

1115 Waiver

Under the 1115 statute, the Secretary of Health and Human Services can allow states to “experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid statute.” 1115 Waivers are flexible, so states have room to develop Medicaid Plans that suit their state’s health care goals. Many states now apply for 1115 Waivers in an attempt to provide health care to more of their poor and near-poor citizens.¹ The terms “experimental” and “pilot” suggest 1115 can’t be used to “permanently” waive or exempt States from statutory requirements deemed undesirable, but many state waivers have become semi-permanent.²

Although waivers vary in the different states, proposals for statewide reform have several common factors:³

- The State wants to expand its use of managed care. This can include Federally or state qualified HMOs, partially capitated systems, primary care case managers or other variations.
- Savings are expected to be achieved as one of the outcomes of increased managed care.
- This savings will finance coverage to individuals previously ineligible for Medicaid.
- The effect of the demonstration is to be budget neutral for the life of the project (generally 5 years)

Section 1115(a)(1) of the Social Security Act authorizes the Secretary to waive compliance with any of the requirements of section 1902 of the Social Security Act, which delineates State Medicaid Plan requirements, to the extent and for the period necessary to carry out the demonstration projects.

Requirements that can be waived under 1115:

- *Statewide Uniformity* – facilitating variations in the program in different areas in the state.
- *Comparability Requirements* – allowing different benefits to be provided to one group and not another.
- *Eligibility* – permitting states to expand Medicaid eligibility standards and criteria

¹ www.arcms.org

² Review Guide for Section 1115 Research and Demonstration Waiver Proposals For State Health Care Reform, www.c-c-d.org

³ Ibid.

- *Provider Choice/ Freedom of Choice* – allowing restriction of recipients’ freedom of provider choice and requiring enrollment in managed care systems.
- *Managed Care Organizations* – permitting recipients to receive services through alternative delivery systems not recognized due to existing State and Federal requirements. Under 1115, States may contract with HMO’s that have Medicare and Medicaid enrollments in excess of 75% and may limit Medicaid recipient disenrollments from HMO’s to an annual “open season.”
- *Reimbursement* – allows reasonable alterations in Medicaid payment requirements.
- *Freedom of Choice of Family Planning Services Providers* – allows states to limit individuals to receiving family planning services from providers within their managed care plans or systems.

Statutory Restrictions (the following are not waivable):

- *Services for pregnant women and children*
- *Drug rebate provisions* – requires that a state provide medical assistance for covered outpatient drugs. Since the drug rebate provisions are imposed on drug manufacturers, and not on the state, this provision cannot be waived through a waiver.
- *Copayments and other cost sharing*
- *Spousal impoverishment provisions* - prohibits the Secretary from waiving spousal impoverishment provisions for institutionalized individuals.
- *Work transition*
- *Qualified Medicare beneficiaries, specified low income beneficiaries and qualified working disabled individuals*
- *FMAP rates* – The rate at which the Federal government matches states expenditures cannot be waived.

Policy Restrictions

- *Programs or policies which reduce access or quality of care cannot be approved*
- *Demonstrations must be budget neutral* – they can’t cost the Federal government more than the States’ Medicaid plans would cost without waivers.
- *Unnecessary utilization and access safeguards*
- *Quality Assurance* – states are expected to maintain quality assurance processes.
- *Boren Amendment* – states are expected to meet the requirements of the Boren amendment to reimburse hospitals and nursing homes in fee-for-service situations.

ERISA

- ERISA preempts a state’s attempts to regulate self-insured health plans. There is no authority in 1115 to waive ERISA provisions which affect self-insured employers.

Medicare

- Medicare waiver authority is very limited.

1115 STATUS NATIONWIDE⁴

- *Approved and implemented in the following states:* Oregon, California, Arizona, Oklahoma, Minnesota, Arkansas, Wisconsin, Kentucky, Tennessee, Vermont, Massachusetts, Maryland
- *Proposals under review:* Utah, Texas
- *Proposal withdrawn:* Kansas, Florida
- *Waiver expired:* Illinois, Ohio
- *Waiver approved, but not yet implemented:* Connecticut, District of Columbia
- *Waiver terminated:* Alabama
- *Pre-application:* Washington
- *No waiver:* Nevada, Idaho, Montana, Wyoming, Connecticut, New Mexico, North Dakota, South Dakota, Nebraska, Iowa, Louisiana, Mississippi, Minnesota, Indiana, Maine, Pennsylvania, West Virginia, Virginia, North Carolina, South Carolina, Georgia

ARIZONA⁵

Name of Section 1115 Demonstration: Arizona Health Care Cost Containment System (AHCCCS)

Date Proposal Submitted: May 22, 1982

Date Proposal Approved: July 13, 1982

Date Implemented: October 1, 1982

Summary:

Arizona has a state Medicaid expansion for parents up to 200% FPL via Medicaid's 1115 and HIFA. Arizona has a state Medicaid expansion for adults without children up to 100% FPL via Medicaid 1115.

