State Medicaid 1115 Waiver
Concerns & Opportunities

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Background

Medicaid waivers have long been used to expand coverage for adults, implement managed care, reform care delivery systems, and establish uncompensated care pools. States can request from the Secretary of the Department of Health and Human Services (HHS), under Section 1115 of the Social Security Act, a waiver of certain Medicaid rules as an "experiment" or "demonstration," so long as the waiver supports the objectives of the Medicaid program. However, in response to encouragement from the current Administration, a number of states are now pursuing a range of particularly problematic policies – including employment mandates, lock-out periods, drug testing and lifetime coverage limits – that would restrict Medicaid eligibility and could cause eligible Medicaid recipients to lose health care coverage.

This document provides an overview of concerning state policy proposals included in recent 1115 Medicaid waiver requests and briefly reviews the implications of these provisions. The goal is to assist the Ministry in advocacy efforts with their State Governors, Medicaid directors, and legislatures to mitigate the impact or prevent such waiver requests. This document is not an exhaustive list of all the initiatives possible for states to pursue under Section 1115 waiver authority, but rather it focuses on provisions of concern that have gained prominence under the Trump Administration. In addition, while not the main focus of this document, Section II provides a brief overview of other provisions that may be of interest to providers and states seeking to use Section 1115 waiver authority to meet unique needs of the Medicaid population.

Ministry Tradition

For decades the Catholic Health Association and our members have carried the message that health care is a basic human right essential to human flourishing, and we have advocated policies to ensure that everyone has access to affordable health care. We are inspired by the wisdom of the social doctrine of the Church, which teaches that each person is created in the image of God; that each human life is sacred and possesses inalienable worth; and that health care is essential to promoting and protecting the inherent dignity of every individual. The first principle in our Vision for U.S. Health Care affirms our call to pay special attention to the needs of the poor and the vulnerable, those most likely to lack access to health care, in our journey towards affordable,

accessible health care for all. This commitment is why the Catholic health ministry has strongly supported public health care programs like Medicaid and CHIP.

CHA'S Policy Position

The Catholic Health Association (CHA) supports efforts to strengthen our nation's public health insurance programs. The fundamental structure of the Medicaid program as an entitlement for the low-income, the elderly and the disabled in our country must be preserved and strengthened. Today, Medicaid provides a safety net for its beneficiaries and states as well through the program's commitment to matching federal funds. CHA advocates a strong federal presence in Medicaid and expansion to all low-income families and individuals.

CHA does not support proposals that would significantly weaken the Medicaid program's ability to provide quality affordable coverage to all eligible low-income individuals and families. Problematic provisions such as coverage lock-out periods, employment mandates, unaffordable premiums and cost sharing, and lifetime coverage limits, eliminate access to health care—a basic necessity.

Catholic social teaching promotes the dignity of work, as a form of continuing participation in God's creation. If the dignity of work is to be protected then the basic rights of those who work must be protected – included the basic right to health care. Our teaching proclaims both work and health care as fundamental rights necessary to human flourishing. These rights must not be set against each other or conditioned, one upon the other. As Pope Francis has written, "It is vital that government leaders … work to ensure that all citizens have dignified work, education and health care." Evangelii Gaudium, 205.

Thus we cannot support policies that make Medicaid coverage for low-income individuals and families conditioned on meeting employment mandates. Such policies do not promote the inherent dignity of the person, they instead serve to reduce the number of Medicaid beneficiaries and increase the number of uninsured. Ensuring access to decent and fair wages, to job training and work supports such as affordable child care and transportation, in addition to basic necessities including food, housing and health care, are critical to enabling individuals to reach their full potential.

Despite the stated goals of these new waivers, such policies are likely to result in significant unintended consequences. As is described in more detail below, emerging waiver provisions are likely to reduce Medicaid enrollment and increase churning of individuals on and off the program, thereby disrupting continuity of care and hindering the ability of healthcare providers to effectively manage and deliver coordinated care. These policies also are likely to increase the number of low-income uninsured, cause individuals to delay need care, and increase emergency room use, thereby also increasing uncompensated care for hospitals and other providers.

