dependent children, ages 19-64, have incomes at zero percent of federal poverty guidelines, and are chronically homeless or involved in the criminal justice system, and in need of substance use or mental health treatment; or only in need of substance use or mental health treatment. The state is also authorized to restore full mental health benefits for currently-eligible individuals (i.e., beneficiaries eligible under the state plan) and cover former foster care youth who were covered by Medicaid in another state.
WV	In October 2017, CMS approved West Virginia’s request for the “Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (SUD) Demonstration.” The demonstration authorizes West Virginia to strengthen its SUD delivery system to improve the care and health outcomes for West Virginia Medicaid beneficiaries with SUD through expanded SUD service coverage and the introduction of new programs to improve the quality of care.

# What do Pending Section 1115 Waiver Applications Propose?

Of the 21 waivers that were pending in September 2017, a dozen would implement behavioral health initiatives, and six or more would change eligibility, enrollment and benefits, or require individuals to verify their employment, job search or job training as a condition of eligibility (see below).

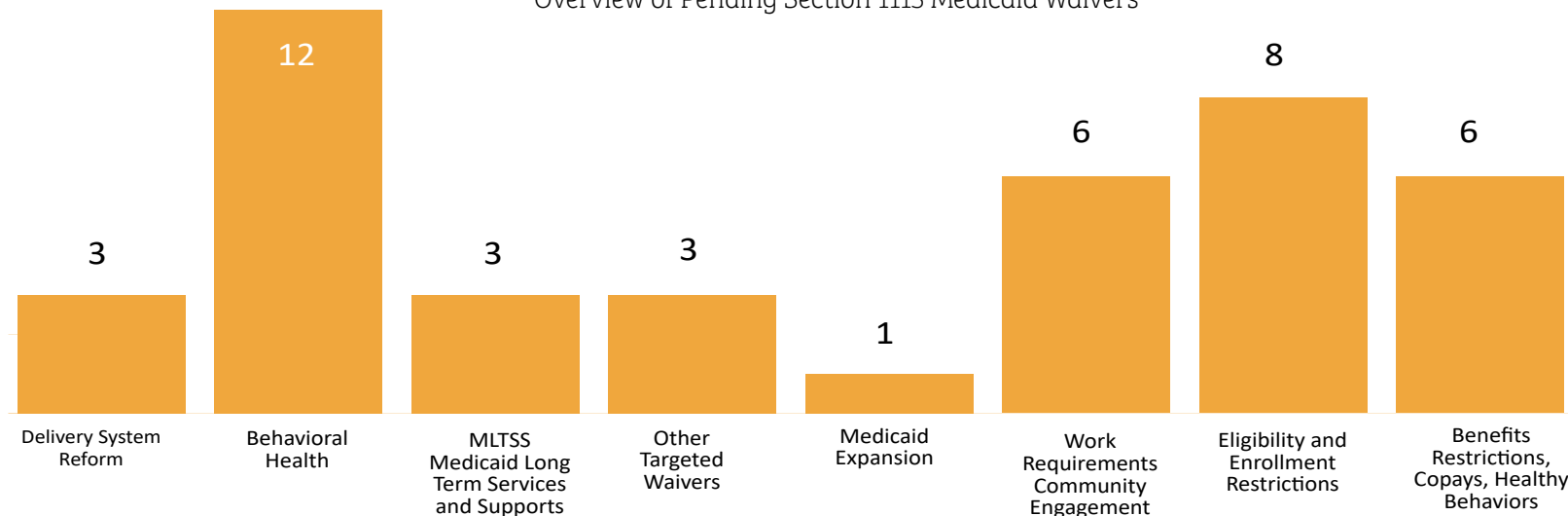
Recent [federal guidance](#) and CMS administrator remarks in November 2017 reinforced such approaches. CMS Administrator Seema Verma outlined the federal agency’s new approach to Section 1115 demonstrations, signaling a “reset” for the federal-state partnership and “more freedom” for states to design innovative programs that meet their needs. Verma further emphasized the agency’s commitment to “considering proposals that would give states more flexibility to engage with their working-age, able-bodied individuals.” She further noted that CMS will openly consider proposals that promote community engagement and work activities.<sup>10</sup>

