



FACT SHEET

Medicaid Waivers in California

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Overview

Medicaid was established in 1965, as part of the federal Social Security Act (SSA), to provide health coverage for people with low incomes. Medicaid rules regarding who gets coverage and which benefits are included are determined by SSA requirements and implemented by the federal Centers for Medicare & Medicaid Services (CMS).

The law also permits CMS to waive certain aspects of the law to enable states to test different approaches to program eligibility, benefits, delivery systems, and financing. This is known as a waiver. Every state uses waivers for elements of their Medicaid programs, with some states operating multiple waivers simultaneously. The widespread use of waivers has contributed greatly to Medicaid program variation across states.

Medi-Cal, California's Medicaid program, provides health coverage for Californians with low incomes, including children and their parents, pregnant women, seniors, persons with disabilities, and nonelderly adults. Enrollees receive a full range of physical and mental health care, substance use disorder treatment, pharmacy, and long-term services and supports. Medi-Cal is operated by the California Department of Health Care Services (DHCS) in partnership with the state's 58 counties.

Medicaid Waiver Authorities

There are three types of waivers that are commonly used in Medicaid — research waivers and demonstration waivers (authorized under Section 1115 of the SSA) and program waivers (authorized under Section 1915[b] and Section 1915[c] of the same statute). Historically, waivers have been used primarily to modify three core tenets of the Medicaid program:

1. **Statewideness:** The same benefits must be provided to enrollees throughout the state.
2. **Comparability:** Enrollees are entitled to an equal amount, duration, and scope of services.
3. **Freedom of choice of provider:** Enrollees are free to obtain services from any qualified provider.

Section 1115 demonstration waivers permit states to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the US Secretary of Health and Human Services determines that the initiative is an “experimental, pilot, or demonstration project” that is “likely to assist in promoting the objectives of the program.”¹ Section 1115 waivers are generally approved for a five-year period. In recent years,

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Section 1115 waivers have been used to test new approaches, including Delivery System Reform Incentive Payment programs, coverage of residential substance use disorder treatment, and efforts to address the social determinants of health. Forty-nine Section 1115 waivers have been approved for operation in 40 states across the country.²

Section 1915(b) “Freedom of Choice” waivers are generally used to require enrollment in managed care delivery systems for certain populations. Section 1915(b) waivers are being used more frequently, at CMS’s encouragement, since the publication of the final Medicaid managed care regulations in 2016.³ Many states originally used Section 1115 waiver authority to move enrollees into managed care, but the new regulations acknowledge that managed care is now the predominant delivery system in Medicaid, and CMS has indicated that Section 1115 waivers are no longer needed for managed care. The agency has provided informal guidance that states should use the more straightforward Section 1915(b) authority instead. There are currently 78 Section 1915(b) waivers in operation in 35 states.⁴

Section 1915(c) Home and Community-Based Services (HCBS) waivers are designed to provide community-based options for people who would otherwise require care in a nursing facility, hospital, or other institution. States often operate multiple

HCBS waivers simultaneously, because they are permitted to limit the number of people served through the waiver and/or to target specific populations and services. There are currently more than 290 HCBS waivers in operation nationally.⁵

Waivers in California

Medi-Cal 2020: California’s Section 1115 Waiver

Since 2005, significant elements of California’s Medi-Cal program have been operated under a Section 1115 waiver, beginning with the Medi-Cal Hospital Uninsured Care 1115 waiver. This waiver fundamentally altered the state’s hospital payment structure and provided significant new federal matching funds for coverage of low-income uninsured people. The success of the 2005 waiver in shoring up the state’s public hospital system, as well as county and state budgets, led California to request and receive approval for the nation’s first Delivery System Reform Incentive Payment (DSRIP) program in the subsequent waiver.

