

Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers

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Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid that differ from what is required by federal statute. Waivers can provide states considerable flexibility in how they operate their programs, [beyond what is available under current law](#). Waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services (CMS) and often reflect changing priorities from one administration to another. In November 2017, CMS, under the Trump administration, posted [revised criteria](#) for Section 1115 waivers that no longer include the goal of increasing coverage, as in prior administrations. In January 2018, CMS posted [new guidance](#) to allow state Section 1115 waiver proposals to condition Medicaid on meeting a work requirement and subsequently has approved the first waivers of that type in the history of the Medicaid program. Each administration has some discretion over which waivers to approve and encourage (see Appendix A) but that discretion is not unlimited. Litigation challenging waiver approvals in Kentucky and Arkansas is ongoing.¹

Section 1115 waiver activity is expected to continue both through administrative actions and the courts. This brief provides basic information about the purpose and function of Section 1115 waivers, describes the current administration's waiver priorities, and discusses trends in recent state waiver requests and waiver decisions. The most current activity is contained in our [Medicaid waiver tracker](#),² which shows approved and pending waivers.

What are Section 1115 Medicaid waivers?

Authority and Purpose. Under Section 1115 of the Social Security Act, the Secretary of HHS can waive specific provisions of major health and welfare programs, including certain requirements of Medicaid and CHIP. This authority permits the Secretary to allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under the federal rules, as long as the Secretary determines that the initiative is an “experimental, pilot, or demonstration project” that “is likely to assist in promoting the objectives of the program.”³ States can obtain “comprehensive” Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs.^{4,5} There also are narrower Section 1115 waivers that focus on specific services or populations. While the Secretary's waiver authority is broad, it is not unlimited. There are some elements of the program that the Secretary does not have authority to waive, such as the federal matching payment system for states, or requirements that are rooted in the Constitution such as the right to a fair hearing.⁶ Waivers are typically approved for a five-year period and can be extended, typically for three years.

Financing. While not set in statute or regulation, a longstanding component of Section 1115 waiver policy is that waivers must be budget neutral for the federal government. This means that federal costs under a waiver must not exceed what federal costs would have been for that state without the waiver, as calculated by the administration. The federal government generally enforces budget neutrality by establishing a per member per month cap on federal funds under the waiver, putting the state at risk for increases in per member per month costs but not for increased costs due to enrollment growth.⁷

Transparency, Public Input, and Evaluation. The Affordable Care Act (ACA) made Section 1115 waivers subject to new rules about transparency, public input, and evaluation. In February 2012, HHS issued new regulations that require public notice and comment periods at the state and federal levels before new Section 1115 waivers and extensions of existing waivers are approved by CMS.^{8,9} Although the final regulations involving public notice do not require a state-level public comment period for amendments to existing/ongoing demonstrations, CMS has historically applied these regulations to amendments. The ACA also implemented new evaluation requirements for these waivers, including that states must have a publicly available, approved evaluation strategy.¹⁰ States have traditionally been required to submit quarterly reports and must submit an annual report to HHS that describes the changes occurring under the waiver and their impact on access, quality, and outcomes.^{11,12}

What waiver priorities have been identified by the Trump administration?

New Waiver Approval Criteria. Marking a new direction for Medicaid waivers, on November 7, 2017, CMS posted revised criteria for evaluating whether Section 1115 waiver applications further Medicaid program objectives (see Appendix B).¹³ The revised criteria no longer include expanding coverage among the stated objectives. Instead, the revised waiver criteria focus on positive health outcomes, efficiencies to ensure program sustainability, coordinated strategies to promote upward mobility and independence, incentives that promote responsible beneficiary decision-making, alignment with commercial health products, and innovative payment and delivery system reforms.

