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Medicaid Expansion Waivers: What Will We Learn?

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Introduction

Six of the 32 states implementing the Affordable Care Act's (ACA) Medicaid expansion to date have done so through Section 1115 waivers. Using these waivers, the Centers for Medicare and Medicaid Services (CMS) has approved terms that extend beyond the flexibility provided by federal law. Section 1115 waivers authorize research and demonstration projects that, in the view of the Health and Human Services (HHS) Secretary, further the purposes of the Medicaid program. The ACA implemented new requirements for these waivers, including that states must have a publicly available, approved evaluation strategy. States also must submit an annual report to HHS that describes the changes occurring under the waiver and their impact on access, quality, and outcomes. Additionally, a federal contract has been awarded to evaluate different types of Section 1115 waivers, including those related to the ACA's Medicaid expansion. This brief examines some of the major research questions and hypotheses relevant to the federal and state evaluations of Medicaid expansion Section 1115 waivers and explores key challenges that may hamper research and evaluation efforts.

The federal evaluation of Section 1115 waivers is designed to consider the experiences of multiple states in implementing policy changes related to Medicaid expansion, including Marketplace premium assistance programs, premiums beyond the limits set in federal law, and healthy behavior incentive programs. While the state evaluations are unique to each state's waiver, the evaluation questions identified by the states relevant to Medicaid expansion waivers can be grouped into five key areas: coverage, access to care and utilization, premiums, healthy behavior incentives, and program costs.

As additional states seek waivers, evaluations are key to understanding Medicaid expansion experiences under existing waivers. Evaluation plans include comprehensive research questions, but a number of challenges may hamper research efforts including: limited access to timely data; difficulty selecting outcome measures; difficulty generalizing the results; administrative complexity; and implementation of waivers in dynamic, continuously evolving environments. Despite the challenges in conducting waiver evaluations, timely and publicly available results are important. In the near term, availability of data can help states and CMS to understand issues and make mid-course corrections in the implementation of current waivers. In the near and longer term, data and analysis of existing waivers also begins to inform policy makers about which policies are effective and could be replicated or implemented more broadly as well as what approaches to avoid.

Background

As of January, 2016, six of the 32 states[1] implementing the ACA's Medicaid expansion are doing so through a Section 1115 waiver (Arkansas, Iowa, Michigan, Indiana, New Hampshire, and Montana).[2] The ACA expands Medicaid eligibility to nearly all adults with income at or below 138% of the federal poverty level (FPL, $16,394 per year for an individual in 2016); however, the Supreme Court's ruling on the ACA's constitutionality effectively made the Medicaid expansion a state option.[3] For states that implement the expansion, the ACA provides for full federal financing from 2014 through 2016 for those made newly eligible by the law, then gradually decreases to 90% federal funding by 2020.

While each of the Medicaid expansion waivers is unique, they contain some common provisions.[4] Common elements of the waivers include a "premium assistance" model, in which the state uses federal Medicaid funds to purchase Marketplace coverage for enrollees or other private coverage; enrollee premiums; elimination of the non-emergency medical transportation benefit, which is otherwise required under Medicaid; and use of "healthy behavior incentives" to reduce enrollee premiums and/or copayments. Indiana's waiver contains additional provisions (some of which were subsequently approved in other states) that allow the state to waive retroactive Medicaid eligibility; make coverage effective beginning on the date of the first premium payment, rather than on the date of application; and bar certain expansion adults from re-enrolling in coverage for six months if they are disenrolled due to unpaid premiums. In addition, under separate Section 1916(f) waiver authority, Indiana received approval to charge higher cost-sharing than otherwise allowed under federal rules for non-emergency use of the emergency room. Also unique among the current expansion waivers, Montana received approval to implement 12-month continuous eligibility for expansion adults to reduce the effects of churn between Medicaid and Marketplace coverage due to small changes in income. Except for Montana, where the evaluation plan is still under development, all of these states have approved evaluation plans.

Table 1: Key Themes in Approved ACA Expansion Waivers

Waiver Provision	AR	IA*	MI*	IN*	NH*	MT*
Premium Assistance	QHP	ESI	QHP	ESI	QHP	
Premiums / Monthly Contributions	X	X	X	X		X
Healthy Behavior Incentives		X	X	X		
Waive Required Benefits (NEMT)		X		X		
Reasonable Promptness				X		
Waive Retroactive Eligibility				X	X	
Co-payments Above Statutory Limits				X		
12-Month Continuous Eligibility						X

NOTES: * New Hampshire transitioned from a SPA to a waiver in 2016. Cost-sharing waiver approved in IN under Section 1916(f), not Section 1115. IA has approval for mandatory QHP enrollment with premium assistance for new adults from 101-138% FPL but has a waiver amendment pending to instead require mandatory Medicaid managed care due to the loss of both QHPs. Under MI's waiver amendment, beneficiaries from 101-138% FPL will choose between coverage in Medicaid managed care and QHPs beginning April 2018. PA transitioned from a waiver to a SPA in 2015 (not included in the table). An evaluation plan has not yet been submitted for MT.

SOURCE: KCMU analysis of waiver proposals.

