

Response to SR 163 of the 2017 Regular Legislative Session

Louisiana Department of Health

Bureau of Health Services Financing

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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 some are choosing to engage in work requirements, particularly for the expansion population. Populations that federal regulations allow to be subject to work requirements include nondisabled, nonelderly, non-pregnant Medicaid adults. Excluded groups include:

- Women during pregnancy through the end of the month following 60 days post-delivery;
- Children under 19 years old;
- Individuals who are the only parent or caretaker relative of a child younger than 6 or a child with disabilities;
- Married individuals under 20 years old who are in secondary school or in an educational program directly related to employment.¹

Cost sharing is a payment mechanism whereby Medicaid recipients are 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. 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 S.Amdt.586 — 115th Congress (2017-2018). Congressional Record Online, Government Publishing Office. <https://www.congress.gov/amendment/115th-congress/senate-amendment/586/text>

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

- Deductible \$2.65
- Managed Care Copayment \$4.00³

Outpatient and Inpatient services for persons under 100% FPL are subject to the CPI-U annual update. Total Medicaid premiums and cost-sharing incurred by all individuals in a Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis. 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.

³ Source: 78 *Fed. Reg.* 42307-42310. (July 15, 2013). Medicaid.gov at <https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html>

Executive Summary

In the Centers for Medicare and Medicaid Services (CMS) State Medicaid Director letter on January 11, 2018 (SMD: 18-002)⁴, CMS formally announced its support of demonstration waivers implementing work and community engagement requirements among Medicaid beneficiaries with certain exclusions.

Section 1115 of the Social Security Act (SSA) allows the Secretary of Health and Human Services to approve a state Medicaid demonstration if, “in the judgment of the Secretary,” the demonstration “is likely to assist in promoting the objectives of . . . Title XIX.” Under Section 1115, the Secretary can (1) “waive compliance with any of the requirements of section . . . 1902” of the SSA; and (2) and can approve “costs of such project which would not otherwise be included as expenditures under section . . . 1903” of the SSA. To date, a number of States applied to implement work requirements, including Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, Mississippi, New Hampshire, Utah, and Wisconsin. CMS approved the Kentucky application on January 11, 2018.⁵

On July 1, 2016, per Executive Order JBE 16-01, Louisiana expanded Medicaid coverage under the Affordable Care Act to adults aged 19 through 64 under 138 percent of the Federal Poverty Level. A healthier workforce is essential for Louisiana’s economic growth. Medicaid Expansion is a major step to improving the productivity of our workforce, as proven in other states. Studies of Medicaid expansion in Ohio and Michigan found that the majority of beneficiaries said that getting health coverage helped them look for work or remain employed.⁶

Medicaid serves as a lifeline for the more than two-thirds of Louisianans who are already employed but are not earning enough to afford health insurance. In Louisiana, expansion has enabled over 450,000 adults to receive health insurance and necessary preventative care, of which, at minimum, 76 percent have reported earned or other income. Of those who are not working, many are either in school or are caring for family members; others are too ill or disabled to work and need the quality healthcare Medicaid provides to help them re-enter the workforce; or are retired.

Personal responsibility by being employed or taking advantage of opportunities to look for job, to get an education, to get some kind of additional education, caregiving, or to do community service demonstrates appropriate stewardship of taxpayer dollars. However, removing people from of the Medicaid program could end up driving up uninsured costs that fall on hospitals, health providers and the state.

In its State Medicaid Director letter *RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries* (SMD 18-002) dated January 11, 2018, CMS has acknowledged that the best way to improve long-term health of low-income Americans is to empower them with skills and employment. CMS is committing to support states through approval of demonstration waivers requiring eligible adult beneficiaries to engage in work or community engagement activities in order to determine whether those requirements lead to improved health outcomes. CMS has declared that states will be required to describe strategies to assist beneficiaries in meeting work and community engagement requirements and to link individuals

⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

⁵ <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=39258>

⁶ <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>

to additional resources for job training or other employment services, child care assistance, transportation, or other work supports to help beneficiaries prepare for work or increase their earnings. However, this demonstration opportunity **will not** provide states with the authority to use Medicaid funding to finance these services for individual.