Reflecting these principles, the CMS website invites states to “propose reforms that build upon the lessons of past demonstrations as well as novel approaches designed to promote Medicaid objectives,” including reforms that:

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

## States with Pending Section 1115 Medicaid Demonstration Waivers, September 2017

Overview of Pending Section 1115 Medicaid Waivers

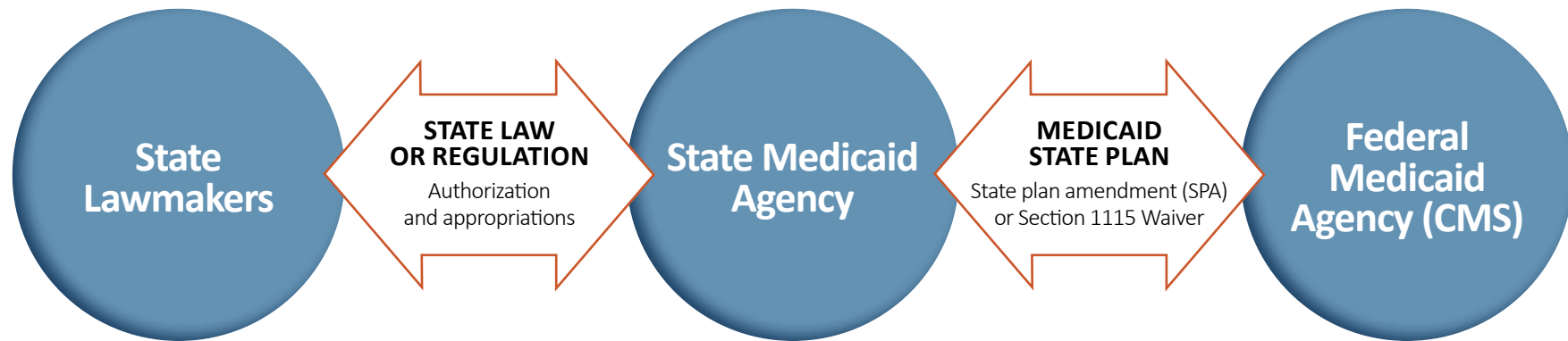


# What Roles do Legislative Policymakers Play in 1115 Waivers?

As a joint state-federal partnership with shared authority and financing, state lawmakers have important roles in funding and overseeing their Medicaid programs—which in 2016 accounted for an average of 17 percent of total state general fund expenditures. Legislative involvement in the Section 1115 process varies across states. According to a 2015 Kaiser Family Foundation brief, “Each state has different rules about which kinds of Medicaid policy changes, if any, can be authorized through changes in regulation (and therefore by agencies at the direction of the governor) or must be made through changes to state law or

statute (and therefore require legislative approval).”<sup>11</sup> States differ on whether legislative action is needed before the state Medicaid agency can submit a Section 1115 waiver request, or whether legislation is needed to change benefits, cost-sharing requirements or other policy changes. Regardless of the differences, state lawmakers are key partners in these decisions and their involvement offers a critical opportunity to influence state investments and priorities.

## The Process for Making Changes to the Medicaid Program Requires State and Federal Partners



*Source: Kaiser Commission on Medicaid and the Uninsured.*

State legislative roles during Medicaid waiver development, implementation and oversight vary. They may include expanding Medicaid coverage, enacting legislation to define 1115 waiver components, defining payment and delivery system reforms, implementing new eligibility rules or incentives, funding Medicaid reforms, and establishing work groups or task forces to study the issues further. The examples that follow are intended to highlight several roles that legislators have played with the Section 1115 waiver process in various

states. It is important to note, however, that the legislative process and the CMS review and approval process are independent of one another. Legislation signals the state’s direction with respect to Section 1115 waivers, but it does not reflect the waiver’s status or likelihood of approval. For example, just because a state passed a law directing the Medicaid agency to submit a waiver request does not guarantee its approval. NCSL will continue to track and update Section 1115 waivers on its web site.

