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Background

Section 1115 demonstration authority is one of the most powerful vehicles available to states to test innovation in their Medicaid programs. Under section 1115 authority, states can waive provisions of Medicaid law and obtain federal approval to fund initiatives not otherwise coverable by Medicaid, provided that proposals are budget neutral to the federal government and further the goals of the Medicaid program. The federal government and states have used the flexibility available under section 1115 authority to advance shared priorities. Common uses of 1115 demonstrations include coverage and benefit expansions, payment and delivery system reforms, and implementation of managed care.

In the past six months, the Centers for Medicare & Medicaid Services (CMS) has approved renewals and/or amendments to several long-standing section 1115 demonstrations, showcasing the Biden administration's priorities for use of 1115 authority. The approvals in [Arizona](#) (10/14), [Arkansas](#) (11/1), [Massachusetts](#) (9/28), [Oregon](#) (9/28), and [Vermont](#) (6/28) highlight that states and CMS are leveraging 1115 demonstrations to:

- Implement new coverage strategies, including continuous enrollment and targeted coverage expansions.
- Offer new services to address social drivers of health (SDOH), which CMS refers to as health-related social needs (HRSN).
- Strengthen the primary care and behavioral health delivery systems.
- Institute value-based payment (VBP) initiatives.
- Advance health equity, consistent with the health equity pillar included in CMS' 2022 [Strategic Plan](#).

As part of the fall 2022 approvals, CMS also released new policy frameworks for budget neutrality and use of designated state health programs (DSHPs) to finance new Medicaid initiatives under 1115 authority. New programmatic flexibilities coupled with these new waiver-related financing policies open the door to other states interested in leveraging section 1115 waivers for transformative coverage, access, workforce, and SDOH-related initiatives that can help address racial and ethnic health disparities, among other public health objectives. Key features of the demonstrations are described below.

Promoting Coverage

Continuous Enrollment

As states look toward the end of the Medicaid continuous coverage guarantee, they are seeking to implement strategies to retain gains in coverage and reduce churn, particularly for individuals at critical life junctures. Accordingly, Oregon and Massachusetts are instituting new continuous enrollment policies for their Medicaid and Children's Health Insurance Program (CHIP) populations:

- **Oregon** will be the first state in the nation to provide continuous enrollment for children from the time of initial Medicaid or CHIP eligibility determination until they reach age six.¹ Additionally, the state will provide two years continuous enrollment for adults and children ages six and older.²
- **Massachusetts** is instituting more targeted continuous enrollment policies, providing 12 months of continuous enrollment for individuals upon release from correctional settings and two years of uninterrupted coverage for individuals who are homeless.

The policies in both states are precedent setting. Without a waiver, states have the ability (and will soon be required under section 5112 of the [Consolidated Appropriations Act, 2023](#)) to offer 12 months continuous coverage to [children](#), but do not have options to offer continuous enrollment for longer time periods, and there is no continuous enrollment state plan option for adults.³ CMS is requiring both states to monitor and evaluate the impact of continuous enrollment to understand their impact on factors such as Medicaid and CHIP enrollment, churn, and utilization.

To reflect that states obtain an enhanced Federal Medical Assistance Percentage (FMAP) for members of the Affordable Care Act's new adult group, and that over time, some new adults would no longer qualify for the new adult group due to income, both states' special terms and conditions (STCs) limit the percentage of expenditures for new adults covered by the continuous enrollment policies that will be matched at the enhanced match rate. For new adults who have been released from correctional facilities in Massachusetts and all new adults in Oregon, the states can claim 97.4% of the expenditures at the enhanced FMAP and 2.6% of expenditures at the state's regular FMAP. Massachusetts will be able to claim enhanced FMAP for all expenditures for homeless members of the new adult group because few individuals who are homeless have an income above 138% of the federal poverty level (FPL).

Coverage Expansions

Oregon and Vermont are leveraging their 1115 demonstrations to expand coverage to targeted high-needs populations with incomes that would otherwise be above Medicaid limits.