Research Questions in Federal Waiver Evaluation Design

CMS is funding a national cross-state evaluation that will consider several issues related to Section 1115 Medicaid expansion waivers, including the impact of Marketplace premium assistance, premiums, and healthy behavior incentive programs.[5] Key research questions identified in the federal waiver evaluation design plan[6] related to these issues include:

- **Marketplace premium assistance:** How do states that require beneficiaries to enroll in Marketplace Qualified Health Plans (QHPs) using Medicaid as premium assistance compare to states implementing traditional expansions using their Medicaid delivery systems, in terms of enrollment rates, continuity of coverage, access to care, health outcomes, and health care and administrative costs?
- **Premiums:** What effect do premiums imposed on beneficiary groups who are not otherwise subject to premiums under federal law, premiums that exceed the limits in federal rules, and lock-out periods for non-payment of premiums have on enrollment and continuity of coverage?
- **Healthy behavior incentive programs:** Do beneficiaries understand healthy behavior incentive programs? Which educational strategies are most effective? Which incentives encourage beneficiaries to actively participate in their care without impairing access to care, and which yield the greatest relative gains in preventive care and management and care of chronic conditions and the greatest reductions in emergency room use? What are the administrative costs to states and managed care plans of implementing healthy behavior incentive programs?

Appendix 1 provides a full list of federal research questions.

Unlike the individual state waiver evaluations (described below), the federal Section 1115 waiver evaluation can assess the experience across states in implementing common waiver provisions. The federal evaluation will examine Marketplace premium assistance programs in Arkansas, Iowa and New Hampshire, and premiums and beneficiary engagement (such as healthy behavior incentives) programs in Arkansas, Indiana, Iowa, Michigan, Montana and Wisconsin (these are the issues most relevant to the expansion waivers).[7] The federal evaluation also will consider questions related to other types of Section 1115 Medicaid waivers, including Delivery System Reform Incentive Payment (DSRIP) programs and managed long-term services and support programs.[8]

Research Questions in State Waiver Evaluation Designs

The Medicaid expansion demonstrations set out fairly broad goals under which the states have identified a number of hypotheses for evaluation. While each state's evaluation is unique, the themes of evaluation questions identified by the states relevant to the Medicaid expansion waivers can be grouped into five key areas: coverage, access to care and utilization, premiums, healthy behavior incentives, and program costs. The rest of this section summarizes the states' waiver evaluation questions in these five areas. A full state-specific summary of evaluation goals and hypotheses that will be tested is included in Appendix 2.

Coverage

While no waiver is required to examine the implications of the Medicaid expansion on changes in coverage, Michigan's and Indiana's evaluations will measure their waivers' impact on change in the number of uninsured. Both states expect to experience reductions in the uninsured as a result of their Medicaid expansions. Michigan expects that both the reduction in uninsured and the increase in Medicaid enrollment will be significant relative to expected state trends absent the Medicaid expansion, similar to the experience of other expansion states, and significantly larger than the changes in non-expansion states. Reductions in the uninsured and increases in Medicaid coverage are expected in all states that implement the Medicaid expansion; so, this issue is not specific to Medicaid expansion waivers; however, other expansions are not required to conduct evaluations so other states may not be explicitly tracking these changes.

Several states plan to examine their demonstration's impact on continuity of coverage and gaps in care. Arkansas and New Hampshire are testing the impact of mandatory Marketplace premium assistance on continuity of coverage. These states anticipate that as a result of Marketplace enrollment, Medicaid expansion adults will experience fewer gaps in coverage and more continuous access to the same health plans and provider networks. Although no longer using a Marketplace premium assistance model as originally intended,[9] Iowa's evaluation will examine whether beneficiaries maintain access to a regular source of care when Medicaid eligibility changes due to income fluctuations. Indiana will test how, in the absence of retroactive eligibility, its waiver provisions to utilize additional presumptive eligibility and fast-track prepayment of premiums (required for enrollment to become effective) affect gaps in coverage. It is expected that Montana's waiver evaluation will examine continuity of coverage, as it relates to the state's adoption of 12-month continuous eligibility.

Arkansas and New Hampshire expect that their premium assistance waivers will impact the premiums and coverage options in their Marketplaces. Arkansas anticipates that providing Marketplace coverage for Medicaid expansion adults will reduce premium costs in the Marketplace. New Hampshire projects that using Marketplace premium assistance could lead to a greater variety of Marketplace health plans, as insurers will have incentives to offer both Medicaid managed care and Marketplace plans.

Indiana plans to test how its demonstration promotes access to employer-sponsored insurance (ESI) and reduces fragmented coverage within families. Indiana's waiver includes a voluntary defined contribution ESI premium assistance program, which the state expects will increase the proportion of Medicaid expansion adults who are covered by ESI. Indiana also expects that its ESI premium assistance option for

family coverage will increase the number of families in which all members have access to the same provider network instead of having parents enrolled in ESI and children in Medicaid or CHIP.

While not directly related to coverage, Indiana's evaluation includes an assessment of its state-funded work search program, which is not considered part of the Section 1115 demonstration by CMS.

Indiana's Work Search and Job Training Program Evaluation

Indiana's evaluation of its Medicaid expansion waiver includes an assessment of its state-run voluntary work search and job training program. CMS did not approve Indiana's request to require a work referral as a condition of eligibility as part of its Medicaid expansion waiver and noted that Indiana's work search and job training program is separate from the Section 1115 demonstration. Indiana expects that Medicaid applicants who are referred to work search and job training resources available through the state's Department of Workforce Development will have increased employment rates over the course of the demonstration.

Access to Care and Utilization

Several state evaluations will examine changes in beneficiary access to care. Arkansas, Iowa, and New Hampshire will assess changes in access to primary, preventive, behavioral health, and specialty care and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for 19- and 20-year-olds. Iowa also plans to measure access to dental care, including preventive dental services. Arkansas will compare access to care in its Marketplace premium assistance model to access in its Medicaid fee-for-service delivery system, while New Hampshire will compare access to care for expansion adults to access for the state's general population. Arkansas, Iowa, and New Hampshire also mention plans to assess beneficiary satisfaction or experience with care as part of their evaluations. In Arkansas and Iowa, the evaluation plans will examine the adequacy of provider networks as part of their evaluations. Iowa expects that its Medicaid expansion enrollees will have the same access to medical providers and improved access to dental providers, relative to traditional (non-expansion) Medicaid populations in the state.

