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I. Background

The devastating economic downturn of the late 2000s had a dramatic effect on the Medicaid program at both the state and federal levels. In the years during and just after the Great Recession, states concentrated primarily on cost containment, not on implementing new reforms, increasing access, or adding services. Now that the economy has improved, states are prioritizing differently. While cost will always be an issue, the Kaiser Family Foundation's recent state Medicaid survey found that states' priorities include health delivery and payment reforms, demonstration waivers, program costs, and new ways to care for an aging population. [FN1]

In what is described as her first major speech on the topic, Seema Verma, Administrator of the Centers for Medicare and Medicaid Services (CMS), outlined her vision for the Medicaid program at a conference of the National Association of Medicaid Directors. Her vision can best be summarized as reducing administrative burdens and strengthening the partnership between the federal government and state Medicaid directors by granting states more flexibility to build their own reforms. According to a press release:

Verma emphasized her commitment to “turn the page in the Medicaid program” by giving states more freedom to design innovative programs that achieve positive results for the people they serve and pledged to remove impediments that get in the way of states achieving this goal. She announced several new policies and initiatives that break down the barriers that prevent state innovation and improvement of Medicaid beneficiary health outcomes[. [FN2]

Notably, one of her new policies is revising CMS web site content on Section 1115 demonstrations. The press release reads:

The revised web site content signals a new, broader view of Section 1115 demonstrations, in which states can focus on evidence-based interventions that drive better health outcomes and quality of life improvements. The update signals CMS's willingness to work with state officials requesting flexibility to continue to provide high quality services to their Medicaid beneficiaries, support upward mobility and independence, and advance innovative delivery system and payment models. [FN3]

The “broader view” of Section 1115 demonstrations includes CMS' willingness to work with states in developing work requirements for able-bodied Medicaid participants of working age. CMS sees this as a way to give dignity to these individuals and a way to lift people out of poverty. The agency first signaled its desire to entertain state proposals that include work requirements in a March 2017 letter. [FN4] A handful of states have work requirements in pending waiver requests, and a handful have been approved. [FN5] In keeping with her vision of decreased burden and increased flexibility, Verma is also instituting new policies for processing State Plan Amendments, Section 1915 waivers, and Section 1115 waivers. Finally, Verma is instituting for the first time Medicaid “scorecards” that will allow for greater transparency and accountability by publishing Medicaid outcomes. [FN6] We discuss the details of her vision more fully in the following sections.

II. WHERE DO WE STAND ON THE AFFORDABLE CARE ACT?

A. Recent Efforts to Repeal and Replace the Affordable Care Act

In March 2010, President Obama signed two bills into law: H.B. 3590, the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and H.B. 4872, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), which make comprehensive changes to Medicaid. The law aims to improve the quality of care, improve the health of the citizenry, and reduce costs. New payment and delivery models are tailored to achieve these goals. Also, the law places emphasis on decreasing fraud, abuse, and waste. While

many hailed the law for its potential to insure tens of thousands more people and make health care less expensive, others decried the law as unconstitutional – an overreach of government power. Lawsuits in several states wended their way through the court system, resulting in inconsistent decisions in different jurisdictions. Everyone understood that disputes about the law would end only when the United States Supreme Court had the last word on it, and everyone anxiously awaited the decision.

In June 2012, the U.S. Supreme Court issued its decision. [FN7] The provision always seen as the most vulnerable was what has come to be called the individual mandate, which requires nearly all individuals to be insured or pay a penalty (which the Supreme Court decided was a tax). Under the law, individuals with incomes between 100% and 400% of the federal poverty level qualify for some type of federal assistance if they are not eligible for Medicaid. The Supreme Court held that, while the individual mandate is unconstitutional under the Commerce Clause, it is within Congress' taxing authority. Somewhat surprisingly, however, the provision requiring a Medicaid expansion in 2014 was not left unscathed. Under that provision, states would have been required to expand their state Medicaid programs to include most persons making up to 133% of the federal poverty level; states refusing to do so would have run the risk of losing all federal Medicaid money. The Court found that provision to be unduly coercive, saying that it does not give states a meaningful choice. Therefore, while the government can go ahead with the expansion, it cannot pull all federal Medicaid funding for states that do not go along with it. In other words, states can “opt out” of the expansion.

Congressional Republicans worked tirelessly in the spring and summer of 2017 to create a plan that would garner enough Republican support to pass. On the second try, the House passed a repeal and replace bill, the American Health Care Act, that went to the Senate. The Senate indicated that it would not consider the House's bill but would write one of its own. The Senate's bill, the Better Care Reconciliation Act, ultimately failed, and subsequent attempts to pass a “straight repeal” and a “skinny repeal” act both failed. Both bills would have called for an eventual end to the Medicaid expansion. All of the maneuvering made for high drama, but the end came with no deal and no good prospects in sight.

The latest challenge to the Affordable Care Act comes not from Congress but from the courts. Nearly twenty attorneys general in Republican-led states filed a lawsuit alleging that the Affordable Care Act is unconstitutional now that the individual mandate has been eliminated. The trial court agreed. [FN8] The Trump Administration is not defending the law; it is now being defended by Democratic attorneys general and the House of Representatives, and they appealed. The Fifth Circuit Court of Appeals heard oral arguments in the case on July 9, 2019. News outlets reported that two of the judges on the three-judge panel appeared to more readily accept the plaintiffs' arguments. Writing for the Commonwealth Fund, Timothy Jost indicated that many of the judges' questions focused on the standing of the respective parties to bring the action or appeal the decision. On the merits, the two judges seems to side with the plaintiffs on whether the individual mandate was constitutional now that the tax has been set back to zero by the recent tax bill. However, according to Jost, the judges expressed some uncertainty about whether the law in its entirety must fail without the individual mandate:

The court seemed a bit more uncertain, however, on the consequences of holding the mandate unconstitutional on the rest of the ACA. The Republican AGs argued that the findings section of the ACA created an ‘inseverability clause’ by declaring that the mandate was ‘essential’ to — and thus not severable from — other sections of the ACA. The Democratic AGs and House disagreed, arguing that when Congress adopted the 2017 tax bill it clearly intended to affect no other provisions of the ACA. [FN9]

If the act is eventually declared to be unconstitutional in its entirety, it would upend the Medicaid expansion and popular consumer protections like the pre-existing conditions provision. If that happens, it could be a major issue in the upcoming presidential election and would put the onus back on Congress to fashion a new health care plan. Congressional Republicans went through great pains to do this in 2017 and were unsuccessful in coming up with a plan that garnered enough votes to pass. [FN10]

B. New Developments on the Medicaid Expansion

As originally passed, the Affordable Care Act included a provision requiring states to expand their Medicaid programs to adults (including childless adults) earning up to 138% of the federal poverty level. States that refused to do so were at peril of losing all of their federal Medicaid funds. The United States Supreme Court decided that this provision was unduly coercive, and it made the expansion optional for states. In subsequent years, many states signed on to the expansion, some by using waivers through which the federal government gave the states additional flexibility to design their own program. Currently, 37 states (including the **District of Columbia**) have adopted the expansion, and 14 states have not. In three states (**Idaho, Nebraska**, and **Utah**), the expansion question was on the ballot in the November 2018 election, and it passed in all three states. [FN11] The list of adopting states includes **Maine**, where the expansion was decided upon by a ballot initiative in 2017. However, former Governor Paul LePage (R) refused to submit the required State Plan amendment (SPA), so the expansion was not implemented. [FN12] After litigation, he submitted the SPA but also wrote to CMS requesting that the agency deny it. The state now has a new governor who favors the expansion, and she signed an executive order shortly after taking office calling for the state to implement the expansion. [FN13]

As indicated, voters in **Utah** approved a full Medicaid expansion last November. [FN14] Lawmakers then pushed to limit the expansion, and they successfully passed a bill to do that. [FN15] The bill is 2019 UT S.B. 96 (NS), which was adopted on February 11, 2019. The state then secured approval from CMS to implement a limited expansion covering all adults up to 100% of the poverty level. The plan would have added 70,000 to 90,000 more individuals to the Medicaid program. [FN16] (The expansion passed by the voters, however,

would have covered adults up to 138% of the federal poverty level and would have added about 150,000 newly eligible adults to Medicaid.) [FN17] However, CMS approved only 70% funding for the partial expansion, which is Utah's ordinary FMAP, [FN18] instead of the 93% it would have covered for a full expansion. [FN19] So far, CMS has refused to offer full Medicaid expansion funds for a partial expansion. Still, Utah filed a waiver request in May 2019 for full expansion funds for its partial expansion. [FN20] Utah calls its new plan the "Per Capita Cap Plan," and explained how it would work:

This spring, the State will also submit a new 1115 Waiver to CMS called the "Per Capita Cap Plan". This plan will replace the plan implemented on April 1, 2019 and will be effective upon CMS approval. The Per Capita Plan covers adults up to 100% FPL and requests the following provisions: self-sufficiency requirement, enrollment cap, up to 12-month continuous eligibility, employer-sponsored insurance enrollment, lock-out for intentional program violation provision, and a per capita cap. This plan will also request 90% federal/10% state funding. [FN21]

The Hill cited statistics from a state analysis indicating that the limited expansion in Utah's Senate Bill 96 (2019 UT SB 96 (NS)) would cover 48,000 fewer people than a full expansion and that the limited expansion would cost $50 million more than the full expansion. [FN22]

CMS has now spoken on the matter of granting full expansion funds for partial expansions. It will not. The agency discussed its reasoning in a statement:

[A] number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy. [FN23]

Utah's Senate Bill 96 included a "fall back" plan in the event that CMS denied the waiver for the Per Capita Cap Plan. While CMS did not formally deny the waiver, the state submitted a new waiver on the assumption that the previous waiver was denied based on CMS' statement on funding partial expansions. In the "Fallback" waiver, the state is seeking to expand Medicaid to individuals with income up to 138% but with certain restrictions, including an enrollment cap. If that waiver is not approved by July 2020, the state will return to the expansion as passed by the voters. [FN24]

When CMS approved the partial expansion for **Utah** at the 70% FMAP, it approved a type of work requirement. [FN25] Adding work requirements is getting a little trickier for states these days, as courts have invalidated such requirements in **Arkansas, Kentucky,** and **New Hampshire**. [FN26] However, the Utah requirements are a bit different than the work requirements in other states, which require non-elderly, non-pregnant, non-disabled adults to work or engage in certain other qualifying activities for a specified number of hours per month unless they are exempted. Participants are required to report their hours upon pain of being dropped from the program. An author from Modern Healthcare explains how the Utah requirements are different:

Expansion enrollees will be required to fill out an online assessment that directs them to a training program. Then they will have to complete 48 job searches in the first 90 days of their Medicaid eligibility. But they won't have to report a minimum number of hours of monthly employment, as in the eight other states with CMS work requirement waivers. [FN27]

As noted, voters in **Nebraska** also approved the expansion in November 2018, and the ballot initiative provided that no additional eligibility restrictions or burdens were to be added to the program. After voters approved the measure, the Nebraska Department of Health and Human Services announced that the expansion would not be implemented until late 2020. It also announced that it was seeking permission from the federal government to have two "tiers" of coverage – basic and prime; the prime tier would include dental, vision, and prescription coverage. In the first year of the program, participants could qualify for the prime level of coverage by having a physical, choosing a primary care physician, and engaging in care and case management. In the second year of the program, participants would have to complete a work requirement to qualify for prime coverage. Proponents of the expansion are angry at the amount of time the state is taking to implement the expansion and at the additional restrictions placed on coverage. The state argues that it needs that amount of time to make sure that the program is put in place in a thoughtful manner. [FN28]

In **Montana**, the legislature had already passed legislation to adopt the expansion, but it was set to expire in June 2019. A ballot initiative was put forward to fund the expansion after June with a tax on tobacco, but it narrowly failed. [FN29] Since then, the legislature passed an expansion bill, and Governor Steve Bullock (D) signed it. The bill contains work requirements, but it is expected that most people who are eligible through the expansion will be exempt. The work requirements need CMS' approval. [FN30] Because approval is pending, the requirements will not take effect on January 1, 2020 as planned. [FN31]

In **Idaho**, a ballot initiative to adopt the legislation was approved. However, Governor Brad Little (R) signed legislation making changes to the Medicaid expansion that voters adopted. Among other things, the changes call for work requirements. In Governor Little's letter to the Senate President indicating that he signed the bill, the governor expressed some reservations about the work requirements, given that courts have recently halted them in other states, and he believes that the plan may not use existing work and training programs to implement work requirements more efficiently. He also stated that he thinks the fiscal impact analysis of the bill underestimated the

administrative costs for implementing the requirements. He is, however, very supportive of work requirements in general. The governor urged the legislature to address his concerns with the bill in its next session. [FN32] The bill also included a “coverage choice provision” that would allow those earning between 100% and 138% of the federal poverty level to choose between the Medicaid program and a plan on the Marketplace with premium subsidies. The state sought a waiver from CMS to implement this provision, but CMS denied it. [FN33] Approval for the work requirements is pending. The bill is 2019 ID S.B. 1204 (NS), and it was adopted on April 9, 2019. [FN34]

Legislators in some states have already begun to explore ways to limit ballot initiatives, like in **Florida** and **Missouri**. [FN35] *Governing* magazine discusses efforts to do so in other states. It also mentions a couple of states in which such efforts have been successful, such as in **Michigan**. [FN36]

III . MEDICAID AND STATE BUDGETS and priorities

As it does each fall, the Kaiser Family Foundation released its 50-state Medicaid budget and policy survey in which it identifies trends and priorities in all aspects of Medicaid, including, for example, eligibility and enrollment, benefits, delivery and payment reforms, premiums and cost-sharing, and provider payments. The latest report is for fiscal years 2019 and 2020. In the area of eligibility, the biggest eligibility expansion comes in the form of the Affordable Care Act expansion, which extends eligibility to all adults earning up to 138% of the federal poverty limit. However, smaller expansions are worth noting as well. [FN37]

To date, 34 states (including the **District of Columbia**) have adopted the Affordable Care Act's expansion either through a State Plan Amendment or through a waiver. **Maine** and **Virginia** are the latest states to adopt the expansion. Three other states (**Idaho, Nebraska,** and **Utah**) adopted the expansion through a ballot initiative in 2018, but it has not yet been implemented due to subsequent legislative or administrative activity seeking to limit the voter-approved expansion in some way. The expansion is still a matter of debate in **Kansas, Missouri**, and **North Carolina**. [FN38]

Six states in fiscal year 2109 adopted more limited coverage expansions, and 19 planned to do so for fiscal year 2020. Kaiser gives examples of some of these narrower expansions:

• In fiscal year 2019, **Iowa** restored retroactive eligibility for nursing home residents. For fiscal year 2020, **Delaware** and **Oklahoma** planned to restore retroactive eligibility for children and pregnant women, and **Hawaii** and **New Mexico** planned to do so for all eligibility groups.

• For fiscal year 2020, **Illinois, Missouri**, and **South Carolina** are seeking waivers to expand eligibility for post-partum women beyond the 60 days currently allowed. Also for fiscal year 2020, **North Dakota** and **West Virginia** plan to increase the income eligibility limit for pregnant women.

• **Louisiana, Rhode Island**, and **Tennessee** are using either a State Plan amendment or waiver to provide at-home services to children with significant disabilities who would not qualify for Medicaid if the income and assets of their families were counted.

• In fiscal year 2019, **Louisiana** eliminated the waiting period for lawfully residing immigrant children.

• For fiscal year 2020, **South Carolina** plans to increase the income limit for parents/caretakers. The waiver also seeks to provide new coverage with an enrollment cap for childless adults who qualify because of homelessness, justice system involvement, or a need for mental health or substance use disorder services. A work requirement for non-exempt parent/caretakers would apply in the new enrollment groups. [FN39]

Seven states reported implementing eligibility restrictions in 2019, and six more have either implemented restrictions or plan to do so for fiscal year 2020. The most common type of eligibility restriction is work (or “community engagement”) requirements. As of October 2019, six states (**Arizona, Indiana, Michigan, Ohio, Utah**, and **Wisconsin**) have approved waivers to implement work requirements, and such waivers are pending in another nine states (**Alabama, Idaho, Mississippi, Montana, Oklahoma, South Carolina, South Dakota, Tennessee**, and **Virginia**). Work requirements in three states (**Arkansas, Kentucky, and New Hampshire**) have been halted by the courts. Other eligibility restrictions include limiting or eliminating retroactive eligibility, conditioning coverage on the payment of premiums, waiving reasonable promptness, and conditioning eligibility on the completion of a health assessment. [FN40]

The report also highlights trends and states' priorities in delivery reform, including:

• Managed care

• Social determinants of health

• Criminal justice-involved populations [FN41]

Managed care continues to be a major delivery model for Medicaid. All states except four (**Alaska, Connecticut, Vermont**, and **Wyoming**) use some sort of managed care for Medicaid. More states (40, up from 39 last year) contract with comprehensive risk-based managed care organizations (MCOs) to provide at least some of the Medicaid services they provide, fewer states (12) use a primary care case management model, and some states use a combination of both models. Of the 40 states that contract with MCOs, 33 of them indicate that 75% or more of their Medicaid participants are enrolled. **North Carolina** plans to implement an MCO model for its

Medicaid program in fiscal year 2020, and **Arkansas** was the one additional state that did so in fiscal year 2019. These are some of the trends that are evident in the states that used managed care in their Medicaid programs:

• Children and adults (and particularly newly eligible adults in the Medicaid expansion) are the populations most likely to be enrolled in managed care. The elderly and those who are disabled are less likely to be enrolled in managed care.

• Pregnant women are most likely to be enrolled in managed care on a mandatory basis, and people with intellectual and developmental disabilities were the least likely to be enrolled on a mandatory basis.

• In fiscal year 2019, six states that use MCOs made policy changes to increase the number of participants enrolled, and eight states planned to do so for fiscal year 2020.

• More than one-half of the 40 states that use MCOs carve-in specific behavioral health

services to their contracts. Eight states in fiscal year 2019 reporting making policy changes to their carve-in rules for behavioral health, and nine states reported plans to do so in fiscal year 2020.

