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The ACA and Recent Section 1115 Medicaid Demonstration Waivers

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Executive Summary

Under the Affordable Care Act (ACA), Medicaid plays a key role in efforts to reduce the number of uninsured by expanding eligibility to nearly all low income adults with incomes at or below 138% FPL ($16,105 per year for an individual in 2014); however, the Supreme Court ruling on the ACA effectively made the expansion a state option. As of November 2014, 28 states including DC are implementing the expansion. Under flexibility provided by the ACA's Medicaid expansion, as well as pre-existing federal Medicaid law, the Medicaid expansion is being implemented differently across states in terms of what specific benefits are provided and how those services are delivered. To date, a limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. However, looking ahead, more states may pursue alternative models as a politically viable way to expansion in order to extend coverage and capture federal dollars.

This brief focuses on waivers related to implementation of the ACA Medicaid expansion to adults, with a particular focus on provisions that have been approved, denied, and those that are pending. Examining what the Centers for Medicare and Medicaid Services (CMS) has approved or not approved can help inform understanding of the parameters and limitations around what CMS is likely to provide for Section 1115 waiver flexibility for the Medicaid expansion.

Prior to the ACA, states could only cover childless adults and receive federal Medicaid funds by obtaining a Section 1115 waiver. In the absence of coverage provided through these waivers, which were required to be budget neutral for the federal government, childless adults generally did not have any other coverage options through Medicaid. Given these considerations, Section 1115 waivers that expanded coverage to these adults, who otherwise would have been uninsured, often included limited benefit packages, higher cost-sharing and/or enrollment caps designed to limit costs. Since the ACA expands Medicaid to nearly all low-income adults with significant federal funding, the need for and role of waivers to cover adults has fundamentally changed. A few states that had waivers in place prior to the ACA have modified and extended these waivers (Wisconsin, Indiana, Oklahoma and Utah), but this coverage is not eligible for the enhanced federal ACA matching funds for newly eligible adults. Some states implementing the Medicaid expansion are continuing to use waivers to provide coverage or assistance to individuals with incomes above 138% FPL (Minnesota, Vermont, Massachusetts and New York).

Using enhanced federal matching funds for those newly eligible for coverage, nearly all states (24 of 28 states) implementing the ACA Medicaid expansion are doing so as set forth by law, without a waiver. The majority of states implementing the expansion are doing so within federal rules and options to receive the associated enhanced federal matching funds for newly eligible. These states do not need a waiver, but implement the expansion by filing a State Plan Amendment (SPA). Like the traditional Medicaid program, the law provides states considerable flexibility to implement the expansion to adults. Due to this flexibility, the expansion will look different across states.

A limited number of states are pursuing Section 1115 waivers to implement the ACA Medicaid expansion in ways that do not meet federal rules and still access enhanced federal matching funds available for newly eligible adults. According to statute, waivers must be used to "promote the objectives" of the Medicaid program and under long-standing federal policy waivers must be budget neutral for the federal government. Under new transparency requirements passed as part of the ACA, expansion waivers have provided for opportunities for public comment in the process. To date, CMS has approved waivers to implement the Medicaid expansion in four states: Arkansas, Iowa, Michigan and Pennsylvania. The Pennsylvania expansion is currently scheduled to go into effect on January 1, 2015, but the newly elected governor may opt to implement a straight-forward expansion via a state plan change instead of the waiver.

Table ES-1: Key Themes in ACA Expansion Waivers and Proposals

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefit Changes	Work Referral
Arkansas[1]	✓	(proposed)		(proposed)	
Iowa	✓	✓	✓	✓ [2]	
Michigan		✓	✓		
Pennsylvania[3]		✓	✓	✓	
Indiana (proposed)	✓ (optional)	✓	✓	✓	✓

[1] Arkansas has proposed a waiver amendment to limit non-emergency medical transportation, require newly eligible individuals to participate in health savings accounts that require monthly contributions beginning at 50% FPL, and impose cost sharing consistent with Medicaid requirements for newly eligible individuals beginning at 50% FPL.

[2] Iowa's NEMT transportation waiver is limited to demonstration year 1. Iowa has a pending waiver amendment seeking extension to years 2 and 3.

[3] The Pennsylvania expansion waiver is currently scheduled to go into effect on January 1, 2015 but the newly elected governor may opt to implement the expansion via a state plan amendment. Governor Corbett's original waiver proposal included premium assistance provisions. Under the current waiver, Pennsylvania's NEMT waiver is limited to demonstration year 1, with NEMT to be provided beginning in year 2. Governor Corbett had proposed additional benefit reductions for current beneficiaries that do not require waiver authority, and he was planning to use state-only funds outside of Medicaid to reduce premium contribution amounts for individuals who fulfill work requirements.

CMS has approved some provisions in the waiver requests, but also denied some provisions. Examining what CMS has approved and not approved can be instructive for other states that may seek waivers in the future to implement the expansion. CMS has approved waivers implementing the ACA's Medicaid expansion through premium assistance, charging premiums; removing certain required benefits, and using healthy behavior incentives. (Table ES-1) In contrast, CMS has denied requests a number of waiver requests:

- Premiums for individuals with incomes < 100% FPL as a condition of eligibility;
- Cost-sharing amounts beyond those allowed under current law;
- Waivers of requirements to provide wrap-around benefits for EPSDT and free choice of family planning provider to the extent that Marketplace plans do not offer coverage for these services;

- Retroactive eligibility, and
- Work requirements as a condition of Medicaid eligibility

Several states have waiver amendments or proposals pending or in development. There is no deadline for states to participate in the Medicaid expansion; however, the 100% federal financing for those newly eligible begins to phase down after 2016 to 90% by 2020. Moving into the legislative sessions for 2015, other states continue to explore opportunities to use waiver authority to implement the Medicaid expansion. Arkansas, Iowa, and most recently Arizona have waiver amendments and Indiana has a waiver request pending at CMS. Other states, including Utah and Tennessee, are actively negotiating with CMS about submitting a waiver to implement the expansion. How CMS decides on future waiver proposals will continue to shape how waivers will be used for coverage post-ACA.

