



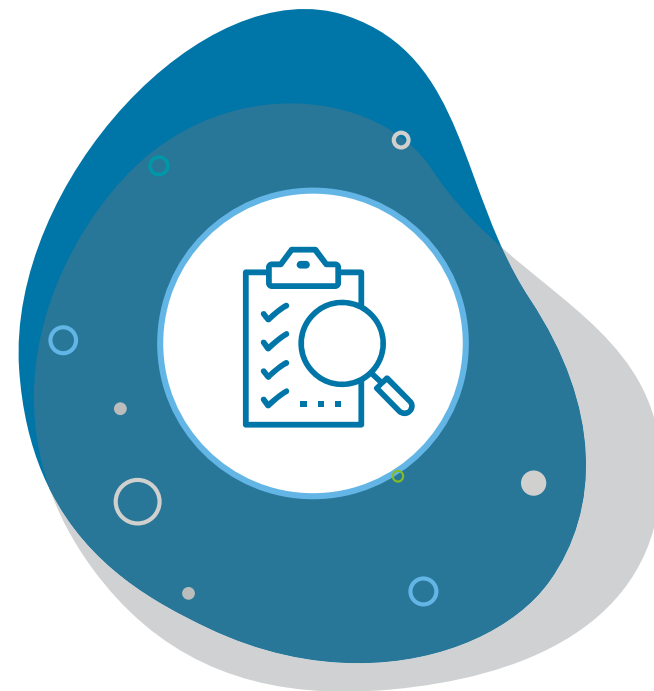
Georgia Department of Community Health  
Waiver Project

**National Environmental Scan Report**

July 8, 2019

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# Executive Summary: Background of National Scan

This national scan provides insights on federal guidance, state waivers, and national healthcare trends to support Georgia in developing its 1115 and 1332 waivers

## Background

Like many other states, Georgia faces challenges with the rising cost of healthcare, high uninsured rates, closure of rural hospitals, and poor health outcomes. On March 27, 2019, Governor Kemp signed the "Patients First Act" into law to help address many of these issues.

The bill authorizes the department to submit a waiver request pursuant to Section 1115, which may include an increase in the income threshold up to a maximum of 100 percent of the federal poverty level (FPL). The bill also allows the governor to submit one or more applications for waiver of applicable provisions of the federal Patient Protection and Affordable Care Act (ACA) under Section 1332 with respect to health insurance coverage or health insurance products.



## Purpose of this Document



This National Scan includes an analysis of the 1115 and 1332 waiver landscapes, analysis and summaries of federal guidance related to 1115 and 1332 waivers, and highlights of national healthcare coverage trends. The purpose of this document is to provide an overview of the national landscape to help inform potential options for Georgia to consider in its waivers.

## Sources



Publicly available data from the Centers for Medicare & Medicaid Services (CMS), Kaiser Family Foundation (KFF), Bureau of Labor Statistics, and the Census Bureau's American Community Survey (ACS) were the primary sources. Industry insights and knowledge from the project team were also included where applicable.

# Executive Summary: Section 1115 Waiver Landscape

Section 1115 waivers provide states flexibility to test approaches that further the objectives of Medicaid



## What is an 1115 waiver?

1115 waivers provide states an avenue to test new approaches in Medicaid that differ from what is required by federal statute.

As of available data June 2019, there are:

- 48 approved waivers across 39 states
- 20 pending waivers across 18 states
- 2 waivers that have been set aside by the courts in AR and KY related to work requirements and community engagement

To be approved by CMS, the 1115 waiver must be budget-neutral to the federal government.



## How are states using 1115 waivers?

Waivers vary in scope from small, targeted changes for specific eligibility groups to broad changes to a state's Medicaid program.

In recent years, states have used 1115 waivers to:

- Increase adult eligibility
- Waive institution for mental disease (IMD) exclusions to combat the opioid epidemic
- Introduce consumer tools (e.g., health savings accounts)
- Introduce tools to address social determinants of health
- Reform delivery systems, including introducing value-based purchasing
- Add community engagement and work requirements



## What is the future of 1115 waivers?

CMS has indicated a willingness under the current administration to allow states to pursue new ideas such as:

- Introduce more flexible, streamlined approaches to respond to the opioid crisis
- Establish Medicaid block grants
- Introduce new requirements to maintain Medicaid eligibility (e.g., work/community engagement)
- Extend waiver demonstrations to up to 10 years

Approvable ideas continue to evolve. For example, Utah is currently pursuing enhanced 90% funding for adult eligibility up to 100% FPL with capped capitation rates.

# Executive Summary: Section 1332 Waiver Landscape

Section 1332 waivers provide states flexibility to pursue innovative strategies to provide residents with access to high-quality, affordable health insurance



## What is a 1332 waiver?

1332 waivers provide states an avenue to pursue innovative strategies for providing their residents with access to high-quality, affordable healthcare.

As of available data June 2019, there are:

- 8 states with approved waivers
- 2 states with pending waivers
- 5 states with draft waivers for public comment

To be approved by CMS, waivers must meet four statutory guardrails. States must provide coverage 1) that is as comprehensive, 2) that is as affordable, 3) provides coverage to a comparable numbers of residents, and 4) does not increase the federal deficit.



## How are states using 1332 waivers?

All but one of the approved and pending waivers are for reinsurance programs.

Seven of the eight reinsurance waivers, take a claims-based as opposed to a condition-based approach.

States vary in how they structure the oversight of their reinsurance programs.

- 4 states administer via non-profit entities
- 3 states have programs administered by state agencies, with 1 under the insurance commissioner

Hawaii's waiver, the only non-reinsurance waiver, waives the SHOP provisions due to state law requiring employer coverage.



## What is the future of 1332 waivers?

CMS, under the current administration, has issued guidance with increased flexibility since 2018 for states to explore new innovations.

In November 2018, CMS released a discussion document with ideas on how states may apply the new flexibilities, including:

- Account Based Subsidies
- Risk Stabilization Strategies
- State-Specific Premium Assistance
- Adjusted Plan Options

CMS also released a Request for Information (RFI) soliciting other ideas from states on how they might use the waivers. Comments were due July 2, 2019.

# Executive Summary: National Healthcare Coverage Trends

National healthcare trends offer comparative points for Georgia to consider in targeting its waivers



## Medicaid and Individual Market Enrollment

Georgia's Medicaid enrollment in 2017 as a percent of the total population falls in the middle of non-expansion states.

- 17% of Georgia's population is enrolled in Medicaid or CHIP. Non-expansion states range from 13-24%
- 9% of adults are enrolled in Medicaid in Georgia. Non-expansion states range from 17-14%

Nationally, 2017 saw a spike in consumers selecting Marketplace plans then a steady decline to 2019.

- Georgia had 458,437 members select a plan in the individual market in 2017, ranking fifth highest nationally for volume



## Estimated Uninsured Rates

Georgia's uninsured rate, based on data from the U.S. Census Bureau ACS 2017 5-year estimates, is 15% for the total population. Non-expansion states range from 10-18% and traditional expansion (ACA) states range from 3-16%

- 21% of adults ages 19-64 are estimated to be uninsured in the State, compared to 14-25% among non-expansion states
- At 27%, Georgia has the second highest uninsured rate among young adults (19-34)
- 8% of children under 19 years old are estimated to be uninsured in the State, higher than the national average of 5%



## Medicaid Coverage for New Adult Group

Since 2014, 37 states plus DC have chosen to provide Medicaid coverage to the New Adult Group.

- 28 states plus DC provide coverage to the New Adult Group up to 138% FPL through State Plan Amendment (SPA)
- 5 states have used 1115 waivers to provide coverage to the New Adult Group up to 138% FPL (IA, AR, MI, IN, NH)
- 2 states have used 1115 waiver authority for limited coverage of the New Adult Group up to 100% FPL (UT, WI)
- 2 states approved coverage for the New Adult Group by voter referendum (ID, NE)
- 13 states do not cover the New Adult Group

# 1115 Waiver Analysis

- Methodology
- Overview of 1115 Waivers
- Federal Guidance
- Landscape of Approved and Pending Waivers
- Spotlight of Utah's Pending Waiver Amendment
- Summary Takeaways



# Methodology

The purpose of this section is to provide an overview of section 1115 waiver guidance, as well as a review of a sampling of the approved and pending 1115 waiver landscape

## Methodology

- The team examined the national landscape of 1115 waivers using publicly available sources and the team's national waiver knowledge to review waivers approved, pending, publicly available drafts, and approved but not implemented.
- To categorize the different attributes of waivers and group by similar provisions, waiver data and categories by Kaiser Family Foundation (KFF) posted June 13, 2019 were used as a starting baseline. KFF only captures pending waivers which have been officially accepted by CMS and posted on Medicaid.gov. This report includes state waiver drafts which have been released publicly. In addition, KFF's classifications, descriptions, and groupings were adjusted to reflect a more detailed description of the landscape based on recent trends.
- For each of the eight categories of waivers within this report, the team reviewed the types of provisions states have implemented under each category, providing state-specific examples, and conducted a review of one or more states to provide a more detailed description of the program.

### 1115 Scan Primary Sources

In conducting the scan, the team examined publicly available sources, including:

- Medicaid.gov 1115 waiver demonstration website
- Medicaid and CHIP Payment and Access Commission (MACPAC) issue briefs on 1115 waivers
- Kaiser Family Foundation's waiver tracker June 13, 2019
- State Medicaid websites
- Detailed program knowledge of the project team





# Overview of 1115 Waivers

Section 1115 waivers give states flexibility to test approaches that further the objectives of Medicaid

## Background on 1115 Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to approve **experimental, pilot, or demonstration projects** that are found by the Secretary to be likely to assist in promoting the **objectives of the Medicaid** program. The purpose of these demonstrations, which give states **additional flexibility** to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations.

In addition to guidance from CMS, the courts have historically played a role in shaping Medicaid policy. Most recently, *Stewart v. Azar*, filed in January 2018 regarding Kentucky's waiver, raised the question of whether Section 1115 permits the HHS Secretary to authorize Medicaid demonstrations that reduce eligibility through work requirements, premium payments, increased reporting requirements, and lock-out periods. The holdings of these court cases are not legally binding on other states but do set precedent for how courts may rule on similar cases in the future.

## 1115 Waiver Considerations

- Prior to submitting an application, a state must provide **public notice and a 30-day comment period** sufficient to ensure a meaningful level of public input
- CMS performs a **case-by-case review** of 1115 waivers
- 1115 waivers must be **budget neutral** to the Federal Government, which means that federal expenditures with the waiver will not be greater than Federal spending without the waiver
- 1115 demonstrations are approved for an **initial five-year period** and can be extended for up to **an additional three to five years**, depending on the populations served
- After a state submits an initial 1115 waiver, it can continue to modify its Medicaid program through the submission of **amendments**, which undergo a similar process

# Federal Guidance for 1115 Waivers

Guidance released by the current administration provides increased state freedom to design 1115 waivers

## Medicaid/CHIP Objectives

CMS evaluates Section 1115 waiver requests to assure that federal Medicaid expenditures will not exceed what would have occurred without the proposed demonstration and that waivers will promote the objectives of the Medicaid program. CMS uses the following criteria to determine whether each state's proposed waiver meets Medicaid/CHIP objectives and will:

- 1 **Increase and strengthen** overall coverage of low-income individuals
- 2 **Increase access to, stabilize, and strengthen** providers and provider networks available to serve Medicaid and low-income populations
- 3 **Improve the health outcomes** for Medicaid and other low-income populations
- 4 **Increase the efficiency and quality of care** for Medicaid and other low-income populations through initiatives to transform service delivery networks

## Recent Federal Guidance

The current administration released guidance, informational bulletins, and letters to state Medicaid directors providing additional insights into 1115 waivers:

- **March 2017:** CMS letter noted key areas where HHS and CMS will work to improve collaboration with states, including improving program management, supporting increased community engagement, and providing more tools to address the opioid epidemic
- **November 2017:** CMS letter to state Medicaid directors outlined a more flexible, streamlined approach to accelerate states' ability to respond to the opioid crisis
- **November 2017:** CMS informational bulletin outlined several process improvements, such as revising and simplifying the application template, the ability to request demonstrations for up to 10 years, and removal of the requirement that states have at least one full extension before using the fast-track review approach
- **November 2017:** CMS posted revised criteria that no longer includes increasing coverage as a goal of the program
- **January 2018:** CMS posted guidance to allow waiver proposals to condition Medicaid on meeting a work requirement
- **August 2018:** CMS letter to state Medicaid directors describing current policy on budget neutrality
- **November 2018:** CMS issued new guidance inviting states to apply for waivers of the federal IMD payment exclusion for services for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED)

# Federal Guidance for 1115 Waivers

Guidance released by the current administration in 2017 invites states to propose reforms that build upon the lessons of past demonstrations as well as novel approaches designed to promote Medicaid's objectives



1

**Improve access to high-quality, person-centered services** that produce positive health outcomes for individuals



2

**Promote efficiencies** that ensure Medicaid's sustainability for beneficiaries over the long-term



3

**Support coordinated strategies** to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals



4

**Strengthen beneficiary engagement** in their personal healthcare plan, including incentive structures that promote responsible decision-making



5

**Enhance alignment** between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition

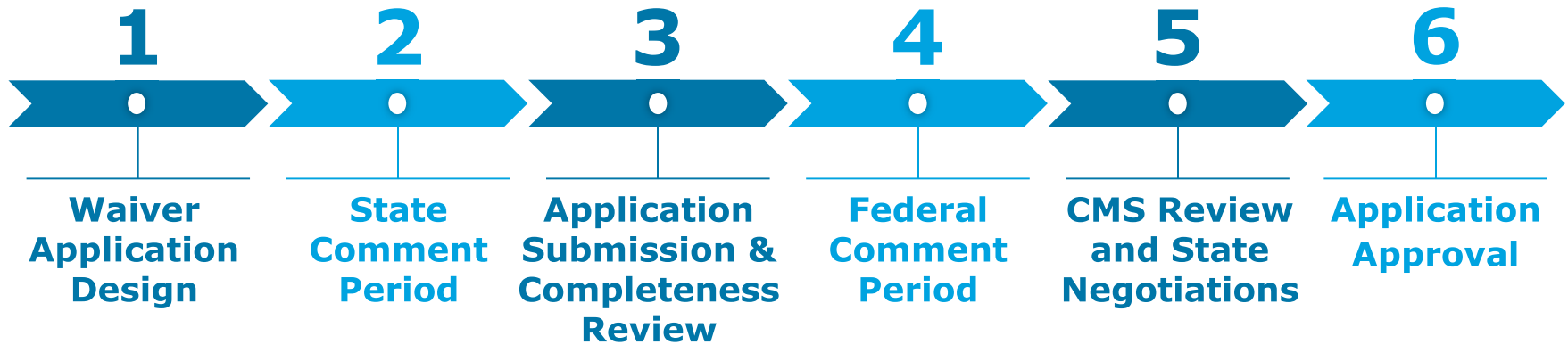


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**Advance innovative delivery system and payment models** to strengthen provider network capacity and drive greater value for Medicaid

# Federal Guidance for Application Process

States and CMS work collaboratively through the development, comment period, submission, negotiation, and approval of 1115 waivers



## State Comment Period

States must provide at least a 30-day public notice and comment period for applications for new demonstrations and extensions of existing demonstrations. Once a state's 30-day public comment period has ended, the state will submit its application to CMS.



## Application Submission

Within 15 days of receipt of the application, CMS will determine whether the application is complete. CMS will send the state written notice informing the state of receipt of the complete application and the date on which the Secretary received the application.



## Federal Comment Period

Following submission, there will be a 30-day Federal comment period for the general public and stakeholders to submit comments. CMS will not act on the demonstration request until 15 days, at a minimum, after the conclusion of the public comment period.



# Emerging Themes in 1115 Waiver Approvals

Themes have emerged on what has/has not been approved by CMS under the current administration, some targeted specifically for the New Adult Group

## Waiver Provisions Approved for the first time under the current administration

- Eliminating retroactive coverage for Medicaid members (Both)
- Conditioning eligibility on the completion of a health risk assessment (Both)
- Coverage loss and lock-outs for non-payment of premiums (Both)
- Fees for missed appointments (Both)
- Approval to charge premiums (Both)
- Tobacco surcharge (Both)
- Coverage lock-outs for failure to timely renew coverage or report changes affecting eligibility (New Adult Group only)
- Conditioning eligibility on meeting work requirements/community engagement activities (New Adult Group only)
- Funding to cover evidence-based non-medical services that address specific social needs linked to health/health outcomes (Traditional Medicaid population)



## Waiver Provisions Denied since 2018 under the current administration

- Limiting ACA coverage for the New Adult Group to 100% FPL with the enhanced match (AR, MA)
- Lifetime limits on Medicaid benefits for eligible members (KS)
- Conditioning coverage on drug screening, and if indicated, testing and treatment (WI)
- Requiring stricter verification of U.S. citizenship and state residency than already required under federal law (NH)
- Imposing asset tests for poverty-related pathways (ME, NH)
- Imposing coverage lock-outs for individuals who misrepresent compliance with work requirements (MI)
- Applying more frequent eligibility redeterminations (AZ)
- Enforcing premiums for individuals with incomes below 100% FPL (OH)
- Waiving fair hearing requirements (OH)



# Landscape of Approved & Pending Section 1115 Waivers

1115 waivers have been used to implement a wide range of mechanisms to test approaches that further the objectives of Medicaid



The types of **innovation** states have pursued with 1115 waivers may be grouped into eight overarching categories:



Eligibility & Enrollment



Behavioral Health



Work Requirements/  
Community Engagement



Delivery System Reform



Benefits



Managed Long Term Services & Supports



Consumerism (e.g., Cost-sharing, Health Savings Accounts, Premiums)

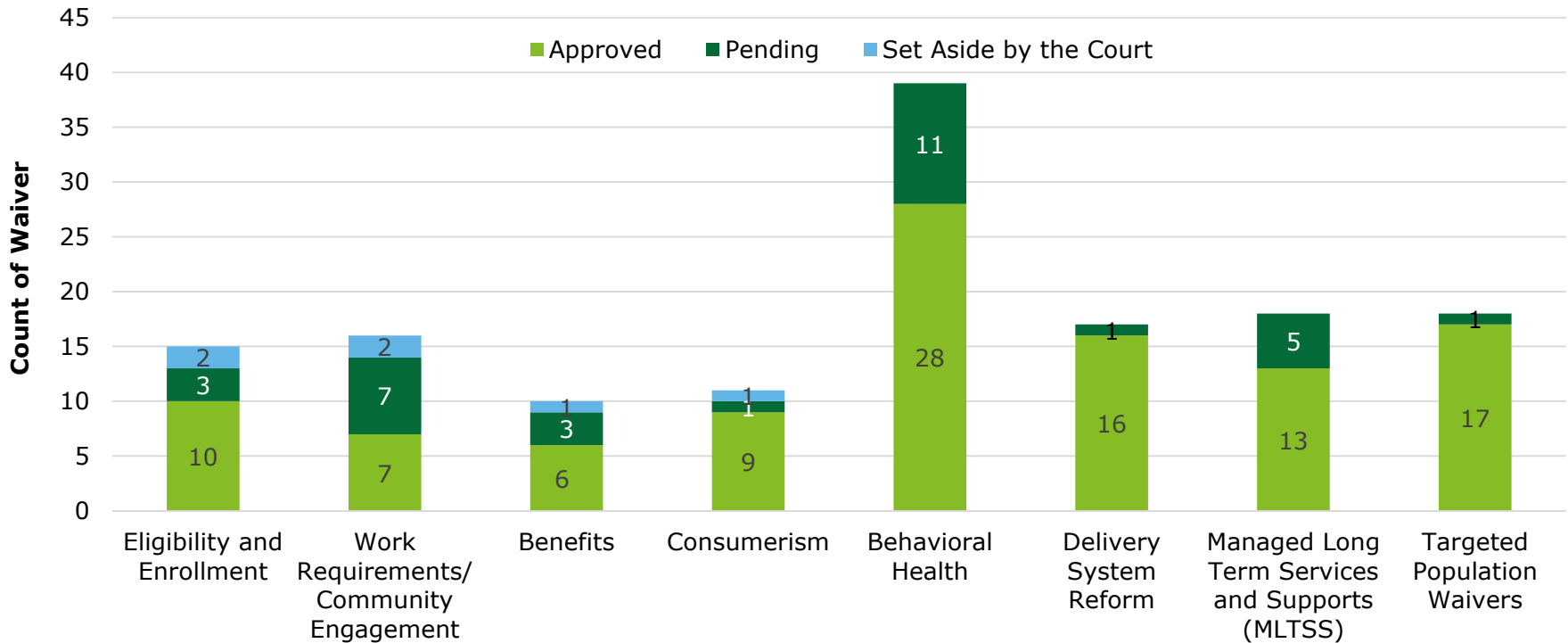


Targeted Population Waivers

# Landscape of Approved & Pending Section 1115 Waivers

Currently approved and pending waivers cover eight broad categories

## Count of Waivers By Category (non-comprehensive list)



### Highlights



- 48 **approved** 1115 waivers across 39 states
- 20 **pending** 1115 waivers across 18 states
- 2 waivers **set aside** across 2 states

### Notes



- Some states have multiple approved and/or pending waivers
- Waivers may address more than one category
- The total number of approved or pending waivers cannot be calculated by summing count in each category

