



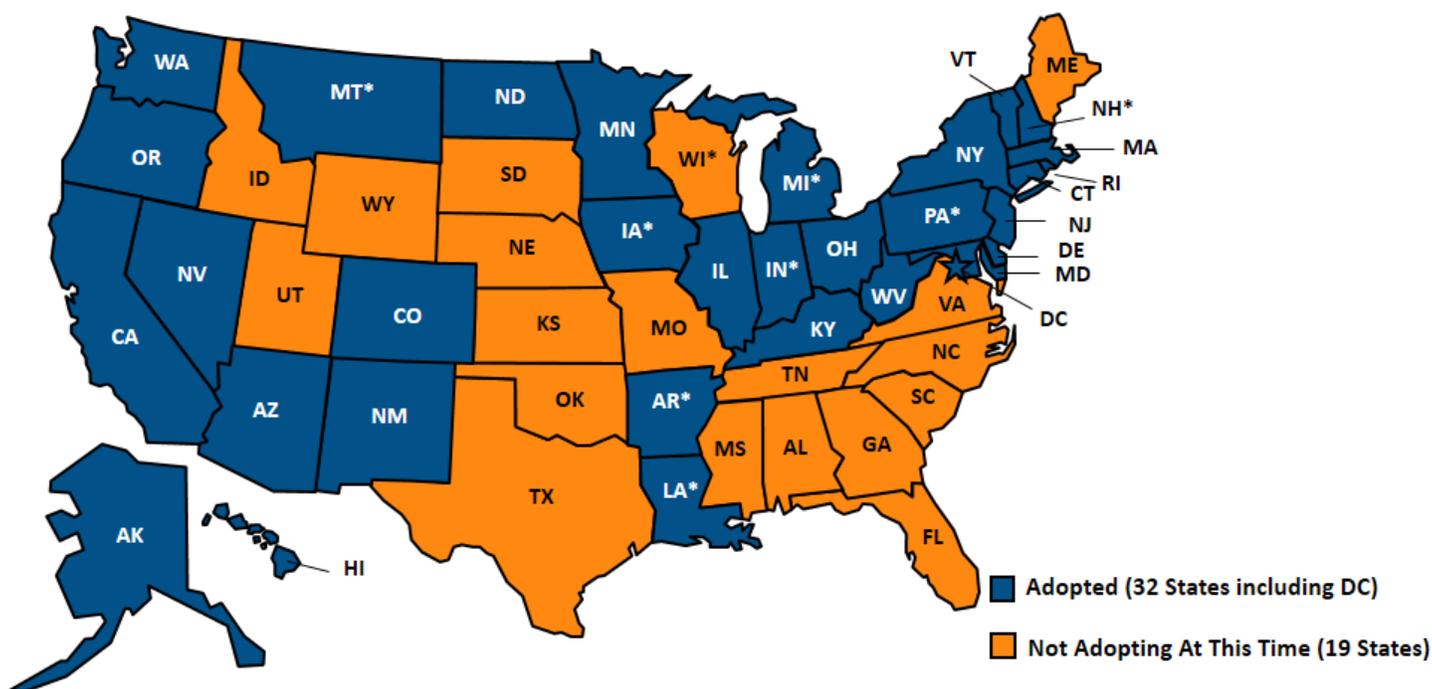
NATIONAL ASSOCIATION OF
Community Health Centers

Update on Medicaid Expansion via 1115 Waivers

State Policy Report #59

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Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/2016. LA's Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as "adoption under discussion."

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated March 14, 2016.

<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



A closer look at waivers as a Medicaid expansion vehicle

As reflected in the map above, to date 32 states including the District of Columbia have adopted the Medicaid expansion made available under the Affordable Care Act (ACA)¹. The majority of these states chose to do so under the existing rules, however, a small number of states have obtained Section 1115 waiver approvals to implement the expansion in ways that allow for greater flexibility. **Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire** have received waiver approval from the Centers for Medicare & Medicaid Services (CMS) and several more states are considering waivers as an option for expansion.

