

SECTION 1115 MEDICAID EXPANSION WAIVERS: IMPLEMENTATION EXPERIENCES

Findings from structured interviews in Arkansas, Indiana, Iowa, & Michigan

FINAL REPORT

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TABLE OF CONTENTS

- 1. ACKNOWLEDGEMENTS.....1**
- 2. EXECUTIVE SUMMARY.....2**
- 3. INTRODUCTION.....4**
- 4. BACKGROUND.....5**
 - Arkansas 6
 - Indiana 7
 - Iowa..... 8
 - Michigan..... 9
- 5. IMPLEMENTATION EXPERIENCES10**
 - Exchange Plan Premium Assistance (Arkansas & Iowa)..... 10
 - Enrollee Contributions (Iowa & Michigan)..... 19
 - Health Savings Accounts (Arkansas & Indiana)..... 24
 - Healthy Behavior Incentives (Indiana, Iowa, & Michigan)..... 30
 - Graduated Copayments for Emergency Department Use (Indiana)..... 34
- 6. DISCUSSION THEMES.....36**
 - These waiver programs were more administratively complex than traditional Medicaid, but the effort was worthwhile in order to expand access to coverage. 36
 - The value in waiver-based Medicaid expansions is testing approaches to incentivize behavior change, not necessarily to save the state money. 36
 - Involving operational staff in the waiver design process as early as possible may help to ensure policy goals are achievable. 37
 - Building off of existing capacity and infrastructure made implementation manageable under short timelines, but it was not necessarily efficient. 38
 - Significant administrative resources were needed to implement and support ongoing operations of these new programs. 39
 - Considerable IT system redesign was required to develop and maintain programs. 39
 - The complexity of policy provisions being tested meant that targeted and ongoing member outreach was essential, but also an ongoing challenge. 40
 - Despite a need for substantial communication and negotiation with states, health plans generally felt equipped to take on additional implementation responsibilities. 41
- 7. FUTURE CONSIDERATIONS.....42**
- 8. CONCLUSIONS.....43**
- APPENDIX A: DISCUSSION METHODOLOGY A1**
- APPENDIX B: DISCUSSION GUIDES B1**
 - Arkansas B1
 - Indiana B3
 - Iowa..... B6
 - Michigan..... B9

1. ACKNOWLEDGEMENTS

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The findings, statements, and views expressed in this report are those of the authors and do not necessarily reflect those of MACPAC.

2. EXECUTIVE SUMMARY

This report was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota under contract to the Medicaid and CHIP Payment and Access Commission (MACPAC). The purpose of the study was to understand how the states of Arkansas, Indiana, Iowa, and Michigan approached the implementation of their Section 1115 Medicaid expansion waivers. The objective was to identify the steps states took to operationalize their programs, not to evaluate the impact of waiver provisions. SHADAC conducted interviews with 33 individuals representing current and former state agency staff and health insurance carriers involved in implementation in the four study states. The interviews focused on the following waiver program elements:

- Exchange plan premium assistance (Arkansas & Iowa)
- Enrollee contributions (Iowa & Michigan)
- Health savings accounts (Arkansas & Indiana)
- Healthy behavior incentives (Indiana, Iowa, & Michigan)
- Graduated copayments for emergency department use (Indiana)

This report provides background information on the waiver program elements implemented in each of the four study states, summarizes the key pieces of administrative capacity that states put in place to implement their waivers, and details the specific program challenges they faced. As interviewees reflected on implementation efforts and challenges, they identified several key themes:

- **These waiver programs were more administratively complex than traditional Medicaid, but the effort was worthwhile in order to expand access to coverage**, when doing so through traditional Medicaid would have been politically difficult.
- **The value in waiver-based Medicaid expansions is testing approaches to incentivize behavior change, not necessarily to save the state money.** Interviewees were not able to provide information about the total costs for administering their waiver programs at the time of interviews. Some states reported that because their program utilized existing infrastructure and staff, or because administrative functions were delegated to contractors, they were not able to directly calculate total administrative costs. Multiple interviewees acknowledged that even without having detailed information on the total administrative costs, they knew the state was spending more to administer the program than it was receiving in member contributions. As a result, several interviewees cautioned states considering similar waiver-based Medicaid policies to weigh the value of testing new approaches to incentivize behavior change with the costs and resources necessary for programmatic changes.
- **Involving operational staff in the waiver design process as early as possible may help to ensure policy goals are achievable.** Interviewees noted that in several cases, the waiver policies designed by state legislative bodies ultimately created administrative and operational difficulties for those who had to implement them. Policies were frequently designed with specific political goals in mind (for example, promoting individual responsibility through cost-sharing requirements), rather than how they would be administered. Interviewees encouraged legislators who are considering similar waiver programs to involve operational staff early on in the design process in order to ensure expectations about timelines, cost, and outcomes are achievable.

- **Building off of existing capacity and infrastructure made implementation manageable under short timelines, but it was not necessarily efficient.** Short implementation timelines, sometimes no more than three months between when a state’s waiver was approved and when a program needed to be operational, as well as last-minute changes from state legislators, created challenges for the study states. Due to time constraints, states often had to make do with existing technology platforms or information systems rather than creating better systems from scratch. This allowed states to get functional systems up and running, but it also was inefficient and sometimes led to unanticipated problems that required considerable staff time to address later in the process.
- **Significant administrative resources were needed to implement and support ongoing operations of these new programs.** Interviewees in all states commented on the heavy administrative lift required to implement their waiver provisions. To do so, most states repurposed existing staff or relied heavily on contractors to get programs up and running. Although the intensity of effort diminished over time, interviewees noted that there were significant ongoing costs. Even those states that delegated most of the administrative functions to third parties, such as health plans or fiscal intermediaries, reported devoting extensive time and resources to addressing technical issues and ongoing coordination, education, outreach, and monitoring efforts.
- **Considerable IT system redesign was required to develop and maintain programs.** Significant effort was required by IT systems staff to implement and monitor the waiver programs. Interviewees called out the importance of taking the time, often substantial, to complete user testing of the end product in order to ensure processes worked as intended. Often there was a tension between the need for adequate development time and the pressure to implement new policy in a timely manner. The ability to access skilled in-house data warehouse staff was cited as a key facilitator.
- **The complexity of policy provisions being tested meant that targeted and ongoing member outreach was essential, but also an ongoing challenge.** Interviewees from all four study states reported dedicating significant resources to ongoing member outreach, education, and communication efforts. Several interviewees reported experiencing higher call volumes and longer call times compared to other lines of Medicaid business due to the administrative complexity of the waiver provisions. In addition, consequences for nonpayment of premiums, such as dis-enrollment, meant that not effectively communicating with beneficiaries had greater consequences for enrollees in waiver states. The continual enrollment of new beneficiaries, the churn of beneficiaries cycling in and out of the program, and the complexity of program requirements required engaging beneficiaries multiple times and via multiple mechanisms.
- **Despite a need for substantial communication and negotiation with states, health plans generally felt equipped to take on additional implementation responsibilities.** Health plans that had previous experience with the Medicaid population, or existing relationships with state officials, generally reported fewer challenges implementing waiver program elements. Those that did not reported more challenges during the implementation process. In some cases, however, it was difficult to distinguish whether the challenges were attributable to the specific waiver program or whether these were typical Medicaid or managed care-related challenges that were simply new to these waiver states. Several health plans also noted that negotiations with states over rates and responsibilities for these programs are ongoing.

3. INTRODUCTION

Since the implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) in 2014, 33 states have expanded their Medicaid programs to certain non-disabled adults. Twenty-five of these states expanded through a traditional approach as envisioned by the ACA, and eight states expanded coverage through an alternative approach allowed under Section 1115 of the Social Security Act.¹ Many states see these alternative approaches to expansion as a politically viable way to expand coverage to low-income adults.

The completion of a state-led evaluation is a mandatory component of Section 1115 waivers. In many cases, the Centers for Medicare & Medicaid Services (CMS) also sponsor state-specific and cross-state evaluations.² These evaluations typically focus on the impact of the waiver provisions on program costs and beneficiary experiences, however questions related to implementation are beyond the scope of required evaluations. In addition, to date, the current evaluations lack detail on whether states implemented all provisions of their waivers as initially planned.

Information about the administrative burden, related financial costs, and states' experiences in implementing their 1115 waivers is important for state and federal policymakers. Assessing 1115 waivers through this lens could help policymakers interpret the evaluation results from current waiver states, aid in decisions about whether to pursue specific waiver provisions, and inform the design and implementation of these waivers moving forward.

The purpose of this study was to understand how the states of Arkansas, Indiana, Iowa, and Michigan have approached the development, implementation, and management of innovative waiver policies, and to provide insight into implementation-related issues such as the following:

- What administrative (e.g., staffing, interdepartmental communication, IT systems, etc.) elements were needed to implement the policies?
- What expected and unexpected challenges arose?
- How did states respond to challenges? What solutions worked, or how did they adapt their policies?
- What considerations should other states take when designing and implementing waivers?

To address these questions, SHADAC conducted interviews with 33 individuals representing current and former state agency staff and health insurance carriers involved in waiver program implementation in the study states. The following report provides background information on the waiver program elements implemented in each of the four study states, and summarizes the state administrative capacity needs as well as the challenges faced. It also presents the key themes identified through discussions with study interviewees. Additional detailed information on the study methods and interview guides can be found in Appendices A and B, respectively.

¹ As of February 1, 2018, 33 states (including the District of Columbia) have expanded their Medicaid programs. Currently, 25 states operate under traditional expansions, and eight operate under 1115 waivers, including Arizona, Arkansas, Indiana, Iowa, Kentucky, Michigan, Montana, and New Hampshire. In some cases, states have changed their Medicaid expansion approaches. For example, Pennsylvania began its expansion with an 1115 waiver and transitioned to a traditional approach. Additionally, Arizona, Kentucky, and New Hampshire transitioned from initial traditional expansions to waiver-based expansions. Maine adopted Medicaid expansion through a ballot initiative in November 2017, which requires submission of a state plan amendment within 90 days and implementation within 180 days.

² Centers for Medicare and Medicaid Services. "Section 1115 Demonstrations." Available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/mt/help-program/mt-help-program-fed-state-eval-dsgn-051617.pdf>

4. BACKGROUND

Section 1115 of the Social Security Act gives states the opportunity to apply for demonstration waivers to test policies in their Medicaid programs that typically are not allowed under federal rules. Historically, states have used these waivers to adjust eligibility rules, restructure benefits, modify provider payments, cover specific populations or services, or extend coverage during an emergency.³ Section 1115 waivers are authorized as time-limited demonstration projects and are typically approved for a period of five years.^{4,5} While each of the approved ACA Medicaid expansion 1115 waivers is distinct, many contain similar provisions. For example, several states have used waivers to test policies such as premium assistance programs to purchase exchange or employer-based plans for Medicaid beneficiaries, requiring beneficiaries to contribute to health savings-style accounts, and implementing healthy behavior incentives. Table 1 provides an overview of the provisions that were examined in each of the four study states: Arkansas, Indiana, Iowa, and Michigan.

Table 1: Major Provisions in Section 1115 Waivers of Study States

State	Enrollee contributions		Exchange plan premium assistance	Healthy behavior incentive	Graduated copayments for non-emergency ED use
	Premiums	Savings-account contributions			
Arkansas	No ⁱ	Yes — Partially implemented, discontinued Tiered based on income, with copayment exemption for making payments: <ul style="list-style-type: none"> • 50–100%FPL — \$5 per month • 101–115% FPL — \$10 per month • 116–129% FPL — \$17.50 per month • 130–138%* FPL — \$25 per month NOTE: <u>Never implemented</u> for 50–100% FPL; <u>discontinued</u> for all groups in 2016.	Yes	No	No
Indiana	Yes (see savings account contributions) ⁱⁱ	Yes — Monthly contributions based on income:ⁱⁱⁱ <ul style="list-style-type: none"> • 0–5% FPL — \$1 per month • 6–138%* FPL — 2% of income 	No	Yes	Yes
Iowa	Yes — Tiered based on income: <ul style="list-style-type: none"> • 0–49% FPL — none • 50–100% FPL — \$5 per month • 101–138%* FPL — \$10 per month 	No	Yes — Discontinued In 2014, enrollees with incomes from 101–138%* FPL were required to enroll in state’s premium-assistance program to purchase exchange plans. NOTE: <u>Became voluntary</u> in 2015 and <u>discontinued</u> in 2016	Yes	No
Michigan	Yes (see savings – account contributions) ⁱⁱ	Yes — Monthly contributions based on income:^{iv} <ul style="list-style-type: none"> • 101–138%* FPL — 2% of income Monthly billing through savings account for copayments incurred for use of services during prior 6 months	No — State plans to implement an exchange plan premium-assistance program in April 2018.	Yes	No

³ Medicaid and CHIP Payment and Access Commission. “Program Administration – Waivers.” Available at: <https://www.macpac.gov/subtopic/waivers/>

⁴ While 1115 waivers are time-limited, they may be extended upon approval by the Secretary.

⁵ Centers for Medicare and Medicaid Services. “Section 1115 Demonstrations.” Available at: <https://www.medicare.gov/medicaid/section-1115-demo/index.html>

Table 1 Notes:

* In accordance with the ACA, income of the expansion population is calculated using the Modified Adjusted Gross Income (MAGI) methodology. When applied, MAGI includes a five percentage point of the FPL disregard which makes the effective minimum income limit five percentage points higher. So, while states' waiver applications reference individuals with incomes at 133 percent FPL, they effectively include individuals with incomes up to and including 138 percent FPL. For consistency in this report, all states' income levels include the five percent disregard.

ⁱ Arkansas began charging premiums in 2017 for enrollees with incomes between 100 percent and 138 percent FPL, but that was not addressed in this study.

ⁱⁱ Indiana and Michigan at times refer to monthly income-based payments by enrollees with incomes from 100 to 138 percent FPL as both "premiums" and "contributions," but are classified here as account contributions because they are placed in enrollees' HSA-style POWER and MI Health Accounts.

ⁱⁱⁱ Indiana implemented a new premium structure with rates based on income ranges (rather than percent of income) in December 2017; however, discussions for this study focused on the two percent of income requirements.

^{iv} Michigan requires that enrollees of all income levels contribute copayments for use of health care services to their MI Health Accounts. However, some groups (e.g., under age 21, individuals residing in a nursing facility, Native American Indians, etc.) and services (emergency, family planning, preventive) are exempt from copayment requirements. Instead of collecting copayments at the point of service to providers, as is typical, enrollees in Michigan's program are instead billed monthly for their use of services during the prior six months.

Arkansas

Arkansas expanded its Medicaid program to the Affordable Care Act's new adult group in January 2014 via a Section 1115 waiver. The program, called the Arkansas Health Care Independence Program (also commonly called the private option), included two main components: 1) exchange plan premium assistance and 2) health independence accounts, modeled on health savings accounts (HSAs).

Under its private option premium assistance program, the state uses Medicaid funds to purchase coverage from exchange plans available on the health insurance exchange. One rationale was that this arrangement would reduce potential negative effects of churn. That is, Medicaid beneficiaries could continue coverage with the same plan even if their incomes changed.⁶ Unlike some other states, Arkansas enrolled beneficiaries in exchange premium assistance regardless of their income level. However, those considered medically frail were exempt from the private option and were supposed to be enrolled in the state's traditional Medicaid program. To identify people considered medically frail, the state developed a screening tool (i.e., a questionnaire) to be completed by applicants, and a transfer protocol to traditional Medicaid coverage for those beneficiaries who were identified as medically frail after having enrolled in an exchange plan.

The state's waiver also created Health Independence Accounts to allow individuals to save money for medical costs. Arkansas originally intended to require beneficiaries with incomes from 50 to 138 percent of the federal poverty level (FPL) to make monthly contributions to their Health Independence Accounts (ranging from \$5 to \$25 per month, depending on income).⁷ Beneficiaries used debit cards associated with their Independence Accounts, called MyIndyCards, to make point-of-service copayments using their contributions and funds contributed by the state. If beneficiaries did not make their contributions, they were responsible for paying any cost-sharing out of pocket. The state began by implementing Health Independence Accounts for beneficiaries with incomes from 101 to 138 percent FPL, planning to expand that component to lower-income beneficiaries later. However, the state did not implement account contributions for beneficiaries with incomes from 50 to 100 percent FPL, and it discontinued the accounts for other beneficiaries with incomes from 101 to 138 percent FPL in 2016.