Work Requirements / Community Engagement. CMS also has issued new guidance identifying waiver policy priority areas and inviting applications from states. In January 2018, CMS issued [new guidance](#) for Section 1115 waiver proposals that impose work requirements (referred to as community engagement) in Medicaid as a condition of eligibility. This action reverses previous Democratic and Republican administrations, which had not approved such waiver requests on the basis that such provisions would not further the program's purposes of promoting health coverage and access. The [guidance asserts](#) that such provisions would promote program objectives by helping states "in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement." In June 2018, a [federal district court invalidated CMS's initial approval of Kentucky's waiver](#), which included a work requirement and other eligibility restrictions, finding that the Secretary failed to consider the waiver's impact on Medicaid's primary objective of providing affordable health coverage. Litigation challenging CMS's re-approval of Kentucky's waiver as well as CMS's approval of a work requirement waiver in Arkansas is ongoing.

Opioids / Behavioral Health. CMS continues to use waivers to help states address the opioid epidemic as well as broader behavioral health initiatives. On November 1, 2017, CMS issued a [state Medicaid director letter](#) revising guidance issued by the Obama administration in [July 2015](#). The revised guidance continues to allow states to use Section 1115 waivers to pay for substance use disorder (SUD) treatment services in “institutions for mental disease” (IMDs), and CMS continues to approve IMD SUD payment waivers.¹⁴ On November 13, 2018, CMS also issued [new guidance](#) inviting states to apply for Section 1115 waivers of the federal IMD payment exclusion for services for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED). This guidance reverses prior CMS policy to not use Section 1115 waiver authority to allow Medicaid payments for non-elderly adults with a primary mental health diagnosis in IMDs¹⁵ and could have implications for states’ community integration obligations under the Americans with Disabilities Act and the Supreme Court’s *Olmstead* decision. As of early February 2019, CMS has not posted any state waiver applications under the new guidance. CMS notes that states may participate in the SUD demonstration opportunity and the SMI/SED demonstration at the same time.

Process and Evaluation. CMS released an [Informational Bulletin](#) in November 2017 indicating it will consider approving “routine, successful, non-complex” Section 1115 waiver extension requests for up to 10 years.¹⁶ [On December 28, 2017](#), CMS approved the [Mississippi Family Planning Medicaid Waiver](#) extension for a 10-year period. Mississippi is the first state to receive a 10-year Section 1115 waiver extension under the new policy. In the same November 2017 guidance, CMS also signaled an interest in moving toward reducing the frequency of reporting required for states from quarterly to semi-annually or annually for certain demonstrations. CMS’s [August 2017 renewal of Florida’s Managed Medical Assistance Section 1115 waiver](#) allows the state to submit annual reports (and semi-annual reports at CMS’s request) instead of quarterly reports.

What waiver themes are emerging under the Trump administration?

WAIVER PROVISIONS APPROVED

Work Requirements and Other Eligibility and Enrollment Restrictions. Under the previous administration, CMS approved certain eligibility- and enrollment-related waiver provisions as part of ACA Medicaid expansion waivers (e.g., charging premiums beyond what is allowed under federal law, eliminating [retroactive eligibility](#), making coverage effective on the date of the first premium payment (instead of the date of application), and locking out certain expansion adults who are dis-enrolled for unpaid premiums). Under the Trump administration, CMS has allowed states to apply these previously approved provisions as well as new eligibility and enrollment restrictions to both expansion and [traditional Medicaid populations \(e.g., low income parent/caretakers\)](#). (See [waiver tracker for details](#).)

Waiver provisions approved by CMS for the first time under the Trump administration include:¹⁷

- conditioning eligibility on [meeting work requirements](#) for ACA expansion and non-expansion populations;¹⁸
- coverage lock-outs for failure to timely renew coverage or report changes affecting eligibility;
- coverage loss and lock-outs for non-payment of premiums for non-expansion populations;
- approval to charge premiums up to 5% of family income;
- a [premium surcharge](#) for tobacco users;
- eliminating retroactive coverage for nearly all Medicaid enrollees, including seniors and people with disabilities;¹⁹
- fees for missed appointments;²⁰ and
- conditioning eligibility on the completion of a health risk assessment (HRA).

Several waivers approved at the end of 2018 or beginning of 2019, which include eligibility and enrollment restrictions, signal notable new waiver process and/or policy developments which are described in more detail below.