States expect their demonstrations to reduce potentially preventable emergency room use and hospital admissions through a variety of measures. For example, Arkansas, Iowa, Michigan, and New Hampshire plan to assess whether improved access to primary care services for expansion adults results in lower rates of non-urgent use of the emergency room and fewer potentially avoidable hospital admissions. Michigan also expects that beneficiaries who participate in its healthy behavior incentive program (described below) will have fewer emergency room visits and hospital admissions. Indiana hypothesizes that non-urgent emergency room visits will be reduced through its use of graduated copayments, prior authorization, and expanded access to urgent care. Iowa will assess whether copayments for non-emergency use of the emergency room (at state plan amounts) decrease inappropriate emergency room use without imposing barriers to access to care.

States that have waived non-emergency medical transportation (NEMT) and those that are delivering these services as a wrap-around benefit plan to measure access to transportation services. States that have waivers of NEMT (Iowa and Indiana) will measure barriers to care resulting from

lack of transportation, but hypothesize that the waivers will not create access barriers. For example, Indiana will measure the effect of its NEMT waiver on missed appointments, by income level, in various geographic areas of the state, and on access to preventive care and overall health outcomes. The state plans to assess the impact of its NEMT waiver on both providers and beneficiaries. Arkansas and New Hampshire do not have waivers of NEMT services but plan to measure access to NEMT, which is provided as a wrap-around service in their Marketplace premium assistance programs.

Premiums

States implementing programs to collect premiums or monthly contributions and/or cost-sharing will test whether these payments are affordable and whether they create barriers to health care access. Indiana and Iowa hypothesize that monthly premiums will not present barriers to access. Indiana will examine the number of individuals who are locked-out of coverage for non-payment of premiums, and the number of beneficiaries who have employers and/or not-for-profit organizations paying all or part of their required premiums. Michigan expects that its model, in which monthly premiums and cost-sharing based on the prior six months of service use are paid into health savings accounts, will not be associated with expansion adults dropping their coverage.

Demonstrations in Indiana and Michigan will test whether policies related to out-of-pocket contributions lead to greater beneficiary engagement in their health care and more efficient use of services. Indiana expects that beneficiaries who make monthly payments into their health savings accounts will exhibit more cost-conscious health care consumption than other Medicaid beneficiaries without harm to their health. Indiana also hypothesizes that its provisions for rollover of health savings account funds and coverage of preventive care without copayments will encourage beneficiaries to make monthly account payments and actively manage their account funds. Michigan expects that cost-sharing will lead to more efficient health care utilization when comparing beneficiaries' total health care costs over time with costs in their first year of enrollment. Michigan hypothesizes that those above poverty, who are subject to both premiums and copayments, will use services more efficiently than those below poverty, who are subject only to copayments. As described below, efficient use of care would mean less emergency room and inpatient care and more primary and preventive care.

Healthy Behavior Incentives

Iowa and Michigan will evaluate whether their healthy behavior incentive programs lead to improved health outcomes for beneficiaries. Iowa anticipates increased utilization of annual examinations, smoking cessation services, and preventive dental services between the first and second years of its demonstration. Additionally, Iowa expects that over half of its expansion adults will earn access to enhanced dental benefits by completing specified healthy behavior activities. Michigan projects improved health over time from its healthy behavior program, as reflected in health risk assessment results, use of preventive care, adherence to medications to manage chronic disease, and self-reported health status.

Iowa and Michigan also will assess beneficiaries' understanding of healthy behavior incentive programs. For example, Iowa will track which activities beneficiaries complete and which characteristics (such as age, race, gender, geographic area, and provider engagement with the program) are predictive of

completing healthy behavior activities. In addition, Iowa and Michigan will assess beneficiaries' understanding of the purpose of the program and how it works. Michigan plans to identify the factors that facilitate beneficiary completion of healthy behaviors and those that serve as barriers. Both Iowa and Michigan also plan to examine the impact of their healthy behavior programs on providers, such as whether providers use information from beneficiary health risk assessments and whether they have changed how they communicate with or care for beneficiaries as a result of the demonstration.

Program Costs

While longstanding federal policy requires Section 1115 demonstrations to be budget-neutral to the federal government, state waiver evaluations also will measure program costs. For example, Indiana expects its demonstration to be budget-neutral for the state as well as the federal government and will compare its waiver expenditures to expenditures in other states. Iowa anticipates that the costs for its demonstration will be comparable to the predicted cost of covering expansion adults in its traditional Medicaid program. Arkansas and New Hampshire expect that their Marketplace premium assistance models will be cost-effective compared to covering expansion adults under their traditional fee-for-service Medicaid programs.[10]

The Michigan and Indiana evaluations will also analyze uncompensated care costs. These states expect significant reductions in uncompensated care costs relative to pre-expansion trends. Michigan expects that hospitals with above-average baseline levels of uncompensated care costs and uninsured patients will experience greater percentage decreases in uncompensated care costs as a result of the expansion. The state also anticipates that its uncompensated care costs will decrease significantly relative to non-expansion states, and that its uncompensated care costs will not significantly differ from those other expansion states. Indiana will measure how its waiver of retroactive coverage impacts uncompensated care costs.

