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MEDICAID 1115 DEMONSTRATIONS

Do Managed Care Programs Covering Long-Term Services and Supports Reduce Waiting Lists for Home and Community-Based Services?

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Introduction

States are implementing programs for Medicaid managed long-term services and supports (MLTSS) in part to reduce avoidable use of institutional services and expand access to home and community-based services (HCBS). One potential measure of this utilization shift is reduction or elimination of HCBS waiting lists. In theory, states can use savings from lower utilization of institutional services to expand the number of available HCBS slots and reduce the number of people waiting for services.

This brief examines changes in the number of people on HCBS waiver waiting lists in a sample of eight MLTSS programs (see Table 1) and identifies MLTSS features that may be associated with the changes as well as other factors that are not directly associated with managed care. The brief also discusses challenges with using waiting lists as a measure of HCBS access and identifies other HCBS access measures used by states.

Key findings. Among seven states that had waiting lists for HCBS waivers before the start of the MLTSS program, two states eliminated the wait for services and four states decreased the number of people on their waiting lists after the MLTSS programs began. The rate of decrease ranged from 12 percent in New Mexico to 92 percent in Wisconsin. One state had virtually no change in its waiting list. The eighth state in the study (New Jersey) did not have an HCBS waiting list before or after MLTSS program implementation. States attributed decreases in their HCBS waiting lists to multiple factors, including but not limited to the MLTSS program. Five of the eight states cited expanded funding as an additional factor in reducing their waiting lists.

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid, which is administered by states, is jointly funded by state and federal governments. Within a framework established by federal statutes, regulations, and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches for administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities who need assistance with activities of daily living. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per member per month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement—combined with contract requirements to protect enrollees—can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability of less costly home- and community-based services as an alternative to institutional care.

Table 1. State MLTSS programs included in the study

Program name	Start date	Federal authority
Delaware Diamond State Health Plan–Plus (DSHP-Plus)	4/1/2012	1115
Florida Statewide Medicaid Managed Care Long-Term Care Program	8/1/2013	1915(b) and (c)
Michigan MI Choice	10/1/2013	1915(b) and (c)
New Jersey Family Care MLTSS	7/1/2014	1115
New Mexico Centennial Care	1/1/2014	1115[a]
Tennessee TennCare CHOICES	3/1/2010	1115
Texas STAR+PLUS	1/1/1998	1115[a]
Wisconsin Family Care	1/1/1999	1915(b) and (c)

Sources: Special Terms and Conditions for 1115 programs; approved waiver applications for 1915(b) and (c) programs.
[a]Predecessor MLTSS program operated under 1915(b) and (c) concurrent authorities.

Background on HCBS Waiting Lists

HCBS includes a broad range of flexible LTSS delivered outside of institutional settings. Specific services are defined by states within the limits of federal rules and often include case management, homemaker, personal care, adult day health care, respite care, and other services.

Individuals who qualify for Medicaid based on categorical and income criteria are entitled to receive HCBS covered by the Medicaid State Plan, such as home health and personal care. But the same is not true for HCBS authorized through Section 1915(c) waivers or Section 1115 demonstration authority. States may limit the number of participants served in 1915(c) HCBS waivers and Section 1115 demonstration programs. The majority of states do limit participants to manage system capacity and costs. When the number of participants reaches a pre-established maximum, new applicants are placed on a waiting list until a slot becomes available.

Among the 48 states with 1915(c) HCBS waivers in 2015, 35 states reported a total of more than 640,000 people waiting to receive HCBS in such programs, with an average wait time exceeding two years (Ng et al. 2013). Three states with MLTSS programs operating under Section 1115 demonstration authority (California, New Mexico, and Texas) also reported waiting lists in 2015 (O'Malley Watts et al. 2017). Waiting lists are often used as yardsticks for measuring HCBS access in state policy debates. For example, when expanding funding for HCBS, state legislatures typically describe appropriations in terms of additional slots to reduce the size of waiting lists.