## Expand Medicaid coverage

Although legislative actions vary in the 31 states and the District of Columbia that expanded Medicaid as permitted under the Affordable Care Act without needing a waiver, most states implemented the expansion through the legislative process. Most also expanded the program through a state plan amendment and didn't need a waiver, but seven states—Arizona, Arkansas, Indiana, Iowa, Michigan, Montana and New Hampshire—implemented the expansion in unique ways that did require a Section 1115 waiver. While the expansion waivers differ in these seven states, a 2017 analysis by the Kaiser Family Foundation found that they contain several common features, such as charging premiums beyond what is currently allowed under state plans (six states), implementing a premium assistance model (five states), and using healthy behavior incentives to lower cost-sharing obligations (four states). Following are some examples of state legislation used to facilitate Medicaid expansion waivers.

- Indiana's waiver contained features that were previously not approved in other states, such as prohibiting adults in the expansion population from re-enrolling in coverage for six months for unpaid premiums, or making coverage effective on the date when the premium was paid instead of the application date. Senate Enrolled Act 165 (2016) revised the existing Healthy Indiana Plan and authorized a premium assistance program for certain individuals with incomes up to 133 percent of the federal poverty guidelines and who are eligible for employer coverage, but unable to afford the premiums.
- Montana's waiver implemented premiums and 12 months of continuous eligibility (without reporting changes or income). Adults with incomes above the poverty level can lose coverage if they do not pay premiums on time. Montana Senate Bill 405 (2015) established the Montana Health and Economic Livelihood Partnership Act to expand health care coverage, improve access to services and control health care costs. The legislation implemented Medicaid reforms and established a health care coverage program to provide low-income individuals access to health care services using Medicaid funds.
- Other states, including Maryland and Minnesota, passed laws in 2013 to implement the Medicaid expansion, while New York and New Mexico incorporated the expansion into their budget enactments.

## Enact Section 1115 Waivers

Some states passed legislation to direct the state Medicaid agency to seek CMS approval for a Section 1115 waiver or to enact provisions contained in an approved waiver. Legislation signals the state's direction with respect to Section 1115 waivers,

but it does not reflect the waiver's status or likelihood of federal approval. The status of these waiver applications is updated regularly on the website of the Centers for Medicare and Medicaid Services.

- Arizona Senate Bill 1092 (2015) required the Arizona Health Care Cost Containment System (the state's Medicaid program) to request a waiver or amendment each year to the current 1115 waiver. Approval would allow the state to implement new eligibility requirements, including work requirements and a lifetime eligibility limit, for "able-bodied adults" who receive Medicaid services.
- Florida Chapter 2011-144 directed the Agency for Health Care Administration to obtain approval of federal waivers or state plan amendments needed to implement the Managed Medical Assistance program.

## Define payment and delivery system goals and reforms

Many states use waivers to establish comprehensive payment or delivery system reforms, such as integrating behavioral and physical health or moving to value-based purchasing.

- Alabama Senate Bill 340, enacted in 2013 (Act 2013-261), transitions the state from a fee-for-service to a managed care Medicaid program, which moves Medicaid beneficiaries to managed care regional care organizations.
- The Arkansas Works Act of 2016 created the Arkansas Works program to achieve the following goals: empower individuals to improve their economic security and achieve self-reliance; build on private insurance market competition and value-based purchasing models; strengthen the ability of employers to recruit and retain employees; and achieve comprehensive and innovative health care reforms that reduce state and federal obligations for entitlement spending.
- California Senate Bill No. 815 (Chapter 111) established the Medi-Cal Demonstration Project Act, which runs through Dec. 31, 2020. The law implements several features of California's Medi-Cal 2020 demonstration, including a new pool known as the Public Hospital Redesign and Incentives in Medi-Cal (PRIME), the global payment program for designated public hospitals, the dental transformation initiative and the whole person care program.
- Washington lawmakers passed HB 2572, Chapter 223, Laws of 2014, to enact value-based purchasing reform and promote chronic illness care integration with needed social supports. SB 6312, Chapter 225, Laws of 2014, promotes integrated managed care for Medicaid enrollees.

