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Proposed Medicaid Section 1115 Waivers in Maine and Wisconsin

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While Congress continues to consider repeal and replacement of the Affordable Care Act (ACA) as well as fundamental changes to the structure and funding of the Medicaid program, states and the Administration may achieve major changes to Medicaid through the use of Section 1115 Medicaid waivers. Section 1115 Medicaid demonstration waivers provide states with an avenue to test new approaches that further the objectives of the Medicaid program in ways that differ from what states can do under current law. On March 14, 2017, the Centers for Medicare and Medicaid Services (CMS) sent a letter to state governors that signaled a willingness to use Section 1115 authority to "support innovative approaches to increase employment and community engagement" and "align Medicaid and private insurance policies for non-disabled adults." In April, 2017, Maine and Wisconsin released for public comment at the state level proposed waivers that include many of these provisions. Wisconsin submitted its amendment request to CMS on June 7, 2017. CMS certified the amendment request as complete and the waiver is open for federal comment period until July 15, 2017.

Unlike previous waivers that encompass the ACA's Medicaid expansion, Wisconsin and Maine are seeking waiver authority to make significant changes to Medicaid that would affect non-expansion Medicaid populations. The proposals seek to impose welfare-like restrictions and make other changes to eligibility and enrollment, premiums and cost-sharing, and benefits to traditional populations that are not allowed under current law. Maine's changes would affect traditional Medicaid adults, such as low-income parents (up to 105% of the federal poverty level, FPL, $20,420/year for a family of 3 in 2017), former foster care youth, those receiving Transitional Medical Assistance, and people with breast/cervical cancer or HIV up to 250% FPL ($30,050/year for an individual in 2017). Wisconsin's changes would affect childless adults up to 100% FPL ($12,060/year for an individual in 2017), who are covered under an existing waiver at the state's regular federal matching rate, rather than through the ACA's Medicaid expansion.

Wisconsin and Maine's proposals include provisions that have not been approved in any state (such as work requirements, drug testing, and time limits). Previously, CMS had not approved state waiver requests to require that Medicaid beneficiaries work as a condition of eligibility, on the basis that such a provision would not further the program's purposes of promoting health coverage and access. Maine and Wisconsin's waiver proposals also include other provisions that have not been approved to date including drug screening and testing (WI), premiums higher than 2% of income for some beneficiaries (ME), and eligibility time limits (both states).

A number of provisions have never been approved for traditional, non-expansion populations (such as lock-outs for failure to pay premiums). Some policies, such as authority to impose premiums

(as well as premium reductions for beneficiaries who participate in healthy behavior programs), eliminate non-emergency medical transportation, and eliminate retroactive eligibility, have been approved in some Section 1115 Medicaid expansion waiver states. Indiana also has Section 1916 (f) waiver authority to test graduated copayments of $25 for non-emergency use of the emergency room with a control group. However, no Section 1115 waivers approved to date for any Medicaid population include premiums as a condition of eligibility or coverage lock-outs for non-payment for those under 100% FPL.

Several provisions included in Maine and Wisconsin's proposals are being tested and evaluated in other states' waivers, with preliminary data and evidence of negative consequences for beneficiaries and administrative costs and complexities for states, health plans, and providers. Available data about healthy behavior programs in Iowa, Michigan, and Indiana suggest that complicated provisions require extensive administrative resources and beneficiary education to implement. Additionally, Indiana's health accounts, coverage lock-out for premium non-payment, and requirement that individuals pay a premium before coverage starts result in some eligible individuals not accessing or losing coverage. A substantial body of research cites access to care barriers created by premiums and cost-sharing. Some conservative policymakers contend that work requirements are ineffective in the health care context, while others contend that such requirements may be ineffective over the long-term in the TANF program on which the proposals are modeled. An assessment of state drug testing programs in TANF found high administrative costs with few drug users identified.

Both states' waiver proposals estimate less coverage under the waiver. Under its waiver proposal, Wisconsin projects that enrollment will be 5,102 lower under the waiver compared to without waiver estimates in the fifth year of the demonstration. Of this reduction, 4,262 would be from the time limit and 840 from the premiums. The state assumed 2-4% reduction in enrollment due to premiums, pointing to research that demonstrates a 5% rate of premium non-payment. A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals, particularly those with incomes below poverty. Maine anticipates that its proposed waiver would cover 56,000 fewer eligible member months but with an increase in per member per month costs from $790 to $815, comparing the "without waiver" estimates to the "with waiver estimates" in the fifth year of the waiver. Maine estimates that the number of covered beneficiaries would decline regardless of waiver implementation but that the decline "may slightly increase over the short-term" due to the waiver provisions. Maine also estimates that costs will increase because the "able-bodied" adults expected to lose eligibility under the waiver have lower costs compared to other coverage groups. Under long-standing policy, CMS has required Section 1115 waivers to be budget neutral to the federal government, meaning that federal costs under the waiver should not exceed what they would have been absent the waiver.

