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Medicaid 201: An Overview of State Plan Amendments & Waivers

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Medicaid is the largest health insurance program in the United States, covering more than 76 million individuals.[1] Federal Medicaid requirements set broad standards for the benefits and populations states must cover, but modifications through state plan amendments and waivers allow individual states to adjust the Medicaid program to fit their residents' needs.[2] State plan amendments and waivers address different aspects of the Medicaid program and therefore have unique requirements and approval processes. This issue brief outlines these two mechanisms for changing payment and delivery system models in state Medicaid programs and presents descriptions and notable uses for five types of Medicaid waivers.

Background

Medicaid is a joint federal-state health insurance program that was enacted as part of the Social Security Amendments of 1965, with the goal of providing health care to low-income individuals.[3] The Medicaid program guidelines are established by the Centers for Medicare and Medicaid Services (CMS), a federal agency within the United States Department of Health and Human Services (HHS). Today, the program provides coverage for health services and assistance to eligible members, including low-income children and families, children in the foster care system, pregnant people, persons with disabilities, aged adults, incarcerated individuals, and in some states, adults with low income, who are ages 19-64 and without dependent children or disabilities, commonly referred to as "expansion adults."[4] Each state develops its own Medicaid infrastructure by establishing state-specific eligibility criteria, provider delivery systems, payment policies, and benefit packages within federal requirements.[5] States may choose how to finance the delivery of Medicaid benefits to members using a fee-for-service (FFS) model, through Medicaid managed care organizations (MCOs), or a combination of the two.[6] In a FFS model, the state contracts with and pays providers directly for all covered services provided to a member. In a managed care model, states contract with and pay MCOs a capitated payment amount per member per month for everyone enrolled in their health plan. In turn, the MCOs pay health care providers for the Medicaid services used by the member.[6]

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

Individual states can modify their program through state plan amendments (SPAs) and waivers to be responsive to local needs and to incentivize the testing of new delivery and payment models, which results in each state's program looking slightly different from any other.

State Plan Amendments versus Waivers

States can implement changes in their payment and delivery system models for their Medicaid programs through SPAs or waivers. These two mechanisms address different aspects of the Medicaid program and therefore have different requirements and approval processes. SPAs are the mechanism through which states propose a change to any component of the Medicaid program, including eligibility, benefits, services to be provided, or provider reimbursement methods.[7] Alternatively, waivers are requests to waive federal Medicaid requirements to experiment with new payment and delivery system models. Waivers support state innovation in state Medicaid program payment and delivery systems by authorizing demonstration projects and alternative benefits, providing plans for a subset of enrollees, or expanding coverage to groups not covered under federal Medicaid law.[2] The goal of using waivers is typically to simultaneously improve a program's quality-of-care delivery, or improve outcomes for enrollees, while reducing or containing costs. This gives states the flexibility to design programs tailored to the needs of their enrollees. Table 1 provides an overview of both options and highlights the key differences between SPAs and waivers.

Table 1. Overview of State Plan Amendments and Waivers

	State Plan Amendments (SPAs)	Waivers
Description	A proposed change to an existing state Medicaid program.	A request made by a state to waive existing federal Medicaid requirements. Can be broadly classified as program waivers and research and demonstration waivers.
Enrollment Populations	All state plan populations except Medicare enrollees, certain children with special needs, and American Indians.	Program waivers include all state plan populations; research and demonstration waivers require all state plan populations as well as individuals not otherwise eligible for Medicaid.
Budget Requirements	No budget requirements or cost analysis.	Depending on type of waiver, must demonstrate cost- effectiveness and efficiency of program or budget neutrality.
Time Frame	Indefinite approval period, approved within 90 days of CMS receipt, no renewal needed.	Program waivers are initially approved for two years, approved within 90 days of CMS receipt, customarily renewed up to two years or up to five years if covering dually eligible enrollees. Research and demonstration waivers are initially approved for three to five years. There is not a required time frame for CMS approval, but there is a minimum waiting period of 45 days after submission, customarily renewed up to three years or up to five years if covering dually eligible enrollees.
Monitoring and Evaluation	CMS monitors implementation to ensure requirements are met; separate evaluation of managed care entities conducted by state.	CMS monitors implementation to ensure requirements are met; depending on type of waiver, either state conducts evaluation or requires periodic evaluation of the project.