Until 1982, Arizona was the only state that did not have a Medicaid program under title XIX. In October 1982, Arizona implemented the Arizona Health Care Cost Containment System (AHCCCS) as a section 1115 demonstration project. AHCCCS is designed primarily to secure health care on a prepaid per capita risk basis under contracts awarded

⁴ Health Care Financing Administration, www.hcfa.gov/medicaid

⁵ Arizona State Information, www.ins.state.il.us/spg/Arizona.htm

to qualified bidders, but it also pays some contractors on a fee-for-service basis when risk-based contracts are impractical.

From October 1982 until December 1988, AHCCCS covered only acute care services, except for 90-day post-hospital skilled nursing facility coverage. In November 1988, a 5-year extension of the program was approved by the Health Care Financing Administration (HCFA) to allow Arizona to implement a capitated long term care (LTC) for the elderly and physically disabled (EPD) and the developmentally disabled populations.

In October 1, 1990, AHCCCS began phasing in comprehensive behavioral health services, beginning with coverage of seriously emotionally disabled children under the age of 18 who required residential care. Over the next five years, behavioral health coverage was extended to all Medicaid eligible persons.

Some of the waivers that have been granted to Arizona enable the state to:

- Have the flexibility to arrange the necessary reimbursement agreements with health care providers; and
- Provide home and community based services to individuals with incomes up to 300 percent of SSI.

CALIFORNIA⁶

Name of Section 1115 Demonstration: Medicaid Demonstration Project for Los Angeles County

Date Proposal Submitted: February 29, 1996

Date Proposal Approved: April 15, 1996

Date Implemented: July 1, 1995

Date Extension Approved: January 17, 2001

Summary:

- California has state Medicaid Healthy Families expansions for parents up to 200% FPL via Medicaid 1931, HIFA 1115.
- Los Angeles has 1115 waiver authority to pay for ambulatory care to the uninsured.

The 1115 waiver provides fiscal relief to the county, stabilizes the public health system, and assists the process of restructuring the county's healthcare delivery system to rely more on primary and outpatient care.

⁶ California's 1115 Medicaid Demonstration For Los Angeles County Fact Sheet, www.hcfa.gov/medicaid/1115/lacnfact.htm

The original 5-year demonstration was approved in April 1996 for the period July 1, 1995 through June 30, 2000. The demonstration made Federal funds available to the county in order to stabilize its public health system, and assist the process of restructuring the County's health care delivery system to rely more on primary and outpatient care. The approved demonstration expired on June 30, 2000.

The state submitted a five-year extension proposal to HCFA in October of 1999, indicating that the County needed more time to complete its restructuring efforts. On January 17, 2001, HCFA approved a five-year extension to the demonstration for the period July 1, 2000 through June 30, 2005. The extension is designed to provide \$900 million in Federal financial support to the county in order to allow it to continue its restructuring efforts; provide health services to its indigent population; and provide enhanced clinic reimbursement to clinics participating in the demonstration. In addition, the extension will hold the State accountable for making important changes to eligibility, reimbursement and enrollment policies and procedures for county patients and fund county/union training for workers to meet the demands of the restructured system.

DELAWARE⁷

Name of Section 1115 Demonstration: Diamond State Health Plan

Date Proposal Submitted: July 29, 1994

Date Proposal Approved: May 17, 1995

Date Implemented: January 1, 1996

Date Extension Request Submitted: December 29, 1999

Summary:

The Diamond State Health Plan (DSHP) implemented a mandatory Medicaid managed care program statewide on January 1, 1996. Using savings achieved under managed care, Delaware will expand Medicaid health coverage to additional low-income adults in the State.

- Beneficiary groups include low-income adults and children with incomes up to 100% FPL.
- The estimated number of eligibles is 61,300
- Delaware's current managed care program, the Nemours CHILD Plan and the state's case managed program for adults receiving general assistance are rolled into the plan.
- There is no cost-sharing.