Review of these waiver proposals could be on a fast timeline. Wisconsin seeks to amend an existing waiver (with some proposed changes required by state law), while Maine is requesting a new waiver. As noted above, Wisconsin's waiver is now open for federal comment period until July 15, 2017. Wisconsin received 1,043 comments at the state level and made some minor adjustments to the amendment (e.g., to monthly premiums, emergency room copays, and drug screening and testing provisions) before submitting to CMS. The state comment period in Maine has closed but the state has not submitted to CMS. If approved by CMS, Maine estimates it would be ready for implementation six months after receiving approval, while Wisconsin would

implement no sooner than one year later. Key proposed waiver provisions in each state are compared in Table 1 below, with more detail about each state's proposal provided in the Appendix.

Table 1: Themes in Non-Expansion States' Proposed Medicaid Section 1115 Waivers		
	Maine	**Wisconsin**
Population(s) Affected	Traditional adults (parents up to 105% FPL, former foster care youth, those receiving Transitional Medical Assistance, those with breast/cervical cancer, and those in the HIV waiver)	Adults without dependent children from 0-100% FPL[i]
Eligibility and Enrollment		
Condition Coverage Start on Premium Payment	X	
Waive Retroactive Eligibility	X	
Asset Test for Poverty-Related Eligibility Pathways	X	
Eliminate Hospital Presumptive Eligibility	X	
Work Requirement	X	X
Drug Screening and Testing		X
Time Limit on Coverage	X	X
Premiums and Cost-Sharing		
Premiums with Lock-Out for Non-Payment	X (Some premiums > 2% income; those with HIV excluded from premium requirements)	X
Healthy Behavior Incentives		X
Co-payments Above Statutory Limits	X	X
Missed Appointment Charges	X	

NOTES: [i] In 2014, Wisconsin implemented a new Section 1115 waiver covering childless adults ages 19 to 64 with income up to 100% FPL ($12,060 for an individual in 2017); those above 100% FPL are covered in the Marketplace. (Wisconsin is the only state opting to cover childless adults without accessing ACA enhanced matching funds.)

Appendix

Appendix Table 1: Key Provisions in Wisconsin's Proposed Amendment to its BadgerCare Reform Section 1115 Medicaid Demonstration Waiver	
Element	**Wisconsin Proposed Waiver Amendment**
Overview:	As directed by state law, seeks to amend existing waiver for childless adults to require monthly premiums for childless adults from 51% to 100% FPL ($8/month per household), with a coverage lock-out of up to 6 months for non-payment; offer premium reductions for completion of a health risk assessment and healthy behavior program; require, as a condition of eligibility, that childless adults complete a drug screening, and if indicated, a drug test at application and renewal; and limit childless adults' eligibility to 48 months followed by a 6 month lock-out. Also seeks authority to charge an $8 copay for emergency department utilization by childless adults; exempt childless adults ages 19 to 49 from the 48 month time limit if working or attending job training 80 hours per month; use Medicaid funds to offer job training as a covered benefit for childless adults; and use Medicaid funds to pay for residential substance use disorder treatment up to 90 days in institutions for mental disease for all Medicaid enrollees.
Duration:	Would amend existing waiver that is in effect through December 31, 2018. State would implement changes no earlier than one year after approval.
Coverage Groups:	Most provisions would apply only to adults without dependent children from 0-100% FPL. Authority to cover 90-day substance use disorder treatment stays in institutions for mental disease would apply to all Medicaid beneficiaries.
Premiums:	Would require childless adults with incomes from 51-100% FPL to pay premiums of $8/month per household. Failure to pay premiums could result in loss of coverage for up to six months unless outstanding premiums are paid. After six months, individuals could re-enroll in coverage without paying past-due amounts. Third parties (including non-profit organizations, hospitals, provider groups, and employers) could make premium payments for enrollees. American Indian and Alaska Natives (AI/AN) would be exempt from paying monthly premiums.
Co-Payments:	Seeks authority (under Section 1916(f)) to charge childless adults who use the emergency department (ED) an $8 co-pay (would be applicable for all ED use not just non-emergency ED use). Providers would be responsible for collecting co-payments but cannot refuse treatment for nonpayment. American Indian and Alaska Natives (AI/AN) would be exempt from paying copays.
Healthy Behavior Incentives:	Would allow childless adults from 51-100% FPL (who are required to pay premiums) to reduce their premium payments by 50 percent if they complete a health risk assessment (HRA) and do not engage in health risk behaviors based on self-attestation. Those who complete the HRA and engage in health risk behaviors but attest to actively managing their behavior and/or to having a condition beyond their control may have premiums

