Texas Public Policy Foundation

# The Saga of 1115—A Waiver Can Fix Texas Medicaid, But Only Temporarily


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# The Saga of 1115

## A Waiver Can Fix Texas Medicaid, But Only Temporarily

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### Executive Summary

Texas Medicaid, like all other Medicaid programs, has very large problems. Medicaid is federally mandated and therefore is the first dollar spent by the state. All other state spending priorities must adapt to Medicaid, which is the single largest expenditure in the Texas budget. While Medicaid creates the expectation in patients' minds of timely, appropriate care, this is not their reality. One-third of U.S. doctors do not accept Medicaid patients, making it difficult for many patients to access care. For those who do find a doctor, one study of medical quality showed that uninsured individuals did better after surgery than those covered by Medicaid.

Medicaid has fiscal imbalances, quality concerns and inadequate access to care. The root cause of these problems lies in Medicaid's administrative structure. Texas Medicaid is controlled by a one-size-fits-all federal bureaucracy in Washington, not locally by Texas.

Medicaid law includes a Section (#1115) by which a state can ask for a temporary waiver of specific mandates within current Medicaid. This allows a state to test an alternative to federally mandated procedure. This paper reviews the history of Sec. 1115 in the U.S. starting in 1965 when the Medicaid law was passed.

Chapter 537 of the Government Code became Texas law on September 28, 2011, after being included in SB 7 passed by the 82nd Texas Legislature during its first called session. It was a directive to the Health and Human Services Commission to seek an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in Washington that would allow Texas Medicaid the flexibility to operate without most of the federal Medicaid mandates. This would have given Texas control of its Medicaid program. In 2012, the Medicaid Reform Waiver Legislative Oversight Committee decided not to pass this waiver request forward to Washington.

The Texas Health and Human Services Commission should immediately begin developing a Chapter 537 waiver request for submission to the Centers for Medicare and Medicaid Services. Given President Trump's first executive order to "exercise all authority and discretion … to waive, defer, grant exemptions from … any provision or requirement of," the Affordable Care Act (ObamaCare) and "to afford the States more flexibility and control to create a more free and open healthcare market," there is a strong possibility that a waiver based on Chapter 537 will be granted. Texas should immediately begin the planning and preparation necessary to implement fundamental changes in the Texas Medicaid program.

An 1115 waiver based on Chapter 537 would give Texas the flexibility to innovate in all components of the Medicaid program: eligibility standards, verification processes, care delivery models, incentivized reimbursement systems, "work requirement" (personal responsibility), benefits packages, most to be market-based rather than centrally regulated. The priorities for the new Texas Medicaid should be: 1) improving direct and indirect indicators of the health of Texans; 2) redirecting funds from healthcare bureaucracy to healthcare providers, i.e., being more dollar efficient; and 3) saving money.

Alternatives to seeking an 1115 waiver based on Chapter 537 are discussed in this paper. None is found to be preferable to the use of Chapter 537.

### Key Points

- Federal Medicaid mandates take the first and biggest bite out of the Texas budget, taking priority over all other state spending.
- If Texas controlled Texas Medicaid, it could provide better care to patients, reduce inefficiencies, and improve reimbursements to providers.
- Washington, not Texas, controls Texas Medicaid.
- Federal funding formula for Medicaid encourages spending, not saving!

## Introduction

In 1962, the Social Security Act of 1929 was amended to add a waiver or exemption process called Sec. 1115. In 1965, the Medicaid act was passed (Stout) including the Sec. 1115 waiver. When granted by Washington, such a waiver exempts a state for a specified period of time from certain federal rules and regulations as part of a "demonstration project." A state would handle its Medicaid program in ways other than that specified by federal law to determine if the alternate approach would more efficiently or effectively achieve the intentions of Medicaid by *doing it the state's way.*

For example, a state could apply to Washington for a waiver of federal specifications regarding the administration or the financing of their Medicaid program. All such waivers *must be budget neutral* for the federal government (Medicaid.gov 2017). If approved by the Centers for Medicare and Medicaid Services (CMS), the waiver is given a sunset date some years in the future.

One might presume that, at the end of the waiver period, if the state did demonstrate that its alternate approach was better—cheaper, higher quality, and/or improved access—the state could continue doing what it proved was effective. However, the 1115 waiver process as written is silent on this point.

## 2007: Texas' First 1115 Waiver

In 2007, Texas was granted its first Sec. 1115 waiver for a five-year period. This waiver provided a limited Medicaid benefit package for family planning services to women ages 18-44 with family income ≤ 185 percent of the Federal Poverty Level (FPL) who had no health insurance coverage.

Texas applied for a renewal of the waiver in December of 2011. Renewal was not approved because the federal government did not approve of the 82nd Texas Legislature's decision to prohibit the Women's Health Program within the Texas Health and Human Services Division from allocating funds to perform elective abortions or to give support to medical facilities that performed elective abortions.

After renewal was denied, Texas commenced its own purely state-funded program for uninsured women called Healthy Texas Women. This program continues to function within the abortion constraints created by the 82nd Texas Legislature's decree.

