Response to SR 163 of the 2017 Regular Legislative Session

Louisiana Department of Health

Bureau of Health Services Financing

August 20, 2017

LOUISIANA DEPARTMENT OF HEALTH

Contents

Preface

As per Senate Resolution 163 of the 2017 Regular Legislative Session, the Louisiana Department of Health (henceforth "LDH") submits this monthly report on the Medicaid expansion population and the experience of other state Medicaid programs with work requirement and cost sharing initiatives.

Many state Medicaid programs have established various cost sharing mechanisms and are choosing to engage in work requirements, particularly for the expansion population. The current version of the federal American Health Care Act of 2017 includes optional provisions for states to adopt work requirements. Populations that could be subject to work requirements include nondisabled, nonelderly, non-pregnant Medicaid adults. Excluded groups include:

- pregnant women through 60-days post-partum
- children under 19
- sole parent/caretaker in family for child under 6 or child with disability
- individuals under age 20 who are married or head of household and maintain satisfactory secondary school or equivalent program attendance or participate in education directly related to employment.[1]

Cost sharing is a payment mechanism whereby Medicaid recipients could be personally responsible for copayments, coinsurance, deductibles, or similar charges on both inpatient and outpatient services. However, it is subject to certain federal restrictions. It cannot be imposed on emergency services, pregnancy related services (including tobacco cessation), or preventive services for children, and exempted groups include:

- Children under age 18 (or 19, 20, or 21 at the state's option)
- Individuals living in an institution who are required to contribute all of their income (except a minimum amount required for personal needs) toward the cost of their care
- Individuals receiving hospice care or terminally ill individuals
- American Indians and Alaska Natives who have ever received a service from the Indian Health Service, tribal health programs, or under contract health services referral
- Women who are enrolled in Medicaid under the Breast and Cervical Cancer Treatment Program are exempted from Alternative out of pocket costs only.[2]

While services cannot be withheld for failure to pay, enrollees may be held liable for unpaid copayments. The maximum allowable amount for copayments allowed is detailed in the table below.

[1] MaryBeth Musumeci, Medicaid and Work Requirements, (The Henry J. Kaiser Family Foundation, March 2017). Accessed July 2017: http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/

[2] Accessed July 2017: https://www.medicaid.gov/medicaid/cost-sharing/cost-share-exemp/index.html

Maximum Allowable Copayments For FY 2013

Services and Supplies	Eligible Populations by Family Income		
	100% FPL	101-150% FPL	>150% FPL
Institutional Care (inpatient hospital care, rehab care, etc.)	$75	10% of the cost the agency pays for the entire state	20% of cost the agency pays for the entire state
Non-Institutional Care (physician visits, physical therapy, etc.)	$4.00	10% of costs the agency pays	20% of costs the agency pays
Non-emergency use of the ER	$8.00	$8.00	No limit *within 5% aggregate limit
Drugs Preferred drugs Non-preferred drugs	 $4.00 $8.00	 $4.00 $8.00	 $4.00 20% of cost the agency pays

Source: Medicaid.gov at https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html

A more detailed accounting of the status of those measures and specified utilization data for Louisiana's Medicaid expansion program are enclosed within as per the requirements of the legislation.

Due to the higher complexity of some of the requested data elements, some sections of this report are currently in development as the data are being compiled and vetted for accuracy. Finalization of all data sections is anticipated for the next monthly report.

Louisiana Medicaid Expansion Population

NUMBER OF INDIVIDUALS ENROLLED IN MEDICAID FOR THE REPORTING PERIOD WHO ARE ELIGIBLE AS PART OF THE EXPANSION POPULATION.

In July 2017, there were 432,215 unduplicated members enrolled in Medicaid under expansion.

NUMBER OF INDIVIDUALS AGE NINETEEN TO FORTY-NINE AND NUMBER OF INDIVIDUALS AGE FIFTY TO SIXTY-FOUR.

Table 1: Expansion enrollment by age cohort, SFY 2018 - July

AGE Group	Unduplicated Recipient Count
Ages 19 to 49	334,644
Ages 50 to 64	97,571

Source: Medicaid Data Warehouse

NUMBER OF INDIVIDUALS IN EACH AGE CATEGORY WITH EARNED INCOME.