To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their impacts. Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated. Recent waivers to implement the ACA Medicaid expansion include requirements for the states to conduct evaluations. Ensuring that evaluations occur and making evaluation findings publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences. What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers.

Introduction

Prior to the ACA, one key reason a number of states used Section 1115 waiver authority was to expand Medicaid coverage to low-income adults who could not otherwise be covered under federal rules. The ACA's Medicaid expansion to nearly all low-income adults at or below 138% FPL ($16,105 per year for an individual in 2014), and the significant federal funding provided to states for this expansion, fundamentally alters the role of Section 1115 waivers in expanding coverage to adults. Through guidance and recent waiver approvals in four states, CMS has identified some of the parameters related to the use of waivers to expand coverage to adults in light of the ACA's Medicaid expansion. This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA and key themes in recently approved and proposed coverage expansion waivers.

Background

Overview of Section 1115 Waiver Authority

Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules. These waivers are intended to allow for "experimental, pilot, or demonstration projects" that, in the view of the HHS Secretary, "promote the objectives" of the Medicaid program (See Box 1). Waivers can provide states with additional flexibility in how they operate their programs, beyond the flexibility already available to states under federal law, and can have a considerable impact on program financing. As such, waivers have important implications for beneficiaries, providers and states. Section 1115 waivers play a notable role in the Medicaid program and have historically been used for a variety of purposes, including expanding coverage to populations who were not otherwise eligible, changing benefit packages, and instituting delivery system reforms.

Box 1: Key Elements of a Section 1115 Waiver

Section 1115 authorizes the HHS Secretary to:

- Waive state compliance with certain federal Medicaid requirements; and
- Provide federal funds for costs that would not otherwise be matched under Medicaid.

Section 1115 waivers are required to be budget neutral for the federal government.

- Under long-standing federal policy (not statute) federal spending under a state's waiver must not exceed projected federal spending without the waiver.
- Budget neutrality is established using a cap on federal matching funds over the life of the waiver.

Waiver approval involves negotiations between a state and HHS as well as consideration of public comments.

- The approval process officially begins when a state submits a waiver application to CMS, which is subject to state and federal public notice and comment requirements.
- If a waiver is approved, CMS issues an award letter to the state specifying the sections of the Medicaid Act that are being waived or modified and the types of expenditures allowed as well as the "terms and conditions" of approval with which the state must comply.
- Waivers are typically approved for a 5 year period and can be extended, typically for 3 years.

Federal law requires that waivers be formally evaluated.

Section 1115 Coverage Expansion Waivers for Adults Prior to the ACA

Prior to the enactment of the ACA, a number of states used Section 1115 waivers to expand coverage to childless adults, who could not otherwise be covered under federal rules. Before the ACA, Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, seniors and people with disabilities. Adults without dependent children, often referred to as childless adults, who did not qualify for Medicaid based on age or disability were ineligible for coverage, and states could not receive federal Medicaid matching funds to cover these adults, regardless of how low their incomes were. The only way a state could extend coverage to these adults was through a Section 1115 waiver. However, states could not receive additional federal funds to expand coverage to these adults and, as such, needed to redirect existing federal funds or find offsetting program savings to finance such coverage.

During the mid-1990s through the early part of 2000, a number of states obtained waivers to expand coverage to childless adults, and in some cases other groups, including parents at relatively higher incomes. Many of these waivers also implemented broader managed care delivery systems than were permitted under federal Medicaid law at the time. Supported by a strong economy, states used savings from mandatory managed care enrollment or redirected Disproportionate Share Hospital (DSH) funds to finance the expanded coverage.

Between 2001 and 2010, a number of states obtained waivers to expand coverage to adults who were otherwise ineligible, but often provided more limited benefits and/or charged higher cost sharing to these adults. In 2001, the Bush Administration released a new Health Insurance Flexibility and Accountability (HIFA) waiver initiative, which provided a streamlined waiver approval process for waivers that expanded coverage within "current level" resources and offered states increased flexibility to reduce benefits and charge higher cost sharing to help finance these expansions.[1] Reflecting the limited financing available to support these coverage expansions, the waivers typically provided adults with more limited benefits and charged them higher cost sharing than otherwise allowed in Medicaid and often limited the number of adults who could enroll in the program. Moreover, some of these waivers covered adults through a premium assistance model that allowed the state to use Medicaid funds to subsidize the purchase of private insurance which did not meet minimum Medicaid benefit or cost sharing rules without requiring the state to supplement that coverage with wraparound benefits or cost sharing.[2] While these expansions provided more limited coverage than otherwise allowed under Medicaid, because these adults were otherwise ineligible for Medicaid, the more limited coverage was generally compared to the alternative option of no coverage and these adults remaining uninsured.