## Implement new eligibility rules or incentives, such as work requirements or incentives for healthy behaviors

- Arizona lawmakers passed Senate Bill 1092 in 2015 to require the Arizona Health Care Cost Containment System to request a waiver or amendment each year to the current 1115 waiver to allow the state to implement new eligibility requirements for “able-bodied adults” who receive Medicaid services. The legislation requires able-bodied adults—defined as those who are physically capable of working—to verify that they are employed, actively seeking work or attending school or a job training program. It also limits lifetime eligibility to five years, not counting time when an enrollee is the family’s sole provider, is receiving disability benefits, is pregnant, or has other specified conditions.
- Michigan House Bill No. 4714, Michigan Public Act 107 of 2013, directs the Department of Community Health to seek a federal waiver and authorizes the Healthy Michigan Plan. The legislation encourages healthy behaviors and use of preventive services, while discouraging “low-value services,” such as non-urgent emergency room visits.

## Fund Medicaid reforms

States may use legislation to address how Medicaid reforms and changes will be financed through their waivers.

- Massachusetts’ Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care, funds the costs associated with health reform. It accomplishes several goals of the MassHealth demonstration extension, such as improving the fiscal integrity of the MassHealth program, directing more federal and state health care dollars to individuals and less to institutions, and subsidizing private insurance for low-income individuals to reduce the number of uninsured.
- Tennessee Public Chapter No. 364 enacted the Annual Coverage Assessment Act of 2017, which imposes assessments on hospitals to help fund the TennCare Program. Public Chapter No. 1190 of 2008 enacted the Long-Term Care Community Choices Act, which consolidated long-term managed care services for the elderly and people with disabilities who qualify for TennCare.
- Washington lawmakers passed Chapter 36, Laws of 2016, which appropriated funds for Medicaid transformation demonstration waiver initiatives, including supportive housing and employment services.

## Establish a work group or task force

States use working groups to examine Medicaid expansion or other policy changes and make recommendations to the legislature.

- In 2013, Wyoming lawmakers passed House Enrolled Act 119 to create a Health Benefit Exchange Study and Select Committee to study the impacts of a health insurance exchange on the state. In 2014, the Wyoming Department of Health recommended the Strategy for Health, Access, Responsibility, and Employment (SHARE) plan, an alternative Medicaid expansion model that emphasized personal responsibility and employment benefits, such as resume assistance and job training. Lawmakers voted against the expansion plan in 2015.
- The Arkansas Health Reform Act of 2015 established the Arkansas Health Reform Legislative Task Force to recommend an alternative health care coverage model and explore and recommend options to modernize Medicaid programs. The 2016 task force report recommended continuing the Arkansas Works waiver (which uses federal funds to cover adults with incomes up to 138 percent of the federal poverty guidelines), care management and coordination for behavioral health and developmentally disabled populations eligible for Medicaid services, and managed care for dental services.

## Other legislative roles

In addition to passing legislation related to Medicaid waivers, legislators engage with state and federal partners in a wide range of ways during waiver development, implementation and oversight. State legislators play important roles by monitoring and tracking state investments, requiring data collection on key Medicaid measures, identifying opportunities to improve the program, and fostering and building relationships and strategic partnerships.

# What Other Waiver Tools are Available to States?

In addition to Medicaid Section 1115 waivers described in this brief, other waivers provide flexibility for states to design and operate their health insurance markets and Medicaid programs outside of the statutory requirements. The table at right summarizes select waivers permitted under federal Medicaid and Affordable Care Act statutes.

