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States often have been leaders and innovators in many aspects of public policy. The paper by John Holahan and colleagues in this volume of Health Affairs highlights a continued interest by researchers and policymakers in one particularly notable arena of state innovation: recent state reforms in the delivery of health care services.

The federal government also provides leadership by supporting programs that test innovations in health care delivery and financing. The Medicaid program is a prime example of this federal strategy of demonstration and testing. The joint federal/state program that provides health care to the poor, disabled, and chronically ill, Medicaid today serves nearly thirty-four million people and spent an estimated $146 billion in fiscal year 1994.

State and federal interests in restructuring Medicaid programs have converged at a time when the health care reform debate continues but consensus remains elusive. Medicaid, built on a foundation of shared federal/state responsibility and financing, is both an optimal and a logical area for reform and demonstration. The very structure of Medicaid—in which individual states have considerable discretion, within broad federal parameters, over whom they will cover, what services they will cover, and how they will pay for those services—has always encouraged substantial variation and “natural” experimentation across the states. More formal Medicaid experimentation also has been part of the program, although in the past it has been constrained by administrations fearful that demonstrations of new services would lead to demands for new public expenditures.

A Key To Innovation

The failure of Congress to enact comprehensive health care reform legislation has meant that the lion’s share of work in the area of overall delivery system reform is now being undertaken as Medicaid demonstration programs. The most important of these programs, the so-called 1115 waivers, are authorized under Section 1115 of the Social Security Act.

The general 1115 research and demonstration authority, enacted in 1962, actually predates the Medicaid program. Section 1115 allows the secretary of health and human services to waive, in the context of projects that test innovative methods of achieving program goals, certain regular requirements of Social Security Act programs, such as Aid to Families with Dependent Children (AFDC) and Medicaid. In the Medicaid program, 1115 demonstration authority allows states to demonstrate, within certain parameters, a variety of innovative concepts in health care financing and delivery. The projects “waive” applicable federal regulations covering such factors as statewideness; the amount, duration, and scope of services covered; eligibility definitions; and reimbursement methodologies.

The Health Care Financing Administration (HCFA) both solicits Medicaid demonstrations to test specific concepts and reviews proposals submitted by states on their own initiative. In either case, proposals are reviewed to assure innovation, feasibility,
and conformity to federal laws and requirements. The review process emphasizes assuring budget-neutral financing and positive results for beneficiaries. HCFA staff also provide a range of technical assistance to help states apply successfully.

Through 1115 demonstrations, state Medicaid agencies can implement changes in their programs related to coverage, eligibility requirements, payment methods, and benefit packages for a limited time to see if the changes will achieve certain objectives. The 1115 authority is broad: It allows tests in limited geographic areas of a state or in an entire state; among defined groups of beneficiaries or for all beneficiaries; and including only a few specified services or entire systems of care. The demonstrations permit states to experiment with their current Medicaid programs when changes appear to improve the program in some way and when the results might benefit other state programs.

Since Medicaid began in 1965, some eighty 1115 demonstration waivers have been granted. More than thirty have been approved since 1993, and fifteen were pending as of February 1995. Approvals include eight welfare reform 1115 demonstration waivers approved during the Clinton administration. These totals represent more waivers than were approved under the two previous administrations combined.

The Past Is Prologue

Many components of today's health care financing and delivery systems have their roots in 1115 demonstration projects. Over the past several decades nearly two-thirds of the states have taken advantage of 1115 demonstration authority, and a number of these projects broke new ground. Although it is beyond the scope of this Perspective to detail all 1115-generated innovations, the following examples highlight some of their contributions that have had lasting value.

Past demonstrations. (1) Georgia, South Carolina, New York, Connecticut, and other states tested ways of providing home or community-based services two decades ago, when nursing home care was the only alternative for most dependent frail and chronically ill patients. Their findings resulted in the enactment of the Medicaid home and community-based program waivers that have been used by all states.

(2) Some early demonstrations focused on facilitating implementation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Many of these projects tested ways of improving access to care for young children that are now standard practice in many areas. In the early 1970s, for example, 1115 demonstration waivers permitted EPSDT services to be provided in schools and day care centers. School-based projects were particularly effective in achieving high participation rates, and many states have expanded Medicaid funding in school settings.

(3) Managed care for Medicaid populations is a common theme in most health care reform proposals. The majority of 1115 demonstration proposals submitted during the past two years have embraced the use of managed care arrangements. The seeds for today's efforts were sown two decades ago in 1115 demonstrations to test the effectiveness of alternative delivery systems and to develop techniques for monitoring and controlling care delivered in managed care settings. Later, demonstrations in the early 1980s focused on developing large systems of competitive managed care plans for Medicaid beneficiaries. One of the oldest and best known of these demonstrations took place in Arizona, which sponsored the first statewide Medicaid managed care program in 1982.

Current 1115 demonstrations continue to build upon the themes of earlier demonstrations. Several widely discussed 1115 demonstrations created Medicaid managed care programs to expand access to care for poor and uninsured persons in Oregon, Ohio, Tennessee, and other states. But not all current Medicaid demonstrations deal with managed care for the traditional Medicaid AFDC populations. Several address ways of expanding access and coverage to targeted populations, such as the disabled.