Each state decides how it will define and maintain HCBS waiting lists. As a result, waiting lists are generally not comparable across states. Among the eight states included in this study, the following variation was identified:

- **States vary in their criteria for placing people on waiting lists.** In some states, such as Tennessee and Wisconsin, people on waiting lists have been assessed and found to meet clinical criteria for LTSS. In other states, such as Florida, New Mexico, and Texas, people can get on a waiting list simply by expressing interest in services, without first receiving a clinical assessment. This is why Texas calls its list an "interest list" and New Mexico calls its list a "registry." New Mexico officials have found that roughly one-third of the people on the registry meet clinical eligibility for HCBS when their names come up, one-third are found ineligible, and one-third cannot be located.
- **The method for compiling waiting lists changes over time.** Three states (Florida, Michigan, and Texas) reported that the method for compiling waiting lists changed when MLTSS was implemented. In all three cases, the state moved from a system of maintaining separate, regional lists at the local level to maintaining a centralized, statewide list. These states reported that in the process of creating centralized lists, they found significant variation in how the lists had been maintained across regions. Because these states standardized their waiting lists with the implementation of MLTSS, the pre- and post-MLTSS lists are likely not fully comparable.
- **Waiting lists are sometimes maintained by an organization separate from Medicaid.** Three states (Florida, Michigan, and New Mexico) indicated that waiting lists either are or were in the past maintained by an administrative entity separate from the Medicaid program. In Florida and New Mexico, the waiting list was maintained by the state agency responsible for aging and disability. In Michigan, it was maintained by the local agencies contracted to manage waiver services. In these cases, waiting lists maintained by different agencies for different populations may not be comparable within a state or across states.

States noted one additional caveat about using HCBS waiting lists as indicators of HCBS access: waiting lists may not adequately reflect relative access to state HCBS programs. Demographic shifts in aging and disability are increasing the demand for LTSS in most states. As demand grows, a program must serve an increasing number of people simply to maintain waiting lists at their current levels. On its face, a flat trend in individuals on a waiting list may appear to indicate no increase in HCBS capacity when in fact a program may be serving increasing numbers of people but not enough to reduce the number waiting.

HCBS Waiting Lists Have Declined in Most of the Study States, with Both Managed Care and Other Factors Cited

Waiting lists declined in most states studied

States were asked to provide waiting list data for a point in time prior to their current MLTSS initiative, and for the most recent period available as of January 2016. For the fee-for-service (FFS) period, waiting lists reported were only for those programs that were subsequently incorporated into the MLTSS programs. To compare the magnitude of change across states, Table 2 expresses change as a rate of individuals on the waiting list per 1,000 beneficiaries in the aged, blind, and disabled Medicaid eligibility category for each state. This rate holds constant the number of Medicaid beneficiaries who are at most risk for needing HCBS in each state over time.

The waiting list rate declined in the target programs in four of the eight states in the sample, with rates of decrease ranging from 12 percent in New Mexico to 92 percent in Wisconsin (Table 2). One state (Florida) showed no significant change in the first two years of MLTSS implementation. Two states (Delaware and Tennessee) eliminated the wait for services when they implemented MLTSS programs. One state (New Jersey) had no waiting list before or after implementation.

These results must be interpreted with caution, based on the caveats discussed above. All state officials interviewed for this study believe that access to HCBS has increased since MLTSS was implemented. Furthermore, they attribute the result, in part, to managed care. However, state officials also identified other factors in addition to managed care that have direct effects on waiting lists. Managed care and other factors are discussed in the next two sections.

Table 2. Change in waiting lists for applicable HCBS programs since MLTSS implementation in eight states