Source: Medicaid and CHIP Payment and Access Commission. (2016). Characteristics of key Medicaid managed care SPAs and waivers. Retrieved from https://www.macpac.gov/characteristics-of-key-medicaid-managed-care-spas-and-waivers/

Unlike state plan amendments, all waivers require that states stay within a predetermined budget, provide continuous program updates in the form of reports and evaluations, and re-apply regularly for extensions to ensure continued eligibility. Similarly, although research and demonstration waivers can be used to target specific populations within the Medicaid program, SPAs must apply to all state plan members, excluding exceptions (i.e., children with special needs, Medicare beneficiaries, and American Indians or Alaska Natives) stated in the federal Medicaid statute.[8] This report will primarily focus on the use and implementation of Medicaid waivers. States frequently apply for waivers to improve their Medicaid programs, especially in the context of responding to a public health emergency. Appendix A includes a table of approved waivers by state as of March 2021. Appendix B includes a table of resources with frequently updated information on state waivers that are pending, are current, or have concluded.

History of Waivers

The first waiver, created under Section 1115 of the Public Welfare Amendments in 1962, predates the Medicaid program.[9] The establishment of the Section 1115 waiver supported testing new approaches in a variety of federally funded programs. In 1962, President Kennedy remarked that the purpose of the waivers was to encourage imagination when addressing the problems faced by those in poverty and ensure that programs could adapt to local needs.[10] This provision was then applied to Medicaid after its establishment through the Social Security Amendments of 1965.[3] However, Section 1115 waivers were not frequently used for policy innovation for many years after Medicaid's enactment.[11]

During the 1980s, the use of waivers changed significantly. Waivers started to be used for the implementation of statewide changes to Medicaid programs rather than to address strictly local initiatives.[12] In addition, the federal government implemented regulations that prohibited waiver programs from adding additional costs for any given year. This restriction was later relaxed in the 1990s by enforcing cost-neutrality over the term of the program rather than annually.[13]

In addition to modifications to the 1115 waiver rules during the 1980s, Section 2716 of the Omnibus Budget Reconciliation Act of 1981 allowed for the development of the 1915(b) and 1915(c) waivers.[14,15] Section 1915(b) waivers, among other uses, allowed states to require enrollment in MCOs, while Section 1915(c) waivers allowed for the funding of home and community-based services (HCBS) as a replacement for care in long-term nursing facilities. Prior to the 1915(c) waivers, Medicaid did not fund non-medical services. Similar to 1115 waivers, any states implementing programs under the Section 1915(c) waivers had to ensure that the programs remained cost-neutral; any states implementing programs under Section 1915(b) waivers had to demonstrate cost-effectiveness.[8] Use of Section 1915(c) waivers began gradually, with only six states participating in 1982. However, this changed throughout the 1980s, with all states and the District of Columbia implementing a Section 1915(c) waiver program by 1997.[16] In 2020, nearly all states and the District of Columbia utilized at least one Section 1915(c) waiver, resulting in more than 300 active Section 1915(c) waiver programs nationwide.[17]

In 2010, a new waiver was established under Section 1332 of the Patient Protection and Affordable Care Act (ACA).[4] The main purpose of this waiver was to allow states to be innovative in providing health insurance under the ACA.[18] States are able to submit Section 1332 waivers in conjunction with other Medicaid waivers but are unable to waive Medicaid program requirements under Section 1332 authority. Only a select group of ACA provisions for small-group and individual markets are permitted to be waived under Section 1332, and basic requirements such as exclusion on the basis of pre-existing conditions was not allowed to be waived.

