Medicaid Expansion and Section 1115 Waiver Demonstrations

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In 2013, the Centers for Medicare & Medicaid Services (CMS) approved §1115 demonstration waivers for Arkansas and Iowa that will permit the States to implement the Affordable Care Act's (ACA) Medicaid expansion using private insurance[1]. Both States will use Medicaid funds as premium assistance to purchase coverage under Qualified Health Plans (QHPs), sold through the States' Marketplaces (formerly called Exchanges), for some or all of the individuals who are newly eligible for Medicaid.[2]

CMS also approved Michigan's §1115 demonstration waiver application, under which the existing Michigan "Adult Benefits Waiver" is amended to establish the Healthy Michigan program, through which the State will test innovative approaches to beneficiary cost sharing and financial responsibility for care. Additionally, CMS approved an §1115 demonstration waiver in Wisconsin that will phase out existing waiver programs, partially expand Medicaid, and move certain populations out of Medicaid – seemingly with the expectation that these individuals will enroll in coverage through the Exchange. This paper provides a high level overview of some of the provisions contained within the demonstration waivers approved to date[3] that Federally Qualified Health Centers (FQHCs) should be aware of.

Covered Populations

In Arkansas, the demonstration will cover all newly eligible beneficiaries aged 19 through 64, including parents with incomes between 17% and 138% of the Federal Poverty Level (FPL) and childless adults with incomes up to 138% FPL. Under the approved demonstration, parents and children who were eligible for Medicaid prior to January 1, 2014 will become eligible to participate in the demonstration in future years. In Iowa and Michigan, the demonstrations will cover those newly eligible beneficiaries aged 19 through 64 with incomes up to 138% FPL. Michigan projects that up to 500,000 residents will be newly eligible for Medicaid under this expansion. In both Arkansas and Iowa,

[1] In Iowa, CMS ultimately approved two waivers: one for the State's Health and Wellness Plan and one for the Marketplace Choice Plan. This paper focuses on the Marketplace Choice Plan.

[2] Pennsylvania has submitted a similar proposed waiver to CMS for consideration, but that waiver has not yet been approved.

[3] In December, Pennsylvania released a draft waiver application for public review. Additionally, reports indicate that New Hampshire and Virginia are likely to also apply for waivers in order to expand Medicaid coverage (see http://www.fiercehealthfinance.com/story/waiver-projects-boost-medicaid-expansion/2014-01-27)

enrollment in a QHP (private insurance) through the Exchange will be mandatory. Both States expressly exclude medically frail populations; Iowa, however, also excludes individuals who are eligible for cost-effective employer-sponsored insurance.

In Wisconsin, the demonstration program (known as BadgerCare Reform) will be available to non-pregnant, childless adults ages 19 through 64, whose effective incomes do not exceed 100% FPL. The waiver also permits the State to charge premiums to parents and caretaker relatives with family incomes above 100% FPL who qualify for Medicaid through the Transitional Medical Assistance (TMA) eligibility group. The State estimates that nearly 99,000 childless adults will enroll in BadgerCare Reform in the first year, while an additional 5,000 childless adults will independently transition to the Federal Marketplace. Based on the nature of this demonstration design, this is not considered a full "Medicaid expansion" under the ACA, which has implications for, among other things, the State's access to Federal funding and the benefits to which individuals in the demonstration are entitled. BadgerCare Reform beneficiaries will generally be enrolled in the existing Medicaid managed care organization (MCO) provider network.

Duration of Demonstration

The Iowa and Arkansas demonstrations have been approved for three years, starting January 1, 2014 through the end of 2016. In both States, the demonstration began statewide as of implementation. Both Wisconsin's BadgerCare Reform and the Healthy Michigan demonstration are effective on or by January 1, 2014[4], and have been approved through December 31, 2018. The BadgerCare Reform demonstration will begin providing coverage on April 1, 2014. Enrollees in the Healthy Michigan Program will begin making premium and cost-sharing contributions to their Medicaid coverage starting April 1, 2014.

Covered Services and Wraparound Benefits

In Wisconsin, all enrollees in the demonstration will receive benefits "as specified in the Medicaid state plan, to the extent that such benefits apply [to] those individuals." In other words, since the State's demonstration does not constitute a Medicaid expansion, the enrollees are not considered benchmark populations. As a result, these enrollees are entitled to any and all Medicaid services provided for under the waiver. Given the language set forth in Wisconsin's waiver, it appears that these enrollees will have access to traditional Medicaid benefits, including all FQHC services, through their MCO.