⁶ Although health coverage provided to private option enrollees was nearly identical to the exchange plans generally available on the state's health insurance Marketplace, there were minor differences. For example, the state provided Non-Emergency Medical Transportation (NEMT) as a wrap-around benefit to Medicaid beneficiaries in addition to the regular exchange plan benefits.

⁷ Total costs of out-of-pocket spending could exceed 5 percent of income, consistent with traditional Medicaid.

Indiana

Indiana expanded its Medicaid program in February 2015 via a Section 1115 waiver called the Healthy Indiana Plan (HIP). The state's program is often called HIP 2.0 because it was based on the design of an earlier, pre-ACA Medicaid expansion that also employed a Section 1115 waiver, now commonly called HIP 1.0. Indiana's waiver is largely structured around an HSA-style component, called Personal Wellness and Responsibility (POWER) Accounts, and the monthly contributions that beneficiaries are required to make to those accounts. The state's waiver also includes other notable components, such as healthy behavior incentives and graduated copayments for non-emergency use of the emergency department (ED).

Under Indiana's HIP 2.0 program, all beneficiaries are required to make monthly contributions to their POWER Accounts, although the amount of those contributions varies based on income.⁸ Beneficiaries with incomes from 0 to 5 percent FPL must contribute \$1 per month, and those with incomes from 6 to 138 percent FPL must contribute 2 percent of their monthly income.⁹ If beneficiaries do not pay their monthly contributions, they incur penalties that also vary based on income; those with incomes from 101 to 138 percent FPL are dis-enrolled from the program and locked out from re-enrolling for six months, while those with incomes from 0 to 100 percent FPL are transferred out of the program's HIP Plus plan (a plan with more-generous benefits, such as vision and dental coverage) and into the HIP Basic plan (a plan with fewer benefits and traditional copayments).

Beneficiaries' POWER Accounts are used to cover the first \$2,500 in health care costs (excluding preventive services). State contributions fund the remaining amount after the enrollee's required contribution. If beneficiaries' use of health care services exceeds the \$2,500 balance, then Medicaid managed care organizations cover the remaining costs. The waiver also includes policies that use POWER Accounts to encourage certain behaviors. For example, if a beneficiary's POWER Account still has a positive balance at the end of his or her eligibility year (due to limiting his or her use of health care services), a portion of those funds may be rolled over into the next year, allowing beneficiaries to reduce or eliminate their required contributions. The state also adopted a healthy behavior incentive, which increases the amount of POWER Account funds that may roll over if a beneficiary meets healthy behavior criteria (e.g., obtains certain preventive health services).

Another unique component of Indiana's waiver is designed to discourage inefficient use of health care services by penalizing beneficiaries for non-emergency use of the ED. Through this provision, the first time a beneficiary uses an ED for a condition determined by the health care provider to be a non-emergency, the beneficiary is subject to an \$8 copayment to the ED provider. (Use of an ED for emergencies is not subject to a copayment.) On the second and subsequent uses of an ED for non-emergencies, the beneficiary is subject to a \$25 copayment to the ED provider.

⁸ Total costs of out-of-pocket spending cannot exceed 5 percent of income, consistent with traditional Medicaid.

⁹ Indiana implemented a new premium structure with rates based on income ranges (rather than percent of income) in December 2017. Beneficiaries with incomes below 5 percent FPL still contribute \$1 a month. Beneficiaries with incomes from 6 to 138 percent FPL contribute amounts equivalent to, or lower, than 2 percent of income.

Iowa

Iowa initially expanded its Medicaid program in January 2014 using a pair of Section 1115 waivers, which were used to implement different waiver programs to different populations based on beneficiaries' incomes. Under the Iowa Health and Wellness Plan Waiver, the state expanded coverage to beneficiaries with incomes from 0 to 100 percent FPL via a more traditional approach but with additional waiver-based elements, including enrollee contribution requirements and healthy behavior incentives. Through the Iowa Marketplace Choice Plan, the state expanded coverage to beneficiaries with incomes from 101 to 138 percent FPL via exchange plan premium assistance.

Health and Wellness Plan

Although the Iowa Health and Wellness Plan is largely based on the state's traditional Medicaid program, this waiver program includes two main components that differentiate it: first, the plan requires beneficiaries with incomes from 50 to 100 percent FPL to pay premiums of \$5 per month for their coverage after their first year of enrollment. (Premiums are waived for beneficiaries' first year of enrollment.) If beneficiaries with incomes from 50 to 100 percent FPL do not pay their premiums, they remain enrolled in the program, but their unpaid premiums become a debt to the state. Beneficiaries may request a financial hardship exemption from premiums. In addition, beneficiaries also have their premiums waived if they meet healthy behavior criteria—completing a health risk assessment and a wellness exam (either a physical exam or a preventive dental visit).

Marketplace Choice Plan

In 2014, beneficiaries with incomes from 101 to 138 percent FPL were enrolled in exchange plan premium assistance—effectively, beneficiaries were enrolled in exchange plans, and the premiums were paid with Medicaid funds.¹⁰ Like in the Health and Wellness Plan, the enrollees in Marketplace Choice were required to pay premiums of \$10 per month (also waived for beneficiaries' first year of enrollment). Also like the Health and Wellness Plan, beneficiaries in Marketplace Choice were eligible to have their premiums waived if they met healthy behavior criteria—completing a health risk assessment and a wellness exam—and could also request a financial hardship exemption. Unlike the lower-income beneficiaries in the Health and Wellness Plan, beneficiaries in Marketplace Choice could be dis-enrolled from the program for non-payment of premiums after a 90-day grace period. They were not subject to a lock-out period and could re-enroll in coverage at any time. Any unpaid premiums became a debt to the state.

Under Iowa's waiver, beneficiaries with incomes from 101 to 138 percent FPL were subject to mandatory enrollment in exchange premium assistance, but the waiver terms with CMS required that beneficiaries be given a choice between at least two exchange plans. In 2014, two health plans participated in Iowa's exchange statewide—and in the Marketplace Choice plan—and the state implemented the waiver as planned. For 2015, one of the plans participating in Marketplace Choice withdrew (CoOpportunity Health), so the state made enrollment in Marketplace Choice voluntary for beneficiaries because they did not have two exchange plan options. (Beneficiaries that opted out of Marketplace Choice were enrolled in the Health and Wellness Plan.) For 2016, the remaining plan participating in Marketplace Choice (Coventry) announced that it would not accept new beneficiaries through the program, so the state discontinued Marketplace Choice and enrolled those members in the Health and Wellness Plan. However, Health and Wellness plan beneficiaries with incomes from 101 to 138 percent FPL remain subject to higher monthly premiums (\$10 per month) and dis-enrollment for non-payment of premiums.

¹⁰ Like Arkansas, the state screened these eligible individuals to identify people who were medically frail and offered them the option to instead enroll in the Health and Wellness Plan, as well as exempting them from paying premiums.

Michigan

Michigan expanded its Medicaid program in April 2014 via a Section 1115 waiver that covered beneficiaries with incomes up to 138 percent of the FPL¹¹ through the state's existing Medicaid managed care system but with additional elements. Those main waiver elements are 1) beneficiary accounts modeled after HSAs called MI Health Accounts, 2) account contributions, and 3) healthy behavior incentives.

The Healthy Michigan waiver program established MI Health Accounts for beneficiaries of all income levels. Beneficiaries receive quarterly statements for their accounts, but their responsibility for account contributions differs based on income. Beneficiaries with incomes from 100 to 138 percent FPL are required to make monthly contributions of 2 percent of their incomes after six months of enrollment in the program. Managed care organizations may use those contributions to pay for their health care services.

Enrollees of all income levels (except for some groups such as those under age 21, individuals residing in a nursing facility, Native American Indians, etc.) are responsible for copayments based on their use of certain health care services over the past six months. Preventive services are exempt from these payments. These copayments are billed quarterly to beneficiaries rather than collected at the point of service by health care providers. If beneficiaries do not make their payments, they are not dis-enrolled from the program, but their unpaid amount becomes a debt to the state.

Through the state's healthy behavior incentive program, beneficiaries can receive rewards that are based on their incomes. Depending on whether and what types of healthy behaviors they engage in (e.g., complete a health risk assessment, agree to address or maintain certain health behaviors, obtain a preventive service, participate in a wellness program), beneficiaries with incomes at or below 100 percent FPL may receive a \$50 gift card and a 50 percent reduction in their copayments (once they have reached a level of paying 2 percent of their income in copayments). If beneficiaries with incomes from 100 to 138 percent FPL complete healthy behaviors, they may have their monthly contributions cut by 50 percent (from 2 percent to 1 percent of income).¹²

¹¹ In accordance with the ACA, income of the expansion population is calculated using the Modified Adjusted Gross Income (MAGI) methodology. When applied, MAGI includes a five percentage point of the FPL disregard which makes the effective minimum income limit five percentage points higher. So, while Michigan's waiver applications reference individuals with incomes at 133 percent FPL, they effectively include individuals with incomes up to and including 138 percent FPL.

¹² Although it has not yet been implemented, Michigan has obtained CMS approval to add a Marketplace premium assistance component to its waiver, which would give enrollees with incomes from 100 to 138 percent FPL the option of enrolling in premium assistance; however, under the new waiver provision, those enrollees would receive mandatory Marketplace premium assistance if they did not complete healthy behaviors.

5. IMPLEMENTATION EXPERIENCES

Interviews conducted with over 30 individuals in Arkansas, Indiana, Iowa, and Michigan revealed insights regarding their experiences implementing the following waiver provisions:

- Exchange plan premium assistance
- Enrollee contributions
- Health savings accounts
- Healthy behavior incentives
- Graduated copayments for emergency department use

Exchange Plan Premium Assistance (Arkansas & Iowa)

Both Arkansas and Iowa used Section 1115 waivers to allow Medicaid funds to pay exchange plan premiums for eligible adults. However, these two states faced very distinct challenges in administering their programs. Since implementing the private option in January 2014, Arkansas has maintained the participation of at least three health plan carriers in the exchange each year. After starting its program at the same time, Iowa ultimately discontinued its exchange plan premium assistance program in 2016 when the sole remaining Medicaid exchange plan carrier withdrew. Because Iowa's Marketplace Choice Plan is no longer offered, the main focus of this section is on Arkansas's experiences implementing its private option.

Administrative Capacity

In order to implement an exchange plan premium assistance program, Arkansas and Iowa undertook several key activities, including the following:

- Negotiating with plans on contract issues including rates, responsibilities, and oversight
- Calculating estimated advanced cost sharing payments to plans and establishing a subsequent reconciliation process to account for plans' actual cost-sharing reduction expenses
- Setting up an enrollment portal and processes for auto-assignment and identifying medically frail individuals
- Training enrollment and call-center staff to inform and enroll members
- Ongoing monitoring for network adequacy and other compliance issues

Both states had to address several administrative issues in order to carry out the key activities listed above. State staff, or where applicable, exchange plan staff, had to build staffing capacity, facilitate new communications and coordination efforts, establish new systems and processes (and resulting infrastructure), and manage associated costs – all of which required a number of steps and activities ([Box 1](#)).

Staffing

Interviewees from Arkansas and Iowa indicated that substantial staff time was required to implement premium assistance programs. In both states, the number of state staff dedicated to implementation efforts was minimal (four to seven full-time equivalent [FTE] employees, for example), but these staff spent the majority of their time on implementation.

While Iowa kept most implementation work in-house, a state legislative mandate prohibited the Arkansas Insurance Department, Department of Human Services, and Department of Health from hiring additional staff.¹³ As a result, Arkansas relied heavily on contractors for legal, policy, actuarial, and project facilitation support. Interviewees in Arkansas noted that overseeing all of the various contractors required significant state effort. In several cases, state officials reported they needed more help from their contractors than originally anticipated, which resulted in having to increase vendor contracts. One interviewee explained, “There were a number of issues we just didn't have internal capacity to do, like those types of sophisticated actuarial analyses, so we did rely on contractors pretty heavily. It seemed like we were amending contract hours about every year, too.”

Communication and Coordination Efforts

Interviewees in both Arkansas and Iowa reported dedicating considerable time to coordinating among stakeholders as part of their implementation efforts.

Arkansas state agency staff from both Medicaid and the insurance department oversaw multiple contractors and facilitated communications with health plans through weekly face-to-face meetings for two years. Because Arkansas did not already employ managed care in its Medicaid program, relationships between the Medicaid agency and the health insurance carriers had to be established during the design and implementation process.

Similarly, state Medicaid agency staff in Iowa reported working closely, through regular meetings, with their insurance department and the two health plans that offered the Marketplace Choice Plans to Medicaid beneficiaries.

Systems & Processes

Many new administratively complex systems and processes had to be put in place in order to operationalize both the private option and Marketplace Choice Plan programs. While those systems varied by state, they often involved a significant amount of legal, policy, and information technology (IT) work. Because Iowa's Marketplace Choice Plan is no longer offered and those systems and processes are no longer in place, they are not detailed here.

In order to operationalize the private option, Arkansas established mechanisms to ensure plan participation and effective oversight, enroll and assign individuals to plans, and reconcile payments to the health plans. Arkansas required exchange plans that participated in the state's marketplace to also participate in the Medicaid exchange plan assistance program. While there was no direct contractual relationship between Medicaid and the exchange plans in Arkansas, two memoranda of understanding (MOUs) were put in place to clarify issues such as how beneficiary complaints would be routed. This gave insurance carriers some comfort that they would not have to be answerable, at least directly, to two different regulating entities.

The state also created a web-based enrollment portal and a process to auto-assign beneficiaries to an exchange plan based on a targeted minimum market share in a region. The latter was explicitly intended to build competition in the exchange. Interviewees in Arkansas felt this guarantee of covered lives was also a strong participation incentive to the potential health plans. In order to identify medically frail individuals who would remain in traditional Medicaid, the state established a system to administer a health needs assessment screening questionnaire to individuals applying for coverage.

¹³ Ark. Act 257, § 16, 17 (March 7, 2014). Available at: <http://www.arkleg.state.ar.us/assembly/2013/2014F/Pages/BillInformation.aspx?measureno=SB111>

Arkansas also had to develop a complex reconciliation process in order to pay the health plans. The state pays an advanced cost-sharing reduction component to the carriers, based on factors such as history, age, region, and tobacco use of the beneficiaries. At the end of the year, the state reconciles these payments based on the plans' actual cost-sharing reduction expenses.

Setting up new systems required a significant amount of IT work within the state's Medicaid Management Information System (MMIS), such as creating read-only permissions for DHS staff so they could see in which plan beneficiaries were enrolled (so state staff could answer questions about enrollment status), implementing a transaction system to process premium payments, and creating the ability to generate notices for beneficiaries' status change. Interviewees from Arkansas indicated that while the IT system changes required for implementation were not necessarily technically difficult, they were time-consuming.

Costs

Interviewees in Arkansas were not aware of any information about the total costs (including the Medicaid agency, insurance department, contractors, and insurance carriers) of administering the private option. However, findings from the Arkansas Center for Health Improvement's 2016 Interim Evaluation Report suggest that commercial exchange plans' private option administrative costs are estimated to be an average of 18 percent of the total claims paid, excluding copayments and deductibles. Commercial exchange plans' administrative costs were estimated to be \$60.61 per member per month (PMPM), compared to \$55.37 PMPM for Medicaid—a 9.5 percent difference.¹⁴

Challenges

Health plans were reluctant to participate in Iowa's Marketplace Choice Plan, which led to the program's termination.