## SECTION 1915(C) WAIVERS

States may submit home- and community-based services (HCBS) waivers to meet the needs of people who want to receive long-term care services and supports in their home or community instead of an institutional setting or long-term care facility. The waiver allows states to meet the needs of a target group by age or population, such as individuals with autism, cerebral palsy or HIV/AIDS. To qualify, a person must demonstrate need for a level of care that would meet the state's requirements for receiving services in an institutional setting.

States can offer a wide range of standard medical and nonmedical services under an HCBS Waiver program. Standard services include case management, homemaker, home health aide, personal care, adult day health services, day and residential assistance and respite care. States may propose "other services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community."

According to the Centers for Medicare & Medicaid Services, state HCBS waiver programs are required to show that providing waiver services will not exceed the costs of providing services in an institution, that there are adequate provider standards to meet the population's needs, and that services follow a person-centered care plan. In 2016, all 50 states and the District of Columbia had at least one program that provided assistance to people living outside of nursing homes, and most states offer more than one program. Currently, more than 300 active HCBS Waiver programs exist nationwide. Additional information about Section 1915 waivers and state examples are available at <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>.

WAIVER TITLE	WAIVER DESCRIPTION
Section 1115 Research and Demonstration Projects	States can apply for program flexibility to waive certain provisions of the federal Medicaid law and test policy innovations that promote Medicaid program objectives. For example, 1115 waivers allow states to provide demonstration populations, such as people with certain diseases or conditions, with different benefits or have different service limitations than are specified in the state's plan.
Section 1915(b) Waiver Programs	States use Section 1915(b) waivers to enroll into managed care delivery systems or to reduce enrollees' choice of providers, as long as such restrictions do not substantially impair access to medically necessary services of adequate quality.
Section 1915(c) Home- and Community-Based Services Waiver Programs	<p>Section 1915(c) waivers allow states to provide long-term services and supports for certain Medicaid populations in home- and community-based settings instead of within institutional settings such as nursing facilities. According to the CMS, all 1915(c) waiver programs:</p> <ul style="list-style-type: none"> <li>• Are authorized under Section 1915(c) of the Social Security Act.</li> <li>• Are fee-for-service programs.</li> <li>• Require individuals to meet criteria that are set by the state and based on their level of need.</li> </ul> <p>States can apply for different Section 1915(c) waiver authority to provide a continuum of services to seniors and people with disabilities, so long as all federal requirements are met.</p>
Combined Section 1915(b)/(c) Waivers	States may apply for different Section 1915(b)/(c) waiver authority to provide home- and community-based services through managed care. These waivers allow states to provide a continuum of services to seniors and people with disabilities, so long as all federal requirements are met.
Combined Section 1332 and 1115 waivers	States may seek multiple waivers from HHS at the same time. Section 1332 of the Affordable Care Act allows states to waive some of the law's requirements and address health systems reform that includes the private health insurance market. States can coordinate Section 1332 waivers and Section 1115 waivers to achieve better alignment across insurance programs and Medicaid related to premium- and cost-sharing, purchasing, and enrollment and eligibility.



## SECTION 1332 INNOVATION WAIVERS

Section 1332 of the Affordable Care Act allows states to waive key private insurance provisions in the marketplace’s qualified health plans provided they retain many of the law’s basic protections. While it is not a Medicaid waiver, states can coordinate Section 1332 and Section 1115 waivers to achieve better alignment across insurance programs related to premium and cost-sharing, purchasing, and enrollment and eligibility. States may seek multiple waivers from HHS at the same time, and may do so by requesting permission to change their Medicaid programs under a Section 1115 waiver and their marketplace coverage under a Section 1332 waiver.