I. Restrictive Waiver Provisions

Work Requirements (Employment Mandates)

Description: In January, the Centers for Medicare and Medicaid Services (CMS) issued guidance outlining parameters for states seeking to pursue employment mandates through work or "community engagement" requirements using Section 1115 waivers. These waivers would generally condition Medicaid eligibility on completion of activities such as working, participating in a job training initiative, or volunteering a minimum number of hours per week or month. The guidance limits work requirements to non-elderly, non-pregnant adult beneficiaries who are eligible for Medicaid on a basis other than disability.

States that seek waivers to establish work requirements have discretion on the eligibility group, the activities required, the system for establishing exemptions, and the consequences of noncompliance within some constraints set out in the guidance. Under the CMS guidance, states implementing work requirements must create exemptions for individuals determined by the state to be medically frail and they must deem TANF and SNAP beneficiaries who are in compliance with work requirements in those programs to be in compliance with Medicaid requirements. States cannot use federal Medicaid funds to pay for employment-related activities (such as job training) or services that can help people participate (such as transportation or child care). In practice, tracking and enforcement mechanisms are likely to vary widely by state, and exemptions may not always be automatic or seamless for individuals not subject to these requirements.

Previous Policy: Compliance with work requirements as a condition of eligibility has not been permitted in Medicaid. The previous administration allowed states to refer Medicaid applicants and beneficiaries to job training and referral programs, but since this was not a condition of eligibility, it did not require states to seek waiver authority.

CHA supports states referring Medicaid beneficiaries to job training and referral programs but does not support conditioning Medicaid eligibility on work requirements.

Status: Currently, four states (KY, IN, NH and AR) have secured approval for work requirements and eight more states have proposals pending before HHS. While the recently-approved Kentucky, Indiana, and Arkansas waivers will impose work requirements only on expansion adults, three states (Alabama, Maine and Mississippi) are requesting authority to apply work requirements to "traditional" Medicaid populations such as parents.

Implications: Most non-elderly adults in Medicaid who are not eligible based on disability are working or likely to be exempt but new, complex rules will make it hard for people to document compliance or demonstrate their exempt status. This will likely lead to loss of coverage and gaps in coverage, including for individuals whom the exemptions were intended to protect. For example, individuals with a disability may have enrolled through the expansion pathway if they were eligible on the basis of income alone. In this situation, the beneficiary would not automatically qualify for an exemption and would

need to either establish his or her disability (or "medical frailty") to receive an exemption, or demonstrate compliance with the work requirement.

Additionally, work requirements thus far have not been designed to reflect the realities of the low-wage labor market, which is characterized by seasonal employment and fluctuating, irregular hours. Individuals working these types of jobs may not consistently meet all of the hours requirements associated with Medicaid work requirements despite the fact that they are gainfully employed.

Evidence from other programs such as SNAP and TANF suggests that work requirements in Medicaid are likely to significantly depress enrollment, reduce access to care and worsen health outcomes, with only limited effects on employment and beneficiary incomes. New research analyzes how Kentucky's recently-approved waiver could similarly depress enrollment.

Enrollment losses are likely to be even greater in states that apply some sort of "lockout" as a penalty for noncompliance; in Arkansas, beneficiaries who fail to comply with the work requirement for three months during the plan year will be dis-enrolled and not permitted to re-enroll for the remainder of the plan year. As a result of these new requirements, hospitals and other health care providers are likely to see an increase in uncompensated care.

Premiums and Cost Sharing

Description: A number of states have requested and received approval to impose premiums or cost sharing above maximum allowable Medicaid cost sharing amounts. Some proposals, including the recently-approved Kentucky waiver, will disenroll individuals with income above 100% of the federal poverty level (FPL)—$20,780 for a family of three—who fail to pay premiums within a specified grace period and prohibit re-enrollment during a lock-out period; premiums can be as high as 4% of income. Additionally, individuals with incomes below 100% of FPL will be subject to state-plan cost sharing, suspension of rewards accounts, and/or reduced benefits. Other states (e.g., Maine) have proposed to impose premiums on people with incomes below 100% of FPL and to disenroll those who do not make payments.