However, it should be noted that while allowing work and community engagement requirements is a major policy shift, it will only impact a small percentage of the Medicaid population. The CMS guidance makes clear that states must exempt the vast majority of Medicaid enrollees from these requirements (e.g., children, pregnant women, elderly individuals, individuals with disabilities, many individuals receiving substance use disorder services) as detailed below.

Limits on the Application of Work and Community Engagement Requirements⁷

SMD Letter #18-002 imposes a number of limits on the populations to which work and community engagement requirements can be applied.

First, CMS expressly states that work and community engagement requirements can only be applied to working-age, non-pregnant adult Medicaid beneficiaries in an eligibility group that is not based on disability.

Second, CMS will require states to ensure there is an exception process for any individual with an “illness or disability” that might interfere with his or her ability to comply with a work requirement, even if that individual is not eligible for Medicaid based on disability. CMS recognizes Medicaid recipients may have a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or section 1557 of the Affordable Care Act.

Third, in alignment with the recently declared opioid epidemic public health emergency, CMS will require States to make “reasonable modifications” to their work requirements for individuals with substance use disorders to ensure that eligible individuals with opioid addiction and other substance use disorders have access to appropriate Medicaid coverage and treatment services. This could include counting time spent in medical treatment as meeting the requirement or as an exemption.

Fourth and finally, “[i]ndividuals enrolled in and compliant with a TANF or SNAP work requirement, as well as individuals exempt from a TANF or SNAP work requirement, must automatically be considered to be complying with the Medicaid work requirements.” In addition, CMS encourages states to align any work or work-related requirements with those imposed in their SNAP or TANF programs.

⁷ Covington. *Joint State Advisory 18-1: CMS Announces It Will Allow States to Impose Work Requirements*. (Jan. 12, 2018). <https://covcommunicate.com/97/1049/uploads/joint-state-advisory-18-1---cms-announces-it-will-allow-states-to-impose..-.pdf>

Louisiana Medicaid Expansion Population

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

In March 2018, there were 471,959 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 - March

AGE Group	Unduplicated Recipient Count
Ages 19 to 49	366777
Ages 50 to 64	105182

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 - March

Health Plan	Age 19 - 49	Age 50 – 64	Total
Aetna	23,012	7,396	30,408
ACLA	33,638	7,343	40,981
HBL	43,456	9,452	52,908
LHCC	71,782	13,471	85,253
UHC	76,429	14,572	91,001
Total By Age Group	248,317	52,234	300,551

Source: MEDS

NOTE: This table reflects total expansion enrollment with reported earned income as per the SR 163 requirement. It is not limited to able-bodied adults and so may include disabled or other exempted persons from work requirements as per the CMS SMD: 18-002 letter. Additionally, it does not include persons with other reported income (disability, retirement, etc.).

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 - March

AGE Group	Health Plans				
	AETNA	ACL A	HBL	LHCC	UHC
Ages 19 to 49	37,761	50,827	64,793	102,914	110,482
Ages 50 to 64	15,687	14,881	19,031	26,258	29,325

Source: Medicaid Data Warehouse

THE PER-MEMBER PER-MONTH COST PAID TO EACH MCO TO MANAGE THE CARE OF THE INDIVIDUALS ASSIGNED TO THEIR PLAN, IDENTIFIED BY EACH INDIVIDUAL MCO.

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

Health Plans					
AETNA	ACL A	HBL	LHCC	UHC	Total
\$27,518,778	\$31,714,102	\$40,376,088	\$60,514,530	\$66,811,073	\$226,934,572

Source: Medicaid Data Warehouse

NOTE: Amendments 10 and 11 effective November 1, 2017 and associated rate-setting were finishing development at the time of December PMPM payments. As a result, December PMPMs were paid as a lump sum. Rate-setting has now been finalized, and recoupment of lump sums followed by payment of capitation rates at the member level took place in March 2018.