- **Oregon** is expanding Medicaid eligibility and benefits for youth with special healthcare needs (YSHCN) ages 19 to 26 with incomes up to 300% of the FPL. To be considered a YSHCN, an individual must meet criteria outlined in Oregon's STCs, which include having an intellectual/developmental disability, a serious mental health issue, or one or more serious chronic conditions as represented by the [Pediatric Medical Complexity Algorithm's](#) list of complex chronic conditions. All YSHCN—regardless of whether they are eligible under Oregon's state plan (e.g., as an expansion adult) or through the coverage expansion authorized by the 1115 demonstration—will have access to full Early and Periodic Screening, Diagnostic, and Treatment benefits and HRSN services (as described below).
- **Vermont** obtained authority to institute a new limited benefit coverage expansion for adults with a substance use disorder (SUD) whose income is above Medicaid limits. Individuals with a SUD whose incomes are above 133% of the FPL, up to 225% of the FPL (up to \$30,578 annually for a single adult), will be eligible for the SUD Community Intervention and Treatment program, which will offer a comprehensive set of SUD benefits, including case management, recovery supports, psychoeducation, peer supports, residential treatment, withdrawal management, counseling, and skilled therapy services.

Offering Services to Address HRSN

Arizona, Arkansas, Massachusetts, and Oregon obtained approval to cover services that address SDOH, referred to in the waiver approvals and new [sub-regulatory guidance](#) as "health-related social needs," or HRSNs. Each state will offer an array of evidence-based housing supports and case management, including services such as pre-tenancy and tenancy sustaining services, housing transition navigation services, and medically necessary air conditioners and air filtration devices (Massachusetts and Oregon only). Arkansas, Massachusetts, and Oregon will offer evidence-based nutrition supports, such as nutrition counseling and education; Massachusetts and Oregon will also offer medically-tailored meals. Additionally, Massachusetts will provide transportation for individuals to obtain covered tenancy and nutrition support services. Notably, Arizona and Oregon have obtained authority to pay for up to six months' rent and temporary housing for qualifying individuals—a flexibility that CMS has not historically permitted because of statutory and regulatory [limitations](#) on using Medicaid funds for room and board in non-institutional settings—subject to having clinical need, as described below. Investments in HRSN services will be significant in all four states, as shown in Table 1.

Arizona, Arkansas, Massachusetts, and Oregon will target HRSN services to members of high-needs populations for whom these services are “medically appropriate ... based on clinical and social risk factors.”

- **Arkansas** is incorporating the delivery of HRSN services into a new intensive care coordination initiative for high-needs populations, called “Life360 HOMEs.” There will be three types of Life360 HOMEs targeted at different populations: (1) Rural Life360 HOMEs for individuals with a serious mental illness or SUD diagnosis who live in rural areas of the state; (2) Maternal Life360 HOMEs for individuals with high-risk pregnancies, who will be eligible to obtain care coordination via a home visiting model and HRSN services for two years postpartum, regardless of whether they otherwise continue to be eligible for Medicaid; and (3) Success Life360 HOMEs for individuals ages 19 to 27 who have been priorly incarcerated or involved with the foster care system, individuals ages 19 to 24 who have been involved with the juvenile justice system, and veterans at-risk of homelessness who are ages 19 to 30.
- To be eligible for **Arizona’s** housing-focused HRSN initiative, individuals must be homeless or at-risk of homelessness in addition to having a health need, such as serious mental illness, complex chronic health conditions, or long-term services and supports (LTSS) needs.
- Building on its existing Flexible Services program and Community Support Programs, **Massachusetts** will offer HRSN services to a broad range of populations that meet health-related criteria (e.g., behavioral health needs, complex physical health needs, frequent emergency department utilization, individuals with a high-risk pregnancy) and have specified risk factors (e.g., at risk for nutritional deficiency); additionally, individuals who are in Community Support Programs due to homelessness, have behavioral health needs associated with risk for eviction, or are involved in the justice system will be eligible for HRSN services. In contrast to Arizona and Oregon, Massachusetts has obtained a waiver giving it the ability to cap the number of individuals obtaining HRSN services.
- **Oregon** is targeting its HRSN initiative primarily toward populations undergoing a transition, including individuals who are homeless or at risk of homelessness; youth involved with the child welfare system; individuals released from incarceration or an institution for mental disease (IMD); YSHCN; individuals transitioning from Medicaid-only coverage to being dually eligible for Medicaid and Medicare; and individuals with a high-risk clinical need who reside in a region that is experiencing an extreme weather event.⁴ Oregon will delineate further eligibility criteria in post-approval documents. Notably, the state plans to offer its services as entitlements, meaning that all eligible individuals will be able to access these services.

Recognizing that many providers offering HRSN services do not traditionally participate in Medicaid and may need support in developing necessary capabilities to participate in this initiative, all four states have received approval to obtain federal Medicaid matching funds to build HRSN infrastructure; funding amounts are displayed in Table 1. The funding can be used for technology costs; development of business or operational practices; workforce development; and outreach, education, and stakeholder convening.