• For fiscal year 2019, 36 of the 40 states that use an MCO model use at least one Medicaid quality initiative; an additional two states reported plans to do so for fiscal year 2020. Most commonly, these initiatives focus on chronic disease management, perinatal/birth outcomes, mental health, eliminating preventable events, and substance use disorder. [FN42]

Increasingly, states and the federal government are recognizing the effects of the social determinants of health, such as food and housing insecurity, education, employment, transportation, and personal safety. [FN43] At the federal level, the Centers for Medicare and Medicaid Services (CMS) launched the Accountable Health Communities Act in 2017 to address social determinants of health. It is ongoing, although CMS has cancelled one of the three tracks for lack of interest. [FN44] At the state level, Kaiser reports that several states are using their MCO contracts to implement strategies that pay heed to the social determinants of health. As of fiscal year 2020, 35 states will be using at least one strategy to do so, including screening for social needs, providing referrals to social services, or partnering with community-based organizations. Approximately 20 states will require MCOs to employ non-traditional health workers, like community health workers, and some will require states to track the outcomes of the social service referrals. [FN45] The issue brief gives examples of how **Colorado, Michigan,** and **West Virginia** are using MCO contracts to address social determinants of health:

• **Colorado** is working with its MCOs to develop a reporting mechanism to track referrals to social services, with the goal of establishing a future performance metric that could be tied to payment.

• **Michigan** establishes a minimum ratio of CHWs to members and requires MCOs to provide or arrange for CHW services as part of the state's comprehensive population health management strategy.

• **West Virginia**'s enrollment broker collects social determinants of health data for beneficiaries enrolling in managed care and shares this data with MCOs. The MCOs use the data to identify and engage members in need of non-medical supports and refer those members to community services. [FN46]

The brief also highlights **North Carolina**'s planned MCO program that focuses on social determinants of health.

States have begun to realize that recognizing the health needs of incarcerated individuals before they are released may improve health outcomes once they are released. States seem to be particularly concerned with substance abuse and mental health services during the transition from incarceration to release. As the Kaiser Family Foundation indicated in its 50-state survey,

Improving continuity of care for individuals released from correctional facilities into the community is important to ensure that individuals with complex or chronic health conditions, including behavioral health needs, have an effective transition to treatment in the community. It can also help address the opioid epidemic by mitigating the risk of overdose in the period following incarceration. [FN47]

According to Kaiser, a total of 13 states in fiscal year 2019 have programs to provide care coordination services to prisoners prior to release, and six more had plans to do so in fiscal year 2020. In fiscal year 2019, five states (**Arizona, Colorado, Louisiana, Ohio**, and **Washington**) were leveraging MCO contracts for this purpose, and eight (**California, Colorado, Connecticut, Kansas, Michigan, Pennsylvania, Rhode Island,** and **South Carolina**) were offering the services through a fee-for-service plan. For fiscal year 2020, three states (**Delaware, Hawaii,** and **Virginia**) had plans to use their MCO contracts to provide care coordination services, and three (**District of Columbia, Delaware,** and **Virginia**) had plans to use a fee-for-service initiative. [FN48] Please see the brief for highlights of initiatives in **Louisiana, Ohio,** and **Washington**.

Finally, the states were asked whether they had implemented or planned to implement delivery or payment reforms such as patient-centered medical homes, accountable care organizations, Affordable Care Act health homes, DSRIP (Delivery System Reform Incentive Payment) programs, or an episode-of-care payment system. Forty-four states had at least one such reform in place in fiscal year 2019, and 14 more planned on implementing or expanding such reforms for fiscal year 2020. The most popular reform is the patient-centered medical home: 30 states in fiscal year 2019 had implemented this reform and another four planned to do so for 2020. [FN49]

Kaiser released another brief in April 2019, this one dealing specifically with state Medicaid policies on eligibility, enrollment, and cost-sharing. Writing first about eligibility, the authors note that all but 14 states have implemented the Affordable Care Act's Medicaid expansion, making most adults who earn up to 138% of the federal poverty level eligible for Medicaid. Eligibility for parents and childless adults remains very limited in the states that did not expand. For example, the median eligibility level for parents in non-expansion states is 40% of the federal poverty level, and childless adults are simply not eligible. The exception is **Wisconsin**, which did not implement the Affordable Care Act expansion but nonetheless covers all adults up to 100% of the federal poverty level. In non-expansion states, many adults fall into a coverage gap because they make too much to qualify for Medicaid but too little to qualify for subsidies in the insurance marketplace; subsidies in the marketplace are only available for those earning 100% of the federal poverty level. Fortunately, Medicaid eligibility for children and pregnant women remains “stable and robust.” States are following a trend to add work requirements to their programs, which has the effect of limiting eligibility. The authors point out that 13 states have approved waivers for work (or “community engagement”) requirements, and several states have waivers pending.

With regard to enrollment, the authors note that most states have modernized and streamlined enrollment and renewal processes, which reflects priorities in the Affordable Care Act. As of January 2019, all states now offer an online application system. States still offer more than one way to apply, like the mail and in person, as not everyone has access to the internet. Because the new systems use electronic data matches to verify eligibility, most states can offer real-time initial eligibility determinations and renewals. [FN50] As for premiums and cost sharing, federal regulations largely set the rules, but CMS has approved waivers for some states to charge higher premiums and cost sharing than would normally be allowed. **Kentucky** and **New Mexico** recently eliminated premiums and cost sharing for children. [FN51] Please see the brief for a more thorough treatments of these policies.

Kaiser Health News reports on the not-insignificant drop in the number of Medicaid enrollments in **Tennessee** and **Missouri**. In these two states, enrollment is falling faster than in other states. In 2018, enrollment fell 9% in Tennessee and 7% in Missouri. Nationally, the drop in enrollment was 1.5% from January to October 2018. [FN52] Some believe that new verification systems are to blame, but state health officials in the two states credit lower unemployment rates and other factors for the drop. In **Missouri**, the new verification process flags people who have some problem with their eligibility. The state said that it sent notices to these people instructing them to update their eligibility information within 10 days. People who did not respond or who could not prove their eligibility were disenrolled. The process to re-enroll is difficult. According to *Kaiser Health News*, some Missouri residents who were dropped from Medicaid waited several hours on the phone to get help in re-enrolling. A health economist from Missouri believes that the eligibility system in Missouri makes it too difficult for participants to remain enrolled, and he explains why re-enrolling might be hard for low-income individuals:

Since low-income people move or may be homeless, their mailing addresses may be inaccurate. Plus, many don't read their mail or may not understand what was required to stay enrolled[. [FN53]

In **Tennessee**, which has a similar system, some enrollees who were dropped were sent lengthy forms to re-enroll, some up to 47 pages. A spokesperson for the Medicaid program in Tennessee points to the state's “robust appeals process” for people whom the state determined to be ineligible under the reverification system. [FN54]

While there is no financial cost to re-enroll in Medicaid, a researcher who conducted a study in 2005 pointed to the non-financial costs of re-enrolling. The study examined disenrollment of children from Medicaid and CHIP, and the researcher highlighted some of impediments to re-enrollment:

[I]ndirect costs can be numerous, including but not limited to transportation, time lost from work, child care, paperwork costs, and postage. Furthermore, the entire process may be stressful and demanding of one's effort and attention, which can be considered psychological costs. [FN55]

Unfortunately, most of the participants who were dropped in **Missouri** were children. An advocate estimated that 57,000 children were dropped from the Medicaid rolls, a drop that is nine times the national average. [FN56]

Of course, when people lose their coverage, it affects hospitals. The president and chief executive of the Missouri Hospital Association believes that the unusual number of people who lost coverage may account for the higher numbers of uninsured people they are seeing in the hospitals. In **Tennessee**, the executive director of a non-profit advocacy center acknowledges that smaller Medicaid rolls mean less expense for the state. However, if people are improperly disenrolled, it may end up costing more in the long run as these now-uninsured individuals begin going to emergency departments to get care. [FN57]

Last, a crisis is looming in Puerto Rico's Medicaid program. Medicaid runs differently in the United States territories than it does in the states. The government is generally less generous with the territories than the states even though poverty is much higher in the territories. **Puerto Rico**'s Medicaid program has suffered recently due to a variety of causes, not the least of which is the recent hurricanes that beset the island. According to the Kaiser Family Foundation, 42% of the island's population is living in poverty, compared to an average of 11% in the states. Forty-one percent of the population relies on Medicaid. [FN58] Unlike in the states, federal Medicaid funding is capped, and the island is subject to a 55% statutory federal medical assistance percentage (FMAP, or matching rate). [FN59] In the states, the FAMP is calculated by the relative wealth of the state. If Puerto Rico was a state, the formula for setting the FMAP would yield an 83% match rate instead of the 55% it is receiving now. [FN60]

In 2018, Congress granted additional temporary funds to Puerto Rico to shore up its Medicaid program. Those funds are set to expire in September 2019. At that point, if nothing else is done, 500,000 to one million Puerto Ricans could become uninsured. [FN61] Commentators and health policy experts are suggesting that the government could fix a long-standing inequity by reforming the way Medicaid is financed in the territories. This could be done by removing or increasing the federal cap and by setting FMAPs in the territories using the same method the government uses to set them in the states. [FN62] A bill is pending in Congress to do just this. (See "Selected Legislative Activity," below.)

Puerto Rico would be on equal footing with the states if Puerto Rico itself was a state and not a territory. Representative Darren Soto (D-Fla.) and Resident Commissioner Jeniffer Gonzalez Colon (R-PR) have introduced the Puerto Rico Admission Act (2019 FD H.B. 1965 (NS)) calling for statehood for Puerto Rico. In his press release, Soto does not specifically mention Medicaid funding as a reason for statehood; rather, he mentions the unequal treatment generally:

"This bill is about respecting democracy and equality in Puerto Rico. Our historic legislation will finally end over 120 years of colonialism and provide full rights and representation to over 3.2 million Americans. We have seen time and time again that colonial status is simply not working. Look no further than the abysmal Hurricane Maria recovery efforts and the draconian PROMESA law to prove this point all too well. The Puerto Rican people have spoken. It's time for Congress to finally make Puerto Rico a state!" [FN63]

The bill is controversial, as Puerto Ricans appear to be deeply divided on the matter of statehood. [FN64]

IV. The Current State of Medicaid Waivers and State Plan Amendments

- **Changing the way the Waiver Requests and State Plan Amendments are Processed**

In March 2017, then-HHS Secretary Tom Price and CMS Administrator Seema Verma penned a letter to state governors to highlight the Administration's commitment to giving states flexibility in their Medicaid programs. The government aims to help states improve their programs by easing restrictions on Section 1115 waivers and on the State Plan amendment process. HHS believes that the Affordable Care Act, as administered by the Obama Administration, strayed from the core mission of the Medicaid program, and the department believes that they can reverse this course by allowing states greater latitude in designing their programs. [FN65] The Administration demonstrated its willingness to provide more flexibility to the states when it extended a **Florida** Section 1115 demonstration that calls for lighter reporting requirements. [FN66]

In line with its stated desire to decrease burdens and increase flexibility, CMS announced on November 7, 2017, its new policies for processing State Plan Amendments, Section 1915 waivers, and Section 1115 waivers. The new policies will allow states to:

• Request approval for certain 1115 demonstrations for up to 10 years;

• More easily pursue "fast track" federal review, which makes it easier for states to continue their successful demonstration programs;

• Spend time administering innovative demonstrations by reducing certain 1115 reporting requirements;

• Expedite SPA and 1915 waiver efforts through a streamlined process and by participating in a new "within 15-day" initial review call with CMS officials. [FN67]

Months later, CMS published two Informational Bulletins fleshing out the commitments it made in its March 14, 2017 letter [FN68] to improve the process for reviewing Medicaid waivers and State Plan Amendments. One bulletin addresses Section 1115 waivers and sets out several new strategies it will use for reviewing and approving these waivers.

• **Reducing the burden on states:** One strategy aims to reduce burdens for states applying for waivers by revising the application template, working with states to develop a timeline for approval, and revising the process for developing the "special terms and conditions" that accompany waiver approvals.

• **Increasing efficiency:** Another strategy seeks to increase efficiency by expediting the approval process, providing for a "fast track" approval process, and allowing extension requests to have separate segments for complex and non-complex components.

• **Promoting transparency:** CMS aims to increase transparency by providing consistent communication during the process, providing technical assistance to the states as they develop their applications, cooperating with states on timelines, providing clear communication about "gaps" in an application, clarifying expectations about budget neutrality, and coordinating efforts with the Center for Medicaid and CHIP Services (CMCS).

• **Enhancing the process for monitoring and evaluating demonstrations:** In monitoring and evaluating demonstrations, CMS will target its resources on priority areas, improve standardization of measurements, strengthen its ability to spot problems and implement mid-course corrections, and strengthen evaluation design to produce better and more meaningful information; it will also decrease the states' monitoring reporting requirements for certain types of demonstrations and provide guidance and technical assistance for designing evaluation tools. [FN69]

In 2017, CMS announced that it approved its first ten-year extension under its new waiver policy for Mississippi's Family Planning Medicaid Waiver. The waiver extension will allow **Mississippi** to extend coverage of family planning services for women and men of

a certain age who have income up to 194% of the federal poverty level that are not currently enrolled in Medicaid or another type of insurance that offers family planning services. [FN70] Also, in keeping with its new policy, [FN71] CMS informed the state that it changed certain special terms and conditions (STCs) for the waiver to reduce administrative burden. CMS explains:

These STC updates include granting a ten-year extension of the demonstration, streamlining monitoring requirements to an annual reporting cycle and establishing templates for annual monitoring reporting as well as for evaluating demonstration outcomes that will facilitate the state's data development, collection, and reporting capacity. [FN72]

The second Informational Bulletin sets out new procedures for processing State Plan Amendments and Section 1915 waivers. Section 1915 (a), (b), and (c) waivers differ from Section 1115 waivers in their breadth. Section 1115 waivers are broader and allow a state to test a wide-range of innovative reforms. Section 1915 waivers are more narrow, dealing with voluntary or mandatory managed care (Section 1915 (a) and (b)), and home- and community-based services (Section 1915(c)). [FN73] The second Informational Bulletin addresses State Plan Amendments and Section 1915 (b) and (c) waivers. CMS explains that it wishes to streamline the process for approving State Plan Amendments and Section 1915 waivers by:

• Making phone calls to states within 15 days of receiving a State Plan Amendment or Section 1915 waiver request so as to easily communicate expectations, timelines, etc.

• Offering toolkits containing preprints, templates, guidance, and so forth.

• Reducing State Plan Amendment backlogs by contacting the states about their pending applications and resolving the issues that are keeping the applications in a pending status.

• Expanding the use of MACPro (an internet-based system for the submission, review, and approval of State Plan Amendments) to additional State Plan Amendment topics. [FN74]

This is a starting point; CMS indicates that it continues to develop ways to simplify the State Plan Amendment and Section 1915 waiver processes. [FN75]

CMS then released a new Informational Bulletin about the progress the agency has made in reviewing SPAs and Section 1915 waivers, supplying data on improved review times. Among other things, CMS also reports that there are now three possible paths for reviewing SPAs and 1915 waiver requests:

• Expedited review path

• Escalation review path

• Standard review path

The expedited review path is being piloted right now. In this path, CMS will streamline the review process for requests that meet the agency's criteria (which it spells out in the Information Bulletin). In the escalation review path, the agency will identify requests that involve policy or legal questions or are at risk of disapproval. In this path, CMS will engage with state officials earlier in the process than it normally would. The standard review path is for requests that do not qualify for either the expedited path or the escalation path. CMS also convened a working group to develop additional process improvements for Section 1915(c) home- and community-based services waivers and has instituted several changes. Please see the bulletin for a detailed account of all of the improvements. [FN76]

In a later blog post, CMS Administrator Seema Verma highlighted some of the improvements in SPA and Section 1915 waiver processing that have resulted from these policies:

• Between calendar years 2016 and 2018, there was a 16 percent decrease in the median approval time for Medicaid SPAs.

• Seventy-eight percent of SPAs were approved within the first 90 day review period during calendar year 2018, a 14 percent increase over 2016.

• Between calendar year 2016 and 2018, median approval times for 1915(b) waivers decreased by 11 percent, 1915(c) renewal approval times decreased by 38 percent, and 1915(c) amendment approval times decreased by 28 percent.

The backlog of pending SPA and 1915 waiver actions pending additional information from the states was reduced 80 percent from previous years. [FN77]

Of course, all waivers must be monitored and evaluated to determine if they are achieving their goals. The demonstrations, however, must be monitored and evaluated for success. [FN78] CMS has released new tools and guidance for monitoring and evaluating the success of demonstrations that test Medicaid eligibility and coverage. Examples of such demonstrations could include work or community engagement requirements, premium assistance for purchasing private insurance, and incentives and disincentives for meeting program requirements. CMS summarizes the new resources in a press release:

The resources include:

Implementation plan template: This template provides a framework for the state to document its approach to implementing CE policies. It also helps to determine the appropriate information for the state to report to CMS in the quarterly and annual monitoring reports.

Monitoring report template: The monitoring report template provides the state with a framework for how to report information to CMS on a quarterly and annual basis including quantitative monitoring metrics.