Several states have extended or amended pre-ACA waivers to maintain coverage that was in place prior to the ACA, but this coverage is not eligible for the enhanced ACA matching funds for newly eligible adults (See Appendix A for a list of these waivers). A small number of states are using waivers to maintain pre-ACA coverage expansions without adopting the full Medicaid expansion. Wisconsin, Indiana, Oklahoma and Utah had waivers to provide coverage to otherwise ineligible adults prior to the ACA. To prevent disruptions in coverage, CMS had granted temporary extensions for waivers in Indiana, Oklahoma and Utah. In these states, the waiver coverage was continued, but coverage is limited to individuals

with incomes below 100% FPL. Because this coverage is limited (in terms of eligibility and benefits) these states cannot receive the enhanced Medicaid financing available under the ACA Medicaid expansion for newly eligible adults and there will still be large gaps in coverage for individuals with incomes below poverty. Indiana submitted and received approval to extend the current HIP program through December 2015 as the state continues to negotiate with CMS about the state's waiver (HIP 2.0) to implement the Medicaid expansion. The waiver in Oklahoma was extended until December 2015 and the Utah waiver expires at the end of calendar year 2014.[3] The Governor in Utah has been negotiating a Medicaid expansion waiver with CMS and HHS and has announced high level agreement with CMS; however, the waiver has not been submitted to CMS and the plan would need state legislative approval.

Wisconsin received waiver approval to cover childless adults with incomes up to 100% FPL as of 2014. As in other states not implementing the Medicaid expansion, individuals with incomes above 100% FPL in Wisconsin are eligible to receive tax credits to purchase coverage in the Marketplace. As such, there will be no coverage gap in Wisconsin, although individuals in the Marketplace could face higher cost-sharing and premiums compared to those enrolled in Medicaid. Compared to the prior coverage expansion waiver in Wisconsin, Medicaid eligibility for childless adults is reduced from 200% to 100% FPL, but there is no cap on enrollment.[4] Wisconsin is ineligible for the enhanced federal funding associated with the Medicaid expansion because it is not extending Medicaid to the entire population up to 138% FPL.

In addition, a few states (Minnesota, Massachusetts, New York and Vermont) are using waivers to maintain coverage or provide assistance for individuals with incomes above 138% FPL. Through a Section 1115 waiver, Minnesota currently provides Medicaid to adults with incomes between 138 and 200 percent FPL who would likely be eligible for Marketplace subsidies; the state plans to move these adults to a Basic Health Plan in 2015. Under the BHP provisions of the ACA, a state receives 95 percent of what the federal government would have spent on premium and cost-sharing subsidies in the Marketplace for the eligible population. The state then provides coverage through a state-managed BHP which is not part of Medicaid. Three states (Massachusetts, New York and Vermont) have eliminated Medicaid coverage for adults with incomes above 138% FPL, but have waivers in place to use Medicaid funds to provide premium assistance that further subsidizes Marketplace coverage; Massachusetts was approved and New York is seeking waiver renewals for this purpose.[5]

Section 1115 Waivers and the ACA Medicaid Expansion

Since the ACA expands Medicaid to adults with significant federal funding, the need for and role of waivers in expanding coverage to childless adults fundamentally changes. The expansion eliminates the historic exclusion of adults without dependent children from the program and provides federal statutory authority to make millions of adults newly eligible for the program. The federal government will fund 100% of the cost of covering newly eligible adults for the first three years of the expansion, gradually phasing down to 90% over time. Under the ACA, the Medicaid expansion was intended to occur nationwide. However, the Supreme Court's ruling on the ACA effectively made the expansion a state option. As of November 2014, a total of 28 states (including the District of Columbia) have implemented the Medicaid expansion.[6] There is no deadline for states to adopt the Medicaid expansion. In states expanding Medicaid, most individuals with incomes above 138% up to 400% FPL (above Medicaid levels) are eligible for tax credits to purchase coverage in the Marketplaces.

The ACA Medicaid expansion eliminates the need for a state to obtain a Section 1115 waiver to cover adults and makes substantial federal funding available to cover these adults. However, a small number of states have still expressed interest in using Section 1115 waivers to implement the Medicaid expansion in ways that differ from options provided to states under federal law. CMS has issued guidance that establishes some parameters for such waivers. Through this guidance, CMS has indicated that states cannot receive the enhanced federal funding available for newly eligible adults unless they implement the full expansion to cover all newly eligible adults through 138% FPL; it will not approve enrollment caps for the adult expansion group; and it will approve a limited number of premium assistance waivers to test the use of Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, subject to certain requirements (Box 2).

Box 2: Key CMS Guidance About the Use of Section 1115 Waivers for Coverage Expansions Post-ACA[7]

Partial Coverage Expansions

- States cannot receive the enhanced 100% federal matching rate for partial Medicaid coverage expansions that do not extend up to 138% FPL (e.g., an expansion only to 100% FPL).
- CMS will consider partial expansion demonstration waivers at a state's regular Medicaid matching rate if the Secretary determines that the proposal would further the purposes of the program.
- In 2017, further demonstration opportunities will become available to states under the ACA's new State Innovation Waiver authority, provided that waivers offer comparable coverage that is comprehensive and affordable at no additional cost to the federal government.

Enrollment Limits

- HHS will not authorize enrollment caps through Section 1115 demonstrations for the new adult group or similar populations (the Secretary has determined that these policies do not further the objectives of the Medicaid program).

Premium Assistance

HHS will consider approving a limited number of Section 1115 demonstrations to test using Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, provided that:

- States ensure wrap-around coverage for benefits and cost sharing to the extent that Marketplace plans differ from Medicaid requirements;
- Beneficiaries have a choice of at least two Marketplace plans;
- Demonstrations include only enrollees eligible for benefits that are closely aligned with Marketplace benefits packages (e.g., not medically frail); and
- Demonstrations end by December 31, 2016.