HAWAII⁸

⁷ medicaid.aphsa.org/waivers

Name of Section 1115 Demonstration: Hawaii QUEST

Original Proposal Submitted: April 19, 1993

Proposal Awarded: July 16, 1993

Implemented: August 1, 1994

Summary:

Hawaii QUEST is a statewide section 1115 program which creates a public purchasing pool that arranges for health care through capitated managed care plans. Hawaii QUEST builds on Hawaii's employer mandate by integrating public and private programs to develop a more efficient, seamless health care delivery system for individuals previously served by three public programs, Medicaid, General Assistance, and the State Health Insurance Program.

- The beneficiary group includes individuals who meet Medicaid financial but not categorical requirements and are uninsured, including pregnant women and infants with incomes below 185% FPL, children up to 6 years with incomes below 133% FPL, and children ages 6-17 with incomes below 100% FPL. An amendment is currently under review to raise children's eligibility back to 300% FPL.
- The estimated number of eligibles is 31,941.
- There are 3 benefits packages:
 - Basic Medical includes inpatient, outpatient, and physician services; EPSDT services; lab and diagnostic services; prescription drugs; rehab, transitional and home health services, and limited mental health.
 - Basic Dental includes ESPDT visits for children, and preventive and emergency services for adults.
 - Mental Health is a supplement to basic medical for "the seriously disturbed mentally ill."
- The delivery system is the Basic Medical Package provided by a number of plans that contract with state. In areas without a plan, state will purchase indemnity insurance and require individuals to select a single primary care provider.
- Cost-sharing (premiums and co-payments) are imposed on the non-traditional Medicaid enrollees.
- No DSH payments will be made to hospitals by the state or by plans for individuals enrolled in managed care.

OREGON⁹

Name of Section 1115 Demonstration: Oregon Health Plan Demonstration

⁸ Hawaii Statewide Health Reform Demonstration Fact Sheet, www.hcfa.gov/medicaid

⁹ Oregon Statewide Health Reform Demonstration, www.hcfa.gov/medicaid/1115

Date Proposal Submitted: August 15, 1991
Date Proposal Approved: March 19, 1993
Date Implemented: February 1, 1994

Summary:

The Department of Health and Human Services approved section 1115 waivers for the Oregon Health Plan Demonstration for a 5-year period, beginning on February 1, 1994. It includes three key features: (1) expanded eligibility; (2) prioritization of health care benefits; and (3) managed care. The demonstration was designed to be cost effective, so that the expansions cost no additional Medicaid dollars. On September 28, 1994, additional waivers were approved to include aged, disabled, and foster care children into Managed Care. The waivers also allowed mental health and chemical dependency services to be included in the demonstration's benefit package.

On March 31, 1998, Oregon was granted a 3-year extension of the State's demonstration authority, which will now continue through January 31, 2002.

- Medicaid and SCHIP covers all adults under 100% FPL, and all children under 170% FPL.
- Family Health Insurance Assistance Program (FHIAP) aids low-income families that are under 170% FPL to buy private coverage
- Oregon has state Medicaid expansions for parents up to 100% FPL via Medicaid 1115.
- Oregon has state Medicaid expansions for adults without children up to 100% FPL via Medicaid 1115
- Oregon's managed care arrangements include fully capitated health plans.¹⁰

MASSACHUSETTS

Name of Section 1115 Demonstration: MassHealth
Date Proposal Submitted: April 15, 1994
Date Proposal Approved: April 24, 1995
Date of Implementation: July 1, 1997

Summary:

MassHealth is a statewide demonstration project that makes health insurance available to a number of previously uninsured individuals. In addition to the traditional Medicaid population, the demonstration provides coverage for the uninsured, the unemployed, the working and non-working disabled, and low-income workers and their families. In

¹⁰ <http://medicaid.aphsa.org/waivers/Or1115>

January 2000, an amendment was approved to expand MassHealth to cover individuals with HIV. The MassHealth demonstration is also designed to stimulate private employers to offer affordable health insurance to their low-income workers. To this end, MassHealth offers insurance payments to small employers who offer health insurance to low-income workers for which the employers pay at least 50% of the premium.

MassHealth will cover approximately 400,000 people who currently are not enrolled in Medicaid including uninsured persons, unemployed individuals, and low-income workers who are at risk of losing their insurance. The program specifically targets the needs of key groups within the uninsured population. The primary target groups are children, families, the disabled, long-term unemployed, and certain employed individuals.