Evaluation design guidance: The evaluation design guidance highlights key hypotheses, evaluation questions, measures and evaluation approaches, which states can use to inform the development of a rigorous evaluation of section 1115 demonstrations. This includes guidance specific for states pursuing community engagement demonstrations. [FN79]

CMS will provide support to states as they work to implement these tools. [FN80]

- **Work Requirements and other Controversial Features of Waivers**

Section 1115 of the Social Security Act allows the HHS Secretary to waive Medicaid program requirements for experimental, pilot, or demonstration programs that are likely to promote the objectives of the Medicaid program. Previous administrations have interpreted this to mean that the waiver program must be designed to expand coverage. Therefore, the government had never before approved program features like work requirements, which could actually limit coverage. For example, the Obama Administration was strict in denying Section 1115 waivers that called for work requirements as a condition of Medicaid eligibility [FN81] and was strict about not allowing states to impose premiums on the poorest Medicaid participants. [FN82] Currently, several waivers are pending are seeking to impose work requirements, and some states have received approval to implement such requirements. Pending waivers include other Medicaid program features that were not allowed under the previous administration. [FN83]

The Trump Administration does not view Section 1115 authority as being limited to plans that expand coverage. According to a brief from the Kaiser Family Foundation,

revised waiver criteria focus on positive health outcomes, efficiencies to ensure program sustainability, coordinated strategies to promote upward mobility and independence, incentives that promote responsible beneficiary decision-making, alignment with commercial health products, and innovative payment and delivery system reforms. [FN84]

The Trump Administration's shift in waiver policy is apparent in the way it has treated waiver requests to approve work requirements in Medicaid. Seeing the writing on the wall, ten states, **Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah** and **Wisconsin,** had submitted proposals seeking to impose work requirements before CMS formally issued guidance on the matter. In January 2018, CMS issued guidance specifically approving such approaches and setting out guidelines for including them in state Medicaid programs. [FN85] CMS firmly believes that education, higher income, and employment are all social determinants of health, so allowing states to impose work/community engagement requirements are all in keeping with sound Medicaid policy. However, states will not be allowed to impose such requirements on the elderly, the disabled, or pregnant women. CMS explained the types of activities it would consider “community engagement,” and it explained that demonstrations should test whether requiring these activities leads to sustained involvement in work or community engagement and whether they lead to improved health outcomes:

Today, CMS is committing to support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities (e.g., skills training, education, job search, caregiving, volunteer service) in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other productive community engagement and whether sustained employment or other productive community engagement leads to improved health outcomes. This is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage, 12 but it is anchored in historic CMS principles that emphasize work to promote health and well-being. [FN86]

The agency indicated that it would approve demonstrations that align work or community engagement requirements with SNAP (Supplemental Nutrition Assistance Program) or TANF (Temporary Aid for Needy Families). However, states need to be flexible in their approach and work within the confines of other federal statutes:

CMS recognizes that adults who are eligible for Medicaid on a basis other than disability (i.e. classified for Medicaid purposes as “non-disabled”) will be subject to the work/community engagement requirements as described in this guidance. These individuals, however, may have an illness or disability as defined by other federal statutes that may interfere with their ability to meet the requirements. States must comply with federal civil rights laws, ensure that individuals with disabilities are not denied Medicaid for inability to meet these requirements, and have mechanisms in place to ensure that reasonable modifications are provided to people who need them. States must also create exemptions for individuals determined by the state to be medically frail and should also exempt from the requirements any individuals with acute medical conditions validated by a medical professional that would prevent them from complying with the requirements. [FN87]

Additionally, states need to take into account the needs and limitations of those suffering from addiction and make appropriate modifications for these people, including counting time in treatment toward the work or community engagement requirement or exempting these individuals from the requirements altogether. Please see the letter for a full explanation of CMS' intent. [FN88]

States that have approved waivers for work requirements include **Arizona, Indiana, Michigan, Ohio, Utah**, and **Wisconsin.** Some states (**Kentucky, Arkansas**, and **New Hampshire**) had approved waivers, but courts have set aside their work requirements. (New Hampshire had earlier voluntarily suspended its program because so many people were on track to lose coverage.) Waivers are pending in **Alabama, Mississippi, Montana, Oklahoma, South Carolina, South Dakota, Tennessee,** and **Virginia**. [FN89]

CMS approved the first waiver under the new policy for the **Kentucky** HEALTH ("Helping to Engage and Achieve Long Term Health") program. The waiver addresses many Medicaid features, including cost-sharing, premiums, incentives, and so forth. The community engagement component, however, is called PATH (Partnering to Advance Training and Health), and the state sees it as a way to build independence and shore up the workforce. [FN90]

Just days after the Kentucky waiver was approved, a small group of Kentucky Medicaid participants sued the federal government in the federal district court for the District of Columbia arguing that the requirements are unlawful. [FN91] The plaintiffs contend that the government improperly used administrative procedures instead of an act of Congress to fundamentally change Medicaid law:

The plaintiffs are asking the court to declare that the work requirement policy and Kentucky's waiver are illegal and cannot be implemented because they violate the Administrative Procedures Act (APA), the Medicaid provisions of the Social Security Act, and the President's Constitutional duty to take care that laws are faithfully executed. The plaintiffs argue that HHS "bypass[ed] the legislative process and act[ed] unilaterally to 'comprehensively transform' Medicaid" using a "narrow statutory waiver authority" that has "effectively rewritten the statute." The plaintiffs argue that the Kentucky waiver puts them at risk of losing Medicaid by creating new eligibility criteria that they contend are beyond HHS's authority, such as the work requirement and the highest premiums ever permitted in Medicaid. In support, they cite Kentucky's waiver application, which projects 95,000 fewer enrollees and $2.5 billion less in spending over five years. [FN92]

The case is styled as *Stewart v. Azar*. [FN93] The plaintiffs are represented by the National Health Law Program, the Kentucky Equal Justice Center, and the Southern Poverty Law Center. [FN94]

The trial court ruled on the case in June 2018. The crux of the court's decision was that the HHS Secretary did not consider how the waiver would advance the purposes of the Medicaid statute. The court explained that, while the HHS Secretary has broad authority to approve waivers, his discretion is not without limits. The secretary is meant to consider two things in approving a Section 1115 waiver: (1) whether the proposed project is an experimental, pilot, or demonstration project, and (2) whether the waiver is designed to promote the objectives of the Medicaid statute. The plaintiffs argued that Kentucky HEALTH, as a whole, does neither. In reviewing the decision, the court asks whether the secretary's decision to approve the waiver is arbitrary or capricious. The court identified a statutory section that outlines the objectives of Medicaid; those objectives are to, as reasonably practicable, furnish low-income people with health insurance and provide rehabilitation services to enable these individuals to "attain or retain capability for independence or self-care." [FN95]

The court held that neither Kentucky nor the secretary maintained the proper focus when evaluating the Kentucky HEALTH waiver proposal. The court pointed to record evidence that the secretary instead determined that the project would,

improve health outcomes, promote increased upward mobility and improved quality of life, increase individual engagements in health decisions, and prepare individuals who transition to commercial health insurance coverage to be successful in this transition.

These are all laudable goals, according to the court, but missing from the analysis was an inquiry into whether the project would help provide insurance coverage to low-income people. That inquiry requires two analyses: "First, whether the project would cause recipients to lose coverage. Second, whether the project would help promote coverage." According to the court, the Secretary neglected both questions. [FN96]

Instead of immediately appealing the decision, HHS reopened a month-long comment period, which ended in August. According to an article in Health Affairs, CMS received about 10,000 unique responses, and they were overwhelmingly critical of the requirements: 96% of the comments were unsupportive of the requirements and 4% were supportive. [FN97]

On November 20, 2018, CMS re-approved the Kentucky Health waiver. In a letter to the Kentucky Medicaid Commissioner, CMS acknowledged that the stated objective of Medicaid is to supply health insurance for needy people. However, according to CMS,

[t]his provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs. [FN98]

In an Issue Brief reviewing CMS' re-approval of the waiver, the Kaiser Family Foundation wrote that the newly approved waiver varies very little from the original one. CMS is now requiring the state to submit evaluation hypotheses for the work requirements:

The recent re-approval of the Kentucky HEALTH program is largely the same as the original approval with a few technical or minor changes. The re-approval also includes requirements for the state to submit implementation and monitoring protocols to CMS for

approval as well as some evaluation hypotheses for the work requirement and other provisions that are likely to have significant implications for beneficiaries' ability to retain coverage for which they are eligible. The original waiver approval only required protocols for the SUD program and made submission of any Kentucky HEALTH protocols optional for the state. [FN99]

After CMS re-approved the Kentucky waiver, further litigation ensued. On March 27, 2019, the same judge once again struck down the Kentucky waiver and halted the work requirements in **Arkansas**. The judge's reasoning was the same: In approving the waiver, the Secretary did not consider how the requirements would advance the essential purpose of Medicaid – to provide health insurance to the poor. [FN100]

CMS firmly believe that work requirements are a viable way to pull people out of poverty and eliminate their need for Medicaid. Opponents contend that most Medicaid participants are already engaged in the activities that would satisfy the work requirements, and the requirements needlessly disenroll participants for failing to comply with the onerous reporting. CMS Administrator Seema Verma suggested in a statement that CMS will continue approving work requirements in other states. [FN101] Like other issues affecting health care these days, the matter is not likely to be resolved until the U.S. Supreme Court rules on the matter.

CMS also announced that it approved **Wisconsin**'s waiver request to impose community engagement requirements (often called work requirements) for a certain population in the Medicaid program. The approval is a part of an amendment and renewal of the state's BadgerCare Reform waiver. That waiver, which was originally approved in 2014, expanded Medicaid to all adults with income below the federal poverty limit. [FN102] This was less than a full-scale Affordable Care Act expansion, which would have expanded Medicaid to all adults earning up to 138% of the poverty limit. CMS' decision marks the first time that the agency has approved community engagement requirements in a state that has not adopted the Affordable Care Act's Medicaid expansion. [FN103] When announcing the approval, CMS Administrator Seema Verma responded to criticism of community engagement requirements by noting the social opportunities that such requirements can bring in a state like Wisconsin:

In Wisconsin, where the unemployment rate has rested just at or below 3% through this entire year, state leaders recognize that employers are struggling to find talent. In one example, an auto parts manufacturer in Sheboygan has even dropped their high school diploma requirement and has begun hiring individuals without manufacturing experience. What this means is that there are real, life-changing opportunities available to help lift individuals out of the shadows of opportunity and into its light. States rightly want to explore innovative ways to achieve that objective. [FN104]

The requirements will only apply to non-exempt individuals under age 50 who do not have children. Those subject to the rules will be required to participate in a qualifying activity (employment, job training, volunteer community service, or enrollment in a qualified work program) for 20 hours per week, but they will have 48 non-consecutive months of coverage to come into compliance with the rule. If they do not comply within that time, they will become ineligible for benefits for six months, after which they may reenroll with a new 48-month time period in which to comply. [FN105] The new approval will also allow the state to require that individuals in the demonstration complete a health risk assessment and will allow the state to require premiums for individuals earning as little as 50% of the federal poverty level. The agency did not, however, approve a request to impose drug testing as a condition of eligibility. [FN106] Instead, the health risk assessment will inquire about substance use, but eligibility will not depend on passing a drug test. [FN107] On election day, Governor Scott Walker, whose administration sought the waiver, lost his office to Governor-elect Tony Evers, a Democrat. It is unclear at this point whether the new administration will implement the waiver.

New Hampshire imposed work requirements for the Medicaid expansion population earlier this year. Beginning in June, the state was to begin removing participants from the Medicaid rolls if they failed to report the required number of hours for two or more months. [FN108] However, in June, when officials discovered that 17,000 individuals had not complied with the reporting requirements despite the state's outreach efforts, the state decided to delay the penalty through September. The state's Commissioner of Health and Human Services said that the department would begin door-to-door outreach campaigns in certain “high density” communities. Governor Chris Sununu (R) explained the reason for the delay:

“Making sure we get this right is just absolutely paramount . . . . So the idea of giving ourselves another 120 days to move forward on this and get the implementation where we need it to be, it's not just fair to the system, but it's fair to those individuals.” [FN109]

Governor Sununu has also signed legislation tweaking the work requirements. Among other things, the bill, 2019 NH S.B. 290 (NS), would add self-employment as a qualifying activity and would change the current exemption for individuals in substance use disorder treatment to include the phrase, “or recovery activities and/or mental health treatment.” Importantly, the bill calls for benefits for non-complying individuals to be initially suspended rather than terminated, and it adds additional provisions to the subsection of the existing statute requiring ongoing monitoring.

In late July 2019, a judge halted the work requirements in **New Hampshire**, ruling that, like in **Arkansas** and **Kentucky**, CMS approved the requirements without consideration of the number of people who could lose coverage because of the requirements. [FN110]

Not everyone is sold on the idea of requiring work or community engagement as a condition of eligibility for Medicaid. The Center for Budget and Policy Priorities (CBPP), for example, contends that there is no sound evidence that these types of requirements lead

to better health. The author of a recent blog post argues that the studies CMS cited do not support CMS' arguments because, while there may be a correlation between work or engagement activities and improved health, they do not establish a causal relationship between the two. In fact, according to the author, the causal effect may be in the opposite direction -- that improved health through access to care enables people to work. States that have proposed such requirements acknowledge that the new policy would lead to a loss of coverage for thousands of people. Often this is because otherwise eligible people lose coverage because of the red tape necessary to prove compliance. [FN111] The authors of a Commonwealth Fund post also contend that demonstrations that admittedly lead to a decrease in people covered may not be consistent with the purpose of Medicaid, which is to provide health insurance to needy individuals. [FN112]

CBPP reviewed the effects of work requirements in **Arkansas** and **New Hampshire**. So far, **Arkansas** is the only state to have actually disenrolled participants from Medicaid for failing to comply with the requirements. In that state, more than 18,000 participants lost coverage in the first seven months for failing to comply; that number represents about 25% of all participants subject to the requirements. According to CBPP, evidence suggests that many of those who lost coverage were either working or had illnesses that would have exempted them. The failure to comply was often because participants did not understand the reporting requirements or did not know about them at all. Moreover, CBPP points to research indicating that, while the uninsured rate in Arkansas rose significantly after the requirements took effect, the employment rate did not. [FN113]

Perhaps because of the coverage losses in Arkansas and the potential losses in New Hampshire, several states are rethinking their work requirements. According to CBPP, **Arizona** has suspended its program, and the governor in Maine has withdrawn a waiver that would have permitted the state to disenroll low-income parents for non-compliance. **Michigan**'s work requirements are to take effect in 2020, but the governor has expressed concern about the potential losses. She is urging the legislature to consider legislation suspending the program if appears that the coverage losses will be too great. CMS has not yet approved **Virginia**'s waiver to impose work requirements, but the state is already having second thoughts. It is worried that without federal funds for workforce supports, it may not be able to implement them. [FN114]

The Trump Administration's new waiver policy direction leads people to wonder how far the government will go with its promised flexibility, as some states have long wanted to impose stricter requirements in their programs. One edge may be coming into focus, as news outlets are reporting that CMS will not approve **Kansas**' waiver request to impose a lifetime limit on Medicaid benefits for able-bodied individuals. The state had requested approval to impose a three-year limit on coverage for these adults. [FN115] CMS Administrator Seema Verma made the announcement in a speech before the American Hospital Association. Verma explained why the agency was denying the request:

We are also determined to make sure that the Medicaid program remains a safety net for those that need it most. To this end, we have determined that we will not approve Kansas' recent request to place a lifetime limit on Medicaid benefits for some beneficiaries. We seek to create a pathway out of poverty, but we also understand that people's circumstances change, and we must ensure that our programs are sustainable and available to them when they need and qualify for them. [FN116]

Many oppose the idea of lifetime limits, with Democrats on the House Energy and Commerce Committee calling them “unspeakably cruel” in a letter to the Secretary of HHS. [FN117] Others question the legality of such a move. According to *The Hill*, Verma sees the lifetime limit as a different sort of requirement than the work requirement because, with work requirements, Medicaid participants are never completely locked out of coverage as long as they comply. [FN118]

For a fuller discussion of CMS' new policies on its waiver approval policies, please see the agency's most recent Informational Bulletin on the topic. [FN119]

On a related note, the Kaiser Family Foundation has released an interactive map of states with approved or pending Medicaid waivers. [FN120]

V. STATE INNOVATIONS IN HEALTH REFORM

A. Alternative Payment Models

The Affordable Care Act emphasized paying for value over fee-for-service, and the Trump Administration has continued many Obama-era policies and initiatives that seek to cut costs and improve care through value-based payment. Many of the new payment models require providers to change the way they deliver care in order to make value-based payments work for them. As a Commonwealth Fund post notes, “Alternative payment models (APMs) provide incentives for health care providers to deliver efficient, coordinated care centered on the needs of each patient rather than simply paying for the number of services delivered.” [FN121]

According to the Commonwealth Fund post, Medicaid programs have primarily used APMs with primary care and acute-care providers. Now, Medicaid officials are eyeing these models for behavioral health, long-term care, and safety-net providers. The post gives a few examples of where Medicaid programs have used APMs for behavioral health providers:

Several states have adopted payment reforms in this area. Rhode Island's accountable care organization (ACO) model holds ACOs accountable for their performance around behavioral health outcomes. Maine and Tennessee adopted health homes focused on integrating care for individuals with behavioral health needs. Tennessee also adopted episode-based payments related to the treatment of attention-deficit/hyperactivity disorder and oppositional defiant disorder. [FN122]

The authors give such examples for safety-net and long-term care providers as well. However, certain challenges make adoption of APMs more difficult for these types of providers. For example, most behavioral health providers have not adopted medical records, [FN123] which can be crucial for compliance with an APM. For safety-net providers, current federal rules require that they be paid based on costs. The post provides several recommendations for overcoming these obstacles. [FN124]

B. Accountable Care/Shared Savings

Shared savings models have been used in the Medicare context with the Physician Group Practice Demonstration and with ACOs in the several Medicare ACO programs, most prominently the Shared Savings Program. CMS recognizes that the Medicaid program is different in important ways from the Medicare program, so states looking to use shared savings models in their Medicaid programs cannot necessarily use Medicare programs as templates. [FN125] For example, in a 2014 Commonwealth Fund Blog post, the authors point out that Medicaid participants have more behavioral health, mental health, and social service needs than Medicare participants. Therefore, in order to provide cost-effective care to their participants, Medicaid ACOs would need to form different partnerships than Medicare ACOs. Also, Medicare ACOs are designed for fee-for-service payments models, and many Medicaid programs use managed care. [FN126]

According to CMS, there are four essential components of a shared savings methodology:

a total cost of care benchmark, provider payment incentives to improve care quality and lower total cost of care, a performance period that tests the changes, and an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality. [FN127]