Recent Waiver Approvals, Denials and Pending Proposals

The majority of the 28 states (including DC) implementing the Medicaid expansion are doing so consistent with the new authority created by the ACA by filing a State Plan Amendment (SPA). In these cases, the state is implementing the expansion under the allowable federal rules and options. Within these options and rules, states have significant flexibility in terms of the benefits they provide and how services are delivered to newly eligible adults.

To date, a few states have sought Section 1115 waivers to implement the Medicaid expansion, in part because they could not otherwise secure political support to expand coverage. These states wanted to fashion their own approach to the Medicaid expansion. As of November 2014, CMS has approved waivers to implement the Medicaid expansion in four states (Arkansas, Iowa, Michigan and Pennsylvania) and a waiver proposal in Indiana is pending at CMS (See Appendix B for a list of these waivers). Utah and Tennessee have not submitted a waiver proposal, but are actively working on proposals. New Hampshire also passed legislation to implement the Medicaid expansion as of July 2014, but the legislation requires the state to submit a waiver proposal to implement premium assistance beginning in January 2016.[8]

States and CMS have complied with new rules about transparency and public input as part of the waiver approval process. As a result of longstanding concerns about the lack of public input and transparency in the waiver approval process, the ACA required the Department of Health and Human Services (HHS) to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver approval process. The rules, issued in February 2012, require public notice and comment periods at the state and federal levels before waivers are approved by CMS. The rules apply to new Section 1115 waivers and extensions of existing waivers.[9] To date, the waivers in Arkansas, Iowa and Pennsylvania followed these transparency rules. It appears that as part of the waiver approval in Michigan, the state must comply with some transparency and public input requirements for amendments to the waiver (the waiver approved in Michigan was technically an amendment and renewal of an existing waiver). Indiana's waiver proposal, as well as proposed amendments in Arkansas and Iowa, have been subject to these transparency rules. The transparency regulations also require states to have an approved evaluation strategy in place that is publicly available.

States must also submit an annual report to HHS that includes, among other things, a description of the changes occurring and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments. Mathematica was awarded a federal contract to conduct an evaluation of a number of Section 1115 waivers.

Each of the approved waivers is subject to budget neutrality requirements. As noted earlier, Medicaid Section 1115 waivers must be budget neutral to the federal government according to long-standing policy. The issue of budget neutrality has been examined by the General Accountability Office (GAO) looking at pre-ACA waivers and more recently looking at the Section 1115 Waiver in Arkansas.[10] Issues around calculating and monitoring compliance with budget neutrality will continue to be issues as waivers are implemented and additional states seek waivers.

The following sections review which provisions CMS has approved and which provisions were included in original proposals that have been denied. Both the approvals and denials can provide insight into the types of waiver requests CMS is likely to approve in the future and certain limits on the flexibility it is willing to grant through waivers. (See Appendix B for a list ACA Medicaid expansion waivers).

Approved Provisions in Expansion Waivers

Consistent with guidance indicating that CMS will approve some expansion waivers to test premium assistance, two states have received approval to implement the Medicaid expansion through a premium assistance model (Arkansas[11] and Iowa[12]). Pennsylvania's original waiver proposal included premium assistance, but the final approved waiver utilizes Medicaid managed care plans to implement the Medicaid expansion.[13] Legislation in New Hampshire requires the state to submit a waiver to implement a premium assistance model by January 2016. Under the premium assistance approach, states use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs). States can implement premium assistance programs without a waiver, subject to certain rules. Arkansas and Iowa received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas all newly eligible adults, including childless adults between 0-138% FPL and parents between 17-138% FPL, are enrolled in premium assistance. In Iowa, only newly eligible adults with incomes above 100% up to 138% FPL are enrolled in premium assistance.[14] Also consistent with the earlier guidance released by CMS related to premium assistance waivers, the Arkansas and Iowa waivers were approved through 2016, instead of the five year approval period typically granted for Section 1115 waivers.

These states indicate that they are using premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churning between Medicaid and Marketplace coverage due to income fluctuations. How premium assistance affects continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from their demonstrations, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective are key issues to monitor and are included in the evaluation requirements of these waivers.[15]

CMS has approved waivers that allow premiums or monthly contributions primarily for adults between 100 and 138% FPL. Under federal law and regulations released in July 2013, Medicaid beneficiaries with incomes below 150% FPL ($17,505 per year for an individual in 2014) cannot be charged premiums. Premiums in the Medicaid program are limited because a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups.[16]

Approved waivers in Michigan[17], Iowa and Pennsylvania allow those states to charge monthly premiums for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums (equal to 2% of income in Michigan and Pennsylvania and $10 per month in Iowa) are about the same level as those allowed for individuals at these incomes who are eligible for tax credits to purchase coverage through the Marketplace in states not expanding Medicaid. In all three of these states, premiums will not be imposed immediately. Iowa waives premiums in the first year of its demonstration. Under Michigan's waiver, premiums were not to be imposed for at least six months after implementation of its expansion, and Pennsylvania's waiver calls for

premiums beginning in year 2. All three states would also allow individuals to have premiums waived or reduced based on compliance with healthy behavior incentives. In Iowa, healthy behavior incentives in year 1 include completing a health risk assessment and obtaining a wellness examination. In addition, beneficiaries in Iowa have a 90 day grace period to pay past-due premiums in full before termination of Medicaid coverage, and the state must waive premiums for beneficiaries who self-attest to financial hardship in paying the premiums. The Michigan waiver terms and conditions specify that individuals may not lose coverage for failure to pay premiums (or other copayments). In Pennsylvania, there is a 90-day grace period before disenrollment for failure to pay premiums, and beneficiaries may re-enroll without a waiting period.