In Michigan, individuals enrolled in the demonstration will receive coverage through the State's existing network of MCOs. The waiver states that Healthy Michigan Program beneficiaries will "receive a full health care benefit package as required under the [ACA] and will include all of the Essential Health

[4] Michigan's demonstration is effective as of December 30, 2013, the date the CMS approval was signed.

Benefits as required by federal law and regulation" and as set forth in the State's Alternative Benefit Plan (ABP) State Plan Amendment (SPA)[5]. The ABP SPA does not specifically reference FQHC services; however, given that these enrollees are benchmark Medicaid beneficiaries under Federal law, the discussion below regarding *access* to FQHC services would apply to these individuals. Additionally, the waiver states that each MCO "must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state."

In both Iowa and Arkansas, demonstration enrollees will have access to all of the services and benefits covered by the QHP in which they enroll (or are enrolled). In Arkansas, Private Option beneficiaries will be permitted to choose among all silver plans offered in their geographic area. In Iowa, the QHPs that will be made available for selection by the beneficiary will be determined by the Medicaid agency.

Furthermore, even though these individuals will be newly covered through private insurance, they remain Medicaid beneficiaries. As a result, they are still entitled to all of the benefits and services that any other newly eligible Medicaid beneficiaries in expansion States are entitled to. Under the ACA (as interpreted by the Supreme Court), States have the authority to expand Medicaid eligibility to all individuals with incomes up to 138% of FPL. All individuals who become eligible for Medicaid through an expansion under the ACA must be covered under benchmark equivalent coverage.[6] Therefore, these individuals are entitled to all of the benefits and services that their State's benchmark population is entitled to (that are not otherwise waived).

Under final rules issued in July, 2013 by CMS, all Medicaid benchmark coverage will be required to cover the ten categories of EHB (as required for QHPs), *plus* all existing Medicaid benchmark plan requirements ("wraparound benefits"). In Arkansas, the State will cover all wraparound benefits on a fee-for-service (FFS) basis. The Arkansas approved waiver specifically highlights non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21 as wraparound benefits, but does not expressly limit the definition of wraparound benefits to only these services. In Iowa, the approved waiver indicates that EPSDT will be provided through FFS (despite a request from the State to waive coverage of such benefits). CMS, however, expressly waived the requirement that the State cover non-emergency transportation (for one year). The Iowa waiver application also indicates that the State will test the hypothesis that individuals enrolled in QHPs "have sufficient access to needed services and do not require Medicaid Benefit Wrap."

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[5] *See* http://www.michigan.gov/documents/mdch/ABP_Amendment_Public_Notice_438191_7.pdf. It is also worth noting the, in the preamble of the final rule on Medicaid expansion, CMS states that "ABPs are required to cover certain benefits including rural health clinics, FQHCs, and family planning services and supplies." 78 Fed. Reg. at 42199.

[6] *See* Centers for Medicare & Medicaid Services, *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule* , 78 Fed. Reg. 4594, at 4629 (Jan. 2013).

What does enrollment in a QHP mean for coverage of FQHC services?

For benchmark populations in Medicaid, the Social Security Act requires that benchmark-eligible beneficiaries have access to FQHC services. Because all Medicaid-eligible individuals must continue to receive all Medicaid benefits to which they are entitled, any individual in the benchmark population would still be required to have access to FQHC services, even if they are covered under a QHP. To date, no definitive "access" standard has been established. In other words, CMS has not expressly defined what it means for an individual to actually *have* access to FQHC services. As a result, and because not all QHPs have contracted with all FQHCs in an area, there is a question as to whether and how demonstration enrollees will be able to access FQHC services. The answer may depend on which QHP an individual enrolls in and whether the plan has contracted with one or more FQHCs. In both Iowa's and Arkansas's approved waivers, CMS states that enrollees "will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC." Based on this (and the out-of-network requirements discussed below), it appears that if an individual has access to one QHP that has contracted with at least one FQHC, CMS considers the FQHC "access" standard to be met.[7]

In Wisconsin, the estimated 5,000 individuals who will enroll in the first year of the demonstration will no longer be considered Medicaid-eligible individuals, even though they may have been covered by BadgerCare or BadgerCare Plus prior to the expiration of these demonstration programs. As a result, these individuals will have access only to those services covered by the QHP in which they enroll and would not be entitled to any additional wraparound Medicaid benefits.