Previous Policy: Medicaid law has strict limits on allowable premiums and cost sharing to assure that low-income beneficiaries can access needed care. Premiums for individuals with incomes under 150% of FPL are generally not permitted. "Nominal" cost sharing is permitted for individuals with incomes under 100% of FPL and at higher levels for those above 100% of FPL. Certain populations and services are exempted, and providers may not deny services if beneficiaries do not pay.

Implications: To the extent that waivers impose premiums that are higher than people can afford, they will lead to loss of coverage. Longstanding research shows that premiums and copays can prevent low-income people from accessing coverage or care. Early evidence from a handful of states with recently-approved waivers suggests that higher premiums and copayments have resulted in beneficiaries accumulating debt and

a significant number of people being disenrolled for failure to pay premiums or never enrolling. Many beneficiaries in these states have also reported confusion regarding program rules and whether or not they owe premiums or other forms of cost sharing.

Lock-outs

Description: A number of recent waiver proposals have requested "lock-out" provisions as enforcement mechanisms for failure to pay premiums or submit redetermination paperwork in a timely fashion. Arkansas is the first state with approval to implement a lock-out from Medicaid coverage for failure to comply with the work requirement. Lock-outs involve barring individuals from re-enrolling in Medicaid for a specified period of time as an added penalty.

Previous Policy: In general, Medicaid programs must enroll eligible people, and lock-outs as a penalty for nonpayment of a premium or failure to submit paperwork are not permitted. A lock-out for nonpayment of premiums was approved as part of Indiana's HIP waiver; the 2015 approval permitted lockouts for individuals with incomes above 100% of FPL. No additional states were permitted to impose lock-outs until the impact was evaluated in the Indiana waiver.

Implications: Lock-outs by definition seek to exclude individuals from coverage who have met all other requirements for Medicaid eligibility. This provision will lead to additional gaps in coverage for individuals who fail to keep up with premium payments, work requirements, or redetermination requirements. Periods of ineligibility could drive up both uncompensated care costs and overall Medicaid costs because coverage gaps may mean that individuals will be sicker, especially individuals with chronic conditions, and more expensive to treat, when their Medicaid coverage is reactivated.

Time Limits

Description: Several states have proposed time limits on Medicaid eligibility. Arizona and Utah have proposed implementing 60-month lifetime limits on Medicaid enrollment for certain adults and individuals receiving limited benefits. Similarly, Wisconsin is proposing a 48-month limit on enrollment but will permit individuals to re-enroll after a 6-month lock-out period. In each of these states, time limits would not apply for individuals complying with work requirements.

Previous Policy: Time limits were incorporated into the TANF program in the 1990s as part of welfare reform but have never before been approved in the Medicaid program.

Implications: If approved, lifetime coverage limits could mean that vulnerable populations lose coverage, without being able to access other forms of affordable health insurance. Whether it is Utah's proposal to limit eligibility for its chronically homeless population receiving only mental health and substance use treatment or Wisconsin's proposal that would create a 6-month period of ineligibility for individuals 19-49 after four years of enrollment, time limits could quickly be exceeded, including by individuals with significant health care needs who nonetheless do not qualify for an

exemption from the limits. Again, time limits could drive up uncompensated care if individuals who hit their lifetime limits have no other source of health care coverage.

Restrictive Access and Provider Reimbursement Provisions

Description: Recent Medicaid waivers have sought to eliminate a number of longstanding Medicaid eligibility-related requirements intended to make it easier for individuals to access Medicaid benefits in a timely fashion. Several states have already received waivers of the retroactive eligibility requirement, and Indiana and Kentucky both received waivers of prompt enrollment (that is, enrollment can be delayed until a premium is paid). Maine and Utah have also requested waivers of hospital presumptive eligibility.

