Section 1115 Waiver Transparency Process

December 2013

The health care system in the United States is quickly changing in response to the passage and implementation of the Patient Protection and Affordable Care Act of 2010. Each individual state will define what these changes will look like within their system. The Centers for Medicaid & Medicaid Services (CMS) has put into place processes to allow states to individualize their Medicaid program to best serve their population. Section 1115 Waivers allows states to waive certain Medicaid requirements in order to test new benefit designs and new approaches for delivering health care as long as they promote the objectives of the Medicaid program. If a State wants to make administrative changes to their Medicaid Plan, they may apply for a State Plan Amendment (SPA). This includes changing provider payment rates, adding or cutting optional services, adding managed care, and changing benefit structures like prescription limits or cost-sharing. However, these proposed changes must comply with federal Medicaid regulations. The difference between a SPA and a 1115 waiver is the a SPA is altering a state rule or policy within the confines of the current Medicaid law and regulations whereas an 1115 waiver allows a state to do (or not do) something otherwise prohibited (or required) under federal Medicaid law such as waive FQHC services and payment protections whereas a state could not do so with a SPA.

Section 1115 Waivers

Section 1115 of the Social Security Act (SSA) allows the Secretary of the Department of Health and Human Services to approve waivers for experimental, pilot or demonstration projects. These waivers provide Federal Financial Participation (FFP) for costs that would not otherwise qualify as expenditures under the Medicaid State plan.[1] Section 1115 demonstrations must be budget neutral to the federal government; this means that federal expenditures needed for the demonstration will not increase to levels greater than federal spending without the waiver.[2]

The Affordable Care Act (ACA) made some important changes to the Section 1115 waiver approval process, requiring more transparency and public input on these waivers. In April 2012, CMS updated the approval process for Section 1115 in accordance with Section 10201(i) of the of the ACA.

Applications

States may develop their own template or use the application template available at Medicaid.gov. Regardless of which application is used there are components that must be included.

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[1] "Section 1115 Demonstrations," *Centers for Medicare & Medicaid Services,* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

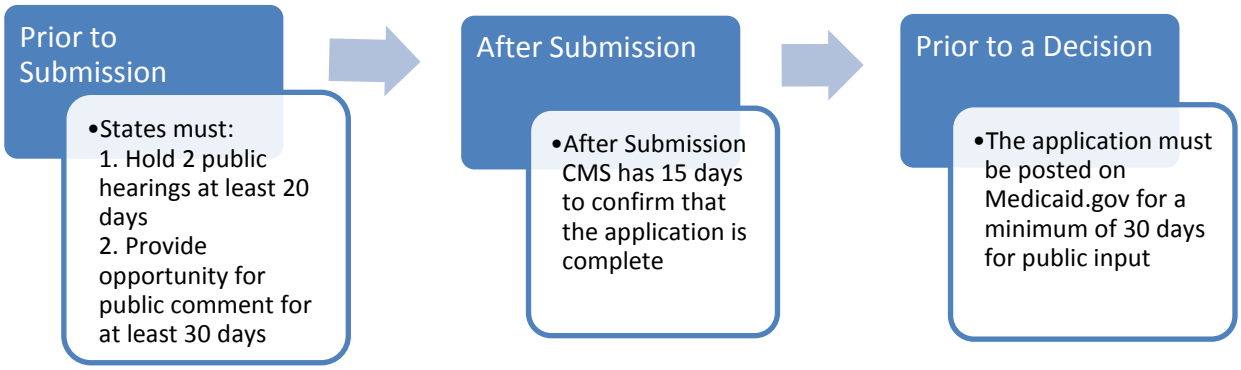
[2] "Section 1115 Demonstrations," *Centers for Medicare & Medicaid Services,* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

These include:

- A comprehensive description of the demonstration, including goals and objectives
- A description of the proposed health care delivery system, eligibility requirements, benefits and cost-sharing requirements for individuals who will be covered under the demonstration
- An estimate of the increase or decrease in annual enrollment and expenditures as a result of the demonstration
- Current enrollment data and projections
- Other program features that would modify the State's Medicaid and CHIP programs
- The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration
- A research hypothesis and evaluation design related to the demonstration proposal
- Written documentation of the State's compliance with the public notice requirements
- The populations affected by the demonstration
- The financing of the demonstration[3]