Current demonstrations. (1) Ohio re-
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Recently received approval to implement a managed care program that includes acute care, mental health services, and capitation of drug and alcohol treatment. The demonstration also is expected to extend coverage to an estimated 400,000 Ohioans living below the poverty line. (2) Postpartum family planning and preventive reproductive services will be made available for five years to a specific group of pregnant women in Maryland and South Carolina, who otherwise would lose eligibility after delivery. (3) Oregon anticipates that savings generated by expanding the use of managed care and using a “priority” list to determine covered conditions and treatments will finance the coverage of an additional 120,000 previously uninsured residents. (4) Several ongoing projects improve access for specified populations, including pregnant substance abusers and disabled persons. New York, South Carolina, and Oregon, for example, are developing programs to improve access to care for pregnant substance abusers.

**Future Directions**

We have learned many lessons in our three-decade partnership with states. The key outcome is that we have developed better ways to deliver and finance care. We have expanded access to care and have developed innovative methods to deliver health services to millions of poor, disabled, and previously uninsured Americans. The conventional wisdom has been that Medicaid is not a vehicle for change or innovation, but it can be and has been. The process has been accelerated, and the credit for this change and for our accomplishments must be shared by the states and the federal government. Future efforts must build on the foundations of innovation and partnership that have been developed between governors and Washington. Some of the necessary links from the past to the future are described below.

Avoid homogenized health policy. Future health policy must continue to strive toward carefully balancing the need to treat states similarly and equitably and the need to consider their individual needs and circumstances. The cookie-cutter approach to national health policy will not work. One size and one shape simply do not fit all, and we must be flexible in our approach.

Not all 1115 demonstrations are statewide reforms, but all of them are customized to build on the diversity inherent in each state and each Medicaid program. In some sense, it is inaccurate to speak of the Medicaid program as one program. The differences are so significant among states that there are really more than fifty Medicaid programs, counting the territories and the District of Columbia.

Continue to streamline the process. A major lesson emerging from our longstanding partnership with states is how we can all work together to reduce the administrative burden associated with demonstration waivers. Through collaborative efforts, 1115 demonstrations have on average been processed more than 50 percent faster than similar waivers have in the past. This in itself has been quite an undertaking, since these proposals are far-reaching and complex.

**Consumer and provider views.** We must make sure that the views of consumers and providers are sought and considered when states undertake major changes in Medicaid. This does not presume that all program beneficiaries and providers can or should be happy with a proposed change—it is human nature to question change and cling to the status quo. But the process for designing and implementing change should be open and available for all to review. Recently promulgated requirements for states to provide public notice and solicit public comment before they submit a proposal to HCFA for review should greatly facilitate such public input.

**Facts and finances.** Longstanding and appropriate federal policy dictates that 1115 demonstrations not cost more than what would have been spent under the traditional Medicaid program. Despite the potential limitations the fiduciary obligations pose, the states and HCFA have developed innovative ways to significantly expand access to care and service delivery. For example, the recent 1115 statewide expansions in Oregon, Ohio, Hawaii, Tennessee, Rhode Is-
land, Kentucky, and South Carolina will make health care available to more than a million previously uninsured persons. These demonstrations were approved within the past two years, and evaluation contracts were recently awarded to determine how the projects are implemented. Increased access to care and innovation can be accomplished without breaking federal and state budgets or bankrupting providers. We have been able to cover new populations in new ways while reducing aggregate Medicaid spending.

**Foster innovation.** The 1115 demonstrations were created because often good ideas must be tested to determine their real-world effects. That is our approach in the Medicaid program. We will try to develop synergies among demonstrations and share the results with the health care community. We are developing a guide to help states prepare their proposals and speed up the process. And we are publishing a monthly status report on 1115 demonstrations in the Federal Register to share information with the health care community about innovative ideas that have been approved.

**Leadership and vision.** In health care, as in all areas, we must envision a bigger picture of where we are going and what must be done. Our past can be a guide to the future. Medicaid has evolved from a program primarily serving women on welfare to a complex system covering a range of health issues and populations: women, children, the chronically disabled, and elderly persons in nursing homes. That evolution resulted from vision and leadership: identifying unmet needs and having the courage to address them. That evolution also resulted from new thinking. As Albert Einstein observed, “The significant problems we face cannot be solved at the same level of thinking we were at when we created them.”

Vision and leadership also mean taking risks. The future cannot rest on the status quo. We must continue to anticipate threats and opportunities, initiate change, and become learning organizations. Investments in people and technology must continue to improve service to beneficiaries and program performance. We need to recognize mistakes and be flexible enough to change strategies when necessary.

HCFA’s vision for the future is to provide equal access to the best health care. This cannot be done alone. It will require a continued partnership with states and others to make the vision a reality.

**Conclusion**

Finding solutions to the complexities of tomorrow’s health care system and our nation’s health care needs will require even more innovation and collaboration with the states. This relationship has been extremely fruitful, and the list of accomplishments is long. It includes improving quality; expanding access to the uninsured and new populations with special needs; upgrading the efficiency and effectiveness of our programs; and reducing aggregate Medicaid spending levels. The 1115 demonstrations have provided the flexibility to experiment with change. Results have been used to make key policy decisions concerning Medicaid and welfare reforms.

As we approach the thirtieth anniversary of Medicaid, it is appropriate to renew our commitment to communication, collaboration, and experimentation with the states. It is a productive partnership on which to build for the twenty-first century.

*The author thanks Maria A. Friedman for her contributions in the preparation of this Perspective.*

**NOTES**

1. Medicaid also grants “program” waivers for home and community-based care and managed care under Section 1915 of the Social Security Act. These waivers are not discussed in this Perspective.

2. The 1115 waiver authority also extends to demonstrations for welfare reform. There are two kinds: demonstrations requiring only Medicaid waivers, which are administered by HCFA, and demonstrations requiring Title XIX (Medicaid) and Title IV-A (welfare) waivers.