MLTSS program (start date)	Pre-MLTSS program			Post-MLTSS (most recent available)			Change in number on applicable waiting lists per 1,000
	Number on applicable HCBS waiting lists (year)	Number of aged, blind, and disabled enrolled in Medicaid (year)	Number on applicable HCBS waiting lists per 1,000 ABD enrollees	Number on applicable HCBS waiting lists (2015/2016, unless otherwise noted)[a]	Number of aged, blind, and disabled enrolled in Medicaid (month-year)	Number on applicable HCBS waiting lists per 1,000 ABD enrollees	
Delaware Diamond State Health Plan–Plus (4/1/2012)	Numbers not available but specific services had waiting lists	—	—	None	—	—	None waiting
Florida Statewide Medicaid Managed Care Long-Term Care Program (8/1/2013)	41,055[b] (2013)	1,076,285 (2013)	38.1	42,488	1,110,055 (March 2014)	38.3	<1%
Michigan MI Choice (10/1/2013)	6,000 (2013)	483,373 (2013)	12.4	4,000	498,546 (December 2014)	8.0	-35%
New Jersey Family Care MLTSS (7/1/2014)	None	—	—	None	—	—	Not applicable
New Mexico Centennial Care (1/1/2014)	16,553 (2013)	107,392 (2013)	154.1	16,370	121,000 (March 2016)	135.3	-12%
Tennessee TennCare CHOICES (3/1/2010)	1,000 (2010)	365,514 (2010)	2.7	None	402,624 (January 2015)	—	None waiting
Texas STAR+PLUS (1/1/1998)	66,787 (2004)	739,020 (2004)	90.4	12,098	1,080,618 (March 2014)	11.2	-88%

(continued)

MLTSS program (start date)	Pre-MLTSS program			Post-MLTSS (most recent available)			Change in number on applicable waiting lists per 1,000
	Number on applicable HCBS waiting lists (year)	Number of aged, blind, and disabled enrolled in Medicaid (year)	Number on applicable HCBS waiting lists per 1,000 ABD enrollees	Number on applicable HCBS waiting lists (2015/2016, unless otherwise noted)[a]	Number of aged, blind, and disabled enrolled in Medicaid (month-year)	Number on applicable HCBS waiting lists per 1,000 ABD enrollees	
Wisconsin Family Care (1/1/1999)	11,353 (1999)	171,100 (1999)	66.4	1,600 (2013)[c]	285,276 (January 2013)	5.6	-92%

Source: Pre- and post-MLTSS waiting list data were provided by the states unless noted otherwise. Pre-MLTSS waiting list numbers correspond to the HCBS programs that were subsumed or replaced by the subsequent MLTSS program. For all states other than Wisconsin, the waiting lists are specific to older persons and persons with physical disabilities. The Wisconsin numbers also include persons with intellectual and developmental disabilities because HCBS services for those groups were included in MLTSS. The number of aged, blind, and disabled beneficiaries enrolled is from the Medicaid Statistical Information System; counts from New Mexico were obtained in April 2016 from the state Medicaid agency website. Data from the post-period are the most current available as of March 2016.

Note: ABD = aged, blind, disabled

[a] Because the waiting lists reported here are limited to those programs that were subsumed or replaced by MLTSS, they may differ from other sources that report on all waiting lists, including those that remain FFS.

[b] Sum of three HCBS program lists; may include duplicates.

[c] HCBS waiting list in 15 counties as of October 2013. Source: Wisconsin Department of Health Services. "Long-Term Care Expansion Report." Submitted to the Wisconsin Legislature, Joint Committee on Finance, December 2013.

States identified managed care factors that increased access to HCBS

States credited several MLTSS program features with expanding the availability of HCBS, including flexible benefits, care coordination, blended capitation rates, and consolidation of functions and accountability within a managed care organization (Table 3).

- **Flexible benefits.** Most of the state officials we interviewed pointed to benefit flexibility as a key feature of managed care that expands access to services in home- and community-based settings as an alternative to institutional settings. States cited two types of flexible benefits. The first type consists of additional benefits (not covered in the state plan or HCBS waiver programs) offered by the managed care plans in their marketing materials to differentiate themselves from one another as they compete for members. For example, among Florida's seven managed care plans, one offers mobile personal emergency response systems, three offer additional nonmedical transportation beyond the normal benefit, six offer bed holds for assisted living, and all seven offer transitional services to leave nursing facilities after a stay.

  The second type of benefit flexibility is the managed care plans' ability to use cost-effective alternatives to covered services on a case-by-case basis. States provided several examples of situations in which managed care plans elected to pay for items or services that were outside of or exceeded the limits of covered benefits to help enrollees remain in their homes. In New Jersey, one managed care plan purchased an air conditioner for an enrollee whose asthma attacks resulted in frequent trips to the emergency room. In Tennessee, managed care plans have provided bedbug treatment, which is outside the normal scope of the program's pest control benefit, for enrollees who otherwise could not remain in their homes. They also frequently provide small allowances as a cost-effective alternative to cover rent, utility deposits, and household goods for people who are transitioning from a nursing facility back to the community.