# Eligibility & Enrollment

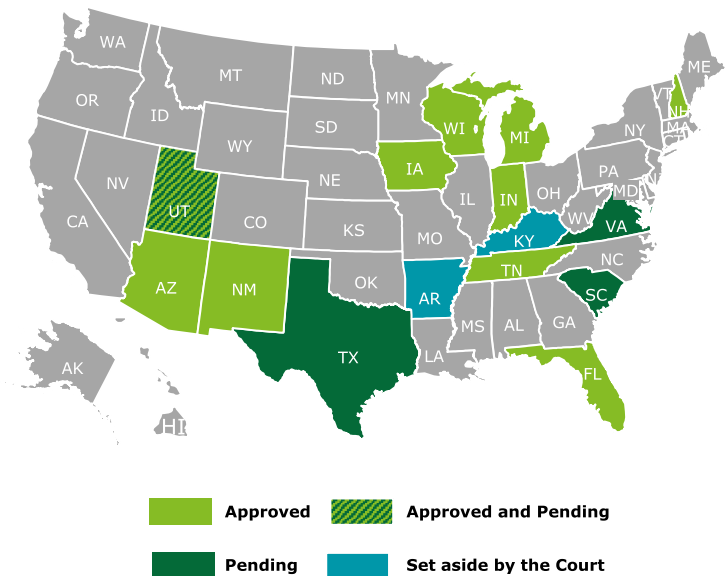
## Overview of Approved and Pending 1115 Waivers

### How States are Using/Proposing to Use 1115 Waivers

- **Imposing limits on standard eligibility/coverage** such as waiving retroactive eligibility, allowing states to delay the coverage start date, and placing overall time limits on benefits
- **Revising eligibility determination/redetermination** to impose additional steps to maintain coverage or lock outs for not taking active steps
- **Limiting New Adult Group income levels and capping enrollments** to better control costs

Waiver Provisions	New Adult Group Population	Traditional Medicaid Population
<b>Coverage</b>		
Waive Retroactive Eligibility	Approved: AZ, IA, IN, NH, NM Court: AR, KY	Approved: AZ, FL, IA, NM, TN Court: KY
Waive Reasonable Promptness/Delayed Coverage Effective Date	Approved: IN, NM Pending: VA Court: KY	Approved: IN Court: KY
Coverage Time Limit		Pending: SC
<b>Determination &amp; Redetermination</b>		
Lock-out for Failure to Timely Renew	Approved: IN Court: KY	Court: KY
Lock-out for Failure to Report Changes	Court: KY	Court: KY
Require Completion of Health Risk Assessment	Approved: MI	Approved: WI
Waive Modified Adjusted Gross Income (MAGI) Methodology		Pending: TX
<b>Eligibility Groups</b>		
Limit New Adult Group to 100% FPL with enhanced match	Requests from AR and MA were denied by CMS when requesting enhanced match, and CMS approved UT for the New Adult Group to 100% FPL but was silent on enhance match funding. UT has a draft waiver for enhanced match and is seeking a per capita cap.	
Authority to cap enrollment		Approved: UT Pending: SC Court: KY

**Eligibility & Enrollment 1115 Waivers**  
*(not comprehensive)*





# Eligibility & Enrollment

## Description of Provisions and State Examples

Waiver Provisions	Description	State Examples
<b>Coverage</b>		
Waive Retroactive Eligibility	Waives the requirements for state Medicaid programs to cover medical bills incurred up to three months prior to a member's application date	Arizona is eliminating the 90-day retroactive eligibility period. Some states limit retroactive eligibility to 10 days prior to submission of the Medicaid application.
Waive Reasonable Promptness/Delayed Coverage Effective Date	Allows states to delay the start of coverage until after the first premium is paid or after the 60-day payment period expires	New Mexico begins coverage for members the first month they make a premium payment.
Coverage Time Limit	Places limits on how long a member may receive Medicaid coverage	South Carolina's pending waiver requests authority to limit coverage for specific population groups (the newly covered childless adults who are eligible due to homelessness, justice system involvement, or need for mental health or substance use disorder (SUD) treatment) to a maximum of 12 months.
<b>Determination &amp; Redetermination</b>		
Lock-out for Failure to Timely Renew	Allows states to restrict enrollment for any member who fails to complete the annual eligibility redetermination process by a deadline	Indiana provides 90 days for members to submit redetermination paperwork. If it is not submitted, members are prohibited from re-enrolling for three months.
Lock-out for Failure to Report Changes	Allows states to restrict enrollment for any member who fails to report a change in income or other "change in circumstance"	Kentucky disenrolls and locks out adults who fail to timely report a change in circumstance affecting eligibility.
Require Completion of Health Risk Assessment	Conditions enrollment on the completion of a health risk assessment in efforts to collect health information	Wisconsin requires low-income adults to complete a health risk assessment in order to get or maintain their coverage.
Waive MAGI Methodology	Waives the standard eligibility determination, modified adjusted gross income (MAGI)	Texas' pending "Healthy Women" family planning waiver seeks to waive the MAGI methodology.
<b>Eligibility Groups</b>		
Limit New Adult Group to 100% FPL with enhanced match	Increased eligibility to 100% FPL at the enhanced match provided through ACA, rather than the traditional match	Requests from Arkansas and Massachusetts were denied by CMS when requesting enhanced match, and CMS was silent on Utah's request for the enhanced match, but did approve its coverage of the New Adult Group up to 100% FPL. Utah plans to submit a new request for an enhanced match and plans to seek a per capita cap.
Authority to cap enrollment	Allows the state to cap enrollment in the program if there are insufficient state funds available to match the federal funds.	Utah can limit enrollment of their New Adult Group based on state appropriations.

# Work Requirements/Community Engagement

## Overview of Approved and Pending 1115 waivers

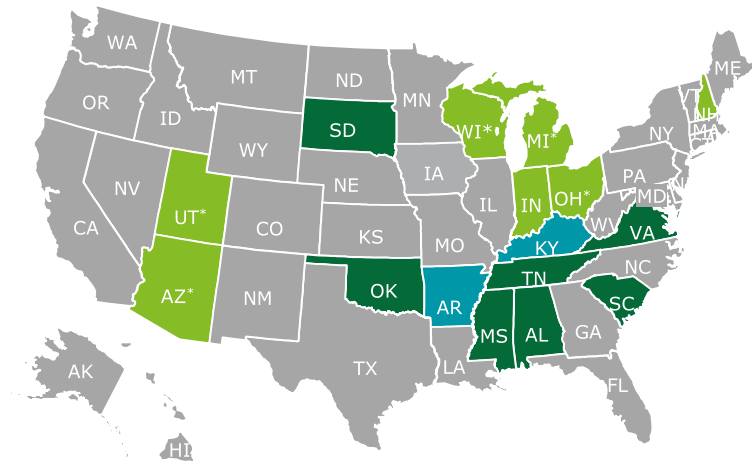
### How States are Using/Proposing to Use 1115 Waivers

- **Help populations** rise out of poverty and attain independence through work
- **Require work or other qualifying activity** as a condition of eligibility, for most of the New Adult Group and/or traditional non-disabled adult populations

### Work and Community Engagement Program Attributes

State	Status	Ages	Hours
Alabama	Pending	19 – 60	35/week
Arizona	Approved (NI)	19 – 50	80/month
Arkansas	Courts	19 – 50	80/month
Indiana	Approved	19 – 60	Increases to 20/week
Kentucky	Courts	19 – 65	80/month
Michigan	Approved (NI)	19 – 63	80/month
Mississippi	Pending	19 – 65	20/week
New Hampshire	Approved	19 – 65	100/month
Ohio	Approved (NI)	19 – 50	80/month
Oklahoma	Pending	19 – 50	Increases to 20/week
South Carolina	Pending	19 – 65	80/month
South Dakota	Pending	19 – 60	80/month
Tennessee	Pending	19 – 65	20/week
Utah	Approved (NI)	19 – 60	No hrs, job training
Virginia	Pending	19 – 65	Increases to 80/month
Wisconsin	Approved (NI)	19 – 50	80/month

### Work Requirements/Community Engagement 1115 Waivers



Approved
  Pending
  Set aside by the Court
  Approved and Pending

\*NI = Not Implemented Yet

# Work Requirements/Community Engagement

States vary in how they have defined the various aspects of their work requirements and community engagement programs

## Examples of Qualifying Activities

- Full time, part time, and self employment
- Education (high school / General Education Development (GED), postsecondary, English for Speakers of Other Languages (ESOL))
- Accredited homeschooling
- Skills or educational training
- Job search activities
- Volunteering
- Participation in other work programs (SNAP, TANF)
- SUD treatment
- Caregiving
- Participation in other state specific programs

## Examples of Exempt Populations

- Disabled / Recipient of SSI
- Physically or mentally unfit to work
- Temporarily ill / incapacitated
- Medically frail / receiving cancer treatment
- Pregnant
- Students
- Caregiver of a dependent child / disabled dependent
- Individuals in SUD treatment
- Homeless / former Foster Youth
- Victim of catastrophic event (domestic violence, natural disaster)
- Incarcerated within the previous six months

## Example of Reporting Requirements


- Initial reporting due 90 days from start of program
- Newly enrolled individuals granted a three-month period from their initial application month before they become subject to the requirements
- Review of hours by 5<sup>th</sup> day of next calendar month
- Retroactive review of full calendar year each December
- Immediate review of each month's hours
- All activities must be completed within three-months of being notified of the requirement; must complete the requirement annually


## Examples of Non-Compliance / Ability to Cure

- Terminated if not cured within a specified period
- Disenrollment letter after period of non-compliance
- Suspension of benefits after period of non-compliance
- Suspension of benefits until requirements are met
- Prohibition against re-enrollment until benefit year following termination
- Reinstatement of benefits possible by completing approved activity (health literacy course, financial literacy course, community engagement)

# Work Requirements/Community Engagement State Examples


States are taking different approaches to their work and community engagement waivers, including qualifying activities, minimum hours, reporting requirements, and penalties for non-compliance

	Kentucky	
	Approved	January 2018
	Current Status	Program set aside by the courts
Target Population	<ul style="list-style-type: none"> <li>• Non-elderly adult group, ages 19-64</li> <li>• Certain population groups exempt</li> </ul>	
Hours	<ul style="list-style-type: none"> <li>• 80 hours per month</li> </ul>	
Qualifying Activities	<ul style="list-style-type: none"> <li>• Full time, part time, self employment</li> <li>• Education</li> <li>• Skills or educational training</li> <li>• Job search activities</li> <li>• Volunteering</li> <li>• Community work experience</li> <li>• SUD treatment</li> <li>• Caregiving for non-dependent relative or person with disabling condition</li> </ul>	
Measurement/Hours Review	<ul style="list-style-type: none"> <li>• Immediate review of each month's hours</li> </ul>	
Non-Compliance	<ul style="list-style-type: none"> <li>• If non-compliant for one month, opportunity to cure the following month through various activities</li> <li>• Immediate suspension following one month opportunity to cure</li> </ul>	

	Ohio	
	Approved	March 2019
	Current Status	State to implement in January 2021
Target Population	<ul style="list-style-type: none"> <li>• New Adult Group only, ages 19-50</li> <li>• Certain population groups exempt</li> </ul>	
Hours	<ul style="list-style-type: none"> <li>• 20 hours per week, 80 hours averaged per month</li> </ul>	
Qualifying Activities	<ul style="list-style-type: none"> <li>• Full time, part time employment</li> <li>• In-kind work</li> <li>• Education</li> <li>• Skills or educational training</li> <li>• Public service activities</li> <li>• Job search activities for up to 30 days</li> <li>• Volunteering</li> <li>• Participation in and compliance with programs such as SNAP and TANF</li> </ul>	
Measurement/Hours Review	<ul style="list-style-type: none"> <li>• 60 days to report compliance and then required to report changes in status</li> </ul>	
Non-Compliance	<ul style="list-style-type: none"> <li>• If non-compliant, will be disenrolled from Medicaid</li> <li>• Option of applying to re-enroll in Medicaid immediately</li> </ul>	

# Work Requirements/Community Engagement State Examples


States are taking different approaches to their work and community engagement waivers, including qualifying activities, minimum hours, reporting requirements, and penalties for non-compliance

 Wisconsin	
Approved	October 2018 (extension)
Current Status	State to implement no sooner than 11/1/2019
Target Population	<ul style="list-style-type: none"> <li>Non-elderly adults without children, ages 19-49 with incomes at or below 100% FPL</li> <li>Certain population groups exempt</li> </ul>
Hours	<ul style="list-style-type: none"> <li>80 hours per month</li> </ul>
Qualifying Activities	<ul style="list-style-type: none"> <li>Full time, part time, self employment</li> <li>In-kind work</li> <li>Skills or educational training</li> <li>Job search activities</li> <li>Volunteering</li> <li>Participation in other work programs, such as Wisconsin Works or Workforce Innovation and Opportunity Act (WIOVA) programs</li> </ul>
Measurement/Hours Review	<ul style="list-style-type: none"> <li>Report activities to the state, in a manner specified by the state in the community engagement implementation plan</li> </ul>
Non-Compliance	<ul style="list-style-type: none"> <li>Each month of non-compliance counts towards the 48 month limit</li> <li>Once a member has been non-compliant for a cumulative 48 months, he/she will be disenrolled for at least six months</li> </ul>

 Arkansas	
Approved	March 2018 (revised)
Current Status	Program set aside by the courts
Target Population	<ul style="list-style-type: none"> <li>New Adult Group only, with income up to 138% FPL, aged 19-49</li> <li>Certain population groups exempt</li> </ul>
Hours	<ul style="list-style-type: none"> <li>80 hours per month</li> </ul>
Qualifying Activities	<ul style="list-style-type: none"> <li>Full time, part time, self employment</li> <li>Education</li> <li>Skills of educational training</li> <li>Job search activities</li> <li>Volunteering</li> <li>Health/Health insurance classes</li> <li>Participation in other work programs, such as SNAP or State Department of Workforce Services Programs</li> </ul>
Measurement/Hours Review	<ul style="list-style-type: none"> <li>Review of hours by 5th day of next calendar month</li> </ul>
Non-Compliance	<ul style="list-style-type: none"> <li>During third month of non-compliance, notice is issued</li> <li>Disenrollment effective first day of month after notice is issued</li> <li>Cannot reapply until next plan year</li> </ul>

# Work Requirements/Community Engagement State Examples

States are taking different approaches to their work and community engagement waivers, including qualifying activities, minimum hours, reporting requirements, and penalties for non-compliance

	Tennessee	
	Approved	Pending CMS approval
	Current Status	Submitted to CMS December 2018
Target Population	<ul style="list-style-type: none"> <li>• Non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category, aged 19-64</li> <li>• Certain population groups exempt</li> </ul>	
Hours	<ul style="list-style-type: none"> <li>• 20 hours per week, averaged monthly</li> </ul>	
Qualifying Activities	<ul style="list-style-type: none"> <li>• Paid employment or self employment</li> <li>• General education</li> <li>• Vocational and educational training</li> <li>• Participation in job search or job skills training sponsored by the State</li> <li>• Accredited homeschooling</li> <li>• Community service in approved settings</li> <li>• Complying with work requirements of another public assistance program, such as SNAP or TANF</li> </ul>	
Measurement/Hours Review	<ul style="list-style-type: none"> <li>• Document compliance monthly</li> <li>• TennCare will assess after six months of eligibility and every six months thereafter</li> </ul>	
Non-Compliance	<ul style="list-style-type: none"> <li>• Must meet the requirement for four months out of every six-month period to maintain coverage</li> <li>• Non-compliance will result in suspension of benefits</li> <li>• Benefits will remain suspended until compliance is demonstrated for one month</li> </ul>	

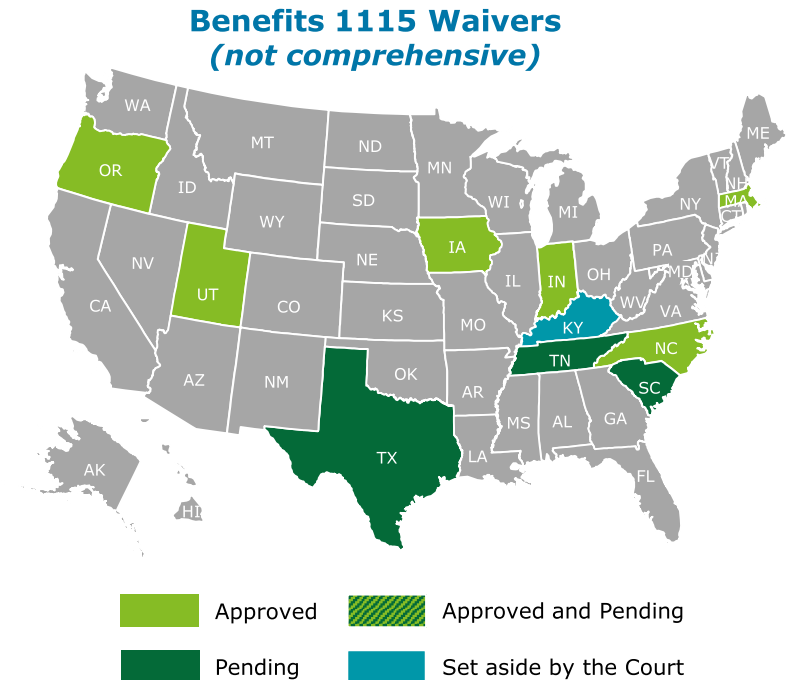
# Benefits

## Overview of Approved and Pending 1115 waivers

### How States are Using/Proposing to Use 1115 Waivers


- **Waiving traditional Medicaid benefits** such as non-emergency medical transportation (NEMT) and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for specific populations
- **Expand benefits** beyond traditional Medicaid benefits to include social services supports such as food and housing

Waiver Provisions	New Adult Group Population	Traditional Medicaid Population
Waive Required Benefits (e.g., NEMT)	Approved: IA, IN Court: KY	Court: KY
Waive EPSDT for 19 and 20 year-olds		Approved: UT
Restrict Free Choice of Family Planning Provider		Pending: SC, TN, TX
Expand coverage to include social services	Approved: MA, OR	Approved: NC, MA, OR



# Benefits State Example

States are taking different approaches to addressing social determinants of health through program design and benefit offerings

	North Carolina	
	Approved	October 2018
	Current Status	RFP for Lead Pilot Entities to be released by November 2019; services begin in 2020
Target Population	<ul style="list-style-type: none"> <li>Members enrolled in a managed care plan that have at least one physical or behavioral health risk factor and at least one social risk factor</li> </ul>	
Pilot Area	<ul style="list-style-type: none"> <li>Will include two to four regions of the state and is expected to serve approximately 25,000 to 50,000 members</li> </ul>	
Funding	<ul style="list-style-type: none"> <li>CMS authorized \$650 million in Medicaid funding for the pilot over five years, \$100 million is available for capacity building</li> </ul>	
Description of Program	<ul style="list-style-type: none"> <li>Creates new pilot program, called "Healthy Opportunities Pilots," to cover evidence-based non-medical services that address specific social needs linked to health/health outcomes.</li> <li>Lead Pilot Entities will develop, contract with, and manage the network of human service organizations that will deliver pilot services.</li> <li>The pilots will address housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress for a limited number of high-need members.</li> </ul>	



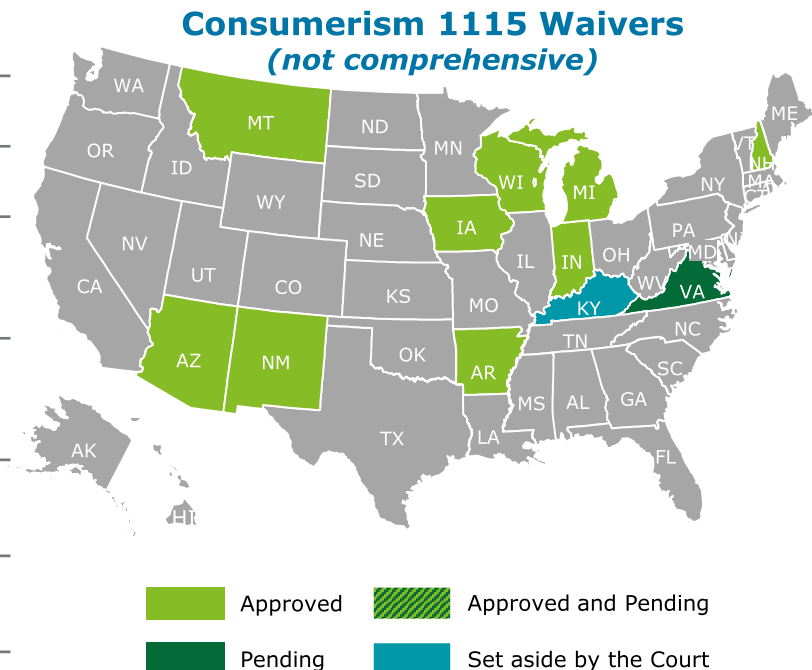
# Consumerism

## Overview of Approved and Pending 1115 waivers

### How States are Using/Proposing to Use 1115 Waivers

- **Implementing healthy behavior incentives** for services such as preventive care (tied to premium or cost-sharing reductions)
- **Charging copays** for various services, sometimes above statutory limits
- **Imposing fees** for missed appointments
- **Charging premiums** and making coverage effective on the date of the first premium payment
- **Creating Health Savings Accounts** to help facilitate these consumer activities

Waiver Provisions	New Adult Group Population	Traditional Medicaid Population
Healthy Behavior Incentives	Approved: AZ, IA, IN, MI, NM Pending: VA Court: KY	Approved: IN, NM, WI Court: KY
Copays above statutory limits	Court: KY	Court: KY
Fees for Missed Appointments	Court: KY	Court: KY
Premiums / Monthly Contributions	Approved: AR, AZ, IA, IN, MI, MT, NM Pending: VA Court: KY	Approved: IN, WI Court: KY
Coverage Loss and Lock-Out for Non-Payment of Premiums	Approved: IN, MI, MT, NM Pending: VA Court: KY	Approved: WI
Disenrollment (w/o Lock-Out) for Non-Payment of Pems	Approved: AZ, IA	
Qualified Health Plan (QHP) Premium Assistance	Approved: AR, NH	
Tobacco Premium Surcharge	Approved: IN	Approved: IN




# Consumerism


## Description of Provisions

Waiver Provisions	New Adult Group Population Description	State Examples
Healthy Behavior Incentives	Allows states to encourage members to adopt lifestyle or other behavioral changes that lead to improved health, such as encouraging use of certain health services, maintaining a healthy diet, or offering financial incentives.	Iowa waives premium contributions for members who complete the healthy behaviors requirements, such as completing a wellness visit or completing a health risk assessment (HRA).
Copays above statutory limits	Increases the limits on the amount that members must pay the provider at the point of service.	Kentucky's waiver, set aside by the court, charged \$20 to \$75 for non-emergent use of the ER assessed as a deduction from member's healthy behavior incentive account rather than as a direct fee/copayment.
Fees for Missed Appointments	Allows states to charge fees for appointment no-shows or cancellations.	Kentucky's waiver, set aside by the court, assessed a deduction from the member's healthy behavior account for missed appointment account rather than as a direct fee/copayment.
Premiums / Monthly Contributions	Waives the federal regulations establishing parameters for premiums for Medicaid and CHIP members.	Montana charges Medicaid premiums for the New Adult population with incomes between 50 and 138% FPL.
Coverage Loss and Lock-Out for Non-Payment of Premiums	Implements lock-out periods for coverage linked to failure to pay premiums, disenrolling members from coverage and barring them from re-enrolling within the lock-out period.	Indiana premiums are in the form of health savings account, called "POWER" account contributions. Those with incomes above 100% FPL must make monthly POWER account payments in order to stay enrolled. Failure will lead to lock-out of six months.
Disenrollment (w/o Lock-Out) for Non-Payment of Premiums	Allows for automatic disenrollment for failure to pay premiums.	Arizona members are subject to premiums in the form of health savings account contributions of \$25 or two percent of income per month, whichever is less. Those who fail to pay their premiums within a two month grace period are disenrolled from the program.
QHP Premium Assistance	Allows Medicaid members to purchase coverage from QHPs from the Marketplace using Medicaid dollars.	Arkansas covers the insurance premiums for non-disabled adults under age 65 whose household incomes are up to and include 133% FPL.
Tobacco Premium Surcharge	Permits a state to charge higher premiums for smokers.	Indiana raises the premiums in HIP Plus for smokers by 50 percent if they do not quit after they are in the program for a year.