Section 1135 of the Social Security Act authorizes the HHS secretary to take actions to temporarily waive or modify Medicaid requirements to ensure that health care items and services meet enrollees' needs in affected areas if the president and HHS secretary declare a public health emergency.[19] These waivers have been used historically for hurricanes and other natural disasters. In March 2020, a national public health emergency was declared in response to the COVID-19 pandemic, triggering Section 1135 emergency waiver authority.[20]

Types of Waivers

Section 1115 Waiver

Authority and Purpose

The Section 1115 waiver, broadly categorized as a research and demonstration waiver, provides the authority to the HHS secretary to waive certain provisions of Medicaid state plan requirements to the extent necessary to carry out a demonstration or experimental project.[11] The waiver also provides authority to the HHS secretary to permit federal financial contributions for costs that are otherwise not matched, which allows states to cover additional populations and services that are not covered in traditional Medicaid state plans.[11] The goal of the Section 1115 waiver is to give states the flexibility to design and improve their state Medicaid programs through experimentation with new and innovative ways to reduce costs and improve access. Section 1115 waivers allow states to extend coverage to otherwise ineligible groups, cover benefits not usually covered by Medicaid, test payment reforms such as cost sharing, and make changes to how the delivery system operates. As mentioned in Table 1, Section 1115 waivers must be budget-neutral, meaning that federal expenditure under the waiver cannot surpass what it would have been in absence of the waiver.[21] States must also obtain meaningful public input, using multiple methods for public notification and having a 30-day comment period prior to submitting the proposal.[11] CMS must post all waiver application-related correspondence and documents on Medicaid.gov and hold a public comment period.[11] States must cooperate with any federal evaluations that CMS might conduct; conduct an evaluation, ensuring the results are publicly available; and provide quarterly and annual reports on waiver enrollment and spending.[11] These waivers are initially approved for a three- to five-year period and can be extended for three to five years.[11]

Notable Uses of Section 1115 Waivers

Section 1115 waiver authority has been widely utilized with the intent of addressing social and economic issues that arise within a state's individual Medicaid program, including managed care enrollment, community engagement requirements, substance use disorders and behavioral health, and disaster relief.

Managed Care Enrollment

Although a waiver is not required to implement managed care, many states have used Section 1115 waivers to require mandatory enrollment in managed care for Medicaid long-term services and supports.[11] States use the waiver authority to require seniors and people with disabilities to enroll in managed care. Some states also choose this waiver authority to authorize home and community-based services.[22]

Community Engagement/Work Requirements

Under the Trump Administration, in January 2018, CMS announced that states could choose to implement community engagement requirements, also referred to as work requirements, as an additional requirement for Medicaid eligibility. Community engagement requirements mandated that certain populations take part in work or some form of community engagement to apply for or maintain Medicaid coverage. CMS, under the Trump administration allowed community engagement requirements under Section 1115 precedence, stating that *"a growing body of evidence suggests that targeting certain health determinants, including productive work and community engagement, can improve health outcomes for the individual. Work and community engagement programs can also help individuals and families rise out of poverty."*[23]

In February 2021, CMS, under the Biden Administration, took the first step to ending Medicaid work requirements. The acting CMS Administrator, Elizabeth Richter, sent letters to states who previously received Section 1115 waivers that included community engagement/work requirements. The states were Arizona, Arkansas, Georgia, Indiana, Kentucky, Michigan, Nebraska, New Hampshire, Ohio, South Carolina, Utah, and Wisconsin. The letters to state Medicaid directors notified them that CMS began a process to determine whether the waiver approvals should be withdrawn.[24] On March 17, 2021, the acting CMS Administrator sent letters to the state Medicaid directors in Arkansas and New Hampshire to withdraw the community engagement authorities that were previously added as amendment approvals by CMS.[25] The withdrawal of the approval would take effect within 30 days but states could appeal the decisions.[25]

This policy primarily targeted adults with incomes below 138 percent of the federal poverty level (FPL) who were eligible for Medicaid, exempting the elderly, children, and pregnant persons.[26] States were required to create accommodations for persons with disabilities, a substance use disorder, or a medical condition that was certified by a medical professional.[23]

Under the Trump Administration, CMS allowed states to exempt additional populations from work requirements, such as parents and other persons considered to be caregivers. In addition, states could choose which activities would fulfill work requirements, including full- or part-time employment, training, education, caregiving, and community service. States were required to provide access to resources that assist enrollees in maintaining employment or community engagement; however, Medicaid funding cannot be used to finance these services.[27] CMS recommended that states consider certain criteria before implementing work requirements as a part of their state program, such as the level of unemployment and the difficulty of obtaining a job in specific state districts.[24]