States implementing an HRSN initiative must meet certain new requirements outlined in the STCs. First, states must meet a maintenance of effort requirement, meaning that spending on their HRSN initiatives must be additive to the state’s baseline level of spending on related social services and cannot supplant existing federal, state, or local funding on similar initiatives. Additionally, as a condition of approving Arizona, Massachusetts, and Oregon’s HRSN initiatives, the three states must meet certain parameters with respect to the rates they pay providers in their Medicaid programs, as described in more detail below.⁵

Finally, states are typically required to use budget neutrality “savings”—accrued when actual spending under a demonstration comes in below projected targets—to cover new services or populations using 1115 authority. With the new HRSN approvals, states will not be required to use budget neutrality savings to pay for HRSN services or infrastructure; however, they will only be able to obtain Medicaid matching up to a capped amount (referred to as a

“capped hypothetical”). If spending exceeds this amount, states will need to repay the excess and will not be permitted to use budget neutrality savings to cover the overage.

	Maximum Permissible Spending on HRSN Services	Maximum Permissible Spending on HRSN Infrastructure	Total
Arizona	\$84.5 M	\$10.5 M	\$95.0 M
Arkansas	\$481.8 M	\$67.5 M	\$549.3 M
Massachusetts	\$687.9 M	\$8.0 M	\$695.9 M
Oregon	\$904.0 M	\$119.0 M	\$1.0 B
Total	\$2.2 B	\$205.0 M	\$2.4 B

Vermont takes a different approach to addressing SDOH than the states with HRSN initiatives described above. Since the initial approval of its 1115 demonstration in 2005, Vermont has had the ability to obtain federal Medicaid matching funds for a wide range of investments in public health, healthcare, and health-related services for Vermonters enrolled in Medicaid or who are uninsured or underinsured. In its current demonstration period, Vermont has the ability to invest approximately \$928.3 million in initiatives that align with priorities outlined in its STCs, many of which relate to SDOH. For example, the STCs permit Vermont to invest in screening for unmet social needs, repairs or remediation for mold or pest infestation, meal delivery services for individuals with a medical-related dietary need, parenting support programs, and connections to legal supports that address housing or interpersonal violence. Given Vermont’s investments address a broader set of areas than SDOH (i.e., public health, payment and delivery system reforms, expansion of medical benefits, etc.), they are not subject to the HRSN framework established in the Arizona, Arkansas, Massachusetts, and Oregon demonstrations. While Vermont has the ability to invest in a more flexible set of initiatives than the other states and is not subject to the maintenance of effort⁶ and provider payment requirements noted above, it must use its budget neutrality savings to pay for these investments. Vermont’s investments are a legacy initiative, and CMS is likely to point other states to Arizona, Arkansas, Massachusetts, and Oregon as models going forward.

Notably, on January 4, 2023, CMS released [State Medicaid Director Letter #: 23-001](#) providing additional guidance on states’ ability to address HRSN through the use of “in lieu of services” (ILOS) in Medicaid managed care. In addition to leveraging section 1115 waiver authority to cover services that address SDOH, states may consider the ILOS option to address unmet needs of enrollees and improve health outcomes.

Strengthening Primary Care and Behavioral Health Delivery Systems and Instituting VBP Initiatives That Advance Health Equity

Arizona, Massachusetts, and Vermont obtained approval for a variety of new waiver features to strengthen their primary care and behavioral health delivery systems and institute VBP initiatives specifically targeted toward advancing health equity.

- **Arizona** is transitioning the Targeted Investments (TI) provider performance incentive program authorized during its previous demonstration period to a new iteration—TI 2.0. With the approval of TI 2.0, Arizona has authority to pay \$250 million to providers in incentive payments, with the goal of “improving health equity for targeted populations through addressing HRSN.” Primary care providers, behavioral health providers, integrated primary care/behavioral health clinics, and justice clinics will be eligible to participate in the program if they meet a minimum set of standards, such as having an electronic health record and policies and procedures for HRSN screening and care coordination. Over the course of the demonstration period, participating providers will be able to obtain incentive payments for completing activities that align with program goals, such as implementing Culturally and Linguistically

Appropriate Services standards and developing and implementing strategies to address HRSN among high-needs populations, in addition to meeting outcome metrics. Post-approval, Arizona will submit to CMS proposed performance metrics.