## 2011: Texas' Second 1115 Waiver

In 2011, Texas was granted a second, different five-year Sec. 1115 waiver, this time from rules and regulations of ObamaCare, which had been passed in March 2010 (Centers for Medicare & Medicaid Services). The new waiver allowed Texas to convert essentially all Medicaid recipients from fee-for-service payment system to managed care in an effort to reduce costs.

A study of the reduction in costs prepared by Milliman for the Texas Association of Health Plans estimated that the managed care structure developed under the 1115 waiver significantly reduced costs "when compared to estimated expenditures on a fee-for-service structure" (Hart). Milliman estimated that over a six-year period (2010-2015) overall Medicaid costs were reduced by $3.8 billion, or 7.9 percent. The reduced costs in state funds totaled about $2 billion over those six years.

Texas' current 1115 waiver was set to terminate in September 2016. CMS extended the waiver for 15 months till December 31, 2017 in order to allow Washington and Austin to complete negotiating terms of a renewal. Negotiation was necessary because of the passage and implementation of the ACA. That law contains provisions that impact both the Delivery Systems Reform Incentive Payment (DSRIP) program and the Uncompensated Care Pool. Austin and Washington must agree on new formulae for state and federal contributions if an extension is to be granted.

## 2011: Texas' "Premature" Medicaid Waiver

In 2001, the 82nd Texas Legislature passed SB 7 during its first called session. SB 7 created Chapter 537 of the Texas Government Code (Texas Government Code. Chapter 537), which is a directive to the Health and Human Services Commission to seek an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in Washington.

Chapter 537 requires that the waiver must be designed to achieve several objectives regarding Medicaid and Texas' ability to innovate alternatives to current Medicaid processes, such as:

## Table 1: New Mexico's Experience with Medicaid Expansion

| | Year | Medicaid Enrollees | Federal Revenue |
|---|---|---|---|
| Actual: Before Expansion | 2014 | 587,103 | $3.1 billion |
| *Projection made in 2012* | *2020* | *799,000* | *$6.2 billion* |
| Actual: After Expansion | 2016 | 830,000 | $4.5 billion |

Source: Brent Earnest, Secretary of Health and Human Service and Director of Medicaid for the state of New Mexico.

- Flexibility in eligibility
- Flexibility in benefits
- Use of private health benefits rather than public benefits systems
- Create a culture of shared financial responsibility
- Consolidate federal funding streams
- Flexibility in the use of state funds to obtain federal matching funds
- Empower the uninsured to acquire health coverage with fees paid at point of service
- Allow re-design of long-term care services

Another provision in SB 7 established a Medicaid Reform Waiver Legislative Oversight Committee to "facilitate the design and development of the Medicaid reform waiver required by Chapter 537." However, in its Report letter (Medicaid Reform Waiver Legislative Oversight Committee) the Legislative Oversight Committee decided:

> "In light of the current Medicaid environment addressed above, uncertainties surrounding the impact of the ACA, and the need for the 83rd Legislature to meet and determine the direction of the Texas Medicaid program, a new Medicaid 1115 waiver request would be premature at this time."

## Texas Rejects Medicaid Expansion

Texas has consistently rejected calls to expand its Medicaid program—eligibility, benefits, administrative process, and funding—under the terms of the ACA. Its reluctance is bolstered by the experience of our bordering state, New Mexico. Medicaid expansion there was approved in 2013 and implemented concurrent with the rest of the ACA in January 2014.

In 2012, the New Mexico (NM) Legislative Finance Committee released its projections for Medicaid expansion. Table 1 compares those 2012 projections to the actual experience up through 2016. Despite the infusion of billions of federal dollars, NM Medicaid experienced a budget crunch when more than 240,000 additional people gained "free" health insurance coverage through the Medicaid program with federally mandated benefits that cost more than the newly available federal dollars.

This occurred because even though Medicaid enrollees had increased after expansion by more than projections, federal revenue increased by less than projections (Boyd). As a result, the $928.5 million in state funds allocated by the New Mexico Legislature for Medicaid—which included a $20.8 million increase—was about $86 million short of what was requested by the state's Human Services Department to keep up with expanding enrollment and costs. This led NM Medicaid to cut reimbursements to physicians an average of 5 percent, which may have exacerbated the problem of Medicaid patients being unable to find a physician. One study reported that in 2011 more than 31 percent of U.S. doctors were not accepting new Medicaid patients (Galewitz).

Medicaid expansion has had the following effects on New Mexicans:

- Within *two years*, Medicaid enrollment exceeded the maximum *six-year* enrollment projection. At present, 41 percent of the NM state population is enrolled in Medicaid.[1] If 41 percent of the Texas population became eligible for Medicaid and signed up, the number of enrollees would increase from 4.4 million to 10.7 million.

[1] Data on New Mexico Medicaid was obtained as direct email communication, October 16, 2016, from Brent Earnest, Secretary of Health and Human Service and Director of Medicaid for the state of New Mexico.

- NM Medicaid cut reimbursements to physicians. This likely reduced the number of available providers, constrained the availability of care services, and may have increased wait times before receiving care.

Since no one knows what Washington will do to the ACA and thus to Medicaid, what can Texas do to solve its Medicaid problems? A review of prior 1115 waiver experience in both Texas and in other states could provide guidance about how to move forward.