Arkansas' work requirement program, Arkansas Works, was temporarily approved and implemented in the state in June 2018 and was in effect through March 2019.[26] Non-exempt enrollees were required to document 80 hours of work-related activity per month.[26] In March 2019, Judge James E. Boasberg, for the United States District Court for the District of Columbia, blocked HHS Secretary Azar's approval of the Arkansas Works Amendments on the grounds that they did not adequately consider if the amendments would support the central objective of the Medicaid program, to provide access to and coverage for medical assistance for state citizens.[28] This decision was upheld by a federal appeals court, and, as of December 2020, was being appealed by the Trump Administration to the U.S. Supreme Court. Elimination of work requirements by the Biden Administration would make the case moot.[25] The Supreme Court called off a March 29th scheduled hearing but as of March 19th has not yet dismissed the case.[25] A 2019 study from the Harvard T.H. Chan School of Public Health, which focused on Arkansas, was the first evaluation of work requirements for Medicaid enrollees.[29] The study demonstrated that nearly 97 percent of low-income individuals in Arkansas who were subject to the policy were already meeting work requirements, with one-third of this population unaware of the requirement mandate; subsequently, only half of the population on Medicaid was

recorded as complying with the requirement.[29] Although the work requirement program is now on hold, while the program was in effect for seven months, more than 18,000 enrollees lost Medicaid coverage in the state.[29]

Behavioral Health/Addressing Opioid Use Disorder

The Medicaid program is the single largest payer of behavioral health services in the United States, covering adults with mental illness and serious mental illness (21 percent and 26 percent, respectively), along with 17 percent of adults with substance use disorder (SUD).[30,31] In November 2017, CMS issued a letter to state Medicaid directors revising previous guidance that allowed states to use Section 1115 waivers to pay for SUD, including opioid use disorder (OUD), treatment in an institution for mental disease (IMD).[32] The 2017 guidance included milestones a state must achieve for an IMD SUD waiver, including supporting access to care and access to sufficient provider capacity for level of care; use of evidence-based SUD criteria for placement, program standards, and measuring residential treatment provider qualifications; implementation of treatment and prevention strategies to address OUD; and improved transition between levels of care and care coordination.[32]

In November of 2018, CMS issued a new guidance that allowed states to create delivery systems specific to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).[30] In addition, the new guidance allowed states to apply for IMD payment exclusions for adults with SMI or children with SED. Similar to a previous guidance, this guidance included milestones that a state must achieve for an IMD payment waiver for mental health services, including ensuring the quality of institutional care; improving care coordination and transition to community-based care; increasing access to crisis stabilization services; and identifying SEDs and engaging in treatment early through increased integration.[30] Previously, Congress had prohibited the use of Medicaid funds for IMD services for non-elderly adults.[33]

Disaster Relief

In response to several national catastrophes, Section 1115 demonstrations have been used to assist states with Medicaid programs during times of natural disasters or other national emergencies. States can choose to amend pending Section 1115 waivers or submit a new Section 1115 demonstration request to address the impact of the emergency on their state. In cases of urgent need, CMS may waive the standard 30-day public comment period to expedite the request.[34] To assist states with addressing the COVID-19 public health emergency, CMS developed a new Section 1115 demonstration opportunity available retroactively to March 1, 2020 until no later than 60 days after the end of the public health emergency.[35] As of March 2021, twelve states had approved Section 1115 waivers to address COVID-19.[36] The waiver could be used to extend HCBS flexibilities to enrollees receiving long-term services and supports. It could also be used to accept self-attestation of applicant resources, which supports Medicaid agencies in streamlining their eligibility determinations.[35] While comment periods and budget-neutrality requirements did not apply, states were required to complete a final monitoring and evaluation report, including data on implementation, lessons learned, and best practices for similar situations, by one year after the end of the COVID-19 Section 1115 demonstration authority.[35]

Section 1915(b) Waiver

Authority and Purpose

In 1981, Section 1915(b) waiver authority was established under the Omnibus Budget Reconciliation Act to allow experimentation within Medicaid delivery systems.[15] States primarily use Section 1915(b) waivers to implement managed care delivery systems by allowing CMS to waive statutory requirements for comparability, state wideness, and freedom of choice.[15] Because of these commonly waived requirements, Section 1915(b) waivers are generally referred to as "Freedom of Choice" waivers. The four types of waivers within Section 1915(b) authority are presented in Table 2. States typically use Section 1915(b)(1) and Section 1915(b)(4) to implement managed care delivery systems.

