Waivers

Program Administration

Federal Medicaid law sets broad requirements for the program and mandates coverage of some populations and benefits, while leaving many optional. States, then, make the many operational and policy decisions that determine who is eligible for enrollment, which services are covered, and how payments are set. Each state specifies the nature and scope of its Medicaid program through the state plan, a comprehensive document which must be approved by the Centers for Medicare & Medicaid Services (CMS) for a state to access federal Medicaid funds. The state plans can be amended as needed to reflect changes in state policy and federal law and regulation.

State Medicaid programs must comply with federal requirements, but states seeking additional flexibility can apply for formal waivers of some of these requirements from the Secretary of Health and Human Services (HHS). For example, states can use waivers to offer an alternative benefit plan to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers, or to extend coverage to groups beyond those defined in Medicaid law. The extensive use of waivers—every state now has at least one Medicaid waiver agreement in place—has contributed to wide variations in program design, covered services, and eligible populations among states and even within states.

Types of waivers

Medicaid waivers can be classified broadly as demonstration waivers or program waivers. Demonstration waivers allow a state to test new or existing approaches to program financing and delivery. Historically, they have been time-limited, research-oriented, and subject to evaluation (Dobson et al. 1992). Program waivers, on the other hand, have generally been designed to enable widespread replication of discrete, relatively formulaic program reforms (Andersen 1993-1994). Thus, program waivers are intended to expand the array of defined program options available to a state, rather than to provide an avenue of experimentation with new models.

Under these waiver authorities, states can receive permission to forgo various federal requirements for their Medicaid programs. Most commonly, states seek to waive these statutory principles:

- 1902(a)(10)(B)—Comparability: A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. Waivers of comparability allow states to limit an enhanced benefit package to a targeted group of persons identified as needing it most and to limit the number of participants to implement a demonstration on a smaller scale.
- 1902(a)(23)—Freedom of choice: All beneficiaries must be permitted to choose a health care provider from among any of those participating in Medicaid. Freedom of choice waivers are typically used to allow implementation of managed care programs or better management of service delivery.
- 1902(a)(1)—Statewideness: Statute dictates that a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state. A waiver of "statewideness" can limit the geographic area in which a state is testing a new program, facilitate a phased-in implementation of a program, or reduce state expenditures by limiting eligible participants.

In exchange for the flexibility offered by waivers, states must meet budgetary criteria and provide regular reports and evaluations to CMS to show that the requirements of the waiver are being met. Unlike most state plan options, waivers require lengthy applications and must be renewed periodically.

Section 1115 waivers

Section 1115 is unique among waiver authorities – it combines extensive waiver authority with a broadly defined purpose for which waivers may be granted. Under Section 1115, the HHS Secretary can waive almost any Medicaid state plan requirement under §1902 (with the exception of citizenship and requirements of another agency as in the case of ERISA) to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program. The Secretary can also permit federal financial participation for costs not otherwise matchable, allowing states to cover services and populations not included in the Medicaid state plan. For example, prior to passage of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), states needed an 1115 waiver to receive federal Medicaid funds for extensions of Medicaid eligibility to nondisabled childless adults under age 65.

Section 1115 waivers can be comprehensive, covering the entirety of a state's Medicaid program, or narrow, such as those that allow otherwise non-eligible adults to access family planning services.

Section 1115 predates the enactment of Medicaid as a vehicle for testing new approaches in a variety of federally funded programs and was used infrequently for policy experimentation for many years after enactment. But beginning in 1994, states sought 1115 waivers more frequently to alter eligibility, benefits, and delivery systems. For example, states used 1115 waivers to provide targeted benefits to individuals with HIV/AIDS, mandate enrollment in a specific capitated managed care plan, and enhance cost sharing for certain populations. Today, Section 1115 is primarily used to negotiate flexible program parameters, rather than to create experiments focused on answering specific research questions.

1915(b) waivers

Section 1915(b) of the Social Security Act, enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97-35), provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. States typically use two provisions in the law to implement managed care delivery systems under the following authorities:

- 1915(b)(1)—Primary care case management or specialty service arrangement. This authority allows states to mandate enrollment in a managed care plan or a primary care case management (PCCM) program. Under both models, freedom of choice must be waived to limit the providers through whom enrollees access services.
- 1915(b)(4)—Restriction to specified providers. States may use waivers to limit the number or type of providers who can provide specific Medicaid services—for example, for disease management or transportation. This includes selective contracting by states paying providers on a fee-for-service (FFS) basis. Freedom of choice cannot be restricted for providers of family planning services and supplies.