In Iowa, the waiver also allows the state to impose monthly contributions of $5 per month for beneficiaries from 50-100% FPL beginning in year two; however, premiums can be waived by completing healthy behavior activities and Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100% FPL.

CMS has approved the use of healthy behavior incentives but requires further approval of specific protocols to implement these incentive programs. The approved waivers in Iowa[18], Michigan[19] and Pennsylvania[20] all include healthy behavior programs. Under the three waivers, individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced. After the first year of waiver implementation, Iowa must submit for CMS approval a protocol for the program and document through data and on-going monitoring that enrollees have adequate access to providers. Any changes to the healthy behaviors protocol must be approved by CMS.[21]

For Michigan, there is little detail in the waiver approval about the healthy behavior provisions. These aspects of Michigan's demonstration will be governed by protocols that the state must submit to CMS for approval at least 90 days prior to implementation. The protocols are required to: specify the types of healthy behaviors (such as health risk assessments); include a diverse set of behaviors as well as a strategy to measure access to providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives; engage stakeholders and the public in developing the healthy behavior standards, show how healthy behaviors will be tracked and monitored at the enrollee and provider level, include a beneficiary and provider education strategy, and include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

Under the approved waiver in Pennsylvania, beginning in demonstration year 2, beneficiaries can reduce their premiums or copayments by completing healthy behaviors including an annual wellness exam. After the first year, eligibility for premium or co-payment reductions based on healthy behavior activities will be evaluated every 6 months. The state must submit for CMS approval a protocol with each year's healthy behavior activities. The year 1 protocol is due March 31, 2015, and subsequent years are due on August 31.

CMS has approved limited waivers allowing states not to cover non-emergency medical transportation (NEMT), an otherwise required Medicaid benefit. In implementing the ACA, states have considerable flexibility in determining benefits packages for those newly eligible for coverage by the ACA's Medicaid expansion. States must cover the ten ACA-required Essential Health Benefits (EHBs) along with certain other mandatory Medicaid services. States also must meet mental health parity requirements. Beyond

these requirements, states have flexibility to choose a benchmark plan for coverage that may include one of several specified private insurance options or "Secretary-Approved Coverage." This coverage may be a state's current Medicaid benefits package for adults.

The approved waiver in Iowa allows a benefit package change beyond that allowed under these federal options. Specifically, under the waiver, the state does not have to provide non-emergency transportation to newly eligible adults for one year. After one year, CMS will evaluate the impact on access to care. Iowa currently has a pending waiver amendment that seeks extension of non-emergency medical transportation waiver for years 2 and 3. Pennsylvania also received a waiver of non-emergency medical transportation for all newly eligible adults in year 1. Pennsylvania's waiver provides that the state will provide NEMT beginning in year 2.

Denied Provisions in Recent and Proposed Expansion Waivers

CMS has not approved waiver requests proposing premiums for individuals with incomes below 100% FPL where payment is a condition of eligibility. As noted above, Iowa does have approval to impose monthly contributions of $5 per month for beneficiaries beginning in year two; however, Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100 percent of poverty. Pennsylvania's proposal to impose a lock-out for failure to pay premiums was not approved by CMS.

CMS has denied requests to waive certain Medicaid benefits. In its waiver proposal, Iowa requested additional changes in benefits that were not approved. Specifically, CMS denied the state's request to waive the provision of EPSDT services to 19 and 20 year olds and to provide free choice of family planning providers for newly eligible adults. The Pennsylvania proposal sought a number of waivers for benefits including a waiver not to cover out-of-network family planning providers or provide wrap-around benefits for those enrolled in premium assistance, including non-emergency medical transportation. Pennsylvania's original waiver proposal sought benefits package changes for current and newly eligible beneficiaries, seeking to replace current state plan benefits with a "high risk" package for people who are medically frail and a "low risk" package for other beneficiaries. These changes are not included in the waiver approval. Instead, CMS has indicated that "agreement on the overall benefits approach" has been reached, pending the state's submission of state plan amendments.

CMS has not approved waivers for states to impose cost sharing in amounts greater than those allowed under federal law. The July 2013 final rules that streamlined and simplified existing regulations around premiums and cost-sharing increased the nominal rate for cost-sharing and increased allowable cost-sharing amounts for non-preferred drugs and non-emergency use of the emergency room.[22] In order to impose higher cost sharing than otherwise allowed under federal law, a state needs to meet the separate cost sharing waiver requirements under Section 1916(f). Section 1916(f) permits a state to seek a demonstration waiver to charge cost sharing above otherwise allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years.

A few of the recent ACA expansion waivers include cost sharing provisions. However, they do not increase beneficiary cost sharing amounts beyond what is allowed under current law. In Arkansas, beneficiaries

between 100-138% FPL have cost-sharing consistent with existing Medicaid state plan and Marketplace QHP rules. In Michigan, after six months, all beneficiaries will have cost-sharing obligations based on their prior six months of copays, billed at the end of each quarter. Cost-sharing will be paid into health savings accounts and can be reduced through compliance with certain healthy behaviors. However, the cost-sharing amounts are the same as what the state would have been able to collect without a waiver. The Michigan waiver terms and conditions specify that beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums.

Iowa is imposing copayments for beneficiaries for non-emergency use of the emergency room (for current and newly eligible beneficiaries) within statutory limits. Pennsylvania was denied a waiver request to impose higher than statutorily allowed cost sharing amounts for non-emergency use of the ER.