MassHealth has multiple components:

- Providing tax credits for employers contributing at least 50% of the cost of purchasing a state-defined basic benefit package for their low-income employees
 - Subsidizing the employee share of the premium
 - Eliminating categorical restrictions to coverage and streamlining the eligibility process for the current Medicaid population
 - Maintaining the current Common Health Program for the low-income working disabled, and
 - Maintaining the Medical Security Plan for the short-term unemployed
- Massachusetts has state Medicaid expansions for parents up to 133% via Medicaid 1115.
- Massachusetts also has state Medicaid expansions for adults without children up to 133% via Medicaid 1115.

MINNESOTA

Name of Section 1115 Demonstration: Prepaid Medical Assistance Program Plus (PMAP +)

Date Proposal Submitted: July 27, 1994

Date Proposal Awarded: April 27, 1995

Extension Submitted: March 18, 1997

Extension Approved: July 1, 1998

Extension Expires: June 30, 1999

Summary

The state Minnesota has enacted several health care reform measures to improve health care quality and create a seamless system of care for its population. The MinnesotaCare Acts of 1992, 1993, and 1994 call for specific changes in the health care delivery and financing systems. Phase I involves the integration of low-income and uninsured

programs and the expansion of managed care, while Phase II would further streamline all publicly funded health care programs in the state.

PMAP currently serves 160,000 Medicaid beneficiaries in eight counties. PMAP+ expands Medicaid eligibility and managed care service delivery, including: (1) coverage of MinnesotaCare children under title XIX; (2) implementation of prepaid dental care; (3) implementation of children's mental health collaboratives; and (4) enrollment of persons with disabilities in PMAP in Itasca County.

Eligibility: The existing PMAP demonstration serves the AFDC population, needy children, pregnant women, and the elderly. PMAP+ expands Medicaid eligibility to cover pregnant women and children up to age 2 with family income at or below 275% of the FPL, without regard to assets, and with no insurance barriers in place. Minnesota also has state Medicaid expansions for adults without children up to 175% FPL via Medicaid 1115.

MISSOURI

Summary

The demonstration expands Medicaid eligibility to: working parents who are transitioning off of welfare and who have a Medicaid eligible child in the home; to absent parents who are participating in Missouri's Parent's Fair share program with incomes up to 125% of the FPL who are actively paying their legally obligated amount of child support.

The state also has a Title XXI plan which provides Medicaid coverage for children up to age 19 with incomes up to 300% of the FPL and which uses the same delivery system as the Section 1115 demonstration. Because the State projects that its Title XXI allotment will run out sometime after year 3, the enrolled children will thereafter continue to receive their care through the existing Medicaid managed care network. At that point, the state will receive its usual FMAP rate rather than the enhanced Title XXI match rate. Together, the Section 1115 demonstration, the Section 1915(b) waiver, and the Title XXI plan provide Medicaid managed care to all eligible adults and children in the State with incomes to 300% of the FPL.

- Missouri has state Medicaid expansions for parents up to 100% FPL via Medicaid 1115.
- Missouri Managed Care Plus gives two year coverage offered to uninsured:¹¹
 - Non-custodial parents up to 125% FPL; must be actively paying all required child support
 - Custodial parents up to 100% FPL

¹¹ <http://medicaid.aphsa.org/waivers/MO1115>

- Non-custodial parents in Missouri's Parent's Fair Share Program
- All eligible people will receive the same benefits offered to State of Missouri employees (limited compared to Medicaid benefits)
- There is no cost-sharing up to 185% FPL. Those 186% - 225% FPL pay \$5 per office visit. Those 226% - 300% FPL pay \$10 per visit and are subject to some premiums.

NEW YORK

Name of Section 1115 Demonstration: The Partnership Plan

Date Proposal Submitted: March 20, 1995

Date Proposal Approved: July 15, 1997

Date Implemented: Phase in implementation beginning October 1, 1997

Amendment Submitted: June 30, 2000

Amendment Approved: June 29, 2001

Summary

On July 15, 1997, New York's Section 1115 Medicaid demonstration was approved. The demonstration is designed to move approximately 2.1 million Medicaid beneficiaries from a primarily fee-for-service delivery system to a mandatory managed care environment. The demonstration also expands health insurance coverage to the State Safety Net recipients. As a result, 370,000 of the State's Safety Net recipients were converted to a Federal Title XIX eligibility group. Safety Net was a state-funded cash assistance program for low-income adults who were not otherwise eligible for Temporary Assistance for Needy Families (TANF) or Medicaid.

On June 29, 2001, the Family Health (FHPlus) amendment to the demonstration was approved. This amendment expands health insurance coverage to additional low-income uninsured adults. All Medicaid-eligible individuals, as well as the Safety Net and FHPlus populations, are included in the demonstration. All managed care enrollees under the demonstration are given six months of guaranteed eligibility.