Of the waiver states, a few have gone the route of premium assistance. In March 2014, NACHC published a [brief](#) on Medicaid expansion waivers and premium assistance that specifically addressed the implications for federally qualified health centers (FQHCs). This report will examine activity since that time in order to provide a better understanding of more recent trends. Provisions that were both approved and denied by CMS will be addressed and FQHC specific language will be discussed.

What has CMS approved to date?

¹Louisiana Medicaid expansion takes effect July 1, 2016. The state is currently accepting applications and determining eligibility for coverage.

In order to encourage more states to utilize the Medicaid expansion, the administration has provided some flexibility to the states. For example, premiums, co-pays, health savings accounts, and incentives for healthy behaviors have all been approved as well as limited waivers of benefits. In terms of the impact of various provisions, each of these has an effect on health center patients as well as health centers themselves. For example, to the extent that patients fail to pay premiums and lose coverage, health centers must continue to treat them, but without Medicaid reimbursement. This puts more demand on health centers' finite resources for the uninsured. The same is true for co-pays. If patients fail to pay co-pays, FQHCs receive less reimbursement. In terms of non-emergency medical transportation (NEMT), health centers will continue to provide transportation as part of their enabling services, which further strain their budgets. Waiving retroactive eligibility² means that FQHCs will not receive payment for services they have already provided. What is the significance of these increased financial pressures on FQHCs? Health centers are often in the position of having to reduce hours, cut services, or even cut staff. **Table 1** identifies the states that have opted for various flexibilities, and the details of these arrangements will be discussed further below.

Table 1:

Waiver Provision	AR	IA	MI	NH	IN	MT
Premium Assistance	Qualified Health Plans (QHP)	QHP & Employer sponsored Insurance (ESI) ³	QHP	QHP	ESI	
Premiums / Monthly Contributions	x	x	x		x	x
Healthy Behavior Incentives		x	x		x	
Waive Required Benefits (NEMT)		x			X	
Waive Retroactive Eligibility				X	x	
Co-payments Above Statutory Limits			x		x	
12-Month Continuous Eligibility						x
Time limit on Coverage			x			
Work Requirement						

Source: <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>

Premiums and/or monthly contributions: Arkansas, Indiana, Iowa, Michigan and Montana have all adopted premiums/monthly contributions although the specifics vary. Premiums and monthly contributions, typically two percent of a patient's income between 101- 138% of the Federal Poverty Level (FPL) are required to supplement the cost of care that is covered by Medicaid. In Arkansas and Michigan, participants pay into Health Service Accounts (HSAs), which can then be used for co-payments. In Iowa, premiums are waived for the first year of enrollment and can be waived in subsequent years if healthy behavior activities are completed. In Indiana, care is not covered until the first premium is paid. In Indiana and Montana, non-medically frail adults above the federal poverty level lose coverage if

² Under retroactive eligibility Medicaid reimburses providers for services in the 3 month period prior to eligibility

³ Iowa has submitted a request to terminate Marketplace Choice program and enroll beneficiaries in Wellness Plan.

premiums are not paid. In Indiana participants face a six-month lockout and in Montana they can re-enroll when they pay their delinquent premiums. The Indiana waiver provides additional benefits to those who pay premiums such as adult vision and dental.

Healthy Behavior Incentives: The waivers in **Iowa, Michigan, and Indiana** all include healthy behavior programs, which are structured to help offset premiums. As mentioned above, in Iowa, participants can participate in healthy behaviors in lieu of paying premiums, while in Michigan and Indiana health behaviors can reduce premium amounts.

Premium assistance: **Arkansas, New Hampshire, and Iowa** chose to expand Medicaid using a premium assistance model that requires enrollment in private coverage through Qualified Health Plans (QHP) in the Health Insurance Marketplace (the Marketplace). Further discussion of implications for FQHCs is provided below.