While a Medicaid shared savings program may include only incentives for improved care and cost savings, a state may, under certain circumstances, also enter into arrangements with providers where providers agree to share in the risk as well. The letter provides more detail about when risk-sharing is appropriate. [FN128] The authors of the Commonwealth Fund Blog post note that Medicaid ACOs may not be able to accept risk immediately because of the significant start-up costs of ACOs and because they need to gain experience in managing risk. [FN129]

The Center for Health Care Strategies, Inc. (CHCS) keeps tabs on Medicaid ACOs, noting which states are actively using this model in their Medicaid programs and which are in the processing of developing them. According to CHCS, as of February 2018, states with active programs include **Colorado, Iowa, Connecticut, Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Utah,** and **Vermont**. States with programs in development include **Delaware, Idaho, Louisiana, Maryland, Missouri, New Mexico, Pennsylvania, Virginia,** and **Washington**, as well as the **District of Columbia**. [FN130] Key features of Medicaid ACOs include a value-based payment structure, measuring quality improvement, and collecting data for analysis. CHCS' Fact Sheet recites some of the positive developments from ACOs in **Colorado, Maine, Minnesota, Oregon,** and **Vermont**. Please see the Fact Sheet for more detail. [FN131] CHCS also maintains a resource center for Medicaid ACOs. [FN132]

C. Health Homes

Section 2703 of the Affordable Care Act created a state option in Section 1945 of the Social Security Act for Medicaid Health Homes to coordinate care for Medicaid participants who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

The chronic conditions listed in the Act include mental health, substance abuse, asthma, diabetes, heart disease and having a BMI of over 25. States may request CMS approval to amend their State Plans to include other conditions, like HIV/AIDS. States will receive a 90-10 match rate for health home services for the first two years. Health home services include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support

• Referral to community & social support services [FN133]

CMS lists the states that currently have approved State Plan Amendments for health homes: **California, Connecticut, Delaware,** the **District of Columbia, Iowa, Maine, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia**, and **Wisconsin**. Some states have more than one amendment or have amendments for specified purposes. [FN134]

CMS has published resources providing guidance on the Health Home Medicaid State Plan Option. First, CMS has provided an FAQ document covering various definitions; enrollment and certification standards; the provider delivery system; quality measurement and evaluation; and payment. [FN135] Other documents added to the Health Home Resource Center include a health home map; a Fact Sheet; a health home State Plan Amendment Overview by state; and an FAQ sheet with a list of chronic conditions that states have been approved to target. [FN136]

D. Managed Care

Thirty-nine states and the **District of Columbia** use managed care to provide services to their Medicaid participants, and nationally, nearly two-thirds of Medicaid participants are enrolled in managed care. [FN137] Many so-called “dual eligibles” (those who qualify for both Medicare and Medicaid) are enrolled in managed care. [FN138]

In 2016, CMS published a final rule on Medicaid managed care. Among its provisions was one allowing managed care programs to pay for inpatient addiction services in Institutions for Mental Disease (IMDs) with more than 16 beds. The rule does not apply to Medicaid fee-for-service plans, and it only pays for 15 days. Previously, Medicaid applied an exclusion for these types of services. Given the epidemic of opioid addiction, many lawmakers [FN139] and health policy experts believe that the 15-day period is too short and may violate CMS' own Medicaid mental health parity rule. [FN140] We discuss IMDs further in the following section.

CMS is once again proposing major changes to Medicaid managed care in order to promote flexibility, strengthen accountability, and promote program integrity. CMS writes that it developed the proposed rules after working with state Medicaid directors and the National Association of Medicaid Directors. According to CMS, it learned from its discussions with stakeholders that they thought that some provisions of 2016 final rule created unnecessary administrative burden and cost without leading to improved outcomes. CMS indicates that the new proposed rule is meant to “relieve regulatory burdens; support state flexibility and local leadership; and promote transparency, flexibility, and innovation in care delivery.” [FN141] Briefly, some of the changes are these:

• Promoting flexibility – giving states more flexibility to establish a rate range; making it easier to transition more services and populations into managed care; allowing states more flexibility to create their own network adequacy standards; and removing outdated and overly burdensome rules about how plans communicate with their members.

• Strengthening accountability – requiring CMS to be accountable by providing states more guidance, and maintaining the requirement for states to develop a quality rating system but allowing states more flexibility to create an alternate system.

• Promoting program integrity - strengthening requirements to protect federal taxpayers from cost shifting. [FN142]

CMS also indicated in its press release that stakeholders expressed concern about the limited exception to the IMD exclusion in the 2016 final rule, [FN143] but the agency is making no changes at this time:

[S]tates expressed their concerns with how the 2016 final rule's limitation of 15 days on lengths of stay for managed care beneficiaries in an institution for mental disease (IMD) created difficult administrative challenges for states. CMS is not proposing any changes to this requirement at this time; however, it is asking for comment from states for data that could support revisions to this policy. Meanwhile, CMS continues to support state flexibility through section 1115 demonstrations, having approved a total of 15 waivers of the IMD exclusion for states to treat patients with substance use disorder (SUD), to expand access to treatment, and is exploring further options remove barriers to important treatment options. [FN144]

The proposed rule is published at 83 F.R. 57264-01 (Nov. 14, 2018). CMS has also provided a summary of the rule's major provisions. [FN145]

VI. BEHAVIORAL HEALTH

While its exact definition is up for debate, the term “behavioral health” encompasses at least mental health and substance use disorder (drugs or alcohol). Medicaid is the single largest payer of mental health services, and the program is an increasingly larger payer for substance use disorder services. [FN146] Most mental health services are optional; however, all states offer some mental health services, [FN147] evidently in recognition of the high cost and undesirable consequences of untreated mental illness. As an essential benefit, mental health and addiction services are required for the newly eligible in states that implement the Medicaid expansion, but only 36 states and the **District of Columbia** have done so. [FN148]

One huge concern in the area of behavioral health is the opioid abuse crisis. Deaths from overdose doubled from 2007 to 2017; in 2017, 47,600 individuals died from overdose. [FN149] According to the Kaiser Family Foundation, Medicaid and CHIP cover about 40% of individuals with an opioid addiction. [FN150] The Medicaid exclusion for services provided in an “institution for mental diseases” with over 16 beds has been a stumbling block to treatment for substance use disorder. The exclusion is a vestige of the original Medicaid law in 1965 that was meant to encourage treatment in smaller, community-based settings instead of large inpatient institutions. However, it has taken away an important option in the fight against opioid abuse. [FN151] Policymakers have been battling for several years to change the provision in order to open up this option. In the meantime, the federal government has been granting waivers to states to develop pilot programs for inpatient substance abuse treatment at facilities with more than 16 beds, and several states are offering, or are seeking to offer such programs. [FN152] **California** is one such state, and officials there see it as a game-changer. [FN153] The final Medicaid managed care rule made a limited exception to the exclusion, but some see it as inadequate.

Section 5052 of the SUPPORT for Patients and Communities Act (P.L. 115-271) created a limited exception to the IMD exclusion, and CMS released a State Medicaid Director Letter offering guidance to states that wish to implement this new State Plan option. Section 5052 enacted a new section of the Social Security Act, Section 1915(l), which created an exception to allow states, at their option, to cover IMD services from October 1, 2019 to September 30, 2023, for individuals aged 19-64 with at least one substance use disorder diagnosis. Among other things, the letter specifically defines which individuals and IMDs are eligible under the exception. [FN154]

Administratively, in November 2018, CMS announced an opportunity for states to participate in a new demonstration program for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); this demonstration also tests a limited exception to the IMD exclusion. CMS described the opportunity in a State Medicaid Director Letter:

This SMI/SED demonstration opportunity will allow states, upon CMS approval of their demonstrations, to receive [federal financial participation] for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services as described below. This SMI/SED demonstration opportunity is comparable to the recent section 1115(a) demonstration opportunity to improve treatment for [substance use disorders], including opioid use disorder (OUD). However, through these demonstrations, states will focus on demonstrating improved care for individuals with serious mental health conditions in inpatient or residential settings that qualify as IMDs as well as through improvements to community-based mental health care. [FN155]

CMS has now announced that it approved such a demonstration program submitted by the **District of Columbia**. At the same time, CMS approved the district's plan to implement a similar demonstration for individuals diagnosed with a substance use disorder. According to CMS's press release, the district has been particularly affected by the opioid crisis and has experienced a 236% increase in fatal opioid-related overdoses from 2014 to 2017. Often, individuals with a substance use disorder also suffer from a serious mental illness, so CMS and the district see the potential for saving thousands of lives. [FN156]

To confront the problems with substance use disorder, CMS announced a new policy that it describes as a “more flexible, streamlined approach to accelerate states' ability to respond to the national opioid crisis while enhancing states' monitoring and reporting of the impact of any changes implemented through these demonstrations.” The new policy replaces the previous SUD Section 1115 demonstration initiative announced in a State Medicaid Director Letter on July 27, 2015. [FN157] In a Press Release announcing the new policy, CMS explained:

Previously, states had been required to build out their entire delivery system for SUD treatment while also meeting rigid CMS standards before Medicaid demonstration approvals could be granted. The new policy will allow states to provide greater treatment options while improving their continuum of care over time. [FN158]

Under the new policy, CMS is encouraging states to develop Section 1115 waiver demonstrations that over a five-year period significantly contribute to improvement on six goals and six milestones. The goals are:

1. Increased rates of identification, initiation, and engagement in treatment;

2. Increased adherence to and retention in treatment;

3. Reductions in overdose deaths, particularly those due to opioids;

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;

5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and

6. Improved access to care for physical health conditions among beneficiaries.

The milestones are:

1. Access to critical levels of care for OUD and other SUDs;

2. Widespread use of evidence-based, SUD-specific patient placement criteria;

3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;

4. Sufficient provider capacity at each level of care;

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and

6. Improved care coordination and transitions between levels of care. [FN159]

The letter suggests a timeframe for reaching each milestone, and it lists performance measures for each goal. As with the policy announced in the July 2015 State Medicaid Director Letter, CMS indicates in this letter that it will waive the IMD exclusion when treatment in such facilities supplements and coordinates with community-based care in a state-implemented continuum of care system. [FN160]

One piece of CMS' plan to combat the opioid crisis is to improve access to care. The bipartisan SUPPORT Act [FN161] is a comprehensive, multifocal plan to combat the country's opioid crisis. [FN162] It directed various departments to take specific actions to further the plan. In its first step toward complying with the act, CMS has committed up to $50 million in planning grants to award to states that are interested in finding innovative ways to increase provider capacity for treating substance use disorder. In a press release, CMS describes how it intends for the funds to be used:

The planning grants are intended to increase the capacity of Medicaid providers to deliver SUD treatment or recovery services through an ongoing assessment of the SUD treatment needs of the State; recruitment, training, and technical assistance for Medicaid providers that offer SUD treatment or recovery services; and improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers. [FN163]

State Medicaid agencies are invited to apply with a description of their 18-month proposal for delivering substance use disorder treatment and recovery services.

Access to behavioral health services for children is also a concern for the federal government. CMS' Innovation Center launched a new accountable payment and delivery model to improve Medicaid and CHIP [FN164] behavioral health services for children (individuals under age 21). Included under the category of behavioral health is misuse of opioids and other substances. [FN165] A crucial aim of the model is early identification in a wide variety of settings in addition to a clinical setting. Personnel in schools, the child welfare system, and the foster care system may be the first to see risk factors. [FN166] The goals of the program are to improve child health (including preventing substance abuse problems); reducing avoidable in-patient stays and out-of-home placements; and developing sustainable alternative payment models (APMs). [FN167] The Innovation Center believes that these goals can be met through these interventions:

Early identification and treatment of children with multiple physical, behavioral, or other health-related needs and risk factors through population-level engagement in assessment and risk stratification.

Integrated care coordination and case management across physical health, behavioral health, and other local service providers for children with health needs impacting their functioning in their schools, communities, and homes.

Development of state-specific APMs [alternative payment models] to align payment with care quality and supporting accountability for improved child health outcomes and long-term health system sustainability. (Emphasis in original.) [FN168]

Two types of participants will be involved in the model: state Medicaid agencies, which will provide the infrastructure for information sharing, provide data, and develop the APM, among other things; and Lead Organizations. The Innovation Center describes the duties of the Lead Organizations:

Lead Organizations will convene community partners to integrate coordination and management of the InCK Model's core child services for the attributed population. The Lead Organization will be accountable for improving population-level care quality and outcomes and developing service integration protocols and processes. HIPAA-covered entities, including state Medicaid agencies, will be eligible to serve as Lead Organizations. (Emphasis in original.)

The Innovation Center announced the model in July 2018, and it is now reviewing applications. [FN169] The program will begin after a two-year pre-implementation period, and once it begins, it will last five years.

Finally, the SUPPORT for Patients and Communities Act [FN170] extended the 90% FMAP (Federal Medical Assistance Percentage, or match rate) for certain health homes for individuals suffering with a Substance Use Disorder. A new CMCS [FN171] Informational Bulletin advises states on how they can request this extended enhanced funding. CMCS also explains the circumstances under which the funds are available:

The extension of the enhanced FMAP period is available only for expenditures for the provision of health home services to “SUD-eligible individuals” under a “SUD-focused state plan amendment” (both terms are defined by the statute) that was approved by the Secretary on or after October 1, 2018. States whose health homes meet those criteria may request that the Secretary extend the enhanced FMAP period beyond the first 8 fiscal year quarters, for the subsequent 2 fiscal year quarters, for a total of 10 fiscal year

quarters from the effective date of the state plan amendment. States interested in this opportunity should submit a proposal for a new SUD-focused health home state plan amendment along with a letter of request for an extension of the period of enhanced FMAP. [FN172]

New reporting requirements accompany the extended enhanced funds. The Informational Bulletin also includes FAQs. In late 2019, CMS added two new reporting measures for these health homes. They are:

(1) Use of Pharmacotherapy for Opioid Use Disorder

(2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or

Dependence (FUA-AD). [FN173]

However, CMS advises that,

unless and until CMS makes specific measures mandatory through rulemaking, states are not required to use any of the CMS-provided health home measures, although states with an extension of the enhanced FMAP period for a SUD focused health home SPA must submit the statutorily required reports. [FN174]

VII. HOME- AND COMMUNITY-BASED SERVICES

The Affordable Care Act emphasizes home- and community-based services (HCBS) for Medicaid participants, including the elderly and persons with physical or cognitive disabilities or mental illness. The idea is to care for seniors and the disabled close to where they live – in a community setting instead of an institutional setting. In 2013, the government reached the point where it is now spending more on HCBS than on institutional care. [FN175] The preference for home- and community-based services is also evident in the increasing number of states that are expanding the number of people they serve in the community. According to the Kaiser Family Foundation's annual budget survey for fiscal years 2019 and 2020, 48 states in 2019 and 47 in 2020 are employing one or more strategies to increase the number of Medicaid participants served in a home or community setting. [FN176] Most are using a HCBS waiver and/or a state plan option under Section 1915 of the Social Security Act.

The final rule [FN177] for HCBS required states to submit a transition plan to CMS demonstrating that they brought existing HCBS settings into compliance with the final rule. CMS recognized at that time that the transition would be complex, so it gave states five years to do so. The original due date was March 17, 2019. In a new Informational Bulletin, CMS announced that it is extending the deadline for another three years, until March 16, 2022. [FN178]

HCBS cannot be offered in an institution-like setting. Certain settings are presumptively institutional. They include:

• Settings that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

• Settings that are in a building located on the grounds of, or immediately adjacent to, a public institution; and

• Any other settings that have the effect of isolating individuals receiving Medicaid home and community-based services (HCBS) from the broader community of individuals not receiving Medicaid HCBS. [FN179]

Settings that are presumptively institutional must undergo a heightened scrutiny process to overcome the presumption. In 2019, CMS published guidance in the form on an FAQ document that addresses the heightened scrutiny process for HCBS settings. CMS explains,

The FAQs discuss settings identified by the regulation as being presumed to have the qualities of an institution, unless CMS determines through a heightened scrutiny review that the settings do not have the qualities of an institution and that the settings do have the qualities of home and community based settings. The FAQs focus on settings that have “the effect of isolating individuals receiving Medicaid [Home and Community-Based Services] HCBS from the broader community of individuals not receiving Medicaid HCBS.” [FN180]

The guidance also addresses these two issues:

whether an individual's private residence should be assessed for compliance with the settings criteria, and whether an individual should reside in a compliant setting in order to receive Medicaid reimbursement for non-residential HCBS. [FN181]

Parts of the guidance replace or supplement previous HCBS guidance; CMS indicates where this is the case.

CMS also issued guidance in 2019 specifically addressing the heightened scrutiny process for newly constructed settings or those under development. CMS addressed this matter in earlier guidance published in 2016 and explained that CMS could only determine whether a setting overcame its institutional presumption after the facility was in use and occupied by Medicaid participants who were receiving services there:

We explained that our determination would consider factors beyond the physical structure of the setting itself to include considerations of how individuals residing or receiving services in the setting actually experience the setting in a manner that promotes independence

and community integration. CMS cannot properly consider the factors that go beyond physical structure until the facility is operational and services are actually being provided to individuals. [FN182]

In August 2019, CMS issued new guidance revising the earlier guidance to allow states to submit a new setting to CMS for heightened scrutiny review while only non-Medicaid individuals are receiving services there. [FN183] The new guidance sets out the specific revisions to the earlier guidance, including a timeline for Medicaid approval under the new process.

Safety in HCBS settings is vital. In 2018, CMS released a report making recommendations to ensure safety in certain HCBS environments. In January 2018, three agencies within HHS - Administration for Community Living, Office for Civil Rights, and Office of Inspector General – released a report titled, “Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight.” The report was compiled after the Office of the Inspector General conducted audits in four states to determine how they were ensuring the health and welfare of those with developmental disabilities living in group homes. The report made three recommendations for doing so. The recent guidance from the Center for Medicaid and CHIP Services (CMCS) focuses on one of those suggestions: “[E]ncourage states to implement compliance oversight programs for group homes, such as the Model Practices, and regularly report to CMS.” CMCS' guidance touches on model practices in four areas: incident management and investigation, incident management audits, mortality reviews, and quality assurance. [FN184] CMS explains why it is committed to this cause:

At the outset, CMS acknowledges that ensuring high quality HCBS [home- and community-based services] to Medicaid beneficiaries is a shared goal among our state partners, provider communities, beneficiaries and their families and caregivers, and other stakeholders. Medicaid-funded HCBS play a critical role in facilitating beneficiary independence and community participation. [FN185]

The guidance does not rescind or supplant any previous guidance on home- and community-based services. CMCS encourages state Medicaid programs and providers to become familiar with the report's model practices. The guidance notes the potential for enhanced matching funds for states that will work to implement these model practices. [FN186] This is the first in a series of guidance documents that will address health and safety.