# Consumerism State Examples


States are taking different approaches to including elements of consumerism into their waivers, such as inclusion of healthy rewards accounts, copays, and premiums

 IN	Indiana	
	Approved	February 2018 (extension)
	Current Status	Operational
POWER Account	<ul style="list-style-type: none"> <li>Members provided with POWER account funded at \$2,500, and is maintained with both state and member contributions.</li> <li>Account is used to pay the first \$2,500 in member claims, which exempts members from cost-sharing.</li> </ul>	
Copayments	<ul style="list-style-type: none"> <li>Member responsibility varies by income.</li> <li>Those in Basic must pay copayments for outpatient services, inpatient services, and prescription drugs.</li> <li>Members in Plus are not subject to cost-sharing for most medical services.</li> <li>All are subject to a \$8 copay for non-emergent use of emergency department.</li> </ul>	
Premiums	<ul style="list-style-type: none"> <li>Individuals with household incomes above 100% FPL are required to make POWER account monthly premium contributions as a condition of eligibility or they may enroll in Basic, which instead requires copays at point of service.</li> <li>Members can reduce required monthly contributions by using preventive services and maintaining a positive POWER balance.</li> <li>Failure to make payments will result in disenrollment and lock-out of coverage for six months.</li> </ul>	

 KY	Kentucky	
	Approved	January 2018
	Current Status	Set aside by the courts
Deductible	<ul style="list-style-type: none"> <li>Members provided a deductible account funded at \$1,000 at beginning of the benefit year.</li> <li>Cover claims for non-preventive services.</li> <li>Up to 50% of funds remaining at end of benefit period can be transferred to rewards account.</li> </ul>	
Rewards Account	<ul style="list-style-type: none"> <li>Members provided with a My Rewards account used to purchase additional benefits and approved items (e.g., vision or dental).</li> <li>Balance can be added to by completing healthy behavior activities and participating in additional community engagement activities.</li> <li>State can reduce account balances for non-payment of premiums, missed appointments.</li> </ul>	
Premiums	<ul style="list-style-type: none"> <li>Members required to make monthly premium contributions, with some exceptions.</li> <li>State determines premium, specifies that these amounts will be at least \$1 per month and no more than 4% of monthly income.</li> <li>Those with incomes below 100% FPL, will have rewards account suspended if they do not make premium payments for 60 days. Those with income above 100% FPL can be disenrolled and subject to a lockout period of up to six months.</li> </ul>	

# Consumerism State Examples

States are taking different approaches to including elements of consumerism into their waivers, such as inclusion of healthy rewards accounts, copays, and premiums

	Michigan	
	Approved	December 2018
Current Status	Operational	
Target Population	<ul style="list-style-type: none"> <li>• Adults age 19–64 with incomes at or below 138% FPL who are not eligible for Medicaid on the basis of disability</li> <li>• Exempt populations for healthy behavior provisions</li> </ul>	
HRA Provisions	<ul style="list-style-type: none"> <li>• To maintain eligibility, members with incomes above 100% FPL who have been enrolled in the Healthy Michigan Plan for more than 48 cumulative months will be required to complete a HRA or an approved healthy behavior activity.</li> <li>• Managed care members who complete a HRA with a primary care provider and agree to address or maintain healthy behaviors will be eligible for a reduction in copays or a gift card.</li> <li>• Members who complete a HRA and initial appointment and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time are also eligible for the incentives.</li> </ul>	
Non-Compliance	<ul style="list-style-type: none"> <li>• Disenrollment, but may reenroll once the requirement is completed</li> </ul>	

# Behavioral Health

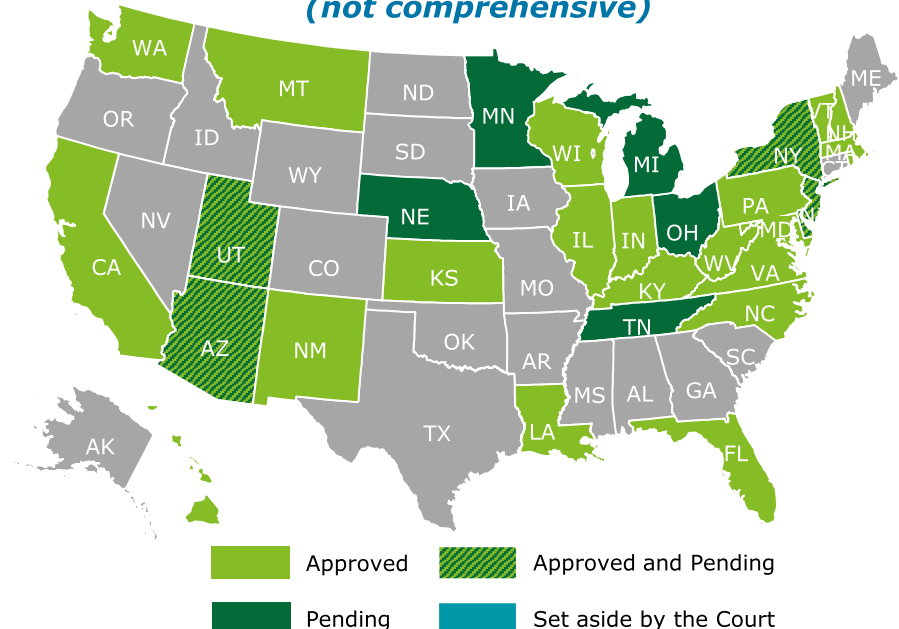
## Overview of Approved and Pending 1115 waivers

### How States are Using/Proposing to Use 1115 Waivers

- **Pay for inpatient SUD treatment and/or mental health services** for individuals in IMDs
- **Fund other behavioral health or supportive services** such as supportive housing and employment, peer supports, and/or community-based mental health or SUD treatment
- **Expand Medicaid eligibility** to cover additional people with needs otherwise uninsured
- Request waiver funding for **delivery system reform initiatives** such as physical/behavioral health integration, value-based purchasing, and workforce development initiatives

Waiver Provisions	New Adult Group and Traditional Medicaid Populations
IMD Payment Exclusion for SUD Treatment	Approved: AK, CA, IL, IN, KS, KY, LA, MD, NC, NH, NJ, NM, PA, RI, UT, VA, VT, WA, WI, WV Pending: AZ, DC, DE, MI, MN, NE, OH, TN
IMD Payment Exclusion for Mental Health Treatment	Approved: VT Pending: DC
Community-Based Benefit Expansions	Approved: AK, DE, FL, HI, IL, KS, MA, MD, NC, NJ, NM, NY, RI, UT, VT, WV Pending: MI, MN, NY, UT
Eligibility Expansions	Approved: AZ, MT, NJ, UT, VA, VT Pending: NJ, NY
Delivery System Reforms	Approved: AZ, CA, MA, NH Pending: MI, MN

### Behavioral Health 1115 Waivers (not comprehensive)




# Behavioral Health

## Description of Provisions

Waiver Provisions	Description	State Examples
IMD Payment Exclusion for Substance Use Disorder Treatment	Waives the IMD payment exclusion for SUD treatment that prohibits the use of federal Medicaid financing for care provided to most patients in SUD residential treatment facilities larger than 16 beds. The day limits authorized under these waivers vary by state.	Maryland's waiver allows two 30-day stays, while California has approval for two 90-day stays for adults and two 30-day stays for adolescents.
IMD Payment Exclusion for Mental Health Treatment	Waives the IMD payment exclusion for mental health treatment that prohibits the use of federal Medicaid financing for care provided to most patients in mental health residential treatment facilities larger than 16 beds.	Vermont has waiver authority to use federal Medicaid funds to pay for IMD mental health treatment services, although those payments must be phased out.
Community-Based Benefit Expansions	Allows states to expand community-based Medicaid behavioral health benefits beyond those available in the state plan benefit package, including the inclusion of supportive housing services, such as community transition services for people leaving institutional placements, tenancy supports, household activity skill building and chore services, and/or case management. Additional included services may include supported employment services, job coaching, and peer recovery services.	States vary in the coverage of expanded benefits. For example, three states (Delaware, Hawaii, and Maryland) offer supportive housing services, such as community transition services for people leaving institutional placements, tenancy supports, household activity skill building and chore services, and/or case management. Two states (Massachusetts and West Virginia) offer peer recovery coaching services.
Eligibility Expansions	Allows a state to cover people with behavioral health needs who are not otherwise eligible for Medicaid and to place enrollment caps on eligibility expansions targeted to people with behavioral health needs.	Arizona's waiver expands its long-term care eligibility criteria to cover non-elderly adults up to 300% of SSI who do not currently require nursing home level of care but are at risk of nursing home care due to mental illness.
Delivery System Reforms	Provides access to federal Medicaid funds to support delivery system reforms.	Massachusetts' waiver funds the state's transition to accountable care organizations that will integrate physical, behavioral health, long-term care, and health-related social services.

# Behavioral Health State Example

States are taking different approaches to their behavioral health waivers, including expanding the benefits package offered to individuals with a behavioral health diagnosis

<b>Virginia</b>		
	Approved	January 2015, has been amended
	Current Status	Operational
Target Population	<ul style="list-style-type: none"> <li>All Medicaid members who meet medical necessity criteria</li> </ul>	
Description of Program	<ul style="list-style-type: none"> <li>Implement a new SUD benefit and delivery system</li> <li>Expand the SUD benefits package to cover the full continuum of SUD treatment including short-term residential and inpatient services</li> <li>Improve access to care by removing service authorization requirements for medication-assisted treatment and increasing payment rates for SUD providers to ensure a sufficient provider network</li> </ul>	
Role of Managed Care Plans	<ul style="list-style-type: none"> <li>Required by contract to employ ARTS Care Coordinators, who are licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, licensed nurse practitioners, or registered nurses with clinical experience in SUD</li> </ul>	
Results	<ul style="list-style-type: none"> <li>Substantial increases in the number of practitioners providing addiction treatment services to Medicaid members</li> <li>During the first year of ARTS, the number of outpatient practitioners billing for ARTS services increased by 173 percent, including 848 providers who prescribed buprenorphine for members with opioid use disorders. In addition, nearly 25,000 Medicaid members used addiction related treatment services, a 57 percent increase from the year before.</li> </ul>	

# Delivery System Reform

## Overview of Approved and Pending 1115 waivers

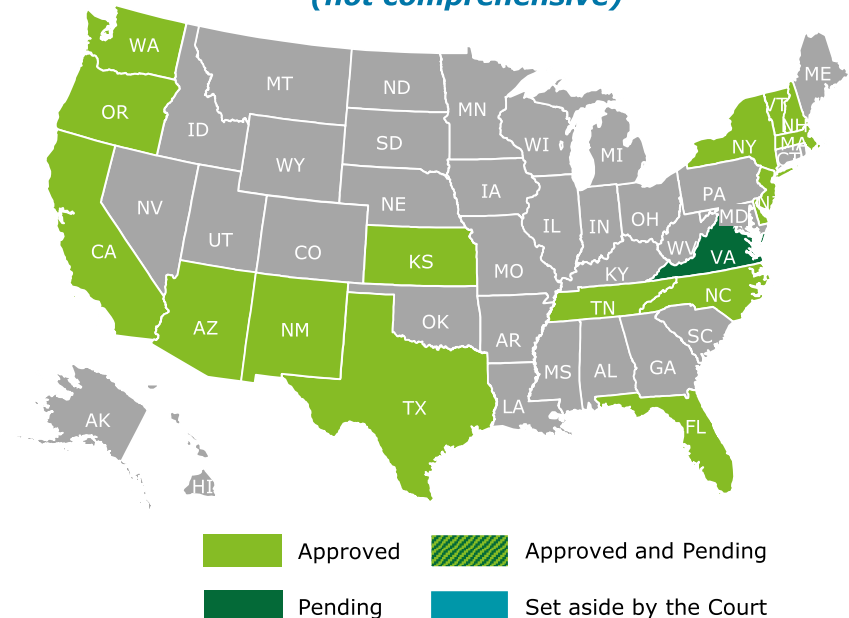
### How States are Using/Proposing to Use 1115 Waivers

- **Implementing Delivery System Reform Incentive Payment (DSRIP) initiatives**, such as value-based care and meeting performance metrics
- **Investing in delivery system reform initiatives** other than DSRIP aimed at changing the structure and incentives in the state's Medicaid program
- **Operating Uncompensated Care Pools** to help healthcare providers, primarily hospitals, with the costs of care that is not reimbursed
- OR and MA have used 1115 waivers to implement **massive transformations** to their programs that include Value Based Purchasing initiatives

Waiver Provisions	New Adult Group and Traditional Medicaid Populations
Delivery System Reform	Approved: AZ, CA, FL, KS, MA, NH, NJ, NM, NY, NC, OR, RI, TN, TX, VT, WA Pending: VA

Oregon's Coordinated Care Organizations (CCOs) are part of an expansive restructuring of the Medicaid system in the State. The program required an 1115 waiver since in some cases the program can restrict members' choice of payer, as there are certain areas of the State with only one CCO.

### Delivery System Reform 1115 Waivers (not comprehensive)





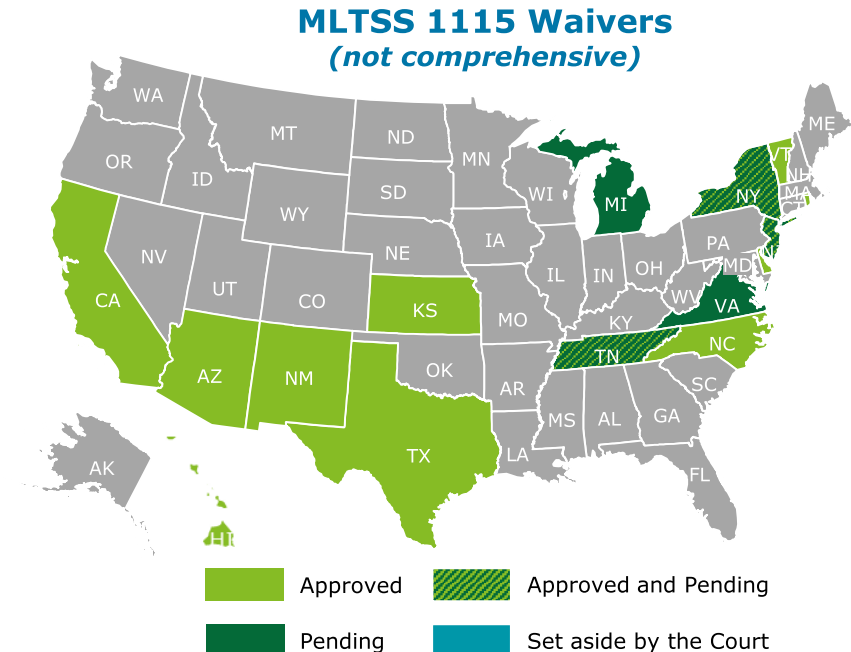
# Managed Long Term Services and Supports

## Overview of Approved and Pending 1115 waivers

### How States are Using/Proposing to Use 1115 Waivers


- **Adopting capitated Medicaid MLTSS** programs
- **Streamlining program administration, improving care coordination, and increasing member access** to home and community-based services (HCBS)
- **Expanding HCBS eligibility** in an effort to keep members in their homes or preferred care delivery setting


Waiver Provisions	New Adult Group and Traditional Medicaid Populations
MLTSS	<p>Approved: AZ, CA, DE, HI, KS, NJ, NM, NY, NC, RI, TN, TX, VT</p> <p>Pending: MI, NJ, NY, TN, VA</p>



# MLTSS State Examples

Tennessee operates its Medicaid program through the TennCare II 1115 demonstration, which provides Medicaid services through managed care. The TennCare II waiver includes two amendments targeted to integrate the LTSS and HCBS services into the statewide managed care program

 TN	Tennessee (HCBS)	
	Approved	2010
Current Status	Operational	
Purpose	<ul style="list-style-type: none"> <li>To offer services to help a person live in their own home or in the community</li> </ul>	
Target Population	<ul style="list-style-type: none"> <li>Elderly people and adults over the age of 21 with physical disabilities</li> </ul>	
Program Administration	<ul style="list-style-type: none"> <li>Program includes three separate groups</li> <li>Availability of benefits dictated by grouping</li> </ul>	
Program Benefits	<ul style="list-style-type: none"> <li>Includes nursing facility services, as ordered by treating physician</li> <li>HCBS services including adult day care, assistive technology, minor home modifications, home delivered meals, personal or attendant care</li> <li>Provides for community based residential alternatives for individuals who can no longer live alone</li> <li>Allows for consumer direction, so the individual controls who provides the care</li> </ul>	
Expenditure Caps	<ul style="list-style-type: none"> <li>Included for HCBS services</li> </ul>	

 TN	Tennessee (I/DD)	
	Approved	2016
Current Status	Operational, with pending amendment	
Purpose	<ul style="list-style-type: none"> <li>To provide services to help people with intellectual/developmental disabilities (I/DD) gain as much independence as possible</li> </ul>	
Target Population	<ul style="list-style-type: none"> <li>Children and adults with I/DD who meet certain medical and financial criteria</li> </ul>	
Program Benefits	<ul style="list-style-type: none"> <li>Supports to help people with I/DD achieve employment and independent living such as job coaching and benefits counseling</li> <li>Assists individuals with independent community living through skills training, community transportation, and minor home modifications</li> <li>Family caregiving supports, respite care, and a family caregiver stipend</li> <li>Self-advocacy supports, individual education and training</li> <li>For people who cannot work or need more support to live in the community, residential and other day services to help them achieve community living goals</li> </ul>	
Expenditure Caps	<ul style="list-style-type: none"> <li>Included for essential family supports, essential supports for employment, and comprehensive supports for employment</li> </ul>	

# Targeted Population Waivers

## Overview of Approved and Pending 1115 waivers

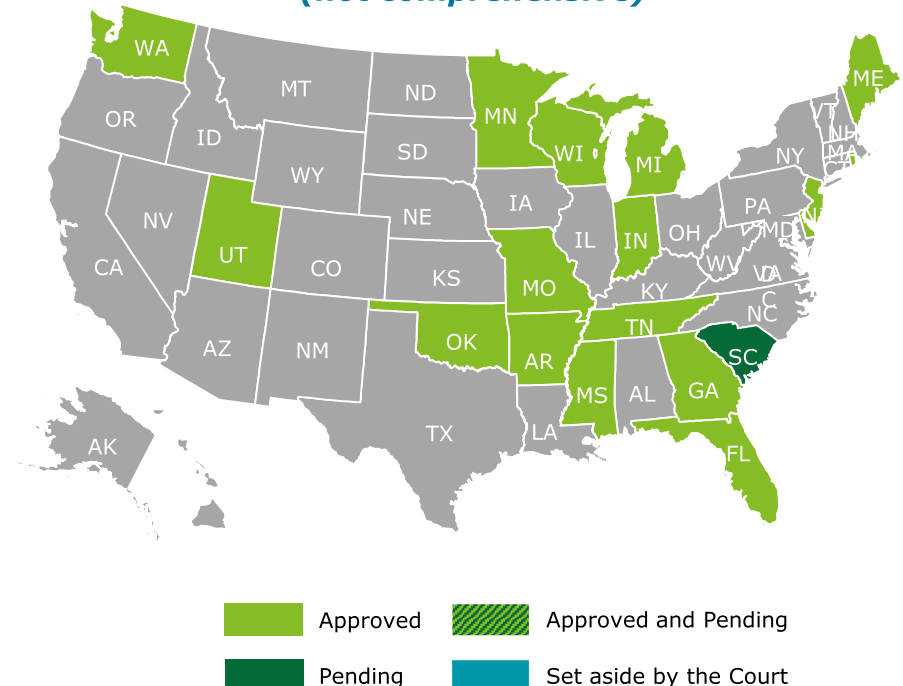
### How States are Using/Proposing to Use 1115 Waivers

- **Expanding eligibility and providing limited benefits** to nonelderly adults
- **Expanding eligibility** for children and seniors with disabilities
- **Expanding eligibility** for individuals with specific chronic diseases such as HIV/AIDS or end stage renal disease (ESRD)

### Other Targeted Population Waiver Attributes

State	Status	Target Population
AR	Approved	children with disabilities
FL	Approved	seniors and people with disabilities
GA	Approved	family planning and family planning related services to women
IN	Approved	Medicare-enrolled people with ESRD
ME	Approved	People with HIV/AIDS
MI	Approved	Pregnant women and children
MN (2)	Approved	HCBS; One-year old children
MS	Approved	Seniors and people with disabilities
MO	Approved	Non-elderly adults in St. Louis
NJ	Approved	HCBS to targeted groups of people with I/DD
OK	Approved	Working people with disabilities, college students, working foster parents, nonprofit employees
SC	Pending	Parents, pregnant, postpartum women, certain childless adults experiencing specific conditions e.g. homelessness or need for MH/SUD treatment
TN	Approved	Children at/above 211% FPL; adult standard spend down; MLTSS at risk
UT	Approved	Nonelderly adults
WA	Approved	Limited HCBS benefit package targeted to seniors with unpaid family caregiver
WI (2)	Approved	Sliding scale premiums for nonelderly adults; pharmacy benefits and cost-sharing for seniors

### Targeted Population 1115 Waivers (not comprehensive)



# 1115 Block Grants and Per Capita Caps

## State interest in alternative funding mechanisms

### Administration's Stated Policy

The current administration has a stated policy goal of encouraging states to experiment with a capped federal payment system to control Medicaid spending growth. Thus far, two states (Alaska and Tennessee) have expressed interest in converting their Medicaid programs to a block grant with Utah pursuing per capita caps.