Table 2. Overview of Section 1915(b) Waivers

Type of Waiver	Description
Section 1915(b)(1)	Freedom-of-choice waiver: This waiver gives states the authority to mandate enrollment into a managed care plan or primary care case management program.[15]
Section 1915(b)(2)	Enrollment broker: A state may allow a county or local government to serve as a central broker helping enrollees choose among competing Medicaid MCOs.[37]
Section 1915(b)(3)	Sharing of cost savings with enrollees: This authority uses cost savings resulting from a managed care program to provide additional services to enrollees.[37]
Section 1915(b)(4)	Selective contracting waiver: Use of the waiver generally limits the number and type of providers accessible to Medicaid enrollees so states can contract specific providers through a fee-for-service or managed care model. States cannot use this waiver to restrict providers of family planning services and supplies.[15]

Section 1915(b) waivers are generally categorized as program waivers. CMS requires states to use a preprinted form in waiver applications and demonstrate cost-effectiveness.[15] Unlike Section 1115 waivers, there is a 90-day clock on the timeframe for approval, meaning that once the state sends their waiver application to CMS, the HHS secretary has 90 days to make a decision, otherwise the change goes into effect.[15] If the secretary requests additional information from the state, the clock resets once the state submits the requested information.[15] These waivers are initially approved for two years, with a renewal for up to two years. If they enroll individuals who are dually eligible in Medicaid and Medicare, the initial waivers can be approved for up to five years.[15]

Notable Uses of Section 1915(b) Waivers

Section 1915(b) waivers are primarily used by states for three purposes: limiting freedom of choice, "carving-out" Medicaid services, and mandating enrollment in managed care.

Limitations on Freedom of Choice

States use Section 1915(b)(4) waivers to limit providers from which an enrollee can receive certain services. This is done for a variety of reasons, including selectively contracting with providers on a capitated basis. Another is to limit the provision of services to specific providers under a program administered by the Medicaid agency, such as is used in the Delaware Pathway to Employment Program. Delaware currently operates a Pathway to Employment Program that provides employment opportunities to teens with low income and young adults with various disabilities, including autism spectrum disorder, physical disabilities, and visual impairment.[38,39] The program offers employment navigation services and non-medical transportation for individuals to get to work. Delaware uses a 1915(b)(4) waiver to limit freedom of choice of providers for the employment navigation service and to utilize selective contracting for non-emergency medical transportation.[39]

"Carve-Outs" of Medicaid Services

States can "carve out" or exclude certain services from the traditional Medicaid program contract. Under a Section 1915(b) waiver, they can limit the provision of these select services to certain providers. An example of this is California's Medi-Cal Specialty Mental Health Services program. California Medicaid (Medi-Cal) currently "carves out" mental health services from operating under the broader Medi-Cal program. Instead of functioning under the Medi-Cal system, which primarily employs MCOs to deliver physical health care, the responsibility of providing mental health services is contracted out to County Mental Health Plans (MHPs). MHPs are paid a capitated rate by the state Medicaid agency and are responsible for arranging the provision of mental health services for enrollees in their counties. California has seen this as beneficial to mental health care, as savings can be reinvested back to the mental health delivery system.[40] This program operates under a Section 1915(b)(4) waiver that has been in place since 1995.[41]

Mandatory Enrollment in Managed Care

Under Section 1915(b)(1), states can require enrollees to obtain medical care through a managed care delivery system. This can be done on a comprehensive scale, for select enrollees, or for select services. Typically, Section 1915(b)(1) waivers are used for mandating enrollment in MCOs for all enrollees in the state. Although less frequent, states also use this waiver to mandate enrollment in primary care case management or an accountable care organization. Colorado uses this waiver to operate their Accountable Care Collaborative Program, establishing seven Regional Accountable Entities (RAEs) to function as primary care case management entities. Each RAE serves a select geographic region and is responsible for coordinating member care, ensuring connection with health care, and developing community-based strategies for addressing health issues.[42] The Section 1915(b)(1) waiver, therefore, is used to ensure that all Medicaid enrollees obtain medical care through the RAE.[43]