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.

Total expenditures within these reporting categories for the expansion population in March 2018 was \$52,732,813 and \$78,988,244 for non-expansion as detailed in Tables 5 and 6 below. It is important to note that the expenditure data below represents a point in time data extraction for claims received for dates of service during the reporting period. Providers have 365 days to file a claim for Medicaid reimbursement. Therefore, in keeping with the instructions of SR 163, the data below represents the prior month's expenditures only. This data will not reflect all services rendered during the reporting period without appropriate time lapse allowing for claims lag (i.e., 365 days from the date of service).

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

Age Group	Expansion											
	ER		Hospital Inpatient		Hospital Outpatient		NEMT		Pharmacy		Physician	
	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments
Age 19-49	15,816	\$2,650,876	1,066	\$3,881,064	32,354	\$6,946,305	922	\$105,063	90,392	\$14,904,771	51,333	\$6,048,233
Age 50-64	3,730	\$717,365	285	\$1,230,935	15,668	\$4,363,596	819	\$62,589	44,678	\$8,756,153	20,924	\$3,062,707

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

Age Group	Non-Expansion											
	ER		Hospital Inpatient		Hospital Outpatient		NEMT		Pharmacy		Physician	
	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments
Age 0-18	18,949	\$2,716,488	1,053	\$2,782,395	38,396	\$5,125,864	614	\$75,598	130,314	\$14,213,308	122,158	\$12,006,866
Age 19-49	7,994	\$1,390,471	1,023	\$3,551,965	18,159	\$3,754,851	1,066	\$85,842	48,795	\$11,335,477	29,003	\$3,867,644
Age 50-64	2,578	\$534,506	381	\$1,731,986	9,044	\$2,795,870	1,396	\$91,001	28,421	\$10,154,678	13,125	\$2,047,983
Age 65+	57	\$11,461	11	\$86,017	267	\$127,689	488	\$24,981	5,363	\$407,006	455	\$68,295

State Waiver Initiatives

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 summary research performed by the department on the status of waiver requests regarding Medicaid work requirements in other states.

Table 7: Work Requirement Waiver Status by State as of April 2018⁸⁹

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Approved						
Arkansas	Arkansas Works	2017	Yes	Phased in by age group, ultimately enrollees ages 19-49. Exemption criteria: income consistent with being employed or self-employed at least 80 hrs per month, student, exempt from SNAP work requirements, receiving TEA Cash Assistance, short-term incapacitation, caregiver for an incapacitated person or dependent child under age 6, lives in a home with a minor dependent child age 17 or younger, receiving unemployment.	Members must demonstrate monthly that they are meeting SNAP work requirements, or completing at least 80 hrs/week combination of following activities: employed or self-employed, educational program, on-the-job training, vocational training, volunteering, job search, job search training, health insurance class, Arkansas Dept of Workforce Services activities.	Approved 3/4/2018

⁸ 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/>

⁹ 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>

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Indiana	Healthy Indiana Plan 2.0	2017	Yes	All able-bodied, working age adult HIP members who are unemployed or working less than 20 hours per week averaged over eight months of the eligibility period. Exemptions: full or part-time students, employed members working more than 20 hours/week, pregnant women, primary caregivers of dependent child below compulsory education age or disabled dependent, medically frail, certified temporary illness or incapacity, active substance use disorder treatment, members over the age of 60, former foster children under age 26, chronically homeless individuals, TANF recipients, recently incarcerated.	Referral to available job training, work search, or employment through the Gateway to Work program (launched as a voluntary participation program in 2015). Will be required to work on average 20 hours per week over eight months during eligibility period, be enrolled in full-time or part-time education, or participate in Gateway to Work. Members who fail to complete the required hours will be suspended from HIP until the member satisfies the Gateway to Work participation requirements for one full month.	Approved 1/31/2018
Kentucky	Kentucky HEALTH	2016	Yes	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 beginning after three months of program eligibility. Number of engagement hours increases from 0-20 over the course of the first year of eligibility. Benefits suspended for failure to comply and not reinstated until compliance for full month.	Approved 1/11/2018