- **CMS approves restrictive waiver provisions not included in original state waiver requests.** CMS is allowing [Wisconsin](#) to condition coverage on the completion of a health risk assessment (HRA) instead of allowing the state to condition coverage on completing a drug screening assessment and, if indicated, drug testing and treatment, as originally proposed.^{21, 22} CMS gave [Michigan](#) the authority to condition eligibility on the completion of an HRA or healthy behavior activity (after 48 months of cumulative eligibility for expansion adults from 100-138% FPL) instead of the state's original request to condition eligibility on meeting "escalating" healthy behavior requirements.
- **CMS decision on the treatment of AI/ANs in work requirement waiver.** In response to state requests to exempt all American Indians and Alaska Natives (AI/AN) from work requirement waivers, CMS's recent approval of [Arizona's](#) work requirement waiver permits the state to exempt only those AI/AN enrollees who are members of federally recognized tribes. AI/ANs have a unique status under Medicaid statute, which include protections related to premiums and cost-sharing and mandatory enrollment in MCOs.²³

Healthy Behavior Incentives and Benefit Restrictions. The current administration has also approved waivers that eliminate non-emergency medical transportation (NEMT) and implement healthy behavior incentives (tied to premium or cost-sharing reductions) – provisions approved by the previous administration as part of ACA expansion waivers.

Behavioral Health. State interest in Medicaid [Section 1115 behavioral health waivers](#), including mental health and substance use disorders, remains high. Current and pending Section 1115 behavioral health waivers address four main areas:

- using Medicaid funds for nonelderly adults receiving substance use disorder treatment services in “institutions for mental disease” (IMDs);^{24, 25}
- expanding community-based behavioral health benefits;
- expanding Medicaid eligibility to cover additional people with behavioral health needs; and
- financing delivery system reforms, such as physical and behavioral health integration or alternative payment models.

[Most behavioral health waiver activity is related to IMD substance use disorder \(SUD\) payment waivers.](#)

IMD SUD payment waivers approved under the Trump administration differ from those approved under the Obama administration in some ways. For example, waivers approved under the Obama guidance specified numeric day limits on IMD stays eligible for federal Medicaid funds. By contrast, most waivers approved under the Trump Administration do not have an explicit day limit.²⁶ In addition, waivers approved under the 2015 guidance were contingent on states covering community-based services along with short-term institutional services that “supplement and coordinate with, but do not supplant, community-based services.” While the 2017 guidance notes that “states should indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state” and directs states to “demonstrate how they are implementing evidence-based treatment guidelines,” most of those waivers generally do not detail the state’s coverage of SUD services across the care continuum as the earlier waivers do.

Social Determinants of Health. Medicaid funds typically cannot be used to pay directly for non-medical interventions that target the social determinants of health.²⁷ However, in October 2018, CMS approved North Carolina’s Section 1115 waiver which provides financing for a new pilot program, called “Healthy Opportunity Pilots,” to cover evidence-based non-medical services that address specific social needs linked to health/health outcomes. The pilots will address housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress. CMS authorized \$650 million in Medicaid funding for the pilot over five years, \$100 million of which will be available for capacity building. The state will complete a summative pilot program evaluation as well as rapid cycle assessments to determine the effectiveness of pilot services.

Uncompensated Care Pools. Several states use Section 1115 authority to operate Uncompensated Care Pools (also called “Low Income Pools” in some states) to help defray the cost of uncompensated hospital care. For example, the Trump administration approved Florida’s Section 1115 waiver extension request in December 2017, which included an increase in funding for the state’s low income pool to \$1.5 billion annually, reversing the trend toward reducing these funds.^{28, 29, 30} CMS also approved an increase in funding for Texas’ uncompensated care pool (\$3.1 billion per year in the first two years, remaining

years subject to new formula) as part of its December 2017 approval of Texas' Healthcare Transformation and Quality Improvement Program waiver renewal.³¹ Both Florida and Texas have not adopted the ACA Medicaid expansion.