Section 1915(c) Waiver

Authority and Purpose

Section 1915(c) waiver authority was enacted in 1981 under the same legislation that established Section 1915(b) waiver authority. A Section 1915(c) program waiver, known as an HCBS waiver, grants a state authority to waive comparability requirements to offer HCBS to a limited group of enrollees who otherwise would require institutional care in nursing homes, intermediate care facilities, or hospitals.[14] Supporting an enrollee in their home rather than in an institution can potentially increase the quality of care received and member satisfaction. Under Section 1915(c) waivers, states allow CMS to waive statutory requirements for comparability, state wideness, and/or income and resource rules applicable in the community.[17] The services covered under a Section 1915(c) waiver are those that are required to avoid institutionalization, including adult day health, rehabilitation, respite care, home health aide and personal care, and case management.[14] States choose the maximum number of people who will be served under a Section 1915(c) waiver program and target the population based on age or diagnosis (e.g., autism, traumatic brain injury, HIV/AIDS, epilepsy, or cerebral palsy).[17] There is no limit on how many HCBS waivers states can operate simultaneously. States are encouraged to use a CMS preprinted application form, and the application must demonstrate cost-neutrality.[14] Similar to Section 1915(b) waivers, there is a 90-day clock for a response from the HHS secretary once CMS receives the application.[14] These waivers are generally approved for three years, with renewals for up to five years.

Of note, if a state would like to deliver HCBS through a managed care delivery system, they must apply for both Section 1915(b) and Section 1915(c) waivers separately and meet separate reporting requirements for each waiver.[37] In a 2018 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended that Congress revise Section 1915(c) waiver authority to permit these waivers to waive freedom of choice and selective contracting, thereby simplifying the application process and reporting requirements for states.[37]

Notable Uses of Section 1915(c) Waivers

Section 1915(c) waivers are traditionally used for the provision of HCBS in lieu of institutional care. States usually target certain populations in the waivers, such as individuals with disabilities or the elderly. States also have used the waivers to administer housing, education, and employment assistance and respond to emergencies.

Housing

Some states use Section 1915(c) waivers to pay for housing-related services. Although Medicaid funds cannot be used to pay for room and board, they can be used to pay for transition services, housing tenancy services, and assistance with locating housing.[44] Minnesota provides housing access coordination to its enrollees through four Section 1915(c) waivers. Under these waivers, housing counseling services are offered to individuals who qualify for HCBS services. These counseling services help individuals find affordable housing, pack and move their belongings, locate affordable furniture, and develop budgets, among other tasks.[45-48] In addition, the waivers fund home modifications, such as doorway widening, wheelchair ramps, and stair-lift installations, that enable individuals with disabilities to live more comfortably.[49]

Education

Many states have integrated educational support into their Section 1915(c) waiver programs. These supports may involve education coaches, peer mentors, career services, transportation, and technology assistance.[50] Most of this assistance is administered at the post-secondary level. Pennsylvania's Consolidated Waiver is unique in that it allows Medicaid funds to be used to pay for tuition and fees. This waiver implements Pennsylvania's Education Support program for individuals with disabilities. Under this program, Medicaid funds can be used for tuition and fees for classes offered by a university, community college, or technical school. This can include classes teaching American Sign Language to individuals who are deaf. The classes must be held at a physical university and cannot be taken online. Over a participant's lifetime, the Medicaid program will pay for up to $35,000 in tuition and fees.[51]

Employment

Section 1915(c) waivers provide many opportunities for administering employment-related services. Although support for employment can be provided to the general Medicaid population, the services provided through Section 1915(c) waivers are often much more comprehensive.[52] These habilitation services are defined as any service assisting participants in acquiring the necessary skills for living in home and community-based settings. According to CMS, this allows for services that support an individual in obtaining and maintaining employment.[52] Wisconsin operates a Vocational Futures Planning and Support program through several of its Section 1915(c) waivers. This program provides employment services for HCBS participants, including résumé and interview services, help with finding jobs, and long-term job follow-up support. Vocational Futures Planning and Support is available to the elderly, individuals with physical disabilities, and individuals with developmental and intellectual disabilities.[53]