What happens if FQHCs provide services to QHP enrollees under a Demonstration?

The Exchanges in Iowa, Arkansas, and Michigan are being run in coordination with the Federal government (known as a Partnership Exchange/Marketplace). Wisconsin has deferred to the Federal government to operate that State's Exchange (known as a Federally-facilitated Exchange/Marketplace, or FFE/FFM).

Both Iowa and Arkansas will retain at least some degree of control over certification of QHPs, subject to minimum Federal standards. Arkansas's waiver application indicates that the State Insurance Department will "evaluate network adequacy, including QHP compliance with Essential Community Provider network requirements." In Iowa, the waiver application indicates that plans in which demonstration participants can enroll in must be "certified through the Iowa Insurance Division's QHP certification process."

[7] In a recent communication to NACHC, however, CMS appears to appreciate and endorse the concept that access to FQHC services must mean actual access and that actual access would mean that the FQHCs contracted by the QHP would have capacity to accept new patients, and would be geographically accessible and culturally competent to serve the patients enrolled in the QHP.

CMS did not waive the requirement that FQHC's be paid their prospective payment system (PPS) rate under any of the three expansion demonstrations. As a result, for services provided to Medicaid-eligible enrollees under these demonstrations, all FQHCs in these three States should be paid the Medicaid PPS rate—most likely by a "wrap-around" payment by the State to the FQHC in addition to the amount that the FQHC has received from the QHP, or possibly from the QHP if the State has contracted with the QHP to pay the full PPS amount to the FQHC.

In the Iowa Department of Human Services FAQs regarding the waiver programs, the State expressly clarifies that if a QHP "pays a rate to a FQHC or RHC that is lower than the Medicaid contracted rate, Medicaid will pay the difference for services received by Iowa Marketplace Choice Plan members at that clinic."[8]

The issue of PPS payment to an FQHC in these States is a little less clear if the individual treated by an FQHC is enrolled in a QHP that has **not** contracted with the FQHC. In that instance, the Medicaid recipient has gone out of network ("OON"). In the preamble to the July 15, 2013, final rules on Medicaid expansion, CMS appears to settle this issue, stating:

> There are several benefits specified by section 1937 of the [Social Security] Act that are required in addition to EHBs. We did not change § 440.365, which reflects section 1937(b)(4) of the Act, providing that states must assure access to these services through the benchmark or benchmark-equivalent coverage or otherwise, to rural health clinic and FQHC services, **even if the state does not contract with an FQHC**… and that payment for these services must be made in accordance with the payment provisions of section 1902(bb) of the Act [(e.g., the Medicaid FQHC PPS payment provisions)].[9]

Further supporting the position that an OON FQHC should be paid PPS when it serves a Medicaid patient that has come to the center is a letter CMS sent to NACHC in June 2012 regarding QHPs participating in the new Exchanges, which clarifies that FQHCs should be paid the equivalent of the Medicaid PPS amount for services provided to a non-Medicaid QHP enrollee that has gone OON to the FQHC.[10] If CMS requires QHPs to pay the Medicaid PPS rate for **non-Medicaid** QHP enrollees who have gone OON to an FQHC, it is difficult to believe that CMS would expect that same QHP to pay any less to a FQHC for services provided to a Medicaid patient who has gone OON to the FQHC.[11] While this issue appears to be fairly settled, there is still an open question about the potential cost-sharing obligations that a QHP could impose on an individual for out-of-network services provided at FQHCs (subject to statutory and regulatory limitations, as well as limitations established under the waiver(s)).

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[8] Iowa Department of Human Services, *Iowa Health and Wellness Plan Waiver Approval: Frequently Asked Questions* 2 (Jan. 2, 2014) (http://www.dhs.state.ia.us/uploads/IHAWP_WaiverApproval_FAQ_01022014.pdf).

[9] 78 Fed Reg 42199 (July 15, 2013) (emphasis added)

[10] *See* Letter from Tim Hill, CCIIO, to Dan Hawkins, NACHC. June 8, 2012.

[11] In a recent Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces, CMS appeared to somewhat qualify this FQHC OON payment policy. A final statement on this policy is expected to be in the final version of the 2015 Letter to Issuers.