Previous Policy: Federal Medicaid law establishes several avenues intended to streamline and safeguard access to coverage for eligible individuals and payment for the care provided:

- ***Retroactive eligibility****:* Medicaid law requires states to provide coverage to individuals for the three months prior to applying for Medicaid if the individual would have been eligible during that time period. Retroactive eligibility has been previously waived, for example in states that have adopted managed care for all populations.
- ***Hospital presumptive eligibility****:* Previously limited to pregnant women and children, the Affordable Care Act expanded the scope of this policy by requiring states to permit hospitals to make temporary, presumptive eligibility determinations for individuals eligible on the basis of modified adjusted gross income. This provision has not previously been waived but Maine is currently seeking a waiver of the provision.
- ***Prompt enrollment****:* Medicaid eligibility must take effect no later than the date of application, but at state option, may take effect on the first day of the month of application. This was waived in the earlier Indiana waiver which imposed premiums.

Implications: Waivers of the above eligibility provisions are likely to result in an increased uncompensated care burden, particularly on hospitals. Retroactive eligibility pays for services provided prior to application – typically by hospitals – and presumptive eligibility makes it possible for eligible people seeking hospital services to get immediate treatment paid for by Medicaid. Estimates suggest that approximately 5% of Medicaid billings occur during the retroactive eligibility period and that hospital presumptive eligibility increases the odds of enrollment in ongoing coverage. Additionally, prompt enrollment allows recently-determined eligible individuals to seek care without delay, where they otherwise could be forced to skip necessary treatments or seek charity care.

Additional Provisions that State May Consider

Drug Testing: Wisconsin has requested authority to condition Medicaid eligibility for certain populations on completion of a drug screening assessment. Individuals who fail an initial drug screening would be required to take a drug test, and in the event of a failure, undergo substance abuse treatment. Individuals who fail to comply with these requirements would be disenrolled from the program. Drug testing has never before been approved in the Medicaid program.

Health Savings Account (HSA)-like Accounts: Several states have requested authority to implement HSA-like accounts in Medicaid, which attempt to mimic the "consumer-driven" nature of tax-advantaged accounts such as HSAs, Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). Medicaid HSA-like accounts are generally funded from some combination of beneficiary cost sharing and state funds and are used to cover additional benefits or services. Some proposals, including Kentucky's recently-approved waiver, would deduct savings from these accounts for non-emergent ED visits and remove access altogether for failure to pay premiums or other required cost sharing. These types of arrangements typically cause individuals to delay necessary care, leading to higher severity of illness when care is sought.

Pharmacy Provisions: Massachusetts has requested a waiver of Section 1927 of the Social Security Act, which requires that state Medicaid programs provide coverage for all drugs for which manufacturers have entered into rebate agreements with the federal government. This would allow the state to establish a "closed formulary," similar to those used in many commercial plans, and exclude certain products from Medicaid coverage on the basis of cost or effectiveness. To date, no waivers of Section 1927 have been approved.

Healthy Behavior Incentives: A number of states have requested authority to condition reductions of premiums or cost sharing, access to enhanced benefit packages, and other inducements on completion of certain healthy behavior activities. These include completing a health risk assessment, attesting to not exhibiting a "health risk behavior," or engaging with a primary care provider. It is important to ensure such provisions are optional incentives and do impose penalties on beneficiaries who do not participate.

Partial Medicaid Expansion: Several states are considering waivers for "partial Medicaid expansions," which would allow these states to access enhanced federal matching funds for expansion adults without providing Medicaid coverage up to 133% of FPL. Massachusetts and Arkansas have proposed rolling back their existing Medicaid expansions, while retaining the enhanced Medicaid match for the remaining adult population. CMS did not act on Arkansas's request when it recently approved other elements of the state's waiver request. Some states may seek this option as a means to do a limited expansion of their Medicaid programs to 100% of the FPL vs 133% FPL. Currently, individuals and families about 100% of the FPL are eligible for subsidies to purchase health insurance coverage in the ACA Marketplace, however, Medicaid coverage is a more affordable option for those between 100% and 133% of the FPL.