WAIVER PROVISIONS NOT APPROVED OR BEING PHASED OUT

The Trump administration has signaled some of its policy directions by not approving some state waiver proposals, including:

- adopting a closed prescription drug formulary (MA);³²
- limiting ACA expansion eligibility to 100% FPL with the enhanced match (AR, MA);^{33, 34}
- lifetime limits on Medicaid benefits for eligible beneficiaries (KS);³⁵
- conditioning coverage on drug screening, and if indicated, testing and treatment (WI);
- requiring stricter verification of U.S. citizenship and state residency than already required under federal law (NH);
- imposing asset tests for poverty related pathways (ME, NH);
- coverage lock-outs for individuals who misrepresent compliance with work requirements (MI); and
- more frequent eligibility redeterminations (AZ).³⁶

The current administration has reduced funding for renewals³⁷ and not approved new [Delivery System Reform Incentive Payment \(DSRIP\) initiatives](#), which provided states with significant federal funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.³⁸ Although DSRIP funding was never intended to be permanent and other states may be interested in developing new DSRIP initiatives, DSRIP does not appear to be a tool the Trump administration will use to advance delivery system reform.

What to Watch in Waivers Going Forward

Each administration has some discretion to approve waivers, although that discretion is ultimately limited by the Medicaid program purposes set out by Congress in federal law. The direction of recent waivers has and may continue to test the bounds of administrative flexibility through waivers, as evidenced by recent litigation challenging waiver approvals in Kentucky and Arkansas as outside the Secretary's statutory authority and inconsistent with Medicaid program objectives. Going forward, areas to watch include CMS decisions on pending waivers, including waivers that would restrict beneficiary freedom of choice for family planning services (SC, TN, and TX), as well as new CMS guidance on evaluating community engagement demonstrations³⁹—a central component of Section 1115 Medicaid demonstration waivers. Arkansas began [implementing its work requirement waiver in June 2018](#) and still lacks (as of early February 2019) a publicly available, approved evaluation plan. Media outlets have also reported CMS may be working to release new waiver guidance to states on Medicaid block grants/aggregate

spending caps in exchange for unspecified additional state flexibility.⁴⁰ However, no specific details regarding this anticipated guidance are available.

States can also change direction on waivers. In December 2018, CMS approved Maine's waiver, including work requirements, premiums, and elimination of retroactive eligibility for traditional populations, which had been submitted by the LePage administration. When Governor Mills took office in January 2019, she [declined to accept the waiver terms and conditions](#) and indicated that Maine instead would make vocational training and workforce supports available to Medicaid enrollees.

As more waivers are submitted and approved, key questions include:

- **Applications:** What are the stated goals and objectives? What does research or experience in other states show about provisions in the waiver? What populations are affected by the proposal? What are the anticipated effects on enrollment and coverage?
- **Approval & Implementation:** What is the implementation plan and timeline? What are the administrative costs and challenges? What new systems will be necessary to implement the waiver? What is the process to receive public input on new waivers, amendments, and operational protocols?
- **Evaluation:** What are the requirements for reporting and evaluation? How often do states need to submit data? Will waiver evaluations be timely and adequate? What data and reporting will be available prior to the completion of formal evaluations?
- **Litigation:** How will litigation in Arkansas and Kentucky be decided? What will be the effect on other states? Will there be lawsuits challenging waiver approvals in additional states?

Appendix A

How Have States Used Section 1115 Demonstration Waivers in the Past?

From Medicaid's beginning in 1965 through the early 1990s, waivers were small in scope. Beginning in the 1990s, there was an increase in waiver activity, and waivers became broader in scope. General periods of waiver activity are discussed below:

Broad Expansion Waivers (Mid-1990s-2001). In the pre-ACA mid-90s through the early part of this decade (before statutory authority/federal funds were directly authorized for coverage expansion to childless adults), most waivers focused on expanding coverage. Many began as state efforts to implement broader managed care systems than were then permitted under federal law. States used savings from mandatory managed care or redirected disproportionate share hospital funds to offset expansion costs, and flush economic times during the mid- to late-90s helped support expansion efforts. Two of the largest waivers approved during this time (Oregon Health Plan and TennCare) also restructured coverage for existing beneficiaries in ways that were considered very controversial at the time.