The major challenge Iowa faced implementing its Marketplace Choice Plan was health plans' unwillingness to offer products for Medicaid beneficiaries. Unlike Arkansas, Iowa did not require exchange plans to participate in its Medicaid plan. At the outset, two exchange plans participated in Iowa's Marketplace Choice Plan, but by 2016, both carriers had exited the exchange. In 2018, only one insurance carrier will remain in Iowa's exchange.¹⁵ Interviewees attributed the health plans' unwillingness to participate to two main factors: the influence of larger exchange dynamics occurring in the state, and health plans' reluctance to take on the additional risk of unknown costs of the new Medicaid beneficiaries.

One exchange dynamic that adversely affected Iowa's overall ACA exchange risk pool was the state's decision to permit transitional plans (pre-2014 plans that are not subject to ACA rules requiring comprehensive coverage and prohibiting charging premiums based on health status) to continue offering coverage. These plans make up an unusually large share of Iowa's individual market compared to other states.¹⁶ As a result, the population covered in the exchange was much sicker and older than anticipated. As one Iowa interviewee explained, "Outside of what was happening in the Medicaid world, [the exchange

¹⁴ Arkansas Center for Health Improvement, "Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report, June 16, 2016." Available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=357>

¹⁵ HealthCare.gov. "Rate Review Submissions." Available at:

<https://ratereview.healthcare.gov/#urrrresults?U2FsdGVkX1%2F%2Bm62UBixqWE68gNmD6hTpwhKQw0Qj0vxQptzNt%2Fms3NS2xoRXsrh0>

¹⁶ Approximately 72,000 individuals were covered in ACA-compliant plans in 2017, while 85,000 individuals were covered outside the exchange. Iowa Insurance Division. "The State of Iowa's Proposed Stopgap Measure for the Individual Health Insurance Market." 2017. Available at: http://premiumtaxcredits.wikispaces.com/file/view/state_of_iowa_proposed_stopgap_measure_6.12.2017.pdf/614576159/state_of_iowa_proposed_stopgap_measure_6.12.2017.pdf

plans] were having difficulties in the exchange. So they were no longer viable options for the exchange, which then made them not viable options for participation in the Marketplace Choice option.”

Interviewees in Iowa also believed that health plans were reluctant to participate in the Marketplace Choice plan because they were hesitant to take on additional risk from unknown Medicaid beneficiary costs on top of their unknown exchange costs. Prior to the Marketplace Choice Plan, Iowa health plans had limited experience covering low-income adults, making it difficult for them to predict Medicaid beneficiaries’ costs. An interviewee commented, “In hindsight the idea of having Medicaid coverage through a health insurance plan was problematic because it put those plans that accepted the higher risk Medicaid participants at a disadvantage compared with those folks who weren’t taking on Medicaid lives and therefore didn’t have quite as much risk built into their overall population.”

One Iowa interviewee noted that the state may have had better success if health plans had been required to participate in Marketplace Choice if they participated in the exchange at all, similar to what Arkansas required. In Arkansas, one interviewee noted this regulatory lever was a powerful facilitator in ensuring plan participation and the overall success of their waiver program. “We probably have one of the most stable individual exchanges because we could put Medicaid down inside of it with a lot of covered lives, and they were a guaranteed purchaser. They were going to pay every month until the individuals redetermined the next 12 months. So unlike an individual that’s writing a check every month and might not next month, Medicaid was a guaranteed purchaser, and that made it attractive for the carriers also.” Interviewees in Arkansas also felt that this requirement helped minimize churn by creating continuity in plan options for individuals who shifted between the eligibility thresholds for the Medicaid private option and exchange plans.

In Arkansas, divergent views across the Medicaid agency, insurance department, and health plans about the state’s role in the exchange made negotiations about the private option time-consuming.

The state Medicaid agency and the Arkansas Insurance Department did not have previous relationships before implementing the private option because Arkansas was not a Medicaid managed care state. Building those relationships and joint decision-making processes to implement the private option was difficult and time-consuming, requiring extensive communication and coordination. Several interviewees noted that implementing the private option required all parties to bridge a significant cultural divide in how they approached the design and implementation work; and the culture gap often went beyond legal and administrative issues to include differing views on the concepts of competition and the use of state purchasing power in the exchange. One interviewee shared, “Our Medicaid program really didn’t have much knowledge of the way insurance worked. And on the insurance department side, they had almost no knowledge of the way Medicaid worked. And we were effectively marrying the Medicaid program, which is a guaranteed benefit, with retrospective eligibility and all the other stuff that came with Medicaid, with a new insurance policy that was a yet unproven actuarial risk pool.”

Interviewees also recalled spending considerable time discussing fundamental questions about whether the private option policies administered by the exchange plans would be treated as commercial insurance or Medicaid, what information could or could not be shared between Medicaid and the private insurers, and how to define a benefit. One health plan representative recalled, “Working through the essential health benefits was more time-consuming than the enrollment process.”

Considerable face-to-face communication, including weekly multi-hour meetings in the two years leading up to implementation, were required in order to address the tension and culture gap that existed across the Medicaid agency, the insurance department, and the health plans. One interviewee recalled that at least 50 percent of his time was spent just on translational and shuttle diplomacy back and forth between the Medicaid agency and the insurance department. An interviewee in Arkansas commented, “It’s like a marriage, you’ve got to keep talking every day. Plan for it to take a lot of time and just keep talking and realize that you’re coming from different cultures.”

Arkansas’s short implementation timeframe created pressure to make decisions rapidly, sometimes without all the needed information.

Many interviewees noted that the tight implementation timeline between the program design and implementation, in conjunction with the significant relationship-building required as described above, made operationalizing the program challenging. The Arkansas legislature passed enabling legislation, the Health Care Independence Act, in April 2013. Five months later, the state’s waiver was approved on September 27, open enrollment began October 1, and private option coverage became effective January 1, 2014. One interviewee commented, “We didn’t have the luxury of a lot of lead time, which resulted in us just finding processes that we could build on that already existed in our system.”

To keep implementation moving forward, decisions had to be made quickly, sometimes without all the information a state would have preferred for a fuller understanding of their effects. For example, Arkansas did not have access to economic actuarial modeling prior to implementation. Interviewees shared that the implementation decision-making process was facilitated by holding an unprecedented amount of face-to-face meetings between Medicaid, the insurance department, and executive branch agency heads who were able to make quick decisions in the room together at the same time. Holding regular meetings helped the process but did not guarantee smooth sailing. As one interviewee noted, “In addition to the forced marriage and the different languages and different perspectives, we were on a pretty incredible timeframe. And almost every week [we] had a major crisis to the point that the train was about to go off the track.”

Health plans did not have experience pricing ACA-covered services for the population, which made rate setting difficult.

Health plans in both Iowa and Arkansas did not have previous experience serving low-income adults, which made the negotiation process regarding pricing and defining covered services difficult and time-consuming. Multiple health plan representatives in Arkansas voiced concerns about the difficulty they had pricing essential health benefits as defined under the ACA, especially habilitative services, for the expansion population. Historically, habilitative services were not covered by group or individual plans. As a result, health plan actuaries did not have sufficient historical data to forecast costs for these benefits. One health plan representative explained, “We’ve always covered rehabilitation. Habilitative services is just maintaining. It’s not going to improve their function, it’s not going to improve their ability. So it’s always been non-covered. And once we had to cover it, we did not know the cost of that, how much of that service was going to be used. Everything else you have databases. We’re data wonks. This population expanded that beyond what our prior history was. Once we had two years’ worth of data, our actuaries are much more confident now in what they’re setting. But before that, it was the unknown. Actuaries don’t like unknown.”

Communicating with beneficiaries was difficult due to unreliable contact information, and addressing this required additional coordination between health plans and the state.

The transient nature of the expansion population (e.g., homeless, displaced, moving continually) meant that often the state and health plans did not have accurate addresses or contact information for enrollees. One health plan representative estimated that 35 percent of mail they sent to beneficiaries in the private option was returned. Because the state was considered the source of truth for addresses, however, health plans could not officially change beneficiaries' addresses.

Health plans realized early on that they needed to dedicate additional resources to consolidating updated contact information and sharing it with the state. One interviewee explained the lengths to which the health plans went to collect accurate contact information: "We immediately started spreadsheets and when we got return mail with new addresses on them, we had to send them to DHS and they would have to research. We tried to get our physicians, when enrollees come in, to confirm their address. Anything we could do to get an address for the member[s], especially those that needed ongoing case management."

In the process of searching for new addresses for beneficiaries, health plans recognized that there were instances in which an enrollee had an out-of-state address. To address this, health plans instituted a new process to search inbound claim files looking for out-of-state addresses. Health plans would report those to DHS so they could confirm whether the member was an Arkansas resident (i.e., had a beneficiary moved out-of-state, or did they temporarily become ill and stranded while traveling, etc.?).

Arkansas private option enrollees needed more member support than members of other programs or product lines, requiring plans and the state to substantially increase member services resources.

Both the state and health plans reported needing to enhance member services resources in order to handle questions from private option beneficiaries, or their providers, about their enrollment status. One health plan representative explained, "One of the things that we noticed immediately is that our average length of calls was significantly higher than our other product lines. A lot of that was we spent more time with them trying to educate them and help them understand. Some of these members had a really hard time understanding where the state's processes started and stopped with their enrollment system and then where we picked up. And they just knew they had a problem and many times they wouldn't know whether to call us or whether to call the state. And we would always try to facilitate helping them get to the root cause of the problem."

The state also recognized that they needed additional customer support resources, but were prohibited by state law from expending funds for the purpose of advertising, promoting, or encouraging enrollment in the private option. Instead, they partnered with Arkansas Foundation for Medical Care (AFMC) to develop a beneficiary relations line where individuals could call if they had questions about the private option. Due to Arkansas's limited administrative staffing capacity, interviewees reported that this relationship with AFMC was ultimately an extremely valuable one, and it has grown over time.

Arkansas's auto-enrollment process sent some medically-frail individuals to the private option rather than traditional Medicaid, creating problems for plans and confusion for some beneficiaries.

As a strategy to streamline enrollment, Arkansas used its Supplemental Nutrition Assistance Program (SNAP) eligibility information to identify and passively enroll potential private option members. Individuals who were eligible through SNAP and who did not actively enroll through the portal were auto-assigned to

one of the health plans based on several rules. Subsequently, individuals who were auto-assigned did not always complete the medically-frail screener and thus did not get screened out and sent to traditional Medicaid. This meant that health plans were not aware of the medical status of individuals who were enrolled in their plans until they began processing claims that indicated that those beneficiaries were medically frail. Regarding the auto-assignment and completing of the medically-frail questionnaire, one interviewee commented, “I wish I could tell you that it was perfect in its execution. But only half of the eligible people took the screener.”

Health plan staff also felt that not all the Division of County Operations staff in Arkansas’s 75 counties (who are responsible for Medicaid eligibility in Arkansas) had a clear understanding of how to handle newly eligible Medicaid beneficiaries when their annual review came up. Instead of leaving medically-frail individuals in traditional Medicaid (where they belonged), some were transitioned to the private option program immediately.

Early on in the implementation process, both the state and health plans recognized that these scenarios needed to be addressed, and they subsequently developed an explicit process for identifying participants who either developed or failed to identify an exceptional health need after enrollment. Health plans reported that establishing a direct communication line to the state care managers was a major facilitator toward transitioning individuals back to traditional Medicaid. However, several interviewees commented that this process resulted in significant confusion for some medically-frail members who were shuffled between Medicaid and the private option.

Retroactive eligibility terminations that occurred as a result of incomplete eligibility determinations or delayed redeterminations in Medicaid were difficult for health plans to manage within the commercial-insurance framework of the private option.

When the private option was implemented, individuals who were assessed as eligible for Medicaid were enrolled in private option plans while the Arkansas Department of Human Services processed their eligibility. Once Medicaid eligibility was determined, the effective date of coverage was retroactive to the date of application. However, due to incomplete income information, or a delay in processing eligibility determinations, large numbers of beneficiaries in Arkansas ended up being retroactively terminated from Medicaid after they had been enrolled. This resulted in the Department of Human Services taking back the premium payments that had been paid to health plans for those individuals when they enrolled.

Individuals whose private option coverage was cancelled retroactively created administrative challenges for health plans and providers, who did not have existing mechanisms to account for that. A beneficiary’s effective date could also change multiple times a month, which made it difficult for health plans to track who actually qualified for the program at any given time. One health plan representative explained, “Sometimes a member would go in and give the Division of County Operations only half the [eligibility] data, and so they’d terminate them. Then they’d go in two weeks later and have some more data, they’d put them back on. It was a continual process. Some people were pretty much revolving door members.”

In many cases, health plans in Arkansas paid claims for services, believing that the beneficiaries were enrolled in their program. When the state retroactively terminated large numbers of applications, health plans found themselves in situations where they had paid for services for individuals who should not have been covered. The state would subsequently claw-back that premium payment from the health plans, and the health plan would attempt to claw-back payments made to the providers. However, the health plans were limited in their ability to recoup payments from providers. A health plan representative explained,

“Retroactivity was our biggest issue for the first 18 months. We would have people retroactively terminated for more than a year. And by state law in Arkansas, we could only recoup money for a specific timeframe. So anything beyond that, we didn't get premium for that member, but we couldn't recoup the payments either.”

Another interviewee noted the magnitude of the retroactive termination problem health plans faced: “At one point in time the DHS here in Arkansas had over 110,000 applications to review. And they were pushing them through and there wasn't a lot of validation. And so they would push them through and we would get 3,000 members a month added to our plan and then three months later we'd get 2,000 of those retroactively terminated back to their effective date because they didn't qualify.”

Although retroactive claw-back of premiums initially caused considerable strain among Medicaid, insurance carriers, and providers, the state and health plans eventually worked out a reconciliation process that addressed the issue.

Several interviewees highlighted this example as one of the fundamental differences between Medicaid and commercial insurance. One interviewee commented, “So this is, again, back to that way the programs work differently. Medicaid is a guaranteed benefit while you're eligible. In the insurance world, you've got coverage as long as you've paid the bill. They [the health plans] had never heard of premiums being clawed back before.”

Box 1: Implementation Steps for Exchange Plan Premium Assistance

01 EXCHANGE PLAN PREMIUM ASSISTANCE: STAFFING CAPACITY

- **Existing state staff in Arkansas were repurposed and focused exclusively on implementation.** Four full-time equivalent (FTE) staff in the state Medicaid agency and three in the Arkansas Insurance Department (AID) were dedicated solely to implementation activities. Arkansas' legislative mandate specified that they could not add new staff nor advertise the private option; however, temporary Division of County Operations staff were brought on for six months to relieve an enrollment backlog.
- **Arkansas relied heavily on contractors for:**
 - **Legal & policy analysis.** Manatt completed a policy analysis examining the alignment of benefits and reimbursement schedules between private policies and Medicaid, and it identified what the Medicaid wrap-around benefit package would have to be for beneficiaries enrolled in exchange plans.
 - **Actuarial support.** Optumas provided actuarial modeling support for the cost-sharing reduction payments and budget neutrality calculations for the waiver.
 - **Enrollment portal build.** Hewlett Packard (Arkansas' MMIS vendor) built a new web-based enrollment portal (InsureArk.org) for eligible beneficiaries to select an exchange plan.
 - **Project facilitation.** The Arkansas Center for Health Improvement (ACHI) had contracts with Medicaid for policy support and to help navigate the waiver negotiation process, and AID to examine network adequacy issues. ACHI also was a member of the Plan Management Committee (see Communication and Coordination Efforts below) and served as a convener among stakeholders.
 - **Technical support.** Arkansas sought technical assistance from the U.S. Agency for Healthcare Research and Quality (AHRQ) to provide input on a High Risk Needs assessment tool used to identify medically-frail individuals who would stay in traditional Medicaid.
 - **Member support.** The Arkansas Foundation for Medical Care (AFMC) developed a beneficiary relations line where individuals could call if they had questions about the private option.
- **Iowa did not hire any new staff to implement Iowa's Marketplace Choice Plan.** Existing Department of Human Services staff handled all implementation activities.

Box 1: Implementation Steps for Exchange Plan Premium Assistance (cont.)