Waivers of benefits: In **Iowa and Indiana, non-emergency medical transportation** was waived (with an exception for the medically frail).

Cost sharing waivers: Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements. In order to impose higher cost-sharing than is otherwise allowed under federal law, a state must meet separate cost-sharing waiver requirements under Section 1916(f), which **Indiana** has done in order to test higher co-payments for non-emergency use of the emergency room.

Eligibility: CMS has approved two significant changes regarding eligibility. **Indiana** has eliminated retroactive eligibility, consequently allowing coverage to begin on the date of the first premium payment. Additionally, **Montana** has added 12-month continuous eligibility for newly eligible adults with the hopes of reducing churn between Medicaid and the Marketplace.⁴

What has CMS denied to date?

CMS has denied a number of provisions included in 1115 waiver proposals including:

- Premiums for individuals with incomes under 100% of the FPL as a **condition of eligibility**;
- Waiver of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits
- Waiver of free choice of family planning provider; and
- Work requirements or incentives as a **condition of Medicaid eligibility**⁵

FQHC specific provisions:

Four states (**Arkansas, Iowa, Michigan, New Hampshire**) included language in their waivers regarding access to FQHCs, which essentially reiterates federal law:

“...enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or Rural Health Clinic.”

On April 26, 2016, CMS issued a State Health Official (SHO) Letter that changes current policy⁶. Starting in July 2017, every Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Organization (MCO) will be required to contract with at least one FQHC in each service area. Under long-standing CMS policy, in areas where patients are enrolled in managed care, only one MCO in each service area is required to contract with one FQHC. The SHO states that starting in July 2017, every MCO must include at least one FQHC (as well as one RHC and one FBC) in the provider network for its service area, if available. When FQHC, RHC, and FBC services are not included under a state’s managed care contracts, the services must be provided or arranged by the state directly.

⁴ Available at: <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>.

⁵ Ibid.

⁶ Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>

In **Michigan**, this is consistent with historic requirements. Health centers sought to have language requiring QHPs to contract with all FQHCs, but were unsuccessful.

In **Arkansas**, such language was already in the regulations governing the Marketplace QHPs so it was extended to the Medicaid expansion waiver. In practice, though, QHPs do not contract with only a single FQHC or RHC – all FQHCs are allowed providers-due to the “any willing provider” requirement in Arkansas.

In **Iowa**, the health centers did not have a role in getting this language included. There isn’t a lot of service area overlap among the FQHCs, so the plans work to contract with all of the health centers in their service area.

In **New Hampshire**, while the waiver includes the above language, statute⁷ requires plans to *offer a contract* to each FQHC and reiterates that FQHCs are to be paid at the prospective payment system rate. The PCA secured this language during the legislative process and with the support of existing plans.

Indiana extended Presumptive Eligibility (PE) to include FQHCs:

“The state shall include Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers, and Health Department sites in an expanded presumptive eligibility program, to allow potentially eligible individuals to gain temporary coverage.”

This language was included at the direction of CMS, in response to the state’s waiver of retroactive eligibility. Prior to this, only hospitals were able to do PE. PE is only for those who are uninsured and would qualify for Medicaid or Indiana’s enhanced Health Indiana Plan (HIP 2.0) based on income and household size. Once a person is deemed “presumptively eligible” he must meet a deadline of the last day of the following month to submit the full application, including all documentation of income. A patient will continue to be presumptively eligible after the full application is submitted until the time it is approved. Prior to this FQHCs could only apply presumptive eligibility to pregnant women. PE allows the health center to receive reimbursement for services provided immediately through the time the full application is approved.