Because these program designs restrict enrollees' freedom of choice, 1915(b) waivers are often referred to as freedom-of-choice waivers. It is worth nothing that managed care programs can also be implemented under state plan authority.

1915(c) waivers

Enacted in the same 1981 legislation as freedom-of-choice waivers, §1915(c) allows states to obtain waivers of comparability requirements, in order to offer home and community based services (HCBS) to limited groups of enrollees as an alternative to institutional care. These waivers also allow states to cap the number of individuals who can receive HCBS. A few other provisions of the Medicaid statute can be waived, as well. For example, under usual state plan rules, an applicant's family income includes the spouse's income unless the applicant is institutionalized. By waiving §1902(a)(10)(C)(i)(III), states can exclude the spouse's income in order to keep individuals eligible for Medicaid and enrolled in HCBS, without requiring institutionalization.

To be eligible, individuals must meet level-of-care requirements—that they would require institutionalization in the absence of HCBS (§1915(c)(1)). Coverable HCBS, then, are the services needed to avoid institutionalization; these include case management, home health aide and personal care, adult day health, habilitation, and respite care (§1915(c)(4)(B)).

Because a separate 1915(c) waiver is generally required for each eligible population, states typically operate multiple waivers under this authority. States may offer home and community-based services under their state plan but often choose waiver authority instead due to the greater flexibility.

Approval process and requirements

State plan amendments, program waivers including 1915(b) and 1915(c), and 1115 demonstration waivers are all different ways a state can change its Medicaid program. Generally, the more flexibility allowed by a waiver compared to what is required by statute, the more requirements a state faces as a condition that flexibility. This section outlines the approval process and requirements for each of these options. At the end of the section, Table 1 provides a side-by-side comparison of the requirements a state must consider when seeking to modify its Medicaid program.

Process and requirements for state plan amendments. To receive federal Medicaid funds, every state needs a state plan, the comprehensive document that describes the state's Medicaid program, including administrative structure and operations, eligibility, covered benefits, and payment methods. As federal requirements and state policies change over time, states must file state plan amendments (SPAs) to

document ongoing compliance with federal rule and state decisions or to indicate state choices where federal statute and regulation provide options. From an administrative perspective, SPAs offer states the simplest route to make program modifications, but are limited to what is explicitly authorized in statute.

When a state proposes an amendment to its state plan, it sends to CMS the revised page(s) with an official transmittal form (Form CMS-179). Once a state plan amendment (SPAs) is submitted, the Secretary has 90 days to make a decision; otherwise the proposed change automatically goes into effect. However, the Secretary (or CMS, operating under the Secretary's delegated authority) can "stop the clock" by writing to request additional information. Once the state submits the requested information, a new 90-day clock begins; however, CMS may stop the clock only once per SPA (§§1116 and 1915(f)(2), 42 CFR 430.16).

Changes made by SPAs generally do not have to be renewed, although the operations of state Medicaid programs are subject to review (42 CFR 430.32). In contrast to waivers, SPA approvals are not contingent on meeting any budgetary target, but the SPA transmittal form requires entry of the expected federal financial impact. Generally, the only public notice requirements for SPAs apply when states would make significant changes in payment methods and standards (42 CFR 447.205).

Process and requirements for 1115 waivers. Demonstration waivers are by their nature open-ended and subject to a great deal of secretarial discretion, so states seeking 1115 waivers must engage in lengthy negotiation processes with CMS. While the approval process is more flexible for 1115 waivers than state plan amendments—there is no 90-day clock—the negotiation process can take several months or years. This is partly because 1115 waivers can be comprehensive in nature, potentially encompassing the majority of a state's Medicaid spending, whereas SPAs and program waivers typically address a narrow, discrete aspect of a state's program. For such a comprehensive 1115 waiver, each program element must be separately understood, discussed, and negotiated.

1115 waivers are required to be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver. Although not defined by federal statue or regulations, this requirement has been in practice for many years. Over time, CMS has allowed states to calculate budget neutrality in multiple ways.