CMS has not approved a waiver to include a work requirement as a condition of eligibility. Pennsylvania initially sought a work requirement as a condition of Medicaid eligibility (later amended to a voluntary work search program) for current and newly eligible beneficiaries as part of its waiver application. None of these elements are included as part of the demonstration approved by CMS. Instead, the state is offering incentives for job training and work-related activities for Medicaid beneficiaries who choose to participate in a state-funded program.[23]

CMS has denied the ability to waive retroactive Medicaid eligibility. Under current law, Medicaid coverage may start retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during the retroactive period had he or she applied then. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.[24] Pennsylvania's waiver proposal included a request to waive retroactive eligibility that was not approved by CMS.

Pending Provisions in Proposed Expansion Waivers

Indiana has a waiver proposal and Arkansas and Iowa have waiver amendments that are pending at CMS. Unlike state plan amendments, there is no set time line for making decisions on waivers.

Pending proposals in Indiana, Arkansas and Arizona seek waivers related to premiums and cost sharing. The proposed waiver in Indiana, submitted in July 2013, and a proposed waiver amendment in Arkansas seeking to impose monthly contributions for beneficiaries below poverty are pending at CMS. In both proposals, beneficiaries would pay a monthly contribution to health savings accounts that ranges based on income (from 50-138% FPL in Arkansas and from 0-138% in Indiana). In Arkansas, beneficiaries above 100% FPL who fail to make monthly contributions would be responsible for cost-sharing at point of service and can be denied service for failure to pay cost-sharing. Those with incomes 50-100% FPL would be billed for copays and would incur a debt to the state (but would not be denied access to services).

In Indiana, beneficiaries between 100% and 138% FPL who do not pay a health savings account contribution (POWER account) within 60 days would be disenrolled from the program, locked out from Medicaid eligibility for six months and required to repay any debt owed upon re-enrollment. Beneficiaries below 100% FPL who do not pay a health savings account contribution within 60 days will be automatically transferred to a more

limited benefit package (HIP Basic that does not include vision and dental benefits) and required to pay co-pays for all services[25]. The waiver proposal would limit cost-sharing (including both health savings account contributions and co-payments) to 5% of household income. The pending Indiana proposal also seeks a cost-sharing waiver to allow the state to impose higher cost-sharing for non-emergency visits to the ER. The proposal would require $8 for first non-emergency visit to ER, $25 for subsequent non-emergency visits to ER (which would apply to all beneficiaries except pregnant women). These levels are higher than those authorized by statute.

Arizona is proposing to amend its "Health Care Cost Containment System Demonstration" to require premiums that are no more than two percent of income and a $200 co-pay for non-emergency use of the emergency room for individuals in the new adult group with income between 100 and 133 percent of the Federal poverty level (FPL). This will be open for federal public comment November 19, 2014 through December 18, 2014.[26]

Iowa, Arkansas and Indiana have proposals to waive the requirement to provide non-emergency medical transportation. Iowa's original waiver included a waiver of NEMT for one year and the state now has an amendment pending to extend this waiver. Indiana and Arkansas are also seeking to waive NEMT. Indiana's pending waiver proposal also seeks to waive vision and dental benefits, which are part of the EPSDT requirements, for beneficiaries ages 19-20 in the more limited benefit package with co-pays (HIP Basic, the plan for beneficiaries that fail to make monthly health savings account contributions). Iowa also has an amendment offering enhanced dental benefits for those who complete periodic dental exams.

Indiana's waiver proposal seeks to waive retroactive eligibility. Coverage for newly eligible adults (including the expanded benefits package) is to begin the first of the month after a beneficiary's first health savings account contribution. Once in the limited benefit package with copays, individual must wait until the next redetermination to be able to move back to the enhanced benefit package with health savings account contributions.

Looking Ahead

To date, 28 states (including DC) are implementing the ACA Medicaid expansion in 2014. The large majority of these states (24 of the 28) will implement the expansion as set forth in the law; however, because of the flexibility that exists under federal Medicaid law to allow states to tailor their benefit packages and decide how best to deliver services, the expansion will look different across these states. CMS has issued guidance and approved waivers to implement the Medicaid expansion in four states. CMS has approved waiver requests to implement the Medicaid expansion using premium assistance with mandatory enrollment in Marketplace QHPs (in compliance with other guidance issued) and to impose premiums up to 2% of income (similar to what individuals with similar incomes would face in the Marketplace in states not implementing the Medicaid expansion) for individuals with incomes from 100-138% FPL. Other monthly contributions have also been approved, but payment is not a condition of eligibility. CMS has also approved the concept of healthy behavior programs (tied to reducing premiums and cost sharing) and limited changes in benefits packages.

On the other hand, CMS has denied requests to impose premiums as a condition of eligibility on individuals with incomes below 100% FPL, waive the requirement to provide wrap around coverage and other benefits in

premium assistance models, impose cost sharing higher than amounts allowed under current law and to waiver retroactive eligibility. CMS has also not approved waiver requests that make work requirements or activities a condition of eligibility. These decisions set parameters on what CMS will approve as other states consider expansion waivers.

Looking ahead, issues around calculating and monitoring budget neutrality as well as understanding the outcomes of waivers to determine if the plans helped states to achieve the goals and objectives they were testing will be important in considering future waivers. Under new rules, states must have an approved evaluation strategy in place that is publicly available and must submit an annual report to HHS that includes a description of the changes occurring and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments. This will help inform decisions on future waivers.