### State Considerations

- Per capita cap (cap per member) versus a block grant (total program cap)
- Populations excluded from the caps
- Trend rate and risk premiums
- Re-basing frequency
- Outlier protection for an epidemic, new treatments (drugs), or natural disasters

### State Interest



#### Alaska

- CMS Administrator Seema Verma urged Alaska to be the first state to receive Medicaid dollars as a block grant.
- In a letter to the President, dated March 1, 2019, Governor Dunleavy expressed eagerness to fund Medicaid through a block grant.



#### Tennessee

- Tennessee legislators passed a bill directing the governor to submit a Section 1115 waiver request within six months.
- The waiver would seek to transform TennCare from an open-ended entitlement program to one where the federal government makes fixed payments.



#### Utah

- The Utah Department of Medicaid recently released a proposed waiver for comment, "The Per Capita Cap," seeking to use an alternative funding mechanism.
- The state explained its per capita cap model as a way to provide increased coverage to Utahans in a fiscally sustainable manner.

# Spotlight of Utah's Pending Waiver

1115 waivers often build on the CMS approved ideas of other states; Utah is the most recent example a state seeking new flexibility from CMS

## Utah's Recent Waiver History

- **March 2018:** Utah House Bill 472 permits the State to seek Medicaid coverage for the New Adult Group.
- **June 2018:** Utah submitted an 1115 waiver amendment, the "Adult Expansion Amendment," seeking to implement a partial and capped Medicaid expansion, as well as Medicaid work requirements for certain populations.
- **April 2019:** Provisions of Utah's "Adult Expansion Amendment" were approved.
- **May 2019:** The Utah Department of Medicaid released a proposed waiver, "The Per Capita Cap" for public comment, seeking a per capita cap. In addition to the previously approved work requirement and enrollment cap, this new waiver application also proposes enhanced federal match for the partial New Adult Group population.

### Significance:

With this "Adult Expansion Amendment," Utah became the first state to receive CMS approval of a partial Medicaid expansion to 100% post-ACA.\* The partial expansion was approved at Utah's traditional federal match (approximately 70%).

In Utah's current pending "Per Capita Cap" amendment, the State is seeking enhanced 90% federal match dollars for the New Adult Group.

# Spotlight of Utah's Pending Waiver

1115 waivers often build on the CMS approved ideas of other states; Utah is the most recent example a state seeking new flexibility from CMS

	Recent 1115 Waivers	
Plan Provisions	Bridge 1115 Waiver (Approved)	Per Capita Cap 1115 Waiver (Pending)
Status	Submitted: June 2018 Effective April 1, 2019	Posted for public comment
FPL	100%	100%
Presumptive Eligibility (PE)	Yes	No Hospital PE
Self-Sufficiency Requirement (Work Requirement)	Yes (effective January 1, 2020)	Yes
Authority to Cap Expansion Enrollment	Yes	Yes
Lock-out for Program Requirements/Violations	No	Yes
Require Enrollment in Employer's Plan with Premium Reimbursement	Yes (effective January 1, 2020)	Yes
12-month Continuous Eligibility	No	Yes
Use Federal Funds for Housing Supports	No	Yes
Use of Federal Funds Limited by Per Capita Cap	No	Yes
Benefit Plan for Adults Without Dependent Children	Traditional Medicaid	Traditional Medicaid
Benefit Plan for Parents	Non-Traditional Medicaid	Non-Traditional Medicaid
Early and Periodic Screening Diagnostic and Treatment	No	No
Dental Benefits	Emergency Only	Emergency Only
Funding (%Federal/%State)	About 70/30	90/10*
Delivery System	Fee for Service - except Parents 45-60% FPL (Managed Care after January 1, 2020 - Except Rural Counties)	Managed Care (except Rural Counties)

Source: Information taken from the Utah Department of Health [Medicaid Expansion: At A Glance \(March 2019\)](#)

\*Seeking 90% federal match starting in 2020 available up to per capita cap limit

# Utah's Pending 1115 Waiver

The following are attributes of Utah's pending 1115 Per Capita Cap Waiver

Utah's Pending 1115 Waiver	
<b>Description</b>	<p><b>Authority to Receive Increased Federal Medical Assistance Percentage (FMAP)</b></p> <ul style="list-style-type: none"> <li>• Receive full FMAP (93% for 2019 and 90% each year after)</li> <li>• Including the Target Adult Population (up to 100% FPL)</li> </ul>
<b>Eligibility &amp; Enrollment</b>	<p><b>Lock-Out due to Intentional Program Violation</b></p> <ul style="list-style-type: none"> <li>• Six-month period of ineligibility if an individual commits an intentional program violation (IPV) to become, or remain eligible for Medicaid</li> </ul> <p><b>Up to 12-Months Continuous Eligibility</b></p> <ul style="list-style-type: none"> <li>• If individual household income exceeds 95% FPL</li> </ul> <p><b>Not Allow Presumptive Eligibility Determined by a Hospital</b></p> <ul style="list-style-type: none"> <li>• State to complete a full determination of eligibility before enrolling the individual</li> </ul> <p><b>Per Capita Cap Funding</b></p> <ul style="list-style-type: none"> <li>• Work with CMS to set the cap, establish enrollment groups, set a base period, re-basing every two years, grow based on trends, and consider special circumstances</li> </ul> <p><b>Enrollment Limits</b></p> <ul style="list-style-type: none"> <li>• Apply enrollment limits when projected costs exceed annual state appropriations</li> </ul>
<b>Behavioral Health</b>	<p><b>Clinically Managed Residential Withdrawal Pilot</b></p> <ul style="list-style-type: none"> <li>• Clinically managed residential withdrawal management services for the New Adult Group to 100% FPL and Targeted Adult Populations only</li> </ul> <p><b>Substance Use Disorder treatment provided in an IMD</b></p>
<b>Work Requirements/ Community Engagement</b>	<p><b>Community Engagement through a Self Sufficiency Requirement</b></p> <ul style="list-style-type: none"> <li>• Eligible for the New Adult Group to 100% FPL, not to include Targeted Adults</li> </ul>

# Utah's Pending 1115 Waiver







The following are attributes of Utah's pending 1115 Per Capita Cap Waiver

Utah's Pending 1115 Waiver	
<b>Delivery System Reform</b>	<ul style="list-style-type: none"> <li>• Services for Demonstration individuals will be provided initially through FFS. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates. By January 2020, the State intends to transition populations covered by this application into managed care</li> <li>• Utah intends to use managed care as the primary service delivery system for populations covered under this waiver</li> </ul>
<b>Benefits</b>	<p><b>Housing Related Services and Supports</b></p> <ul style="list-style-type: none"> <li>• Housing related services and supports (HRSS) to the New Adult Group to 100% FPL (including Targeted Adults), who meet needs-based criteria</li> </ul> <p><b>Waiving EPSDT</b></p> <ul style="list-style-type: none"> <li>• For adults age 19 and 20 years old in the New Adult Group to 100% FPL and Targeted Adult Population</li> </ul> <p><b>Employer Sponsored Insurance (ESI) Reimbursement</b></p> <ul style="list-style-type: none"> <li>• Requires individuals in the New Adult Group who have access to ESI, to purchase such plans. The state will reimburse the eligible individuals for the health insurance premium amount for that individual. Failure to enroll in, and purchase, the insurance plan will result in ineligibility for Medicaid.</li> </ul>



# 1115 Summary Takeaways

The following are key takeaways from the scan of the 1115 waiver landscape

-  **Use of Waivers:** The purpose of 1115 demonstrations are to give states flexibility to design and improve their Medicaid programs to better serve Medicaid populations. Traditionally, 1115 waivers have been used to expand benefits or extend coverage to new populations, but waivers are also now being approved that place new expectations on participation in the Medicaid program.
-  **State Flexibility:** CMS has streamlined the waiver process and is encouraging states to experiment with waivers.
-  **Consumerism:** States are utilizing consumer tools, such as premiums and copays, with an aim to strengthen members' engagement in their personal health care, motivate members to use health services more efficiently, and mirror elements of commercial coverage.
-  **Work Requirements/Community Engagement:** An increasing number of states are including provisions for work and community engagement requirements in their waivers which are relatively consistent in the overall design across the states to date.
-  **Waiver Strategy:** The 1115 process is being used by states in various ways: overhauling the entire program with one waiver, submitting an initial waiver and several amendments, or submitting a targeted waiver for a very specific purpose.
-  **Block Grants and Per Capita Caps:** CMS is in discussions with states on how to design block grant or per capita cap programs that meet the objectives of both parties and are statutorily permissible.

# 1332 Waiver Analysis

- Methodology
- Overview of 1332 Waivers
- Federal Guidance
- Landscape of Waivers
- Summary Takeaways



# Methodology

The purpose of this section is to provide a review of 1332 waiver guidance, as well as a review the approved, pending, denied, or withdrawn 1332 waivers to date

## Methodology

- The team examined the national landscape of 1332 waivers using publicly available sources to review waivers approved, pending, denied, and withdrawn.
- To categorize the different attributes of waivers, the team leveraged waiver data from KFF and the State Health Access Data Assistance Center (SHADAC) from the University of Minnesota.
- To identify trends in pass through funding, including the state's initial request and the final determination, the team reviewed individual state waiver applications and letters of correspondence posted on CMS' Center for Consumer Information and Insurance Oversight's (CCIIO's) waiver website.
- Most of the information on recent federal guidance is taken from the November 2018 Discussion Paper and May 2019 CMS Release. The full list of sources includes: *CMS-9930-F: Final HHS Notice of Benefit and Payment Parameters for 2019 / Federal Register/Vol. 83, No. 74/Tuesday, April 17, 2018/Rules and Regulations; Federal Register/Vol. 77, No. 38/Monday, February 27, 2012 / Dept. of Treasury 31 CFR Part 33 / DHHS 45 CFR Part 155 (CMS -9987-F); CMS April 9, 2018 - Example of an Acceptable Methodology for Comparing Benefits of a State's EHB- benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii); March 2019, CMS release, Overview of Section 1332 State Relief and Empowerment Waiver Concepts; May 2019, CMS release, Steps for States Considering a 1332 Waiver.*

### 1332 Scan Primary Sources

In conducting the waiver review, the team reviewed publicly available sources including:

- The CMS CCIIO's section 1332 state innovation waiver website
- SHADAC, University of Minnesota June 2019
- KFF waiver tracker June 2019



# Overview of 1332 Waivers

Section 1332 waivers provide states with the ability to waive provisions of ACA to develop innovative coverage programs

## Background on 1332 Waivers

Section 1332 of ACA permits a state to apply for a waiver to pursue innovative strategies to provide residents with access to high-quality, affordable health insurance with ACA protections. For approval waivers must meet four statutory guardrails:

1. **Comprehensiveness:** Coverage at least as comprehensive as provided absent the waiver
2. **Affordability:** Cost-sharing protections against excessive out of pocket spending at least as affordable as absent the waiver
3. **Coverage:** Healthcare coverage to a comparable number of residents as absent the waiver
4. **Deficit Neutrality:** Projected net federal spending must not increase the federal deficit

The first 1332 reinsurance waiver was approved in 2017 and implemented in 2018. Most waivers to date have focused on reinsurance since CMS initially took a strict interpretation of the four guardrails. In October 2018, CMS released guidance that provided states with flexibility on how to meet the statutory guardrails.

## Key Questions for Waiver Design

- Does the proposed waiver meet the four statutory guardrails?
- Has the state completed a public notice and comment period, sufficient to ensure a meaningful level of public input?
- Does the state's legislative authority allow for the implementation of the proposed program?
- Does the proposed waiver require state funds to achieve budget neutrality? If so, is the source of state funds identified?
- Is infrastructure required to operate the 1332 waiver program? Does that infrastructure currently exist?
- What agency will implement and operate the 1332 waiver program?
- Does the waiver require participation from multiple agencies?

# Federal Guidance for 1332 Waivers

In 2018, CMS renamed 1332 Waivers from State Innovation Waivers to State Relief and Empowerment Waivers and has provided states with greater flexibility in how they structure and run their programs

## 2018 CMS Highlights

### **Benefit and Payment Parameters Rule:**

- Provided states with flexibility to define their essential health benefit package (EHB)
- Enhanced the role of states regarding the certification of qualified health plans (QHPs)

### **October Guidance and November Discussion Paper:**

- Provided states with flexibility to meet the state legislative authority requirement
- Provided states with flexibility to meet the requirements of the four statutory guardrails
- Outlined five guiding principles that support CMS goals
- Indicated that technical enhancements of the federally facilitated platform would allow for some greater flexibility and variation across states to support 1332 waivers
- Outlined four waiver concepts to provide states with examples of how to apply the new flexibility
- Outlined the federal process for approval

# Federal Guidance on Increased Flexibilities for 1332 Waivers

Guidance released by CMS in October 2018 provided flexibility and clarification for states seeking 1332 waivers

## Examples of Increased Flexibilities from October 2018 CMS Guidance

### Guardrails

- **Comprehensiveness and affordability:** States may focus on the nature of the coverage made available to residents, rather than on the coverage that is actually purchased
- **Comprehensiveness and affordability:** States may look at the impact on state residents as a whole, for example, if a waiver that makes coverage substantially more affordable for some without making others substantially worse off, or a waiver that makes coverage more affordable for some and slightly more costly for a larger number would both be considered for approval
- **Number of residents covered:** States may consider all forms of private coverage in addition to public coverage, including employer-based coverage, individual market coverage, and other forms of private health coverage, thus looking at the population in aggregate rather than those that receive benefits through the marketplace.
- **The actuarial and economic analyses** must compare comprehensiveness, affordability, coverage, and net federal spending and revenues under the waiver to those measures absent the waiver for each year of the waiver.

### Technology

- **The federal platform underwent technical enhancements** necessary for the Federally Facilitated Marketplace's operations that will enable it to support increased variation and flexibility for states that may want to leverage components of the federal platform to implement new models through section 1332 waivers.
- **CMS may provide support services** including but not limited to: eligibility determinations or data verification services to support eligibility determinations, so long as the state covers the full costs of those or other federally provided services.
- While CMS can provide some accommodations, the **Internal Revenue Service (IRS) is unable to accommodate most variances.** It may accommodate small adjustments to the existing system for administering federal tax provisions.

### Pass Through Funding

- CMS and IRS will calculate the state's pass-through funding amount based on prior years. This funding may only be used to implement the approved section 1332 state plan.

# Federal Guidance for Principles for Consideration

CMS stated that waivers which address any or all of the five guiding principles will be looked upon favorably



**Provide Increased Access to Affordable Market Coverage:** Increase issuer participation and promote competition



**Encourage Sustainable Spending Growth:** Promote more cost-effective health coverage



**Foster State Innovation:** Craft solutions that meet the needs of their consumers



**Support and Empower Those in Need:** Support state residents in need in the purchase of private coverage with financial assistance



**Promote Consumer-Driven Healthcare:** Empower Americans to make informed choices and encourage consumers to seek value

# Federal Guidance for New 1332 Waiver Concepts

CMS provided states four examples of how regulatory flexibility can be utilized and sought industry input on additional concepts

## Account Based Subsidies



States would have the flexibility to direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay health insurance premiums or other health care expenses.

## Risk Stabilization Strategies



States can consider ways to address the costs of individuals with expensive medical conditions to mitigate the impact of those expenses on people who purchase coverage in the individual market.

## State-Specific Premium Assistance



States could consider options to create and implement a new state subsidy structure that changes the distribution of subsidy funds compared to the current premium tax credit structure.

## Adjusted Plan Options



States would have the flexibility to provide state financial assistance for non-QHPs. They could also choose to expand the availability of catastrophic plans beyond the current eligibility limitations.

## Other Ideas

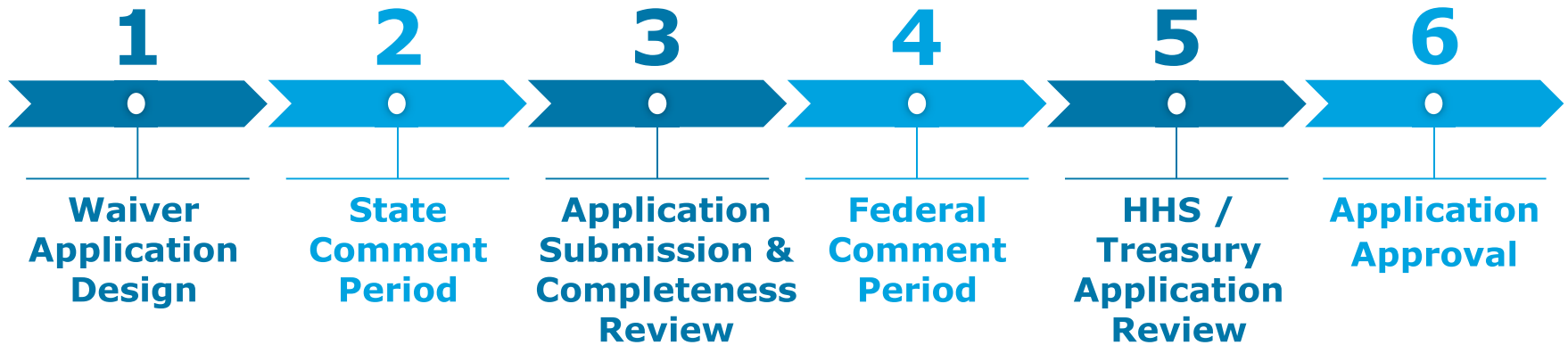


CMS issued an RFI on May 1, 2019 soliciting public comment on ideas for innovative programs and waiver concepts that states could consider in developing a section 1332 waiver plan. Comments were due on July 2, 2019.



# Federal Guidance for Application Process

Key steps in applying for a 1332 waiver



## Completeness Review

HHS/Treasury will conduct a preliminary review of the application for completeness within 45 days of receipt of the application.

## Federal Comment Period

Complete applications will have a 30-day federal comment period.

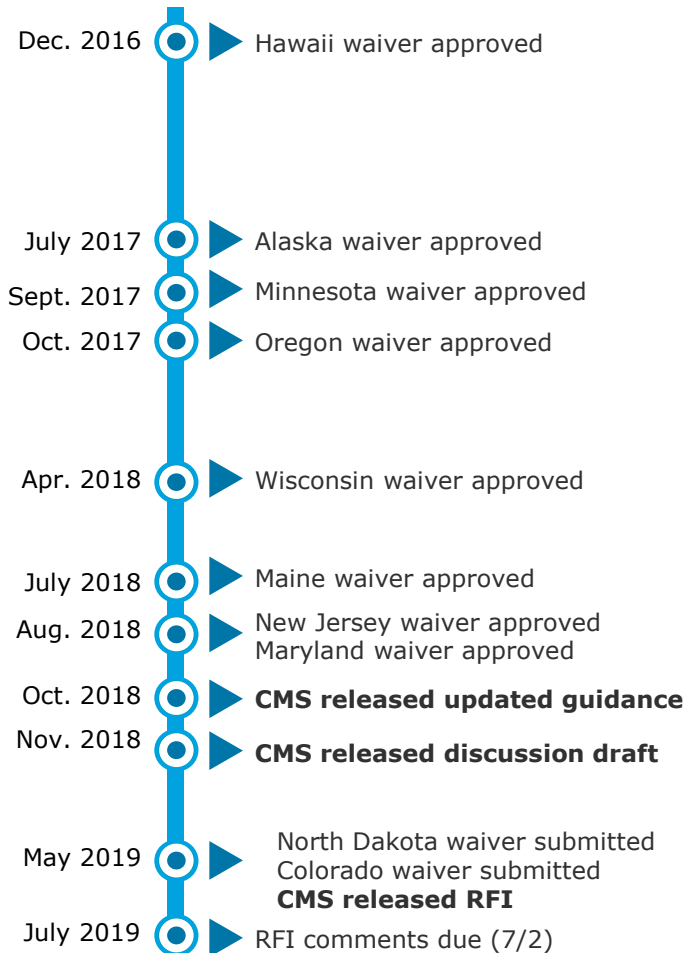
## Application Review

The final decision of HHS/Treasury will be issued no later than 180 days after the application completeness determination is made.