Table 3. Features of MLTSS that state officials associate with reduction in waiting lists or increase in access to HCBS

Managed care feature	State							
	DE	FL	MI	NJ	NM	TN	TX	WI
Flexible benefits	✔	✔		✔	✔	✔	✔	✔
Care coordination	✔	✔		✔	✔	✔	✔	✔
Blended nursing facility–HCBS capitation rates	✔	✔			✔	✔		✔
Consolidation of functions and accountability in contractor	✔	✔	✔	✔	✔	✔	✔	✔

Source: Truven interviews with state officials, January 2016.

- **Care coordination.** Most state officials described the importance of care coordination in increasing the number of MLTSS enrollees who receive HCBS and remain living in the community. MLTSS programs achieve this coordination by conducting an initial needs assessment and having ongoing involvement in coordinating members' care across the spectrum of their health (medical and behavioral), LTSS, and social needs. LTSS needs that may have gone undetected in the FFS program may be identified as part of an initial needs assessment for new members, allowing earlier intervention and monitoring of needs that, if unaddressed, could lead to institutional placement. Delaware observed that when it moved "community well" dually eligible beneficiaries into MLTSS from FFS, the state saw an increase in the number of people receiving HCBS because care coordinators identified significant need that had previously been undetected. Several states emphasized the effectiveness of assigning care coordinators across the continuum of care to facilitate members' receipt of HCBS (Delaware, Florida, and Texas). They observed that extending the reach of care coordination to all members, regardless of setting, helped divert avoidable nursing home admissions from hospitals and identify individuals residing in nursing facilities who were good candidates for transition to the community.

- **Blended nursing facility–HCBS capitation rates.** Five states (Delaware, Florida, New Mexico, Tennessee, and Wisconsin) credit blended nursing facility–HCBS capitation rates with expanding HCBS access for MLTSS enrollees. The specific method varies by state, but the general approach is similar. To arrive at a blended rate, separate capitation rates are developed for individuals who meet nursing facility level of care (LOC) and are receiving nursing facility services and for individuals who meet nursing facility LOC and are receiving HCBS. The current mix of individuals receiving services in nursing facilities versus HCBS is calculated and a target is established for how the percentages are expected to change during the rating period. The two capitation rates are then blended according to those percentages, which results in a single capitation payment for all persons who meet nursing facility LOC. If the managed care plan can exceed the HCBS target that is assumed in the rate (and thereby use fewer nursing facility services than targeted), the plan gains financially. On the other hand, if the plan exceeds the target for nursing facility use, it loses financially.

  In Florida, a specific blend assumption was mandated by the legislature. Florida calls its target mix the "transition percentage." The transition percentage is the amount of change expected each year in the mix of individuals who are served in nursing facilities versus those who are served in HCBS (with the total being the sum of all people receiving Medicaid-funded LTSS). The transition percentage was set at 2 percent in the first year of the program and 3 percent each year thereafter until the managed care plan achieves a mix of 35 percent receiving services in nursing facilities and 65 percent in HCBS. As of January 2016, the mix in Florida was approximately 50 percent in each setting.

- **Consolidation of functions and accountability.** Most states described managed care as an opportunity to consolidate facets of their LTSS systems that were fragmented previously. In addition, they attributed more effective management of LTSS resources to the consolidation. Florida had fourteen 1915(c) waivers prior to implementation of its MLTSS program. It consolidated four of them into a single 1915(c) waiver for the MLTSS program. Delaware converted three of its four 1915(c) waiver programs into an HCBS benefit under 1115 demonstration authority. Tennessee terminated its aging and disability 1915(c) waiver upon the implementation of the CHOICES program. Some states (Delaware and Texas) folded their Money Follows the Person (MFP) programs into MLTSS, which requires managed care plans to be responsible for transitions out of nursing facilities. In addition to changing to a centralized waiting list, Florida also centralized its complaints intake process, both of which have improved accountability and transparency.

States identified additional factors not related to managed care that affected waiting lists

Although states believe managed care has contributed indirectly to reductions in HCBS waiting lists, they also reported that other factors have had more direct effects. Some of these additional factors were implemented concurrently with managed care. However, they are not integral to the managed care model and could be implemented in a FFS environment. The additional factors are discussed below and summarized in Table 4 (see next page).

Table 4. Other factors that state officials reported as impacting waiting lists and HCBS access

Factors	State							
	DE	FL	MI	NJ	NM	TN	TX	WI
Policy changes to make HCBS an entitlement					✔		✔	✔
Expanded HCBS funding		✔	✔	✔			✔	✔
Role of the Aging and Disability Resource Center		✔			✔			✔

Source: Truven interviews with state officials, January 2016.

- **Policy to make HCBS an entitlement.** Three of the states interviewed (New Mexico, Texas, and Wisconsin) adopted policies that entitle certain individuals to HCBS, so they are not barred due to enrollment caps on HCBS waiver programs. As part of the legislation that enabled Family Care, Wisconsin made HCBS an entitlement for anyone who is financially and clinically eligible in a county within three years of Family Care having been implemented in that county (that is, giving counties up to three years to expand capacity to serve all individuals who qualify, including those on a waiting list). As part of the special terms and conditions of their 1115 demonstrations, which include both LTSS and non-LTSS populations, Texas and New Mexico offer immediate access to HCBS for individuals who are already Medicaid-eligible based on financial income and assets if they subsequently experience a decline in health or function that triggers the need for LTSS. This effectively entitles all existing managed care enrollees to LTSS as their needs change. People who are not enrolled in managed care because they do not qualify for Medicaid under regular program financial eligibility rules, but would be eligible under the higher income standard for LTSS, are still subject to a waiting list.
- **Expanded funding.** Five states reported that additional appropriations were made to expand HCBS (Florida, Michigan, New Jersey, Texas, and Wisconsin). In some states, additional funding was a high-profile political issue, such as in Michigan, where Governor Rick Snyder announced his intention to eliminate waiting lists in his 2014 State of the State address. States emphasized that managed care efficiencies are viewed positively in these debates, but the additional appropriations have exceeded the savings attributed to managed care.
- **Role of the Aging and Disability Resource Centers (ADRCs).** Three states (Florida, New Mexico, and Wisconsin) cited ADRCs as effective information sources and entry points to HCBS. Wisconsin, in particular, noted that the state's ADRCs have grown concurrently with the implementation of Family Care and play an important role in helping both Medicaid and non-Medicaid eligible persons identify HCBS as an alternative to nursing homes. States credited ADRCs with helping divert people away from nursing homes, thereby saving money that can be applied to additional HCBS.

Section 1115 authority offers added program flexibility, but is not associated with waiting list reductions

States did not identify any advantages in using Section 1115 versus 1915(c) authority for reducing waiting lists. For example, states can cap HCBS enrollment in programs operating under Section 1115 demonstrations just as they can for HCBS programs operating through 1915(c) waiver authority. As noted earlier, MLTSS programs in California, New Mexico, and Texas that operate under Section 1115 authority establish such caps. However, because each state negotiates the terms and conditions of Section 1115 demonstration individually with CMS, they have greater flexibility to adopt policies that expand access to HCBS but are not allowed in HCBS 1915(c) waiver programs.

Tennessee, for example, made the LOC criteria for nursing home admission more stringent in the Section 1115 demonstration for its MLTSS program. It also grandfathered in beneficiaries who were eligible for HCBS on the basis of the previous, more lenient LOC criteria, which allowed them to continue receiving services that they would otherwise lose. Such transitional policies are not authorized in 1915(c) programs. Under the terms of their Section 1115 demonstrations, both Tennessee and Delaware decoupled HCBS clinical eligibility from that of nursing homes, which allowed them to provide HCBS to people who meet less stringent criteria than required for nursing home admission. Under 1915(c) waiver authority, states must establish the same clinical and functional criteria for HCBS participants as those that apply to people who are eligible for institutional admission.