- During the new demonstration period, **Massachusetts** is required to wind down its Delivery System Reform Incentive Payment program; however, it has obtained approval to continue to pursue ambitious payment and delivery system reforms through new mechanisms.
 - **Primary Care and Behavioral Health Workforce Investments.** Massachusetts is leveraging its 1115 demonstration to invest \$43.24 million in strengthening its primary care and behavioral health workforce. The funds will be used to cover student loan repayments for primary care providers and behavioral health providers, including but not limited to psychiatrists, licensed behavioral health clinicians, primary care physicians, nurse practitioners, advanced practice registered nurses, and physician assistants. To be eligible for student loan repayment, providers must commit to working for four years in a setting where at least 40% of the patient panel is Medicaid enrollees and/or uninsured individuals. Certain provider types are also required to work in a community-based setting. Per provider, the loan repayment amounts are substantial, ranging from \$50,000 to \$300,000, depending on provider type. Additionally, Massachusetts will make \$105,000 grants to community health centers to support family nurse practitioner residency slots.
 - **Prospective Payment Model for Primary Care.** Massachusetts may require its Primary Care Accountable Care Organizations to pay participating primary care practices using a per-member per-month prospective payment, rather than fee-for-service (FFS) payments. To participate in this initiative, primary care practices must agree to “increased clinical and care delivery expectations” related to goals such as increased access to care and behavioral health integration.
 - **Hospital Quality and Equity Initiative.** Massachusetts will implement a \$490 million Hospital Quality and Equity Initiative—a hospital performance incentive program—with separate incentive pools for private acute care hospitals (\$400 million) and the Cambridge Health Alliance, a non-state-owned public hospital (\$90 million). The Commonwealth is required to propose to CMS a set of metrics for the performance incentives; metrics must fall under a series of priority domains, such as improving demographic and HRSN data and promoting equitable access and quality.
- Historically, **Vermont’s** 1115 demonstration has included many initiatives to advance access to and quality of care for individuals with behavioral health and LTSS-related needs. Through its 1115 demonstration renewal, Vermont has obtained approval for several new initiatives that support these goals, including:
 - **Coverage of Maternal Health and Treatment Services.** The Lund Home—Vermont’s residential mental health and SUD treatment program for pregnant and postpartum individuals and mothers—is an IMD with a specialized care model that allows families to stay together during treatment, regardless of length of stay. Through the Global Commitment renewal, Vermont is the first state to obtain federal Medicaid matching funds for maternal health and treatment services offered in a residential facility meeting the definition of an IMD that is focused on this targeted population.
 - **Medicaid Data Aggregation and Access Program (MDAAP).** With the approval of the \$14.9 million MDAAP, Vermont will leverage Medicaid funding to administer incentive payments to expand providers’ health information technology (HIT) capabilities. Vermont plans for the MDAAP funding to be used to help over 275 Medicaid-enrolled mental health, SUD, and LTSS providers—which have historically been **excluded** from federal HIT initiatives such as Health Information Technology for Economic and Clinical Health—purchase the tools they need in order to capture and exchange data and use it meaningfully to improve population health.

Medicaid Financing Provisions and Other New Policy Precedents

Provider Payment Rate Requirement

As a condition of approving the HRSN initiatives in Arizona, Massachusetts, and Oregon, DSHPs in Arizona and Oregon (described in more detail below), and the provider performance incentive programs in Arizona and Massachusetts, CMS is requiring the states to meet and maintain minimum provider payment rates in primary care, behavioral health, and obstetric care. For each of these service categories, the state's Medicaid-to-Medicare provider rate ratio must be at or above 80%. If the Medicaid rate is below 80% of the Medicare provider rate in any of these categories for either managed care or FFS, the state must increase the provider payment rate for each service by “an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points” in the relevant delivery system(s).⁷ In other words, if a state's Medicaid-to-Medicare ratio for behavioral health services in FFS is 68%, the state would be required to increase provider payment rates so that the ratio increased to at least 70%. The state must then maintain that higher payment level for the duration of the demonstration, though there is no requirement for further annual increases.

Designated State Health Programs (DSHPs)

Historically, in limited circumstances, states have been able to obtain demonstration authority to obtain federal Medicaid matching for programs that had formerly been state funded—called “designated state health programs” or DSHPs—and use the “freed up” state funds to finance other initiatives approved under their demonstrations. In 2017, CMS issued a State Medicaid Director [letter](#) indicating that it would no longer approve DSHPs under 1115 demonstrations. With the Arizona and Oregon demonstration approvals, CMS reversed its position and allowed the use of DSHPs. Specifically, in Oregon, the DSHPs are approved to fund \$535 million (total computable) in HRSN services, HRSN infrastructure, and the YSHCN eligibility and benefits expansion. And in Arizona, the DSHPs will fund \$440.9 million (total computable) in HRSN services, HRSN infrastructure, and the TI 2.0 program.

In the approval letters for Arizona and Oregon's 1115 demonstrations, CMS indicates that it is willing to approve DSHPs in other states with the following guardrails (in addition to the provider payment requirement described above):

- DSHPs may only be used to finance the nonfederal share of new initiatives that advance the objectives of the Medicaid program; they cannot supplant funding for programs already in place.
- States must have “skin in the game” for initiatives funded through DSHPs, meaning that they must contribute 15% of the nonfederal share through non-DSHP funding sources.
- Over a demonstration period, DSHP spending will be capped at 1.5% of total Medicaid expenditures.
- DSHP funding is intended to be temporary; states must develop a sustainability plan for initiatives funded through DSHPs.

Budget Neutrality

With the September Massachusetts and Oregon approvals, CMS unveiled significant new budget neutrality policies, reflecting the most notable changes in budget neutrality policy in more than a decade, as described further in this recent [issue brief](#). The new budget neutrality policies:

- Increase the amount of savings that states can roll over across the demonstration period from five years now up to 10 years.
- Update CMS' methodology for “rebasings” budget neutrality caps at demonstration renewals so that states have additional “room” under budget neutrality caps.
- Consistently use the President's Budget trend rate instead of the lower rate among the President's Budget trend rate and the state's historical trend rate, resulting in higher budget neutrality caps.

- Allow for “mid-course corrections” to account for provider rate increases, new high-cost treatments, and changes in federal/state law, among other factors.⁸

Additionally, CMS continues to rely on the “hypothetical” treatment of certain services to reduce the need for savings to cover the costs of new investments. In sum, the budget neutrality policies will reduce risk for states operating 1115 demonstrations, enable states to sustain their innovative initiatives at renewals, and level the playing field across states by making it easier for states without previous waiver savings to invest in innovations.

Moving Forward

The Arizona, Arkansas, Massachusetts, Oregon, and Vermont 1115 demonstration approvals provide an important view into states’ and the Biden administration’s priorities for the use of 1115 authority. First, the approval of continuous enrollment policies in Massachusetts and Oregon and the coverage expansions in Oregon and Vermont indicate CMS’ willingness to work with states to implement creative, large-scale efforts to promote coverage stability and expansion. Second, all of these approvals demonstrate the administration’s support for states’ transformational investments in addressing SDOH and advancing health equity, approving several billion dollars in support of these goals across states. Third, the approvals emphasize CMS’ focus on building more robust primary care and behavioral health payment and delivery systems; the demonstrations authorize innovative new care models and approaches for strengthening value-based care, while at the same time, requiring some states to have adequate payment rates for primary care and behavioral health services. Finally, CMS’ new DSHP and budget neutrality policies will better enable states to leverage their 1115 demonstrations to test and sustain innovative new programs.

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ENDNOTES

1. Washington has a similar 1115 request pending; it has [requested](#) to provide continuous coverage to children with incomes up to 215% of the FPL up to age six. New Mexico's draft 1115 demonstration renewal [request](#) similarly includes continuous enrollment for children up to age six. California state [law](#) requires that the state implement continuous enrollment for children up to age five no sooner than January 2025, contingent on federal approval and state appropriations.
2. Most individuals will be covered by the policy except for individuals who are eligible for Medicaid on the basis of eligibility for home and community-based services under 42 CFR § 435.217.
3. Other states, such as [Montana](#) and [New York](#), have obtained 1115 authority to offer 12 months continuous enrollment to adults. Montana's continuous enrollment is no longer in effect.
4. Six months' rent/temporary housing will only be available to "individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care." Oregon's STCs further require that qualifying extreme weather events must "place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon."
5. Arkansas did not have to establish that it met these payment standards presumably because its 1115 demonstration is focused on the Medicaid expansion population. In Arkansas, most expansion adults are enrolled in qualified health plans offered through the Marketplace, which generally pay [higher rates](#) to providers than Arkansas' Medicaid fee-for-service program.
6. Vermont is subject to a different maintenance of effort requirement, where it cannot use its investments to supplant existing federal funding.
7. Note that this language is from the Oregon STCs; the relevant Massachusetts requirement uses slightly different language.
8. Vermont's 1115 demonstration, which was approved in June 2022—before CMS finalized its new budget neutrality policies—also permits the state to adjust budget neutrality to account for provider rate increases. In addition, Vermont's STCs permit it to adjust its budget neutrality without amending its demonstration in the event of a change to federal budget neutrality policy.