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Pending						
Arizona	Arizona Health Care Cost Containment System	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 5/3/2017
Kansas	KanCare	2017	Yes	Able-bodied adults. Exclusions: members receiving long-term care, those enrolled in HCBS waiver programs (autism, serious emotional disturbance, technology assisted, frail elderly, traumatic brain injury, intellectual and developmental disabilities, and physical disability), children, pregnant women, members receiving SSI for disabilities, caretakers for dependent children under six or those caring for a household member with a disability, beneficiaries with a retroactive eligibility period, MediKan members, persons whose only coverage is under a Medicare Savings Program, PACE enrollees, and members with TBI, HIV, or in	Align KanCare work requirements with TANF program requirements. Min 20-30 hrs/week in one-adult household, 35-55 hrs/week in two-adult household, max requirement for an individual is 40 hrs/week. Work includes unsubsidized employment, subsidized public employment, subsidized private employment, work experience, on-the-job-training, supervised community service, vocational education, job search/job readiness, job readiness case management, job skills training directly related to employment, education related to employment, secondary school attendance. Those who do not meet work requirements can have max KanCare coverage of 3 months out of 36 month period.	Submitted 12/19/2017

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
				the Breast and Cervical Cancer Program.	Members who meet work requirements can enroll in KanCare for 36 months.	
Maine	MaineCare	2017	Yes	Individuals ages 19 and 64. Exemptions: institutionalized, residential substance abuse or rehabilitation program, caring for dependent child under age six, providing caregiver services for an incapacitated adult, pregnant, physically or mentally unable to work more than 20 hours/week, receiving temporary or permanent disability benefits.	Compliance includes at least one of the following activities: work in paid employment at least 20 hours/week; if self employed, earnings must equal 20 hours/wk at minimum wage rate; participate in and comply with approved work program for at least 20 hours/wk; workforce or volunteer community service 24 hours/month; individual or group job search and job readiness assistance; student; combination of employment and education to achieve 20 hours/week; receiving unemployment benefits; complying with work requirements for SNAP or TANF. Members deemed required to work may receive up to three months of MaineCare coverage in a 36 month period without meeting the community engagement and work requirements. MaineCare may authorize additional months of eligibility in exceptional circumstances.	Submitted 8/4/2017

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Mississippi	Medicaid Workforce Training Initiative	2018	Yes	Non-disabled adults, including low-income parents and caretakers, and individuals eligible for transitional medical assistance. Exemptions: diagnosed mental illness, SSDI or SSI, primary caregiver of person who cannot care for themselves, physically or mentally unable to work, receiving or applied for unemployment insurance, participating in alcohol or other drug abuse treatment program, enrolled at institution of higher learning at least half-time, high school student age 19 or older attending high school at least half-time, treatment for cancer including through Department's Breast and Cervical Cancer Program.	Working in paid employment at least 20 hours/week, Self-employed at least 20 hours/week, participating with Office of Employment Securing, volunteering with approved agencies, participating in an alcohol or other drug abuse treatment program, or compliant with SNAP and TANF work requirements. Eligibility lost on first day of the month following report of non-compliance. Reinstated upon future compliance, provided they are within original period of eligibility.	Submitted 1/15/2018
New Hampshire	NH Health Protection Program Premium Assistance	2017	Yes	Newly eligible, able-bodied adults. Excludes: temporarily unable to participate due to illness, person participating in state-certified drug court program, parent or caretaker where care is considered necessary by health professional, parent or caretaker of dependent child under 6 years of age.	Must engage in one or more of the following activities: employment, work experience, on-the-job training, job search and job readiness assistance, vocational education training, job skills training, education directly related to employment, satisfactory attendance at secondary school. Hours required increase from 20 - 30hrs/week depending on number of months receiving benefits.	Submitted 10/24/2017