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	reduced by 50 percent. Health risk behaviors include alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use. State would use target measures set by national organizations such as the CDC to determine the threshold for when a behavior becomes a risk. Enrollees would complete the HRA and self-attest to any changed health risk behavior at annual eligibility renewal.
Benefits:	Would use Medicaid funds to cover stays up to 90-days for residential substance use disorder treatment services in "institutions for mental disease" for all Medicaid beneficiaries ages 21-64 (in MCOs and FFS).
Drug Screening and Testing:	Would require as a condition of eligibility that childless adults complete a drug screening questionnaire about current and prior substance use and, if indicated, a drug test at application and renewal. Individuals who indicate they are ready to enter treatment on the drug screening questionnaire may forego the drug test and enter treatment. For individuals who test positive for a controlled substance without evidence of a valid prescription, eligibility will be conditioned on completing a substance abuse treatment program. If treatment is not immediately available, Medicaid eligibility continues. Refusal to participate in treatment would result in Medicaid ineligibility but individuals may reapply (at any time) when they are willing to consent to treatment.
Work Requirement:	Would require childless adults ages 19 to 49 to work or participate in job training for 80 hours per month. Enrollees would be exempt from the work requirement if diagnosed with a mental illness; receiving Social Security Disability; serving as primary caregiver for a person who cannot care for him/herself; physically or mentally unable to work; receiving or applied for unemployment insurance; taking part in alcohol or drug abuse treatment program; enrolled in an institution of higher learning at least half-time; or attending high school at least halftime. DHS will consider comments to add performing community service and actively seeking work as qualified activities in discussions with CMS and when developing an operational protocol. Also would use Medicaid funds to pay for costs associated with job training as a covered benefit for childless adults.
Time Limit on Eligibility:	Would limit Medicaid enrollment for childless adults to 48 months (beginning the first month the policy goes into effect or upon initial program enrollment). After 48 months, enrollees would be ineligible for Medicaid for six months, but the 48-month time limit would re-start if an individual re-enrolls after the six-month period. Enrollees over age 49 and those that meet the work requirement (described above) would not be subject to the 48-month eligibility limit (the time limit clock would stop during the time a beneficiary works and/or receives job training for at least 80 hours per month). Individuals exempt from the work requirement would also be exempt from the 48-month time limit on eligibility.

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Element	**Wisconsin Proposed Waiver Amendment**
Next Steps:	State submitted its waiver amendment to CMS on June 7, 2017. The federal public comment period will be open from June 15, 2017 to July 15, 2017.
SOURCE: BadgerCare Reform Demonstration Project Section 1115 Demonstration Waiver Amendment Application, submitted June 7, 2017 and certified as complete on June 15, 2017.	

Appendix Table 2: Key Provisions in Maine's Proposed Section 1115 Medicaid Demonstration Waiver	
Element	**Maine Proposed Waiver**
Overview:	State seeks waiver to require premiums and work for traditional adults ages 19-64 (such as parents up to 105% FPL, former foster care youth, those receiving Transitional Medical Assistance, and people with breast/cervical cancer) as conditions of eligibility. Work also would be required for those eligible based on HIV status. State also seeks to delay coverage until first day of the month in which a beneficiary makes an initial premium payment. Premium nonpayment (after a grace period of no less than 60 days) would result in a lock-out period of 90 days. Noncompliance with work requirements for more than three months in a 36-month period would result in disenrollment. State also seeks waiver to apply a $5,000 asset test to all households eligible based solely on low income; impose limits on Medicaid-compliant annuities for long-term care eligibility determinations; eliminate hospitals' ability to make presumptive eligibility determinations; waive retroactive eligibility; impose a $20 copay for ER use that does not result in an admission; and charge beneficiaries for missed appointments.
Duration:	Seeks 5-year waiver (Jan. 1, 2018 through Dec. 31, 2022). Would implement changes 6 months following CMS approval (estimated start: January 1, 2018); however, premiums would be required 6 months later (estimated start: July 1, 2018).
Coverage Groups:	Proposed work and premium requirements would apply to traditional adults, ages 19-64, at *all income levels*,[i] such as: -parents from 0-105% FPL (up to $20,420/year for a family of 3 in 2017); -young adults who have aged out of foster care up to age 26; -those eligible for family planning services (up to 209% FPL, $42,678/year for a family of 3 in 2017); -those receiving Transitional Medical Assistance (TMA, for up to one year after leaving cash assistance due to earnings); and -people with HIV up to 250% FPL ($30,150/year for an individual in 2017) Individual exemptions discussed under "work requirement" section below apply to both work and premium requirements except that premiums do not apply to HIV group. All other proposed provisions would apply to all applicants or beneficiaries (as applicable per provision).
Asset Test	Seeks authority to apply a $5,000 asset test to all coverage groups that currently do not have an asset test (there is no asset test under current law for coverage groups based solely on low income (vs. old age/disability)).
Limits on Annuities:	Seeks authority to impose a transfer penalty for the purchase of Medicaid-compliant annuities for long-term care eligibility determinations and to set a minimum pay out period at 80% of the annuitant's life.
Presumptive Eligibility:	Seeks to remove requirement for hospitals to make presumptive eligibility determinations.

Appendix Table 2: Key Provisions in Maine's Proposed Section 1115 Medicaid Demonstration Waiver	
Element	**Maine Proposed Waiver**
Coverage Effective Date:	Would begin coverage on the first day of the month in which a beneficiary makes an initial premium payment instead of the month of application. Beneficiaries would have 60 days from the date of their eligibility determination to make this payment.
Retroactive Coverage:	Seeks waiver of retroactive eligibility so that coverage would begin no earlier than 1st day of month of application.
Premiums and Lock-Out for Non-Payment:	Would require monthly premiums for traditional adults (such as parents, former foster care youth, those receiving TMA, people with breast/cervical cancer) as follows: 0-100% FPL ($1,701/month for a family of 3 in 2017) = $14 101%-200% FPL ($1,719-$3,403/month) = $43 201% and above ($3,420+/month) = $66 Beneficiaries may be disenrolled for nonpayment of premiums (after a grace period of no less than 60 days) and locked out of coverage for 90 days. Disenrolled beneficiaries may re-enroll after lock-out period only if they pay any past-due amounts. The same exemptions that apply to the work requirement (described below) apply to premiums. In addition, people eligible based on HIV status are exempt from premiums. Seeks to charge premiums without regard to the total cost-sharing limit of 5% of income (point-of-service copayments would remain subject to 5% limit)
Co-Payments:	Beneficiaries would continue to be subject to point-of-service cost sharing at state plan amounts up to 5% of quarterly household income. All beneficiaries (except for dual eligible beneficiaries who do not receive full Medicaid benefits) would be subject to $20 copayment for use of the emergency room that does not result in an inpatient admission. The state would collect these payments after periodic claims reviews; payments to providers would not be decreased. Seeks authority to allow providers to charge beneficiaries for missed appointments, according to the provider's "standard office policy." However, the missed appointment fee could not exceed the Medicaid reimbursement amount for the service that would have been delivered.
Work Requirement:	Would require traditional adults (such as parents, former foster care youth, those receiving TMA, people with breast/cervical cancer or HIV)) ages 19-64 to meet a work requirement. The following activities would comply: paid employment at least 20 hours per week (averaged monthly), approved job training program at least 20 hours per week, volunteer work at least 24 hours per month, enrollment at an academic institution at least half time, combination of work and education that meets the 20 hours per week threshold, receive unemployment benefits, or provide caregiver services for a non-dependent person with disability *if* also coupled with career planning in this area.

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Element	**Maine Proposed Waiver**
	Beneficiaries would be exempt from the work requirement (and premium requirement) if they reside in an institutional or residential facility; reside in a residential substance abuse treatment and rehabilitation program; care for a dependent with a disability *or* dependent under age six; are pregnant; are physically or mentally unable to work 20 or more hours per week; or are receiving temporary or permanent public or private disability benefits.
Time Limit on Eligibility:	Coverage for traditional adults (such as parents, former foster care youth, those receiving TMA, people with breast/cervical cancer or HIV) would be limited to no more than 3 months in a 36-month period unless beneficiaries comply with work requirement (described above). Coverage for an additional month (beyond the three months) may be authorized in exceptional circumstances and the state may provide additional exemptions with a determination of good cause.
Next Steps:	The state's 30-day public comment period closes on May 25, 2017. Public hearings are being held on May 17, 2017 (Portland, ME) and May 18, 2017 (Augusta, ME).

NOTE: [i] Eligibility groups that would be affected by proposed work requirements and premiums include the following mandatory categorically needy groups: low income families, parents/caretaker relatives, transitional medical assistance (TMA), extended Medicaid due to child or spousal support collections (no work requirement for this group), former foster care children AND the following optional categorically needy groups: certain women needing treatment for breast or cervical cancer, individuals eligible for family planning services, reasonable classifications of individuals under age 21, medically needy individuals age 18 through 20, medically needy parents and other caretaker relatives, and special benefits waiver (HIV waiver) (no premium requirement for this group).

SOURCE: 1115 Waiver Application Department of Health and Human Services State of Maine.