Cost Sharing

In Arkansas, the State will require cost-sharing for demonstration enrollees with incomes between 100% and 138% FPL. Such cost-sharing must be "consistent with Medicaid requirements and must include an aggregate cap of no more than 5 percent of family monthly or quarterly income." The State indicates in its application that it plans to submit amendments to implement cost-sharing for individuals with incomes between 50% and 100% FPL in years two and three of the demonstration.

In Iowa, the State will require cost-sharing for demonstration enrollees who use an emergency room for non-emergency services. The approved waiver provides that "Iowa Marketplace Choice demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with incomes above 100 percent of the FPL, up to and including 133 percent of the FPL (plus a 5% income disregard), can be imposed in year 2 of the demonstration and shall be waived if enrollees complete all required healthy behaviors during year 1 of the demonstration. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions waived based on those activities, i.e., healthy behaviors performed in year 2 will be permitted to waive premiums for year 3."

Furthermore, "[i]n any year an individual is subject to premiums, enrollee premiums cannot exceed two percent of household income." Similarly, in Michigan, adults with incomes between 100% and 133% of FPL (plus a 5% income disregard) will have a monthly premium equal to 2% of income. Additionally, all expansion adults will be subject to cost-sharing obligations and be eligible for healthy behavior incentives. With respect to the cost-sharing obligations, Healthy Michigan program enrollees will have their cost-sharing capped at traditional Medicaid levels and will make copayments through a credit facility operated in coordination with the Medicaid Health plan. Copayments may be reduced by demonstrating achievement of recommended Health Behaviors.

In Wisconsin, the waiver permits the State to charge premiums to adults who are eligible for Medicaid through TMA. The monthly premium is determined as a percentage of income and is scaled up from 2% of income for individuals at 100% FPL to 9.5% of income for individuals at and above 300% FPL.

Provisions Specific to FQHC Services

As noted above, demonstration enrollees "will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC."[12] Additionally, Arkansas, in its final waiver application, states that "[t]o assure their continuing viability, Arkansas Medicaid, in consultation with the FQHCs/RHCs, intends to develop an alternative payment methodology to reimburse FQHCs for serving Private Option enrollees, as permitted under Section 1902(bb). During 2014, FQHCs/RHCs will be

[12] But see footnote 7 on page 3. Also, in that CMS communication, the Agency noted that this condition in the Arkansas waiver requires contracting with both an FQHC and a RHC.

reimbursed for services provided to Private Option enrollees by QHPs at commercial rates consistent with Arkansas law and market dynamics, with supplemental payments made by the Arkansas Medicaid." Arkansas Medicaid will therefore require FQHCs to provide historic and prospective cost and utilization data to enable the development of an alternative payment methodology. The State "intends to implement this alternative payment methodology as early as possible after initiation of the Demonstration." If an alternative payment methodology cannot be timely developed, Arkansas "reserves the right to seek a waiver of FQHC reimbursement rules during year one of the waiver and/or for years two and three of the Demonstration."

The Arkansas waiver application also notes that, QHPs establish their own criteria for network participation. Such criteria "may include requiring that providers participate in the [Arkansas Health Care Payment Improvement Initiative (AHCPII)]… Providers will be free to assess whether they are able to comply with the conditions of participation set forth in the plans' provider contracts." In other words, the State is not requiring providers to participate in AHCPII, but has given the authority to QHPs to do so.

In the approved Iowa waiver, the only FQHC-specific provision, noted above, provides that demonstration enrollees "will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC." This standard is similar to the FQHC contracting requirements that CMS included in the Arkansas waiver and in other earlier State Medicaid demonstration waiver programs unrelated to the premium assistance model. : It is probably not a coincidence that a very similar approach has also been applied by CMS with regard to QHP requirements in contracting with Essential Community Providers (ECP) to provide coverage through an Exchange. *See* CMS's 2014 *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, and CMS's *Draft 2015 Letter to Issuers in Federally-facilitated Marketplaces*. However, the FQHC contracting requirements in the Arkansas and Iowa Medicaid waiver demonstrations are particularly compelling legally, since FQHC services are required services that must be made available to Medicaid recipients in the these States.

Under the Wisconsin demonstration, CMS provides only that, with respect to FQHC settlement expenses, State "will assign FQHC settlement expenses to claims covered under the demonstration for BC Reform Adults and will report these costs on the appropriate [f]orms." Neither the waiver application nor the STC for Michigan's demonstration program specifically address FQHCs.

Appendix

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Overview:	Propose using Medicaid funds to pay premiums for Marketplace QHPs for some or all newly eligible Medicaid beneficiaries under ACA's expansion.			Services will be provided through a managed care delivery system.	*Not a Medicaid expansion under ACA.
	Covers all newly eligible beneficiaries (estimated 200,000) statewide. Anticipates developing a pilot project with health savings accounts for demonstration beneficiaries in 2015 or 2016 (not included in current demonstration approval).	Covers newly eligible beneficiaries above 100% to 138% FPL (estimated 36,000) statewide. Also covers beneficiaries up to and including 100% FPL through Medicaid managed care arrangements under another approved § 1115 demonstration.	Would cover all newly eligible beneficiaries (estimated >500,000) statewide. Able-bodied adults ages 21-64 must register for work with state DOL and actively engage in work search or job training activities. Must complete 12 approved unspecified work search activities per month during first 6 months to maintain eligibility Exemptions for crisis, serious medical condition or temporary situation that prevents work search, such as domestic abuse or substance abuse treatment. Failure to comply results in 3 months ineligibility for 1st instance, 6 months ineligibility for 2nd instance, and 9 months ineligibility for 3rd instance. Application seeks changes to benefits packages, premiums, cost-sharing, and work search requirements applicable to currently eligible beneficiaries who are covered through managed care.	Covers childless adults ages 19 to 64 from 0 to 138% FPL (estimated 300,000 to 500,000) statewide. Requires copayments for beneficiaries 0-138% FPL (not greater than those allowable under current law), which can be reduced by participating in specified healthy behavior activities. Also requires beneficiaries 100-138% FPL to make income-based contributions to health savings accounts. 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.	The waiver will implement the following changes to BadgerCare Plus: Provide all BadgerCare Plus members with Standard Plan benefits; Eliminate the BadgerCare Plus Core Plan; Remove the current enrollment cap for childless adults under 100% FPL; and Require all parents and caretaker relatives who qualify for transitional medical assistance (TMA) to pay a monthly premium. TMA adults with incomes above 133% FPL will be required to pay a monthly premium once they qualify for TMA and adults with incomes from 100% FPL to 133% FPL will begin paying monthly premiums after the first six months of TMA coverage.
Duration:	9/27/13 to 12/31/16	12/10/13 to 12/31/16	2015 to 2019	12/30/13 to 12/31/18. Enrollment begins 4/1/14.	12/30/13 to 12/31/18. Eligibility changes begin 4/1/14.
	Enrollment begins 10/1/13, with eligibility effective 1/1/14.				

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Demonstration Goals:	Cite promoting continuity of care, increasing access to care, and increasing Marketplace QHP enrollment.			Cites reducing uncompensated care, reducing the number of uninsured, encouraging healthy behaviors, improving access, and understanding the impact of contribution requirements and health accounts.	Wisconsin aims to provide full Medicaid benefits through the Standard Plan, including enhanced mental health benefits, substance abuse treatment and prevention benefits, to all adults in poverty who are enrolled in Medicaid and BadgerCare Plus. Previously, this level of coverage had not been available to childless adults.
Coverage Groups:	Newly eligible parents ages 19-64 between 17-138% FPL, and newly eligible adults without dependent children ages 19-64 between 0-138% FPL. Anticipates amending waiver in 2015 or 2016 to add parents at or below 17% FPL and children (not included in current demonstration approval).	Newly eligible beneficiaries ages 19-64 above 100% to 138% FPL who do not have access to cost-effective employer-sponsored insurance (ESI). (People who have access to cost-effective ESI will be required to receive premium assistance for ESI.)	Newly eligible parents ages 21-64 between 33-138% FPL, and newly eligible adults ages 21-64 without dependent children between 0-138% FPL. (Newly eligible 19 and 20 year olds will be covered under Medicaid managed care.) Provides for premium assistance for cost-effective ESI if available. Eliminates medically needy spend-down coverage group for adults under 65 who are blind/disabled; this group will enroll in premium assistance as newly eligible.	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) Childless adults ages 19-64 from 0 to 35% FPL currently eligible for Michigan's limited benefit package covered by the Adult Benefits Waiver (ABW) will transition to full Medicaid coverage as part of the new expansion group.	Adults ages 19 - 64 years old, up to 105% FPL, who are not otherwise eligible for BadgerCare Plus for Families or Medicaid, are not entitled to Medicare, and meet all Medicaid non-financial requirements like citizenship and identity, SSN, etc.
Enrollment:	QHP enrollment required for demonstration beneficiaries.			Managed care enrollment is required for demonstration beneficiaries.	Medicaid coverage through existing MCO network.