Emergency Response

In the case of an emergency (e.g., pandemic or epidemic, natural disaster, national security emergency, or environmental emergency), states can use the stand-alone Appendix K to request an amendment to approved Section 1915(c) waivers.[54] State strategies to respond to the COVID-19 pandemic have included modifying or expanding HCBS eligibility or services, modifying or suspending service planning and delivery requirements, and/or adopting policies to support providers.[36]

Section 1332 Waiver

Authority and Purpose

Under Section 1332 of the ACA, states are permitted to apply for State Relief and Empowerment Waivers – more commonly known as State Innovation Waivers – to support innovative strategies for providing affordable, high-quality health care while maintaining basic protections under the ACA.[55] Section 1332 authority allows for waiving of ACA requirements for individual and small-group markets. Although states are unable to change Medicaid program requirements through Section 1332 waivers, they may submit Section 1332 waivers alongside other Medicaid waivers.[56] States have expressed interest in using Section 1332 waivers to calculate budget-neutrality across Medicaid and Section 1332 waivers, substitute for Medicaid expansion, and receive enhanced federal funding without fully expanding Medicaid. However, the strict guardrails that must be met before a Section 1332 waiver is approved will likely impede states from using Section 1332 waivers to achieve those goals.[57] A proposed Section 1332 waiver must satisfy the following four guardrails:[57]

- Cover at least as many people under the waiver as would have had coverage without the waiver.
- Coverage must be as affordable under the waiver as it would be without the waiver; this includes protection against excessive out-of-pocket spending.
- Coverage must be at least as comprehensive under the waiver as it would be without the waiver.
- The waiver cannot increase the federal deficit.

Section 1332 waivers are approved for five-year periods and can be renewed.[18]

Potential Use of Section 1332 Waivers

Section 1332 waivers could potentially be used by states for Medicaid buy-in programs.

Medicaid Buy-In

States have the option of using Section 1332 waivers to permit individuals with incomes above the threshold for Medicaid eligibility to "buy-in" to Medicaid. This would allow the state to increase coverage for this population and strengthen the state Medicaid program. By buying-in, states could improve marketplace coverage and affordability and create similar health plans to standardize care received by individuals. The lower-premium plan created from a buy-in would lower federal tax credit subsidies, which the state can receive as pass-through funding.[58] As of March 2021, no states have had a Section 1332 waiver approved for this purpose.

Section 1135 Waiver

Authority and Purpose

Under Section 1135 of the Social Security Act, in the event of an emergency or disaster, the HHS secretary can waive certain Medicaid requirements to guarantee that sufficient health care items and services are available to enrollees in affected areas.[19] Waiver authority is triggered by the president of the United States declaring an emergency or disaster, under the Stafford Act or the National Emergencies Act, and the HHS secretary declaring a public health emergency.[19] A Section 1135 waiver can be used by the HHS secretary on a blanket basis or as an individual in response to a provider request. A blanket waiver would be used if it is determined that a situation is affecting a large group of providers in similar situations because it is more efficient than responding to several similar requests.[59] Those exercising flexibility under a blanket waiver must do so in good faith, absent any fraud or abuse.[19]

In response to the COVID-19 pandemic in March 2020, CMS issued blanket waivers and put forth a waiver request template for states to apply for individual waivers. The waiver request template lists five key areas and flexibilities, including Medicaid prior authorization requirements, long-term services and supports, fair hearings, provider enrollment, and reporting and oversight. States also are allowed to request additional flexibilities not listed in the templates.[19] The Section 1135 waivers typically end no later than the termination of the emergency period, or up to 60 days from when the waiver is first published.[59]

Notable Uses of Section 1135 Waivers

Section 1135 waivers were used to address the COVID-19 pandemic.

Emergency Response

As of March 2021, CMS approved at least one Section 1135 waiver for all 50 states and the District of Columbia (and three U.S. territories) to support state responses to the COVID-19 pandemic.[36] The most common waiver provisions approved for all states and the District of Columbia were provider enrollment and included waiving provider screening requirements, postponing deadlines for revalidation of providers, allowing out-of-state providers with equivalent licensing in other states, and permitting out-of-state providers to provide care to Medicaid enrollees. Additional Section 1135 waiver provisions included:[36]

- 48 states suspended pre-admission screening and annual resident review for levels I and II for 30 days in their long-term services and supports programs;
- 46 states modified their deadline for submission of COVID-19 related SPAs effective in a previous calendar quarter;
- 46 states waived providing public notice for submission of emergency-related SPAs and/or Section 1115 waivers;
- 44 states allowed service provision in alternative settings, including unlicensed facilities;
- 43 states suspended fee-for-service prior authorizations; and
- 43 states gave enrollees additional time to request a state fair hearing.