- In December 2016, Hawaii became the first state to receive approval for its waiver application. The approved waiver allows Hawaii to end operation of the Small Business Health Options Program (SHOP) and its requirements for the small business marketplace and instead align the ACA with the Hawaii Prepaid Health Care Act’s requirements for private employers.
- In July 2017, CMS approved Alaska’s Section 1332 state innovation waiver application to fund a state-operated reinsurance program that covers claims in the individual market for people with one or more of 33 high-cost conditions.

Additional information about Section 1332 waivers, including links to approved, pending and withdrawn waivers, is available on the web site of the Centers for Medicare & Medicaid Services, and on NCSL’s [web site](#).

## Key Facts: 1332 Waivers

Allow states to modify key ACA provisions related to private coverage within specific limits.

State legislatures play a key role: They must pass authorizing legislation to implement Section 1332 waiver-based reforms.

Section 1332 allows states to implement approved waivers beginning in January 2017. Alaska, Hawaii, Minnesota and Oregon have received approval as of October 2017, and others have pending applications.

# Where Can I Learn More About Section 1115 Waiver Activities in my Own State and Others?

The Centers for Medicare & Medicaid Services (CMS) maintains a list of all Section 1115 waivers, including pending, approved and previously approved waivers. See some following resources for additional information about Medicaid waivers below.

Topic	Resources
Section 1115 and Other Waivers: Federal Resources and Guidance	<ul style="list-style-type: none"> <li>• About Section 1115 Demonstrations, CMS, 2017</li> <li>• CMCS Informational Bulletin: Section 1115 Demonstration Process Improvements, Nov. 6, 2017</li> <li>• CMCS Informational Bulletin: State Plan Amendment and 1915 Waiver Process Improvements to Improve Transparency and Efficiency and Reduce Burden, Nov. 6, 2017</li> <li>• CMCS Letter to State Medicaid Directors: Strategies to Address the Opioid Epidemic, Nov. 1, 2017</li> <li>• State Waivers List, CMS, 2017</li> <li>• Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program,” Nov. 7, 2017</li> <li>• 1115 Substance Use Disorder Demonstrations, CMS, 2017</li> </ul>
Section 1115 Waivers: NCSL and Other Resources	<ul style="list-style-type: none"> <li>• Actions Toward Health System Change, NCSL, 2017</li> <li>• Health Care Waivers Two Part Series, NCSL, 2016</li> <li>• Key Themes in Section 1115 Medicaid Expansion Waivers, Kaiser Family Foundation, 2017</li> <li>• Medicaid Reform, Innovations, and Waivers, NCSL</li> <li>• Waivers, Medicaid and CHIP Payment Access Commission, Accessed April 2017.</li> <li>• Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers, Kaiser Family Foundation, September 2017</li> </ul>
Other Related Medicaid and Waiver Resources	<ul style="list-style-type: none"> <li>• ACA and Medicaid Expansion, NCSL, 2017</li> <li>• Current Flexibility in Medicaid: An Overview of Federal Standards and State Options, Kaiser Family Foundation, 2017</li> <li>• Health Innovations State Law Database, NCSL, 2017</li> <li>• Medicaid: A Changing Federal/State Partnership, 2017 blog</li> <li>• Medicaid and CHIP: Strengthening Coverage, Improving Health, CMS, January 2017</li> <li>• Medicaid: Key Issues Facing the Program, GAO, 2015</li> <li>• State Roles Using 1332 Waivers, NCSL, 2017</li> </ul>





## Notes

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8. CMS. 1115 Application Process. <https://www.medicaid.gov/medicaid/section-1115-demo/how-states-apply/index.html>
9. Letter to the governors, Secretary Tom Price, March 2017  
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11. "An Overview of Actions Taken by State Lawmakers Regarding the Medicaid Expansion," Kaiser Family Foundation Issue Brief, March, 2015

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UD30A22893, National Organizations for State and Local Officials. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS or the U.S. Government.

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NCSL would like to acknowledge the contribution of Kristine Goodwin to the development of this publication.



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