COMMUNICATIONS AND COORDINATION EFFORTS

- **In Arkansas, much of the waiver program implementation discussions happened within the Arkansas Insurance Department Plan Management Committee.** Arkansas structured its Plan Management Committee to be inclusive of legislators, providers, agents and brokers, patient advocates, community representatives, as well as Medicaid and insurers (including regulatory, operational, IT, and policy development representatives). Bi-weekly meetings of the Plan Management Committee were held to discuss benefit, coverage, and program administrative details.
- **Arkansas state inter-agency meetings were convened by an outside facilitator.** The Arkansas Center for Health Improvement (ACHI) facilitated regular meetings (every two weeks, roughly) to bring together key stakeholders from Medicaid and the insurance department to ensure everyone was consistently on the same page throughout the implementation process.
- **Iowa DHS regularly communicated and coordinated with the Insurance Division and the two health plans that offered exchange plan products.** Regular meetings were held to discuss policy issues, provider outreach strategies, necessary updates to eligibility systems and application processes, setting up IT infrastructure, as well as extensive contract negotiations with the exchange plans.

SYSTEMS AND PROCESSES ESTABLISHED

- **Memoranda of Understanding** were put in place between Arkansas Medicaid Agency and Arkansas Insurance Department (AID), and between AID, Medicaid, and the insurance carriers.
- **Arkansas built a web-based enrollment portal** (insurereark.org) that enables beneficiaries to select a marketplace plan.
- **Significant IT system modifications were made to Arkansas' Medicaid Management Information System (MMIS),** including the following:
 - Incorporating Supplemental Nutrition Assistance Program (SNAP) eligibility information to identify potential private option members
 - Algorithms to auto-assign beneficiaries to an exchange plan, in the event that they did not actively select a plan
 - Permissions for DHS staff to have read-only privileges so they could see in which plan people were enrolled
 - Edits to the MMIS claims payment system to implement a transaction system to process premium payments. Arkansas utilized IDE and X12 transactions. Changes or deletions occur through an 834 transaction, and payments are made through an 820 transaction.
 - Ability to complete edits and audits
 - Ability to generate notices for beneficiaries' status change
- **Arkansas had to transition from date-specific eligibility to month-to-month coverage in Medicaid** in order to align with the mechanics of private insurance (i.e., paying a premium for a month, not part of a month).
- **Arkansas established means for administering a screening tool to identify medically-frail beneficiaries.**
- **Arkansas established processes to communicate to beneficiaries about wrapped benefits.**
- **Arkansas established an annual cost-sharing reduction payment reconciliation process between carriers and the state.**

Enrollee Contributions (Iowa & Michigan)

This section presents the experiences of both Iowa and Michigan, which implemented new premium and monthly contribution programs through their Section 1115 waivers, Iowa’s Health and Wellness program and Michigan’s MI Health Account. While Indiana also implemented monthly beneficiary contributions under its waiver, its experiences requiring enrollee contributions are discussed in the context of its health savings accounts (i.e., POWER Accounts) in the next section of this report ([Health Savings Accounts](#)).

Administrative Capacity

In order to implement new enrollee contribution programs, Iowa and Michigan undertook several key activities, including the following:

- Establishing systems and processes to determine each enrollee’s required contribution based on their income level and—in Michigan—service use
- Designing invoice statements to convey contribution requirements to beneficiaries and educating them about the program
- Collecting payments and reconciling them with enrollee accounts
- Setting up processes to take appropriate action when enrollees do not pay their premiums

Both states had to address several administrative issues in order to carry out the key activities listed above. State staff, or where applicable, their contractors, had to build staffing capacity, facilitate new communications and coordination efforts, establish new systems and processes (and resulting infrastructure), and manage associated costs – all of which required a number of steps and activities ([Box 2](#)).

Staffing

Interviewees from both Iowa and Michigan indicated that the administrative lift required to implement new enrollee contribution programs was substantial. Iowa constructed and administered its premium collection process completely in-house with a small staff (approximately six FTEs) of data warehouse specialists. Interviewees in Iowa noted how fortunate they were to be able to leverage this skilled team. In addition to core data warehouse expertise, one team member had a banking background and was able to help the state operationalize its lock-box approach to collecting and applying premium payments. One Iowa representative noted, “In terms of hours I don’t have a number. But I can tell you it took a lot of hours to put it together. It really did. It was not a small effort.”

Although Michigan delegated responsibilities for collecting monthly contributions and copayments to a third-party vendor, state agency staff indicated that they also devoted significant staff time to designing and monitoring the program. State officials in Michigan were aware that their contracted enrollment broker had to significantly increase its call-center staff to support the program. Michigan’s managed care plans, however, reported that because most of the work to set up the MI Health Account resided with the enrollment broker, the health plans did not need to bring on additional staff to support that work.

Communication and Coordination

Interviewees in both Iowa and Michigan recalled the extensive amount of communication and coordination that was required to implement their programs, both between entities responsible for implementation—which often occurred in the form of regular in-person meetings among multiple stakeholders—and with beneficiaries. For example, Michigan coordinated with its contracted enrollment broker, which was already

collecting premiums for the state's CHIP program, to implement the MI Health Account. For over a year, state staff worked closely with both health plans and the broker to develop the collection system.

State staff in both Iowa and Michigan also noted the amount of work that was necessary to coordinate with their respective Departments of Treasury in order to establish processes to collect debts owed to the state (Iowa) or recoup state income tax or lottery winnings (Michigan) for individuals who failed to pay their premiums. Michigan has begun its collection process while Iowa is still working on implementation of that process.

Systems & Processes

Both Iowa and Michigan reported that implementing a premium collection system involved a substantial technical effort. In Iowa, a significant amount of IT work was required to create the databases, systems, and processes to establish the state's premium payment system. The state's premium payment system generates a monthly invoice for enrollees (based on a MMIS eligibility file) and applies and processes payments received from a payment lockbox. Manual processes have been created to handle overpayments, track missed payments, apply back-payments, and to send enrollees to collections.

Michigan's contracted enrollment broker instituted a process to calculate enrollees' monthly contribution based on 2 percent of income and copayment amounts based on utilization of health care services. The contracted enrollment broker then had to reconcile the copayments with the health plans. Michigan representatives noted that several modifications were needed to develop the MI Health Account statements, which summarized this information monthly for beneficiaries.

Costs

Both Iowa and Michigan leveraged existing vendor infrastructure and much of their existing staff; therefore, neither state could share specific information regarding how much it cost to administer their programs. State officials said they were aware of the increase in administrative expenses incurred by the state, but they were not able to provide exact amounts at the time of interviews. Michigan, for example, does not directly contract with its vendor to administer the MI Health Account. The Medicaid managed care plans all contract with a single third-party vendor for those services, and those costs are built into their rates. Interviewees from both Iowa and Michigan referenced, in general terms, needing to significantly increase resources for certain contracts, such as for IT development and call-centers, in order to support the implementation of their waiver programs.

Challenges

It was difficult to convey the concepts of premiums, account contributions, and retroactively billed cost-sharing in simple and meaningful ways to beneficiaries.

Interviewees from both Iowa and Michigan pointed out the difficulties they faced in explaining the contribution requirements to beneficiaries, as well as reaching them. They especially faced challenges in conveying how the various components of their programs worked together (e.g., that members could reduce their monthly contributions by completing healthy behavior activities), and the concept of first dollar coverage.¹⁷

Interviewees in both states reported investing significant time and effort in designing and refining a paper statement that could present a complex concept of payment for health care that includes rewards or incentives for engaging in healthy behaviors. Interviewees also acknowledged that some beneficiaries may

¹⁷ In Michigan, beneficiary contributions to the MI Health Account are not the first source of payment for health care services rendered. Health plans are responsible for 'first dollar' coverage of any covered services up to \$1,000 (minus the required amount of a beneficiary's annual contribution, which varies by individual).

not fully understand all of the complexities, and that state staff continue to evaluate and make changes to the statements as appropriate. For example, early findings from evaluation focus groups led Michigan to make changes to simplify the MI Health Account statements.

Interviewees from both Iowa and Michigan also reported needing to significantly increase resources spent on call-center staff and training to accommodate the new program and population. High call volumes, long call hold times, and high abandonment rates were common challenges that call centers faced when implementing their programs. Respondents also noted their concern with making sure call center staff were trained properly on the complex programs. Call-center staff in both Iowa and Michigan had to be trained regarding how to answer questions about the new invoices and statements.

Collecting and processing beneficiary payments is a time-intensive, administratively burdensome process.

Interviewees in both Iowa and Michigan mentioned the multiple challenges they faced in setting up systems and processes for collecting and, where applicable, applying premium or monthly contribution amounts to beneficiaries' accounts. Interviewees in Iowa noted the substantial amount of time state staff spent manually handling issues through a batch processing system where they would apply and process payments to batches of invoices monthly. One state staff explained, "The most difficult portion of the project was our batch processing, which was challenging because we went through multiple stages of applying payments and processing payments to make sure that the files that we received were not duplicating payments that we'd already received and applied. So just having all those safeguards built in caused a lot of overhead to the project. The batch processing really took the most time, we did it manually for probably a year."

To simplify the payment process for beneficiaries, interviewees in Michigan noted that they continue to evaluate opportunities to make additional payment options available, such as via credit card or online. However, because of the contractual arrangement between the state's managed care plans and the vendor they use to collect payments, all 11 plans must come to agreement on the payment mechanisms offered, and to date some of the plans feel it would be too costly to offer a credit-card payment option.

In contrast, Indiana (whose experiences with enrollee contributions is discussed further in the subsequent section: [Health Savings Accounts](#)) set out contractual obligations for participating managed care organizations in order to ensure beneficiaries had multiple opportunities to make account contributions, including credit-card, online, and via a mechanism to make cash payments through a no-fee MoneyGram capability. Health plans in Indiana report that a very high volume of their members (one health plan reported 63 percent) pay with a noncash option, mostly credit-card and online payments.

The limitations of claims data made calculating an average copayment amount based on prior utilization difficult in Michigan.

Beneficiaries in Michigan have cost-sharing obligations based on their average prior six months of copayments, billed at the end of each quarter, with payments due monthly. In order to calculate the average prior six months of copayments, the state's contractor had to implement a complex look-back process to analyze beneficiaries' claims. Interviewees noted that common limitations of working with claims data, such as time lags in data availability and completeness of the data, made that look-back process challenging. It took significant effort on the part of the state and its vendor to define a workable structure for those copayment calculations using data that was constantly changing.

Collecting unpaid premiums as debts to the state required more administrative work than originally anticipated, and in some cases it is not yet occurring.

Both Iowa and Michigan are authorized to treat and collect unpaid contributions as debts to the state, but they have experienced coordination challenges setting up the necessary procedures.¹⁸

Michigan had to establish a process to define which individuals would be sent to the Department of Treasury for the collection of tax offsets. State staff in Michigan made a decision based on a cost/benefit analysis that individuals who owed more than \$50, and who consistently failed to pay, would go to collections. That process involved setting up an interagency agreement with the Department of Treasury, establishing a process for sending the files, deciding where the garnished money would be held (i.e., the state or a bank), and having the legal department involved to make sure there were specific protections in place for beneficiaries.

Iowa continues to work on establishing its process for collection of non-payments, which is not yet operational. Interviewees noted that the processes and IT systems needed to support the collection of non-payments ended up requiring more administrative work than originally anticipated.

¹⁸ Both Iowa and Michigan have provisions in their waiver to allow for the collection of unpaid premiums. Michigan does not dis-enroll for failure to pay, but Iowa does for individuals between 101 percent and 138 percent FPL.

Box 2: Implementation Steps for Enrollee Contributions

02 ENROLLEE CONTRIBUTIONS: STAFFING CAPACITY

- **In Iowa, the systems and infrastructure to allow collection and administration of premiums were all constructed in-house.** The Iowa Department of Human Services (DHS) leveraged its existing Medicaid staff (approximately six FTEs including a project manager, several database developers, and an IT lead) to complete all design and technical work. Existing DHS mail-room staff assumed responsibilities for mailing invoices to enrollees.
- **State staff in Michigan oversaw the program concept and design;** however, the state's 11 Medicaid health plans contracted with the state's existing enrollment broker to complete the actual system design and to collect the monthly contributions and copays.

COMMUNICATIONS AND COORDINATION EFFORTS

- **Iowa instituted a working group that met regularly during implementation,** representing multiple areas within the Medicaid agency, including policy, legal, member services, and data warehouse.
- **Michigan reported spending over a year working closely with its enrollment broker and health plans,** designing its contribution and copayment collection system. It also reported carrying out extensive statewide outreach to providers.
- **Michigan state staff also communicated regularly with the Department of Treasury and representatives from the legal department.** Coordination among the departments was required to set up a collection process for individuals who failed to pay their premiums, and to make sure legal agreements were adequate.

SYSTEMS AND PROCESSES ESTABLISHED

- **Iowa created a premium payment system that generates a monthly invoice for enrollees** (based on a MMIS eligibility file) and applies and processes payments received from the payment lockbox. Manual processes have been created to handle overpayments, track missed payments, apply back-payments, or send enrollees to collections.
- **Iowa established a relationship with Wells Fargo bank** to create a payment lockbox where members remit their premium payments.
- **A process to calculate and reconcile enrollees' monthly contribution and copayment amounts was created in Michigan.** Michigan's contracted enrollment broker instituted a process to calculate enrollees' monthly contribution and copayment amounts based on utilization, and to reconcile the copays with the health plans.
- **MI Health Account statements were created and subsequently modified based on focus group feedback.** Michigan reported dedicating significant time to working with its contractor and the health plans to design and modify the MI Health Account statements.

Health Savings Accounts (Arkansas & Indiana)

Arkansas, Indiana, and Michigan all implemented health savings-style accounts (HSAs) through their waivers. This section focuses on the experiences of Arkansas and Indiana. Michigan’s experiences with the HSA feature of the MI Health Account were discussed as part of the previous section, [Enrollee Contributions](#).

Arkansas and Indiana started from very different points when implementing their HSA programs. Arkansas established a brand new program, called Health Independence Accounts. The state planned to implement them for beneficiaries with incomes from 50 to 138 percent FPL, but it took a phased approach of starting smaller with an intention of scaling up—beginning with beneficiaries with incomes from 101 to 138 percent FPL and planning to expand later to those with incomes from 50 to 100 percent FPL. However, the Health Independence Accounts only ran for 18 months in the higher-income group (without expanding to the lower-income group) before the state legislature ended the program in 2016. In contrast, Indiana expanded its use of an existing HSA-style program (called POWER Accounts) in its HIP 2.0 waiver based on its experiences with the longstanding (since 2008) HIP 1.0 waiver. Because Arkansas’ Health Independence accounts are no longer offered, the main focus of the following sections is on the steps Indiana took to implement its POWER Accounts.

Administrative Capacity

In order to implement health savings account programs, Arkansas and Indiana undertook several key activities, including the following:

- Setting up procedures for communicating with and educating beneficiaries (including account statement design)
- Establishing a process for collecting payments from beneficiaries
- Establishing a process for reconciling information about beneficiary information, contributions, and completion of healthy behaviors, etc. between the state and its vendors, including MCOs

To carry out these activities, state staff (or their contractors) had to build staffing capacity, facilitate new communications and coordination efforts, establish new systems and processes (and resulting infrastructure), and manage associated costs – all of which required a number of steps and activities ([Box 3](#)).

Staffing

Both Arkansas and Indiana delegated administration of their HSA programs to third-party contractors, and state staff reported spending considerable time overseeing those contracts and activities. For example, in Arkansas, one full-time staff person was solely devoted to overseeing the program, which was administered by a third-party vendor. One interviewee commented, “I would say one of our staff basically spent all of his time [implementing the Health Independence Accounts]. I can’t really emphasize enough for the little sliver of the program that this was, how much in terms of program and staff time it consumed.”¹⁹

Indiana delegated most of the responsibilities for administering the Healthy Indiana Plan (HIP) 2.0, and the associated POWER Accounts, to the state’s Medicaid managed care organizations (MCOs). While state Medicaid staff did not indicate a large administrative burden as a result of implementing HIP 2.0, they did report hiring additional state and county-level staff. Indiana also utilized health care navigators to help educate beneficiaries about HIP 2.0. The state Medicaid agency worked with the Department of

¹⁹ We did not talk to the Health Independence Account vendor in Arkansas about their experiences coordinating this program because it has been discontinued for over a year.