Key Evaluation and Research Challenges

While it is important to understand states' experience with implementing current expansion waivers to help inform future program directions, some key challenges that will hamper the ability to conduct meaningful evaluation of the Medicaid expansion waivers.[11]

Data Limitations

Robust evaluations depend on access to reliable and timely data, which may not be available within the timeframes for the state and federal waiver evaluations. All of the evaluations include quantitative data analysis, but there are often lags in the availability of federal survey data that is needed for the evaluations. The federal evaluation design plan also points to potential problems with the availability of administrative data from the national Medicaid data systems. States will soon transition from the Medicaid Statistical Information System (MSIS) to a revamped version known as Transformed MSIS (T-MSIS). During the transition, MSIS data may be incomplete as states shift to reporting in T-MSIS, but T-MSIS will likely need start-up time before its data are considered to be reliable. Some states plan to rely on state surveys or surveys of beneficiaries; however, state surveys can be expensive to administer and data from the surveys may not be comparable to data in other states to enable cross state comparisons.

Selection of Outcome Measures and Interpreting Data

Selecting outcome measures and interpreting evaluation findings can be extremely complicated. The selection of outcome measures to study in evaluations of Medicaid expansion waivers and the interpretation of data findings are both important challenges. Some outcome measures, such as change in the coverage status of low-income adults and change in out-of-pocket costs for health care, are more direct measures of the impact of Medicaid expansion. However, other expected downstream impacts of increased coverage, such as increases in access to care and improvements in health status, may be mediated by other individual-level or system-level factors, take a longer time to materialize or not materialize, or simply be difficult to interpret. Conflicting interpretations of early findings about access to care and health outcomes from the seminal (pre-ACA) Oregon Health Insurance experiment highlight issues associated with evaluating the impacts of Medicaid expansions, related to study design, methodological choices, timing, and other matters.[12,13,14]

Generalizability

Small sample sizes and unique state circumstances make it difficult to generalize findings from state evaluations to broader populations. One of the goals of Section 1115 waivers is for states to identify new approaches that may be effective elsewhere. However, evaluation results may not be generalizable because some state evaluations call for comparisons of Medicaid expansion adults to other populations in the state. Each state has a unique set of factors from the Medicaid delivery system to broader health care market factors. So, even evaluations that show robust results for a specific state may not be generalizable to other states due to these specific state circumstances.

Administration

The waivers' administrative complexity makes it difficult to interpret evaluation findings. For example, in states that assess a premium, there are often options to mitigate the effect of the premium for beneficiaries. In Indiana a third party may contribute to the premiums payments which may may make it hard to determine the effect of premiums on low-income individuals. Many aspects of the expansion waivers are extremely complicated for states to administer, and in some cases, states have delayed implementation of certain provisions. This administrative complexity could cause provisions to be implemented in ways that differ from what was originally intended. For example, Indiana's implementation of the lock-out provision for non-payment of premiums was delayed; Arkansas received approval to implement monthly contributions for individuals down to 50% FPL but, due to administrative costs has only implemented the policy for those above poverty, to date. Sometimes, these changes are course corrections where a state is able to assess available data and information to assist in the implementation process.

Most states are not specifically considering administrative costs as part of their waiver evaluations, despite the programs' complexity. Only New Hampshire specifically plans to look at the administrative costs of its waiver. It anticipates that using Marketplace premium assistance may result in lower administrative costs. Other states are not planning to assess the impact of their waivers on state administrative costs even though their waivers often introduce complicated program elements, such as premiums, cost-sharing, and healthy behaviors, that require ongoing tracking by the state.

Dynamic Environment

It is challenging to isolate the effects of policy changes related to the expansion waivers from the effects of policy and other changes unrelated to the waivers. State Medicaid expansion demonstrations do not operate in a vacuum. Along with the expansion, broader coverage expansions, enrollment and application streamlining, and insurance market reforms are also being implemented as part of the ACA. In addition, states are simultaneously implementing a variety of other reforms, including multi-payer delivery system reforms through State Innovation Model grants, Medicaid managed care initiatives, and Accountable Care Organizations – any or all of which could affect access to care, health outcomes, and costs. In such a dynamic environment, isolating the impacts of an expansion waiver can be difficult. With multiple large-scale policy changes underway all at once, it will be hard, in both the state-level and federal cross-cutting evaluations, to attribute observed changes to particular waiver-related interventions or reforms.

States have also amended original waivers adding complexity to the evaluation process. Upon waiver approval, states usually have a set period of time to develop implementation protocols and an evaluation plan. The evaluation plans are based on the terms of the waiver as originally approved. However, since waivers were first approved, various aspects have been amended. For example, in response to legislative requirements, Arkansas added monthly contributions to its waiver and has indicated that it will seek additional amendments that could further change the program.[15] Iowa's initial plan included a Marketplace premium assistance waiver (for expansion adults above poverty); however, the Marketplace premium assistance program no longer is being implemented due to the loss of participating QHPs.

Looking Ahead

As additional states seek waivers to expand Medicaid or amend existing expansion waivers, it will be important to understand states' experience with implementing current expansion waivers. A combination of federal and state waiver evaluations can capture cross-state assessment as well as in-depth state specific analysis to reveal which initiatives have been effective, which have proven too complicated, and which may add barriers to needed care for beneficiaries. The combination of state and federal waivers (in addition to other independent research) can also help to guard against bias from a singular perspective (state or federal) given that the evaluations are taking place in an environment with a lot of scrutiny, consequences for beneficiaries, and often political stakes. To learn from the expansion waivers, it will be important for the evaluations to be conducted and disseminated in a timely manner. Final results from the federal waiver evaluation will not be available until 2019, although interim reports will be available. However, states have already or will soon be required to release some waiver evaluation results. For example, Iowa already submitted data to CMS about the effects of its NEMT waiver, and Indiana is expected to release data from its NEMT waiver evaluation soon.[16] Michigan has published analyses about reductions in uncompensated care after the expansion.[17] Studies in Arkansas report on the early impact of its Marketplace premium assistance model on coverage, access to care, utilization, and other areas.[18,19,20]

For waiver evaluation results to be meaningful, it is also important for data and results to be accessible to policy makers, researchers, and the public in a timely manner. States are required to submit data to CMS quarterly, but much of this data is not public. Monitoring of waiver evaluations by stakeholders can help ensure that waiver implementation is on track and help policy makers to know if corrections are needed during the

course of implementation. Keeping track of waiver evaluation results and understanding the issues and challenges that states and researchers faced in conducting these evaluations will help inform future efforts make changes to the Medicaid program.

