SECTION 1115 MEDICAID WAIVERS

Section 1115 of the Social Security Act gives the DHHS Secretary authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid. The purpose of these demonstrations is to demonstrate and evaluate approaches such as:

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

States are required to include the following components in the 1115 application:

- A comprehensive description of the demonstration, including its goals and objectives
- A description of the proposed health care delivery system, eligibility requirements, benefits and cost-sharing requirements for individuals who will be covered under the demonstration
- An estimate of the increase or decrease in annual enrollment and expenditures as a result of the demonstration
- Current enrollment data and projections
- Other program features that would modify the state’s Medicaid program
- The specific waiver and expenditure authorities that the state believes to be necessary to authorize the demonstration
- A research hypothesis and evaluation design related to the demonstration proposal
- Written documentation of the state’s compliance with the public notice requirements
- The populations affected by the demonstration
- The financing of the demonstration
- Budget neutrality for the demonstration

The general criteria CMS uses to review waiver applications are:

- Whether waiver increases/strengthens overall coverage of low-income individuals
- Whether waiver increases access to, stabilizes, and strengthens providers and provider networks
- Whether waiver improves health outcomes
- Whether waiver increases efficiency/quality of care through initiatives to transform service delivery networks
- Whether waiver is budget neutral—during the course of the waiver federal Medicaid expenditures will be no more than federal spending without the waiver—the federal government enforces budget neutrality by establishing a cap on federal funds under the waiver.

Waivers are approved by CMS through a series of negotiations between the state and CMS. That is why talking to CMS early in the process is critical—Alaska wants CMS to buy-in early. As a result, Alaska will be submitting a concept paper by the end of early fall, 2016.

1115 waivers are usually granted for an initial 5-year period of time; the State can request an extension of 3 additional years.

The waiver requires a rigorous evaluation process to be a part of the demonstration from the outset.

There have been several waiver themes\(^1\) that have been observed over the last 35 years:

- Broad expansion coverage waivers, many with managed care systems. States used savings from mandatory managed care to offset expansion costs. mid-1990s-2001. Oregon and Tennessee examples.
- Reform waivers from mid 2000s on—restructuring financing by setting global caps on federal funds and allowing states to shift new authority to private managed care plans. Continued federal emphasis on controlling/increasing predictability of costs, promoting personal responsibility, and reflecting private market trends. Vermont, Florida, Rhode Island examples.
- Focus on cost control/restructuring has, in some cases, led to losses in coverage or created new challenges for beneficiaries. Oregon example. Oregon and Florida examples
- These waivers have limitations as a coverage expansion tool, reflecting that primary purpose is not coverage expansion because of the budget neutrality policy. This is important for Alaska currently, because Alaska has a budget shortfall—AK must carefully examine its ability to obtain savings/redirect existing resources toward new coverage if Alaska choses to expand coverage with an 1115 BH waiver.

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The transparency of waiver approval process has diminished over the years regarding public comment/input.

Specific 1115 Issues for Alaska to consider:

- What specific eligible populations will the demonstration cover?
- Will the demonstration be statewide or first set up on a regional basis?
- What is proposed timeframe for the demonstration?
- What hypotheses will be evaluated? (Remember: it is a research-based waiver)
- What/if any enrollment limits will apply?
- What will the benefit package look like?
- Will there be cost sharing requirements? Exemptions from such?
- What delivery system reforms will be included?
- What is the proposed demonstration’s impact on quality, access, cost, and potential to improve health status of covered populations?
- What delivery system will be used—a managed system of care, fee-for-service, primary care case management, health homes, or other? (The waiver can deploy multiple systems)
- Will enrollment be voluntary or mandatory?

States with approved 1115 waivers with either behavioral health or mental health included:

- Arizona
- California
- Hawaii
- Louisiana
- Montana
- New Mexico
- Texas