Medicaid Managed Care Authorities

The Social Security Act provides multiple authorities for states to operate Medicaid managed care programs with federal approval. Most comprehensive Medicaid managed care programs are authorized through a state plan amendment (SPA), a Section 1915(b) program waiver, or a Section 1115 research and demonstration waiver.

Topic	Section 1932(a) state plan amendments (SPA)	Section 1915(b) program waivers	Section 1115 research and demonstration waivers
General authority	Exempts states from state plan requirements for statewideness, comparability, and freedom of choice.[1]	Provides states with a time-limited waiver from state plan requirements for statewideness, comparability, and freedom of choice. May be used to provide additional services that are not provided to enrollees who are not covered by the waiver, as well as limit the number of service providers.	Broad authority permitting all of the flexibility allowed under 1915(b) waivers as well as waiver of other federal Medicaid requirements contained in Section 1902 of the Social Security Act. The Secretary of the U.S. Department of Health and Human Services may also provide federal matching funds for services, activities, or costs not otherwise matchable.
Approval period	Indefinite	Initially approved for two years.	Initially approved for five years, although the U.S. Department of Health and Human Services may approve shorter or longer periods.

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Populations states may require to enroll	All state plan populations except certain children with special needs, Medicare beneficiaries, and American Indians unless enrolled with an IHS, Tribal, or Urban Indian program.	All state plan populations.	All state plan populations, as well as any individuals not otherwise eligible for Medicaid (authorized through costs not otherwise matchable).
State application requirements	Completion of mandatory Centers for Medicare and Medicaid Services (CMS) state plan preprint.	Completion of CMS application template.	No CMS standard preprint form or template available but must submit proposal describing design features of program (e.g., populations covered, design of Medicaid managed care program).
Federal budget requirements	No required budget or cost analysis.	Demonstrate cost effectiveness and efficiency of program (actual expenditures cannot exceed projected expenditures for approval period).	Demonstrate budget neutrality. Federal expenditures under the waiver cannot exceed the costs in the absence of the demonstration (without waiver costs) during the approved waiver period.
CMS review time frame	Approved within 90 days of CMS receipt unless written disapproval or request for additional information. If additional	Same as SPA time frame.	No required time frame for CMS review or approval, but CMS will not make a final decision on a

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	information requested, 90-day period begins again on day CMS receives additional information.		demonstration until at least 45 days after submission.
Renewal period	No renewal needed.	Customarily up to two years; CMS has discretion to approve for five years if the waiver covers dually eligible enrollees.	Customarily up to three years; CMS has the discretion to approve for five years if the waiver covers dually eligible enrollees.
Program documentation	Contained within overall CMS state plan preprint.	Contained within CMS application template.	Special terms and conditions negotiated between CMS and states and documented.
Monitoring and evaluation	CMS monitors implementation of SPA to ensure requirements are met; state conducts separate evaluation of managed care entities.	Same as SPA.	CMS monitors implementation of waiver to ensure requirements are met; requires the State to hire an independent evaluator and submit an evaluation design plan to be approved by CMS.

[1]Statewideness refers to a requirement that the managed care program must be operational statewide. Comparability refers to a requirement that benefits for managed care enrollees must be equivalent to fee-for-service benefits. Freedom of choice refers to enrollees' ability to receive services from any qualified provider; waiving this requirement requires enrollment in a managed care program and limits choice of providers to those in the health plan's network.