In addition, 1115 waivers can be used to allow a state to use savings generated by one initiative to pay for other changes, such as eligibility expansions, as long as the waiver as a whole is budget neutral. The calculations of budget neutrality can be controversial. Over the years, for example, the U.S. Government Accountability Office (GAO) has repeatedly questioned HHS approvals of some waivers, finding they "could increase the federal financial liability substantially" (GAO 2012).

The ACA responded to concerns surrounding the closed 1115 waiver approval process and instituted substantial requirements for public process and transparency at both the state and federal level. A state must solicit significant public input by using multiple methods for public notification (like electronic mailing lists and notices in newspapers) and having a 30-day comment period before submitting the proposal to CMS. At the federal level, CMS must post all waiver application-related documents and correspondence on Medicaid.gov, among other requirements (CMS 2012).

Section 1115 waivers are initially approved for five years. They are renewed for up to three years at a time. In the ACA, Congress authorized the Secretary to approve 1115 waivers, as well as 1915(b) and (c) waivers, for five years if they enroll individuals dually eligible for Medicare and Medicaid (§1915(h)(2)). States may choose not to implement an approved waiver, or to implement it only partially.

In exchange for the flexibilities provided under 1115 waivers, states must sponsor periodic evaluations of the waiver's outcomes and provide annual reports on their waiver enrollment and spending.

Process and requirements for 1915 (b) waivers. Because §1915(b) closely outlines the standards for and content of the programs to be implemented under its authority, CMS requires states to use a preprint form in these waiver applications. The application requires states to show that the 1915(b) waiver will be cost effective, meaning that its use will not cause expenditures to be higher than they would have been without the waiver (42 CFR 431.55). To demonstrate cost effectiveness, states trend forward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.

The 90-day clock that applies to SPAs also applies to 1915(b) waivers. 1915(b) waivers are initially approved for two years, with renewals of up to two years. The 2010 provision that initial waiver approvals and renewals can be up to five years when enrolling individuals dually eligible for Medicare and Medicaid also applies.

Process and requirements for 1915(c) waivers. CMS encourages states requesting a 1915(c)waiver to use a preprint application form, but does not require it. 1915(c) waivers have a cost neutrality requirement, meaning that states must provide assurances that the average per capita expenditures for covered HCBS services will not exceed 100 percent of the average per capita expenditures that would have been made for the level of care provided in an institution. If states' aggregate spending exceeds their projections, however, the Secretary cannot limit federal Medicaid payments or deny a waiver renewal, so long as the waiver is still cost neutral on a per capita basis (§1915(c)(6)).

The approval process for 1915(c) waivers has the same 90-day clock as SPAs and 1915(b) waivers. Section 1915(c) waivers are initially approved for three years, with renewals of up to five years. The 2010 provision that initial waiver approvals and renewals can be up to five years when enrolling individuals dually eligible for Medicare and Medicaid also applies.

Table 1: Comparison of Approval Process and Requirements for State Plan Amendments and Various Medicaid Waivers

	Typical State Plan Amendment (SPA)	**§1115**	**§1915(b)**	**§1915(c)**
Format	Use of CMS preprint form required	Use of CMS preprint form recommended	Use of CMS preprint form required	Use of CMS preprint form recommended

	Typical State Plan Amendment (SPA)	§1115	§1915(b)	§1915(c)
Public review	Public notice only required for certain changes in reimbursement	Robust public process required, with additional requirements added by the ACA	Public process encouraged; tribal input required	Public process encouraged; tribal input required
Federal budget requirements	No budget neutrality requirement; SPA must report expected fiscal impact	Budget neutrality required	Cost effectiveness required	Cost neutrality required
Timeframe for Approval	90-day clock	No required timeframe for CMS approval	90-day clock	90-day clock
Monitoring and Evaluation	Not mandated beyond standard Medicaid requirements for CMS to ensure state plan compliance	Annual state reports required; evaluations required	Must monitor access; independent assessment required	Annual state reports required
Approval period	Indefinite	Initially approved for five years	Initially approved for two years (up to five years if dual eligibles are included)	Initially approved for three years (up to five years if dual eligibles are included)

	Typical State Plan Amendment (SPA)	§1115	§1915(b)	§1915(c)
Renewal	Not required	Customarily up to three years (up to five years if dual eligibles are included)	Customarily up to two years (up to five years if dual eligibles are included)	Customarily up to five years

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About MACPAC

The Medicaid and CHIP Payment and Access Commission is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).