## States' Experience with Medicaid Waivers

Forty-five states including Texas and the District of Columbia have applied for a total of 101 waivers under Sec. 1115 of the 1965 Medicaid addition to the Social Security Act of 1935. Ninety-eight waivers were approved of the 101 requested. Most were renewed multiple times. Sixty waivers remain ongoing at present. The data reported here on Texas Medicaid waiver experience was found on the CMS website (Medicaid.gov 2016).

Many of the waivers were for the purpose of extending Medicaid coverage to people who were not eligible, such as childless adults and childbearing-age or postpartum women. Many other waivers were used to convert the Medicaid payment structure from fee-for-service to managed care. Several waivers were for the purpose of getting more money to cover uncompensated care—the "unfunded mandate" created by the Emergency Medical Transport and Labor Act of 1986.

The Affordable Care Act of 2010 required all states to expand their Medicaid programs. By its decision in *National Federation of Independent Businesses (NFIB) v. Sebelius*, No. 11-393 in June 2012, the U.S. Supreme Court struck down that provision of the ACA and made Medicaid expansion voluntary rather than mandatory (*NFIB v. Sebelius*).

The precise wording of Chief Justice John Roberts' majority (5-4) opinion in the 2012 *NFIB v. Sebelius* case is noteworthy:

> "In the typical case we look to the States to defend their prerogatives by adopting 'the simple expedient of not yielding' to federal blandishments when they do not want to embrace the federal policies as their own. *Massachusetts* v. *Mellon*, 262 U. S. 447, 482 (1923). The States are separate and independent sovereigns. Sometimes they have to act like it." (*NFIB v. Sebelius*, 49)

There is no provision under the Medicaid law to make permanent what was *demonstrated* as useful by the 1115 waiver "demonstration process." Thus, almost all successful waivers must be renewed or extended in order to continue the proven better process, but the law itself and its rules have not been changed.

Appendix I lists the experience of the states with the 1115 waivers. Of 101 requests for Sec. 1115 waivers, three were disapproved. One from Minnesota was rejected because the application was incomplete. The other two rejections are instructive.

In 2013, Connecticut asked for an 1115 waiver to limit Medicaid eligibility based on parental family assets: if assets were great enough, free Medicaid coverage would be denied. The Centers for Medicare and Medicaid Services (CMS) rejected this application.

In 2016, Ohio sought an 1115 waiver to effect two changes: the state wanted to 1) charge Medicaid enrollees some amount of the premium costs, even a nominal sum, regardless of income, so that individuals would have some "skin in the game," and 2) withhold coverage from Medicaid enrollees who failed to pay whatever fees were due. CMS rejected this waiver.

These two attempts to inject some level of personal responsibility into state Medicaid programs were deemed unacceptable by Washington.

## Options for Texas Medicaid

Texas, like all other states, has a fundamental budget problem: spending by the state of Texas on Medicaid is not controlled by the state of Texas. This produces two adverse outcomes: 1) Texas cannot fulfill its medical care obligations to the Medicaid population, such as timely care, as there are too few physicians who accept Medicaid reimbursement schedules (Galewitz), and 2) because Medicaid spending is federally mandated, it is the first dollar spent. All other spending needs—education, infrastructure, even border security—must make do with what is left over after Medicaid takes the biggest bite out of the Texas budget.

Here are two useful short-term solutions that Texas can pursue immediately:

### *Option—Renew Current Sec. 1115 Waiver*

The current 1115 waiver for Texas Medicaid has been a successful demonstration. Conversion to managed care is estimated to have achieved cost savings of more than $1 billion. Those funds could then be used to pay more of the costs of uncompensated care. In fact, without those additional funds, many rural Texas hospitals would not be able to keep their doors open.

In the past, virtually all requests for renewal of 1115 waivers from any state have been approved. It is likely that the new Trump administration—with former Rep. (Dr.) Tom Price (R-GA) as secretary of Health and Human Services and Seema Verma as director of CMS—will look favorably on Texas' request for renewal. It is unlikely that the new administration would link renewal of the Texas waiver to expansion of Texas Medicaid, as was done by the Obama administration.

To use an old doctor adage, "We have good news and bad news." The good news is that Washington is likely to grant Texas a renewal of the current (2011) 1115 waiver. The bad news is that such a renewal merely maintains the status quo. It does not solve the fundamental structural problem: Texas does not administer (control) its own Medicaid program.

### *Option—Move Forward with a New 1115 Waiver*

With the new Trump administration and a Republican majority in Congress more closely aligned to Texas in attitudes and philosophy, it seems likely that the 1115 waiver deferred in 2012 would be viewed favorably today.

President Trump's first Executive Order (Jan. 20, 2017) supports this conclusion. Note the presidential advice to accommodate a request for waivers:

> Sec. 2. To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications. (Proclamation No. 13,765)

Texas Medicaid run by Texas would be more efficient and more locally responsive when not constrained by unnecessary, expensive federal requirements.

If the Chapter 537 waiver were granted, it would effectively give Texas control of both revenue and spending for its Medicaid program and would restore the original (1965) concept of Medicaid programs "administered by [the states]" (Social Security Act). Texas could innovate and improve its Medicaid program in many ways. This list is exemplary and in no way exhaustive:

A 2015 study by the Texas Public Policy Foundation (Davidson and Ginn) showed that subsidizing private insurance for certain risk groups—pregnant women, children, and adults eligible for Temporary Assistance for Needy Families (TANF)—could save Texas Medicaid as much as $4 billion per year. This financing change, with its large savings, would only be possible if Texas were released from federal mandates.