Appendix 1: Federal Waiver Evaluation Design

Federal Section 1115 Waiver Evaluation Plan		
Domain	**Research Questions**	
Medicaid-supported Enrollment in Qualified Health Plans (QHPs)	How do states supporting QHP enrollment for newly eligible beneficiaries compare to Medicaid expansion states in terms of access and health outcomes?	Are beneficiaries enrolled in QHPs able to access care at similar or better rates, compared to beneficiaries enrolled in Medicaid?
		Does provider participation improve under premium assistance?
		What is the unmet need for medical care?
		Is there continuity of coverage between Medicaid and Marketplace coverage?
	How do states supporting QHP enrollment compare to Medicaid expansion states in terms of total spending, especially given premium variability over time with QHPs?	How do premium assistance states compare to Medicaid expansion states in terms of per beneficiary spending on direct medical services and capitation payments?
		How do premium assistance states compare in terms of states' administrative costs?
	How do states supporting QHP enrollment compare to Medicaid expansion states in terms of take-up rates?	Does the take-up rate among likely eligible individuals suggest that premium assistance (i.e., enrollment in QHPs) is more attractive to beneficiaries than traditional Medicaid?
		Are there patterns in the timing of Medicaid beneficiary enrollment that may be related to the Marketplace open enrollment period, even though Medicaid beneficiaries are not subject to open enrollment periods?
Beneficiary Engagement/ Premium Incentive Structures and Other Financial Contributions	To what extent do requirements for premiums act as a disincentive to enrollment?	How does requirement to make premium payments to complete enrollment, as compared to following an initial period of enrollment, affect take-up of coverage?
		How do the premium amounts affect take-up of coverage?
	What effects do premiums appear to have on continuity of coverage?	Do incentive programs that require premiums affect continuity of coverage?
		What is the effect of premium enforceability rules, such as required time lapses (or "lock-out" periods) before reenrollment?
Beneficiary Engagement/ Premium Incentive Structures	What strategies are states using to educate beneficiaries about preferred healthy behaviors?	What strategies are states using to explain incentives and disincentives? Which are perceived to be effective?
		Conditional on qualitative information suggesting successful education strategies, or on survey or focus group data from state evaluations that explores beneficiary understanding, what is the effect of mode, content, and/or timing of education?
	To what extent can program incentives encourage Medicaid enrollees to actively participate in their care without impairing access to needed care?	To what extent can program incentives encourage Medicaid enrollees to actively participate in their care?
		Do program incentives impair access to needed care?
	Do incentives for wellness behaviors work?	Which behavior incentives yield the greatest relative gains in preventive care?
		Which behavior incentives yield the greatest relative gains in management and care of chronic conditions?
		Which behavior incentives yield the greatest reductions in dis-incentivized care (i.e., non-emergent ED visits)?
	What are the administrative costs to states and managed care companies of implementing incentive programs?	What administrative costs do states with healthy behavior incentive programs incur to establish and maintain these programs? To what extent are costs borne by the state versus contracted health plans?
Link to Evaluation Design	https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf (Tables III.4, III.5, and III.6)	

Appendix 2: State Waiver Evaluation Design Plans

Arkansas		
#	Goals	Hypotheses*
1	HCIP beneficiaries will have equal or better access to health care compared with what they would have otherwise had in the Medicaid fee-for-service system over time.	Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
		Premium Assistance beneficiaries will have lower non emergent use of emergency room services.
		Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
		Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
		Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
2	HCIP beneficiaries will have equal or better care and outcomes compared with what they would have otherwise had in the Medicaid fee-for-service system over time.	Premium Assistance beneficiaries will have equal or better access to preventive care services.
		Premium Assistance beneficiaries will report equal or better experience in the care provided.
		Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
		Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
3	HCIP beneficiaries will have better continuity of care compared with what they would have otherwise had in the Medicaid fee-for-service system over time.	Premium Assistance beneficiaries will have fewer gaps in insurance coverage.
		Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
		Maintenance of continuous access to the same providers.
4	Services provided to HCIP beneficiaries will prove to be cost effective.	Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs
		Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
		The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
	Link to Evaluation Design	https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-demo-waiver-proposed-eval-02202014.pdf

* Research questions of interest identified in the development and approval process for the HCIP waiver include those examining the goals of improving access, improving care and outcomes, reducing churning, and lowering costs. The final waiver design collapses some of these hypotheses and identifies measures to assess the four main goals.