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Utah	Utah Primary Care Network	2017	Yes	Enrollees who do not meet an exemption. Exemptions: age 60+, mentally or physically unfit for employment, parents or members of households with responsibility of dependent child under age six, responsible for care of incapacitated person, receiving unemployment, participating regularly in drug or alcohol treatment program, student, participating in refugee employment services, Family Employment Program recipients, working at least 30 hours/week.	Eligible members must participate in online job search/training within the first three months of being notified that they have been enrolled in the program. Once they've met the requirement, they will be eligible for the remainder of their eligibility period (12 months). Failure to comply will result in loss of eligibility, which is restored upon completing all required activities or meeting an exemption.	Submitted 8/16/2017
Wisconsin	Badger Care	2017	No	Members ages 19 through 49 years old. Exemptions: mental illness diagnosis, SSDI, primary caregiver for a person who cannot care for themselves, physically or mentally unable to work, receiving or applied for unemployment insurance, taking part in an alcohol or other drug abuse program, enrolled in institution of higher learning at least half-time, high school student age 19 or older attending high school at least half-time.	Medicaid benefits are limited to 48 months; however, those who meet specified work requirements for at least 80 hours per month while receiving Medicaid benefits will not accrue time in their 48 month eligibility time limit (i.e. those who work can receive benefits for longer than those who do not).	Submitted 6/15/2017

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Denied or Withdrawn						
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
Indiana		2015	No	Expansion adults	Work referral	Not included as part of waiver approval by CMS – state established separate voluntary state-funded work search and job training program. Managed care entities responsible for creating incentive program to get enrollees to participate in state work search and job training program.
New Hampshire		2015	No	Expansion adults	Referral to state job counseling service if unemployed	Not included as part of waiver approval by CMS

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
Ohio	Ohio-MetroHealth Care Plus	2016	No	Included expansion and traditional adults 18 and older	Referral to work development agency if not working 20 hours/week,	Waiver application denied in its entirety
Pennsylvania		2014	Yes beginning in year 2, would lose eligibility for 3 months, then 6 months, then 9 months for noncompliance	Included 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 2	Not included as part of waiver approval; Governor Corbett planned to offer incentives for Medicaid beneficiaries who chose to participate in state-funded job training and work activity; Governor Wolf did not pursue this program.
Utah		2014	No, although state was considering sanctions related to benefits under other state	Included able-bodied expansion adults	Automatic enrollment in work program with access to online assessment, job training, and job postings, upon Medicaid application	Was not seeking waiver authority for work proposal and overall waiver was never submitted to CMS

State	Waiver Name	Year	Condition of Medicaid Eligibility	Population	Proposal	Status
			programs for noncompliance			
NOTE: 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.						

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 summary research performed by the department on cost sharing waiver requests and implementation in other states.

Table 8: Cost Sharing Waiver Status by State as of April 2018¹⁰¹¹

State	Waiver Name	Year	Population	Cost-sharing optional	Proposal	Status
Approved						
Arizona	Arizona Health Care Cost Containment System	2016	Expansion enrollees	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	Approved 12/28/2017

¹⁰ 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/>

¹¹ 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

State	Waiver Name	Year	Population	Cost-sharing optional	Proposal	Status
					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.	
Arkansas	Arkansas Works	2017	Adults with income > 100% FPL. Exemptions: dual eligibles, individuals who are medically frail/have exceptional medical needs who do not have access to cost effective ESI through a participating employer and choose to receive standard Medicaid coverage under the State Plan.	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 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.	Approved 3/4/18

State	Waiver Name	Year	Population	Cost-sharing optional	Proposal	Status
Indiana	Healthy Indiana Plan 2.0	2017	Adult enrollees with income less than 138% FPL.	Yes for those at or below 100% FPL. No for those from 101-138% FPL.	Premiums: Enrollees at or below 100% FPL must pay into an HSA. