Overview of Select Medicaid Authorities to Support Innovation

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Type of Authority	Specific Authority	Description	Federal and State Requirements
Waiver Authorities	Section 1115 Demonstration Waivers	• Allow states to design and test innovative service delivery programs or financial models	• Subject to CMS approval (initially approved for 5 years) • Demonstrate federal budget neutrality, with new actuarial certification requirements under HR1 • Evaluation
	Section 1915(a) and (b) Waivers	• Allow states to implement managed care delivery systems (voluntary under 1915(a))	• Subject to CMS approval (initially approved for 2 years) • Demonstrate cost effectiveness and efficiency of program
	Section 1915(c) Home and Community-Based Services (HCBS) Waivers	• Allow states to provide long-term services and supports in home and community settings, as alternatives to institutional care • Subject to federal budget neutrality and evaluation requirements	• Subject to CMS approval (initially approved for 3 years) • Demonstrate federal budget neutrality • Evaluation
State Plan Authorities	Section 1905(a) State Plan Authority	• Basic authority that allows states to administer their Medicaid programs, including mandatory and optional benefits	• Subject to CMS approval (approved indefinitely) • Written agreement between federal and state governments
	Section 1932(a) State Plan Amendments	• Allow states to make changes to its program policies or operational approaches	• Subject to CMS approval (approved indefinitely) • Subject to federal and state monitoring and oversight
Managed Care Authorities	In Lieu of Services	• Allow states to authorize managed care plans to cover medically appropriate, cost-effective substitutes of state plan services	• Subject to state monitoring and oversight
	Value-Added Services/Benefits	• Allow states and managed care plans to voluntarily offer services in addition to state plan services	• Subject to state monitoring and oversight
	State-Directed Payments	• Allow states to direct plan expenditures in connection with implementing delivery system and provider payment initiatives under managed care contracts	• Subject to CMS approval and quality evaluation requirements
	Medical Loss Ratio (MLR) Requirements	• Federal regulations require standards for the calculation and reporting of a MLR applicable to managed care plans	• Subject to federal and state monitoring and oversight; states can require plans to remit or reinvest excess profits (i.e., community reinvestment)