

December 8, 2022

# Recent Developments in Section 1115 Demonstration Waivers

*Implications for Future Policy*

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Medicaid and CHIP Payment and Access Commission



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# Overview

- Background
- Section 1115 demonstration waiver authority
- Current Section 1115 waivers
- Demonstration policy development
- Key policy issues



# Section 1115 Demonstration Waiver Authority

- Section 1115 of the Social Security Act provides broad authority for Secretary of HHS to waive federal Medicaid requirements for demonstration projects likely to assist in promoting Medicaid objectives
  - Generally intended to test new approaches
  - Research oriented
  - Requires evaluation
- Section 1115 waivers have been used to make changes to eligibility, benefits, cost sharing, delivery systems, and supplemental payments
- May be used for a state's entire Medicaid program or a small portion

# Section 1115 Waivers

- Demonstration waivers must meet several requirements
  - Budget neutral
  - Public input process before and after application submission
  - Periodic reporting and evaluation
- Waivers can be granted for 5 years and then renewed or amended
- Section 1115 authority can be used to:
  - allow states to use federal funds to cover services and populations that would not otherwise be eligible for federal match, as long as the waiver as a whole is budget neutral
  - allow states to use savings generated by one initiative to pay for other changes (e.g., eligibility expansions), as long as the waiver as a whole is budget neutral

# Current Section 1115 Waivers

- Almost every state has at least one Section 1115 waiver and many have multiple waivers
- Centers for Medicare and Medicaid Services (CMS) has already approved seven comprehensive demonstrations in 2022, with several more applications pending
- Several recent waivers include innovative practices to improve the delivery of Medicaid services and population health and new or revised policies on financing, payment, and budget neutrality
  - MassHealth, renewal approved September 28, 2022
  - Oregon Health Plan, renewal approved September 28, 2022
  - Arizona Health Care Cost Containment System, renewal approved October 14, 2022

# Demonstration Policy Development

- State develops a demonstration waiver application, which must be presented for public comment within the state and at the federal level
- CMS reviews the application and public comments
- State and CMS typically negotiate the parameters of specific program flexibilities and waiver financing and spending projections
- Final agreements regarding policy changes, financing mechanisms, and reporting and evaluation requirements are documented in the waiver special terms and conditions (STCs)
  - MACPAC reviewed the waiver applications and STCs for several newly approved demonstration waivers with novel program flexibilities and financing approaches

# Budget Neutrality

- Longstanding CMS policy requires waivers to be budget neutral
  - Based on projections of baseline federal financial participation (FFP) the state would have received without the waiver compared to projected demonstration spending
  - Reviewed on a case-by-case basis, subject to negotiations between states and CMS
  - Especially important when states request authority for costs not otherwise matchable
- States with long-term demonstrations have trended baseline estimates forward over long periods, which allows estimates of substantial savings
  - In 2018 CMS amended budget neutrality guidance to reduce the amount of savings that could be carried forward
  - In recent approvals CMS modified the approach described in 2018 guidance to allow states to carry forward more savings
- CMS can designate some expenditures as hypothetical spending that is largely exempt from budget neutrality requirements

# State Designated Health Programs

- Section 1115 authority does not allow the Secretary to change the federal matching percentage but does allow expenditure authority for costs not otherwise matchable
- Beginning in 2005 CMS authorized states to use federal matching funds for designated state health programs (DSHP), existing state-funded programs that do not otherwise qualify for Medicaid match
  - This frees up state funds that could be used to support demonstration expenditures
- In 2017, CMS indicated that it would no longer allow demonstrations to fund initiatives through the DSHP mechanism
- In recent approvals CMS has allowed states to use DSHP funding to support state funding of specific initiatives outlined in the waivers



# Social Determinants of Health

- Medicaid covers a small number of services that address the social determinants of health (SDOH) (e.g., transportation, case management) but does not cover many other services (e.g., food, housing assistance, other social services) that could address social needs
- States have previously used Section 1115 demonstrations to finance and test new SDOH models via pilots, delivery system reform, or enhanced Medicaid benefit packages
  - Many of these have provided broader access to support and connecting services for all members affected by SDOH
- In recent approvals CMS has allowed states to address food insecurity and housing instability for high-need populations that meet specific health and social risk criteria

# Housing

- Housing is a subcategory of health-related social needs or SDOH
- Medicaid can pay for housing-related services that promote health and community integration
  - Assistance finding and securing housing, home modifications when transitioning from an institution back to the community
  - Medicaid cannot pay rent/room and board except in certain institutions
- In recent approvals CMS has allowed states to provide various housing-relating interventions to support stable housing for specific populations at risk for homelessness/housing instability or experiencing transitions

# Continuous Eligibility

- States have the option to provide 12 months of continuous eligibility to children in Medicaid and CHIP
  - 23 states have implemented this option in Medicaid and 25 in separate CHIP
- For other groups, states must redetermine eligibility at least once every 12 months
- MACPAC has found that disruptions in coverage can result in unnecessary administrative costs and delays in care for beneficiaries
- In recent approvals CMS has allowed states to provide continuous eligibility for children up to age 6, young adults who have aged out of foster care until age 26, and adults in groups at special risk due to transitions (e.g., justice-involved individuals, individuals who are homeless)

# Capacity Development

- Generally, state Medicaid programs cannot use federal funds for provider capacity development unless specifically earmarked
- States have previously used Section 1115 waiver expenditure authority to support delivery system reform investments, especially in integrated care, payment reform, and primary care capacity
- States continue to request waiver expenditure authority for investments in provider capacity development
- In recent approvals CMS has allowed states to make investments in provider capacity that targets health-related social needs, behavioral health, and health equity

# Payment Adequacy

- Social Security Act Section 1902(a)(30)(A) requires provider payments to be sufficient to enlist enough providers so that care and services are available under [Medicaid] at least to the extent that such care and services are available to the general population in the geographic area
- States have not generally been required to meet a specific payment level to demonstrate compliance with this requirement
- In recent approvals CMS has required states to increase Medicaid provider payment rates for primary care, behavioral health, and obstetrics care to at least 80 percent of the Medicare fee-for-service rate as a condition of receiving other federal financial investments

# Terms and Conditions

- In addition to payment adequacy requirements, CMS has tied many additional terms and conditions to the new initiatives and spending and financing agreements in these waivers
- Some new spending, such as spending on SDOH investments, is subject to specific caps and must be tracked and reported separately
- States must develop implementation, spending, and reporting plans for new initiatives and these must be submitted to and approved by CMS before they can go forward
- States are required to develop evaluation plans that address the specific goals of the new initiatives
  - must assess the effectiveness of each approach in meeting demonstration goals, addressing beneficiary health outcomes, and affecting spending in related programs

# Demonstration Results

- Monitoring and evaluation findings can inform decision making at the state and federal levels
  - Monitoring provides ongoing updates on implementation and collects data on process and outcome measures, which may help states and CMS identify whether mid-course corrections are needed
  - Evaluations are completed later in the demonstration period or after the demonstration is complete; their purpose is to assess whether demonstrations have achieved their goals and to inform decisions about the future of the policy being tested
- MACPAC will collect and review monitoring and evaluation reports to learn more about state activities and findings and identify opportunities for future MACPAC discussion

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