Section 1135 waivers to address the COVID-19 pandemic are continuously updated during the pandemic as needed. Please refer to Appendix A for the state waivers that are currently approved and Appendix B, for a resource list to follow updated Medicaid emergency authority approvals to address COVID-19. This issue brief was published during the COVID-19 pandemic, so the information presented reflects actions taken up until March 2021.

Appendix A. Approved Waivers by State as of March 1st, 2021

	Section 1115[22, 60]	Section 1915 (b)[60]	Section 1915 (c)[60]	Section 1135[36]
Alabama	X	X	X	X
Alaska	X		X	X
Arizona	X			X
Arkansas	X	X	X	X
California	X	X	X	X
Colorado	X	X	X	X
Connecticut		X	X	X
Delaware	X	X	X	X
District of Columbia	X		X	X
Florida	X	X	X	X
Georgia	X		X	X
Hawaii	X		X	X
Idaho	X	X	X	X
Illinois	X	X	X	X
Indiana	X	X	X	X
Iowa	X	X	X	X
Kansas	X		X	X
Kentucky	X	X	X	X
Louisiana	X	X	X	X
Maine	X	X	X	X
Maryland	X	X	X	X
Massachusetts	X	X	X	X
Michigan	X	X	X	X
Minnesota	X	X	X	X
Mississippi	X	X	X	X
Missouri	X	X	X	X
Montana	X	X	X	X
Nebraska	X	X	X	X
Nevada		X	X	X
New Hampshire	X	X	X	X
New Jersey	X		X	X
New Mexico	X		X	X
New York	X	X	X	X
North Carolina	X	X	X	X
North Dakota		X	X	X
Ohio	X	X	X	X
Oklahoma	X		X	X
Oregon	X	X	X	X
Pennsylvania	X	X	X	X
Rhode Island	X			X
South Carolina	X	X	X	X
South Dakota	X		X	X
Tennessee	X		X	X

Appendix A. Approved Waivers by State as of March 1st, 2021 (Continued)

	Section 1115[22, 60]	Section 1915 (b)[60]	Section 1915 (c)[60]	Section 1135[36]
Texas	X	X	X	X
Utah	X	X	X	X
Vermont	X			X
Virginia	X	X	X	X
Washington	X	X	X	X
West Virginia	X	X	X	X
Wisconsin	X	X	X	X
Wyoming	X	X	X	X

Note: As of March 2021, 15 states are using Section 1332 waiver authority in their individual and/or small-group markets, none of the 50 states or DC is using a Section 1332 waiver to make changes to their Medicaid program.

Appendix B. State Medicaid Waiver Tracking Resources

Resource Description	Link to Location
Centers for Medicare and Medicaid Services Searchable, dynamic database of all current and concluded state programs authorized under Section 1115, Section 1915(b), and Section 1915(c).	https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
Kaiser Family Foundation Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19 including Section 1115, Section 1135, and Section 1915(c) Appendix K strategies Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State Tracking Section 1332 State Innovation Waivers (State Relief and Empowerment Waivers)	https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table4 https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/ https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/
Institute for Medicaid Innovation Characteristics of State Medicaid Programs and Actions Taken by States to Address COVID-19, including Section 1135 waivers and Section 1915(c) Appendix K waivers (as of June 2020)- The Institute for Medicaid Innovation (Appendix pages 9, 10) Medicaid State Fact Sheets contain a comprehensive overview of Medicaid programs across all 50 states, the District of Columbia, and Puerto Rico and include important updates, eligible populations, current Section 1115 waivers, and delivery systems used in each state.	https://www.medicaidinnovation.org/_images/content/2020-IMI-Medicaid_Enrollment_During_COVID19_Report.pdf https://www.medicaidinnovation.org/current-initiatives/state-facts

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