

## Summary of Waivers Under 1115

Social Security Act section 1115 allows the Secretary of Health and Human Services to waive statutory and regulatory provisions for health and welfare programs, including Medicaid and CHIP. Specifically, states can request a waiver of specific subsections within section 1902 and 1903 of the Social Security Act in order to effectively create an 1115 demonstration project.

### I. Social Security Action § 1902

Section 1902 lists the requirements for Medicaid state plans ranging from administrative requirements to eligibility and benefit requirements. To facilitate the administration and goals of an 1115 demonstration project, it is often necessary to seek a waiver of certain of the state plan requirements listed in section 1902. Of the many requirements in section 1902, the ones that are most commonly at odds with a state's demonstration project relate to (i) statewide application, (ii) proper and efficient administration, (iii) benefits, (iv) cost sharing, (v) freedom of choice, (vi) nursing facility requirements, and (vii) eligibility requirements.<sup>1</sup> Through waiving these sections of 1902, many 1115 demonstration projects seek to cap enrollment, offer alternative benefit packages to different populations, implement cost sharing requirements, cover individuals who would otherwise not be eligible for Medicaid/CHIP, and combine physical, behavioral and long term care services into a single service delivery system.

The following is a list of section 1902 waivers that have been recently requested by states.

#### 1. Statewideness/Uniformity

**Section 1902(a)(1)**  
**42 CFR 431.50**

Has been requested to limit application of a demonstration to a certain part of the state or to phase in a statewide demonstration.

#### 2. Proper and Efficient Administration

**Section 1902(a)(4)(A)**  
**42 CFR 438.52**

Has been requested to permit a state to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan in which he or she was previously enrolled.

Has also been requested to permit a state to restrict the ability of members to disenroll from a managed care plan for a certain number of days.

Has also been requested to allow the state to have only pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

#### 3. Reasonable Promptness

**Section 1902(a)(8)**

Has been requested to enable a state to limit enrollment in certain programs to the enrollment targets established by a state.

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<sup>1</sup> See Social Security Act § 1902, available at [http://www.ssa.gov/OP\\_Home/ssact/title19/1902.htm](http://www.ssa.gov/OP_Home/ssact/title19/1902.htm). See also FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS June 2011, available at <http://www.kff.org/medicaid/upload/8196.pdf>.

**4. Amount, Duration and Scope of Services**

**Section 1902(a)(10)(B)  
42 CFR 400 Subpart B**

Has been requested to enable a state to offer a different benefit package or cost-effective alternative benefit packages to different populations under a demonstration.

**5. Member Rewards**

**Section 1902(a)(10)(C)(i)**

Has been requested to enable a state to exclude funds provided through member reward programs from income and resource tests established under state and Federal law for purposes of establishing Medicaid eligibility.

**6. Comparability and Amount Duration and Scope**

**Sections 1902(a)(17) and  
1902(a)(10)(B)**

Has been requested to enable a state to determine whether an individual has a continuing need for nursing facility services and home and community-based services based on criteria in use when the individual first was determined to need the service.

**7. Freedom of Choice**

**Section 1902(a)(23)  
42 CFR 431.51**

Has been requested to enable a state to require mandatory enrollment in managed care plans for all populations.

Has been requested to enable a state to limit the choice in managed care plans.

Has been requested to require all eligible members of a single family unit to enroll in the same managed care plan.

**8. Retroactive Eligibility**

**Section 1902(a)(34)  
42 CFR 435.914**

Has been requested to enable a state not to extend eligibility prior to the date that an application for assistance is made.

**9. Payment for Outpatient Drugs**

**Section 1902(a)(54)  
42 CFR 440.120, 447.331-  
447.334, and 456 Subpart K**

Has been requested to enable a state to establish a drug formulary that does not comply with the requirements of section 1927(d)(4) of the Act.

**10. Cost Sharing**

**Sections 1902(a)(14) and 1916  
42 CFR 447.51-447.56**

Has been requested to permit a state to impose an enrollment fee or a copayment that is in excess of the nominal amount permitted pursuant to section 1916 of the Act.

**11. Grievance and Appeals**

**Section 1902(a)(3)  
42 CFR 438.400**

Has been requested to allow a state to provide a uniform appeals process for Medicare and Medicaid dual eligibles.

**12. Eligibility**

**Section 1902(a)(10)**

**45 CFR 233.90(c)(1)(v)**

Has been requested to allow a state to expand eligibility to individuals who would not otherwise be eligible for Medicaid.

**13. Reimbursement/Disproportionate Share Hospital Payment      Section 1902(a)(13(A)(iv)  
42 CFR 447 Subpart E**

Has been requested to relieve the state from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low income patients.

**II. Social Security Act § 1903**

Under the authority of Social Security Act section 1115(a)(2), the state may seek to include expenditures that will arise under an 1115 demonstration that are not otherwise included in the list of expenditures in Social Security Act section 1903 as expenditures made under the State Medicaid Plan. These expenditures are limited by the special terms and conditions for the section 1115 demonstration.

Expenditures that are commonly sought through 1115 waivers include the following:

1. Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Some states have requested that managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m), except the following:
  - a. Section 1903(m)(2)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and Federal regulations at 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.
  - b. Section 1903(m)(2)(A)(xii) but only insofar as to allow mandatory enrollment into managed care plans.
  - c. Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g) but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditures to provide HCBS and care coordination services not included in the Medicaid state plan.
3. Expenditures that reflect the enhanced matching share for health home services under section 2703 of the Affordable Care Act for qualified health home models.
4. Expenditures for member rewards programs.
5. Expenditures for sole community hospital pool program where hospitals would be entitled to UPL funds if they meet certain targets.
6. Expenditures for expanded benefits and coverage of cost-effective alternative services to the extent those services are provided in compliance with federal regulations and the 1115 demonstration.

7. Expenditures for a uniform Medicare and Medicaid appeals process.
8. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients.
9. Expenditures to provide coverage of individuals who would not otherwise be eligible for Medicaid.
10. Expenditures for the continued receipt of nursing facility care or home and community based services – to the extent the state should change the level of care criteria.