Texas Medicaid run by Texas would be more efficient and more locally responsive when not constrained by unnecessary, expensive federal requirements. This would generate large financial savings as well as greatly improved physician and patient satisfaction. For example, a recent report (Suderman) described how improper payments by Medicaid rose over the past year. In 2015, 9.8 percent ($29 billion) of Medicaid expenditures were classified as improper whereas in 2016, the overpayment was $36 billion or 10.5 percent of that year's budget. Most improper payments were due to errors, not fraud or embezzlement. Such errors are inevitable. The sheer size and complexity of Washing-

ton-controlled Medicaid coupled with constant changes in the administrative structure and rules has created a situation where people simply cannot follow the rules.

A Texas-run Medicaid program could streamline its verification process while inserting frequent re-verification during the year so that those who are ineligible would be quickly identified (Ingram). Paying for ineligible individuals creates large improper payments as noted previously. Rather than seeking to recoup these monies after the fact, which is very expensive, real-time verification would pre-empt such unnecessary payments. In this way, Texas could address up front problems such as those identified in a GAO report on Medicaid abuse in Arkansas (Horton), which revealed that 43,000 enrollees in Arkansas Medicaid had home addresses outside the state; 12,000 had net worth greater than $100,000; and hundreds of deceased individuals were enrolled. As the report concluded, "Every dollar spent on ineligible enrollees is a dollar stolen from the truly needy."

- Texas could release free market forces into the insurance market by eliminating mandates for insurance carriers as well as the odious individual mandate. Sellers of insurance could then offer for sale what customers want. Customers could then shop for the best deal—"best" being determined by the individual, not Washington.

- Texas could insert a personal responsibility obligation such as the Reagan-Carlton work requirement, or the "Community Engagement and Employment" program incorporated into the Kentucky 2016 1115 waiver request that has not been decided yet by CMS.[2]

The only problem with the Chapter 537 waiver is that it is temporary and will expire typically five years after granting.

There is precedent for a single state having overlapping 1115 waivers. This occurred 45 times out of the 98 waivers granted. In addition, several states did ask for and were granted two different 1115 waivers in the same year. For Texas to ask for renewal of the 2011 waiver and at the same time to request a new 2017 Sec. 1115 waiver is not new or even unusual.

A Texas-run Medicaid program could streamline its verification process while inserting frequent re-verification during the year so that those who are ineligible would be quickly identified.

The elements of the Chapter 537 1115 waiver would go a long way to ameliorate many of the egregious aspects of Medicaid as it is currently structured. However, these improvements would be impermanent, by definition of an 1115 waiver. Texas would be forced to repeatedly ask Washington for permission to do what is best for Texans.

There are other options that Texas could pursue as noted below. However, these may have less chance of successfully addressing the long-term problems Texas faces.

### *Option—Amend Sec. 1115 of Medicaid Law*

Instead of requesting repeated renewals, Texas could seek an amendment to Sec. 1115 of the 1965 Medicaid law to allow conversion of successful "demonstrations" into permanent process. This is consistent with the wording and the spirit of Sec. 1115: test a process different from the standard and see if it works better than the standard. Why would one do a test or demonstration project, find something that works, and not then memorialize it? Allowing for permanent solutions proven successful through the waiver process would help end the constant uncertainty states face when dealing with the federal government about Medicaid today.

[2] Request for Section 1115 waiver dated August 24, 2016 signed by Kentucky Governor Matthew G. Bevin, for their Medicaid program titled, KentuckyHealth. Copy is available from Dr. Waldman at dwaldman@texaspolicy.com.

### *Option—Medicaid Block Grant*

Also known as consolidated annual funding, a block grant can be currently interpreted as simply giving a fixed lump sum to the state, rather than an amount proportional to how much the state spends. A block grant would eliminate the perverse incentive states have to spend more to get more from Washington.

If combined with a "no strings" approach, with Texas controlling all aspects of its own program as described in Chapter 537, this would allow Texas to solve its Medicaid problem (Waldman 2016). The key difference from Chapter 537 is that a No Federal Strings Medicaid Block Grant would be permanent, not temporary.

The Trump administration and the new Congress are discussing Medicaid block grants. Whether these block grants will become available to the states is pure speculation at this time.

### *Option—Request an Alternate Waiver*

There are other administrative waivers in addition to Sec. 1115, available to waive Medicaid federal requirements. Two such waivers are Section 1915, also in the Medicaid law, and Section 1332 of the Affordable Care Act.

The 1915 Waiver—parts (b) and (c) but not (a)—is expressly for the purpose of converting programs from a fee for service model to managed care. Texas has utilized the 1915 waiver five times in the past. Since Texas wants to do more with its current waiver than simply continue managed care, a 1915 waiver will not accomplish all of Texas' goals.

The Affordable Care Act of 2010 has a waiver process in its Section 1332 similar to Sections 1115 and 1915 in Medicaid. Under Section 1332, a state may request a variance from virtually any component of the president's namesake law. However, such a waiver does not exempt the state from "accomplishing the aims of the ACA" (Howard and Benshoof).