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Exempt Populations:	People who are medically frail (unless they opt in).			Noncitizens eligible only for emergency services; Program for All-Inclusive Care for the Elderly (PACE) participants, and individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IDD).	Not defined.
	Would be identified through state-established process; 12 question online screening assessment, including health self-assessment, living situation, assistance with ADLs/IADLs, acute and psychiatric overnight hospital stays, and number of physician or mental health professional visits. May be disenrolled from QHP if determined medically frail. Could opt for FFS coverage of same ABP offered to new adult group or an ABP that includes state's standard benefits package. Would exempt people with "exceptional medical needs," American Indian/Alaska Natives, pregnant women, and duals.	Would be identified through screening questions on the state's web portal, unless beneficiary opts out of assessment. Beneficiaries who become medically frail after QHP enrollment will be able to be reassigned to other Medicaid coverage. American Indian/Alaska Natives can voluntarily opt into demonstration.	Would be identified through screening algorithm focused on higher, more complex physical or behavioral health care needs. Will enroll in the high risk ABP available to currently eligible beneficiaries, unless choose to receive QHP premium assistance. Proposes specific criteria for medically frail determinations. Also would exempt pregnant women, dual eligible beneficiaries, individuals who are institutionalized and those receiving or deemed to be receiving SSI.		

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Plan Choice and Auto-Assignment:	Beneficiaries will choose between at least 2 silver level Marketplace QHPs and may choose among all silver plans available in geographic region. If beneficiaries do not choose a plan, they will be automatically assigned to one. (IA provides that state must ensure that beneficiaries authorize auto-assignment.)		Beneficiaries would choose between at least 2 QHPs. If ESI not available, could choose among all available QHPs in geographic region.	Enrollment broker will assist beneficiaries with plan selection before relying on auto- assignment. Auto-assignment shall first take into account beneficiary's prior or current MCO history and then MCO affiliation of beneficiary's historic providers. In rural counties, there will only be 1 MCO. In all other areas, beneficiaries will have a choice of MCOs. There will be 1 PIHP per region. MCO lock-in for 12 months after initial 90 days to switch plans.	Demonstration enrollees will be required to join an MCO as a condition of eligibility, as long as there is at least one MCO available in their county of residence, and the county has been granted a rural exception under Medicaid State plan authority.
	Demonstration QHPs would be "high value" silver level plans. 30 days to change QHPs after auto-assignment. Auto-assignment based on target minimum market share of demonstration beneficiaries in each QHP in region.	Waiver application indicates that: demonstration QHPs would offer 100% actuarial value; beneficiaries may call Medicaid enrollment broker for assistance with QHP selection; beneficiaries must remain enrolled in QHP for 12 months, except for initial 90 day period to change plans for any reason, unless they experience a qualifying event triggering a special enrollment period; auto assignment will be on an alternating basis between QHPs.	No details on auto-assignment or options counseling provided in demonstration application.		
Premiums:	State would pay monthly premiums directly to QHPs.			Beneficiaries above 100% FPL will pay monthly premiums in the amount of 2% of income.	Applies to TMA adults only.
Cost-Sharing:	Cost-sharing limited to 5% of annual income (limit includes premiums in Iowa).		State will cover cost of in-network QHP cost-sharing.	All demonstration beneficiaries will have cost-sharing obligations based on their prior 6 months of copays.	TMA beneficiaries pay percentage of monthly premium based on sliding scale by FPL; ranges from premium