Approved as part of California’s Bridge to Reform waiver in 2010, the DSRIP program continued the flow of enhanced federal funding into the public hospital system and began the discussion around moving toward value-based purchasing and efforts to improve the quality and integration of care. The

Waiver Types Compared: 1915(b) and 1115		
	1915(b) Waiver	1115 Waiver
What Can Be Waived	Statewideness, comparability, and freedom of choice, including mandatory managed care enrollment, choice limited to a single managed care plan	Statewideness, comparability, and freedom of choice (everything in 1915[b]); federal matching funds for populations, services, cost sharing, and costs not otherwise matchable under the Medicaid state plan
Budget Requirements	Cost-effectiveness and efficiency (actual expenditures cannot exceed projected expenditures for approval period)	Budget neutrality (federal expenditures cannot be greater with the waiver than without the waiver)
Approvals and Renewals	Two years initially (five years if dual eligibles are included)	Five years initially, with three- or five-year renewals
Federal Review	Ninety-day clock; if CMS requests additional information, the clock stops and restarts when the state responds	No required time period

Budget Neutrality

While not set in statute or regulation, a longstanding component of Section 1115 waivers is that they must be “budget neutral” to the federal government. This means that federal spending under the waiver cannot exceed the level of funding that would have been provided to the state without the waiver.

States have historically been able to use savings generated by one initiative to pay for other initiatives. For example, many states initially used 1115 waiver authority to expand eligibility to additional populations using the savings that was generated through managed care. The capitation rates devised for these relatively healthy populations (families and children) were assumed to be lower than the cost of providing care through the fee-for-service system. The savings that were generated as a result were used to finance other program expansions. For two decades, California relied heavily on these savings to finance the many coverage and financing initiatives it executed under Section 1115 waivers.

However, in 2018, CMS released new guidance indicating that budget neutrality savings from more than five years ago can no longer be applied in financing 1115 waiver renewals. CMS requires the budget for the waiver be established based on more recent cost data and has nearly eliminated the ability for states to carry forward savings accumulated during previous waiver periods.

In light of this new policy, California’s Department of Health Care Services is rethinking its approach to the structure and financing of the Medi-Cal program.

Source: Timothy B. Hill (acting director, CMS) to state Medicaid directors, “Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects,” SMD 18-009, August 22, 2018.

2010 waiver included a number of other key components, such as early adoption of the Medicaid expansion to low-income adults without children.

Many of these 2010 waiver components were extended in 2015 with the approval of the Medi-Cal 2020 waiver. This waiver launched on January 1, 2016, and includes many distinct initiatives:

- **The Whole Person Care (WPC) Pilots** are county-based initiatives that coordinate primary care, behavioral health, and social services for

Medi-Cal enrollees with complex health needs.⁶ There are 25 pilots in operation across the state that are building infrastructure, integrating service delivery across agencies and providers, and delivering a range of wraparound services to enrollees that include care coordination, disease management, access to housing supports, respite care, and sobering centers.

- **The Public Hospital Redesign and Incentives in Medi-Cal (PRIME)** program is the continuation of the DSRIP program in California. PRIME provides incentive funding for California’s 17 designated public hospitals and 35 district and municipal public hospitals to undertake quality improvement and performance measurement efforts. The hospitals are paid according to their performance on a series of metrics related to clinical projects designed to improve care delivery.
- **The Drug Medi-Cal Organized Delivery System (DMC-ODS)** provides federal Medicaid matching funds to expand substance use disorder treatment benefits to include a full complement of evidence-based services that accord with American Society of Addiction Medicine (ASAM) levels of care. The services are delivered through county-based behavioral health managed care organizations. To date, 30 counties are participating in the waiver program, providing access to treatment and prevention services for 93% of the state’s Medi-Cal population.
- **Dental Transformation Initiative (DTI)** provides incentive payments to dental providers to increase preventive services for children, treat more early childhood caries, and increase continuity of dental care for children.
- **The Global Payment Program (GPP)** established a statewide pool of funding by combining a portion of California’s federal disproportionate share hospital allotment with uncompensated care funding. This funding supports public health care system efforts to provide health care for California’s uninsured population and to promote the delivery of more cost-effective and higher-value care to the uninsured.