While **Pennsylvania** has since moved to traditional Medicaid expansion, they originally did have a waiver approved by CMS, which contained re-affirming language for FQHCs, due to a massive effort by the Primary Care Association (PCA) and health centers to educate stakeholders and payers on Medicaid requirements regarding FQHCs:

“QHPs will be required to provide participants access to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as described in subparagraphs (B) and (C) of section 1905(a)...private health plans in the Private Coverage Option will be required to cover the services of FQHCs/RHCs on an in-network basis, with reimbursement at the Medicaid determined Prospective Payment System (PPS) rate.”

FQHC considerations around premium assistance

For benchmark⁸ 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 he is 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. In some cases, the answer may depend on which QHP an individual enrolls in and whether the plan has contracted with one or more FQHC. As mentioned above, in four states (Arkansas, Iowa, Michigan, and New Hampshire) the approved waivers indicate that enrollees “will have access to at

⁷ <http://www.gencourt.state.nh.us/rsa/html/XXXVII/415/415-25.htm>

⁸ Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Benchmark-Benefits.html>

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), where an individual has access to one QHP that has contracted with at least one FQHC, CMS considers the FQHC “access” standard to have been met.

As a result, for services provided to Medicaid eligible enrollees under these demonstrations, all FQHCs in these four states should be paid the Medicaid PPS rate. As with traditional Medicaid, FQHCs are most likely made whole up to their PPS rate through a “wrap-around” payment by the state to the FQHC in addition to the amount that the FQHC has received from the QHP. In other instances, the state may have contracted with the QHP to pay the full PPS directly to the FQHC, in which case there would be no need for a wraparound payment.

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 this circumstance, 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)].”

ARKANSAS

Arkansas received CMS approval to implement Medicaid expansion via a **premium assistance** program that they called the “private option”. This demonstration requires newly eligible beneficiaries to enroll in a QHP from the Marketplace. The state provides key services outside the benefits of QHPs such as free choice in a family planning provider and non-emergency transportation through the state’s Medicaid fee-for-service delivery system.⁹

In 2014, the waiver was slightly amended with CMS approval. The new changes established income-based **health savings accounts** to which beneficiaries are required to contribute, but failure to pay does not result in dis-enrollment, and medically frail individuals are excluded.¹⁰

INDIANA

In early 2015, CMS approved Medicaid expansion via an amendment to the state’s “Healthy Indiana Plan.” Indiana sought and received more flexibility than previous states. For example, they waived **retroactive eligibility** and made coverage effective the date of the first premium payment.¹¹ The state also created four different Medicaid benefit packages for the populations covered by the waiver. Non-medically frail adults above the federal poverty level are prevented from re-enrolling in coverage for six months after they are dis-enrolled for non-payment of premiums.¹²

The waiver also includes § 1916(f) authority to test graduated co-payments for non-emergency use of the emergency room up to \$25. Separate from the waiver, Indiana has developed a voluntary state-run work search and job training program.¹³

IOWA

In 2013, Iowa approached the Medicaid expansion with two waivers. The first moved those below poverty level into Medicaid managed care and the second waiver moved those above poverty level into QHPs. Premiums outlined in the

⁹ Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf>.

¹⁰ Available at: <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/>.

¹¹ Available at: <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>.

¹² Ibid.

¹³ Available at: <http://www.in.gov/fssa/hip/2466.htm>.

waiver were \$10 per month for beneficiaries living at 101-138% of the FPL and \$5 per month for beneficiaries living at 50-100% of the FPL, beginning in the second year of enrollment (with the exception of medically frail, who are exempt).¹⁴ As mentioned above, premiums can be waived in subsequent years if specified healthy behaviors are completed. Iowa also added dental benefits for those who complete periodic dental exams. Also included were co-pays for non-emergency use of the emergency room and a waiver of NEMT.¹⁵

Due to problems in the Marketplace, the state requested to terminate the Marketplace Choice waiver on June 1, 2016.¹⁶