Time Frame

The application and approval process time frame has been defined by CMS. Before submitting an application states must provide the public with the opportunity to assess and comment on the proposed waiver. The state must hold at least two public hearings at least 20 days prior to submission of the waiver application to CMS. The public must have a minimum of 30 days prior to submission of the application to CMS to provide comments. The state must include in their application how they evaluated and addressed the comments provided by the public. After submission of an application CMS has 15 days to confirm that the application is complete. The application must then be posted on www.medicaid.gov for a minimum of 30 days for public input before CMS renders a decision. CMS will not provide a decision until at least 45 days after the application is complete.[4]



[3] "How States Apply," *Centers for Medicare & Medicaid Services,* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/application.html

[4] Mann, Cindy, "Re: Revised Review and Approval Process for Section 1115 Demonstrations." Federal Policy Guidance Letter, April 27, 2012, *Centers for Medicare & Medicaid Services* http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-001.pdf

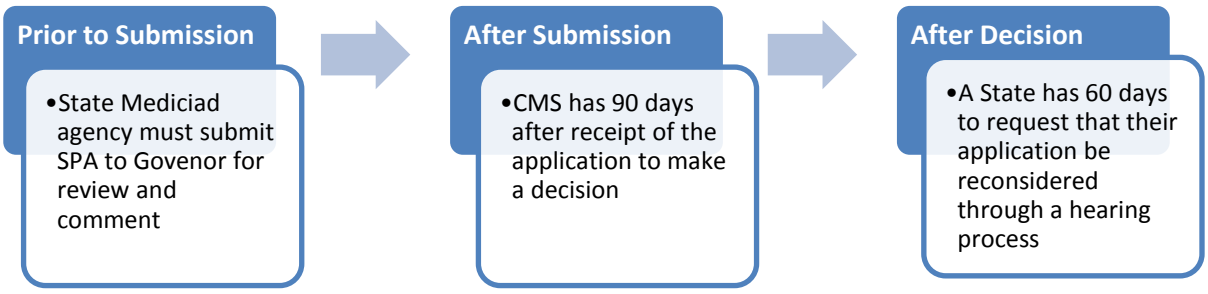
Medicaid State Plan Amendments

If a state wants to make changes to its payment methods it may be required to submit a State Plan Amendment (SPA). The State Plan serves basically as a contract between a state and the Federal Government, and a SPA is a change or addition to that agreement that must be approved by CMS. This contract describes how the state will administer its Medicaid program in accordance with federal rules and regulations in order to receive federal funding. As Medicaid is funded jointly by the federal government and the states, part of the approval process includes an evaluation of the financing of the program. Before approving a SPA, CMS must verify that states will be able to fulfill their funding obligations in accordance with statutes and regulations so that the state can receive FFP.[5]

New payment methods must be consistent with regulations set forth within the SSA and other federal statutes and regulations. Specifically, states must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[6][7] As states update and change their Medicaid programs they must send a SPA to CMS for review and approval. Before the effective date the state must issue public notice of the change in order to "widely inform providers and other stakeholders of changes to Medicaid payment rates".

Process

Section 430.12 of Title 42 of the Code of Federal Regulations defines the process for submitting a SPA. The Medicaid agency must submit the State plan and SPA to the State Governor or his/her designee for review and comment before submitting them to the CMS regional office. Any comments from the Governor must subsequently be submitted with the SPA. CMS then has 90 days after receipt of the SPA to notify the state of the approval decision. If a plan is not approved a state has 60 days after receipt of notice to request that the plan be reconsidered through a hearing process.[8]



[5] "Medicaid State Plan Amendments," *Centers for Medicare & Medicaid Services,* http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html

[6] Of course, payment requirements with regard to FQHCs are specifically provided in the Medicaid statute and go well beyond this general requirement. Section 1902(bb) of the SSA.

[7] "Financing & Reimbursement," *Centers for Medicare & Medicaid Services*, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html

[8] "Electronic Code of Federal Regulations," *U.S. Government Printing Office*, http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=8389bd7cc246df497bbc277846a32bb6&rgn=div8&view=text&node=42:4.0.1.1.1.2.1.2&idno=42

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