California's Section 1915(b) Specialty Mental Health Services Waiver

Section 1915(b) of the Social Security Act permits states to establish mandatory managed care programs or to otherwise limit enrollees' choice of providers. States can also use Section 1915(b) authority to waive statewideness and comparability requirements. These waivers are generally approved for two years with two-year renewal periods. Section 1915(b) has four subsections that specify these permissions for states:

1. Require Medicaid participants to enroll in managed care.
2. Designate a "central broker" to assist Medicaid enrollees in choosing a plan.
3. Use savings generated by using more cost-effective care to provide additional services.
4. Limit enrollee choice of providers (except in emergency situations, for those needing long-term care, and for family planning services).

California's Medi-Cal Specialty Mental Health Services Section 1915(b)(4) waiver requires enrollees who meet medical necessity criteria for specialty mental health services to receive those services through their county mental health plan. California's current Specialty Mental Health Services waiver is approved through June 30, 2020. DHCS requested a six-month extension of the waiver so its expiration date aligns with the expiration of the 1115 waiver on December 31, 2020.

California's Home and Community-Based Services Waivers

Section 1915(c) authorizes states to serve people who would otherwise qualify for institutional care in community-based settings. States offer a broad range of HCBS waivers for enrollees with long-term service and support needs, such as meals, non-medical transportation, and home modifications. Room and board are not included. This waiver authority permits states to cap enrollment and retain waiting lists, as long as the programs pass a cost-effectiveness test.

California operates seven Section 1915(c) waivers serving seniors, persons with disabilities, people

with HIV/AIDS, and medically fragile and technology dependent enrollees:

- **The Multipurpose Senior Services Program** operates in 46 counties and provides enhanced care coordination and purchased services (such as home modifications).
- **The Assisted Living waiver** operates in 15 counties. Services are delivered in residential care facilities and public subsidized housing.
- **The Home and Community-Based Alternatives waiver** serves enrollees living at home and in congregate living settings, providing enhanced care coordination and additional HCBS services.
- **Californians with developmental disabilities waiver** program operates statewide in regional centers, serving enrollees living in community settings and in their homes.
- **The HIV/AIDS waiver** operates in 30 counties and delivers enhanced care coordination and additional HCBS services in homes.
- **In-Home Operations** (part of the In-Home Supportive Services program) provides personal care services in homes and congregate living settings.
- **Self Determination for Individuals with Developmental Disabilities** gives participants the opportunity to manage their community-based service mix within an individual budget.

Conclusion

Waivers have long been a foundation for innovation in Medicaid, providing states the freedom to extend coverage and benefits beyond mandatory levels and to tailor the rules around who qualifies, what services are covered, and how the delivery system is designed to meet their needs and priorities. With the expiration of the state's Medi-Cal 2020 waiver approaching, state officials are undertaking a renewed approach to delivery system transformation in Medi-Cal, with emphasis on providing intensive care coordination for enrollees with the most complex care needs, addressing the social determinants of health, and advancing integration of physical, behavioral, and oral health care. This effort, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, promises to test the boundaries of federal and state Medicaid authority.

Endnotes

1. Section 1115 of the Social Security Act.
2. "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," KFF, October 9, 2019, www.kff.org.
3. "Medicaid and CHIP Managed Care Final Rule," Centers for Medicare & Medicaid Services (CMS), n.d., www.medicaid.gov.
4. "State Medicaid Waiver List," CMS, www.medicaid.gov.
5. "Waiver List," CMS.
6. Lucy Pagel, Carol Backstrom, and Hilary Haycock, *Whole Person Care: A Mid-Point Check-In*, California Health Care Foundation, March 2019, www.chcf.org.

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.