Arkansas, Iowa and Arizona have waiver amendments and Indiana has a waiver request pending at CMS. Other states, including Utah and Tennessee are negotiating with CMS about an alternative Medicaid expansion plan. These waivers are likely to continue to provide a pathway for states to be able to reach a politically acceptable plan to implement the expansion, which will allow the state to expand coverage and access additional federal resources. How CMS decides on these and other future waiver proposals will continue to shape how waivers will be used for coverage post-ACA.

Appendix A

Extensions or Amendments of Waivers in place before the ACA as of November 2014				
State	**Waiver Program**	**Approval Period**	**Eligibility**	**Scope of Benefits**
DC	Childless Adults Waiver		Childless Adults up to 215% FPL (Including disregard-Based on CMS table)	Medicaid
IN	Healthy Indiana Plan	Approved: 9/3/13 - 12/31/15	Parents: Above 1931 level through 100% FPL Childless adults: up to and including 100% FPL Also includes parents below AFDC limit with resources above $1,000 who are not otherwise eligible for Medicaid Enrollment cap of 36,500 for childless adults	More limited than Medicaid
MA	MassHealth	Approved: 7/1/14 – 6/30/19	Adults with incomes up to 300 percent of the FPL.	Premium assistance (also uses state funds to maintain pre-ACA benefit levels for this population)
MN	MinnesotaCare	Approved: 1/17/14 - 12/31/14	Parents, Childless adults and 19-20 year olds 138 ≤ 200% FPL (including 5 percentage point disregard)	Currently more limited than Medicaid (Plan to cover under Basic Health Plan starting 1/1/15)
NY	Partnership Plan	Approved: 3/31/14 - 12/31/14	Parents 133-150% FPL who purchase health insurance through the Marketplace who are eligible for tax credits	Premium assistance
OK	Insure Oklahoma	Approved: 6/27/14 - 12/31/15	Individuals up to 100% FPL who are self-employed or unemployed. Working disabled, full-time college students without access to ESI, foster parents, and qualified employees of not-for-profit businesses up to 100% FPL Non-disabled low-income workers and spouses, working disabled, full-time college students, foster parents, and qualified employees of not-for profit businesses ≤200% FPL who work for a qualifying employer are eligible for premium assistance for ESI.	Premium assistance for Insure Oklahoma program (<100% FPL): More limited than Medicaid OR Premium assistance for ESI (≤200% FPL)
UT	Primary Care Network	Approved: 12/24/13 - 12/31/14	Non-Traditional Medicaid Adults eligible through 1925 and 1931; Medically needy non-disabled, non-elderly adults Parent/Caretaker adults with income up to 100% FPL (Enrollment limit of 16,000) Non-custodial parents and childless adults with income up to 100% FPL (Enrollment limit of 9,000) Working adults and spouses with family income up to 200% FPL	More limited than Medicaid and Premium assistance
VT	Global Commitment to Health	Approved: 10/3/13 - 12/31/16	Individuals up to and including 300% FPL who purchase health insurance through the Marketplace and are eligible for the APTC	Premium assistance

Appendix B

New Waivers to Implement the ACA Medicaid Expansion (as of November 2014)				
State	**Waiver Program Name**	**Approval Period**	**Eligibility**	**Scope of Benefits**
AR	Health Care Independence Program / Private Option	Approved: 10/1/13 – 12/31/16 Proposed Amendment submitted: 9/17/14	Newly eligible parents ages 19-64 between 17-138% FPL, and newly eligible adults without dependent children ages 19-64 between 0-138% FPL.	Premium Assistance with wrap-around benefits provided on a fee-for-service basis (non-emergency medical transportation and EPSDT). Cost-sharing limited to 5% of annual income. Beneficiaries between 100-138% FPL have cost-sharing consistent with Medicaid and Marketplace QHP rules. No cost-sharing for beneficiaries below 100% FPL in 2014. Pending waiver amendment seeks CMS approval to limit for non-emergency transportation for beneficiaries who are not medically frail. Pending waiver amendment seeks CMS approval of monthly cost-sharing payments to health savings accounts for demonstration beneficiaries from 50-138% FPL.
AZ	Arizona Health Care Cost Containment System (AHCCCS),	Proposed Amendment Submitted: 11/19/14	Newly Eligible Adults between 100-138% FPL	Pending waiver seeks to to require premiums that are no more than two percent of income and a $200 co-pay for non-emergency use of the emergency room
IA	Iowa Marketplace Choice and Iowa Wellness Plan	Approved: 1/1/14-12/31/16 Proposed Amendment submitted: 9/4/14	1. Newly Eligible Adults between 100-138% FPL 2. Individuals ages 19-64 with income up to 100% FPL in the new adult group, as well as individuals above 100-133% FPL who are medically frail, are American Indians and Alaska Natives, or have access to ESI	1. Premium Assistance with wrap-around benefits (EPSDT) provided through FFS. One year waiver of obligation to provide non-emergency medical transportation for all newly eligible beneficiaries. 2. Medicaid Pending waiver amendment seeks extension of non-emergency medical transportation waiver for years 2 and 3 for those newly eligible adults between 100-138% FPL.
IN	HIP 2.0	Submitted: 7/2/14	Parents and childless adults 0-133% FPL (including 1931 parents)Would eliminate enrollment cap	1931 parents: State plan Other parents and adults: More limited than Medicaid Monthly contributions and cost sharing optional for those below 100% FPL
MI	Healthy Michigan	Approved: 12/30/13 – 12/31/18	Adults ages 19-64 up to 138% FPL (childless adults 0-138% FPL and parents above pre-ACA levels of 37% FPL for non-working parents and 64% FPL for working parents)	Medicaid (aligned with 10 essential health benefits) Beneficiaries above 100% FPL will pay monthly premiums in the amount of 2% of income. All demonstration beneficiaries will have cost-sharing obligations based on their prior 6 months of copays, billed at the end of each quarter. Cost-sharing will be paid into health accounts and can be reduced through compliance with healthy behaviors. Amount of cost-sharing is based on state plan. Cost-sharing and premiums cannot exceed 5% of household income.
PA	Healthy Pennsylvania	Approved: 1/1/15 – 12/31/19	Newly eligible parents between 33-138% FPL and newly eligible adults without dependent children between 0-138% FPL.	The benefits package for current and newly eligible beneficiaries will be pursuant to state plan amendments still to be submitted. Waiver of non-emergency medical transportation for all newly eligible adults in year 1. Requires monthly premiums for newly eligible adults above 100% FPL.