MICHIGAN

CMS approved the state's "Healthy Michigan Plan" in December 2013 and two years later in December 2015, CMS approved amendments that give the state new authorities that will take effect in April 2018. Under the waiver all beneficiaries are required to make monthly payments into a health savings account. Beneficiaries who fall between the 100-138% of the FPL are required to also make income-based monthly premium contributions to health savings accounts, approximately two percent of their income. Similarly to other state waiver demonstrations, the plan has payment reductions for healthy behaviors and failure to pay does not result in a loss of Medicaid eligibility.¹⁷

Under the new waiver amendment, beneficiaries between 100% and 138% of the FPL (but not those deemed medically frail) have a choice of two coverage options: 1) Medicaid managed care (with a requirement to adopt a healthy behavior after a one-year grace period or they will be transferred to a QHP), or 2) premium assistance for Marketplace coverage through a QHP.¹⁸

MONTANA

Montana's waiver plan, the Health and Economic Livelihood Partnership (HELP) Act, went into effect on January 1, 2016. CMS agreed to allow the state to contract with a managed Fee-For-Service (FFS) Third Party Administrator (TPA) which will manage care coordination, reimburse providers and collect premiums.¹⁹

Beneficiaries receive care through the TPA network which required a freedom of choice waiver (except for medically frail). Monthly premiums of approximately two percent of the participant's income are required between 51-138% of the FPL. If a beneficiary falls between 101-138% of the FPL and fails to pay, he can be dis-enrolled and will only be re-enrolled if the payment is made or the state assesses the debt against income at the end of a quarter.²⁰

NEW HAMPSHIRE

Originally in August 2014, New Hampshire applied a straight Medicaid expansion via a state plan amendment but then went back to CMS with a waiver to move the expansion population into a Marketplace premium assistance program as of January 2016. The waiver requires newly eligible adults to enroll in Marketplace QHPs, but the state will provide services outside of the QHP benefits such as EPSDT, NEMT, and limited adult dental and vision benefits via Medicaid fee-for-service. The state did waive retroactive eligibility and plans to work with CMS to develop wellness programs and a referral systems for job counselling services.

¹⁴ Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf>.

¹⁵ Available at: <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/>.

¹⁶ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-pa.pdf>

¹⁷ Available at: <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/>.

¹⁸ Ibid.

¹⁹ Available at: <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-montana/>.

²⁰ Montana Dep't of Public Health & Human Servs., Montana Health and Economic Livelihood Partnership Program Section 1115 Research and Demonstration Waiver Application (Montana Dep't of Health & Human Servs., Sept. 15, 2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-pa.pdf>.

ARIZONA (pending at CMS)

Arizona chose to fully expand Medicaid in 2013, but the state has since developed a new waiver proposal that is currently pending at CMS. The proposed program, titled “Choice, Accountability, Responsibility, and Engagement (CARE)” includes monthly premiums of two percent of participant income and co-pays of up to three percent of income (to be paid into HSA) for those between zero to 138% of the FPL. Failure to pay premiums or co-pays can result in a six-month lock-out (for those above the poverty level). Healthy behavior incentives could reduce cost-sharing. The program also proposes to create a work incentive program, though this is not a condition for eligibility. A one year waiver of NEMT for adults living above the poverty level is included. The state proposes a \$25 co-pay for nonemergency use of the emergency room for every such incident where there is a community health center, rural health center, or urgent care center within twenty miles of the hospital.

In addition, the proposal includes three controversial requests that CMS has not approved to date: 1) a requirement for able-bodied Medicaid beneficiaries to work, actively seek work, or attend school or job training for 20 hours per week, 2) a one-year lock out for individuals who knowingly fail to report changes in family income or make a false statement about compliance with work requirements, and 3) a five-year lifetime limit on Medicaid benefits for able-bodied adults.

Other resources: June 2015 policy report on Medicaid waivers and FQHCs:

<http://www.nachc.org/client//Section%20115%20Waivers%20and%20Medicaid%20FQHC%20Reimbursement%206%2016%2015.pdf>

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