Insurance to make sure there was a HIP component to the navigators' certification and training and to require that navigators in Indiana take a special Indiana certification course.

The managed care plans interviewed said that they had to increase their staffing capacity in member services, outreach, billing, and IT infrastructure in order to implement HIP 2.0. Specifically, health plans reported needing to substantially increase resources dedicated to member services for HIP 2.0. For example, call center staffing was increased due to considerable increased call volume for HIP 2.0 members. One representative explained, "HIP had about seven times the call volume coming in compared to all of our other traditional Medicaid plans in other states. So we really had to staff up at a seven to one ratio initially. We're down to averaging about five to one."

Coordination and Communication

Interviewees in Indiana reported devoting considerable amounts of time to coordinating and communicating across the state and health plans, during the design and implementation phase and on an ongoing basis, but they cited their close existing relationship with health plans as a facilitator for their implementation efforts. One state staff member commented, "We had a manageable number of MCOs, not 20 or 12 or a larger number that makes it a little harder to be in close relationships with each one. And we had worked together over some of the Affordable Care Act changes, but I would say that the level of day to day interaction and the large group meetings with the same team of people representing different organizations, that was probably an unprecedented amount of interaction."

Health plan representatives involved in implementation of HIP 2.0 reported spending multiple hours two to three times a week meeting to construct administrative- and operational-level program details with state staff. For example, the state Medicaid team was very prescriptive in making sure each MCO's POWER Account invoices were conveying similar information in a simple and informative way.

In addition to the design and implementation meetings, Indiana state staff still hold weekly meetings where vendors discuss issues as they arise, as well as regular one-on-one executive-level meetings with health plans to discuss current issues or concerns with the program.

Systems & Processes

Indiana's health plans' prior experience from HIP 1.0 meant most systems and processes needed to be modified and expanded, not built from scratch. Three of the four MCOs in Indiana had administered HIP 1.0. Because of this, they indicated that they did not have to create new systems; however, they did have to significantly modify how they managed the POWER Account contributions in the systems that they had. One health plan representative explained, "There were a lot of capabilities that we had under HIP 1.0 that we had developed, the invoicing, the statements, those sorts of things, payments online. But we really expanded it with HIP 2.0."

The design of the program required that health plans have IT systems capable of reconciling information across health plans and the fiscal intermediary, DXE Technologies (DXE), regarding state and beneficiary contributions, beneficiary uses of health services, and account balances. Health plans reported making investments in IT infrastructure and billing processes in order to accurately reconcile the POWER Account contributions received from the state (via DXE) with the health plan's records to ensure that members received credit for the payments they made (and did not lose coverage) and that the health plans received the correct account contribution from the state. One health plan representative explained, "One of the first things we did was hire someone whose sole function is just to oversee everything having to do with a POWER Account. How they're being managed, how the reconciliation goes, kind of making sure all of the

cogs in the wheel are turning, and that the data that we're getting from the state matches with what we're showing in our system, which usually works and sometimes doesn't. Sometimes the files that we get from the state, occasionally there's one that's inaccurate, and then we have to go back and unbraided that. Because at the end of the day, obviously the number one concern is ensuring that any technology issue doesn't result in any kind of human impact as far as anybody losing coverage.”

To allow beneficiaries to make contributions more easily, health plans built on, or developed, a number of systems and processes. They created a third-party payment portal to allow employers, not for profits, churches, or other family members to make payments on an enrollee's behalf. Health plans also implemented a real-time transaction system with the state's enrollment program in order to accept a Fast Track²⁰ prepayment (via credit card) at the time of application. Because beneficiaries have only 60 days to make a payment from the date they receive their first invoice before they are enrolled in HIP Basic or locked out of coverage, health plans also established back-end processes to identify individuals were at risk of losing coverage due to non-payment, and outreach programs to remind them to pay.

Costs

Interviewees in Arkansas noted the high cost of administering the Health Independence Accounts, approximately \$9 million a year, in comparison to the small number of people who were using the accounts (only 7,000–8,000 out of 40,000 who were eligible). One interviewee explained, “The cost per person for this program ended up being just astronomical because the participation rates were never high. Nobody was participating and it was costing more to actually pay the company to collect the premiums from these people in order to put it in a Health Independence Account and give them these cards so that they could use them than it was actually saving any money.”

State staff in Indiana were unable to provide information on the administrative costs of the program. Health plans in Indiana receive a capitated payment, and the cost of administering HIP 2.0 components is included as part of the capitated rate they are paid each month. Health plan representatives indicated that the calculation of those rates continues to be an ongoing issue of concern, but not necessarily any more so for HIP 2.0 specifically than any of the traditional Medicaid programs. One interviewee explained, “When I talk to my colleagues in other states, it's always a moving target for them, too, and they don't have any of these types of programs. So I think you could look at any Medicaid program, hybrid, expansion or not, in any state, and that would probably be a familiar refrain [that] everyone is worrying about, or whether the payment rates are going to be adequate to cover the cost of care and the administrative side of things.”

Health plan representatives did note, however, that as they look to the state's next iteration of the 1115 waiver, they expect to have a very robust discussion with the state about who is going to be responsible for which operational and administrative tasks, and they want to request that rates be calculated ahead of time to ensure that they are adequate to cover any additional staffing or system changes. One interviewee noted, “That's always the big thing. Are the rates adequate to cover the additional administrative and operational costs? Or what efficiencies on the plan side can we put in place to lower those costs so that the state dollars go farther.”

²⁰ Fast Track is a payment option that allows for a \$10 prepayment at the time of application. This prepayment can help move up the effective date of coverage and enrollment in HIP Plus. Individuals who make a Fast Track payment and are eligible for HIP have their HIP Plus coverage begin at the first of the month in which they made their Fast Track payment. Individuals who do not make a Fast Track payment have 60 days to make either a Fast Track payment or POWER Account contribution, but their coverage will not begin until the first of the month in which they make the first payment.

Challenges

It was difficult to convey how the accounts operated in a way that was understandable and meaningful to beneficiaries.

Similar to the experiences of Michigan with the MI Health Accounts, multiple interviewees in Indiana noted the challenges their organizations faced in communicating and educating beneficiaries about how their POWER Accounts worked. Health plans reported having to completely overhaul their outreach and education strategies in order to reach the population, including revising member handbooks to include shorter, more focused pieces of information; offering more outbound education via social media and emails that link members to online resources; and providing additional training for call center staff to be able to communicate with new members about the details of the program, including explaining what a POWER Account was, how to make a payment, and offering to help members make a payment over the phone.

Although Indiana developed strategies for educating beneficiaries about program expectations, health plans had difficulty reaching people who were conditionally eligible.

Health plan representatives reported being successful in keeping beneficiaries enrolled once they started making payments, but not always in reaching and explaining to beneficiaries the importance of the first payment, which is required to begin coverage in HIP. If higher-income beneficiaries (101 to 138 percent FPL) fail to make their first payment, they are locked out of enrollment for six months before their coverage can begin. Those with lower incomes (0 to 100 percent FPL) who fail to make their first payment are moved to the HIP Basic plan after 60 days, with reduced benefits and extra cost-sharing.

Health plan representatives voiced concern about the number of individuals they saw who never made it out of conditional eligibility (i.e., did not make their first payment), and the challenge in addressing the ongoing problem. Health plans continue to struggle with connecting with beneficiaries in a timely way in order to educate those individuals on the importance of making their monthly contributions. One interviewee remarked, “I think that's kind of one of the challenges that if I could wave a wand, would be to figure out how do we better—and I don't know where the glitch is. Do we need better data or better outreach or what? How do we go from someone being deemed eligible by the State, and selecting their plan to then making that first payment?”

Small fluctuations in income required constant recalculations of enrollee contributions in Indiana.

Because required contributions in Indiana were based on 2 percent of enrollee income, monthly income fluctuations meant that plans had to recalculate premiums every month. As one health plan representative explained, “A lot of the changes [in income] were small. It could be a dime, a nickel a change. And it's not really impactful to either party but it is a lot of administrative burden to keep up with it.”

Monthly changes in POWER Account contributions also resulted in churn for some beneficiaries who lost coverage due to underpayment because their income, and subsequent contribution amount, had changed. As one interviewee explained, “I think the biggest risk is that we encourage people to pay upfront if they can. If you can pay \$12 for your whole year of coverage at once, that's obviously a lot better. But then the problem we have is what if someone pays \$12, and then three months in their income changes and then they really owe \$1.16 (not \$1) a month, and then their \$12 doesn't quite get them to the end of the year.”

In December 2017 Indiana implemented a new tiered premium approach in order to address these challenges.²¹ The tiered approach determines monthly contributions based on income ranges (e.g., 0 to 22 percent FPL) that are still approximately equal to 2 percent of income but do not require adjusting the contribution continuously. Several interviewees expressed their support for this change, noting “Hopefully this will also alleviate concerns we have with people losing coverage over what may be a very small amount of unpaid monthly contributions levels.”

Discrepancies that arise during the POWER Account balance reconciliation process are administratively burdensome to resolve.

Discrepancies between state and health plan records, particularly those regarding account balance amounts or member enrollment status, often surfaced during the POWER Account reconciliation process at the end of beneficiaries’ benefit period and had to be manually addressed. Interviewees in Indiana noted that reconciling account balances at the end of beneficiaries’ benefit periods is an ongoing, administratively challenging process because three different entities are involved in the reconciliation process. When the state Medicaid agency determines someone is eligible for Medicaid, they pass that information down to the fiscal agent, which then passes the information on to the appropriate health plan. A health plan representative explained, “So you can see already that we've got three different players, each with varying responsibilities. And anything to do with eligibility has to begin and end with that state system and then be communicated down all three channels there. Anytime you've got two degrees of separation and electronic file formats and things like that, you're going to run into some problems.”

In addition, beneficiaries often have several benefit periods in the course of a year due to churn in and out of the program, and they may have coverage through different managed care plans over the course of a year. To help address the challenges of multiple benefit periods, the state has proposed a set 12-month benefit period and assigning beneficiaries to the same MCO throughout in its pending waiver extension.

²¹ Centers for Medicare and Medicaid Services. Medicaid Section 1115 Demonstrations, Healthy Indiana Plan 2.0. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=25478>

Box 3: Implementation Steps for Health Savings Accounts

03 HEALTH SAVINGS ACCOUNTS: STAFFING CAPACITY

- **Arkansas contracted out the technical implementation and administration of the Health Independence Accounts to a third-party vendor.** One full-time state staff oversaw the program.
- **Indiana delegated most administrative functions of HIP 2.0 to its Medicaid MCOs and its fiscal intermediary, DXE Technologies.** Indiana initially hired two new state staff to implement HIP 2.0, as well as some Division of Family Resources and county-level staff in anticipation of increased enrollment applications.
- **Indiana MCOs reported investing in significant staffing increases** in member services, outreach, billing, and IT infrastructure in order to administer HIP 2.0.
- **Indiana's Department of Insurance required navigators to pass an Indiana-specific certification,** which included a HIP 2.0 component.

COMMUNICATIONS AND COORDINATION EFFORTS

- **Indiana conducted widespread outreach to multiple stakeholders,** including town halls held around the state with providers, hospitals, community organizations, faith-based organizations, and community members during the program design and implementation phases of HIP 2.0.
- **For the year and a half prior to HIP 2.0, Indiana hosted many hour meetings with managed care organizations and the fiscal agent,** two to three times a week, to discuss operational program details. During implementation, the state hosted daily, and sometimes multiple daily, meetings with MCO technical staff.
- **Indiana still holds weekly office hour meetings with MCOs to discuss ongoing issues.** Every three weeks the state also holds executive team meetings between MCO executives and Medicaid executives to ensure everyone is working collaboratively and in partnership.

SYSTEMS AND PROCESSES ESTABLISHED

- **Arkansas instituted changes to its MMIS system to communicate FPL income bands** (e.g., whether an individual's income fell between 0% and 17% FPL or 17% and 23% FPL determined what contribution they should pay.)
- **In Indiana, processes were put in place to facilitate data file transactions** (e.g., eligibility files or no-pay files) between the Medicaid eligibility system and the fiscal agent, and from the fiscal agent to the MCOs.
- **In Indiana, MCOs track accounting for each member's POWER Account** (whether the funds are from the member or from the state), track debits out, process claims against the POWER Account, and produce invoices and monthly statements. MCOs also created online viewing capabilities, as well as an app where individuals can view their balances.
- **MCOs in Indiana created a third-party payment portal** to allow employers, not for profits, churches, or other family members to make payments on an enrollee's behalf.
- **MCOs in Indiana instituted a fast-track eligibility system** to allow for the ability to accept a real-time credit card payment that came out at the time the member was applying.
- **MCOs in Indiana instituted back-end processes to identify people** that were at risk of losing coverage due to non-payment.

Healthy Behavior Incentives (Indiana, Iowa, & Michigan)

Three study states, Indiana, Iowa, and Michigan implemented healthy behavior incentives through their waivers. Iowa and Michigan established new programs, while Indiana built off an existing program in HIP 1.0. The purpose of these programs is to encourage use of certain health services.²² The programs differed in terms of who designed and administered them, how they were structured, and what behaviors they targeted, but all three required extensive, ongoing beneficiary outreach and education.

In general, interviewees felt the healthy behavior incentive initiatives were successful features of their waiver program. Interviewees in all the states were happy with participation rates and felt that they were just at the beginning of starting to see behavior change. One state staff noted, “I would say on that point, we did have a pretty clear success in the first year we implemented the Healthy Behaviors with this group, which was largely new to a comprehensive coverage. Our standard rate of people getting what we would call a physical or wellness exam for the Medicaid population as a whole was [previously] up around 6 percent or 7 percent. But with this Healthy Behaviors program, we got about 30 percent of these people into that exam.”

Administrative Capacity

In order to implement new healthy behavior incentive programs, Indiana, Iowa, and Michigan undertook several key activities, including the following:

- Establishing a process for beneficiaries to complete a health risk assessment tool
- Providing outreach and education to beneficiaries about healthy behaviors
- Setting up procedures for tracking healthy behaviors and participation in qualifying activities
- Instituting reconciliation processes to account for qualifying preventive services, healthy behaviors, and resulting account balances
- Providing incentives to beneficiaries for the completion of a healthy behavior
- Monitoring of health plans (in Indiana and Michigan) to ensure account reductions are applied appropriately when someone has earned a healthy behavior

Indiana, Iowa, and Michigan had to address several administrative issues in order to carry out the key activities listed above, although this varied depending on whether they were establishing new programs (Iowa and Michigan), or building off of an existing program (Indiana). State staff, or their contractors, had to build staffing capacity, facilitate new communications and coordination efforts, establish new systems and processes (and resulting infrastructure), and manage associated costs – all of which required a number of steps and activities ([Box 4](#)).

Staffing

Interviewees from both Iowa and Michigan reported that administering their state’s healthy behavior incentive programs was taxing for state staff. Iowa used existing staff to make IT system changes to track healthy behaviors. Michigan delegated administrative responsibilities to its health plans, but state staff performed ongoing monitoring and compliance functions. Michigan health plans also reported significantly increasing staff to support the administration of the health risk assessments.

²² Medicaid and CHIP Payment and Access Commission. “The Use of Healthy Behavior Incentives in Medicaid.” 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf>

Conversely, interviewees in Indiana reported that administering their healthy behaviors program was not extremely burdensome. Indiana relied heavily on consultants to design and develop the program, and it delegated administration to MCOs. Many of the Indiana MCOs reported that the staffing, communication, and processes they put in place to accommodate the healthy behavior requirements were not vastly different from what they were already doing as a core function of their business. One health plan representative explained, “Obviously we do this kind of across the board, preventive care is not only beneficial to low income adults, it's also beneficial to our kids and pregnant women population. So this isn't anything specific to the program.”