HIFA Waivers (2001 Forward). In August 2001, under President Bush, the administration announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative, which promoted the use of waivers to expand coverage within "current-level" resources and offered states increased flexibility to reduce benefits and charge cost-sharing to offset expansion costs. However, states had limited interest and success in expanding coverage under HIFA, and waivers instead began to increasingly focus on cost control as the nation moved into an economic downturn. Expansions that did move forward under HIFA waivers were generally limited, particularly when compared to the larger expansions of the 1990s.

Reform Waivers (2005 Forward). Beginning in 2005, some broad waivers were approved that restructured Medicaid financing and other key program elements, including a couple (RI, VT) that set a global cap on federal funds. These waivers stemmed from continued federal emphasis on and interest by some states in controlling and increasing predictability of program costs as well as ideas about reshaping Medicaid to promote personal responsibility and reflect private market trends. However, during this same period, Massachusetts obtained a waiver that provided support for its efforts to provide universal coverage without significantly restructuring its Medicaid program.

Pre-ACA Expansion Waivers (2010-2013). Six states (California, Colorado, the District of Columbia, Minnesota, New Jersey, and Washington) used waivers to expand Medicaid coverage to adults after the enactment of the ACA to prepare for 2014.

Emergency Waivers (periodic over time in response to emergencies). Beyond these themes, waivers have also helped states quickly provide Medicaid support during emergencies, for example, by enabling a vastly streamlined enrollment process in New York in the wake of the September 11th attacks, and by assisting states in providing temporary Medicaid coverage to certain groups of Hurricane Katrina survivors.

Appendix B

What are the CMS Criteria for Approving Section 1115 Medicaid Demonstration Waivers?

In response to criticism from the General Accounting Office (GAO) about the lack of standards used to determine whether proposed Section 1115 demonstrations further Medicaid program objectives, the CMS posted a set of criteria to use when considering waiver requests in 2015. These criteria were revised by the Trump Administration in November 2017. For comparison, both sets of criteria are listed below.

2015 CMS Waiver Approval Criteria:

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

November 2017 Revised CMS Waiver Approval Criteria:

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

Endnotes

¹ In June 2018, the DC federal district court [set aside](#) the work requirement and other provisions that restrict eligibility and enrollment in the Kentucky HEALTH waiver approval and sent it back to HHS to reconsider. In November 2018, CMS [re-approved](#) the Kentucky waiver. In January 2019, the plaintiffs filed an amended complaint challenging CMS's re-approval of the waiver, and briefing is underway.

² Major areas of focus of current approved state Section 1115 waivers include: the implementation of alternative ACA Medicaid expansion models; eligibility and enrollment restrictions; work requirements; benefit restrictions, copays and healthy behaviors; delivery system reform initiatives; behavioral health; authorizing the delivery of Medicaid long-term services and supports (LTSS) through capitated managed care; and responding to public health emergencies and providing coverage for other targeted groups.

³ 42 U.S.C. § 1315.

⁴ Some states have multiple waivers, and many waivers are comprehensive and may fall into a few different areas.

⁵ Increasingly, states are using Section 1115 waivers to combine programs under one single authority (e.g., including authorities otherwise available under Section 1915 (b) managed care waivers and/or Section 1915 (c) home and community based services waivers, along with Section 1115 authority for other eligibility, benefits, delivery system, and payment reforms).

⁶ The Secretary's waiver authority is limited to the provisions of 42 U.S.C. § 1396a, provided that waivers are demonstration projects that further Medicaid program objectives. 42 U.S.C. § 1315.

⁷ On August 22, 2018, CMS [released a letter](#) to state Medicaid directors describing current policies related to budget neutrality for Section 1115 Medicaid demonstration projects.

⁸ Kaiser Commission on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2012), <http://kff.org/health-reform/fact-sheet/the-new-review-and-approvalprocess-rule/>.

⁹ Indiana filed an amendment to its pending extension on May 25, 2017 and Kentucky filed an amendment to its pending application on July 3, 2017. Neither state held a state-level public comment period before submission to CMS. Although the final regulations involving public notice do not require a state-level public comment period for amendments to existing/ongoing demonstrations, CMS has historically applied these regulations to amendments. However, these amendments were not to ongoing demonstrations but to a new waiver request (KY) and extension request (IN).