In the 2012 *NFIB v. Sebelius* lawsuit against the ACA, the U.S. Supreme Court said that the aims of President Obama's signature healthcare reform act could be either the wording of the law or as intended by the framers (*NFIB v. Sebelius*, 12). This decision attributes the power of mindreading to the executive branch, which can claim that it knows what the actual intent of the ACA law was regardless of what the law says.

The language in Sec. 1332 (45 CFR Part 155) also requires a state seeking a waiver to provide insurance coverage to at least a "comparable" number of persons as the statutory implementation of the ACA would cover, no fewer. That would require Texas to expand its program—a move that Texas has wisely avoided.

It would not make sense for Texas to apply for a 1332 waiver under the ACA. The Trump administration and Congress have both vowed to repeal or certainly drastically revise ObamaCare. Without knowing what the new regulatory and financial landscape will be, seeking a 1332 waiver is premature.

### *Option—Reform the FMAP*

Texas could request a change in the Federal Medical Assistance Percentage (FMAP) formula trying to increase the federal contribution to Texas Medicaid.

The FMAP formula is:

State average income ÷ National average income * 100.

The FMAP gives no credence to factors other than average income, such as percentage of impoverished citizens, cost of living, number of employed citizens, and burden of uncompensated care.

Texas contributes 8.4 percent of federal tax revenues yet receives only 6.8 percent of federal Medicaid contributions (Texas HHSC; Nevada Department of Health and Human Services). This means Texans contribute approximately $3 billion per year to other states' Medicaid enrollees.

By law, the federal contribution to a state Medicaid program cannot be less than 50 percent of the state's Medicaid budget, meaning Washington cannot contribute less than one federal dollar for each state dollar expended on Medicaid. The current Texas FMAP is made up of a 56.18 percent federal contribution and of 43.82 percent from Texas (ASPE).

Based on a Medicaid budget for FY 2017 of $30.6 billion, Texas General Revenue will contribute $13.4 billion and Washington will contribute $17.2 billion.

Note that the FMAP offers each state a powerful perverse incentive: it rewards spending rather than cost saving. The more a state spends on Medicaid, the more federal dollars the state receives.

While revising the FMAP might bring more federal Medicaid dollars into Texas, it will not solve the long-term, systemic fiscal concerns inherent in Texas Medicaid.

## Conclusion

Management guru Russ Ackoff (Ackoff) taught that the best way to solve a problem is to dissolve the root cause. Doctors say the only way to cure a patient is to treat and eliminate the etiology of disease, also called the root cause (Waldman 2015).

The root cause of Texas Medicaid problems is the lack of control by Texas of a supposedly jointly funded, state administered program for people "unable to support" themselves. If the root cause is lack of local control, then the obvious cure is to restore control to Texas.

For a number of reasons, including but not limited to the likely policy directions of the new administration in Washington, we believe that Texas can *dissolve* its Medicaid problem. That starts by Texas regaining control of its own Medicaid program. That can start with a new 1115 waiver that gives Texas a Medicaid block grant with no strings attached.

The question that would naturally follow this happy event—Texas controlling Texas Medicaid—is, what should we do with that control? How should Texas design a program for its vulnerable population? That question will be answered in a forthcoming paper titled, "What Should Texas Do With Medicaid?" ★

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## Appendix 1: National Experience with Section 1115 Medicaid Waivers

| State | Year of waiver | Renewed? | Expand Medicaid? | Waiver did the following: | Individuals Affected (N≈) |
|---|---|---|---|---|---|
| **Alaska** | None | | Yes | | |
| **Alabama** | 2000 | 3 times, Ongoing | --- | Provided family planning services for women not eligible for Medicaid (<133% FPL) | 400,000 |
| | 2016 | Ongoing | No | Transfer FFS to managed care | 1,044,000 |
| **Arkansas** | 1996 | 4 times, Ongoing | --- | Provided family planning services for women not eligible for Medicaid (≤200% FPL) | Not available |
| | 1997 | 4 times, Ongoing | --- | Increased number of children eligible for Medicaid | Not available |
| | 2002 | 3 times, Ongoing | --- | Changes distribution source for disabled children under Medicaid coverage | 3000 |
| | 2006 | 2 times, Expired 2013 | --- | Assists small businesses in providing employer-supported health insurance. Transfers previous 1915 waiver to 1115. Replaced by the ACA | Small business number unknown. 410,000 transferred |
| | 2013 | On-going | Yes | Premium assistance for childless adults to enroll through State Health Exchange | 240,000 |
| **Arizona** | 1982 | On-going | Yes | Used the 1115 waiver to opt the entire state into Medicaid program | ≈2,000,000 |
| **California** | 2005 | 1 time, Ongoing | Yes | Covers low-income childless adults. Created funding for uncompensated care. Created DSRIP. Increased managed care enrollment | ≈7,500,000 |
| **Colorado** | 2006 | 2 times, Ongoing | --- | Coverage for uninsured pregnant women with income ≤ 185% of FPL | ≈20,000 |
| | 2012-13 | No | Yes | Study of needs, capacity and delivery in population of childless adults ≤10% FPL. Done in preparation for Medicaid expansion under ACA | ≈10,000 |
| **Connecticut** | 2013 | Not approved | Yes | Impose asset limit of $10,000 for eligibility of dependents 19-25 yo. Would include parents' assets and income >185% FPL | 13,381 |
| **Delaware** | 1995 | 5 times, Ongoing | --- (Yes) | Converts enrollees from FFS to managed care. Special programs also specified as carve-outs | 200,000 |
| **District of Columbia** | 2010 | Expired in 2015 | Yes | Provides coverage for childless adults <200% FPL. Replaced by Medicaid expansion | 150,000 |
| **Florida** | 1998 | 4 times, Ongoing | --- | Supports coverage for 2 years for: (a) family planning for women who lost Medicaid coverage; and (b) women with family income <185% FPL | 80,000 |
| | 2005 | 2 times, Ongoing | --- | Covers specified aged and disabled individuals without other coverage and with income <88% FPL | 45,000 |
| | 2013 | One year only | No | Extends eligibility for specified individuals | Not available |
| | 2014 | Ongoing | No | Converts FFS to managed care. Provides money to caregivers when patients are underinsured or uninsured | 400,000 |