CMS has offered states the opportunity to implement some federally-developed HCBS programs. One such program is the Community First Choice Option (CFC), which can be approved as a Section 1915 waiver. Under the Affordable Care Act, states choosing this option receive a 6% bump in their Medicaid federal matching funds to design programs that provide community-based attendant services and supports to those who would otherwise be institutionalized. [FN187] Services that fall under the CFC program include such things as attendant services to help with daily living activities (e.g., eating, toileting, grooming, dressing, and bathing), instrumental activities of daily living (e.g., meal preparation, managing finances, and transportation); and health-related tasks, (e.g., catheterization, range of motion exercises, and medication administration). Other personal services, plus the cost of moving patients back into the community from an institution, may also be covered. [FN188] Currently, only five states have an approved State Plan Amendment for a CFC program. [FN189]

CMS has provided guidance in the form of a State Medicaid Director Letter for states wishing to implement the CFC Option for providing home- and community-based services. CMS explains in the guidance:

The purpose of the CFC option is to provide individuals meeting an institutional level of care the opportunity to receive necessary personal attendant services (PAS) and supports in a home and community-based setting. The CFC option expands Medicaid opportunities for the provision of home and community-based long-term services and supports (LTSS) and is an additional tool that states can use to facilitate community integration while receiving enhanced Federal match of six (6) additional percentage points for CFC services and supports. [FN190]

The guidance includes a link to a State Plan Amendment template and a technical guide for Community First Choice. [FN191]

PACE is both a Medicare and Medicaid program. To be eligible, one must be 55 or older, live in the service area of a PACE organization, be eligible for nursing home care, and be able to live safely in the community instead of in a nursing facility. PACE is an optional Medicaid benefit, and not every state offers it. [FN192] According to Medicaid.gov, PACE,

provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits . An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. Financing for the program is capped, which allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for PACE participants. [FN193]

CMS published a final rule in 2019 that updates PACE. According to CMS, the final rule updates the program by:

• Strengthening protections and improving care for PACE participants; and

• Providing administrative flexibility and regulatory relief for PACE organizations [FN194]

The final rule is published at 84 F.R. 25610-01 (June 3, 2019).

Finally, the Money Follows the Person program helps people transition from institutions to home- and community-based settings. Funding for the program ended in 2016, but any funds authorized in 2016 may be used until 2020. [FN195] House Bill 259 (2017 FD H.B. 259 (NS)), the Medicaid Extenders Act, extends the demonstration until September 30, 2021. However, the act contains a special rule for 2019: The extended funding will only apply to states that had an approved program as of December 31, 2018.

Please see “Additional Resources” at the end of this brief for more information about home- and community-based services.

VIII. CARE FOR THOSE WITH COMPLEX NEEDS

The government is keen on integrating care and aligning incentives and payments for the so-called dual eligibles – those who are eligible for both Medicare and Medicaid. CMS explains that some of these people qualify first for Medicare based on their age or disability and then additionally qualify for Medicaid based on their income. The opposite may be true as well. Of all dual eligibles, only 10% are receiving care in a program that integrates services between Medicare and Medicaid. Others must navigate the murky waters between two programs that have different benefits, services, and payment structures. CMS believes that better aligning the two programs could improve care for this population and save federal health care dollars. [FN196] The estimates vary, but approximately ten to twelve million individuals fit in this category. [FN197] CMS has always been concerned about this population because they tend to be sicker and suffer from multiple chronic illnesses:

Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive long-term care services and supports (LTSS), and 60 percent have multiple chronic conditions. [FN198]

Because of their poor health, dual eligible have historically been disproportionate users of federal health care funds. According to CMS:

In 2012, Medicare-Medicaid enrollees accounted for 20 percent of Medicare enrollees, yet 34 percent of Medicare spending. The same individuals comprised only 15 percent of Medicaid enrollees but represented 33 percent of Medicaid spending. [FN199]

CMS is hoping to provide better, less costly care to these individuals through several initiatives, including the Medicare-Medicaid Financial Alignment Initiative. In this program, the federal government partners with states to integrate care for these patients and align Medicare and Medicaid payments and incentives. The initiative uses two models:

• Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.

• Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. [FN200]

Thirteen states are participating. [FN201] CMS has released multiple reports from various states. Please see the initiative's web page for more information.

In 2018, CMS issued a State Medicaid Director Letter that outlines ten opportunities for states to better care for dual eligibles, none of which, according to CMS, requires complex demonstrations or waivers. These include:

• State contracting with D-SNPs [dual eligible special needs plans]

• Default enrollment into a D-SNP

• Passive enrollment to preserve continuity of integrated care

• Integrating care through PACE [Programs for All-inclusive Care for the Elderly]

• Reducing the administrative burden in accessing Medicare data for use in care coordination

• Program integrity opportunities

• MMA [Medicare Prescription Drug, Improvement and Modernization Act] file timing

• State buy-in file data exchange

• Improving Medicare Part A buy-in

• Opportunities to simplify eligibility and enrollment [FN202]

CMS explains more fully about each opportunity in the State Medicaid Director Letter.

In a 2019 State Medicaid Director Letter, CMS informs states about new and existing opportunities to improve care for dual eligibles by better aligning the two programs and integrating care. [FN203] Two of these models already exist. They are the capitated financial alignment model and the managed fee-for-service model, both of which are a part of the Medicare-Medicaid Financial Alignment

Initiative, but CMS is willing to make revisions to the program to better suit both existing and new participants. Some of the revisions are based on experience with the initiative to date. CMS also offers a third opportunity, which would allow states to design their own models. The agency gives some guidance on what it would like to see in these new designs:

States could consider approaches broadly applicable to all dually eligible individuals or focus on certain segments of the population, such as people using LTSS, younger people with disabilities, and/or people living in rural areas. These approaches could build off elements from the FAI [Financial Alignment Initiative] demonstrations or other types of delivery system reforms including alternative payment methodologies, value-based purchasing, or episode-based bundled payments. An important priority for the Innovation Center and across CMS is addressing social determinants of health. [FN204]

The new State Medicaid Director Letter complements CMS' December 2018 letter, which reminded states about existing opportunities for better caring for dual eligibles. [FN205]

For more information about caring for those with complex needs, please see “Additional Resources” at the end of this brief.

IX. MEDICAID AND SOCIAL SUPPORTS

In many respects, social needs are related to medical needs. People have to prioritize their concerns, and if they have no home, they are unlikely to follow a medication regimen, for example. Some make a distinction between social needs and social determinants of health, arguing that addressing someone's social needs is helpful only to that particular person's health, while addressing social determinants of health means making systemic changes to improve way people live. [FN206] Authors in a *Health Affairs* Blog post argue that conflating the two may impede efforts to actually make a difference on social determinants of health:

[The referenced articles on social determinants of health] aren't about improving the underlying social and economic conditions in communities to foster improved health for all – they're about mediating patients' individual social needs. If this is what addressing the social determinants of health has come to mean, not only has the definition changed, but it has changed in ways that may impede efforts to address those conditions that impact the overall health of our country. [FN207]

The authors' observations are well-taken and thoughtful; however, policymakers, writers, and advocates have not widely made a distinction. For purposes of this discussion, we will use the terms that our sources use.

Citing the World Health Organization, the Kaiser Family Foundation sets out these factors as social determinants of health:

• Economic stability (employment, income, debt, bills, etc.)

• Neighborhood and physical environment (safety, housing, transportation, recreation, walkability, etc.)

• Education (literacy, language, level of education)

• Food (hunger and access to decent food)

• Community and social context (social integration, support, involvement in the community, discrimination, etc.)

• Health care system (coverage, access to providers, the level of the provider's cultural competence, etc.) [FN208]

Experts see a need to rebalance spending on clinical needs and social needs. According to some experts, the United States spends more of its GDP on medical needs than most other developed countries but does not experience better health outcomes (and sometimes experiences worse outcomes). On the other hand, our spending on other social services is considerably less than other developed countries. [FN209] The question is how to effectively add health-related social supports to programs like Medicaid. The Commonwealth Fund has released a brief describing various ways that states can enable Medicaid managed care organizations and their providers to offer health-related social supports. The organization offers six strategies, and it discusses at length the pros and cons of each:

We identify the following options: 1) classify certain social services as covered benefits under the state's Medicaid plan; 2) explore the additional flexibility afforded states through Section 1115 waivers; 3) use value-based payments to support provider investment in social interventions; 4) use incentives and withholds to encourage plan investment in social interventions; 5) integrate efforts to address social issues into quality improvement activities; and 6) reward plans through higher rates for effective investments in social interventions. [FN210]

The brief also includes brief descriptions of strategies used in **Arizona** and **Oregon.**

Several initiatives are afoot to address social determinants of health, and the Kaiser Family Foundation mentions several Medicaid initiatives that do so: the State Innovation Model Initiative, Section 1115 waivers, Delivery System Reform Incentive Payment (DSRIP) initiatives, health homes, housing supports through an optional State Plan authority or a waiver, Medicaid managed care, and voluntary supported employment assistance through various authorities. [FN211]

Finally, the Commonwealth Fund has worked with other health policy leaders to release “The Evolving Roadmap to Address Social Determinants of Health,” which is an extensive library of tools, resources, guidance, and best practices. Many of the resources focus on

Medicaid's potential for addressing social problems, lessons learned from Medicaid initiatives, and so forth. The roadmap focuses on six areas that are deemed to be “drivers” for successfully addressing social needs in clinical settings. These drivers are:

• patient identification and screening;

• navigation and resource connections;

• social health team and workflow;

• data and evaluation

• community partnerships;

• leadership and change management [FN212]

On the state level, CMS approved **North Carolina**'s Section 1115 waiver for its Health Opportunities pilot program in 2018. The waiver allows the state to provide case management and other services to address social determinants of health, such as “socioeconomic status, education, neighborhood and physical environment, employment, nutrition/food security, and social support networks, as well as access to health care.” [FN213] To be eligible, a person must be enrolled in managed care and must exhibit at least one physical or behavioral health risk factor and at least one social risk factor. The program, which has not yet begun, will be implemented in two to four regions of the state, and officials estimate that 25,000 to 50,000 Medicaid participants will benefit from the program.

The brief describes some of the services that the pilot will offer:

Pilot services will include evidence-based enhanced case management and other services designed to address enrollee needs related to: housing, food, transportation, and interpersonal safety. For example, pilot services may include housing modifications (e.g., carpet replacement, air conditioner repair) to improve a child's asthma control, travel vouchers to a community-based food pantry or a medically-targeted healthy food box for an adult with diabetes living in a rural food desert, or assistance securing safe housing for a pregnant woman experiencing interpersonal violence. The care manager will recommend pilot services at the lowest intensity level that can be reasonably expected to meet an individual's needs. Pilot transportation services include non-emergency health-related transportation including transportation to social services or to access pilot services. (Transportation services under the pilot are in addition to the non-emergency medical transportation (NEMT) benefit states are required to provide which helps ensure Medicaid beneficiaries have transportation to and from medical providers.) [FN214]

The authors point out that this waiver differs a bit from the types of waivers that CMS has typically approved in the last couple of years. CMS' new direction in waiver approval has been favoring work and community engagement requirements and reporting requirements, while North Carolina's pilot is aimed at ameliorating the causes of health disparities and poor health. The authors write of CMS' new waiver policies, which favor work requirements and reporting,

In its approval of these demonstrations, the administration asserts such policies are designed to address health determinants (like employment) and to ultimately improve health outcomes. These new waivers run counter to many other efforts to address social determinants of health that focus on identifying social needs and facilitating links to services rather than making individuals' health coverage dependent on meeting certain requirements – like reporting minimum monthly work hours. [FN215]

Please see the brief for a fuller discussion of the program.

X. ENSURING MEDICAID COVERAGE FOR NEWLY-RELEASED PRISONERS

The authors of the Kaiser Family Foundation's 2018 fifty-state Medicaid survey identified care coordination for criminal justice-involved individuals as a high priority for states. [FN216] According to an Issue Brief from the Commonwealth Fund, now that a majority of states have adopted the Medicaid expansion, [FN217] many more individuals are eligible for Medicaid upon release. States are taking advantage of opportunities to reach and enroll these individuals and to connect them to care before release so that care can start immediately upon release. However, experts find that it is not enough just to enroll these individuals. Because many prisoners leave prison with greater health needs than the public at large, it is necessary for states to focus on effective health delivery in order to meet the needs of releasees. [FN218]

The Commonwealth Fund notes that individuals with a history of incarceration have higher physical and behavioral health needs than the population at large. The organization cites these figures:

• An estimated 80 percent of individuals released from prison in the United States each year have a substance use disorder, or chronic medical or psychiatric condition.

• Incarcerated individuals have four times the rate of active tuberculosis compared to the general population, nine to 10 times the rate of hepatitis C, and eight to nine times the rate of HIV infection.

• Correctional facilities in Los Angeles County, New York City, and Cook County, Illinois, have become the three largest mental health care providers in the country.

The issue brief examines strategies that states have used to reach and care for this population. They include:

• using data sharing to identify persons who are leaving prison so that a plan or a provider is ready for them upon release;

• conducting jail or prison “in reach” before release to help inmates connect with primary care, identify health needs, get medical records sent to the right places, and establish community-based care;

• addressing social determinants of health that could impede health care, including stable housing;

• connecting individuals to peer support specialists who can help them navigate the health system and secure resources; and

• securing the services of a primary care provider or other specialist who is experienced in working with previously-incarcerated individuals and who is familiar with their unique needs.

Please see the Issue Brief for a full discussion of these strategies. [FN219]

XI. SELECTED FEDERAL ACTIVITY

• President Donald Trump (R) signed the Medicaid Extenders Act (2019 FD H.B. 259 (NS)) on January 24, 2019. Section 2 of the bill extends funding for the Money Follows the Person program until September 30, 2021. For 2019, the funding is available only for states that had an approved program in place as of December 31, 2018. Section 3 extends protections against spousal impoverishment for Medicaid participants receiving home- and community-based services, and Section 4 reduces the federal medical assistance percentage (FMAP) after 2020 for states that do not have an asset verification program in place. Finally, Section 5 makes changes to appropriations for the Medicaid Improvement Fund.

• Senate Bill 585 (2019 FD S.B. 585 (NS)), the States Achieve Medicaid Expansion Act of 2019 (the SAME Act), would allow all states the same levels of enhanced federal Medicaid expansion funds regardless of when the state adopted the expansion. For example, a state adopting the expansion in 2019 would receive three years of 100% federal funding for the newly eligible, and then the funding would decrease yearly until it reached its low of 90%. If passed, the bill would have retroactive effect. Senate Bill 585 was introduced on February 27, 2019.

• If passed, the State Public Option Act (2019 FD S.B. 489 (NS)) would allow states to create a Medicaid buy-in program for people wanting a public option, regardless of their income. The bill was introduced on February 14, 2019. Senator Tammy Baldwin (D-Wis.), one of the bill's sponsors, explains why she supports the bill:

The State Public Option Act will allow states to create a Medicaid buy-in program for all their residents regardless of income, giving everyone the option to buy into a state-driven Medicaid health insurance plan. At least 14 states are exploring implementing a Medicaid public option within their legislatures. A recent Kaiser Family Foundation survey found broad, bipartisan support for a Medicaid public option. Medicaid is a popular and cost-effective program with a large provider network. The program has the same positive ratings as private insurance, but provides health coverage at a much lower cost. Based on partnerships between state and federal governments, Medicaid also gives states the flexibility to adapt services and models of care based on their individual needs. [FN220]

• CMS and the Department of Health and Human Services' Office of the Inspector General have published a final rule making changes to state Medicaid Fraud Control Unit rules. CMS explains the rule's purpose in the summary of the rule, which is published at 84 F.R. 10700 (March 22, 2019) explains:

This final rule amends the regulation governing State Medicaid Fraud Control Units (MFCUs or Units). The rule incorporates statutory changes affecting the Units as well as policy and practice changes that have occurred since the regulation was initially issued in 1978. These changes include a recognition of OIG's delegated authority; Unit authority, functions, and responsibilities; disallowances; and issues related to organization, prosecutorial authority, staffing, recertification, and the Units' relationship with Medicaid agencies. The rule is designed to assist the MFCUs in understanding their authorities and responsibilities under the grant program, clarify the flexibilities the MFCUs have to operate their programs, and reduce administrative burden, where appropriate, by eliminating duplicative and unnecessary reporting requirements.

• Introduced in the Senate on March 26, 2019, 2019 FD S.B. 873 (NS) calls for 12-month continuous enrollment for Medicaid and CHIP. The bill is sponsored by Senators Brown (D-Ohio), Baldwin (D-Wis.), Warren (D-Mass.) and Whitehouse (D-RI). A press release on Senator Brown's web site explains the need for the bill:

Each year, millions of Medicaid and CHIP beneficiaries who enroll in coverage are at risk of losing that coverage as a result of taking on an extra shift or working overtime, simply because their income fluctuates slightly. As a result, these short-term changes set in motion bureaucratic snafus that cause taxpayers to be disenrolled from their insurance. This breakdown in coverage often disrupts treatment plans and undermines the progress of their care, but can also cause significant administrative challenges that result in higher costs for states, providers, and health plans. Brown's bill eases that burden by ensuring beneficiaries can depend on their coverage for a continuous 12-month period regardless of their age. [FN221]

A related bill in the House is 2019 FD H.B. 1879 (NS), which was introduced on April 5, 2019.

• In Congress, 2019 FD H.B. 1839 (NS) will enact the Medicaid Services Investment and Accountability Act of 2019, which makes several changes in Medicaid policy. Among other things, the bill extends spousal impoverishment protections for patients receiving home- and community-based services by amending the newly-enacted Medicaid Extenders Act of 2019. It also establishes an option for states to provide coordinated care through a health home for children with medically complex conditions; adds funding for the Money Follows the Person Demonstration; adds provisions to prevent drug misclassification in the Medicaid Drug Rebate Program; and denies federal funding for vacuum erection systems and penile prosthetic implants under certain circumstances. The primary sponsor of the bill, which was introduced on March 21, 2019, is Raul Ruiz (D-Cal.). The President signed the bill on April 18, 2019.

• Resident Commissioner Jeniffer Gonazalez-Colon (R-PR) introduced 2019 FD H.B 2306 (NS) on April 12, 2019. The bill would remove the statutory FMAP for **Puerto Rico** and raise the statutory cap on federal funding.

• CMS published a final rule removing a regulatory provision that allows a state to make Medicaid payments to a third party of behalf of a provider. The rule, "Reassignment of Medicaid Provider Claims," is published at 84 F.R. 19718-01 (May 6, 2019).

• CMS has published its quarterly list of program issuances for the quarter beginning in January 2019 and ending in March. Please see 84 F.R. 18040-01 (Apr. 29, 2019).

• Congressman Mark Green (R-Tenn.) is the primary sponsor of 2019 FD HB 2715 (NS), which was introduced in May 2019. The bill would enact the Medicaid Improvement and State Flexibility Act, which would allow for waivers for pilot programs that offer more flexibility in the way participants use their benefits. Representative Green explains what the bill would do:

The bill, named the Medicaid Improvement and State Flexibility Act, would authorize states to begin pilot programs giving Medicaid recipients a 'swipe card' with dollars on it designated for medical purchases. What is not spent from the card is returned to the holder at year's end in the form of an Earned Income Tax Credit. Coupled with a catastrophic insurance plan, this ensures Medicaid recipients a safety net while at the same time introducing competition into the healthcare market that will improve the quality of care and drive down costs.

Green likens his program to SNAP (the Supplemental Nutrition Assistance Program), in which participants receive a swipe card for food and are allowed to shop anywhere they choose. He also notes that Republican plans for health care call for "more choice and better care." [FN222]

• Introduced in the Senate on June 11, 2019, 2019 FD SB 1773 (NS), the Territories Health Equity Act of 2019, would improve how the federal government treats the territories for purposes of the Medicare and Medicaid programs. As it applies to Medicaid, the bill would eliminate the funding cap for the territories, eliminate the specific federal medical assistance percentage (FMAP) for the territories and temporarily set the FMAP for **Puerto Rico** and the **Virgin Islands** to 100%, grant waiver authority to the territories, and allow Medicaid disproportionate share hospital payments in the territories. A related bill in the House is 2019 FD H.B 2306 (NS).

• Representative Nydia Velazquez (D-N.Y.) is the primary sponsor of 2019 FD H.B. 3371 (NS), which would improve the way **Puerto Rico** is treated in terms of Medicaid financing. Among other things, the bill would increase the FMAP (federal medical assistance percentage) to 83% from 2020 until 2024, with provisions allowing this percentage to be reduced if Puerto Rico does not meet the set number of program enhancement requirements specified in the bill.

• Senate Bill 1880 (2019 FD SB 1880 (NS)) would direct the HHS Secretary to issue guidance to states on treatment family care services. The bill defines these services as,

structured daily services and interventions provided in a home-based setting for children who have not attained age 21, and who, as a result of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, need the level of care provided in a psychiatric residential treatment or congregate care facility the cost of which could be reimbursed under the State Medicaid program or the title IV-E program but who can receive services in a family-based setting.

The required guidance would advise states on existing opportunities and flexibilities for providing these services in Medicaid and Part E of Title IV of the Social Security Act and on ways to employ and coordinate funding in these programs to support states in providing these services. Senator Tammy Baldwin (D-Wis.) and others are sponsoring the bill, which was introduced on June 19, 2019.

• CMS gave guidance to the states about receiving enhanced federal funds for health IT improvements connected with Section 1115 waivers. The guidance, in the form of an FAQ document, specifically addresses using the Advanced Planning Document to secure the funding. CMS explains in the guidance,

In the December 4, 2015 Federal Register, the Centers for Medicare & Medicaid Services (CMS) published a final rule, 'Mechanized Claims Processing and Information Retrieval Systems (90/10),' which became effective January 1, 2016. The final rule extended increases in the level of federal support from 50 percent to 90 percent for new Eligibility and Enrollment (E&E) systems builds. It also increased federal support for maintenance and operations of such systems from 50 percent to 75 percent, if the systems meet certain standards and conditions. States may obtain this funding for IT system development needed to implement demonstrations under Section 1115 of the Social Security Act. Section 1115 authority permits the Secretary of Health and Human Services (Secretary) to approve certain experimental, pilot, or demonstration projects . . . . CMS is issuing the following frequently asked questions to provide states with information on how they can obtain funding for Medicaid information technology (IT) system development related to demonstrations under Section 1115 of the Social Security Act via the Advance Planning Document (APD)[.]

The guidance discusses how states can file Advanced Planning Documents seeking funds for IT improvement before the waiver request is approved. [FN223]

• In 2015, the Obama Administration published a final rule requiring states to document whether its Medicaid payments were sufficient to enlist enough providers to ensure adequate access to services in fee-for-service programs. CMS is now proposing to rescind this rule, as it believes that the process is too onerous for the states. More specifically, CMS believes that the process is a valuable tool for states to assess their payments, but it does not believe that making the process mandatory for states justifies the undue burden it imposes. The proposed rule is published at 84 FR 33722-01 (July 15, 2019).

• In a CMCS [FN224] Informational Bulletin, CMS reminds states that they are still required to ensure adequate access to services; however, the proposed rule would eliminate the regulatory process for states to demonstrate this. Instead, CMS will be working with states to develop a new, comprehensive, streamlined process that will evaluate access in fee-for-service programs as well as managed care and home-and-community based services. [FN225]

• House Bill 1856 (2019 FD H.B. 1856 (NS)) aims to end homelessness. A provision in the bill would direct the federal government, in using the funds to be allocated under the bill, to strive to: (1) help states and localities align and integrate funding for Medicaid, behavioral health providers, and housing providers; and (2) engage State Medicaid directors, governors, state housing and homelessness agencies, and other relevant state offices and local government entities to help States increase use of their Medicaid programs to finance supportive services for homeless people.

• Senator Bob Casey (D-Penn.) is sponsoring 2019 FD S.B. 2067 (NS), the Affordable Health Care for Children with Disabilities Act, which would encourage States to disregard parental income and assets when determining Medicaid eligibility for disabled children by offering an enhanced FMAP [FN226] of 90% for services provided to these children.

• Introduced in the House on July 9, 2019, 2019 FD H.B. 3631 (NS) would temporarily increase the FMAP and the limit on Medicaid payments for the territories. The bill has bipartisan sponsorship. Representative Darren Soto (D-Fla.) one of primary sponsors of the bill, explained in a press release why he supports the bill:

“Our plan ensures families have continued access to health care while immediately relieving financial pressures on the territories. Following the news of rampant corruption of officials in Puerto Rico, we know that merely funding the Medicaid system in the territories is insufficient. That's why we included stringent integrity measures to ensure the allocated funds reach our fellow citizens in need of medical assistance, instead of lining the pockets of corrupt officials[.]” [FN227]

• House Bill 3649 (2019 FD H.B. 3649 (NS)) would direct the HHS Secretary to issue guidance to states on treatment family care services. The bill defines these services as,

structured daily services and interventions provided in a home-based setting for children who have not attained age 21, and who, as a result of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, need the level of care provided in a psychiatric residential treatment or congregate care facility the cost of which could be reimbursed under the State Medicaid program or the title IV-E program but who can receive services in a family-based setting.

The required guidance would advise states on existing opportunities and flexibilities for providing these services in Medicaid and Part E of Title IV of the Social Security Act and on ways to employ and coordinate funding in these programs to support states in providing these services. A related bill in the Senate is 2019 FD SB 1880 (NS).

• House Bill 3253 (2019 FD HB 3253 (NS)) has become law under the title “The Sustaining Excellence in Medicaid Act of 2019.” Among other things, the act extends the Money Follows the Person program, the Community Mental Health Services Demonstration, and spousal impoverishment protections for participants receiving home- and community-based services. The president signed the bill on August 6, 2019.

• Representative Bobby Scott (D-Va.) is sponsoring the Supporting Positive Outcomes after Release Act (2019 FD H.B. 3953 (NS)), which was introduced on July 24, 2019. The bill would expand to inmates of all ages the requirement that states suspend rather than terminate Medicaid benefits for inmates who are eligible under the State Plan.

• In 2017, CMS published a proposed rule setting out a methodology for calculating DSH payment reductions. [FN228] The rule has now been finalized. It employs the five statutorily set factors, including the uninsured percentage factor, the high volume of Medicaid inpatients factor, the high level of uncompensated care factor, the low DSH adjustment factor, and the budget neutrality factor. The aggregate amount of the reductions will be $4 billion in 2020 and $8 billion in each of the years from 2021 to 2025, inclusive. The final rule is published at 84 F.R. 50308-01 (Sept. 25, 2019). House Bill 4378 (2019 FD H.B. 4378 (NS)), which was signed into law on September 27, 2019, will delay the reductions.

• On May 23, 2019, President Donald Trump (R) signed a Presidential Memorandum addressing the statutory requirement that sponsors of aliens reimburse the government when the individuals they sponsor receive means-based benefits from public programs, including Medicaid and CHIP (the Children's Health Insurance Program). Further, federal law requires that the sponsors' financial resources must be counted with the aliens' resources when determining eligibility for such programs. The memorandum indicated that these provisions may not be consistently enforced, and the president called for guidance from administrative agencies to ensure

compliance. [FN229] On August 23, 2019, CMS issued guidance in the form of a State Health Official Letter to advise states on implementing and enforcing these provisions. The letter addresses these matters:

• Application of the sponsor deeming requirements;

• Methodologies for deeming a sponsor's income and resources;

• Reimbursement obligations of, and recovery of costs from, a sponsor;

• Data collection and reporting on sponsor recovery; and

• Other operational considerations. [FN230]

• Introduced on September 18, 2019, and sponsored by Representative Eric Swalwell (D-Calif.) and others, House Bill 4393 (2019 FD H.B. 4393 (NS)) would provide a state option for covering genetic and genomic testing for children to improve treatment and outcomes. Representative Swalwell explains in a press release that the bill would allow the health care system to find "21st century cures with 21st century technology," and he explains specifically what the bill would do:

The Advancing Access to Precision Medicine Act would pilot-test whether Medicaid coverage of a variety of types of genetic and genomic sequencing for children can help settle their diagnostic challenges, improve clinical outcomes, and ultimately reduce program expenditures. It also would direct the Department of Health and Human Services to work with the National Academy of Medicine to study, utilizing the information gained from the Medicaid pilot-testing, how genetic and genomic testing may improve health outcomes and how the federal government may reduce barriers to use of genetic and genomic testing. [FN231]

• CMS and its Center for Medicaid and CHIP Services (CMCS) announced a new program to help states address asthma in Medicaid and CHIP [FN232] participants. The Improving Asthma Control Learning Collaborative includes an educational component and an implementation component:

The Learning Collaborative has two components: a webinar series beginning in October 2019 and an affinity group beginning in March 2020. The webinar series will include presentations from experts in the field as well as tools that states can use to drive improvement in asthma control and outcomes. States interested in taking action on the concepts and tools introduced through the webinar series will have the opportunity to participate in an action-oriented affinity group, which will support states in designing and implementing QI projects in their state. [FN233]

The webinar seminars, four in all, begin in late October 2019 and run through January 2020. The affinity group begins in March 2020; an expression of interest form will be released in January 2020.

• Increasingly, the federal government and the states are recognizing that health outcomes are tied to social determinants. Representatives Lisa Blunt Rochester (D-De.) and Gus Bilirakis (R-De.) are sponsoring 2019 FD H.B. 4621 (NS), which would require the federal government to give guidance to the states on addressing social determinants of health in their Medicaid and CHIP programs. On her web site, Representative Blunt Rochester explains what the Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2019 would do, if enacted:

The Blunt Rochester-Bilirakis legislation will provide guidance to State Medicaid programs regarding how to implement research-proven strategies to optimize social determinants of health under existing Medicaid authority or waivers, especially for pediatric populations. This legislation builds upon the success that some state Medicaid programs have already had since testing innovative delivery and payment models designed to improve health outcomes while reducing costs. [FN234]

The bill would require the federal government to advise states about strategies for addressing social determinants of health, to advise states on how to encourage and offer incentives to managed care organizations to consider social determinants of health, and to offer examples of how states are already addressing social determinants of health. [FN235]

• To avoid reductions in their FMAPs, [FN236] states are required to implement electronic visit verification systems for personal care services by January 1, 2020, and for home health services by January 1, 2023. States are entitled to receive federal financial participation for setting up these systems, but to continue receiving the federal funds, they must have the systems certified under an outcomes-based approach. The government describes outcomes-based certification on Medicaid.gov:

CMS has developed a streamlined, outcomes-based approach to EVV certification. This approach focuses on achieving business outcomes embodied in the [21st Century Cures Act, P.L. 114-255] and is intended to reduce the certification burden on states. In doing so, CMS aims to ensure that systems receiving FFP are meeting the business needs of states and of CMS. EVV certification is structured around the following elements:

• Outcome statements. These describe the desired results once the system is implemented. CMS-provided outcomes are based on the Cures Act.

• Evaluation criteria and required evidence. These correspond to outcome statements and are used by a state and CMS to evaluate the system's functionality and its compliance with laws, regulations, and industry good practices.

• Key performance indicators (KPIs). These metrics support the outcome statements and are used to track the performance of the system over time. [FN237]

CMS has now released guidance in the form of a CMCS Informational Bulletin explaining the certification process and what states must do to qualify for enhanced federal financial participation. [FN238]

• Senate Bill 2690 (2019 FD S.B. 2690 (NS)), which was introduced on October 23, 2019, would enact the Restoring, Enhancing, Securing, and Promoting Our Nation's Safety Efforts (or "RESPONSE") Act of 2019. The bill aims reduce mass violence, improve school safety, and improve collaboration on mental health services in communities, among other things. As it relates to Medicaid, the bill would direct the Secretary of Health and Human Services (HHS) to submit to the specified Senate committee a report on current state Medicaid strategies for addressing "the mental health needs and criminogenic risk among individuals with mental illnesses involved in the criminal justice system." It would also direct the HHS Secretary to release a State Medicaid Director Letter highlighting best practices based on that report, including information on existing Medicaid authorities for implementing the practices. In developing the letter, the Secretary would be directed to consult with State Medicaid Directors, providers and suppliers of Medicaid services, Medicaid managed care organizations, health care consumers or groups representing them, and other entities the Secretary believes to be important resources for developing the State Medicaid Director letter. The bill is sponsored by Senator John Cornyn (R-Tex.) and others.

• Introduced in the House on October 16, 2019, 2019 FD H.B. 4701 (NS) seeks to remove barriers to health insurance coverage, including through the federal health programs and the marketplace, for immigrants who are lawfully present in the United States. The bill, which would enact the Health Equity and Access under the Law ("HEAL") for Immigrant Women and Families Act of 2019, is particularly concerned with expanding access to sexual, reproductive, and maternal health services.

• In the Senate, 2019 FD S.B. 2613 (NS) seeks to end homelessness through a variety of means. Section 6 of the bill is titled, "Technical Assistance Funds to Help States and Local Organizations Align Health and Housing Systems," and it calls for the Secretary of Housing and Urban Development to use appropriated funds to help states align policies and funding among state Medicaid programs, behavioral health providers, and housing providers in order to create support for housing opportunities. Section 6 also calls for the Secretary to,

engage State Medicaid program directors, Governors, State housing and homelessness agencies, any other relevant State offices, and any relevant local government entities, to assist States in increasing use of their Medicaid programs to finance supportive services for homeless individuals.

Senate Bill 2613 was introduced on October 16, 2019, and it has Democratic sponsorship.

• President Donald Trump (R) signed 2019 FD H.B. 4378 (NS) on September 27, 2019. This appropriations bill includes extensions for certain health programs. As it relates to Medicaid, the bill would extend the Community Mental Health Services Demonstration program for two months, temporarily increase the FMAP [FN239] for the territories (**Puerto Rico, the Virgin Islands, Guam**, the **Northern Mariana Islands**, and **American Samoa**), and delay the reductions in disproportionate share hospital payments.

XII. SELECTED STATE ACTIVITY

In **Arizona:**

• House Bill 2351 (2019 AZ H.B. 2351 (NS)) called for a study committee to look into establishing a medical services buy-in program. The bill was introduced on April 22, 2019, but it did not pass this session.

In **California:**

• Senate Bill 29 (2019 CA S.B. 29 (NS)) seeks to extend full-scope Medi-Cal benefits for individuals who would otherwise be eligible but for their immigration status. The law would first extend full benefits to individuals aged 19 to 25 and over 65. In 2020, full benefits would be extended to individuals aged 65 or older. Financial funds may not be available, as the federal government generally only extends funds for those who are lawfully admitted for permanent residence or otherwise permanently lawfully residing in the country. The bill was introduced in December 2018 and passed the Senate on May 29, 2019. It has moved to third reading in the Assembly.

• Governor Gavin Newsom (D) signed 2019 CA S.B. 104 (NS) on July 9, 2019. The bill affects health care in important ways. Among other things, the bill extends full Medicaid coverage to immigrants aged 19-25 regardless of their immigration status if they otherwise qualify for Medicaid.