¹⁰ However, CMS relieved Montana from the requirement to evaluate its expansion waiver based on its participation in a cross-state federal evaluation.

¹¹ Robin Rudowitz, MaryBeth Musumeci, and Alexandra Gates, *Medicaid Expansion Waivers: What Will We Learn?* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), <http://kff.org/medicaid/issue-brief/medicaid-expansion-waivers-what-will-we-learn/>.

¹² The November 6, 2017 CMCS Information Bulletin (found at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617-2.pdf>) on Section 1115 demonstration process improvements also signaled CMS's interest in moving toward reducing the frequency of reporting required for states to semi-annually or annually for certain demonstrations.

¹³ "About Section 1115 Demonstrations," CMS, last accessed Jan. 29, 2019, <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.

¹⁴ Federal law generally bars states from receiving "any such [federal Medicaid] payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an [IMD]." 42 U.S.C. § 1396d (a)(29)(B).

¹⁵ One state, Vermont, currently has waiver authority for IMD mental health services, but those payments must be phased out between 2021 and 2025. Vermont had sought expanded waiver authority for IMD mental health services, and other states, including Illinois, Massachusetts, and North Carolina, had sought IMD mental health authority; all of these requests were denied by CMS. In the [Vermont](#), [Illinois](#), and [North Carolina](#) denials, CMS specifically cited its

policy to not allow Medicaid payments for individuals who receive only mental health treatment in IMDs. [Maryland](#) also indicated that CMS had denied its request for IMD mental health payment waiver authority.

¹⁶ This CMCS Information Bulletin also outlines changes to the “fast track” federal review process for Section 1115 waiver extension requests, removing the requirement that states must have at least one full extension cycle without “substantial program changes” before they are eligible to be considered for the “fast track” review process. (The “fast track” process was designed to expedite the federal review of certain Section 1115 waiver extensions requests that meet specified criteria.)

¹⁷ Waiver provisions in some states may be approved but not yet implemented.

¹⁸ In December 2018, CMS approved Maine’s waiver, including work requirements, premiums, elimination of retroactive eligibility for traditional populations, which had been submitted by the LePage administration. When Governor Mills took office in January 2019, she [declined to accept the waiver terms and conditions](#) and indicated that Maine instead would make vocational training and workforce supports available to Medicaid enrollees.

¹⁹ In October 2017, CMS approved an amendment to Iowa’s waiver eliminating 3-month retroactive coverage for nearly all new Medicaid applicants. The retroactive coverage waiver applies to all other state plan populations, including low-income parents, children over age 1, ACA expansion adults, seniors, and people with disabilities. Pregnant women and infants under age 1 still qualify for retroactive coverage in Iowa. In 2018, the state restored retroactive coverage for nursing facility residents. CMS also approved retroactive coverage waivers in Florida (November 2018), New Mexico (December 2018), and Arizona (January 2019) which apply to waiver populations including seniors and people with disabilities.

²⁰ Under the Kentucky HEALTH demonstration, adults required to and making monthly premium payments have a My Rewards incentive account that may be used to access additional benefits not otherwise covered. Enrollees can earn incentive funds for specified activities and can lose funds under certain circumstances including for each appointment missed without adequate notice of cancellation or good cause.

²¹ In doing so, CMS is allowing the state to implement a restrictive policy provision that was not part of the original waiver application and was not subject to public comment.

²² These provisions apply only to adults without dependent children from 0-100% FPL. Wisconsin’s BadgerCare waiver covers childless adults ages 19 to 64 with income up to 100% FPL (without enhanced ACA matching funds).

²³ 42 U.S.C. § 1916(j) and 42 U.S.C. § 1932(a)(2)(C).

²⁴ On November 1, 2017, CMS issued a state Medicaid director letter revising the July 2015 guidance. The revised guidance continues to allow states to use Section 1115 waivers to pay for IMD substance use treatment services and affirms many components of the earlier guidance. For example, it notes that “states should indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state” and directs states to “demonstrate how they are implementing evidence-based treatment guidelines.” The revised guidance requires certain demonstration components, such as residential treatment provider qualifications and capacity, opioid prescribing guidelines, access to naloxone, prescription drug monitoring programs, and care coordination between residential and community settings. States must report on core and state-specific quality measures, perform waiver evaluations, and are subject to a \$5 million deferral per item for failure to comply with evaluation and reporting requirements.