Communication and Coordination

Interviewees in all three study states recalled the extensive amount of ongoing communication and coordination that was required among state agencies and contractors to implement the systems and processes needed to operationalize their healthy behavior programs. Interviewees in Indiana, Iowa, and Michigan all reported devoting significant amounts of time to holding regular meetings between state agencies and health plans or contracted vendors to discuss roles, responsibilities, and program logistics. Further descriptions of the coordination and communication required among the states and their contractors can be found in the [Enrollee Contribution](#) and [Health Savings Account](#) sections of this report.

Interviewees also noted the considerable amount of ongoing effort required to communicate and educate beneficiaries specifically about their healthy behavior incentive programs. State Medicaid staff took on the responsibility of educating beneficiaries in Iowa, while health plans took on that responsibility in Michigan and Indiana. In both Michigan and Indiana, health plans created extensive member outreach and education materials, including revamped handbooks, mail communications, and outreach through texts and phone calls.

Systems & Processes

States and health plans put several new systems and processes in place in order to identify beneficiaries' health needs and opportunities to achieve healthy behaviors. For example, Iowa and Michigan both instituted a health risk assessment tool designed to identify health needs and risk factors, and opportunities for beneficiaries to improve their health through behavior changes (e.g., quit smoking).

States and health plans also implemented new processes to track and reconcile the provision of healthy behaviors. Iowa made modifications to its MMIS in order to track the receipt of preventive services and include it in the file that automatically generates the premium invoice, which is sent to the beneficiary. Health plans in both Michigan and Indiana track the provision of healthy behaviors or participation in qualifying activities via claims data. Because healthy behavior incentives and health savings accounts were linked, both Michigan and Indiana also had to establish processes to reconcile achievement of healthy behaviors and individuals' account balances. In Indiana, for example, if a HIP Plus member receives all recommended preventive care services, his or her unused POWER Account balance (or roll-over amount) is doubled. In Michigan, if beneficiaries engage in certain healthy behaviors, they receive a gift card and a reduction in their copayments once they have paid 2 percent of their income in copayments, or monthly contributions (depending on their income).

Costs

None of the three study states could share specific information regarding the cost of administering their healthy behavior incentive programs. Several interviewees did note, however, that the incentives are not likely to reduce the cost of a state's Medicaid program—at least not initially. The concept underpinning

these policies is that they encourage beneficiaries to take an active role in their health and make healthier choices. One interviewee explained they never expected short term cost savings: “Needless to say the ROI—and we knew this upfront, I would say that—the ROI is probably not great. And that wasn't really necessarily designed for that purpose. The program was designed to get beneficiaries engaged in their health. And take personal responsibility. Not necessarily for us to get \$2 back in collections for every \$0.50 we put into setting up the system.”

Challenges

In Michigan, beneficiaries and providers faced difficulties completing and submitting health risk assessments.

One of the major implementation challenges in Michigan was getting health risk assessments returned to health plans after they were completed. Interviewees noted a common pattern: a member’s health plan would mail a health risk assessment to complete with the member’s doctor at an appointment, but the beneficiary would forget to bring the health risk assessment form to the appointment. As a work-around, doctors would often complete generic health risk assessments with the members, but because the healthy behavior incentives were administered by members’ health plans, doctors did not know which health plan to send them to, which led to a backlog of un-submitted health risk assessments.

Interviewees in Michigan also highlighted the difficulty of getting the health risk assessments to the members in the first place, due to the transient nature of the population. Although Michigan reports achieving a relatively high health risk assessment completion rate in its Healthy Michigan Plan population (18 percent), state staff would like to see much higher rates because, under Michigan’s new waiver beginning in 2018, completion of a health risk assessment will determine whether a beneficiary is enrolled in the existing Medicaid managed care program or a planned exchange plan premium assistance program.

Iowa and Indiana experienced technical challenges crediting beneficiaries for healthy behaviors.

Interviewees in Iowa and Indiana both spoke to the technical and operational difficulties they faced in reconciling claims systems with systems used to credit beneficiaries for preventive service use or for adopting healthy behaviors. In Indiana, for example, the state collects and validates data from multiple sources: encounter data, reports from MCOs, and data from the fiscal intermediary about the POWER Account balance amounts. The state then has to reconcile this information to determine how many people earned a rollover of their POWER Account balance based on preventive care use.

Despite repeated and varied education efforts, it was difficult to engage some beneficiaries, especially those who were struggling to meet daily needs such as housing and food.

Several interviewees reiterated the need to provide ongoing, intense education for beneficiaries in order to help them understand the healthy behavior incentive program. They also acknowledged that the work was difficult and that it takes time to see evidence of behavior change. One interviewee explained, “I think you have to start somewhere. And I think we do have some people that it is hard, but the more you require it, the more it's going to hopefully catch on and people will get it. But it's going to take some time. We have people that haven't had a medical home for a long time. They use the emergency room as that. So we've put the workings in place to help discourage that, but it just takes time to get people to change their habits. Even though there is a lot of work upfront and a lot of planning and education and outreach that goes along, it is the right thing to try to get people to get in and get their preventative care before they need something.”

Interviewees also noted that they had come to appreciate the importance of addressing the social determinants of health in conjunction with beneficiary education about healthy behaviors. One health plan representative explained, “Trying to get our members connected to their health care benefits if they are not even getting their daily needs met with a safe and secure home and food and clothing is challenging—the value [of addressing those issues first] goes so much further towards [helping] the members to make healthy choices and behaviors.”

Box 4: Implementation Steps for Healthy Behavior Incentives

04 HEALTHY BEHAVIOR INCENTIVES: STAFFING CAPACITY

- **Indiana relied on consulting support that developed the original concept for the Healthy Indiana Plan** and was involved in all aspects of design, development, and securing waiver authority. Program administration responsibilities are delegated to the MCOs, and Indiana regularly monitors compliance with contract provisions.
- **Iowa utilized its existing data warehouse team to modify its MMIS system to allow for the tracking of healthy behaviors.**
- **Michigan state staff designed the healthy behavior incentive program, but Medicaid health plans are responsible for tracking behaviors and providing the incentives to patients.** Michigan monitors its contracted enrollment broker and the Medicaid health plans to ensure they are complying and handling the reductions appropriately when someone has earned a healthy behavior.

COMMUNICATIONS AND COORDINATION EFFORTS

- **Indiana and Michigan coordinated closely with their health plans** to implement their healthy behavior incentive programs. Both states reported hosting regular meetings (sometimes multiple daily meetings) with health plans to discuss operational program details.
- **Health plans in both Indiana and Michigan are responsible for outreach and education to their members about the healthy behavior incentives.** Health plans distribute a member handbook and mailings, utilize a texting program, and call members to inform them about their recommended preventive services.
- **Iowa communicates with members regarding their healthy behaviors via their monthly statements.**

SYSTEMS AND PROCESSES ESTABLISHED

- **Medicaid managed care organizations in Iowa have beneficiaries complete a health risk assessment tool.**
- **Michigan designed a standard health risk assessment tool that beneficiaries are required to complete annually.** Health plans can add questions to the health risk assessment, but certain questions are standardized across all plans. Primary care providers submit the completed health risk assessment to the beneficiary’s health plan. Each health plan has its own submission instructions.
- **Health plans in Michigan track designated healthy behaviors via encounter data.** Once someone has completed a healthy behavior, it is the health plan’s responsibility to issue the incentive.
- **Medicaid managed care organizations in Indiana track encounter data,** using the preventive care list from the ACA, in order to identify who has had a set of qualifying preventive services. MCOs also track and report how many people participate in certain qualifying activities.
- **Medicaid managed care organizations in Indiana instituted a monthly rollover logic and POWER Account reconciliation process** to account for healthy behaviors.
- **Iowa set up new areas within its MMIS file formats to account for the completion of healthy behaviors.** That information is automatically generated and indicated on monthly statements.

Graduated Copayments for Emergency Department Use (Indiana)

Indiana was the only state in our study to implement a graduated copayment policy for non-emergency use of the emergency department (ED). The goal of the intervention was to encourage appropriate ED utilization by beneficiaries, which was expected to result in substitution of some ED visits with office visits, nurse helpline calls, or other alternative treatment.²³

As a waiver requirement, the graduated copayment model was designed as a pilot, which included a test group and a control group. Beneficiaries in the test group were subject to an \$8 copayment (the maximum typically allowed under Medicaid rules) the first time they use an ED for a condition determined by the ED provider to be non-emergent. Beneficiaries were then subject to a higher \$25 copayment for any subsequent non-emergent use of the ED. Beneficiaries in the control group continued to be subject to an \$8 copayment regardless of how many times they went to the ED for a non-emergent condition. Additionally, both groups were exempt from ED copayments if the visit was determined by the ED provider to be an emergency or if the beneficiary called their health plan's nurse-line prior to the visit.

In order to implement the copayment model pilot, Indiana health plans undertook several key activities, including the following:

- Establishing processes for Indiana's eligibility verification system to confirm the eligibility of beneficiaries in either the test group or the control group
- Communicating to members about their responsibilities regarding copays and emergency use determinations
- Setting up back-end procedures to see if there was a call to the nurse call line to determine copayment amounts

Indiana and its health plans had to address several administrative issues in order to carry out the key activities listed above (**Box 5**), although several systems and processes already existed to make determinations about emergent claims, which facilitated implementation

Administrative Capacity

The health plans which administer the graduated copayment pilot in Indiana did not report significant administrative burden to operate this program. In general, the skill sets, systems, and processes required were already in place or were already viewed as a core part of health plans' business functions. Health plans, for example, were already required to provide a 24-hour nurse call line for members to receive medical advice. As one health plan representative noted, "We've always had the nurse line in place and we've always had education materials developed to encourage use of the nurse line."

Indiana also had experience conducting a prudent layperson review process, which made implementing the program easier. Under previous state legislation, MCOs in Indiana were required to look at emergent versus non-emergent claims, so no new systems or processes needed to be put in place to make those determinations under HIP 2.0.

²³ Milliman. "HIP 2.0 ER Co-Payment Protocol." 2015. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-er-copay-protocol.pdf>

Challenges

Neither the state nor health plans in Indiana reported any significant challenges implementing this provision of the waiver. Interviewees had not encountered problems determining or applying copayment amounts. However, the design of Indiana’s graduated copayment model placed the administrative responsibility for collecting the copayments on ED providers, and interviewees expressed doubt about whether providers were collecting those copayments.

Although the determination of whether or not a beneficiary owed an ED copayment was typically determined after a claim was submitted, the collection of copayments was the responsibility of ED providers at the point of service. The established process was for ED providers to call beneficiaries’ health plans (using a phone number on their insurance card) to determine whether a copayment was due, a process that placed most of the administrative burden on providers. While this made the program relatively easy to implement, several interviewees questioned whether the program was having its intended effect and was worthwhile. One health plan representative commented, “Health plans allow their customer service representatives to advise the ER administrator what copayment to collect at the point of service. I will say that that never, ever happened. Never once did we get a call from an emergency room asking us, hi, so and so is here with a gunshot wound, should we charge him \$8, \$25, or is this a non-covered, or \$0 copayment? It would exclusively happen on back end. And by backend I mean we pay the claim, there would be an \$8 or \$25 hole in it and then they would bill the member if they wanted to. They probably didn't, truth be told.”

Box 5: Implementation Steps for Graduated Copayments

05 GRADUATED COPAYS FOR EMERGENCY DEPARTMENT USE: STAFFING CAPACITY

- **The pilot program is administered by Indiana’s Medicaid managed care organizations.** The MCOs withhold the copayment for a non-emergent claim that comes out of the ER, operate the prudent layperson standard to determine whether something was or was not an emergency, and operate the 24-hour nurse helplines.
- **Providers were responsible for billing and collecting any outstanding copays.**

COMMUNICATIONS AND COORDINATION EFFORTS

- **Indiana’s MCOs developed state-approved notices for members selected for the control group,** which informed them of their placement within the non-graduated \$8 ED copayment group.
- **Indiana’s MCOs are responsible for communicating to members** about their responsibilities regarding copayments and emergency use determinations.

SYSTEMS AND PROCESSES ESTABLISHED

- **Indiana eligibility verification (EVS) confirms the eligibility of members** in either the test group or the control group.
- **Providers are instructed via the HIP member card to contact the MCO by phone to verify the copayment amount** if the member owes a copayment for non-emergency use of the ED.
- **Copayment determination occurs as a back-end function, once a claim is submitted.** MCOs look to see if there was a call to the nurse call line to determine whether or not a copayment is waived. Diagnoses that are categorized as emergent always get paid without a copayment.
- **Standard managed care appeal process is used to address questions about determination.**

6. DISCUSSION THEMES

As interviewees from the four study states reflected on the activities implemented and challenges faced as they operationalized their state's Section 1115 Medicaid expansion waiver programs, they identified several key themes.

These waiver programs were more administratively complex than traditional Medicaid, but the effort was worthwhile in order to expand access to coverage.

Interviewees acknowledged that their respective waiver programs were more administratively complex to implement than traditional Medicaid was. Ultimately, however, interviewees said that the effort was worthwhile because they were able to expand coverage to groups (such as childless adults) under the waivers when doing so through traditional Medicaid would have been politically difficult.

For example, several interviewees noted that the political climate in Arkansas at the time meant that pursuing traditional Medicaid expansion was not a viable strategy. Regardless of the complexity of administering the private option, expansion via the private sector was key to securing the support of the state's business-minded conservatives. One interviewee explained, "We had the leanest eligibility of any state in the nation. We had a 25 percent uninsured rate for 19 to 64 year olds. Some counties as high as 40 percent, 45 percent. We were an increasingly red, conservative state, but we had a Democratic governor in 2011. And just by way of background, to spend a dollar in our state, federal or state dollar, it requires a 75 percent appropriation agreement on both the House and the Senate end every year. So the cards were pretty much stacked against us. Although the need was huge, there was no way they were going to do a traditional Medicaid expansion."

Another Arkansas interviewee noted of their waiver program, "It was a big positive in the state of Arkansas. I know that for many, regardless of our politics here in Arkansas, this made a big difference in a lot of people's lives. And at the end of the day, yes, there were some problems, but for some of these people, gut-wrenching stories that we heard about the difference that we made in people's lives, that at the end of the day was really what this was about. It did make a tremendous impact on the state of Arkansas for the folks that had never had coverage. And also for providers that had a lot of uncompensated care in the past. For the first time, now they were getting paid for these people. So a lot of positives are tied up in this program."

An interviewee in Iowa echoed, "We got people into coverage very quickly. The decision to expand Medicaid came down to the wire because it was so high-profile, and there was a lot of pressure on the agency to get that done . . . It took a lot of collaboration to try and put things together very, very quickly and have it make sense to the folks that you're rolling this out to. But I would say it was a big success. We had a lot of people pulling the rope in the same direction."

The value in waiver-based Medicaid expansions is testing approaches to incentivize behavior change, not necessarily to save the state money.

Interviewees were not able to provide information on the total costs for administering their waiver programs at the time of interviews. Some states reported that because their program utilized existing infrastructure and staff, or because administrative functions were delegated to contractors, they were not able to directly calculate total administrative costs. However, multiple interviewees acknowledged that even without having detailed information on the total administrative costs of their enrollee contribution

programs, they knew the state was spending more to administer the program than it was receiving in member contributions. One interviewee explained of their premium collection program, “I think with our fees being \$5 and \$10, this wasn't a moneymaker. Is it cost-effective to deal with \$5 or \$10 premiums? No. But it was the right thing to do because our governor wanted to encourage people to move to a primary care physician, stop using the emergency room, and find a medical home.”

Several interviewees cautioned states considering similar waiver-based Medicaid policies to weigh the value of testing approaches to incentivizing behavior change with the costs and resources necessary for programmatic changes. One interviewee noted, “If the purpose is really about trying to change behaviors and implement policy differently and these are important objectives, it could be considered worthwhile. If it's something to save the state money, it's pretty clear that based on the amount of premium that we get in versus the effort level to implement it and to maintain it on an ongoing basis, it's not something that's realistically going to save you money per se. So I think that's the balance.”

Another interviewee commented, “If any state is looking at collecting premiums to offset the cost of a program, don't do it. If the state is looking to utilize premiums in a different way, or they have a different purpose for it, just as an educational method or opportunity for members to have a little bit of skin in the game and understand how insurance works, then there's value in that.”