Table 2: Unduplicated expansion enrollment with earned income by health plan, SFY 2018 - July

Health Plan	Age 19 - 49	Age 50 – 64	Total
Aetna	21,867	7,080	**28,947**
AMG	37,238	7,848	**45,086**
ACLA	30,906	6,936	**37,842**
LHCC	64,563	12,329	**76,892**
UHC	67,807	13,218	**81,025**
No MCO Info*	982	158	**1,140**
Total By Age Group	**223,363**	**47,569**	**270,932**

*Member could be pending auto-assignment

NUMBER OF INDIVIDUALS IN EACH AGE CATEGORY ASSIGNED TO A MEDICAID MANAGED CARE ORGANIZATION (MCO), IDENTIFIED BY EACH INDIVIDUAL MCO.

Table 3: Unduplicated expansion enrollment by health plan, SFY 2018 - July

	Health Plans				
AGE Group	AETNA	AMG	ACLA	LHCC	UHC
Ages 19 to 49	36,615	56,416	47,793	93,825	99,995
Ages 50 to 64	15,407	16,265	14,458	24,289	27,152

Source: Medicaid Data Warehouse

Table 4: Expansion per member per month payments by health plan, SFY 2018 - July

Health Plans				
AETNA	**AMG**	**ACLA**	**LHCC**	**UHC**
$27,791,794	$36,725,236	$31,746,386	$59,143,398	$64,229,068

Source: Medicaid Data Warehouse

Note: Initial report included PMPM payments for SFY 2017 made as of July 26, 2017. Ongoing reporting will include PMPM payments made during reporting month only.

Medicaid Expansion Utilization

Comparison of individuals age nineteen to forty-nine, age fifty to sixty-four, and those who are covered by Medicaid who are not part of the expansion population utilizing the following services during the reporting period:

- *Emergency department*
- *Prescription drugs*
- *Physician services*
- *Hospital services*
- *Non-emergency medical transportation*

Expenditures associated with each service for individuals age nineteen to forty-nine, age fifty to sixty-four, and those who are covered by Medicaid who are not part of the expansion population during the reporting period.

Table 5: Service expenditures for expansion enrolled individuals, SFY 2018 - July

	Expansion											
	ER		Hospital Inpatient		Hospital Outpatient		NEMT		Pharmacy		Physician	
Age Group	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments
Age 19-49	16,333	$2,614,919	1,137	$3,945,888	30,241	$6,294,791	1,156	$121,160	85,474	$13,633,509	48,266	$5,927,244
Age 50-64	4,114	$731,126	418	$1,860,512	14,537	$3,909,370	960	$66,429	44,006	$8,274,462	19,788	$3,139,116

Table 6: Service expenditures for non-expansion enrolled individuals, SFY 2018 - July

	Regular/Non-Expansion											
	ER		Hospital Inpatient		Hospital Outpatient		NEMT		Pharmacy		Physician	
Age Group	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments
Age 0-18	16,394	$2,242,052	1,107	$3,251,288	31,232	$4,169,998	1,165	$104,657	105,920	$12,943,359	102,006	$10,405,259
Age 19-49	9,841	$1,666,651	1,325	$4,843,098	19,239	$4,103,365	1,896	$140,567	53,920	$11,771,532	31,972	$4,398,691
Age 50-64	3,129	$589,856	453	$1,990,467	9,356	$2,756,103	2,442	$143,380	30,832	$10,451,310	14,093	$2,255,338
Age 65+	51	$8,012	21	$134,529	221	$43,786	772	$39,952	5,630	$397,784	426	$64,167

State Waiver Initiatives

Tables 5 and 6 below reflect key themes found in LDH's research regarding other state expansion waivers and also additional pending provisions requested in those waivers that have not been approved or implemented yet.