# Landscape of 1332 Waivers

This high-level scan offers an overview of how states are using 1332 waivers and guidance from CMS

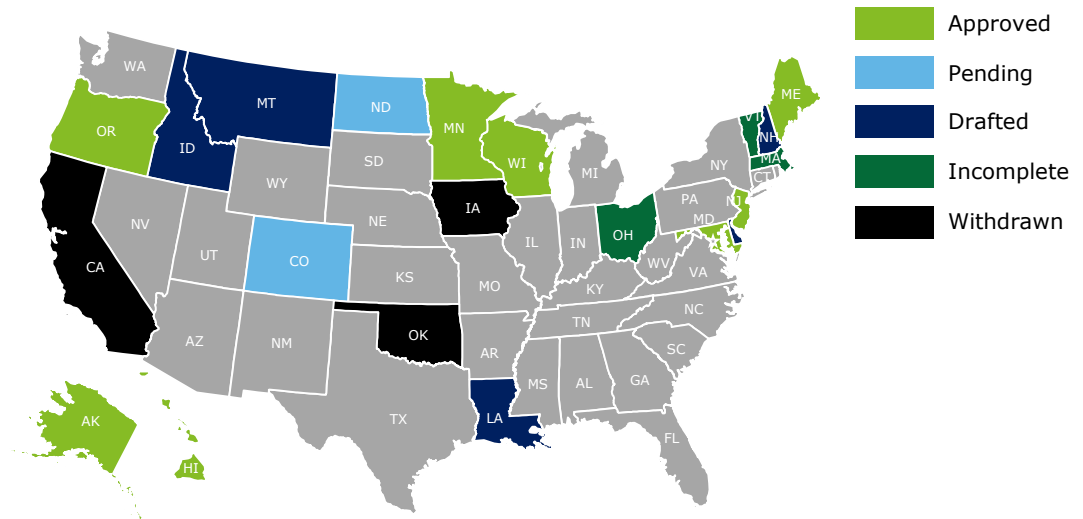
## Timeline of 1332 Waiver Activity



## Summary

- **Approvals/Pending:** Eight states have approved 1332 waivers with two states pending. All but one are focused on reinsurance with Hawaii's waiver targeting the Small Business Health Operations Program (SHOP).
- **Drafted:** Five states have submitted drafts for public comment.
- **Withdrawn/Incomplete:** Three waivers have been withdrawn and three deemed incomplete by CMS.
- **Current Landscape:** CMS is seeking input on how states might take advantage of new regulatory flexibilities.

## Current Landscape of 1332 Waivers



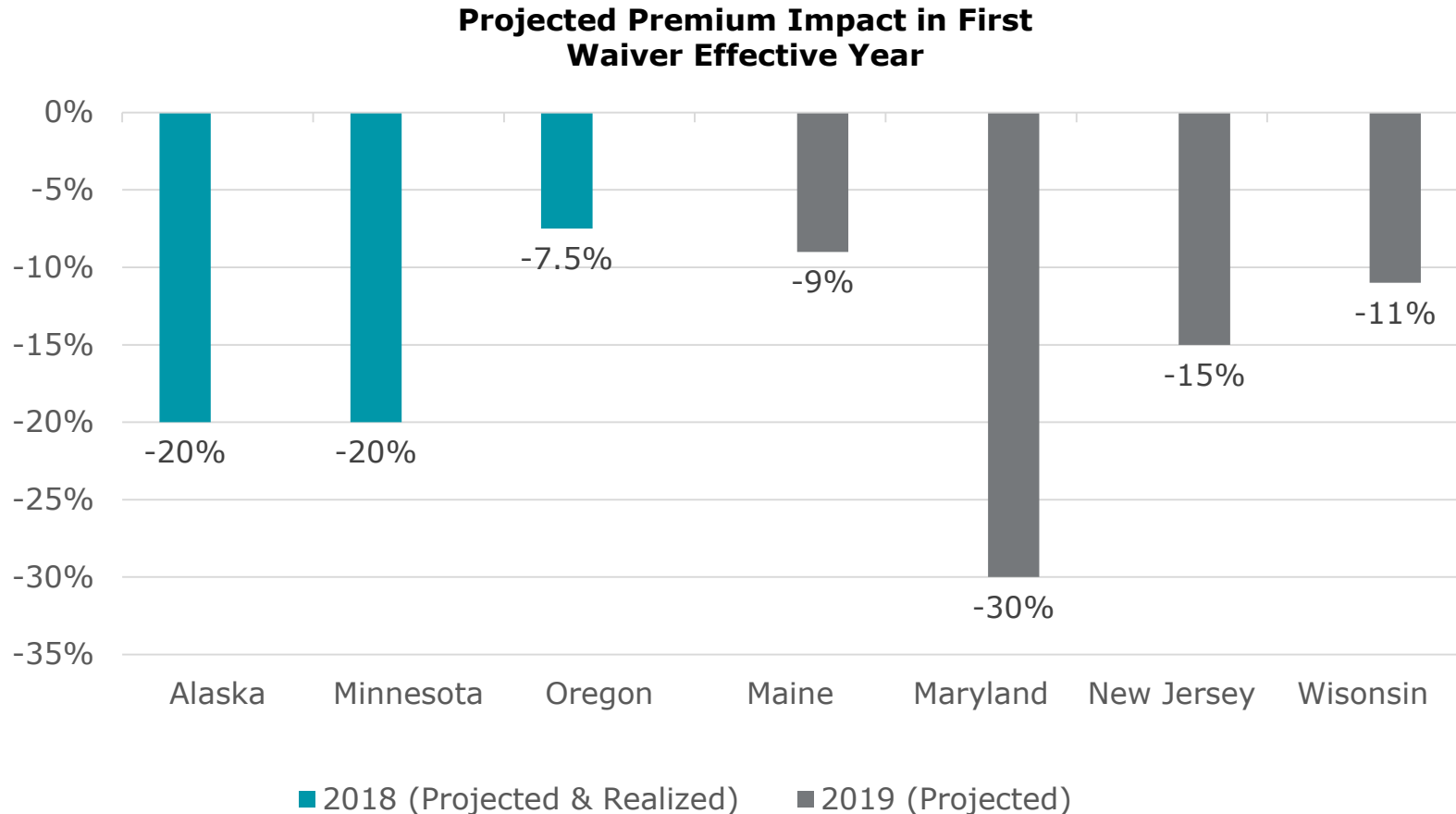
# Approved 1332 Waivers

## State Summaries

State	Submitted	Approved	Time to Approve	Implemented	Description
HI	8/10/2016	12/30/2016	8 mo	1/1/2017	Waive ACA Small Business Health Options Program requirements that conflict with the state's Prepaid Health Care Act (1974) requiring employers to provide more generous coverage than required by ACA. Also waives the requirement that the small business tax credits only be available through the SHOP.
AK	12/29/2016	7/7/2017	7 mo	1/1/2018	Pass through funding to partially finance Alaska's Reinsurance Program (ARP). The ARP would fully or partially reimburse insurers for incurred claims for high-risk members diagnosed with certain health conditions.
MN	5/5/2017	9/22/2017	4 mo	1/1/2018	Pass through funding to partially finance the Minnesota Premium Security Plan (MPSP), a reinsurance program that would reimburse insurers 80% of claims above \$50,000 and up to a cap of \$250,000. The waiver also seeks federal pass-through funding equal to the amount the federal government would have spent on tax credits and cost sharing subsidies for residents eligible for the state's Basic Health Program, MinnesotaCare if the reinsurance program were not in place. The federal government approved pass-through funding for the reinsurance program, but did not approve pass-through funding for BHP, providing the state with less funding than it had sought.
OR	8/31/2017	10/18/2017	2 mo	1/1/2018	Pass through funding to partially finance the Oregon Reinsurance Program (ORP). The ORP would reimburse insurers 50% of claims between an attachment point (to be determined) and an estimated \$1 million cap.
ME	5/9/2018	7/30/2018	2 mo	1/1/2019	Pass through funding to partially finance reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA), the state's reinsurance program that operated in 2012 and 2013. The MGARA will reimburse insurers 90% of claims paid between \$47,000 and \$77,000 and 100% of claims in excess of \$77,000 for high-risk members diagnosed with certain conditions or who are referred by the insurer's underwriting judgment.
WI	4/19/2018	7/29/2018	3 mo	1/1/2019	Pass through funding to partially finance the Wisconsin Healthcare Stability Plan (WIHSP). The WIHSP will reimburse insurers 50%-80% (exact percentage to be determined) of claims between \$50,000 and \$250,000.
MD	5/31/2018	8/22/2018	3 mo	1/1/2019	Pass through funding to partially finance the Maryland Reinsurance Program. The plan will reimburse insurers 80% of claims between an attachment point that is to be determined and a cap of \$250,000.
NJ	7/2/2018	8/16/2018	1 mo	1/1/2019	Pass through funding to partially finance the Health Insurance Premium Security Plan to reimburse insurers 60% of claims between \$40,000 and \$215,000.

## Approved 1332 Waivers: Projected Premium Impact

States that implemented a reinsurance program in 2018 realized their projected reductions in marketplace premiums, while new waiver states project a decrease in premiums for the first year of their waiver implementation



Alaska, Minnesota, and Oregon realized their projected savings after the initial year of their waiver according to the CMS November 2019 Discussion Paper. Maine, Maryland, New Jersey, and Wisconsin are in their initial implementation year and the total realized savings have yet to be determined.

# Approved 1332 Waivers: Common Attributes

The following are common attributes from the environmental scan of approved 1332 waivers

- **Waiver Duration:** The duration for all 1332 waivers is five years, except for Colorado which is for two years as determined by the authority granted by the state legislature.
- **Claims-based Reinsurance Approach:** All states, with the exception of Alaska, take a claims-based approach as opposed to conditions-based. Under the claims-based approach, claims in a specified range are paid, minus a coinsurance rate. Under a conditions-based approach, costs are covered for a small number of high-cost individuals with specific, defined medical conditions.
- **Non-Profit Administration:** AK, MD, ME, and MN administer their reinsurance programs via non-profit entities which were in existence prior to the program. The non-profit entities previously administered some sort of risk stabilization program (high risk pool) in AK, ME, and MN. The same entity in MD also operates the state's health insurance exchange.
- **State Agency Administration:** The reinsurance program in NJ, OR, and WI are administered by divisions of state agencies. The NJ agency was in existence prior to the 1332, but was repurposed to oversee the program. OR and WI are newly-established programs.
- **Governance:** Of the three programs administered by state agencies, NJ has a board of directors, OR has an advisory committee, and WI appears to be under the authority of the insurance commissioner.

# Approved 1332 Waivers: State Funding Sources

States are responsible for fully funding the total reinsurance program, even if the federal pass-through funding is less than expected.

Approved Waivers	Source of State Funds
AK	Legislature appropriated \$55 million to initially fund the program in 2017 from the General Fund, then funded via assessments on all insurers. Health insurers: 6% of premiums net of claims, Title insurers: 1% of gross premiums*, Other insurers: 2.7% of gross premiums
MD	2.75% assessment on Maryland health plans and Medicaid MCOs, based on annual net premiums
ME	Assessment on health insurers and third-party administrators of \$4 PMPM (Individual, Small Group, Large Group, and Self-insured markets); 90% of member premium for ceded members and dependents
MN	Dedicated funding from Health Care Access Fund (financed via 2% provider assessment) and General Fund
NJ	Penalties from state individual coverage mandate, general fund
OR	1.5% assessment on fully insured commercial major medical premiums
WI	State general fund

# Approved 1332 Waivers: Pass Through Funding

To help fund these efforts, Section 1332 allows the federal government to “pass through” the money that it would have spent on premium tax credits, cost-sharing reductions, and small employer tax credits to the state

## Pass Through Funding in Millions for States with 2018 Implementations

State	Initial Estimated Federal Savings (Pass Through)	Final Pass Through Dollars Approved	Difference (Approved – Estimated)	Estimated Total Cost of the Program (Year 1)	Estimated State Share of Program	% State Share of Program	Source of State Funds
Source	<a href="#">Taken from state 1332 Applications</a>	<a href="#">Taken from CMS Correspondence</a>	Calculated	<a href="#">Taken from state 1332 Applications</a>	Calculated	Calculated	<a href="#">Information found on State Health Access Data Assistance Center (SHADAC)</a>
AK	>\$51.6 (2018)	\$58.5 (2018) \$68.7 (2019)	\$6.9 (2018)	\$64	\$5.5	9%	Legislature appropriated \$55 million to initially fund the program in 2017 from the General Fund, then funded via assessments on all insurers. Health: 6% of premiums net of claims, Title: 1% of gross premiums, Other: 2.7% of gross premiums
MN	\$138 - \$167* (2018)	\$130.7 (2018) \$84.8 (2019)	-\$7.3 (2018)	\$271	\$140.3	52%	Dedicated funding from Health Care Access Fund (financed via 2% provider assessment) and General Fund
OR	>\$30 (2018)	\$54.5 (2018) \$41.8 (2019)	\$24.5 (2018)	\$90	\$35.5	39%	1.5% assessment on fully insured commercial major medical premiums

# Approved 1332 Waivers: Pass Through Funding

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## Pass Through Funding in Millions for States with 2019 Implementations


State	Initial Estimated Federal Savings (Pass Through)	Final Pass Through Dollars Approved	Difference (Approved – Estimated)	Estimated Total Cost of the Program (Year 1)	Estimated State Share of Program	% State Share of Program	Source of State Funds
Source	<a href="#">1332 Applications</a>	<a href="#">CMS Correspondence</a>	Calculated	<a href="#">1332 Applications</a>	Calculated	Calculated	<a href="#">State Health Access Data Assistance Center (SHADAC)</a>
ME	>\$33	\$62.3	\$29.3	\$93	\$30.7	33%	Assessment on health insurers and third-party administrators of \$4 PMPM (Individual, Small Group, Large Group, and Self-insured markets); 90% of member premium for ceded members and dependents
MD	\$304	\$373.4	\$69.4	\$462	\$88.6	19%	2.75% assessment on Maryland health plans and Medicaid MCOs, based on annual net premiums
NJ	\$218	\$180.2	-\$37.8	\$324	\$143.8	44%	Penalties from state individual coverage mandate, general fund
WI	\$166	\$127.7	-\$38.3	\$200	\$72.3	36%	State general fund



# Approved 1332 Waivers: State Examples

Alaska was the first state with a reinsurance waiver and took a condition-based approach where costs are covered for a small number of high-cost individuals with specific, defined medical conditions. All other states have taken a claims-based approach where claims in a specified range are paid, minus a coinsurance rate

Alaska	
	
Effective Dates	January 1, 2018 through December 31, 2022, with an option to renew for an additional 5 years
Section Waived	<ul style="list-style-type: none"> <li>The requirement to consider all members in a market to be part of a single risk pool</li> </ul>
Responsible Agency	<ul style="list-style-type: none"> <li>Alaska Reinsurance Program (ARP)</li> </ul>
Purpose	<ul style="list-style-type: none"> <li>To mitigate rate increases by removing high cost claims from the individual health market</li> </ul>
State Projections	<ul style="list-style-type: none"> <li>Premiums will be 20% lower in 2018 than they would be without the waiver</li> <li>An average of 1,460 additional individuals will have health insurance coverage</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>Stabilize the individual market by using funds to totally or partially reimburse the insurer for incurred claims from high-risk residents</li> <li>State defines high-risk residents in regulation as individuals with one or more of 33 identified high cost conditions, such as hemophilia, lung cancer, other serious cancers</li> <li>The insurer will still be administering the claims; the Alaska Comprehensive Health Insurance Association (ACHIA) will receive the state funding, audit the claim requests, and disburse the funds on a periodic basis upon acceptance.</li> </ul>

Wisconsin	
	
Effective Dates	January 1, 2019 through December 31, 2023, with an option to renew for an additional 5 years
Section Waived	<ul style="list-style-type: none"> <li>The requirement to consider all members in a market to be part of a single risk pool</li> </ul>
Responsible Agency	<ul style="list-style-type: none"> <li>Wisconsin Healthcare Stability Plan (WIHSP), administered by the Wisconsin Office of the Commissioner of Insurance (OCI)</li> </ul>
Purpose	<ul style="list-style-type: none"> <li>To bring certainty and stability back into the individual market</li> </ul>
State Projections	<ul style="list-style-type: none"> <li>Premiums will be about 11% lower in 2019 than they would be without the waiver</li> <li>Enrollment will increase by nearly 1% in 2019</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>Creates an attachment point model, with the attachment point at \$50,000 and a reinsurance cap of \$250,000</li> <li>Coinsurance range between 50% and 80%, established 50% for 2019</li> <li>OCI must consult with an actuarial firm to design and adjust payment parameters</li> <li>Reimburse qualifying individual health insurers for a percentage of a member's claims between an attachment point and a cap</li> </ul>

# Pending 1332 Waivers

State summaries of waivers submitted and currently pending

State	Submitted	Status	Description
ND	5/10/2019	Pending with CMS	Allow federal pass through funding to partially finance the Reinsurance Association of North Dakota (RAND). RAND would reimburse insurers 75% of claims paid between \$100,000 and \$1,000,000.
CO	5/20/2019	Pending with CMS	Allow federal pass through funding to partially finance a reinsurance program to be administered by the Colorado Department of Insurance. The reinsurance program will reimburse insurers 60% of claims paid between \$30,000 and an estimated \$400,000 cap. Waiver authority for two years.

# Drafted 1332 Waivers

State summaries of drafted waivers not just submitted

State	Draft Released	Status	Description
MT	5/15/2019	Comment period closed	Develops a state reinsurance program. The Waiver is intended to further stabilize the individual market, reduce rates, and to encourage insurance companies to offer plans in more parts of the state. Montana's enacting legislation for the program specifies a coinsurance rate of between 50% and 80%, an attachment point no less than \$40,000 and a cap of no more than \$1 million.
ID	11/1/2017	Waiver not submitted	Extends marketplace coverage to low-income adults with incomes below 100 percent of poverty, changing the rules for premium tax credits instead of expanding Medicaid.
DE	6/5/2019	Open for comment	Establishes the Delaware Health Insurance Individual Market Stabilization Reinsurance Program & Fund (the "Fund") to reinsure high dollar claims on the Exchange. The Fund would be administered by the Delaware Health Care Commission (the "DHCC") and financed through an assessment of 2.75% on all amounts used to calculate a health insurer's premium written on the individual market, as well as the small and large group markets in Delaware.
NH	7/19/2017	Waiver not Submitted	Proposes a traditional reinsurance program with a corridor of \$45,000 – \$250,000 and a 40% / 60% coinsurance rate. The application seeks \$12.8 million in federal pass-through funding.
LA	4/9/2018	Waiver not submitted	Establishes a state-based reinsurance program, the Louisiana Health Reinsurance Association (LHRA). Louisiana is seeking \$103.5 million in federal pass-through funding for 2019 in addition to \$24.8 million in state funding coming from a proposed per-member assessment on Louisiana health insurers.

# Incomplete 1332 Waivers

State summaries of waivers submitted but deemed incomplete

State	Submitted	Deemed Incomplete	Description
MA	9/8/2017	10/23/2017	<p>Waive cost sharing reduction (CSR) payments to insurers in Massachusetts and allow federal pass-through funding of those CSR payments and any advanced premium tax credit (APTC) payments resulting from lower premiums to partially finance a Premium Stabilization Fund (PSF). The PSF will make payments to insurers that are equivalent to the payments that would have been made through the federal CSR program.</p> <p>CMS indicated in the letter that given the required federal comment period, the waiver could not be implemented for the 2018 coverage year.</p>
OH	3/30/2018	5/17/2018	<p>Waive the individual mandate requirement. Although Congress “zeroed out” the penalty associated with the individual mandate beginning in 2019, it did not eliminate the requirement.</p> <p>In its letter to the state, CMS indicated that the application did not comply with section 1332 requirements.</p>
VT	5/15/2016	6/9/2016	<p>Allow small employers to enroll directly with health insurance carriers rather than through an online SHOP web portal. The state had adopted the direct enrollment approach for small businesses after the SHOP portal developed by the state failed to launch in 2014.</p> <p>Waiver deemed incomplete on June 9, 2016. Guidance from CMS issued on April 18, 2016 delayed the required implementation of the SHOP online portal until 2019 and the final Notice of Benefit and Payment Parameters for 2019 permanently eliminated the requirement. As a result, the state is no longer pursuing the waiver.</p>







# Withdrawn 1332 Waivers

## State summaries of withdrawn waivers

State	Submitted	Withdrawn	Description
CA	12/16/2016	1/18/2017	<p>The state requested approval to provide California Qualified Health Plans (CQHPs) to individuals ineligible to purchase coverage through Covered California, the state's marketplace, due to their immigration status (undocumented). Individuals purchasing CQHPs would not be eligible for premium tax credits or cost sharing subsidies.</p>
IA	8/21/2017	10/23/2017	<p>The state sought to establish the Iowa Stopgap Measure (ISM) to restructure the coverage offered in the state's individual market and to establish a reinsurance program.</p> <ul style="list-style-type: none"> <li>Require participating insurers to offer a single, standard health plan in the ACA-compliant market with an actuarial value of 68%-72% and a deductible of \$7,350/individual and \$14,700/family</li> <li>Provide flat premium credits based only on income and age in lieu of ACA premium tax credits, and provide premium credits to eligible consumers with income above 400% of poverty who purchase the standard plan.</li> <li>Continue to provide cost sharing subsidies for individuals with incomes up to 200% FPL by increasing the actuarial value (AV) of the standard plan to 94% for those with income 133%-150% FPL and 83% for those 150%-200% FPL; eliminate cost sharing subsidies for those with incomes 200%-250% FPL</li> <li>Create an alternative process for applying for premium credits and enrolling in coverage.</li> <li>Use federal pass through funding to establish a reinsurance program to reimburse insurers for 85% of claims between \$100,000 and \$3 million, and 100% of claims above \$3 million</li> </ul>
OK	8/15/2017	9/29/2017	<p>The state requested federal pass-through funding to partially finance the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP). The OMSP would reimburse insurers 80% of claims above \$15,000 and up to \$400,000. The state estimated OMSP would reduce premiums by over 30% and requested that funds the federal government would have paid in premium tax credits to eligible marketplace members had the reinsurance program not been in place be provided to the state to finance the program.</p>

# Key Takeaways of 1332 Waivers

The following are key takeaways from the scan of the 1332 waiver landscape

-  **Claims-based Reinsurance Approach:** All but one of the approved state reinsurance 1332 waivers takes a claim-based approach as opposed to condition-based approach.
-  **Program Administration:** States vary in their approach to administering reinsurance programs. Four states administer via non-profit entities (AK, MD, ME, MN) which were in existence prior to the program. Three state programs are administered by state agencies (NJ, OR, WI), with one under the authority of the insurance commissioner (WI).
-  **New Flexibilities:** CMS has expressed an interest in new and innovative ways for states to potentially use 1332 waivers and has provided greater flexibility in the interpretation of approval guardrails.
-  **Technology:** The increased policy flexibility to be gained by new 1332 guidance could be limited by a state's or CMS' ability to operationalize the flexibility.
-  **State-Wide Coverage:** States may focus on providing access to affordable coverage across all programs looking at their population as a whole regardless of the point of access
-  **Pass Through Funding:** If a state's 1332 waiver plan is projected to reduce federal costs, then the state may be able to receive federal "pass-through" payments equal to the difference. The federal government calculates each state's pass-through funding annually, using information such as enrollment by income and will issue a final determination of the state's "pass-through" payments.