The administrative cost of the Health Independence Account program ultimately did overwhelm the perceived value of the program in Arkansas. Arkansas interviewees noted that the high cost of administering its health independence accounts (roughly \$9 million to implement), along with low participation rates, resulted in the decision to end the program.

Involving operational staff in the waiver design process as early as possible may help to ensure policy goals are achievable.

Interviewees noted that in several cases, the waiver policies designed by state legislative bodies ultimately created administrative and operational difficulties for those who had to implement them. Policies were frequently designed with specific political goals in mind (for example, promoting individual accountability through cost-sharing requirements), rather than how they would be administered.

One consistent piece of advice interviewees shared was to encourage legislators who are considering similar waiver programs to involve operational staff early on in the design process. One interviewee recommended, “Use your insurance department and any other agencies to help frame policy and process. If there's any way that you could have the opportunity and luxury of developing the operational protocol first, and then develop the policy, you're better off. If you develop your policy first and try to wrap your operations around it, that's when you get in trouble. At least make sure operations and policy are at the same table so that you come with the best way to accomplish the goals of the policy in a way that's possible.”

Interviewees also noted that they were often limited in their ability to make modifications to their programs along the way because it would require a legislative change. This did not allow for a nimble process if changes were needed, which ultimately affected timelines and costs. One interviewee noted, “I think sometimes there's a policy desire that doesn't always track to industry standard. And that doesn't mean industry can't respond and create new approaches. It just means people in the policy arena need to rethink their expectations as far as timeframes and timelines and cost. And so there needs to be the happy balance between implementation and overall vision. But our job is to make policymakers' vision come true,

so I'm not trying to dissuade that. We're all for big, bold goals. I guess there has to be some operational reality attached to the aspirational goals.”

Interviewees encouraged policymakers who design the policies to consider, or seek input on, the impacts of waiver policies on beneficiaries and providers, in addition to the administrative capacity burden. As one interviewee explained, “I think any policymaker needs to always design these policies with two things in mind: Does the policy negatively or positively impact members and providers? And will the implementation negatively or positively impact members or providers? And if you can answer those questions positively, then you designed it right and you should proceed. But if the answer is negative, then you need to rethink what you're doing.”

Building off of existing capacity and infrastructure made implementation manageable under short timelines, but it was not necessarily efficient.

Short implementation timelines (sometimes no more than three months between when a state’s waiver was approved and when a program needed to be up and running), as well as last minute design changes from state legislatures, created challenges for all four of the study states.

Due to time constraints, states often had to make do with existing technology platforms or information systems rather than creating better systems from scratch. One interviewee commented, “When we implemented it, we had no time. There was no way we could have done some of the things we did in the time we had. And we didn’t have the electronic capacity at that time. There’s nothing that could have been done about the timing. It was the way it happened. The legislation passed and we had to have that thing up and going practically overnight.” Another interviewee noted, “It’s building the plane as we were flying it...I’m not sure how you make that sort of thing better when you have that level of uncertainty and then tight, tight implementation timeframes.”

The functional – but sometimes inefficient - systems states were able to get up and running in a short time period, led to unanticipated problems that required considerable staff time to address later in the process. One interviewee observed, “We had to have something workable, out the door, so that we could send the first bill out within six months of starting to get some of our design completed. So that's why we went in a phased approach. It's like okay, hold on, what do you have to have done first? Let's get the invoices implemented and roll on those into our database so we can create statements. What's the next thing we need to do? We need to be able to receive payments. But when we receive payments, we can't give anybody a refund yet, so what do we do about that? Well, we'll worry about that later, we can't do it yet. Okay, now we've got 10 people out here that have been asking for a check, can we just cut them a check? Okay, now we've got a spreadsheet over here. Don't lose track of those, because we've got to update our system. And then later on you get your system updated and okay, now we can issue refunds through the system. So we took it step by step . . .”

Overall, interviewees felt that when they were implementing something new, especially initiatives that had not been done in a lot of other states, they just had to start somewhere. In general, they tried their best to pick something that was achievable. A state staff member remarked, “We tried to say, let’s just start here and see how it goes, and then be willing to take a look at and modify things as you go along.”

Significant administrative resources were needed to implement and support ongoing operations of these new programs.

Although the actual number of state staff dedicated to implementation efforts was minimal (four to five FTEs on average across the study states), many interviewees reported that the administrative lift of implementation was heavy and ongoing, even if the actual operational work fell to contractors. To create the administrative capacity needed, most states repurposed existing staff or relied on contractors to get programs up and running. Arkansas, for example, could not hire additional people to implement the private option due to a legislative mandate. Instead, it relied heavily on contractors for legal, policy, actuarial, and project facilitation support. Even states like Indiana and Michigan, which delegated most of the administrative functions to third parties such as health plans or fiscal intermediaries, reported devoting extensive time and energy to addressing technical issues and ongoing communication, coordination, education, outreach, and monitoring efforts.

Indiana, which built upon its previous HIP 1.0 model rather than creating a new program from scratch, dedicated extensive amounts of time to ongoing stakeholder engagement with its managed care organizations in order to launch HIP 2.0. Several interviewees in Indiana praised the state's ongoing communication and coordination with the health plans as key to the success of the program. One Indiana interviewee observed, "Key stakeholder engagement is a best practice we believe our state did very, very well. They made sure that all the vendors who had some part in implementing HIP 2.0 were together in the room, so we were all hearing it, we were getting the same directives, the same explanation of the waiver component, and were starting to talk through how it could work."

Iowa was unique among the four study states in how much implementation work it kept in-house. Iowa interviewees specifically called out the ongoing work and costs it takes to keep their premium payment system running: "We've worked on this system for two years and we've still got little things left to do to it. It's a very costly system to run in my opinion. There is still overhead constantly with the system. Not to mention the size of the database that is just growing, the images of the statements that we have to retain for however long. And the strain on our mailroom and the print room. I think we mentioned this before and I stick to this, and that's I don't think you want to look at this as a way to offset costs of the program."

Considerable IT system redesign was required to develop and maintain programs.

Significant effort was required by IT systems staff to implement and monitor the waiver programs. For example, Arkansas built its own enrollment portal for the private option, and the Iowa Medicaid agency's existing data warehouse team created a premium payment system completely in-house. Indiana had to create a way to send eligibility information first to its fiscal intermediary, then to its managed care organizations, and back again. Michigan had to create processes to look at claims data from the past six months in order to calculate average copayment amounts for beneficiaries. States reported that IT staff were consistently stretched thin, often dealing with ongoing and unexpected technical glitches.

Interviewees in Indiana called out the importance of taking the time, often significant, to complete user testing of the end product in order to ensure the reconciliation process works as intended. Repurposing unutilized fields in the 834 file format (a federally mandated standard form that managed care plans use to send enrollment and dis-enrollment information to another covered entity) helped accommodate information exchange with MCOs in a format that they were used to receiving. However, often there was a tension between the need for adequate development time and the pressure to implement new policy in a timely manner. One interviewee explained, "We spent a whole lot of time doing end testing. And this

can be really quite complex, involve a whole lot of different systems and people and coordination . . . (We run tests) with multiple loops of getting somebody on the system and then changing a POWER Account contribution and then changing from Basic to Plus or Plus to Basic. Making sure all the files and financials are all accountable and working. That can be quite an extensive effort and a lot of states—and we were guilty of this early on – shortchanged the testing. We learned that we really can't. I would encourage a lot of focus on testing.”

Many interviewees noted the critical importance of using skilled in-house data warehouse staff. Involving data warehouse staff early in the design process helped in anticipating what kinds of data would be accessible for ongoing monitoring dashboards and evaluation activities once the program was up and running. One interviewee noted, “Our data warehouse was involved far earlier than they probably typically would be because we wanted an operational dashboard and informational dashboard built and they understood the rules and the evolution of the data and where to pull it from. And it was factored into our design development that I'm going to need an extract that tells me X because I know the governor's office or senior management is going to want to know this. There was a lot of good documentation that came out of [having data warehouse staff involved] in flow charts and in decision documents that have a lot of history as to how we got to where we got to and why. We reflected back on those a number of times just to make sure we were all still baselined, so I think that was hugely important.”

The complexity of policy provisions being tested meant that targeted and ongoing member outreach was essential, but also an ongoing challenge.

Interviewees from all four study states reported needing to significantly increase resources for call centers and member education services in order to address the ongoing questions beneficiaries had about the programs. Although traditional Medicaid expansion states have reported needing to increase resources for outreach and education services to reach this population as well,²⁴ interviewees in the study states reported experiencing higher call volumes and longer call times compared to other lines of Medicaid business due to the administrative complexity of many of the waiver provisions. In addition, consequences for nonpayment of premiums, such as dis-enrollment of coverage, meant that not adequately or effectively communicating with beneficiaries had greater consequences in waiver states.

Interviewees noted the need to completely overhaul their outreach and education strategies in order to reach the waiver population, including revising member handbooks to include shorter, more focused information, offering more outbound education via social media and emails that link members to online resources, and providing additional training so that call center staff would be able to communicate with new members about the details of the program including explaining new requirements like how to pay, when to pay, and where to pay. That type of outreach had to be conducted regularly and repeatedly, and health plans reported having to institute a great deal of back-end work to ensure that they could identify people that were at risk of losing coverage due to non-payment. One health plan representative observed, “It's important for policymakers to comprehend that states are asking members to function at a higher level of health care engagement. When you're asking [that], there's a commensurate responsibility to provide meaningful education. We've learned over time that this education can't be provided in any traditional way, you have to become sophisticated in how you deliver it, and you have to do it in a multi-modal approach that is never-ending.”

²⁴ Kaiser Commission on Medicaid and the Uninsured. “Key Lessons from Medicaid and CHIP for Outreach and Enrollment under the Affordable Care Act, June 2013.” Available at: <http://files.kff.org/attachment/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act-issue-brief>

While the initial implementation phase required the most significant outreach, education, and communication with beneficiaries, the continual enrollment of new beneficiaries, the churn of beneficiaries cycling in and out of the program, and the complexity of program requirements required engaging beneficiaries multiple times and via multiple mechanisms. Michigan interviewees, for example, pointed out the continuous assistance their enrollment broker provides to beneficiaries, resolving issues and addressing questions on a daily basis. They noted that even as their waiver program has become more established, new beneficiaries enroll and need to be oriented and educated on the program design.

Despite all of the additional educational outreach, several interviewees remained concerned that their efforts were not completely successful in reaching people. One individual commented, “We definitely had plenty of education and collateral materials which were distributed and communicated often. There was a user guide that was created. It seemed like a pretty good educational tool. I think you just have to wonder if this type of program really is that enticing to this income population.”

Despite a need for substantial communication and negotiation with states, health plans generally felt equipped to take on additional implementation responsibilities.

Overall, health plans in all of the study states indicated that they felt ready to take on additional implementation responsibilities. Health plans that had previous experience with the Medicaid population, or who had existing relationships with state officials, generally reported fewer challenges implementing waiver program elements. Several health plans in Indiana, for example, had six years’ experience administering their HIP 1.0 program, during which time they developed close working relationships with the state’s Medicaid agency before they implemented HIP 2.0. Michigan also had strong previous relationships with the state’s 11 Medicaid health plans, and an existing enrollment broker, which facilitated the design and implementation process of their waiver program elements.

Health plans in states that did not have previous experience serving low-income populations or working with the state Medicaid agency reported more challenges during the implementation process. Health plans in Arkansas, for example, detailed several challenges they faced such as overcoming differences with the Medicaid agency in how benefits were defined, difficulties communicating with beneficiaries due to unreliable contact information, and difficulty pricing new ACA-covered services. Interviewees from Iowa noted that health plans in their state faced similar challenges to those in Arkansas, which ultimately resulted in no health plans being willing to offer Medicaid exchange plans. In these cases, however, it was difficult to distinguish to what extent challenges raised by health plans were attributable to the specific waiver program per se, or whether these were typical Medicaid or managed care-related challenges that were simply new to these waiver states.

In spite of feeling equipped administratively, several health plan representatives noted that negotiations about payment rates to support that work were ongoing. Interviewees were especially concerned about upcoming changes to waiver programs. One health plan representative in Indiana noted, “There's a lot more administratively and operationally that goes into running a Healthy Indiana Plan versus a Medicaid plan in another state. The stage is set for a very robust discussion between the state and the plans about who is going to be responsible for what in the [next] waiver. And do we need to be thinking about rates ahead of time to ensure that they're adequate to cover the additional staffing or the additional system changes. That's always a moving target.”

7. FUTURE CONSIDERATIONS

As interviewees reflected on their implementation experiences, many identified concerns for the future of their waiver programs that they were monitoring closely:

- Interviewees in Michigan were worried about the administrative capacity required to implement their MI Marketplace Option for Medicaid beneficiaries, who start enrolling in April 2018.
- Interviewees in Arkansas and Indiana were concerned about the state’s proposed work requirement and having to construct another administratively complicated system to exempt certain individuals from that requirement. They expressed hope that the requirement would not be a barrier for individuals trying to get health coverage.
- Interviewees in Arkansas also voiced concerned about losing coverage gains once individuals with incomes from 100 to 138 percent FPL are no longer eligible for the private option. Several interviewees indicated that they expected many of those individuals to go without coverage, rather than transitioning to exchange plans.

Several interviewees also voiced concerns about the future of Medicaid, in general, and what effect changes to the program would have on states that operate Section 1115 waivers. As one interviewee in Indiana explained, “For a while it looked like Medicaid was seriously going to change. There’s no way you can argue that things like HIP don’t cost more money than traditional Medicaid for the purposes of administration. If states are faced with even less money to do the job, it will be interesting to see where they decide to make those cuts.”

In light of their experiences implementing Section 1115 waivers, interviewees were also asked what advice they would have for the Centers for Medicare & Medicaid Services (CMS) as it considers approval of new waivers. Many of the interviewees felt that CMS was extremely responsive during the waiver discussions, brought agency resources and technical assistance to the states, and helped make connections to other states that had implemented similar initiatives. While states appreciated these efforts, they also desired more easily accessible information upfront about how states worked through common implementation, negotiation, and legal issues. Additionally, interviewees were interested to know, if a state did not implement a certain waiver provision, why or how much it cost. Finally, states were especially interested in having a clear understanding of which elements of particular initiatives CMS is willing to approve.²⁵

²⁵ In January, 2018 CMS released federal guidance describing considerations for states interested in pursuing projects under Section 1115 that have the goal of creating incentives for Medicaid beneficiaries to participate in work and community engagement activities. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

8. CONCLUSIONS

This report documents the experiences of individuals in four states that implemented Section 1115 Medicaid expansion waivers. Regardless of the waiver program element implemented, interviews with over 30 individuals revealed that implementation involved major administrative efforts, requiring significant coordination among multiple stakeholders, sophisticated IT systems, and ongoing education of beneficiaries. While the total costs of the program implementation and administration were unclear, interviewees felt that the overall value in the waiver approach was in carrying out policy differently, not necessarily saving the state money; and that the waiver programs were ultimately worthwhile because they led to increased health care coverage for a population that would not otherwise have been covered.

APPENDIX A: DISCUSSION METHODOLOGY

To gain a full picture of states' experiences implementing their Section 1115 waivers, we conducted interviews with current and former state agency staff and health insurance carriers who were identified for their ability speak to the details of implementation and operational issues. As a first step, we contacted each state's Medicaid Director, requesting their assistance in identifying the individuals who were involved with the waiver program's implementation or operations. Based on discussions with Medicaid Directors or their designees, we employed a chain-referral sampling methodology to identify additional interviewees across key informant groups, including current and former state Medicaid agency staff, insurance department staff, waiver program staff, and health plan representatives. To protect the identities of the interviewees, their names and organizations were not included in the report. We have, however, summarized the types of interviewees to whom we spoke by state and provided sample project titles (see **Appendix Table A1**).

Table A1. Section 1115 Medicaid Expansion Implementation Study Discussions Completed (September 11–October 24, 2017)

State	Current + Former State Staff	Health Plans	Total
Arkansas	7	4	11
Indiana	2	7	9
Iowa	6	0	6
Michigan	6	1	7
Total	21	12	33

Sample titles for the interviewee categories include the following:

State Staff: Business Analyst, Deputy Commissioner, Deputy Medicaid Director, Division Director, Federal Compliance Officer, Information Systems Manager, Project Manager, Technical Lead

Health Plan: Chief Operating Officer, Enrollment Manager, Government Relations Director for Medicaid, Medicaid Policy Director, Plan President, Vice President of Operations

We used a multi-site case study methodology with open-ended discussion guides. While the core questions remained static across discussions to facilitate meaningful comparisons, individualized guides were developed in advance of each discussion. Individual guides were modified based on the following criteria: role and organization of the interviewee, state context (e.g., waiver program elements), and theme probes based on previous discussions. Appendix B includes the core list of potential questions developed for our primary discussion categories by state. To support the development of individual state guides, the research team developed detailed profiles for each of the study states, which are available upon request. In addition, prior to initial discussions, the research team searched for recent news regarding ongoing political or policy debates related to the waiver programs in each state. Finally, in advance of all discussions, we conducted a search of publicly available information on the subject and organizational affiliation to inform our discussions.

Discussions were one hour in length and were conducted over the phone. Two to three SHADAC researchers participated in each discussion with a senior researcher taking the lead in directing the questions. Interviews were recorded and transcribed verbatim. The lead researcher who participated in the discussions reviewed the transcriptions and made corrections when necessary. We used a theme-content analysis approach. A senior researcher reviewed each of the reports and identified key themes, focusing first on themes that represented administrative capacity issues that states faced when implementing their waivers. Additional themes around challenges and lessons learned were identified based on response repetition. The themes were sorted and organized by waiver program element and synthesized into the final five categories. The final synthesis of our study included a narrative organized by waiver program element and a discussion of key themes, with state-specific examples and quotations to illustrate states' specific experiences.

Each of the study interviewees was provided an opportunity to review the draft report in order to ensure that it accurately characterized the experiences of their state and provided correct program details. Due to the political sensitivity of some of the discussion topics, participants from Michigan subsequently requested that their direct quotations not be included in the final report. As a result, Michigan's implementation experiences are included in the final synthesis; however, all direct Michigan quotations have been removed.

APPENDIX B: DISCUSSION GUIDES

Arkansas

1. To what extent did the Arkansas Department of Human Services share responsibility or collaborate with other agencies such as the Department of Insurance in implementing and administering the premium assistance program?
2. What state administrative capacity, in terms of new skills, technology, or knowledge base, did you need to implement the premium assistance program?
3. Can you briefly describe the systems and processes that were put place for enrollees to select and enroll in exchange plans, and for the state to pay monthly premiums to health plans? Was the state able to leverage existing IT systems for this purpose, or were new or expanded systems necessary?
4. What systems or processes did the state set up to ensure that wrap-around benefits typically not offered through QHPs (e.g., non-emergency transportation, EPSDT) were provided to enrollees?
5. Did the state encounter any challenges related to churn, as enrollees switched between Medicaid premium assistance and Advanced Premium Tax Credits as their income eligibility fluctuated?
6. What strategies did Arkansas employ to encourage health plans to participate in the private option?
7. Were there other challenges related to the implementation or administration of the private option that you would highlight for other states considering a similar program?
8. Reflecting on the implementation of premium assistance option, tell us about the successes. What did your state/agency do well related to implementation?
9. How prepared was your office/staff for implementation?
10. Are you aware of any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the premium assistance approach?
11. What new skills, technology, or knowledge base did you need to implement/administer the Independence Accounts? What kind of administrative burden was associated with that?
12. Although Arkansas's waiver allowed the state to collect Independence Account contributions for enrollees from 50 to 138 percent FPL, the state chose not to collect them for enrollees with incomes below 100 percent of FPL. What factors influenced the decision not to collect contributions for lower-income enrollees?
13. What strategies did the state develop in order to educate beneficiaries and encourage them to engage with their Health Independence Accounts?
14. What were the key factors in the decision not to continue the Health Independence program?
15. Are you aware of any resources or reports that we could access to learn more about the program, including how much the state spent per year on administration of the Health Independence Accounts?

16. What advice would you give to states, or what promising practice would you share, as they discuss or implement similar 1115 waiver activities?
17. What could CMS do to support states in their waiver program design or implementation of similar activities?
18. Looking back, would you recommend a different approach?
19. What challenges for the future of the program are you anticipating?
20. Were there additional provisions included in the original waiver proposal that were not implemented? Provisions that were implemented but not as originally approved or intended?
21. Are there questions I have not asked or topics we have not covered that you think are important to discuss?
22. Are there other key individuals involved in the implementation or administration of these programs to whom you think we should speak?

Indiana

1. Can you describe the breakdown of main responsibilities of FSSA, the MCOs, and other entities involved in administering the POWER Accounts?
2. What new or scaled-up skills, technology, or knowledge base did you need to implement POWER Accounts for HIP 2.0?
3. What processes or systems did the state need to:
 - a. Set up to collect monthly contributions based on income?
 - b. Allow for employers and not-for-profit organizations to contribute to enrollees' POWER Accounts?
 - c. Allow the payment of claims from enrollees?
 - d. Determine whether someone with unpaid premiums is eligible for dis-enrollment or for HIP Basic?
 - e. Transfer individuals from HIP Basic to HIP Plus (e.g., how are they flagged, how are they notified, how are the plans/providers informed)?
4. For individuals dis-enrolled for non-payment of premiums, we understand that the state halts coverage for six months. Please confirm and describe the processes in place to implement this policy.
5. What kinds of education or training are enrollees provided on the POWER Accounts? Who develops and/or provides that?
6. What factors did the MCO and the state consider when establishing rules around where and by what means beneficiaries can make contributions? Have some of these options been more difficult to set up and administer than others, and if so, why?
7. Were there other challenges related to the implementation or administration of the POWER Accounts that you would highlight for other states considering a similar program?
8. Reflecting on the implementation of the POWER Accounts, tell us about the bright spots. What did your state/agency do well related to implementation?
9. How prepared was your office/staff for implementation? Did you have what you needed (resources, information, etc.)? Please explain.
10. Are there any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the POWER Accounts?
11. Can you describe what state administrative capacity, in terms of new skills, technology, or knowledge base, you needed to implement the healthy behavior incentives? How did you develop that capacity (e.g., contract out, hire new staff, leverage staff members from other agencies, etc.)?
12. Can you briefly describe the systems and processes in place to track healthy behaviors through the program?
13. How did the state determine which healthy behaviors would qualify for incentives?
14. What kinds of education or training are enrollees provided on the Healthy Behaviors Incentives?

15. Were there other challenges related to the implementation or administration of the healthy behavior incentives that you would highlight for other states considering a similar program?
16. Reflecting on the implementation of healthy behavior incentives, tell us about the bright spots. What did your state/agency do well related to implementation?
17. Are there any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the healthy behavior incentives?
18. Can you briefly describe the main breakdown of responsibilities of the state, MCOs, and other entities in administering and implementing the graduated cost-sharing strategy? Were other contractors or consultants used? If so, what was their role?
19. Can you describe what state administrative capacity, in terms of new skills, technology, or knowledge base, you needed to implement the graduated cost-sharing strategy? How did you develop that capacity?
20. We understand that the MCO is responsible for establishing new resources for individuals to determine whether a condition is an emergency, including establishing nurse call lines, and providing educational materials. Are you aware of any challenges they faced in doing so (e.g., were enough resources dedicated to the strategy)?
21. What role did the state play related to providing member access to non-ED settings when primary care clinics are typically closed (e.g., after-hours, weekends, holidays, etc.)?
22. What does the determination process look like on the ground at hospital emergency departments?
 - a. Are emergency department personnel informed if the beneficiary called a nurse line? If so, how?
 - b. What process do MCOs have to validate determinations? If determinations are reversed, how are copayments refunded?
 - c. Has the determination process worked well, or have there been challenges for plans and/or enrollees?
23. We understand that the operational protocol was delayed, and as a result, implementation of the graduated copayment was delayed until February 2017. Is that correct? Can you describe challenges and factors that led to this delay, and what solutions the state and MCOs considered to address those challenges?
24. Are there any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the graduated copayment program test?
25. What advice would you give to states or promising practice you would share as they discuss or implement similar 1115 waiver activities?
26. What could CMS do to support states with waiver program design or implementation?
27. Looking back, would you recommend a different approach? Did anything surprise you about implementation?
28. What challenges for the future of the program are you anticipating? How are these concerns being addressed?

29. Were there additional provisions included in the original waiver proposal that were not implemented? Provisions that were implemented but not as originally approved or intended?
30. Are there questions I have not asked or topics we have not covered that you think are important to discuss?
31. Are there other key individuals involved in the implementation or administration of these programs to whom you think we should speak?

Iowa

1. Who/what agency was responsible for implementing and administering the collection of enrollees' premiums? Were contractors or consultants used, such as an MCO? Can you describe the breakdown of main responsibilities?
2. What state administrative capacity, in terms of new skills, technology, or knowledge base, did you need in order determine monthly premiums based on income?
3. Can you briefly describe processes or systems the state put in place to facilitate the collection of monthly premiums? Was the state (or entity responsible) able to leverage existing IT systems for this purpose, or were new or expanded systems necessary? Are you able to describe the cost of new or expanded systems in terms of staff time, new hires, or other administrative costs?
4. Has Iowa examined or approved systems providing multiple options for beneficiaries to pay premiums, such as allowing them to pay via credit card or in-person at bank branches or Walmart stores? Are you aware of enrollees encountering challenges in making payments/contributions? If so, how has the state addressed those challenges?
5. What is the process for enrollees to request a hardship exemption and the state to grant one?
6. What processes or systems did the state need to set up to dis-enroll beneficiaries for non-payment of premiums?
7. Were there other challenges related to implementation that you would highlight for other states considering a similar program?
8. What solutions did the state employ in addressing those challenges, and how effective have they been?
9. Reflecting on the implementation of the collection of monthly premiums, tell us about the key successes. What did your state/agency do well related to implementation?
10. How prepared was your office/staff for implementation?
11. Are there any resources or reports that we could access to learn more about the costs of the program, or the program in general? Are you able to share with us how much the state spends per year on administration of the program, or your general sense about whether premiums collected offset some or all of that cost of collecting premiums?
12. Can you describe the breakdown of main responsibilities between the state and the managed care organizations in administering the Healthy Behavior Incentive program?
13. Can you describe what state administrative capacity, in terms of new skills, technology, or knowledge base, you needed to implement the healthy behavior incentives?
14. Can you briefly describe what systems/processes the state had to develop to administer the Healthy Behaviors Incentive program?
15. How did the state determine which healthy behaviors would qualify for incentives?
16. What is the process for enrollees to complete annual medical or dental wellness exams?
17. What kinds of education or training are enrollees provided on the Healthy Behaviors Incentives?

18. Were there other challenges related to the implementation or administration of the healthy behavior incentives that you would highlight for other states considering a similar program?
19. Reflecting on the implementation of healthy behavior incentives, tell us about the successes. What did your state/agency do well related to implementation?
20. How prepared was your office/staff for implementation?
21. Are there any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the healthy behavior incentives?
22. What agency was responsible for implementing and administering the Marketplace Choice Plan? Were contractors or consultants used? What kinds of coordination with outside parties did the state have to engage in to set up and maintain the premium assistance approach under Marketplace Choice Plan?
23. What state administrative capacity, in terms of new skills, technology, or knowledge base, did you need in order to implement the Marketplace Choice Plan?
24. Can you briefly describe the systems and processes that enrollees used to select and enroll in exchange plans, and for the state to pay monthly premiums to health plans? Was the state (or entity responsible) able to leverage existing IT systems for this purpose, or were new or expanded systems necessary? Are you able to describe the cost of new or expanded systems in terms of staff time, new hires, and other administrative costs?
25. What was required for the state to ensure that wrap-around benefits typically not offered through QHPs (e.g., EPSDT) were provided to enrollees? Did the state encounter any challenges with this?
26. Would you consider participation by health plans to be the primary barrier to continuing the Marketplace Choice Plan past the first year (i.e., 2014)? What efforts did the state make to preserve the Marketplace Choice Plan?
27. When one of the plans dropped out, we understand beneficiaries could choose whether to enroll in the remaining plan or transition into MCOs along with Iowa Wellness Plan enrollees. How did that change affect the processes/systems that had already been established? What challenges did the state, beneficiaries, remaining MPC plan, and MCOs experience in this transition process? How did the state manage those challenges?
28. Are there any resources or reports that we could access to learn more about the program, including how much the state spent per year on administration of the program?
29. Many of the individual provisions of Iowa's waiver are interconnected. For example, some enrollees' required premiums can be waived if they have completed their healthy behavior incentives. What challenges have those interconnections posed in administering the waiver? How has the state addressed those challenges?
30. What advice would you give to states or promising practice you would share as they discuss or implement similar 1115 waiver activities?
31. What could CMS do to support states in their waiver program design or implementation of similar activities?

32. Looking back, would you recommend a different approach? Did anything surprise you about implementation?
33. What challenges for the future of the program are you anticipating? How are these concerns being addressed?
34. Were there additional provisions included in the original waiver proposal that were not implemented? Provisions that were implemented but not as originally approved or intended?
35. Are there questions I have not asked or topics we have not covered that you think are important to discuss?
36. Are there other key individuals involved in the implementation or administration of these programs to whom you think we should speak?

Michigan

1. Who/what agency was responsible for implementing and administering the MI Health Accounts? Were contractors or consultants used, such as an MCO? Can you describe their main roles and responsibilities versus those of the agency? What is the state's role in overseeing the contractor's ongoing administration of MI Health Accounts?
2. What state administrative capacity, in terms of new skills, technology, or knowledge base, did you need to implement/administer the MI Health Accounts?
3. Can you briefly describe the systems and processes in place to collect enrollee premiums and co/pays? Was the state able to leverage existing IT systems for this purpose, or were new or expanded systems necessary?
4. What were your expectations for how enrollees would engage with their MI Health Accounts? How did you set up the accounts to facilitate that engagement?
5. What strategies did the state (or entity responsible) develop in order to educate beneficiaries and encourage them to engage with their MI Health Accounts?
6. Were there other challenges related to the implementation or administration of the MI Health Accounts that you would highlight for other states considering a similar program?
7. Reflecting on the implementation of the MI Health Accounts, tell us about the successes. What did your state/agency do well related to implementation?
8. How prepared was your office/staff for implementation?
9. Are you aware of any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the program?
10. Who/what agency was responsible for implementing and administering the Healthy Behavior Incentives?
11. What state administrative capacity, in terms of new skills, technology, or knowledge base, did you need to implement the healthy behavior program?
12. Can you briefly describe the systems and processes in place to provide/track preventive services through the program?
13. Can you briefly describe the process for enrollees to complete health risk assessments and annual wellness exams and receive credit for it? (i.e., what has to happen on the level of the enrollee, provider, MCO, other contractors, and/or Medicaid department staff?)
14. Were there other challenges related to the implementation or administration of the healthy behavior program that you would highlight for other states considering a similar program?
15. Reflecting on the implementation of the healthy behavior program, tell us about the successes. What did your state/agency do well related to implementation?
16. How prepared was your office/staff for implementation?
17. Are you aware of any resources or reports that we could access to learn more about the program, including how much the state spends per year on administration of the program?

18. How did the state's experience with implementing and administering healthy behavior incentives contribute to the decision to require, beginning in 2018, enrollees with incomes above 100 percent FPL to complete a healthy behavior before they are moved to Marketplace premium assistance?
19. What advice would you give to states, or what promising practice you would share, as they discuss or implement similar 1115 waiver activities?
20. What could CMS do to support states with waiver program design or implementation?
21. Looking back, would you recommend a different approach? Did anything surprise you about implementation?
22. What challenges for the future of the program are you anticipating? How are these concerns being addressed?
23. Were there additional provisions included in the original waiver proposal that were not implemented? Provisions that were implemented but not as originally approved or intended?
24. Are there questions or topics we have not covered that you think are important to discuss?
25. Are there other key individuals involved in the implementation or administration of these programs to whom you think we should speak?