Table 7: Key Themes in Approved ACA Expansion Waivers as of August, 2017[3]

	AR	AZ	IA	IN	MI	MT	NH
Premium Assistance	QHP & ESI*		ESI	ESI	QHP		QHP
Premiums/Monthly Contributions	X	X	X	X	X	X	
Healthy Behavior Incentives		X	X	X	X		
Waive Required Benefits			X	X			
Waive Reasonable Promptness				X			
Waive Retroactive Eligibility	X			X			X
Co-payments Above Statutory Limits				X			
12-month Continuous Eligibility						X	

**Note: QHP = Qualified Health Plan; ESI = Employer Sponsored Insurance*

Table 8: Pending Provisions Not Approved as of August, 2017[4]

	AR	AZ	IN	KY
Population(s) Affected	Expansion Adults	Expansion and Traditional Adults	Expansion and Traditional Adults	Expansion and Traditional Adults
Work Requirement	X	X	X	X
Time Limit on Coverage		X		
Limit Expansion Eligibility to 100% FPL with Enhanced Match	X			
Monthly Income Verification and Eligibility Renewals		X		
Lock-out for Failure to Timely Renew Eligibility			X (expansion adults)	X
Tobacco Surcharge			X	

[3] MaryBeth Musumeci, Elizabeth Hinton, Robin Rudowitz, Key Themes in 1115 Medicaid Expansion Waivers, (The Kaiser Family Foundation, August 16, 2017). Accessed August 2017: http://www.kff.org/medicaid/issue-brief/key-themes-in-section-1115-medicaid-expansion-waivers/

[4] Ibid.

STATES THAT HAVE SUBMITTED WAIVER REQUESTS TO CMS TO IMPLEMENT WORK REQUIREMENTS OR OTHER COMMUNITY ENGAGEMENT INITIATIVES OR ACTIVITIES AS A CONDITION OF ELIGIBILITY FOR ABLE-BODIED MEDICAID RECIPIENTS TO INCLUDE THE NAME OF THE STATE, THE YEAR THE WAIVER WAS SUBMITTED, WHETHER THE WORK REQUIREMENT IS OPTIONAL OR A MANDATORY CONDITION OF ELIGIBILITY, THE POPULATION COVERED, A SHORT SUMMARY OF THE PROPOSAL, AND THE CURRENT STATUS OF THE WAIVER APPLICATION.

Table 7 below reflects preliminary research performed by the department on waiver requests regarding Medicaid work requirements in other states. Additional research will follow in the next monthly report.

Table 9: Work Requirement Waiver Status by State[5][6][7]

State	Year	Condition of Medicaid Eligibility	Population	Proposal	Status as of 03/2017
Arizona	2015	Yes	Able-bodied expansion and traditional adults	Work, actively seek work, or attend school or job training for 20 hours/week; also proposed voluntary work incentive program for medically frail expansion adults	Denied by CMS
	2017	Yes	Includes able-bodied expansion and traditional adults; excludes full-time high school students, sole caregiver for family member under age 6, receiving temporary or permanent long-term disability benefits, determined physically or mutually unfit for work by health care professional	Work, actively seek work, or attend school or job training for 20 hours/week; requires monthly verification and one year lock-out for making false statement	Submitted to CMS 05/03/2017
Arkansas	2017	Yes	Expansion adults	Work requirement	Submitted to CMS 06/30/2017
Indiana	2015	Yes	Expansion adults	Work referral	Not included as part of waiver approval by CMS – state established

[5] MaryBeth Musumeci, Medicaid and Work Requirements (The Henry J. Kaiser Family Foundation, March 23, 2017). Accessed August 2017: http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/

[6] Montana did not seek § 1115 authority for a work program as part of its Medicaid expansion waiver, but state law creates a state-funded voluntary program.

[7] Additional sources: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/dynamic-list/WA-508.xml

					separate voluntary state-funded work search and job training program
Kentucky	2016	Yes-benefits suspended for failure to comply and not reinstated until compliance for full month	Includes all able-bodied working age adults; excludes children, pregnant women, medically frail, students, and primary caregivers of dependents	Volunteer work, employment, job search, job training, education, or caring for non-dependent relative or person with disabling chronic condition for 5 hours/week in year one and 20 hours/week in year two	Waiver application pending with CMS - modifications proposed 07/03/2017
New Hampshire	2015	No	Expansion adults	Referral to state job counseling service if unemployed	Not included as part of waiver approval by CMS
Ohio	2016	No	Expansion and traditional adults 18 and older	Referral to work development agency if not working 20 hours/week	Waiver application denied in its entirety by CMS
Pennsylvania	2014	Yes beginning in year two, would lose eligibility for 3 months, then 6 months, then 9 months for continued noncompliance	Expansion and traditional adults, ages 21 to 64; exemption for those experiencing crisis, serious medical condition, or temporary condition that prevents work search such as domestic violence or substance use treatment. Excluded: seniors, children under 21, pregnant women, SSI beneficiaries, those in institutions, dual eligible, & full and part-time students must register but do not have to complete work activities	20 hours/week of work or complete 12 job training and employment-related activities/month; those working more than 20 hours/week could have premiums or cost-sharing reduced or other incentives beginning in year two	Not included as part of waiver approval by CMS; previous administration planned to offer incentives for Medicaid beneficiaries who chose to participate in state-funded job training and work activity (current gubernatorial administration did not pursue this program)
Utah	2014	No, although state was considering sanctions related to benefits under other state programs for noncompliance	Able-bodied expansion adults	Automatic enrollment in work program with access to online assessment, job training, and job postings upon Medicaid application	Not seeking waiver authority for work proposal and overall waiver was ultimately never submitted to CMS

STATES THAT HAVE SUBMITTED WAIVER REQUESTS TO CMS WITH COST-SHARING PROVISIONS SUCH AS PREDICTABLE MONTHLY PREMIUM PAYMENTS, COPAYMENTS, HEALTH SAVINGS ACCOUNTS, REWARDS ACCOUNTS, OR OTHER COST COMPONENTS FOR ABLE-BODIED MEDICAID RECIPIENTS CONSISTENT WITH COMMERCIAL INSURANCE TO INCLUDE THE NAME OF THE STATE, THE YEAR THE WAIVER WAS SUBMITTED, WHETHER THE COST-SHARING IS OPTIONAL OR A MANDATORY CONDITION OF SERVICE RECEIPT, THE POPULATION COVERED, A SHORT SUMMARY OF THE PROPOSAL, AND THE CURRENT STATUS OF THE WAIVER APPLICATION.

Table 8 below reflects preliminary research performed by LDH on cost sharing waiver requests and implementation in other states. Additional research will follow in the next monthly report.

Table 10: Cost Sharing Waiver Status by State[89]

State	Year submitted	Population covered	Cost-sharing optional	Summary of proposal	Current status of waiver
IA	2013, amendment in 2015	Adults ages 19-64 from 101-138% FPL	No	After first year of enrollment, beneficiaries with income from 50-100% FPL pay $5/month premium. Cannot be disenrolled for non-payment. Beneficiaries with income from 101 - 138% FPL pay $10/month premium. Can be disenrolled for non-payment. State must waive premium for beneficiaries who self-attest to financial hardship. Unpaid premiums will be considered debt to state, which will be forgiven if the beneficiary does not re-apply or is no longer Medicaid-eligible at renewal. Premiums can be waived if beneficiaries complete specified healthy behavior activities. Cost sharing limited to 5% of quarterly income, including premiums. Co-pay required for non-emergency use of the ER beginning in year two of enrollment.	Approved 12/2013, Extended 11/2016
		Adults ages 19-64 from 50-100% FPL	Yes		
		Exempt: Adults age 19-64 with income below 50% FPL, those who are medically frail, and American Indians/Alaska Natives			
MI		Working parents from 64-138% FPL	No	Expansion adults with income from 100-138% FPL pay monthly premiums of 2% of income (~$20-	Approved 12/2013,

[8] MaryBeth Musumeci and Robin Rudowitz, The ACA and Medicaid Expansion Waivers, (The Henry J. Kaiser Family Foundation, updated November 2015). Accessed August 2017: http://www.kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief/

[9] Additional sources: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/dynamic-list/WA-508.xml https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html

	11/2013, amendment in 09/2015	Jobless parents from 37-138% FPL Childless adults from 0-138% FPL		27/month) into health accounts for services used in the previous six months. Failure to pay does not result in loss of Medicaid eligibility, past due premiums can be recouped from state income tax refunds or lottery winnings. Payments are due until six months of enrollment. Compliance with specified healthy behaviors results in a 50% reduction in future premiums for those above poverty and a $50 gift card for those below poverty.	extended 12/2015
IN	06/2014, extension request 08/2016	Working parents from 24-138% FPL Jobless parents from 18-138% FPL Childless adults from 0-138% FPL	No	Premiums are 2% of income for all waiver beneficiaries (including some traditional Medicaid enrollees such as parents). This with income 0-5% FPL (up to $50/month in 2016) pay a flat $1.00/month. Premiums are paid into a Personal Wellness and Responsibility (POWER) health account. Adults with income from 100-138% FPL must pay a premium to effectuate coverage, those who fail to pay premiums within 60 days are dis-enrolled and locked out of coverage for six months. Coverage for expansion adults from 0-100% FPL who fail to pay premiums within 60 days are moved to a more limited benefit package (HIP Basic, without dental and vision benefits and with more limited prescription coverage) and incur point-of-service copayments. Traditional Medicaid enrollees who do not pay premiums are guaranteed state plan benefits. Graduate copayments ($8 for first visit and $25 for second visit) for non-emergency use of ER. Health plans provider care after exhausting the $2,500 POWER account deductible (funded by the state and beneficiary premiums).	Approved 01/2015, temporary extension 11/2016
AR	08/2013, renewal request 07/2016	Childless adults from 0-138% FPL Adult parents from 17-138% FPL	No	Enrollees with incomes above 100% FPL will be subject to premiums of up to 2% of household income. Failure to pay premium within a 90-day grace period will incur a debt to the state. Incentive	Initial application approved 09/2013,

		Exemptions: Dual eligibles, individuals who are medically frail/have exceptional medical needs who do not have access to cost effective ESI, individuals who are medically frail/have exceptional medical needs who have access to cost-effective ESI through a participating employer and choose to receive standard Medicaid coverage under the State Plan		benefit (e.g., dental services) for new adult population available to those who make timely premium payments and achieve healthy behavior standards. All beneficiaries will receive information on referrals to work and work training opportunities.	renewal approved 01/2017, amendment approval pending.
MT	03/2016 amendment application submitted	Childless adults from 0-138% FPL and parents from 50-138% FPL	No	State can charge enrollees monthly premiums of 2 percent of aggregate household income for people with incomes 50-138% FPL and childless adults with income 0-138% FPL. Enrollees with income at or below 100% FPL cannot be disenrolled for failure to pay premium. Enrollees above 100% FPL who fail to make a premium payment after a 90-day grace period may be disenrolled, can be re-enrolled upon payment of arrears or when deb is assessed, the state will establish a process to exempt individuals from disenrollment for good cause. Premium payments will be a credit toward copayment obligations so that they shall not accrue out of pocket expenses for copayments until copayments exceed 2 percent of household income. Preventive health services, immunizations, and medically necessary health screenings exempt from copayments. [10]	Amendment approval pending

[10] Montana Section 1115 Waiver for Additional Services and Populations (December 5, 2016). Accessed July 2017: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-basic-medicaid-fs.pdf

AZ	07/2016	All Medicaid expansion adults from 0-138% FPL	No	Monthly premium of 2% of income or $25 (whichever is less) and copayments up to 3% of income which would be paid monthly into HSAs for services already used instead of at point of service. Enrollees from 101-138% FPL would be disenrolled and locked out of Medicaid eligibility for six months for non-payment of premiums and co-payments. Also proposed imposing co-payments in excess of federal limits for non-emergency use of ER and missed appointments. Beneficiaries below 100% FPL would not lose Medicaid eligibility for failure to pay, but would have unpaid amounts counted as a debt to the state. Monthly payments for beneficiaries from 101-138% FPL could reduce monthly payments for complying with healthy behaviors and work incentives.	Approved

For additional information, the following resource from The Kaiser Family Foundation provides a state by state survey of cost sharing requirements by eligibility group as of January 2017:

http://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey/