§1115 Medicaid Expansion Waiver Summaries

Kentucky HEALTH – CMS approved Kentucky's §1115 demonstration waiver, known as Kentucky HEALTH (Helping to Engage and Achieve Long Term Health), on January 12, 2018. Kentucky initially expanded Medicaid coverage through a State Plan Amendment on January 2014.

Population

Adults in the new Expansion Group: parents and other caretaker relatives, transitional medical assistance, pregnant women, and former foster care youth. Beneficiaries considered medically frail, former foster care youth, and pregnant women will participate in the Kentucky HEALTH program, but are **exempt from several Kentucky HEALTH requirements**, including the community engagement requirement.

Major Provisions

1. **Healthy Behavior Incentives.** Two consumer-driven tools, My Rewards Account, similar to a Health Savings Account, and a Deductible Account, provide incentives to encourage beneficiaries to seek preventive services and engage in their personal health care plan.
2. **Community Engagement Requirement.** Able-bodied adults, ages 19 to 64, must complete 80 hours per month of work or community engagement activities, such as employment, education, job skills training, and community service. Eligibility is contingent upon completion of these requirements.
3. **Cost-sharing (Premiums).** Premiums are required with some exceptions (pregnant women, former foster care youth, and those determined medically frail). For those with incomes above 100% the federal poverty level (FPL), premium payment is a condition of coverage. There are consequences for beneficiaries who do not pay premiums after a 60-day payment period.
4. **Premium assistance for employer sponsored insurance (ESI).** Medicaid and CHIP eligibility re-determinations are aligned with the individual's ESI open enrollment period.
5. **Non-emergency medical transportation (NEMT) waived.** NEMT to and from methadone treatment is waived for all Medicaid enrollees and NEMT for the new adult group is waived (both provisions have certain population exceptions).
6. **Retroactive eligibility for certain populations waived.** Kentucky will not provide retroactive eligibility to Kentucky HEALTH beneficiaries, except for former foster care youth and pregnant women.
7. **Non-eligibility period for failure to comply.** Imposes six-month non-eligibility period and disenrollment for failure to comply with eligibility redetermination, failure to report a change in circumstance, or failure to pay required premiums
8. **New Substance Use Disorder (SUD) Services.** Expands access to SUD services to beneficiaries with SUD, in an effort to help improve the quality, care, and health outcomes for Medicaid beneficiaries with SUD.

Timeline/Implementation

The SUD program Began on January 12, 2018. **The Kentucky HEALTH portion of the demonstration:** Roll out for the Kentucky HEALTH program is scheduled to begin April 1, 2018.

Implementation of Kentucky's waiver may not be able to move forward due to a lawsuit filed January 24, 2018 against the federal Health and Human Services and Centers for Medicare and Medicaid Services (CMS). The lawsuit alleges the federal officials who approved the plan acted illegally and in conflict with Medicaid law that only Congress has power to change.

Healthy Indiana Plan – CMS approved Indiana's §1115 Waiver, known as the Healthy Indiana Plan (HIP) 2.0 to expand Medicaid coverage on January 27, 2015. HIP 2.0 aims to promote personal responsibility for healthcare choices through consumer-directed program features similar to commercial insurance plans. Indiana also aims to encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness.

Population

HIP 2.0 extends Medicaid coverage to adults with incomes through 133%. Indiana enrolled 1,473,414 individuals in its Medicaid/CHIP Program as of July 2016. Indiana's uninsured rate declined from 15.3% in 2013 to 11.1% in 2015.

Major Provisions

The Healthy Indiana Plan offers a tiered benefit package through two primary routes to coverage:

1. **HIP Plus –** Offers an enhanced benefit package for members who make required monthly contributions to their Personal Wellness and Responsibility (POWER) Account, which functions like a Health Savings Account (HSA). HIP Plus members who fail to make contributions within a 60-day grace period are terminated from the plan (and individuals over 100% FPL are locked out for a 6 month period.)
2. **HIP Basic –** Individuals, who are below the poverty line and are terminated from HIP Plus, are transferred to the HIP Basic plan. This plan offers a more limited benefit package without dental and vision benefits.

Program Administration: Managed Care Organizations (MCOs) administer the HIP Plus and HIP Basic coverage options. HIP Plus members receive a $2,500 high deductible health plan (HDHP) paired with the $2,500 "POWER" Account. Members add money to their POWER account through their MCO. Funds in the POWER account pay for health care services until the deductible amount is met, at which point the HDHP becomes solely responsible for paying any further claims. HIP Plus members originally received one card to serve as both their medical insurance card and a POWER account debit card, but Indiana terminated the debit cards due to issues with its database.

Timeline/Implementation

HIP 2.0 coverage began February 1, 2015 and was scheduled to end January 31, 2018. Indiana submitted a waiver application to extend HIP 2.0 through January 31, 2021 and to establish Medicaid work requirements. This waiver amendment is in pending status with CMS.

Early Outcomes

Program Successes: Approximately 86% of HIP Plus members and 61% of HIP Basic members received at least one qualifying preventive care service in the first full demonstration year. Approximately 60% of members report checking their POWER account balance.

Program Challenges/Criticisms: A report assessing HIP 2.0 showed that mandatory monthly contributions created an enrollment barrier for 29% of adults. The report found that between February 1, 2015 and November 30, 2016, a total of 57,189 members were disenrolled or not enrolled due to non-payment of required monthly contributions (The Lewin Group, June 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/in/healthy-indiana-plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf).

Healthy Michigan Plan – CMS approved Michigan's §1115 Waiver to expand Medicaid, known as the "Healthy Michigan Plan," on December 30, 2013. Michigan implemented on April 1, 2014. The waiver is set to expire on December 31, 2018.

Population

Adults in the new Expansion Group: Adults ages 19-64 up to 138% FPL (childless adults 0-138% FPL, non-working parents from 37-138% FPL, and working parents from 64-138% FPL).

Major Provisions

1. **Managed Care Delivery System.** The waiver uses Michigan's pre-existing Medicaid Managed Care Organizations (MCOs), and Pre-paid Inpatient Health Plans (PIHPs) for mental health and substance abuse services
2. **Premiums and Health Savings Accounts (HSAs).** Enrollees from 100-138% FPL make monthly premium contributions to HSAs in the amount of 2% of income. Enrollees cannot lose Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay premiums.
3. **Co-payments Based on Previous 6 months.** Enrollees make monthly payments into an HSA based on their average copayments from the previous six months. Enrollees receive account statements, but funds do not accumulate in accounts. Cost-sharing payments are disbursed to providers. Compliance with specified healthy behaviors can reduce HSA payments. Individuals may not lose eligibility or be denied access to services for failure to pay copayments.
4. **Medicaid Coverage.** Unlike several states, Michigan does not waive any Medicaid benefits, such as non-emergency medical transportation (NEMT). Michigan also does not waive retroactive coverage.

Recent Waiver Amendment

In December 2015, CMS approved a waiver amendment to the Healthy Michigan Plan, which is set to become effective April 1, 2018. Michigan is transitioning to a tiered benefit with healthy behavior requirements.

Under the waiver amendment, beneficiaries between 100% and 138% FPL who are not medically frail will choose between two coverage options:

1. **Continued coverage through Medicaid managed care (Healthy Michigan Plan)** and compliance with a healthy behavior requirement; **OR**
2. **The Marketplace Option,** Medicaid premium assistance and cost-sharing subsidies for Marketplace coverage through a Qualified Health Plan (QHP)**.**

If beneficiaries choose Medicaid managed care, they will be required to complete a healthy behavior, or they are subject to transition to a QHP. Enrollees above 100% FPL will face monthly premiums of up to 2% of income in both Medicaid managed care and QHPs, but failure to pay would not result in termination of eligibility.

Early Outcomes

The state of Michigan and its residents have seen significant financial savings following Medicaid expansion. A 2017 New England Journal of Medicine study found the state costs of Michigan's Medicaid expansion will be fully covered through 2021 and are very likely to be so in subsequent years as well. In addition, low-income adults who paid directly for health care services or premiums before the expansion can redirect their spending to other needs, such as housing, transportation, and food (NEJM, Feb 2017, http://www.nejm.org/doi/pdf/10.1056/NEJMp1613981).