Other HCBS Access Measures Used by States

Many of the state officials we spoke to acknowledged the importance of waiting lists as indicators of HCBS access. Stakeholders use waiting lists to advocate for more funding, while legislatures often appropriate additional funds specifically to reduce waiting lists. However, state officials also underscored the inadequacy of waiting lists as the sole indicator of HCBS access. They reported using several other indicators, as summarized in Table 5.

The first two indicators (people receiving HCBS and member months of HCBS) measure change over time in the use of HCBS, regardless of demand. As noted earlier, LTSS demand is increasing with demographic shifts and it is possible to serve more people while waiting lists remain constant or even grow. The third indicator (system balance) represents a key federal and state goal. It is often related to waiting lists in that states generally achieve a more balanced system by both increasing access and use of HCBS and by reducing the use of institutional services. Although the fourth indicator (nursing home transitions) and fifth indicator (use of participant-directed options) are not by themselves measures of HCBS utilization, they describe a quality of access (consumer preference and control) that is important to LTSS stakeholders. Finally, the average length of time a person is on the waiting list before receiving HCBS indicates the capacity constraints of each HCBS waiver. For example, in 2013, the average waiting time was four months for people waiting to enroll in HIV/AIDS waiver programs and 43 months for people waiting to enroll in Intellectual/Developmental Disabilities waiver programs (Ng et al. 2016). In addition, only people who eventually receive services are included in the indicator, so people who are ineligible but on the list, for example, do not skew it.

Conclusions

Although six of eight states in this study either reduced or eliminated their HCBS waiting lists after they implemented MLTSS programs, the states reported that managed care alone was not responsible for the change. States attributed some waiting list reduction to managed care features, including flexible benefits, care coordination, blended rates, and consolidation of functions and accountability. However, they also identified other important factors that are not directly related to managed care, including entitlement policy, increased HCBS funding, and the role of ADRCs. States that converted their MLTSS programs from Section 1915(c) to 1115 authority cited increased flexibility to expand HCBS, but did not see any relative advantages for reducing their waiting lists.

Waiting lists are one indicator of HCBS access that are watched closely by stakeholders. However, using waiting lists as an access measure has limitations. Waiting list data are not comparable across (and sometimes within) states, may include people who are not eligible for services or who no longer require services, and do not capture increases in the number of people receiving HCBS.

States reported using other measures of HCBS access, including the number of individuals receiving HCBS, member months of HCBS delivered, and percentage of all LTSS users who are receiving HCBS. These and other measures should be considered for MLTSS evaluations.

Table 5. HCBS access indicators cited by state officials

HCBS access indicators	State							
	DE	FL	MI	NJ	NM	TN	TX	WI
1. Number of people receiving HCBS annually		✔	✔	✔	✔	✔		
2. Member months of HCBS provided annually		✔			✔			
3. Number of people receiving HCBS divided by total number receiving LTSS annually (system balance)	✔	✔		✔	✔	✔	✔	✔
4. Number of people who transitioned out of nursing homes or other reductions in nursing home use	✔	✔		✔	✔	✔	✔	✔
5. Number of people using participant-directed options	✔	✔			✔	✔	✔	✔
6. Average length of time on waiting list			✔				✔	

Source: Truven interviews with state officials, January 2016.

METHODS AND DATA SOURCES

In January 2016, Truven Health conducted hour-long, semi-structured telephone interviews with Medicaid officials who represent managed long-term services and supports (MLTSS) programs in eight states. The states were selected for diversity of program maturity, geographic region, and federal Medicaid authorities utilized.

The interview protocol addressed the following research questions:

- Has the implementation of MLTSS affected waiting lists for home and community-based services (HCBS) and, if so, how? What evidence do state officials use to answer this question?
- What program or policy factors do state officials identify as key to affecting waiting lists?
- Do state officials believe that MLTSS has expanded access to HCBS or reduced use of institutional services in additional ways beyond reductions in waiting lists? If so, how do they measure the expanded access?

After the interviews, state officials were asked to provide data and other evidence discussed during the interviews. State officials were given an opportunity to review a draft of this brief for accuracy.

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ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to inform CMS's decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. These briefs will inform an interim outcomes evaluation report in 2017 and a final evaluation report in 2019.