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
	Beneficiaries between 100-138% FPL would have cost- sharing consistent with Medicaid and Marketplace QHP rules. No cost-sharing for beneficiaries below 100% FPL in 2014. Waiver application indicates that state intends to add cost-sharing for beneficiaries between 50-100% FPL in 2015 and 2016. No cost-sharing for beneficiaries who are exempt under federal Medicaid law.	All demonstration beneficiaries would be subject to a copay for non-emergency use of the emergency room. (Amount per state plan in IA; PA proposes $10.)		No cost sharing for first six months of enrollment in MCO. Cost-sharing will be paid into health accounts and can be reduced through compliance with healthy behaviors. Amount of cost-sharing based on state plan. 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. Cost-sharing and premiums cannot exceed 5% of household income.	payments equal to 2% of income at 100% FPL to 9.5% of income at 300% FPL and above.
Benefits:					
QHP benefits package:	QHPs would provide services in the Medicaid Alternative Benefits Package (ABP).			Not applicable: MCOs would provide services in the Medicaid Alternative Benefits Package (ABP).	Not applicable: Medicaid-eligible individuals not enrolled in QHPs.

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
	ABP will be the same as Medicaid state plan benefits package.	Waiver application indicates that ABP will be at least equivalent to state employee plan benefits package and that state will provide dental benefits through a capitated commercial dental plan carve-out.	QHPs would provide essential health benefits based on small group plan with largest enrollment benchmark. For currently eligible beneficiaries, state would create 2 adult benefits packages: 1 for "low risk" beneficiaries and 1 for "high risk beneficiaries." Enrollment in benefits package based on health screening during online application. Exceptions to limits on benefits will be granted for chronic illness/serious health condition and denial jeopardizes life or results in serious deterioration; if cost-effective; if necessary to comply with federal law.	State will use existing Medicaid MCOs and PIHPs to serve the newly eligible population. MCOs will provide acute, physical health, and pharmacy benefits and PIHPs will provide inpatient and outpatient mental health, substance use disorder and developmental disability services statewide to all demonstration enrollees. MCO/PIHP contracts must allow direct access to specialist for beneficiaries with special health care needs as appropriate to health condition. The waiver also specifies benefits should be coordinated and integrated using an interdisciplinary team to coordinate physical and behavioral health. MCOs and PIHPs will refer and coordinate access to services excluded from managed care delivery systems. Covered services will include medically necessary services as prior authorized, as well as other services required to be covered pursuant to state or federal law, regulation or policy.	
Federally qualified and rural health centers:	Beneficiaries will have access to at least 1 QHP that contracts with at least one FQHC/RHC.		QHPs will be required to provide participants access to FQHC and RHC as described in subparagraphs (B) and (C) of section 1905(a).	Not specified in waiver approval.	

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
	Waiver application indicates that state will develop alternative FQHC/RHC payment methodology that moves from FFS per visit payments to those that account for service intensity and reduction in the uninsured. If unable to do so timely, state reserves right to seek waiver of FQHC/RHC reimbursement rules.	No other FQHC/RHC provisions in demonstration approval.			
Prescription drugs:	Limited to the QHP formulary. Prior authorization within 72 hours instead of 24 hours.			Prescription drugs, as defined under EHB.	Not specified.
Family planning providers:	State covers out-of-network family planning providers on FFS basis.		Seeks waiver of requirement to cover all family planning providers.	No waiver of beneficiary's free choice of family planning.	Beneficiaries in the demonstration childless adult demonstration population will not receive family planning services. Beneficiaries in the demonstration adult population will not receive pregnancy related services, but instead must be administratively transferred to the pregnant women group in the state plan if they are pregnant.
Wrap-around benefits:	Provided on a FFS basis (non-emergency medical transportation and EPSDT).	One year waiver of obligation to provide non-emergency medical transportation for all newly eligible beneficiaries, after which impact on access to care will be evaluated. EPSDT provided on FFS basis.	Seeks authority to waive provision of any benefits available through low risk ABP that are not included in QHP benefits package, such as non-emergency medical transportation. (Newly eligible 19 and 20 year olds would receive EPSDT through Medicaid managed care plans.)	Healthy Michigan beneficiaries enrolled under the demonstration in the new adult group (i.e., Healthy MI Adults) will receive the benefits in the approved Alternative Benefit Plan (ABP) SPA.	Not specified.