Endnotes

[1] Samantha Artiga and Cindy Mann. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Kaiser Commission on Medicaid and the Uninsured, 2005), http://www.kff.org/medicaid/issue-brief/new-directions-for-medicaid-section-1115-waivers/.

[2] All HIFA waivers were required to include at least a feasibility study of premium assistance.

[3] Primary Care Network: Factsheet. (Centers for Medicare and Medicaid Services.) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-fs.pdf.

[4] Wisconsin Department of Health Services. *BadgerCare+ Reform Project Waiver* (December 31, 2013), http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm.

[5] *MassHealth Medicaid Section 1115 Demonstration Approval* (page 55), (Centers for Medicare and Medicaid Services.) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf.

Section 1115 of the Social Security Act Medicaid Demonstration: New York Partnership Plan Approval. (Centers for Medicare and Medicaid Services) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-partnership-plan-ca.pdf.

Global Commitment to Health Section 1115 Demonstration Approval. (Centers for Medicare and Medicaid Services.) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf

[6] Pennsylvania's waiver to implement the Medicaid expansion was approved in August 2014; the state plans to implement the expansion beginning in January 2014.

Status of State Action on the Medicaid Expansion Decision, 2014. (Kaiser Family Foundation). http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[7] Robin Rudowitz, Samantha Artiga and Rachel Arguello. *A Look at Section 1115 Medicaid Demonstration Waivers Under the ACA: A Focus on Childless Adults* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October, 2013) http://www.kff.org/medicaid/issue-brief/a-look-at-section-1115-medicaid-demonstration-waivers-under-the-aca-a-focus-on-childless-adults/

[8] *See* N.H. Sen. Bill 413, available at http://www.gencourt.state.nh.us/legislation/2014/SB0413.pdf.

[9] *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers.* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2012) http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/

[10] *Medicaid Demonstrations: HHS's Approval Process for Arkansas' Medicaid Expansion Waiver Raises Cost Concerns*. (Government Accountability Office,) August 2014. http://www.gao.gov/products/GAO-14-689R.

Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency. (Government Accountability Office,) June 2013. http://www.gao.gov/products/GAO-13-384.

[11] *Medicaid Expansion in Arkansas.* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2014). http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/

[12] *Medicaid Expansion in Iowa. (Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, October 2014). http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/

Iowa Marketplace Choice Plan, CMS Special Terms and Conditions (Jan. 1, 2014-Dec. 31, 2016), available at http://www.dhs.state.ia.us/uploads/Iowa_Marketplace_Choice_STCs_12_30_13%20Final.pdf

[13] *Medicaid Expansion in Pennsylvania.* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2014), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/

[14] CoOportunity Health will withdraw from the Iowa Health and Wellness Plan at the end of November. 9,700 members be notified and transition to the Wellness Plan with no loss in coverage. Coventry Health Care of Iowa, Iowa's other Marketplace Choice provider, will accept all new Marketplace Choice enrollees in the month of December while the state explores options. Press Release from Iowa Department of Human Services, October 17, 2014. https://dhs.iowa.gov/sites/default/files/PR_10-17-14_CoOp.pdf

[15] MaryBeth Musumeci. *Medicaid Expansion Through Marketplace Premium Assistance* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2013), http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/.

[16] Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings.* (Kaiser Commission on Medicaid and the Uninsured, February 2013). http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/

[17] Michigan Department of Community Health, Healthy Michigan § 1115 Demonstration (December 30, 2013), available at http://www.michigan.gov/documents/mdch/Healthy_Michigan_Plan_1115_Demonstration_Approval_443686_7.pdf.

[18] *Medicaid Expansion in Iowa. (Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, October 2014). http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/

[19] *Medicaid Expansion in Michigan.* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, January 2014), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/

[20] *Medicaid Expansion in Pennsylvania.* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2014), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/

[21] Iowa also has an amendment offering enhanced dental benefits for those who complete periodic dental exams.

[22] 78 *Fed. Reg*. 42307-42310 (July 15, 2013).

[23] Letter from Marilyn Tavenner, CMS Administrator, to Secretary Beverly Mackereth (Aug. 28, 2014), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf.

[24] *Eligibility*, Medicaid.gov website (Centers for Medicare and Medicaid Services.) http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html

[25] *Proposed Medicaid Expansion in Indiana through HIP 2.*0. (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2014). http://kff.org/medicaid/fact-sheet/proposed-medicaid-expansion-in-indiana-through-hip-2-0/

[26] *Arizona Section 1115 Waiver Amendment Request Cost Sharing for Arizona's Expansion Population.* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa-cost-sharing-request.pdf