| State | Year of waiver | Renewed? | Expand Medicaid? | Waiver did the following: | Individuals Affected (N≈) |
|---|---|---|---|---|---|
| **Georgia** | 2010 | Ongoing | No | Supports family planning services to women not otherwise eligible with family income <200% FPL | |
| **Hawaii** | 1993 | 6 times, Ongoing | Yes | Converts Medicaid program from FFS to managed care | 340,000 |
| **Iowa** | 2005 | 1 time, Ongoing | --- | Created uncompensated care pool. Transitioned eligibility to comply with ACA. Pilot project for "Medical Home" | 47,211 |
| | 2006 | Ongoing | --- | Family planning services to: postpartum women who lost Medicaid coverage + non-pregnant women with income ≤300% FPL + men capable of bearing children | 65,000 |
| | 2008-9 | No | --- | Exempts Medicaid from federal compliance when natural disaster—flooding—occurred | |
| | 2013 | Ongoing | Yes | Pays insurance premiums to buy insurance from Health Exchange for childless adults <134% FPL who cannot receive employer-supported insurance | Suspended: No QHPs available. |
| | 2013 | Ongoing | Yes | Implements ACA but limits Medicaid expansion to 100% FPL, not 138% | 140,000 |
| **Idaho** | 2004 | 2 times, Ongoing | --- | Premium assistance for childless adults <185% FPL | 70,000 |
| | 2009 | No | No | Premium assistance for childless adults ≤185% FPL who are employed by small business. Replaced by SHOP | 119 employers were enrolled. |
| **Illinois** | 2003 | 1 time | --- | Supports family planning activities for women with family income ≤200% FPL | Not available |
| | 2012-14 | No | Yes | Demonstration project for specified payment methodology for Cook County Hospital System | 116,500 |
| | 2014 | Pending | Yes | Transformation waiver: convert from FFS to managed care | 500,000 |
| | 2016 | Pending | Yes | Carves out behavioral and mental health care from FFS to put into managed care | Not available |
| **Indiana** | 2008 | 3 times, Ongoing | --- | Categorical coverage: Medicare-enrolled, not eligible for standard Medicaid, with end-stage renal disease | 350 |
| | 2015 | Ongoing | Yes | Coverage for childless adults ≤133% FPL; incentives for healthy living | 559,000 |
| **Kansas** | 2013 | Ongoing | No | Converts Medicaid program from FFS to managed care; Created uncompensated care pool. | 150,000 |
| **Kentucky** | 1997 | 4 times | --- | Expired in 2012. Coverts FFS to managed care | <1,200,000 |
| | 2016 | Pending | Yes | Seeks to use Medicaid funds for premium support to people with employer-supported insurance. Nominal cost sharing for Medicaid recipients. Includes work requirement ("community engagement and employment") | 428,000 |