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Retroactive coverage:	Would provide 3 months' coverage prior to application date on FFS basis.	State will provide direct Medicaid coverage between date of eligibility and QHP enrollment. Retroactive coverage not mentioned.	Seeks authority to waive the requirement to provide retroactive coverage.	No retroactive eligibility for ABW program.	Not specified.
Appeals:	Demonstration enrollees would use the state fair hearing process for all appeals. State may submit SPA delegating hearing responsibility to another state agency.		Demonstration enrollees would use the QHP appeals process for denials of QHP-covered benefits and state fair hearing process for eligibility appeals.	The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. The state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.	The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Financing:	Estimates that the cost of covering the demonstration population will be the same with the waiver as without the waiver: $118 million in CY 2014, $126.4 million in CY 2015, and $135.4 million in CY 2016.	Does not specify cost without the waiver. Estimates that the waiver will cost $137 million in CY 2014, $205 million in 2015, $213 million in 2016, $221 million in 2017, and $230 million in 2018.	Waiver application indicates that state "is proposing a per capita budget neutrality model for the populations covered under the demonstration, including [premium assistance] participants. Actual waiver expenditures for these populations will be applied against the without waiver budget limit." No further detail specified.	The budget neutrality limit calculations for the "Healthy Michigan Waiver" are estimated to be the PMPM for each year ($515.85 million in the first year increased by 5.1%) multiplied by the number of eligible member months and adding the products across years and applying the federal share. The waiver application estimated 5 year budget neutral costs of $15.2 billion: $2.2 billion in CY 2014, $3 billion in CY 2015, $3.2 billion in CY 2016, $3.4 billion in CY 2017, and $3.5 billion in CY 2018.	
Cost- Effectiveness:	May use state-developed tests of cost-effectiveness that differ from those otherwise permissible.	Not specified.			Not specified.
Oversight:	State Medicaid agency (and state insurance departments in AR and IA) will enter into MOU with QHPs regarding enrollment, payment of premiums and cost-sharing reductions, reporting and data requirements, notices, and audits.			Not specified.	Not specified.
Public comment and waiver submission:	Demonstration approved 9/27/13.	Demonstration approved 12/10/13.	Released for state public comment period prior to CMS submission on 12/6/13.	Demonstration approved 12/30/2013.	Demonstration approved 12/30/2013.
	Within 6 months of implementation and annually thereafter, state must hold forum for public comment.			Within 6 months of implementation and annually thereafter, state must hold forum for public comment.	

States' Medicaid Expansion Premium Assistance Proposals Compared[i]					
Element	**Arkansas (approved)**	**Iowa (approved)**	**Pennsylvania (proposed)**	**Michigan (approved)**	**Wisconsin (approved)**
Evaluation:	State must submit draft evaluation design within 60 days of demonstration approval.		Waiver application lists hypotheses to be tested.	State must submit draft evaluation design within 120 days of demonstration approval.	State must submit draft evaluation design within 120 days of demonstration approval.
		Evaluation shall be conducted by an independent entity.		State proposes the following evaluation topics: uncompensated care analysis, reduction in number of uninsured, impact on healthy behaviors and health outcomes, beneficiary views on impact of demonstration, impact of contribution requirements, and impact of health accounts.	State proposes the following evaluation topics: For the TMA demonstration participants, will the premium requirement reduce the incidence of unnecessary services, slow the growth in healthcare spending, and increase the cost effectiveness of Medicaid services?; impact on utilization and/or costs; impact of 3-month restrictive re-enrollment period; impact of premiums; impact on health outcomes.
Reporting:	State must submit quarterly and annual reports to CMS.		Not specified.	State must submit quarterly and annual reports to CMS. Includes reporting requirements for MCO/PIHP encounter data. The state must also comply with the Tribal consultation requirements and regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408. The waiver applies these to waiver amendments.	State must submit quarterly and annual reports to CMS.

[i] The information provided in this table with respect to Arkansas, Iowa, Pennsylvania, and Michigan has been produced by the Kaiser Family Foundation, Commission on Medicaid and the Uninsured. This document compiles the charts prepared by Kaiser and supplements them with information from Wisconsin's §1115 waiver. The original charts created by Kaiser may be found at: http://kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/; and http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/.

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Medicaid Expansion and Section 1115 Waiver Demonstrations

Prepared By:

Greenberg Traurig LLP for NACHC

National Association of Community Health Centers
1400 I Street, NW, Suite 910
Washington, DC 20005

For more information about this publication, please contact:
Dawn McKinney
Director, State Affairs Department
Federal and State Affairs
dmckinney@nachc.org
202.296.3800