• Assembly Bill 1088 (2019 CA A.B. 1088 (NS)) has been adopted. The bill will direct the Department of Health Care Services to apply to CMS for a State Plan amendment or waiver to implement an income disregard for aged, blind, or disabled Medicaid applicants. The bill, which Governor Gavin Newsome (D) signed on October 2, 2019, provides:

(a) The department shall seek a Medicaid state plan amendment or waiver to implement an income disregard that would allow an aged, blind, or disabled individual who becomes ineligible for benefits under the Medi-Cal program pursuant to Section 14005.40 because of the state's payment of the individual's Medicare Part B premiums to remain eligible for the Medi-Cal program under Section 14005.40 if their income and resources otherwise meet all eligibility requirements.

• Governor Gavin Newsome signed 2019 CA A.B. 1642 (NS) on October 2, 2019. Among other things, the bill imposes additional requirements on managed care providers who request alternative access standards for the time and distance requirements used to prove network adequacy.

• Assembly Bill 1128 (2019 CA A.B. 1128 (NS)), which was adopted on October 12, 2019, relates to licensing for PACE organizations. [FN240] PACE organizations operate clinics, adult day health centers, and, sometimes, home health agencies. Their licensing and approvals have been provided through both the Department of Public Health and the Department of Health Care Services. According to the bill, the lengthy dual process hinders the speed at which new PACE organizations can begin work. Therefore, this bill will shift responsibility for PACE licensing from the Department of Public Health to the Department of Health Care Services in order to increase efficiency and expedite approval of new or expanding PACE programs.

In **Colorado:**

• Governor Jared Polis (D) signed 2019 CO H.B. 1176 (NS) on May 31, 2019. The bill directs the state to establish a task force to study all aspects of the state's health care financing structure. The task force will be directed to seek and contract with an appropriately qualified analyst to conduct a study, and the analyst will be required to consult with various stakeholders to determine the methodology of the study. At a minimum, the analyst will be required to examine these health care systems:

• the current system, in which individuals receive coverage from private or public insurance remain uninsured;

• a public option; and

• a multi-payer universal health care system

In **Connecticut:**

• House Bill 6681 (2019 CT H.B. 6681 (NS)) sought to enact statutory provisions allowing the Department of Social Services to establish a Medicaid pilot program to provide telemedicine services in a rural, underserved county where access to health care is impeded by transportation challenges. The bill was introduced on January 29, 2019. It did not pass before the legislature adjourned.

In the **District of Columbia:**

• The Public Welfare Department adopted rules to allow the Director of the Department of Health Care Finance to make quarterly supplemental payments for one fiscal year to physician groups with 500 physicians that contract with a public, general hospital in underserved areas of the District to deliver at least two of the following services to Medicaid participants: (1) inpatient services, (2) emergency department services, and (3) intensive care physician services. The notice is published at 2019 DC REG TEXT 499229 (NS) (Oct. 4, 2019).

In **Florida:**

• Filed on January 10, 2019, 2019 FL S.J.R. 284 (NS) would have amended the state constitution to adopt and implement the Affordable Care Act's Medicaid expansion. Another bill, 2019 FL H.B. 223 (NS), also sought to adopt and implement the expansion. Both bills died in committee on May 3.

• On June 25, 2019, Governor Ron DeSantis (R) signed 2019 FL H.B. 7099 (NS) which would, among other things, extend mandatory Medicaid eligibility to a child who is eligible for the Guardianship Assistance Program.

• Filed on September 24, 2019, 2020 FL H.B. 219 (NS) would have extended Medicaid eligibility to the newly eligible group under the Affordable Care Act's Medicaid expansion. It did not pass before adjournment.

In **Hawaii:**

• Introduced on January 18, 2019, and amended on February 12, 2019 HI S.B. 720 (NS) would have expanded access to home- and community-based services for individuals who:

(A) Require home care services more than twice weekly;

(B) Do not have ready access to reliable transportation; and

(C) Live thirty miles or more from the nearest hospital[.]

The bill did not pass before adjournment.

In **Idaho:**

• A concurrent resolution directs a committee to study and make recommendations on the effect a Medicaid expansion would have on other programs that serve the poor. Idaho voters adopted the expansion in November 2018, but it has not yet been implemented. The bill, 2019 ID S.C.R. 117 (NS), was introduced on March 27, 2019 and was subsequently passed by both chambers.

• Introduced on March 18, 2019, 2019 ID H.B. 277 (NS) sought to add work requirements for the expansion population. It passed the House, but after a federal judge's ruling invalidating the work requirements in **Kentucky** and halting similar requirements in **Arkansas**, a Senate committee decided to hold House Bill 277. [FN241] The legislature has now adjourned.

In **Illinois:**

• If passed, 2019 IL H.B. 41 (NS) would extend Medicaid to all women of childbearing age, regardless of income. The bill was introduced on January 9, 2019.

• House Bill 176 (2019 IL H.B. 176 (NS)), which was introduced on January 9, 2019, would require Medicaid eligibility redeterminations to be conducted every 12 months.

• The Illinois Health Care for All Act (2019 IL H.B. 207 (NS)) would establish the Illinois Health Services Program, a universal health care program for state citizens. The bill lists the sources of funding for the program, which would include all federal Medicaid funds. The bill was introduced on January 9, 2019. House Bill 8 (2019 IL H.B. 8 (NS)) is a related bill.

In **Indiana:**

• The Office of the Secretary of Family and Social Services gave notice that it will be seeking an amendment to its Family Supports waiver. The waiver provides services in a variety of home- and community-based settings to individuals with a developmental disability, intellectual disability, or autism. The amendment would provide priority status for children of an individual who is an active member or veteran of the U.S. Armed Forces or the National Guard. The notice is published at 2019 IN REG TEXT 523232 (NS) (May 8, 2019).

In **Iowa:**

• If passed, 2019 IA H.F. 135 (NS) would have directed the Department of Human Services to terminate its contracts with managed care organizations in the High Quality Care Initiative for the Medicaid long-term care services and supports population. This group would have moved into the fee-for-service program. The bill would have also directed the department to recalculate capitation rates for Medicaid managed care home- and community-based services provided under the intellectual disabilities waiver. The bill was introduced on January 25, 2019; it did not pass this session.

• The Human Services Department gave notice that it intends to amend administrative provisions relating to appeals and hearings. The Department explains the purpose of the amendments in its notice, which is published at 2019 IA REG TEXT 534887 (NS) (Sept. 25, 2019):

In light of the State's transition to Medicaid managed care, and in an ongoing effort to improve Department of Human Services' processes and accessibility to consumers, the Department has revised its appeals rules with the following goals in mind: simplification, uniformity, clarification of scope, clearly defining appeal rights, and protecting self-represented litigants. In this effort, the Department has sought to eliminate redundancies and ambiguities, streamline processes across programs where permissible under state and federal law, explicitly clarify the circumstances in which contested case hearings are granted, ensure conformity with substantive federal and state standards, and include procedural protections for self-represented litigants.

In **Kansas:**

• Had it passed, House Bill 2102 (2019 KS H.B. 2102 (NS)) would have established KanCare Bridge to a Healthy Kansas, a Medicaid expansion program. While the bill did not contain work requirements, unemployed individuals or those working less than 20 hours per week would have been referred to existing job training programs and resources. The Kansas Hospital Association had been advocating for expansion and approved of this plan, and the plan was expected to help boost rural hospitals. [FN242] Senate Bill 54 (2019 KS S.B. 54 (NS)) was a related bill in the Senate that likewise did not pass this session.

• If passed, 2019 KS S.B. 208 (NS) would have made an appropriation to the Department for Aging and Disability Services and specified that some of the appropriated funds would have had to be used to increase Medicaid payments for providers of home- and community-based waiver services. The bill was introduced on February 20, 2019; it did not pass before adjournment.

In **Kentucky:**

• Governor Matt Bevin (R) signed 2019 KY H.B. 320 (NS) on March 26, 2019, which seeks to improve Medicaid inpatient payments to hospitals in both the managed care and fee-for-service programs. The bill provides for hospital assessments to be used as matching funds for federal dollars and supplemental payments to hospitals.

In **Louisiana:**

• The Department of Health, Bureau of Health Services Financing adopted an emergency rule extending until September 30, 2020, the Transitional Rate Extension for public intermediate care facilities for those with intellectual disabilities. The notice is published at 2018 LA REG TEXT 507158 (NS) (Oct. 20, 2018). A final rule was published on February 20, 2019.

• The Department of Health, Bureau of Health Services Financing published an emergency rule in order to continue a July 2018 emergency rule addressing nursing home reimbursement in a specific situation. The agency explained in the rule's summary,

As a result of a budgetary shortfall in state fiscal year 2018-2019, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities in order to adopt provisions governing the transition of a private nursing facility to a state-owned or operated nursing facility through a change of ownership (Louisiana Register, Volume 44, Number 7). This Emergency Rule is being promulgated in order to continue the provisions of the July 5, 2018 Emergency Rule. This action is being taken to avoid a budget deficit in the Medical Assistance Program.

The emergency rule is published at 2018 LA REG TEXT 498641 (NS) (Oct. 20, 2018). A final rule was adopted on February 20, 2019.

• House Bill 199 (2019 LA H.B. 199 (NS)) passed both chambers, and Governor John Bel Edwards (D) signed the bill on June 20, 2019. The bill will establish a program in Medicaid known as the TEFRA [FN243] option in which children with disabilities can access Medicaid services regardless of their parents' income. The bill sets out the eligibility requirements for the program, which will be established though an amendment to the State Plan. The services are an option only in the fee-for-service program, unless the Louisiana Department of Health determines that the services can be offered more efficiently through the managed care program.

• The Department of Public Health is proposing to give a one-time supplemental payment for Medicaid-certified intermediate care facilities for persons with intellectual disabilities. The proposed rule, which is published at 2019 LA REG TEXT 537231 (NS) (Oct. 20, 2019), sets out the methodology for calculating the payments.

In **Maine:**

• Introduced on January 2, 2019, 2019 ME H.P. 21 (NS) would have provided coverage for legal abortion services for MaineCare members. The bill provided that any cost for services not covered by federal funds would need to be covered by state funds. With very few exceptions, abortion services are not covered by federal funds. The bill died in committee.

In **Michigan:**

• Adopted on September 23, 2019, 2019 MI S.B. 362 (NS) revises some of the work (or “community engagement”) requirements that are to take effect on January 1, 2020. According to a press release from Governor Gretchen Whitmer (D), the state's requirements were the most onerous in the nation. An analysis revealed that 183,000 people could potentially lose coverage if the work requirements go into effect as they were passed. This bill will attempt to reduce that number by giving Medicaid participants more time to report compliance with the requirements and by exempting participants from reporting if compliance can be verified through other data. When she signed the bill, the governor asked the legislature to also suspend the requirements if it appears that too many people are on track to lose coverage as a result of the requirements. [FN244] Courts have halted work requirements in **Arkansas, Kentucky**, and **New Hampshire**. [FN245] New Hampshire had previously suspended the requirements because it was evident that too many people stood to lose coverage. [FN246]

• Introduced on October 8, 2019, 2019 MI H.B. 5065 (NS) and 2019 MI S.B. 559 (NS) would appropriate funds and direct the state's Department of Health and Human Services to increase the payment rates for certain psychiatric services:

DEPARTMENT OF HEALTH AND HUMAN SERVICES Sec. 301. The department shall increase the practitioner rates paid for current procedural terminology (CPT) codes in psychiatric diagnostic procedures through Medicaid fee-for-service and through the Medicaid health plans by 15% for psychiatric diagnostic procedure provided for Medicaid beneficiaries under the age of 21. It is the intent of the legislature that the CPT specific rates paid through the Medicaid health plans are not increased by a uniform 15% but reflect the greater of either the actual rates paid . . . during the previous fiscal year or 100% of the Medicare rate received for those services on the date the services are provided.

• Also in Michigan, 2019 MI H.B. 5066 (NS) would appropriate funds and increase reimbursements for neonatal services to 95% of the Medicare rate. The bill, which was introduced on October 8, 2019, lists the current procedural terminology codes affected. Its companion in the Senate is 2019 MI S.B. 553 (NS).

• House Bill 5064 (2019 MI H.B. 5064 (NS)) and Senate Bill 554 (2019 MI S.B. 554 (NS)) aim to increase payments for Medicaid services provided by critical access hospitals. The bill provides:

DEPARTMENT OF HEALTH AND HUMAN SERVICES Sec. 301. The department shall provide an additional $5,099,100.00 in general fund/general purpose revenue and any associated federal match and restricted dollars to further increase outpatient Medicaid rates for services performed at critical access hospitals.

In **Maryland:**

• If passed, 2019 MD S.B. 976 (NS) would have directed the Secretary of Health to convene a workgroup to develop implementation plans to improve efficiency, accountability, and outcomes of behavioral health services as a part of the state's ongoing plan to provide a combined specialty behavioral health delivery system for behavioral health and substance use disorder services. In addition to setting out the composition of the workgroup, the bill set out its goals:

(c) The workgroup shall develop implementation plans for uniform and system-wide adoption of measurement-based care standards for mental health and substance use disorder services delivered:

(1) to recipients in the specialty community behavioral health system;

(2) by Medicaid managed care organizations to their members in primary care settings; and

(3) in State-run psychiatric facilities and any publicly funded behavioral health service settings not included in items (1) and (2) of this subsection.

Senate Bill 976 did not advance and was withdrawn.

In **Minnesota:**

• If passed, 2019 MN S.F. 273 (NS) would have extended medical assistance coverage to in-reach community-based services in jail. The purpose of the law was to prevent future incarcerations. The bill, which was introduced on January 17, 2019, set out the coverage:

(3) Medical assistance covers in-reach community-based service coordination that is performed at a jail for purposes of diverting a person from being incarcerated. Jail in-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization.

The bill did not advance, and the legislature has now adjourned.

• Introduced on February 27, 2019, 2019 MN S.F. 1778 (NS) would have added a provision to existing statutory language relating to Medicaid disproportionate share hospital payments. The new provision would have provided for a payment adjustment for hospitals that administer a high level of high-cost drugs to participants in the Medicaid fee-for-service program. The bill did not advance, and the legislature has now adjourned.

In **Missouri:**

• The Department of Mental Health announced at 2018 MO REG TEXT 506383 (NS) (Oct. 15, 2018) that it proposed to amend rules pertaining to Behavioral Health Healthcare Homes. According to the agency, the proposed rules would mostly update terminology, but the proposal would also add a new provision clarifying that enrollment in this model is based on the participant's option. The proposed rules were finalized on February 15, 2019.

In **Montana:**

• House Bill 658 (2019 MT H.B. 658 (NS)) will make the Medicaid expansion permanent and impose community engagement requirements. The bill was introduced on March 12, 2019, and it underwent amendments in both chambers. Governor Steve Bullock (D) signed the bill on May 9, 2019.

In **New Jersey:**

• Senate Bill 3365 (2018 NJ S.B. 3365 (NS)) was approved on May 8, 2019. The bill will establish a Medicaid perinatal episode of care pilot program.

• Assembly Bill 4744 (2018 NJ A.B. 4744 (NS)) will ensure that specified drugs used to treat substance use disorders be provided without prior authorization. The bill was introduced in December 2018 and was adopted on July 15, 2019.

• Introduced on May 29, 2019, 2018 NJ S.B. 3787 (NS) would provide that prescription drugs in the Medicaid program be administered through a fee-for-service delivery system, and the bill sets out how reimbursement for various types of drugs is to be calculated.

In **New Mexico:**

• House Bill 68 (2019 NM H.B. 68 (NS)) would have allocated funds to enroll additional individuals in the Developmental Disabilities Waiver. The bill was introduced on January 16, 2019. It did not pass this session.

• Introduced on January 29, 2019, 2019 NM S.B. 405 (NS) would have established a Medicaid buy-in program to allow uninsured people an opportunity to purchase insurance through Medicaid. Those qualified would have been individuals who were not eligible for Medicaid, Medicare, or subsidies through the Marketplace. The bill was introduced on January 19, 2019. It did not pass.

In **New York:**

• Introduced on May 7, 2019, 2019 NY A.B. 7492 (NS) would have, among other things, directed the Commissioner of Social Services to maintain specific reimbursement and billing procedures for complex rehabilitation technology products so that Medicaid payments would ensure adequate access to products and services for patients with complex needs. It has passed both chambers, but Governor Andrew Cuomo (D) vetoed it on November 20, 2019.

• If passed, 2019 NY S.B. 933 (NS) would direct the Commissioner of the Department of Health to seek a waiver from CMS to establish work and community engagement requirements for Medicaid participants.

• Senate Bill 2502 (2019 NY S.B. 2502 (NS)) seeks to align Medicaid optional benefits with the section of state law that dictates minimum benefits in private insurance. The opening paragraph of the bill, which was introduced on January 25, 2019, explains that the bill seeks to address existing inequities and to end a situation that may encourage more people to stay on Medicaid:

The legislature hereby finds that it is fundamentally unfair to the taxpayers of the state for Medicaid optional services to exceed the minimum health insurance benefits levels that are required for private sector health insurance plans. Higher benefit levels for Medicaid compared to private insurance create a disincentive for people to leave public assistance and accept private employment and private health coverage. Higher Medicaid benefit levels are also a contributing factor causing the state to have the highest Medicaid costs in the nation and some of the highest property taxes in the nation.

The new sub-section would not apply to long-term care services.

• Introduced on January 28, 2019, 2019 NY A.B. 2927 (NS) would create presumptive Medicaid eligibility for youth leaving a court-ordered placement. The eligibility would begin on the day of release and end upon a formal determination of eligibility. In the case of a youth who does not file an application for Medicaid after release, the presumptive eligibility would end 60 days after release. The bill was amended in committee.

• If passed, 2019 NY S.B. 2664 (NS) would provide for a special Medicaid reimbursement rate for facilities that provide services to newly-released prisoners. The bill was introduced on January 28, 2019.

In **North Carolina:**

• Introduced on March 28, 2019, 2019 NC S.B. 387 (NS) would establish work requirements as a condition of eligibility for Medicaid. Pursuant to federal guidance on the matter, the requirements would only apply to non-elderly, non-pregnant, and non-disabled adults.

• North Carolina intends to transform its program by shifting to Medicaid managed care. The state indicates that it is the most significant change to the program in 40 years. [FN247] Several bills have been introduced to realize this goal. Among others, Senate Bill 548 (2019 NC S.B. 548 (NS)) proposes several statutory changes needed to implement the plan, Senate Bill 549 (2019 NC S.B. 549 (NS)) would establish a child welfare and behavioral health pilot program to improve access to comprehensive health services for children in foster care. Senate Bill 537 (2019 NC S.B. 537 (NS)) seeks to change payment methodologies for adult care homes. The version of the bill that was adopted calls for a working group to study various reimbursement methods for adult care homes. Governor Roy Cooper (D) signed the bill on November 6, 2019.

• In furtherance of the state's ongoing Medicaid transformation efforts, House Bill 883 (2019 NC H.B. 883 (NS)) would direct the Department of Health and Human Services to enter into capitated contracts with at least two prepaid dental plans in order to provide dental services in the Medicaid and North Carolina Health Choice programs. The bill was introduced on April 22, 2019.

• House Bill 655 (2019 NC H.B. 655 (NS)) is concerned with uninsured workers with incomes too high to qualify for Medicaid as it currently exists and too low to afford private insurance. The bill would establish the NC Health Care for Working Families program. The findings supplied with the bill cite the societal costs of uninsured people: citizens ultimately pay for health care costs when uninsured people seek emergency care and it results in uncompensated care costs for hospitals. Further, uninsured individuals cannot afford preventive care and thus defer services until they are very sick and the medical costs are high. The program would be a Medicaid expansion for adults earning up to 133% of the federal poverty level, and work requirements would apply. The findings also note that the program would be paid for with a combination of participant premiums, intergovernmental transfers, current hospital assessments, gross premiums tax revenue, newly enacted hospital assessments, and federal funds, and thus would not increase taxes for other citizens. The bill was introduced on April 10, 2019, and it has been amended.

In **North Dakota:**

• Governor Doug Burgum (R) signed 2019 ND S.B. 2012 (NS) on May 2, 2019. The bill makes an appropriation to fund the Medicaid expansion. The expansion was implemented in North Dakota on January 1, 2014. [FN248]

In **Oregon:**

• Governor Kate Brown (D) signed House Bill 2267 (2019 OR H.B. 2267 (NS)) on July 15, 2019. The bill relates to coordinated care organizations. It will require coordinated care organizations to collaborate with local public health authorities and hospitals to conduct a community health assessment and to adopt a community health improvement plan. The bill explains the purpose of such a plan:

A coordinated care organization shall collaborate with local public health authorities and hospitals located in areas served by the coordinated care organization to conduct a community health assessment and adopt a community health improvement plan, shared with and endorsed by the coordinated care organization, local public health authorities and hospitals, to serve as a strategic population health and health care services plan for the residents of the areas served by the coordinated care organization, local public health authorities and hospitals. The health improvement plan must include strategies for achieving shared priorities.

The bill requires the Oregon Health Authority to work with CMS in establishing a reinsurance program that complies with federal law in order to receive federal financial participation for the costs of the community health improvement plan.

• Senate Bill 1041 (2019 OR S.B. 1041 (NS)) was adopted on June 20, 2019. It is a lengthy bill that tightens oversight of the state's coordinated care organizations. [FN249]

• Citing the need for transparency and accountability in health care costs and the need to contain costs, 2019 OR S.B. 889 (NS) will establish a health care cost growth benchmark for all providers and payers. The purpose of establishing such a benchmark is to,

(a) [s]upport accountability for the total cost of health care across all providers and payers, both public and private;

(b) [b]uild on the state's existing efforts around health care payment reform and containment of health care costs; and

(c) [e]nsure the long-term affordability and financial sustainability of the health care system in this state.

The bill will establish the Health Care Cost Growth Benchmark program to develop a benchmark that would promote a predictable and sustainable growth rate, use established economic indicators, be measurable on a per capita basis, and be applicable to all providers and payers in the state. Governor Brown signed the bill on July 15, 2019.

In **Pennsylvania:**

• Senate Bill 314 (2019 PA S.B. 314 (NS)) would establish the Pennsylvania Rural Health Redesign Center Authority and the Pennsylvania Rural Health Redesign Center Fund to "protect and promote access by the residents of this Commonwealth to high-quality health care in rural communities by encouraging innovation in health care delivery." The bill sets out the make-up of the board as well as its powers and duties. Medicaid managed care organizations are listed under the definition of "payer."

• Introduced on June 24, 2019, 2019 PA H.R. 422 (NS) would urge Congress to increase Pennsylvania's FMAP (federal medical assistance percentage) for long-term care nursing services. According to the resolution, the need for these services continues to increase, and reimbursements are not keeping up with the increased cost of providing them. Some long-term care facilities in the state have indicated that they may not be able to continue to offer their current services with the reimbursement rate that currently exists, according to the resolution.

• The Department of Human Services gave notice that it has adopted amendments to regulations governing licensing for home- and community-based services. The agency explains that the amendments are needed to ensure continued federal financial participation in the commonwealth's Section 1915 waivers for persons with an intellectual disability or autism. The notice sets out the benefits of the amendments to individuals, families, advocates, providers, and county intellectual disability and autism programs. The notice is published at 2019 PA REG TEXT 441245 (NS) (Oct. 5, 2019).

• Senate Bill 906 (2019 PA S.B. 906 (NS)) relates to care for those receiving mental health and intellectual disability services. The bill would put a moratorium on the closure of state facilities until all eligible individuals are authorized to begin receiving services under a home- and community-based services waiver. Once that happens, a Task Force on the Closure of State Centers will be convened to comprehensively evaluate the State facilities and provide recommendations to the Department of Human Services prior to closure of any such facilities. The bill sets out how the task force is to be comprised and what the task force is to consider.

In **Texas:**

• Introduced on February 21, 2019, 2019 TX H.B. 610 (NS) sought to ensure that women who are eligible for Medicaid because of pregnancy retain their eligibility for 12 months following the birth of a child or an involuntary miscarriage. The bill did not pass before adjournment.

• 2019 TX H.J.R. 40 (NS) proposed a constitutional amendment to adopt the Affordable Care Act Medicaid expansion, and it called for the matter be placed on November 5, 2019 ballot. The bill, which was introduced on February 12, 2019, did not pass before adjournment. Introduced on February 20, 2019, House Bill 590 (2019 TX H.B. 590 (NS)) likewise proposed that the state adopt the expansion; it did not pass either.

• Introduced on February 21, 2019, 2019 TX H.B. 606 (NS) sought to establish automatic enrollment in the Healthy Texas Women Program for women who are eligible for Medicaid or who are enrolled in the Child Health Plan Program but who would lose their eligibility due to their age. It did not pass this session.

• A resolution, 2019 TX H.J.R. 46 (NS), sought a constitutional amendment to adopt the Affordable Care Act's Medicaid expansion. The bill was introduced on January 16, 2019, but it was not adopted before adjournment.

• Introduced on January 10, 2019, 2019 TX H.C.R. 29 (NS) would have urged Congress to fund the Texas Medicaid program with a block grant. It did not advance, and the legislature has now adjourned.

• Also introduced on January 10, 2019, 2019 TX H.B. 713 (NS) would have set up certain preferences for supported employment services. The bill would have added this language:

An individual with a disability qualifies for an employment preference under this chapter if the individual is eligible to receive supported employment services from the commission or through a Section 1915(c) Medicaid waiver program.

It did not pass this session.

• House Bill 1179 (2019 TX H.B. 1179 (NS)) sought to establish a Medicaid buy-in program for Medicaid participants whose Medicaid eligibility would have been terminated because of increased income from employment. The bill called for the Health and Human Services Commissioner to promulgate rules governing the program by January 1, 2020. The bill was introduced on January 29, 2019, but it did not pass this session.

• Governor Greg Abbott signed 2019 TX H.B. 72 (NS) on June 14, 2019. It will direct the Health and Human Services Commission, in consultation with the Department of Family and Protective Services, to develop a program to allow certain adoptive parents or permanent managing conservators of a child formerly in the care of the state to receive Medicaid benefits for their children. The version of the bill that passed specifies that such children may receive benefits in either the STAR Health Program or the STAR Kids Managed Care Program.

• A resolution introduced on February 12, 2019 (2019 TX H.J.R. 33 (NS)) proposed a constitutional amendment that would have allowed a county, at its option, to exempt a certain amount of property tax for physicians who did not seek Medicaid or other state or federal reimbursement for their treatment of indigent patients. The proposal would have appeared on a ballot that would have asked the voter to approve or deny this proposition:

The constitutional amendment authorizing a local option exemption from ad valorem taxation by a county of a portion of the value of the residence homestead of a physician who provides health care services for which the physician agrees not to seek payment from any source, including the Medicaid program or otherwise from this state or the federal government, to county residents who are indigent or who are Medicaid recipients.

It did not pass before the legislature adjourned.

• A resolution would have urged Congress and the President to establish a single-payer health care system. The bill, 2019 TX H.C.R. 80 (NS), was introduced on February 25, 2019; it was not adopted this session.

• Senate Bill 1780 (2019 TX S.B. 1780 (NS)) will allow the state to enter into value-based purchasing arrangements for drugs. The bill was filed on March 6, 2019, and it was adopted on May 28, 2019.

• Senate Bill 170 (2019 TX S.B. 170 (NS)) will direct the Health and Human Services Commission to establish a prospective payment methodology to reimburse rural hospitals that provide inpatient or outpatient services in Medicaid. The bill explains,

(b) To the extent allowed by federal law and subject to limitations on appropriations, the executive commissioner by rule shall adopt a prospective reimbursement methodology for the payment of rural hospitals participating in Medicaid that ensures the rural hospitals are reimbursed on an individual basis for providing inpatient and general outpatient services to Medicaid recipients by using the hospitals' most recent cost information concerning the costs incurred for providing the services. The commission shall calculate the prospective cost-based reimbursement rates once every two years.

Governor Greg Abbott (R) signed Senate Bill 170 on June 4, 2019.

• Senate Bill 436 (2019 TX S.B. 436 (NS)) has been adopted. The bill will direct the Department of State Health Services to develop and implement initiatives to better support and care for women with an opioid use disorder. The initiatives will be required to:

(1) improve screening procedures to better identify and care for women with opioid use disorder;

(2) improve continuity of care for women with opioid use disorder by ensuring that health care providers refer the women to appropriate treatment and verify the women receive the treatment;

(3) optimize health care provided to pregnant women with opioid use disorder;

(4) optimize health care provided to newborns with neonatal abstinence syndrome by encouraging maternal engagement;

(5) increase access to medication-assisted treatment for women with opioid use disorder during pregnancy and the postpartum period; and

(6) prevent opioid use disorder by reducing the number of opioid drugs prescribed before, during, and following a delivery.

• The Health and Human Services Commission gave notice that it intends to file a request with CMS for an amendment to the state's Section 1915(c) home- and community services waiver. In the notice, the agency explains that the amendment would, “[c]hange the rate methodology to temporarily increase the direct care portion of the supervised living and residential support services rates.” Please see 2019 TX REG TEXT 536581 (NS) (Oct. 11, 2019).

In **Utah:**

• Introduced on January 28, 2019, 2019 UT H.B. 41 (NS) would have directed that certain funds generated by a sales and use tax be transferred to the Division of Health Care Financing to fund the Medicaid expansion. It did not pass. A ballot measure to adopt the Affordable Care Act Medicaid expansion was passed in the November 2018 election. However, the legislature later passed a bill to limit the expansion. Please see Section II.V. (Recent Developments on the Medicaid Expansion) for more information.

• A resolution (2019 UT S.C.R. 1 (NS)) urges Congress to extend Medicaid coverage beyond 15 days for mental health services provided to adults with serious mental illness in an Institute for Mental Disease. The resolution was introduced on January 28, 2019, and it was adopted on March 25.

• In a notice published at 2019 UT REG TEXT 528504 (NS) (Oct. 15, 2019), the Department of Health gave notice that it amended certain policies for Medicaid Inpatient Hospital Services. Many of the changes relate to inpatient hospital intensive physical rehabilitation, which the rule defines as “an intense program of physical rehabilitation provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.” New language was also added for reporting routine hospital services. The rule provides that routine services must be included in the daily service charge, and it sets out a list of services that are not reported separately.

• The Department of Health gave notice at 2019 UT REG TEXT 528520 (NS) (July 15, 2019) that it is adjusting its certain Medicaid rates based on established methodologies.

In **Vermont:**

• Introduced on January 29, 2019, 2019 VT H.B. 108 (NS) addressed Medicaid disproportionate share hospital payments. It would have prohibited a formula that would have provided for an additional allotment based on a hospital's status as an academic medical center. The bill did not pass this session.

In **Virginia:**

• Introduced on January 10, 2019, 2018 VA H.J.R. 680 (NS) would have directed the Department of Medical Assistance Services to study the costs and benefits of implementing a full provider service network capitation model for Medicaid. The bill failed to advance.

• House Bill 2530 (2018 VA H.B. 2530 (NS)) would have required most Medicaid participants earning more than 100% of the poverty level to pay cost-sharing to the greatest extent allowed by federal law for nonemergency services rendered in a hospital emergency department. The bill would have also required hospitals to inform Medicaid participants receiving such services of the amount of cost-sharing for which they would be responsible. The bill was introduced on January 9, 2018. It died in committee.

• Introduced on January 9, 2019, 2018 VA H.B. 2558 (NS) was adopted on March 5, 2019. The bill places limitations on providers' ability to impose out-of-pocket costs for Medicaid participants receiving services involving opioids for pain management or a prescription for buprenorphine-containing products, methadone, or other opioid replacements approved by the FDA for treating addiction. Senate Bill 1167 (2018 VA S.B. 1167 (NS)) is a related bill.

• A resolution (2018 VA H.J.R. 681 (NS)) would have required the Joint Legislative Audit and Review Commission to conduct a study to evaluate how recent changes in health care financing and delivery, including the Medicaid expansion and new facility assessments, would affect the demand for charity care and the ability of providers to meet the charity care requirements that may be imposed for certificates of public need. The resolution was introduced on January 9, 2019. It died in committee.

• The Department of Health announced proposed rules to establish the Commonwealth Coordinated Care Plus program, which is described in the rules' summary as a "statewide Medicaid managed long-term services and supports program servicing individuals with complex care needs through an integrated delivery system model across the full continuum of care." These proposed rules address eligibility and enrollment, covered services, responsibilities of participating managed care organizations, requirements for continuity of care, payment rates, participant appeal processes, and provider appeals. To learn more about the program, please consult the Virginia Department of Medical Assistance Services' fact sheet. [FN250] The proposed rules are published at 2019 VA REG TEXT 462399 (NS) (Jan. 21, 2019).

In **Wyoming:**

• House Bill 244 (2019 WY H.B. 244 (NS)) would have directed the Department of Health, with the governor's approval, to amend the Medicaid state plan to adopt the Affordable Care Act Medicaid expansion. As part of the expansion, the state would have adopted work requirements and a mental health and substance abuse program tailored specifically to the state's needs. The act would have been repealed if the federal contribution for the expansion ever fell below 90%. The bill was introduced on January 25, 2019, but it failed to pass.

XIII. Additional Resources

The Kaiser Family Foundation has published new data on Medicaid fee-for-service long-term care spending. [FN251]

Using information supplied by CHCS, [FN252] the Commonwealth Fund has created an interactive tool giving state-by-state information on current care models for patients with complex health care needs. Individuals with complex care needs include those with multi-faceted needs, such as multiple chronic health conditions, behavioral health conditions, addiction, unmet social needs, and so forth. According to the Center for Health Care Strategies (CHCS), 50% of Medicaid funds are spent on just 5% of the Medicaid population, and many of that number have complex needs. [FN253] The tool is a map of the United States with several ways to filter the information, including by target population, program elements, state, insurance, number of sites, and the program or model name. [FN254] Using the "insurance" filter, a user may choose "Medicaid" or "Medicare/Medicaid," and learn more about the programs and models that use Medicaid as a payer.

The Kaiser Family Foundation has published a set of Medicaid Fact Sheets – one for each state. The Fact Sheets are presented as an interactive tool: The user clicks on a state to view Medicaid facts for that state. Each Fact Sheet provides information on the state's population and how many of them are low-income, the uninsured rate, the number of individuals (in categories) covered by Medicaid, the number of working Medicaid participants, Medicaid eligibility levels, party affiliations in state government and in Congress, and so forth. [FN255]

CMS has announced that it will be offering a new podcast called "Beyond the Policy." [FN256] According to CMS, the new podcast responds to stakeholder feedback indicating that they often do not have time to read lengthy policy documents and engage in training, and some suggested that a podcast would be a good way to easily learn about new developments. The podcast will keep stakeholders abreast of new proposals, policies, and programs.

The Kaiser Family Foundation has announced three new issue briefs examining various aspects of home- and community-based services. One examines enrollment and spending, [FN257] another looks at state policy choices about HCBS, [FN258] and the third answers questions about waiting lists for HCBS. [FN259]

XIV. Conclusion

In a dramatic defeat, Congressional attempts to repeal and replace the Affordable Care Act failed in the summer of 2017. However, in the first volley of litigation challenging the Affordable Care Act, a Texas trial court ruled that, because the individual mandate was unconstitutional, the entire act fails. For now, CMS continues to administer the Affordable Care Act initiatives put in place under the Obama Administration. However, the agency has set forth a new policy for waivers and amendments to State Plans. Of particular note, CMS has advised that it is willing to consider waiver requests including work, or "community engagement," requirements. CMS has approved such requirements in several states, and a handful more have waivers pending. However, the requirements have been blocked in three states. In the future, we can expect to see longer approval periods for demonstration waivers and waiver extensions and additional waiver flexibility. However, we now know that CMS' flexibility will only stretch so far: It has refused permission for a waiver to impose lifetime limits on Medicaid benefits and has refused to grant full expansion funds for partial expansions.

This Issue Brief contains information on introduced and pending legislation. Subscribers to Legislation To Watch can view the full text of these bills, along with related information and actions. If you do not have access to Legislation To Watch or for information about other HPTS products, please contact 1-800-WESTLAW (1-800-937-8529), *for information about subscribing to Westlaw.*

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