| State | Year of waiver | Renewed? | Expand Medicaid? | Waiver did the following: | Individuals Affected (N≈) |
|---|---|---|---|---|---|
| **Louisiana** | 2006 | 3 times | --- | Expired in 2014. Family planning services for women ≤200% FPL | Not available |
| | 2010 | Expired | Yes | Covers primary care and mental health services for individuals ≤200% FPL living in New Orleans+4 adjacent parishes (only) | 16,000 |
| **Massachusetts** | 1995 | 5 times, Ongoing | Yes, eventually | Premium support for QHPs; creates uncompensated care pool; Central administration for Massachusetts Medicaid | Not available |
| **Maryland** | 1997 | 3 times, Ongoing | Yes, eventually | Converts Medicaid program from FFS to managed care; 2007: expanded Medicaid coverage to ≤133% FPL | 1,000,000 |
| **Maine** | 2002 | 2 times | --- | Expired in 2013. Coverage extended to childless adults≤100% FPL | 20,000 (capped) |
| | 2002 | 3 times, Ongoing | No | Expands access to care to HIV-positive individuals who are ≤250% FPL | 793 |
| **Michigan** | 2006 | 1 time, Ongoing | --- | Family planning services to women ≤185% FPL | 43,000 |
| | 2010 | 2 times, Ongoing | Yes | Cost-sharing test project for newly eligible adults ≤133% FPL: beneficiaries must contribute co-pays regardless of income | 620,000 |
| | 2016 | Ongoing | Yes | Expand Medicaid to all pregnant women and children under 21 years of age with income ≤400% FPL who were or are served by Flint Water District | 16,000 |
| | 2016 | Pending | Yes | Combines multiple mental health programs into one | 220,000 |
| **Minnesota** | 1995 | 9 times, Ongoing | --- | Coordination of care under managed care systems | Not available |
| | 2006 | 2 times, Ongoing | --- | Provides family planning services for men and women, 15-50 yo, with income ≤200% FPL | 600,000 |
| | 2013 | Ongoing | Yes | Combines two elder care programs into one | 25,000 |
| | 2014 | Rejected | Yes | Incomplete application | |
| **Missouri** | 1998 | 3 times, Ongoing | --- | Provides family planning services for women with income ≤185% FPL and assets <$250,000 | 200,000 |
| | 2016 | Ongoing | No | Creates incentive payment structure to safety net providers for adults ≤200% FPL | 22,022 (capped at 22,600) |
| | 2016 | Pending | No | Increases access for youths to mental and behavioral health services | 19,000 |
| **Mississippi** | 2003 | 2 times, Ongoing | No | Provides family planning services for women with income ≤185% FPL | 40,000 |
| | 2006 | 2 times, Ongoing | No | Provides coverage for aged and disabled with income ≤135% FPL and who are eligible for neither Medicare nor Medicaid | 4,891 (capped at 6000) |

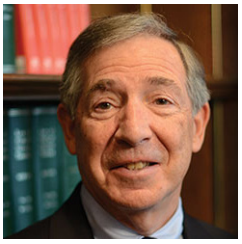
| State | Year of waiver | Renewed? | Expand Medicaid? | Waiver did the following: | Individuals Affected (N≈) |
|---|---|---|---|---|---|
| **Montana** | 2004 | 3 times, Ongoing | --- | Expires in 2016. Deletes selected optional services from parents/caretaker relatives of dependent children with income ≤150% FPL. | 3,000 |
| | 2012 | Ongoing | Yes | Provides family planning services for women with income ≤211% FPL | Capped at 4000 |
| | 2015 | Ongoing | Yes | Authorization to require some premiums and co-payments for adults with income between 50% and 133% FPL | 55,000 |
| **Nebraska** | None | | No | | |
| **Nevada** | 2013 | Ongoing | Yes | Extends coverage to individuals with qualifying conditions not eligible for current coverage under existing rules | 35,000 |
| | 2015 | Pending | Yes | Programs expansion for behavioral health | 14,000 |
| **New Hampshire** | 2016 | Ongoing | Yes | Premium assistance for QHPs in state Health Exchange | 44,000 |
| | 2016 | Ongoing | Yes | Creates DSRIP for state Medicaid | Not available |
| **New Jersey** | 2003 | Expired | --- | Coverage for custodial parents and caretaker relatives for children under either Medicaid or CHIP family income ≤200% FPL | Not available |
| | 2011-12 | Expired | Yes | General care for childless adults with income <25% FPL | 57,000 |
| | 2012 | Ongoing | Yes | Expands eligibility to disabled individuals, ages 18-65, for long-term care and community-based services with household income between 25% and 100% FPL. Also establishes DSRIP | Not available |
| **New Mexico** | 1999 | 3 times | --- | Continued coverage for childless adults who had been covered by previous Demonstration project, now expired. If employed, state receives employer support. | 27,000 |
| | 2009-14 | No | --- | The 1999 waiver was under Title XX; this waiver is under Title XIX. Otherwise, it is precisely the same. | 27,000 |
| | 2014 | Ongoing | Yes | Converts all Medicaid FFS into managed care and consolidates prior 1915 waivers into this waiver. | 640,000 |
| **New York** | 1997 | 4 times, Ongoing | --- | Converts FFS to managed care. Expands home and community-based programs; created indigent care pool. Amended 14 times | >2,000,000 |
| | 2006 | Yes | --- | Invest in health IT; modernize acute & long-term care infrastructure; expand capacity in primary/ambulatory care | Not available |
| | 2012 | Withdrawn | Yes | Convert people with developmental disabilities to managed care; Waiver withdrawn and resubmitted as 1915 | Not available |

| State | Year of waiver | Renewed? | Expand Medicaid? | Waiver did the following: | Individuals Affected (N≈) |
|---|---|---|---|---|---|
| **North Carolina** | 2004 | Yes; expired in 2014 | --- | Family planning for men and women over 18 yo with family income ≤185% FPL | 30,000 |
| | 2016 | Pending | No | Introduces two prepaid health plans: managed care & capitated payment plus incentives. Created DSRIP program | Not available |
| **North Dakota** | None | | Yes | | |
| **Ohio** | 2013 | No | Yes | Coverage specifically for residents in Cuyahoga county | 30,000 |
| | 2016 | Disapproved | | "CMS is concerned with request to charge premiums regardless of income to 600,000 individuals and to exclude from coverage those people who do not pay all arrears." | 600,000 |
| **Oklahoma** | 1996 | >4 times, Ongoing | --- (No) | Covers childless adults <200% FPL. Provides premium to low income workers | 550,000 |
| **Oregon** | 1994 | >5 times, Ongoing | --- | Developed priority list of medical treatments. Updated every two years. Coverage based on a cut-off of this list | >500,000 |
| | 1999 | 4 times, Ongoing | --- (Yes) | Family planning for men and women with household income ≤250% FPL | 34,469 |
| **Pennsylvania** | 2007 | 2 times, Ongoing | --- | Family planning for women 18-44 yo with family income ≤185% FPL who have no coverage and are not eligible for any other government support programs | 2000 |
| | 2013 | No | Yes | Three month demonstration project of alternate process and standards for eligibility determination | >2 million |
| | 2014 | Terminated | Yes | Extends coverage to childless adults with income ≤133% FPL | No reports |
| **Rhode Island** | 2009 | 1 time, Ongoing | --- (Yes) | Restructured Medicaid to "establish a sustainable cost-effective person-centered, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options and results-oriented system of coordinated care." | 200,000 |
| **South Carolina** | None | | (Yes) | | |
| **South Dakota** | None | | (Yes) | | |
| **Tennessee** | 2002 | 3 times, Ongoing | No | Converts FFS to managed care and uses savings to pay Disproportionate Share to hospitals serving low income patients | 1,200,000 |
| **Texas** | 2007 | No | --- | Family planning services to women 18-44 yo with family income ≤185% FPL | 292,680 |
| | 2011 | Renewal pending | No | Converts FSS to managed care and uses savings to fund uncompensated care pool | 3,800,000 (80% of TX Medic-aid population) |
| **Utah** | 2002 | 5 times, Ongoing | No | Expand primary health care to 25,000 uninsured adults incomes<95% FPL; if employed, receive premium support from Medicaid. Expands CHIP eligibility | 93,000 |
| **Vermont** | 2005 | Expired 2015 | (Yes) | Reduce institutionalization of elders and thereby save money. Expands home & community-based services | Not available |
| | 2005 | 3 times, Ongoing | (Yes) | Offers premium support to currently uninsured, with income ≤300% FPL | 200,000 |

| State | Year of waiver | Renewed? | Expand Medicaid? | Waiver did the following: | Individuals Affected (N≈) |
|---|---|---|---|---|---|
| **Virginia** | 2005 | 3 times, Ongoing | --- | Family planning services for uninsured pregnant women with income <200% FPL. Covers children ≤143% FPL | 1200 |
| | 2013 | No | No | Demonstration project to study use of modified adjusted gross income as eligibility standard for Medicaid & CHIP | No report |
| | 2015 | Ongoing | No | Expands coverage for behavioral and physical health services to uninsured with income <80% FPL with diagnosis of serious mental illness | 7000 |
| | 2016 | Pending | No | Creates DSRIP, converts some long-term care to managed care | 50,000 |
| **Washington** | 2001 | 3 times, Expired 2013 | --- | Family planning services for men and women with income ≤250% FPL | 16,000 |
| | 2011 | No | Yes | Extends coverage to childless adults with income ≤133% FPL, who are enrolled in basic care services of alcohol or drug addiction programs. Bridge to ACA Medicaid expansion | 63,300 |
| | 2015 | Pending | Yes | Switches physical and behavioral health services to managed care; integrates mental health and substance abuse programs with behavioral health programs | 1,800,000 |
| **West Virginia** | 2013-14 | No | Yes | Demonstration project to study use of modified adjusted gross income as eligibility standard for Medicaid & CHIP | 200,000 |
| **Wisconsin** | 1999 | 3 times, Ongoing | --- | Coverage for parents and caretaker relatives with income between 133% and 200% FPL. Penalty allowed for non-payment of premiums | 99,000 |
| | 2002 | 2 times, Ongoing | No | Covers drugs and optional medication therapies to residents ≥65 years old with ≤200% FPL | 75,000 |
| | 2013 | Ongoing | No | Benefits to childless adults with income ≤100% FPL | Not available |
| **Wyoming** | 2008 | 1 time, Ongoing | --- | Covers family planning services for women 19-44 yo losing Medicaid coverage 60 years postpartum with income ≤133% FPL. | <1000 |
| | 2016 | Pending | No | Provides funds for uncompensated care for Tribal members through Indian Health Services | 761 |
| | | | | | |
| 45 states requested Sec. 1115 waivers. | 101 waivers sought: | 98 approved. Almost all were renewed. 3 disapproved. | 32 states & D.C. expanded Medicaid | | |

Legend: N/A=not applicable. ACA=Affordable Care Act of 2010. (---) ACA had not been passed at this time and therefore Medicaid expansion was not possible. yo=years old. FPL=federal poverty line. FFS=fee for service payment system. QHP=qualified health plan, as qualified under the ACA rules. SHOP=Small Business Health Options Program, under ACA. DSRIP=Delivery System Reform Incentive Payment. IT=information technology. Data summarized above was obtained from the CMS website at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

## About the Author



**Dr. Deane Waldman MD MBA** is a retired pediatric cardiologist and system theorist analyst for American healthcare. He brings 37 years of clinical experience plus the business and administrative experience as Chief of Pediatric Cardiology at University of Chicago to the position of Director of the Center for Health Care Policy at the Texas Public Policy Foundation. He is also the Consumer Advocate member on the Board of Directors of the New Mexico Health Insurance Exchange.

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