Indiana		
#	Goals	Hypotheses
1	Reduce the number of uninsured low income Indiana residents and increase access to health care services.	HIP will reduce the number of uninsured Indiana residents with income under 138% FPL over the course of the demonstration.
		HIP will increase access to quality health care services among the target population.
		POWER account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to health care access. - Few individuals will experience the lockout period because the policy will deter nonpayment of POWER account contributions policy for HIP Plus beneficiaries.
		Presumptive eligibility and fast-track prepayments will provide the necessary coverage so as not to have gaps in health care coverage.
		Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care.
2	Promote value-based decision making and personal health responsibility.	HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds, including: - HIP policies surrounding rollover and preventive care will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER account funds.
		HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members in the areas of primary, specialty, and pharmacy service utilization without harming beneficiary health.
		HIP's (i) graduated copayments required for non-emergency use of the emergency department (ED), (ii) ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health. - The graduated copayment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health. - The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED utilization without harming beneficiary health.
3	Promote disease prevention and health promotion to achieve better health outcomes.	HIP will effectively promote member use of preventive, primary, and chronic disease management care to achieve improved health outcomes.
4	Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.	HIP's defined contribution premium assistance program (HIP Link) will increase the proportion of Indiana residents under 138% FPL covered by employer-sponsored insurance (ESI).
		HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to the same provider network.
5	Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance.	Referrals to Department of Workforce Development (DWD) employment resources at the time of application will increase member employment rates over the course of the demonstration.
6	Assure state fiscal responsibility and efficient management of the program.	HIP will remain budget-neutral for both the federal and state governments.
	Link to Evaluation Design	https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-draft-eval-design-10292015.pdf

Iowa – Wellness Plan		
#	Goals	Hypotheses
1	What are the effects of the Wellness Plan on member access to care?	Wellness Plan members will have equal or greater access to primary care and specialty services.
		Wellness Plan members will have equal or greater access to preventive care services.
		Wellness Plan members will have equal or greater access to mental and behavioral health services.
		Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.
		Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.
		Wellness Plan members ages 19-20 years will have equal or greater access to EPSDT services.
2	What are the effects of the Wellness plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?	Wellness Plan members will experience equal or less churning.
		Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.
3	What are the effects of the Wellness Plan on member quality of care?	Wellness Plan members will have equal or better quality of care.
		Wellness Plan members will have equal or lower rates of hospital admissions.
		Wellness Plan members will report equal or greater satisfaction with the care provided.
4	What are the effects of the Wellness Plan on the costs of providing care?	The cost for covering Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.
5	What are the effects of the premium incentive and copayment disincentive programs on Wellness Plan enrollees?	The premium incentive for the Wellness Plan enrollees will not impact the ability to receive health care.
		The copayment for inappropriate emergency department (ED) use for the Wellness Plan enrollees will not pose an access to care barrier.
		In year two and beyond, the utilization of an annual exam will be higher than in the first year of the program.
		In year two and beyond, the utilization of smoking cessation services will be higher than in the first year of the program.
6	What is the adequacy of the provider network for Wellness Plan enrollees as compared to those in the Iowa Medicaid State Plan?	Iowa Wellness Plan members will have the same access to an adequate provider network as members in the Medicaid State Plan.
	Link to Evaluation Design	http://dhs.iowa.gov/sites/default/files/WellnessPlanEvaluationDesignApproval.pdf

Iowa – Healthy Behaviors Plan		
#	Goals	Hypotheses
1	Which activities do members complete?	The proportion of Wellness Plan (WP) and Marketplace Choice(MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) or IowaCare members.
		The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.
		The proportion of WP/MPC members who are eligible to participate and complete at least one behavior incentive is greater than 50%.
		Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.
		Members (WP/MPC) will be least likely to complete incentivized behaviors requiring sustained enrollee participation.
		Members (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.
2	What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?	Members (WP/MPC) who have heard of the program from their health care provider are more likely to complete at least 1 behavior.
		Members (WP/MPC) who are young, white, female, and/or live in metro areas are more likely to complete at least 1 behavior.
		Members (WP/MPC) with poorer health status are less likely to complete the behaviors when compared to members with better health status.
		Members who do not pay a contribution (WP members less than 50% FPL) are less likely to complete behaviors compared to those who pay a contribution.
		Members (WP/MPC) receiving care at federally qualified health centers, rural health clinics, and public hospitals will be more likely to participate in the incentive programs than members receiving care in other settings.
3	Is engaging in behavior incentives associated with health outcomes?	The program will improve WP/MPC members' access to health care.
		Health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.
4	What are the effects of the program on health care providers?	Providers use the information from the Health Risk Assessment.
		Providers are encouraging patients to participate in the behavior incentive program.
		Providers are receiving their additional reimbursement.
		Providers are more likely to use the HRA with Wellness Plan members compared to Marketplace Choice Plan members
		The HRA changes communication between the provider and patient.
		The HRA changes provider treatment plans.
		There are barriers to providers using the HRA information.
5	What are the effects of HBI on Medicaid costs?	The costs of the program do not exceed the savings.
6	What are the implications of disenrollment?	Disenrolled members do not understand the disenrollment process.
		Disenrolled members do not understand premiums.
		Disenrolled members do not understand the HBI program.
		Disenrolled members find it difficult to meet their health needs.
		Disenrolled members are unable to re-enroll due to administration issues.
7	What are members' knowledge and perceptions of the HBI program?	Members (WP/MPC) will value incentives offered to complete healthy behaviors.
		Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.
		Members (WP/MPC) with a greater sense of locus of control will be more willing to participate.