²⁵ The recently enacted federal [Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities \(SUPPORT\) Act](#) creates a new state plan option from October 2019 through September 2023, for states to receive federal Medicaid payments for non-elderly adults with SUD in an IMD up to 30 days per year.

²⁶ Some waivers approved by the Trump Administration, such as [Illinois](#) and [Vermont](#), note that those state “will aim for a statewide average length of stay of 30 days. . . to ensure short-term residential treatment stays.”

²⁷ Several states have used Section 1115 authority to implement payment and delivery system reform initiatives which include incentives for plans and providers to address social determinants of health (often through “DSRIP” demonstrations). However, these demonstrations do not include funding/expenditure authority to directly pay for non-medical services that aim to address social determinants of health.

²⁸ Uncompensated Care Pool funding was being phased down according to post-ACA guidelines established by the Obama Administration. These guidelines established that 1) uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion, 2) Medicaid payments should support services provided to

Medicaid beneficiaries and low-income uninsured individuals, and 3) provider payment should promote provider participation and access, and should support plans in managing and coordinating care.

²⁹ Florida Managed Medical Assistance Program (MMA), Special Terms and Conditions, #11-W-00206/4, approved August 3, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf>.

³⁰ Under Florida's LIP, funding was set at \$1 billion in SFY 2016 and \$608 million in SFY 2017. CMS indicated the new LIP funding amount approved as part of the state's extension request reflects "the most recent available data on hospitals' charity care costs." Florida's LIP funds may be used for health care costs incurred by the state or by providers (hospitals, medical school physician practices, and federally qualified health centers (FQHCs)/rural health centers (RHCs)) to furnish uncompensated medical care for uninsured low-income individuals up to 200% FPL.

³¹ Texas Healthcare Transformation and Quality Improvement Program, Special Terms and Conditions, # 11-W-00278/6, approved January 1, 2018 through September 30, 2022, <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf>.

³² In its rejection of Massachusetts' prescription drug formulary proposal, CMS said it would be willing to consider a closed formulary proposal under which the state agrees to negotiate directly with manufacturers and forgo all manufacturer rebates available under the federal Medicaid Drug Rebate Program.

³³ The Trump administration rejected Massachusetts' request for partial expansion to 100% of the FPL using the ACA enhanced match on June 27, 2018. The current administration did not make a decision on Arkansas' partial expansion request in its March 5, 2018 approval of the Arkansas Works waiver amendment request.

³⁴ The Obama Administration issued [policy guidance](#), consistent with its legal interpretation of the ACA, indicating that states cannot receive enhanced federal ACA expansion funding unless they cover all newly eligible adults through 138% FPL.

³⁵ In a [CMS administrator letter to Kansas](#) on May 7, 2018, CMS rejected Kansas' proposal to impose a lifetime limit on Medicaid benefits for eligible beneficiaries.

³⁶ Arizona proposed to redetermine eligibility every 6 months for all expansion enrollees and every 3 months for individuals who have a change in circumstance that results in non-compliance with waiver requirements.

³⁷ In December 2017, CMS approved a five-year renewal of Texas' Healthcare Transformation and Quality Improvement Program Section 1115 waiver. The waiver renewal decreases federal matching funds for the state's DSRIP program between year one and year four, eliminating federal funding for DSRIP in the fifth year.³⁷

³⁸ Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals and often grew out of negotiations between states and HHS over the appropriate way to finance hospital care.

³⁹ Letter from Andrea J. Casart to Dawn Stehle regarding Arkansas' draft evaluation design (Nov. 1, 2018), available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-feedback-eval-dsgn-20181101.pdf>.

⁴⁰ Rachana Pradhan and Dan Diamond, "Trump wants to bypass Congress on Medicaid plan," Politico, January 1, 2019, available at: <https://www.politico.com/story/2019/01/11/trump-bypass-congress-medicaid-plan-1078885>.