# National Healthcare Coverage Trends

- Methodology
- Landscape of Medicaid New Adult Group Coverage Initiatives
- Medicaid Enrollment
- Marketplace Consumers
- Estimated Uninsured Rates
- Rural Health



# Methodology

The purpose of this section is to provide an overview of national healthcare coverage trends and how Georgia compares to other states nationally

## Methodology

- The team examined the national landscape using publicly available sources to review trends in Medicaid enrollment, marketplace consumers, estimated uninsured rates, and rural health trends.
- Kaiser Family Foundation served as a primary source of data for Medicaid enrollment. Their analysis relies on the U.S. Census Bureau's American Community Survey (ACS) data from 2008 to 2017.
- To estimate current uninsured rates, this report utilized ACS 2017 5-year estimates as it is the most recent and comprehensive survey data available.
- To examine marketplace activity, data was taken from CMS Marketplace Open Enrollment Period Public Use Files.

### National Healthcare Coverage Scan Primary Sources

In conducting the waiver review, the team reviewed publicly available sources including:

- Kaiser Family Foundation
- U.S. Census Bureau ACS 2017 5-Year Estimates
- CMS Marketplace Open Enrollment Period Public Use Files





# Landscape of New Adult Group Coverage Initiatives

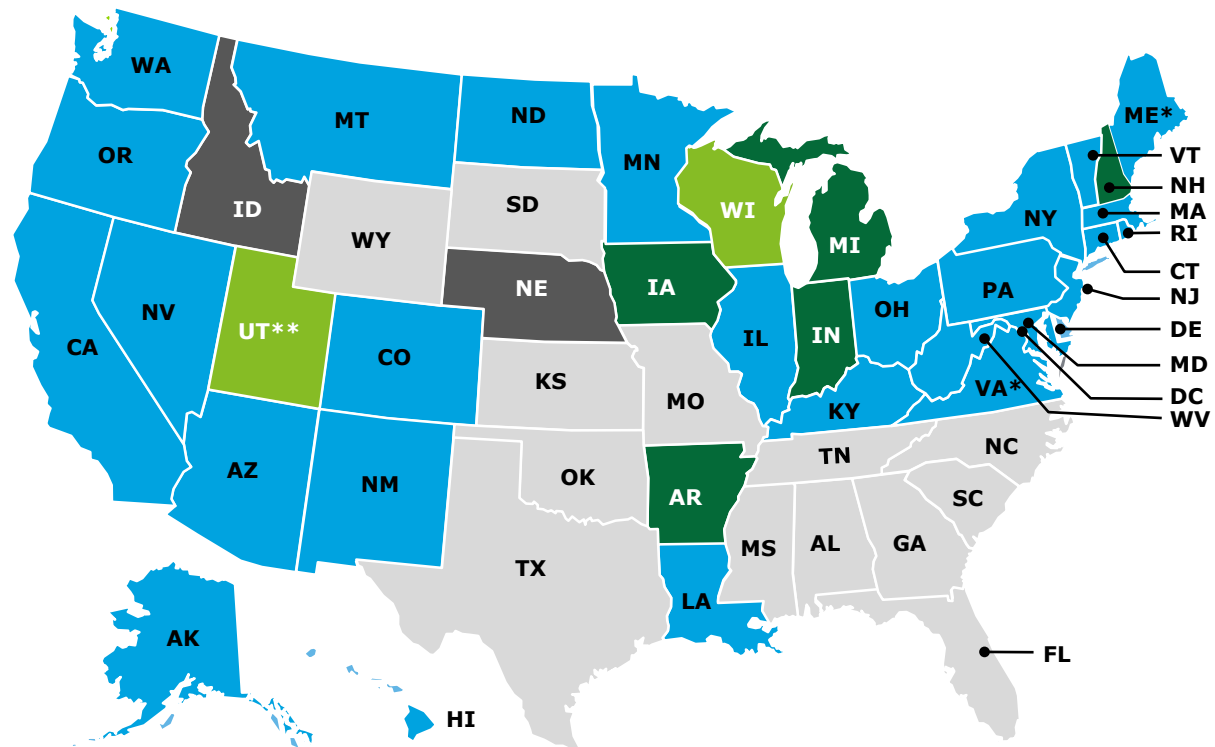
States have taken various approaches to increasing Medicaid eligibility to include the New Adult Group of able-bodied adults without dependents who were not traditionally eligible.

## How States have Increased Medicaid Coverage to the New Adult Group

To date, 37 states plus the District of Columbia have chosen to expand Medicaid to the New Adult Group either traditionally through ACA authority via State Plan Amendment (SPA) or through 1115 waivers. 13 states have not expanded to the New Adult Group



State Initiatives for New Adult Group Coverage	Total
<b>Traditional (ACA) Expansion to 138% FPL</b>	<b>28 states (plus DC)</b>
<b>1115 Expansion to New Adult Group to 138% FPL</b>	<b>5 states</b>
<b>1115 Limited Expansion to New Adult Group to 100% FPL</b>	<b>2 states</b>
<b>Voter Referendum for expansion for New Adult Group (Not Yet Implemented)</b>	<b>2 states</b>
<b>Non-Expansion States</b>	<b>13 states</b>



**Note: 1115 Waiver Expansion identified above only includes states who used 1115 waiver authority to increase eligibility to New Adult Group**

\* Virginia and Maine are currently included as Traditional (ACA) Expansion states, but data from 2018 and before reflect the states as non-expansion states prior to year of implementation

\*\* Utah originally passed ballot measures to expand Medicaid to the New Adult Group to 138% FPL. The governor submitted a waiver to limit expansion to 100% FPL. The state has a second waiver seeking enhanced match for its limited expansion. Data from 2018 and before reflect the state as non-expansion

# Medicaid Adult Eligibility Criteria in Non-Expansion States

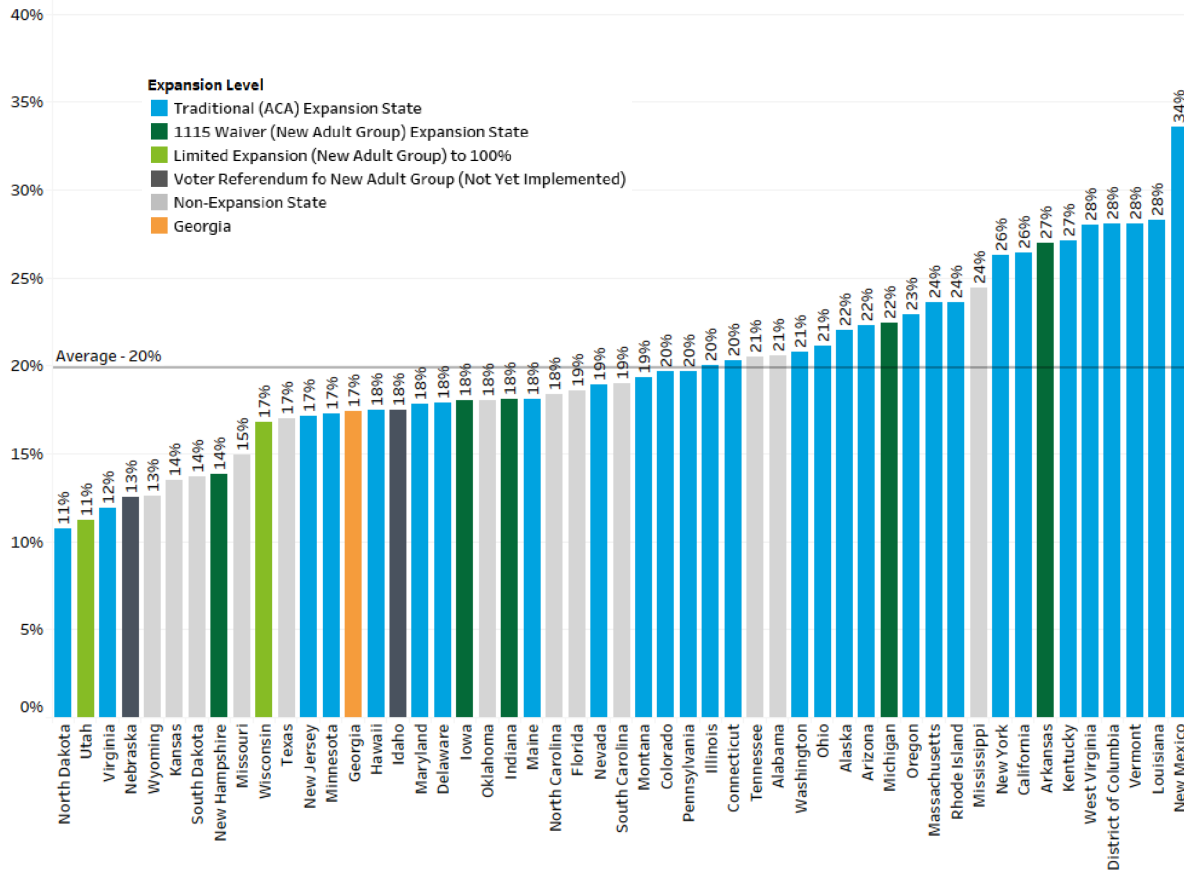
Eligibility for Medicaid for adults with dependents varies across non-expansion states; able-bodied adults without dependents are not eligible for Medicaid in non-expansion states

State	Parents of Dependent Children Eligibility Level January 2019 (in a family of three)		Other Adults (Non-Disabled) January 2019 (for an individual)	
	FPL	Income	FPL	Income
<b>Tennessee</b>	95%	\$20,263	Not eligible	Not eligible
<b>South Carolina</b>	67%	\$14,291	Not eligible	Not eligible
<b>Wyoming</b>	54%	\$11,518	Not eligible	Not eligible
<b>South Dakota</b>	49%	\$10,451	Not eligible	Not eligible
<b>North Carolina</b>	42%	\$8,958	Not eligible	Not eligible
<b>Oklahoma</b>	42%	\$8,958	Not eligible	Not eligible
<b>Kansas</b>	38%	\$8,105	Not eligible	Not eligible
<b>Georgia</b>	35%	\$7,465	Not eligible	Not eligible
<b>Florida</b>	32%	\$6,825	Not eligible	Not eligible
<b>Mississippi</b>	26%	\$5,545	Not eligible	Not eligible
<b>Missouri</b>	21%	\$4,479	Not eligible	Not eligible
<b>Alabama</b>	18%	\$3,839	Not eligible	Not eligible
<b>Texas</b>	17%	\$3,626	Not eligible	Not eligible

# 2017 Medicaid and CHIP Enrollment of Total Population

17% of Georgia's total population is enrolled in Medicaid or CHIP. Non-expansion states range from 13-24% and traditional expansion (ACA) states range from 11-34%

2017 Percent Total Population on Medicaid and CHIP

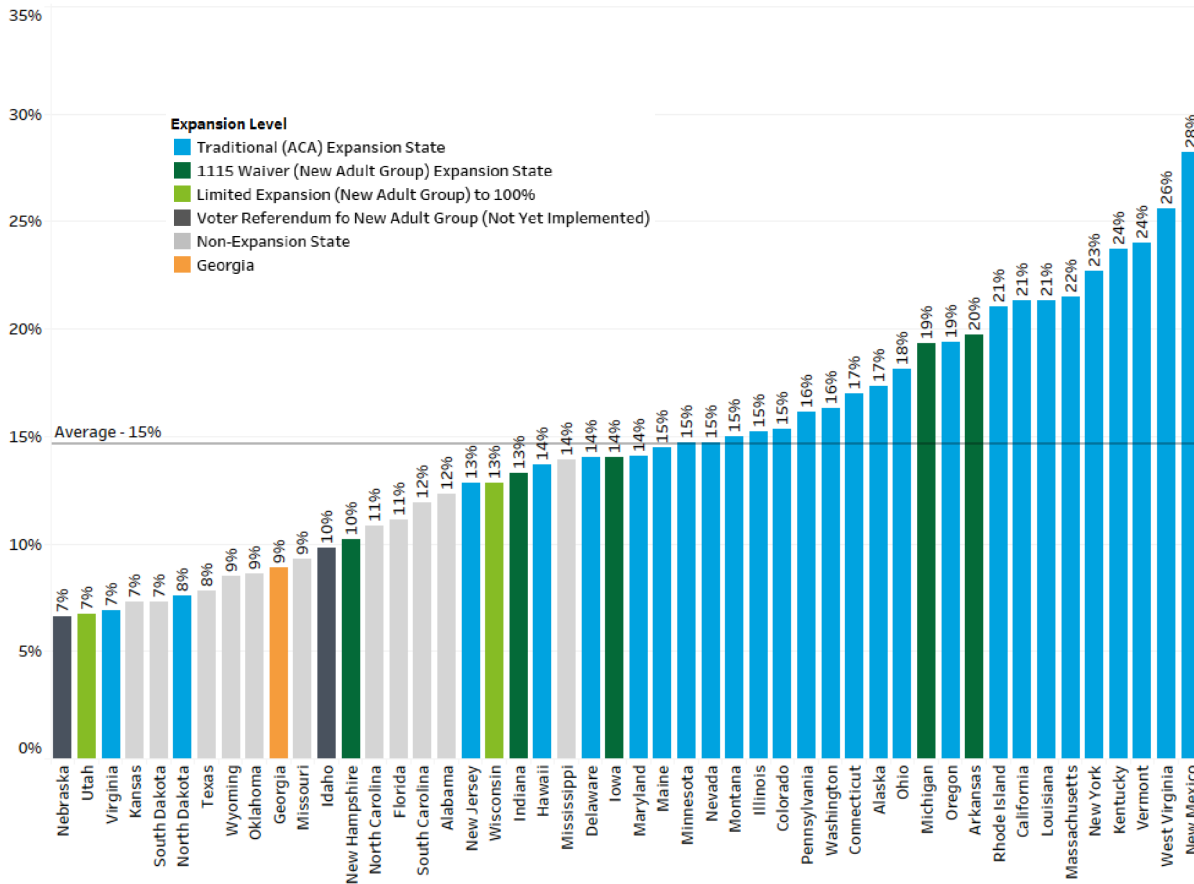


- VA and ME are currently included as traditional (ACA) expansion states and Utah is included as a limited expansion (New Adult Group to 100% FPL) state, but data prior to 2019 reflect non-expansion levels
- Enrollment data includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligible who are also covered by Medicare
- Percentages have been rounded to the nearest whole number

# 2017 Medicaid Enrollment of Adult Population (19-64)

At 9% of the adult population, Georgia's Medicaid enrollment for adults ages 19-64 falls in the middle of non-expansion states which range from 7-14%. Traditional expansion (ACA) states range from 8-28%

2017 Percent Adults (19-64) on Medicaid

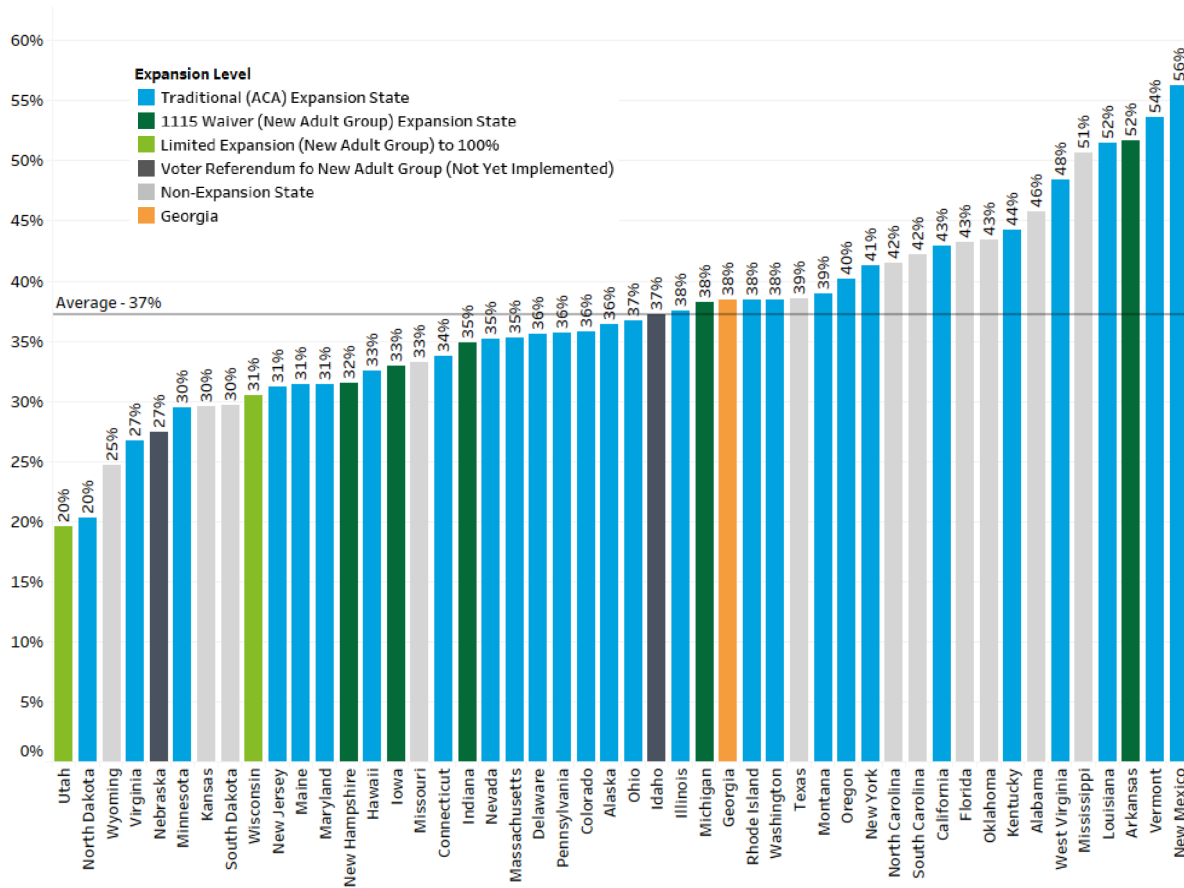


- VA and ME are currently included as traditional (ACA) expansion states and Utah is included as a limited expansion (New Adult Group to 100% FPL) state, but data prior to 2019 reflect non-expansion levels
- Percentages have been rounded to the nearest whole number

# 2017 Medicaid and CHIP Enrollment for Children (under 19)

38% of Georgia's population under 19 is enrolled in either Medicaid or CHIP, placing it right at the national average. Non-expansion states range from 25-51% and traditional expansion (ACA) states range from 20-56%

2017 Percent Children (under 19) on CHIP

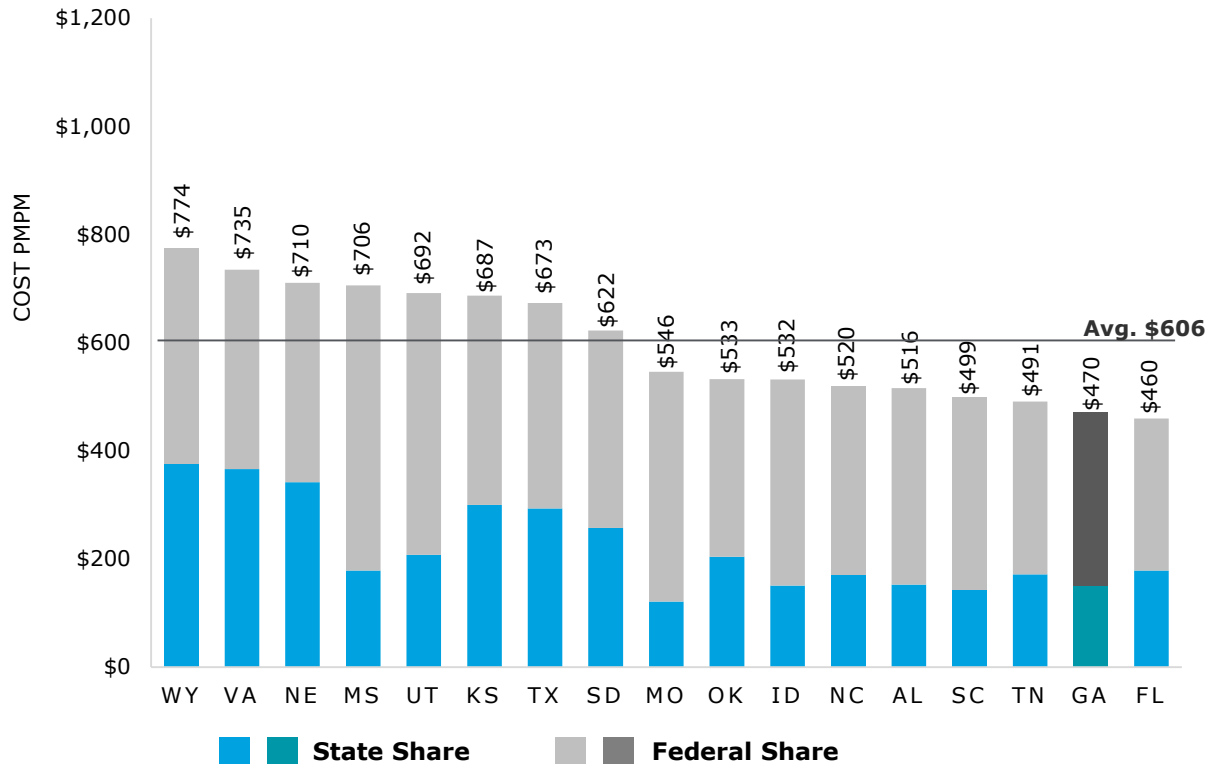


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- Enrollment data includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligible who are also covered by Medicare
- Percentages have been rounded to the nearest whole number

# Medicaid PMPM for Non-Expansion States

Georgia's Medicaid average per member per month (PMPM) cost is \$135 less than the average across non-expansion states

**2017 MEDICAID PMPM COST  
GEORGIA COMPARED TO OTHER NON-EXPANSION  
STATES**

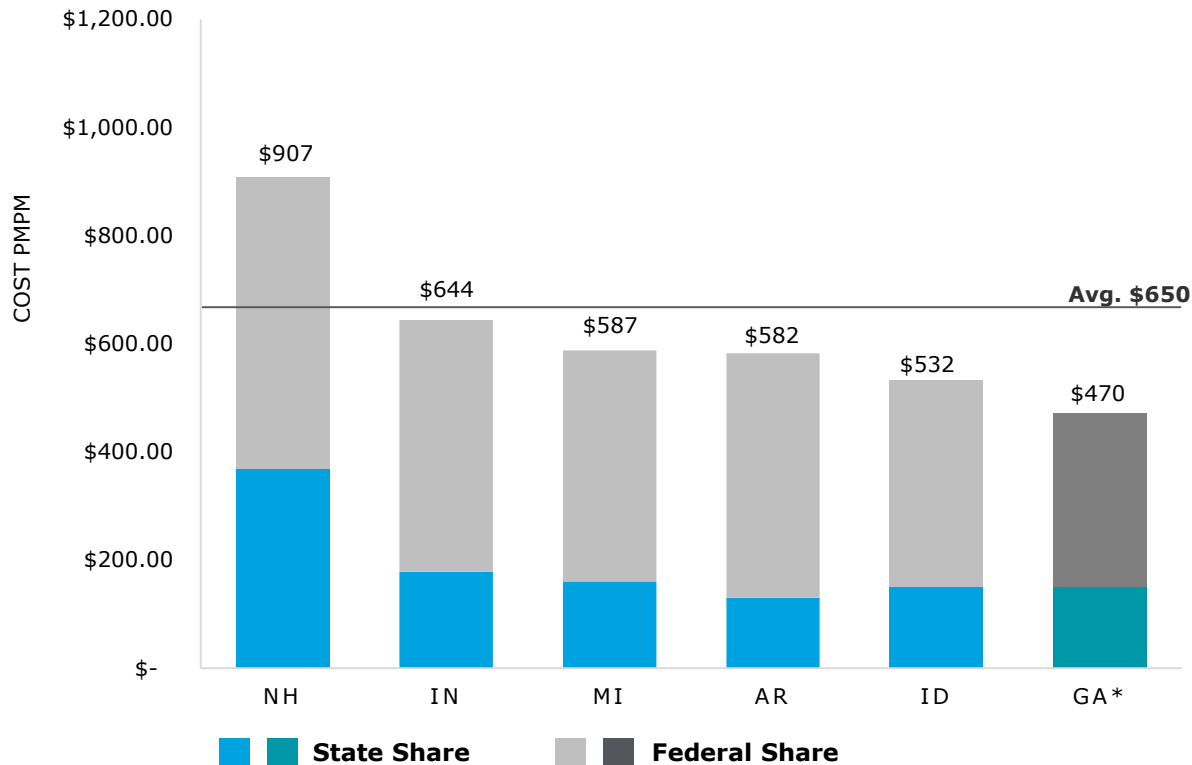


- Medicaid is financed by both the federal government and the states using a formula that is based on a state's per capita income. The federal share (FMAP) varies by state from a floor of 50% to a high of 74% with exceptions for certain services or populations.
- NE and ID have been included in the non-expansion comparison, as they have not yet implemented expanded coverage for the New Adult Group from the voter referendums. UT and VA have been included in the non-expansion since data is prior to expansion period.
- **Methodology:** Due to lack of consistency in publicly available data comparing PMPM rates across states, PMPM values were calculated by taking the total Federal and State Medicaid spending per state in a 2017, divided by total membership, and divided by 12 months for comparison. PMPM rounded to nearest whole dollar. GA's reported PMPM for FY2017 is \$435

# Medicaid PMPM for 1115 States with New Adult Group

Georgia's Medicaid average PMPM cost is \$180 less than the average for 1115 waiver states with New Adult Group coverage to 138% FPL

**2017 MEDICAID PMPM COST  
GEORGIA COMPARED TO 1115 STATES WITH NEW  
ADULT GROUP COVERAGE TO 138% FPL**



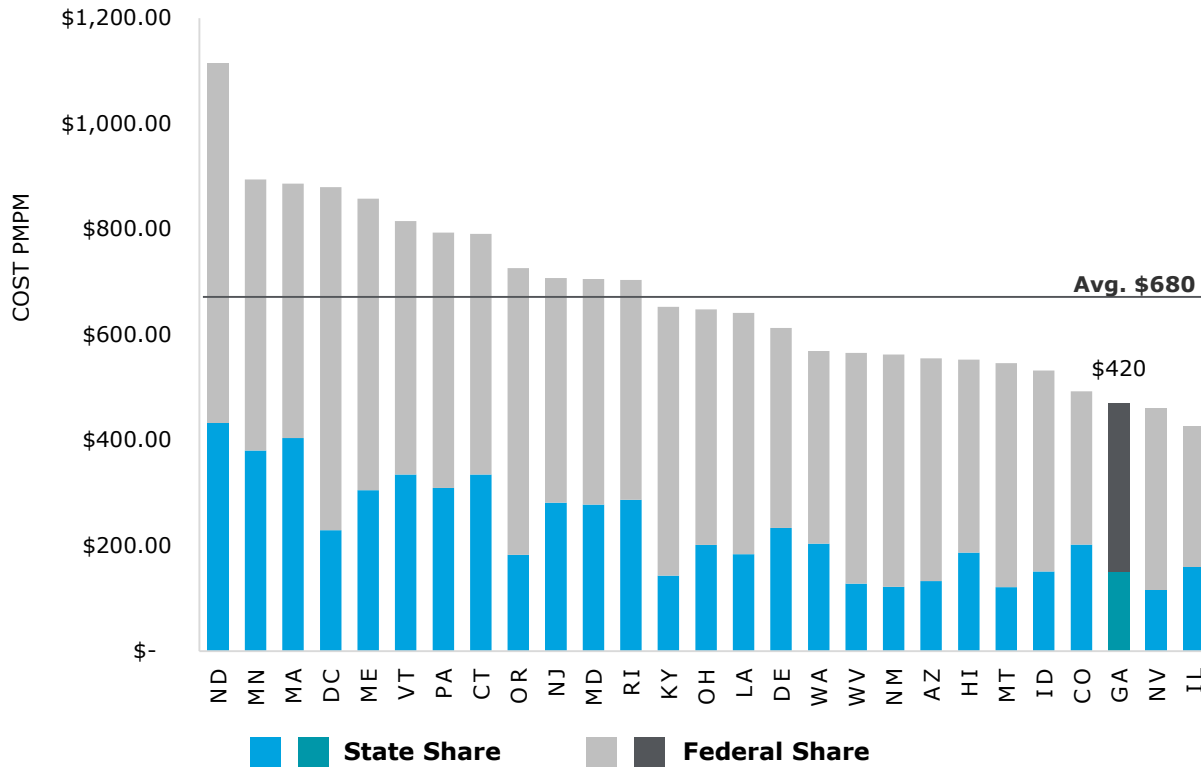
\*Georgia included on the chart for comparison only. It is not an 1115 State with New Adult Group coverage

- Medicaid is financed by both the federal government and the states using a formula that is based on a state's per capita income. The federal share (FMAP) varies by state from a floor of 50% to a high of 74% with exceptions for certain services or populations. ACA expanded Medicaid eligibility for adults under age 65 and provided the states that chose to expand with an Enhanced FMAP of 100% federal funding through 2016 for the newly eligible adults. The federal share for the expansion population phased down to 95% in 2017 and to 90% by 2020 and beyond.
- **Methodology:** Due to lack of consistency in publicly available data comparing PMPM rates across states, PMPM values were calculated by taking the total Federal and State Medicaid spending per state in a 2017, divided by total members, and divided by 12 months. PMPM rounded to nearest whole dollar. GA's reported PMPM for FY2017 was \$435

# Medicaid PMPM for Traditional (ACA) Expansion States

Georgia's Medicaid average cost PMPM is approximately \$210 less than the average for traditional (ACA) expansion states

**2017 MEDICAID COST PMPM  
GEORGIA COMPARED TO TRADITIONAL (ACA)  
EXPANSION STATES**



\*Georgia included on the chart for comparison only. It is not a traditional expansion state

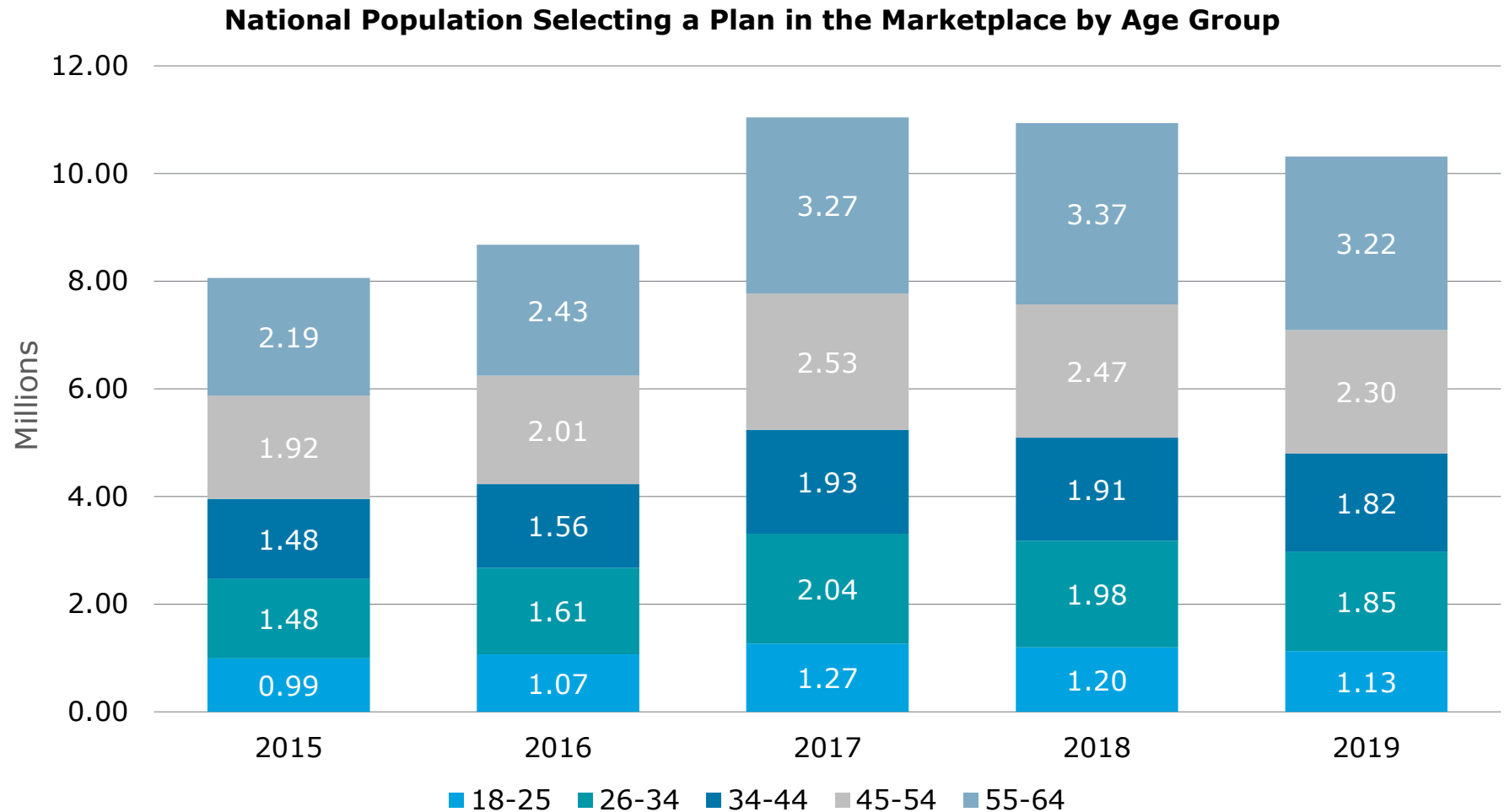
- Medicaid is financed by both the federal government and the states using a formula that is based on a state's per capita income. The federal share (FMAP) varies by state from a floor of 50% to a high of 74% with exceptions for certain services or populations. The Affordable Care Act (ACA) expanded Medicaid eligibility for adults under age 65 and provided the states that chose to expand with an Enhanced FMAP of 100% federal funding through 2016 for the newly eligible adults. The federal share for the expansion population phased down to 95% in 2017 and to 90% by 2020 and beyond.

- Methodology:** Due to lack of consistency in publicly available data comparing PMPM rates across states, PMPM values were calculated by taking the total Federal and State Medicaid spending per state in a 2017, divided by total membership, and divided by 12 months for comparison. PMPM rounded to nearest whole dollar. GA's reported PMPM for FY2017 is \$435



# Marketplace National Trends by Age Group

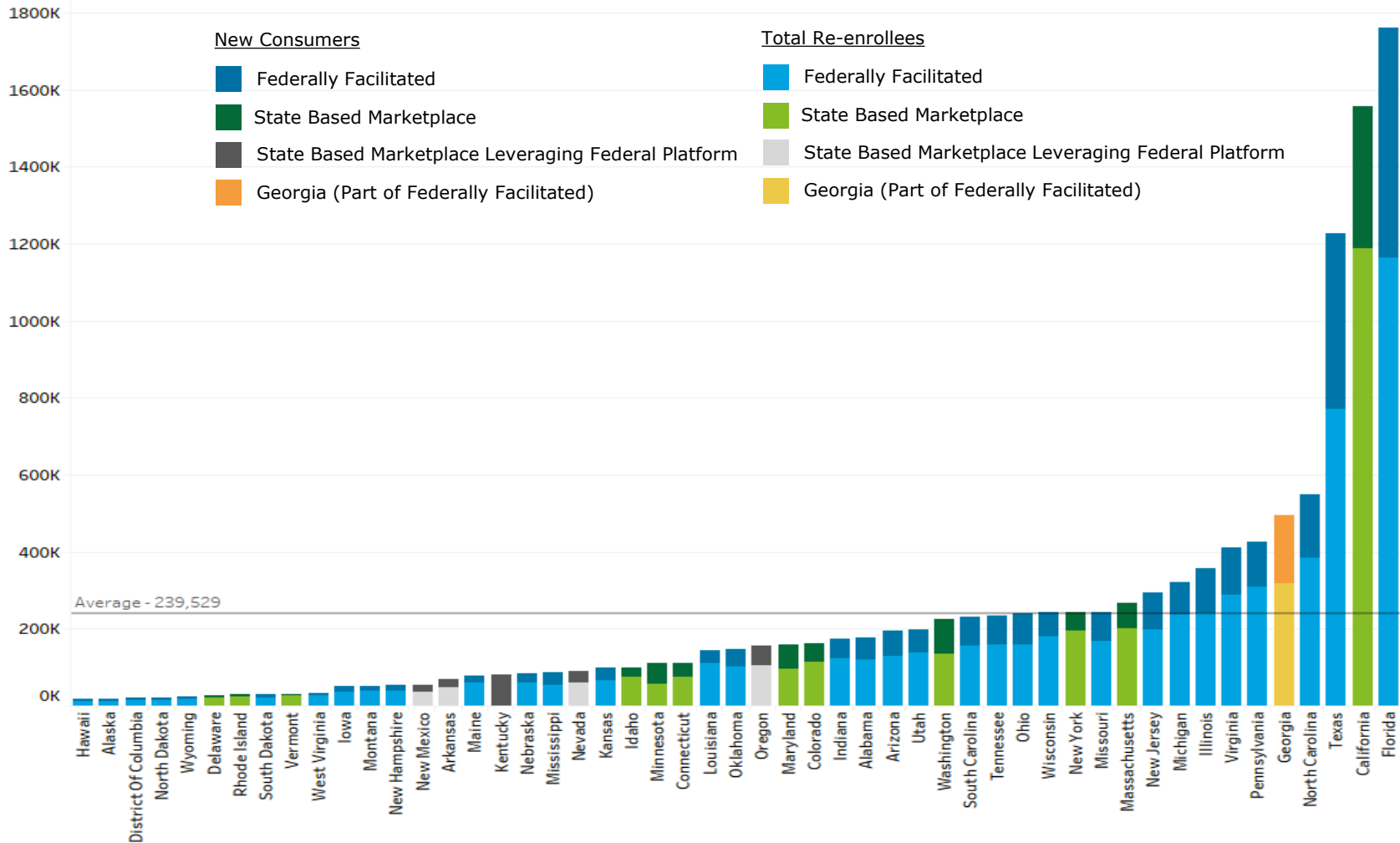
The nation saw a spike in the total population in the Marketplace in 2017 then a steady decline until 2019



# Marketplace Consumers by State

Georgia had 458,437 members select a plan in the individual marketplace in 2017, ranking fifth highest in overall volume nationally

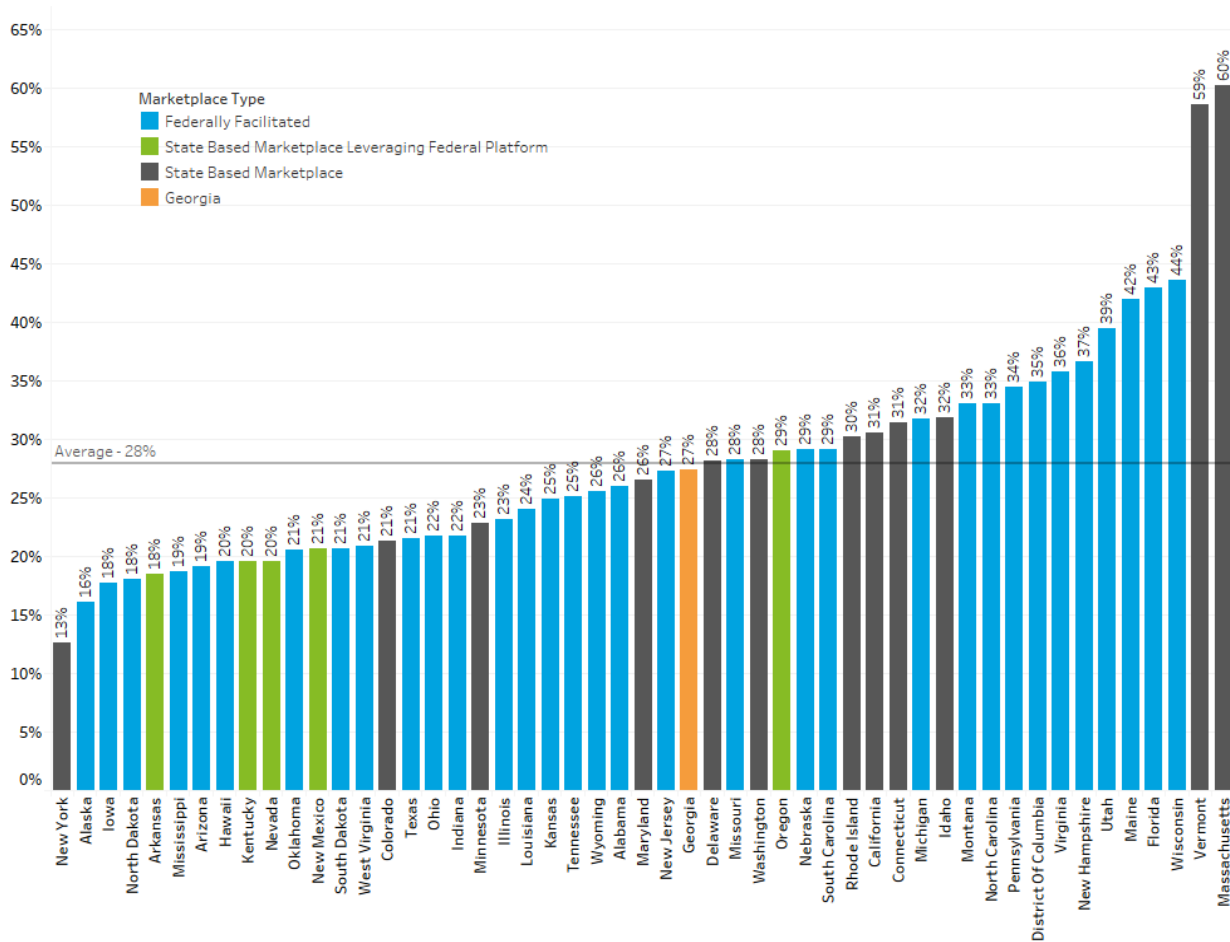
**Total Number of Consumers Who Have Selected a Marketplace Plan 2017**



# Marketplace Estimated Consumer Penetration

27% of potential adults 19-64 years old in Georgia who would be likely to purchase individual insurance selected a marketplace plan in 2017, place Georgia in the middle of nationally

**Estimated Marketplace Penetration for Adults (19-64)**

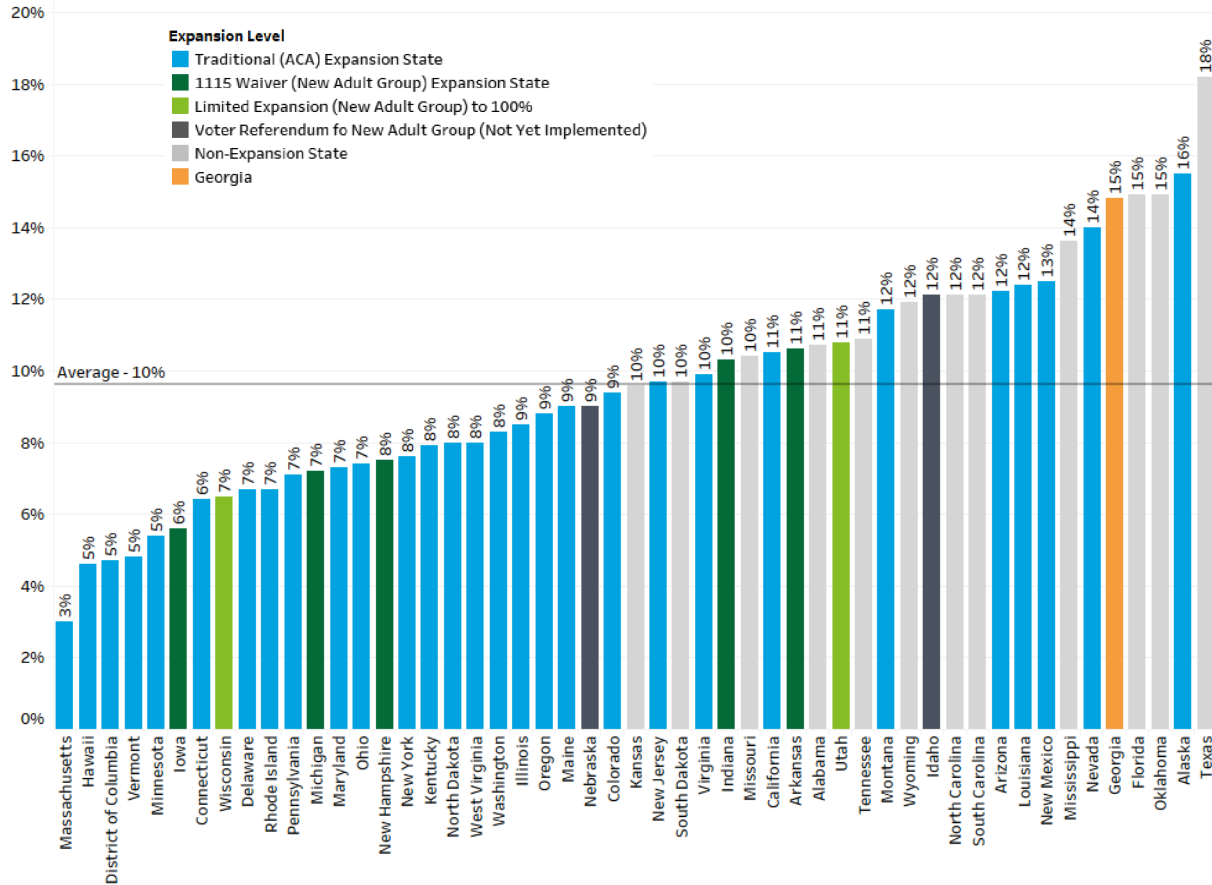


- Methodology:** Marketplace penetration was estimated by taking data provided by Kaiser Family Foundation Health Insurance Coverage of Adults 19-64 (2017) to identify the total population 19-34 and subtracting the population enrolled in employee provided insurance, Medicaid, and other public insurance to get the market size of adults who would be likely to purchase from the marketplace. The total number of adults selecting a plan in Georgia is from 2017 CMS data.
- CA, CO, MN, and RI had Special Enrollment Periods which extended their Open Enrollment deadline; this file does not include these additional plan selections
- Percentages have been rounded to the nearest whole number

# Estimated Uninsured Rates of Total Population

At 15%, Georgia's uninsured rate is higher than most other states. Non-expansion states range from 10-18% and traditional expansion (ACA) states range from 3-16%

**2017 Percent Uninsured Total Population**

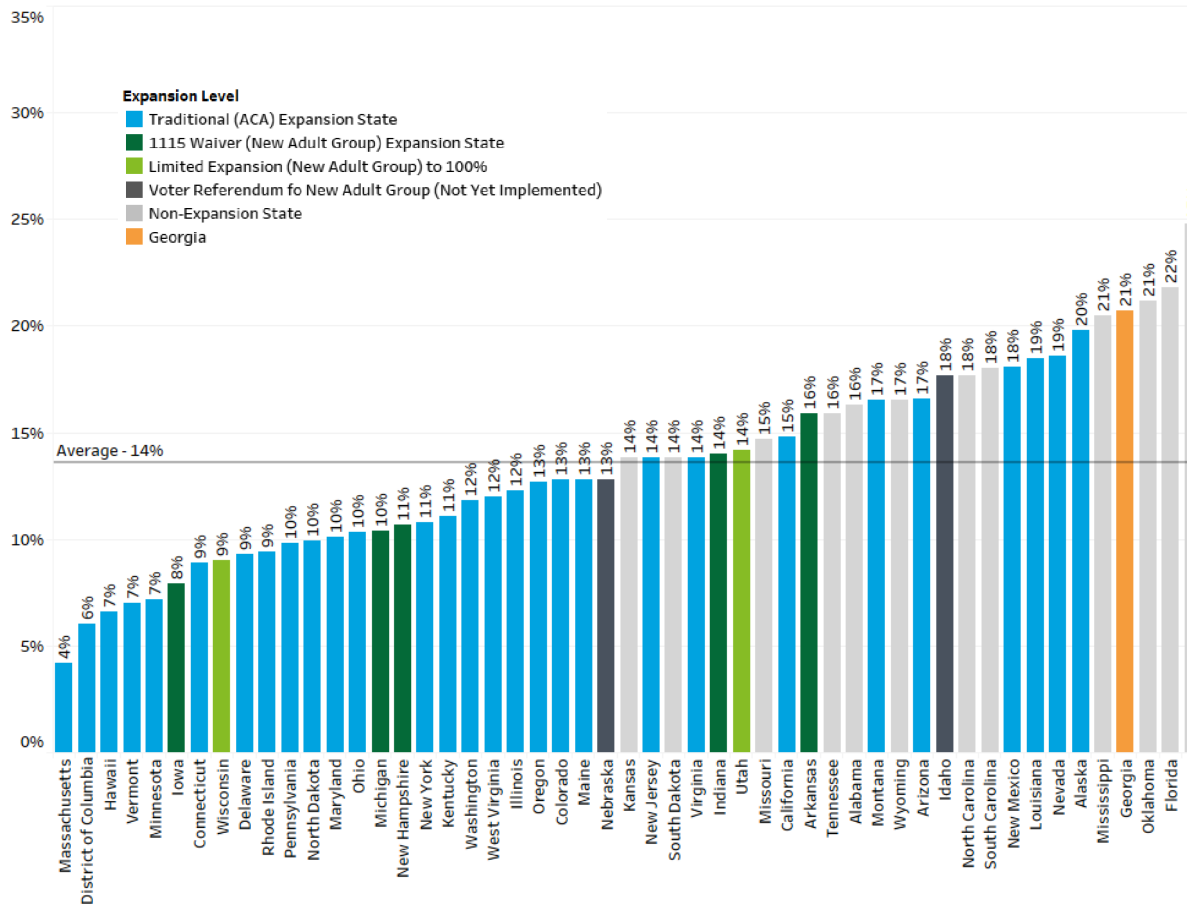


- VA and ME are currently included as traditional (ACA) expansion states and Utah is included as a limited expansion (New Adult Group to 100% FPL) state, but data prior to 2019 reflect non-expansion levels
- Percentages have been rounded to the nearest whole number

# Estimated Uninsured Rates of Adults (19-64)

Among the adult population, Georgia's uninsured rate is 21%, which is higher compared to both non-expansion states which range from 14-25% and traditional expansion (ACA) states ranging from 4-20%

**2017 Percent Uninsured Adults (19-64)**

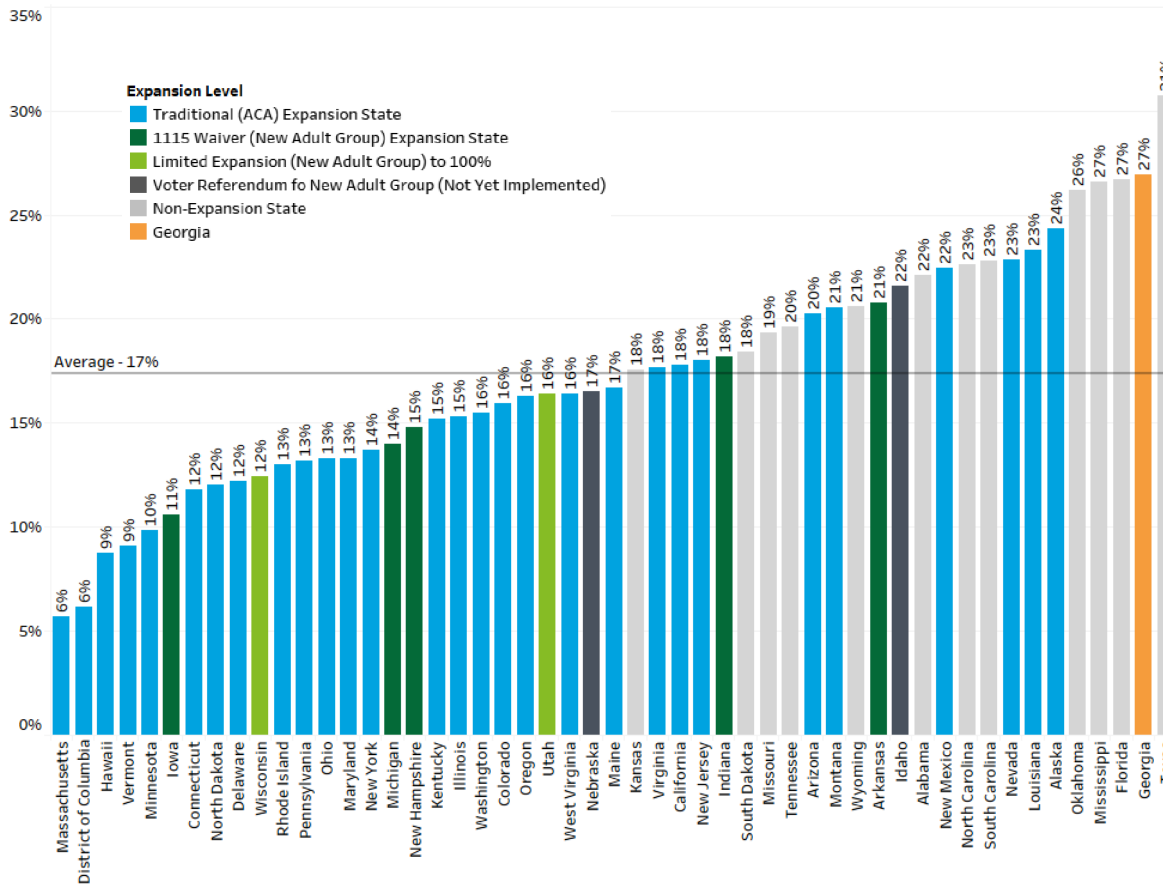


- VA and ME are currently included as traditional (ACA) expansion states and Utah is included as a limited expansion (New Adult Group to 100% FPL) state, but data prior to 2019 reflect non-expansion levels
- Percentages have been rounded to the nearest whole number

# Estimated Uninsured Rates of Young Adults (19-34)

At 27%, Georgia has the second highest uninsured rate among the young adult population ages 19-34 in the country

**2017 Percent Uninsured Adults (19-34)**

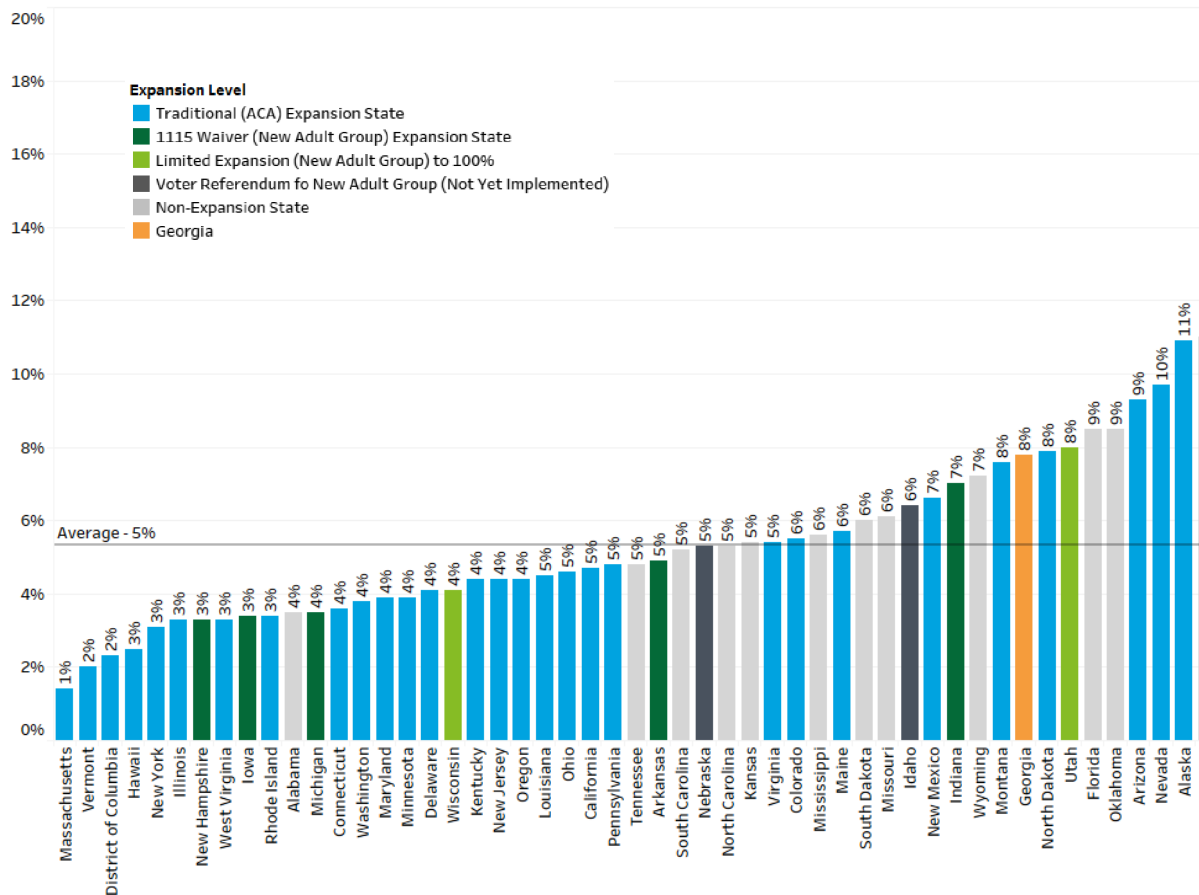


- VA and ME are currently included as traditional (ACA) expansion states and Utah is included as a limited expansion (New Adult Group to 100% FPL) state, but data prior to 2019 reflect non-expansion levels
- Percentages have been rounded to the nearest whole number

# Estimated Uninsured Rates for Children (under 19)

Georgia's uninsured rate for children is 8% which is higher than the national average of 5%

**2017 Percent Uninsured Children (under 19)**



- VA and ME are currently included as traditional (ACA) expansion states and Utah is included as a limited expansion (New Adult Group to 100% FPL) state, but data prior to 2019 reflect non-expansion levels
- Percentages have been rounded to the nearest whole number

# Rural Health Trends

Since 2010, 97 rural hospitals have closed across 27 states

## Factors Driving Rural Hospital Crisis Include:

- **Payer mix degradation:** A loss of agricultural and manufacturing jobs has led to a corresponding degradation of the payer mix
- **Declining inpatient care driving excess capacity:** the average rural hospital has 50 beds and 321 employees, but a daily census of just 7 patients
- **Inability to leverage innovation:** hospitals lack the capital to invest in updated, innovative technologies



 **2,045** Rural hospitals across 43 states

 **21%** Rural hospitals at high risk of closing

 **34** States have five or more rural hospitals at high financial risk

- More than **1/5** of the nation's rural hospitals are near insolvency
- The greatest financial burden to many rural hospitals is supporting a **24/7** emergency department, where standby staffing costs are high, volumes are relatively low, and reimbursement does not cover expenses
- When a community loses a hospital, per capita income falls **4%** and the unemployment rate rises **1.6%**

## Top Ten States by Percentage of Rural Hospitals at High Financial Risk

State	Total Rural Hospitals	Hospitals at High Financial Risk	% at High Financial Risk
<b>AL</b>	42	21	50%
<b>MS</b>	64	31	49%
<b>GA</b>	63	26	41%
<b>ME</b>	20	8	40%
<b>AK</b>	15	6	40%
<b>AR</b>	49	18	37%
<b>OK</b>	58	17	29%
<b>KS</b>	101	29	29%
<b>MI</b>	71	18	25%
<b>KY</b>	65	16	24%

Source: Information from [Modern Healthcare: Nearly a quarter of rural hospitals are on the brink of closure \(February 2019\)](#). High financial risk determined by an average 1.4% operating margin over the past three years, 78.5 days cash on hand and 49.8% debt-to-capitalization ratio to determine financial viability. Percent at High Financial Risk was rounded to the nearest whole number



# Pennsylvania Rural Health Model Example

The commonwealth is testing whether care delivery transformation in conjunction with hospital global budgets will increase rural access to high-quality care, improve/maintain health, reduce cost, and improve financial viability

## Summary

- Under this model, CMS and other participating payers will pay participating rural hospitals on a global budget—a fixed amount, set in advance—to cover all inpatient and hospital-based outpatient items and services
- Participating rural hospitals are working to redesign the delivery of care for their patients
- The model will test whether the predictable nature of global budgets will enable participating rural hospitals to invest in quality and preventive care and be able to tailor their services to better meet the needs of their local communities
- Pennsylvania has secured the participation of commercial payers and Medicaid and has committed to having each participating rural hospital's global budget represent at least 75 percent of that hospital's net revenue for inpatient and outpatient hospital-based services in Performance Year 1 (2019), and at least 90 percent of each participating rural hospital's global budget for each of Performance Years 2 through 6

**Year 0**  
2017-2018

**Year 1-6**  
Jan. 2019

## Performance Period

- CMS made funds available to Pennsylvania to begin model operations, obtain participation from participants and payers, collect data, and calculate global budget
- Participating hospitals developed Rural Hospital Transformation Plans and submitted them to CMS for approval
- Participating rural hospitals will be paid based on prospectively-set, all-payer global budgets, and will implement their Rural Hospital Transformation Plans
- During this time the model targets must be met including:
  - payer and rural hospital participation scale targets
  - financial targets
  - population health outcomes, access, and quality targets

# Key Takeaways of National Healthcare Trends

The following are key takeaways from the National Healthcare Trends Analysis



**Medicaid Eligibility:** Since 2014, 37 states plus DC have expanded Medicaid coverage to low-income adults.

- 28 states plus DC have expanded using the traditional approach under ACA with amendments to state plans; 5 states have used 1115 waivers to expand coverage for the New Adult Group to 138% FPL (IA, AR, MI, IN, NH); 2 states have used 1115 waiver authority for limited expansion for the New Adult Group to 100% FPL (UT, WI); 2 states have approved expansion under voter referendum for the New Adult Group but have not yet implemented (ID, NE)
- 13 states have not expanded



**Medicaid Enrollment:** 17% of Georgia's total population is on Medicaid or CHIP. Non-expansion states range from 13-24% and traditional expansion (ACA) states range from 11-34%.

- 9% of adults (19-64) in Georgia are enrolled in Medicaid, placing the State in the middle of the distribution for non-expansion states ranging from 7-14%. Traditional expansion (ACA) states range from 8-28%
- 38% of children in Georgia are enrolled in Medicaid or CHIP, placing Georgia in the right at the national average.
- Georgia's PMPM cost is one of the lowest in the country based on a straight calculation of total Medicaid cost over total members



**Estimated Uninsured Rates:** Georgia's uninsured rate is 15% for the total population. Non-expansion states range from 10-18% and traditional expansion (ACA) states range from 3-16%

- 21% of adults (19-64) are estimated to be uninsured in Georgia, compared to 14-25% among non-expansion states.
- At 27%, Georgia has the second highest uninsured rate among young adults (19-34).
- 8% of children are estimated to be uninsured in Georgia compared to the national average of 5%.



**Hospital Closures:** Since 2010, 97 rural hospitals have closed across 27 states. Georgia has had 10 rural hospitals close with an additional 26 at risk of closure. Factors driving these closures include:

- Loss of agriculture and manufacturing jobs leading to a decline in payer mix
- Decline of inpatient care leading to an excess capacity of beds
- Lack of capital to invest in updated technologies