		Members (WP/MPC) understand the logistics (for example - payment, payment options, requirements of the program, …) of the HBI program.
		Members (WP/MPC) understand the purpose of HBI and how it is supposed to influence their behavior.
		Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME.
8	What are the experiences of ACOs related to the Health Behavior Incentives Program?	ACOs experience barriers to reaching targets for wellness exams and HRA.
		ACOs promote the HBI program.
		ACOS experience advantages and successes from the HBI program.
	Link to Evaluation Design	http://dhs.iowa.gov/sites/default/files/HealthyBehaviorsEvalDesignApproval_042015.pdf

Iowa – Dental Wellness Plan		
#	Goals	Hypotheses
1	What are the effects of DWP on member access to care?	DWP members will have equal or greater access to dental care.
		DWP members will be more likely to receive preventive dental care.
		DWP members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-traumatic dental care.
		DWP members will have equal or greater access to dental EPSDT services.
		High risk populations in the Dental Wellness Plan will be more likely to receive preventive dental care.
2	What are the effects of the DWP on member quality of care?	DWP members will have equal or better quality of care.
		DWP members will report equal or greater satisfaction with the care provided.
		DWP members will be equally or more likely to return for a second recall exam within 6-12 months.
3	What are the effects of the DWP on costs of dental care as compared to traditional Medicaid adult dental coverage?	The cost for providing dental care to DWP members will be comparable to the predicted costs for providing dental care to DWP members had they been enrolled in Medicaid State Plan.
4	What are the effects of the earned benefit structure on DWP members?	The earned benefit structure for DWP members will increase regular use of recall dental exams.
		Over 50% of DWP members will earn access to Enhanced Benefits.
		Over 50% of DWP members will earn access to Enhanced Plus Benefits.
		In year two and beyond, the regular use of dental recall exams will be higher than in the first year of the program.
		The earned benefit structure will not be seen as a barrier to care perceived as needed by DWP members.
5	What is the adequacy of the provider network for DWP members?	DWP members will have better access to an adequate provider network than those in the Medicaid State Plan as reflected by travel distance and time, access to safety net providers, and provider acceptance of new patients.
6	What are provider attitudes towards the DWP?	The earned benefit structure will not be perceived by DWP providers as a barrier to providing care.
		Over 50% of DWP providers will remain in the plan for at least 3 years.
7	What are the effects of DWP member outreach and referral services?	DWP member outreach services will address dentists' concerns about missed appointments.
		DWP member referral services will improve access to specialty care compared to members in the State Medicaid Plan.
		DWP member outreach will improve members' compliance with follow-up visits, including recall exams.
	Link to Evaluation Design	http://dhs.iowa.gov/sites/default/files/DentalWellnessPlanEvaluationDesign_Sept2014.pdf

Michigan		
#	Goals	Hypotheses
1	**Uncompensated Care Analysis**: Uncompensated care in Michigan will decrease significantly.	Uncompensated care in Michigan will decrease significantly relative to the existing trend in Michigan.
		Uncompensated care will decrease more by percentage for Michigan hospitals with baseline levels of uncompensated care that are above the average for the state than for hospitals with levels that are below the average for the state.
		Uncompensated care will decrease more by percentage for Michigan hospitals in areas with above average baseline rates of uninsurance in the state than for hospitals with below state average levels
		Uncompensated care in Michigan will decrease significantly relative to states that did not expand their Medicaid programs.
		Trends in uncompensated care in Michigan will not differ significantly relative to other states that did expand their Medicaid programs.
2	**Reduction in the Number of Uninsured**: The uninsured population in Michigan will decrease significantly.	The uninsured population in Michigan will decrease significantly relative to the existing trend within Michigan.
		The uninsured population in Michigan will decrease more by percentage for subgroups with higher than average baseline rates of uninsurance in the state than for subgroups with lower than state average baseline rates.
		The uninsured population in Michigan will decrease significantly relative to states that did not expand their Medicaid programs.
		The uninsured population in Michigan will decrease to a similar degree relative to states that did expand their Medicaid programs.
	Reduction in the Number of Uninsured: Medicaid coverage in Michigan will increase significantly.	The Medicaid population in Michigan will increase significantly relative to the existing trend in Michigan.
		The Medicaid population in Michigan will increase significantly more by percentage for subgroups with rates of uninsurance higher than state average baseline than for subgroups with baseline rate lower than the state average.
		The Medicaid population in Michigan will increase significantly relative to states that did not expand their Medicaid programs.
		The Medicaid population in Michigan will increase to a similar degree relative to states that did expand their Medicaid programs.
3	**Impact on Healthy Behaviors and Health Outcomes**: Emergency Department Utilization	Emergency department utilization among the Healthy Michigan beneficiaries will decrease from the Year 1 baseline.
		Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not have primary care visits.
		Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.
	Impact on Healthy Behaviors and Health Outcomes: Healthy Behaviors	Receipt of preventive health services among the Healthy Michigan Plan population will increase from the Year 1 baseline.
		Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits.
		Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment.
		Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change.
		Healthy Michigan Plan beneficiaries who receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who do not receive such incentives.
	Impact on Healthy Behaviors and Health Outcomes:	Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline.

	Hospital Admissions	Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits.
		Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.
4	Participant Beneficiary Views of the Healthy Michigan Plan	Describe Healthy Michigan Plan enrollees' consumer behaviors and health insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan.
		Describe Healthy Michigan Plan enrollees' self-reported changes in health status, health behaviors (including medication use), and facilitators and barriers to healthy behaviors (e.g. knowledge about health and health risks, engaged participation in care), and strategies that facilitate or challenge improvements in health behaviors.
		Understand enrollee decisions about when, where and how to seek care, including decisions about emergency department utilization.
		Describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.
5	Impact of Contribution Requirements & MI Health Accounts	Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more efficient use of health care services, as measured by total costs of care over time relative to their initial year of enrollment, and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care.
		Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more effective use of health care services relative to their initial year of enrollment, as indicated by a change in the mix of services from low-value (e.g., non-urgent emergency department visits, low priority office visits) to higher-value categories (e.g., emergency-only emergency department visits, high priority office visits), and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.
		Cost-sharing and contributions implemented through the MI Health Account framework will not be associated with beneficiaries dropping their coverage through the Healthy Michigan Plan.
		Exemptions from cost-sharing for specified services for chronic illnesses and rewards implemented through the MI Health Account framework for completing a health risk assessment with a primary care provider and agreeing to behavior changes will be associated with beneficiaries increasing their healthy behaviors and their engagement with healthcare decision-making relative to their initial year of enrollment. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.
		This increase in healthy behaviors and engagement will be associated with an improvement in enrollees' health status over time, as measured by changes in elements of their health risk assessments and changes in receipt of recommended preventive care (e.g., flu shots, cancer screening) and adherence to prescribed medications for chronic disease (e.g., asthma controller medications).
	Link to Evaluation Design	http://www.michigan.gov/documents/mdhhs/Healthy_Michigan_Plan_2nd_Waiver_STCs_12_17_15_508663_7.pdf (Attachment B)

New Hampshire		
#	Goals	Hypotheses
1	**Continuity of coverage**: For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.	Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
		Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
2	**Plan Variety:** The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts	Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
		The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts
3	**Cost-effective Coverage**: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.	Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.
		Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
		The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
4	**Uniform Provider Access:** The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
		Premium assistance beneficiaries will have equal or better access to preventive care services.
		Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
		Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
		Premium assistance beneficiaries will have appropriate access to non-emergency transportation.
	Link to Evaluation	https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-draft-eval-design-03042015.pdf

Endnotes

[1] The 32 states include DC. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision (Jan. 12, 2016), http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[2] In January 2016, New Hampshire transitioned from a state plan amendment to a waiver, and expansion coverage in Montana became effective. Pennsylvania initially obtained a waiver to implement the expansion but subsequently transitioned to a traditional expansion under a state plan amendment. Detailed summaries of the expansion waivers are available at http://kff.org/tag/waivers/.

[3] Kaiser Family Foundation, A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion (Aug. 2012), http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/.

[4] Robin Rudowitz and MaryBeth Musumeci, *The ACA and Medicaid Expansion Waivers* (Washington, D.C.: Kaiser Family Foundation, November 2015), http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/.

[5] The federal waiver evaluation contract was awarded to Mathematica Policy Research and its partners, Truven Health Analytics and the Center for Health Care Strategies.

[6] Mathematica released the waiver evaluation design plan in May, 2015.

[7] Wisconsin is included in the federal evaluation but this brief does not include an analysis of the state evaluation plan because the state has not adopted the Medicaid expansion.

[8] In addition, CMS contracted with the Urban Institute to conduct a federal evaluation of HIP 2.0 in addition to the state evaluation that will be conducted by the Lewin Group. Governor Pence wrote a letter to Secretary Burwell expressing concerns about need for the second evaluation and the objectivity of the selected contractors. No information has been released about the design plan for the federal evaluation of HIP 2.0. The Governor's letter from December 3, 2015 can be found here: http://media.mcguirewoods.com/mwc/Mike-Pence-Letter-Dec-3-2015.pdf

[9] Originally, Iowa's waiver required expansion adults from 100-138% FPL to enroll in a Marketplace QHP with Medicaid premium assistance. As of October, 2014, Marketplace enrollment was voluntary for this group after one of the two QHPs serving Medicaid beneficiaries left the Marketplace. Subsequently, the other QHP decided that it would no longer accept new Medicaid enrollees, and Iowa submitted a waiver amendment request to CMS seeking to require all expansion adults to enroll in capitated Medicaid MCOs as of January, 2016.

[10] Both states have waiver authority to use state-developed tests to measure the cost-effectiveness of their premium assistance programs that differ from those otherwise permissible under federal law.

[11] Many of these challenges were highlighted in the Federal Evaluation Design Plan. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf

[12] The Oregon Health Insurance Experiment, The National Bureau of Economic Research, http://www.nber.org/oregon/

[13] Kronick and Bindman, NEJM 368;18, May 2, 2013

[14] Harold Pollack, *Oregon Medicaid experiment "is a Rorschach test of people's views of the ACA"* (The Incidental Economist, May 2013), http://theincidentaleconomist.com/wordpress/oregon-medicaid-experiment-is-a-rorschach-test-of-peoples-views-of-the-aca/

[15] Letter from Governor Asa Hutchinson to Secretary Burwell (Dec. 29, 2015), http://posting.arktimes.com/media/pdf/asaletter.pdf.

[16] Peter Damiano, Suzanne Bentler, Mark Pooley, Susan McKernan, Elizabeth and Momany, *Non-Emergency Transportation Services for IHAWP Members: The early experiences of Iowa Health and Wellness Plan members* (Iowa City, Iowa: University of Iowa Public Policy Center, March 2015), http://dhs.iowa.gov/sites/default/files/NEMT_Brief_IHAWP_Early_Experiences_042015.pdf

[17] Sayeh Nikpay, Thomas Buchmueller, and Helen Levy, "Affordable Care Act Medicaid Expansion Reduced Uninsured Hospital Stays in 2014," *Health Affairs* 35, no.1 (2016):106-110, http://content.healthaffairs.org/content/35/1/106.full.html

[18] The Stephens Group, *Status Report #2 on Health Care Reform/Medicaid Consulting Services for the Arkansas Health Reform Task Force* (Manchester, New Hampshire: The Stephen Group, July 2015), http://ee-governor-2015.ark.org/images/uploads/TSG-1_June_report-No.2-corrected_7-16_version.pdf.

[19] Jocelyn Guyer, Naomi Shine, MaryBeth Musumeci, and Robin Rudowitz, *A Look at the Private Option in Arkansas* (Washington, D.C.: Kaiser Family Foundation, August 2015), http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/

[20] Benjamin Sommers, Robert Blendon, and E. John Orav, "Both The "Private Option" And Traditional Medicaid Expansions Improved Access to Care For Low-Income Adults," *Health Affairs*, 35, no.1 (2016):96-105, http://content.healthaffairs.org/content/35/1/96.full.html