II. Waivers to Meet Needs of Medicaid Populations

IMD Exclusion: Federal Medicaid law generally prohibits states from obtaining federal matching funds for care delivered through "institutions of mental disease" (IMDs) with more than 16 beds. The so-called "IMD exclusion" has limited the ability of states to use federal funds to provide a full continuum of services to individuals with mental health and substance use disorders (SUDs), including residential drug treatment, which is often delivered through facilities considered to be IMDs. As of 2013-2014, 21 states provided no short- or long-term residential SUD treatment benefit in Medicaid. In the face of the growing SUD epidemic, CMS has sought to provide states with additional tools to address the opioid crisis through Medicaid and recently issued guidance encouraging states to apply for waivers of the IMD exclusion for SUD treatment services. To date, ten states[1] have received waivers of the IMD exclusion, and at least eight[2] more have waivers pending before CMS.

Other Behavioral Health-Targeted Initiatives: The Trump Administration has approved several targeted waivers aimed at expanding coverage and improving care delivery for individuals with behavioral health conditions. For example:

- Utah received approval to expand full Medicaid coverage to childless adults ages 19-64 with incomes less than 5% of FPL who are chronically homeless or in need of SUD or mental health treatment (including justice-involved populations).
- Virginia received approval to expand coverage from 80% of FPL to 100% of FPL for childless adults and non-custodial parents ages 21-64 with serious mental illness and incomes of less than 100% of FPL for a limited package of behavioral and physical health benefits.

Initiatives Addressing the Social Determinants of Health: Social determinants of health have been estimated to be responsible for up to 40% of variation in health outcomes. Federal law generally limits the ability of states to spend Medicaid dollars on housing and other non-medical services that could assist low-income populations, but states can leverage Medicaid case management and other authorities to help connect beneficiaries to needed social services (e.g., assisting beneficiaries in securing appropriate housing). Some states have used state plan authorities and Home and Community Based Services (HCBS) waivers to address these goals, others recently have used – or are seeking – section 1115 waivers to address social determinants of health for the Medicaid population. For example:

- Maryland received approval to operate two "Community Health Pilot Programs," including: (1) the "Assistance in Community Integration Services Pilot," which provides a set of tenancy support and sustaining services to no more than 300

[1] California, Indiana, Kentucky, Massachusetts, Maryland, New Jersey, Utah, Virginia, Vermont, West Virginia

[2] Arizona, Illinois, Michigan, New Hampshire, New Mexico, North Carolina, Wisconsin; Massachusetts currently has a limited IMD exclusion waiver approved but is pursuing a more comprehensive version in line with recent guidance.

high-need Medicaid enrollees who are at risk of homelessness upon release from institutions or at risk of institutional placement, and (2) the "Evidence-Based Home Visiting Services Pilot," which provides home visiting services promoting whole person care to at risk pregnant women and children aged 0-2.

- Washington received approval for its "Foundational Community Supports" program, which allows the State to provide high-need Medicaid enrollees who are chronically homeless or have histories of institutional-level care with tenancy support and sustaining services. The State may also offer employment support services to high-need Medicaid enrollees that have had difficulty maintaining or gaining employment for a variety of reasons such as physical disability or substance use disorder.
- North Carolina is requesting federal matching funds to address social determinants of health by investing in "evidence-based public-private regional pilots" in 2-4 areas of the State that will focus on providing Medicaid enrollees with information, services and benefits targeted to measurably improve health, and lower costs. These pilots will focus on addressing enrollees' needs in housing, transportation, food, interpersonal safety, and toxic stress.

III. Resources

Waiver Tracking Tools

- Kaiser Family Foundation, Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers?
- Families USA, Medicaid 1115 Coverage Waivers Resource Center
- National Health Law Program (NHeLP), Section 1115 Requests: Analysis and Overview Chart

Works Cited

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- Iowa DHS, Iowa Premium Monitoring Report - 4th Qtr 2015
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