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Trends in Medicaid Restrictions

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Last year saw two huge trends in Medicaid restrictions: work requirements and a change in retroactive coverage. Several states have been approved for these Section 1115 Medicaid waivers and are already implementing these changes. Other states have applied for waivers that are pending.

In this issue of *The ElderCounselor*, we will explain what a Section 1115 Medicaid waiver is, how work requirements and retroactive coverage are changing Medicaid benefits, why these changes are happening, what to watch for in 2019, and how these trends may impact other states.

What is a Section 1115 Medicaid Waiver?

Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services (HHS) can waive specific provisions of major health and welfare programs, including certain requirements of Medicaid. This gives the Secretary authority to allow states to use federal Medicaid funds in ways that are not otherwise permitted under the federal rules, as long as the Secretary determines that the initiative is an "experimental, pilot or demonstration project" that "is likely to assist in promoting the objectives of the program."

These Section 1115 Medicaid demonstration waivers let states test new approaches in Medicaid that are different from federal program rules, giving them flexibility in how they operate their programs, as long as they promote the government's objectives.

States can obtain comprehensive Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs. There are also narrower Section 1115 waivers that focus on specific services or populations.

Waivers are typically approved for a five-year period and can be extended, typically for three years. Also, they must be budget neutral for the federal government. In other words, federal costs under a waiver must not exceed what those costs would have been for that state without the waiver. The federal government enforces this by placing a cap on federal funds under the waiver, putting the state at risk for any costs beyond the cap.

Section 1115 waivers are also subject to new rules about transparency, public input, and evaluation. Public notice and comment periods at the state and federal levels are required before the Centers approve new Section 1115 waivers and extensions of existing waivers for Medicare and Medicaid Services (CMS). States must also have a

publicly available, approved evaluation strategy and are required to submit reports at least annually that describe the changes occurring under the waiver and their impact on access, quality, and outcomes.

Waiver Objectives Changed

In 2017, CMS changed the criteria for evaluating whether Section 1115 waiver applications further Medicaid program objectives. Instead of including expanding coverage, the revised criteria now focus on "positive health outcomes, efficiencies to ensure program sustainability, coordinated strategies to promote upward mobility and independence, incentives that promote responsible beneficiary decision-making, and innovative payment and delivery system reforms."

Waivers Imposing Work Requirements

On January 11, 2018, CMS posted new guidance for waiver proposals that impose work requirements as a condition of eligibility for Medicaid. CMS asserts that such provisions would promote program objectives by helping states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement. States are invited to submit proposals designed to promote better mental, physical, and emotional health, or help individuals and families rise out of poverty and attain independence.

As of January 3, 2019, seven states (Arkansas, Indiana, Kentucky, Maine, Michigan, New Hampshire, and Wisconsin) have received approval for waivers that impose work requirements. An additional nine states (Alabama, Arizona, Kansas, Mississippi, Ohio, Oklahoma, South Dakota, Utah, and Virginia) have submitted waivers that are pending.

Kentucky was the first state to receive the approval as part of a broader overhaul of the state's Medicaid program. However, a federal judge blocked those work requirements just days before they were to take effect in July 2018. Kentucky modified their waiver and again received approval in November 2018. The work requirements are aimed at the newly eligible Medicaid enrollees who gained coverage through Medicaid expansion as part of the Affordable Care Act (ACA).

Under the work requirement waivers for most states, able-bodied adults will be required to complete 80 hours a month of community engagement to qualify for coverage. This would include work, education, volunteering/community service or job training. Drug treatment is considered a work activity, not an exemption.

Enrollees can seek "good cause" exemptions if they can verify one of the following in their month of noncompliance: disability, hospitalization or serious illness of the enrollee or immediate family member in the home; birth or death of family member living with the enrollee; severe inclement weather including natural disaster; family emergency or other life-changing event such as divorce or domestic violence. In addition, one primary caregiver of a dependent minor child or adult with disabilities per household is exempt, and caregiving for a non-dependent relative or another person with a disabling medical condition is considered a work activity.

Arkansas was the first state to implement Medicaid work requirements. The most recent data shows around 18,000 recipients have lost coverage due to the new rules. While studies do expect some people to lose coverage, they predict that most would transition off Medicaid because they enter the workforce, get a better job and higher wages, and gain access to employer-sponsored insurance or other private insurance. One study has proposed that implementing a work requirement could increase lifetime earnings by nearly $1 million for non-disabled people who leave Medicaid.

However, one major challenge is that low-income adults often have a hard time finding jobs with decent pay and health benefits, and may lack transportation to get to available jobs. Research also shows that all but a small percentage of non-disabled Medicaid enrollees are already employed, in school, or caring for children or disabled family members.

What to Watch for in 2019

For states with approved work requirement waivers, CMS requires follow up evaluations and reporting to determine if the work requirements lead to improved health, well-being, and independence. Individuals who experience a lapse in eligibility or coverage because they failed to meet the program requirements or because they gained employer-sponsored insurance will also be surveyed.

Watch for some pending states to become approved, which will lead to larger pools of data for CMS' evaluations.

Waivers Changing Retroactive Benefits

On October 26, 2017, CMS approved an amendment to Iowa's Section 1115 demonstration waiver eliminating three-month retroactive coverage for nearly all new Medicaid applicants as of November 1, 2017. Those affected include low-income parents, children over age one, ACA expansion adults, seniors, and people with disabilities. Retroactive coverage waivers have also been approved in a limited number of other states with certain conditions.

Federal law directs state Medicaid programs to cover (and provides federal matching funds for) medical bills incurred up to three months prior to a beneficiary's application date. To qualify for retroactive coverage, a Medicaid beneficiary must have been eligible for coverage during the three months prior to application when the bill was incurred, and the services must be those that Medicaid covers.

Some people may not become eligible for Medicaid until after they experience a traumatic event, such as a fall or a stroke, that requires hospitalization and long-term care. Also, many people mistakenly think that Medicare covers long-term care and often do not learn about Medicaid until they need to seek a nursing home placement or other long-term care services. The initial focus is often on stabilizing the person's medical condition, and it may take several days or weeks for the patient, their family, and providers to figure out complex medical issues before they turn to consider payment, including Medicaid eligibility. During this time, sizeable medical bills can start adding up. Retroactive coverage protects patients and providers by ensuring that medical bills are paid even if a Medicaid application is not filed immediately following the need for care.

Initially, Iowa's Section 1115 demonstration waiver was limited to adults newly eligible under the ACA and did not apply to traditional Medicaid populations. However, on October 26, 2017, CMS approved an amendment to Iowa's waiver, eliminating three-month retroactive coverage for nearly all new Medicaid applicants as of November 1, 2017. Coverage for people affected by Iowa's waiver will now begin no earlier than the first day of the application month.

In approving Iowa's retroactive coverage waiver, CMS concluded that Medicaid program objectives are furthered "by encouraging beneficiaries to obtain and maintain health coverage, even when healthy." For seniors and people with disabilities seeking long-term care coverage, CMS states that "this waiver will encourage beneficiaries to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility to ensure primary or secondary coverage through Medicaid to receive these services if the need arises." Iowa's waiver amendment submission to CMS acknowledged that most of the public comments received were opposed to the elimination of three-month retroactive coverage. However, the state "assures CMS that it will provide outreach and education about how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by this change."

Iowa admits the change is being made to reduce program costs and estimated that eliminating retroactive coverage would likely reduce monthly enrollment by about 3,400 enrollees and reduce federal and state Medicaid expenditures by $36.8 million annually ($9.7 million state share)."

Other States with Waivers for Retroactive Eligibility

Prior to Iowa's waiver, CMS (under the Obama Administration) waived retroactive eligibility for certain populations as part of three other ACA expansion waivers (New Hampshire, Arkansas, and Indiana) provided that certain conditions to safeguard beneficiaries were met. Unlike Iowa, these waivers do not apply to seniors and people with disabilities.

Delaware, Massachusetts, Maryland, Tennessee, and Utah have retroactive coverage waivers that pre-date the ACA. Some of these waivers apply to limited populations, and most have exceptions for seniors and people with disabilities. Florida was the latest state to obtain a waiver for retroactive eligibility, receiving approval in December 2018.

What to Watch in 2019

Other states may seek similar waivers. For example, Kentucky's pending retroactive coverage waiver application includes most populations (except pregnant women and children under age one). The new transparency rules, including public notice and comment periods at the state and federal levels, help stakeholders learn about state proposals and provide input.

The steps that states take to encourage eligible people to enroll in Medicaid and prevent delays in coverage that can lead to unpaid medical bills will be an important area to watch. Navigating the Medicaid application process can be confusing, particularly for seniors and people with disabilities who are seeking long-term care coverage. Eliminating retroactive coverage means that the ability to recognize eligibility and apply as quickly as possible will become very important, to minimize unpaid bills.

Evaluations can provide information about the impact of retroactive coverage waivers on beneficiaries and providers, and whether these waivers help promote or hinder access to coverage and care, specifically for seniors, people with disabilities, those with long-term care needs, children, and adults. It will also shed light on providers' uncompensated care costs.

Other Recently Approved Section 1115 Medicaid Waivers Include:

- Coverage lock-outs for failure to timely renew coverage or report changes affecting eligibility
- Approval to charge premiums up to 4% of family income
- Premium surcharge for tobacco users
- Fees for missed appointments
- Elimination of non-emergency medical transportation (NEMT)
- Healthy behavior incentives tied to premium or cost-sharing reductions
- Allowing states to use federal Medicaid funds to pay for mental health and substance use treatment services in institutions for mental disease (IMDs) with no limit on the number of days; expanding community-based behavioral health benefits; and expanding Medicaid eligibility to cover additional people with behavioral health needs

Waiver Provisions Not Always Approved

It is also important to note that CMS has not approved some state waiver proposals. For example, it did not approve requests in Arkansas or Massachusetts to limit ACA expansion eligibility to 100% of the federal poverty limit (FPL) with the enhanced match. CMS also rejected Kansas' proposal to impose a lifetime limit on Medicaid benefits for eligible beneficiaries. Also, Massachusetts' proposed waiver amendment requesting a closed prescription drug formulary was denied.

Conclusion

We care deeply about issues that affect the elderly, the disabled, and our Veterans and will continue to watch future developments, especially restrictions to Medicaid benefits and how they affect our most vulnerable, to keep you informed.

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