- New York has Medicaid expansion for parents under 150% FPL and childless adults under 100% FPL.
- Healthy New York promotes employer-sponsored insurance by offering affordable small group and individual insurance.

RHODE ISLAND

Name of Section 1115 Demonstration: Rhode Island Rite Care

Date Proposal submitted: July 20, 1993

Date Proposal Approved: November 1, 1993

Date Implemented: August 1, 1994

Date Extension Request Submitted: March 17, 1998

Date Extension Request Approved: September 17, 1998

Date Extension Expires: July 31, 2002

Summary:

The Rhode Island Rite Care project is a statewide initiative that seeks to increase access to, and the delivery of, primary and preventive health care services for all Family Independence Program families and certain low-income women and children through a fully capitated managed care delivery system.

- The beneficiary group includes pregnant women and children up to age 6 below 250% FPL. Eligibility also expanded to families with children under 18 *including parents with income up to 185% FPL.*
- The benefits package includes the same acute care benefit package currently offered under the Medicaid program. It emphasizes primary and preventive care and includes enhanced services such as home visits, nutritional aid, childbirth education and parenting skills.
- The delivery system is fully capitated, risk based prepaid health plans and HMO's. Prepaid health plans are state certified but not federally qualified.
- Individuals with family incomes of 185-250% are subject to cost sharing.

TENNESSEE

Name of Section 1115 Demonstration: TennCare

Date Proposal Submitted: June 16, 1993

Date Proposal Approved: November 18, 1993

Date Implemented: January 1, 1994

Summary

TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured State residents and those whose medical conditions make them uninsurable. Enrollment is capped at 1.4 million. TennCare benefits are more generous than those offered under Medicaid for acute care, generally in that they remove most limitations on number of episodes covered. The plan emphasizes preventive care by providing all preventive care to adults and children without copayments or deductibles.

- Beneficiary groups include individuals unable to obtain health insurance due to existing health conditions and uninsured individuals ineligible for an employer or government health plan and uninsured as of 7/1/94.
- The estimated number of eligibles who aren't currently on Medicaid is 546,000.

- The TennCare benefits are more generous than those offered under Medicaid for acute care generally in that they remove most limitations on number of episodes covered.
- All enrollees receive care through either an HMO or a PPO.
- DSH payments to hospitals no longer exist. These funds are redirected to support the TennCare program.

VERMONT

Name of Section 1115 Demonstration Plan: Vermont Health Access

Date Proposal Submitted: February 24, 1995

Date Proposal Approved: July 28, 1995

Date Implemented: January 1, 1996

Summary

Vermont's Section 1115 Medicaid demonstration proposal entitled "The Vermont Health Access Plan." Originally the program provided health care coverage to uninsured adults up to 150% of the Federal Poverty Level. Children had already been covered up to 225% FPL since 1992. Through multiple amendments to the demonstration, coverage has now been extended to 300% of the FPL for children and up to 185% of the FPL for parents and caretakers of Medicaid eligible children.

- The estimated number of eligibles other than current Medicaid is 26,500.
- A newly eligible group will be entitled to benefits package similar to comprehensive package available in private sector.
- Vermont will contract, on a capitated basis, with a sufficient number of health plans throughout the state to assure that all Medicaid beneficiaries have a choice of at least two plans.

WISCONSIN

Name of Title XXI Amendment and Section 1115 Demonstration: BadgerCare

Title XIX Plan Submitted: December 18, 1998

Title XXI Amendment Submitted: December 30, 1998

Date Plans Approved: January 22, 1999

Effective Date of Both Plans: July 1, 1999

Second Title XXI Amendment Submitted: March 18, 2001

Date second Amendment Approved: January 18, 2001

*Summary:*¹²

Beneficiary groups include all children up to age 18 in families below 185% FPL and their parents. The estimated number of eligibles with current Medicaid is 6,500 children and 56,500 adults. The estimated number of “other” eligibles is 83,000. BadgerCare families will use the current Medicaid managed care delivery system. When employer-sponsored insurance is available, the State will determine if it is more cost-effective for a family to purchase coverage through the state Health Insurance Premium Payment Program or through the ESI. The federal matching rate will vary accordingly. Families with incomes above 150% FPL must pay premiums of 3% - 3.5% of family income. Failure to pay results in disenrollment from BadgerCare. Families must wait at least six months to re-enroll unless there was good cause.

¹² <http://medicaid.aphsa.org/waivers/Wi1115>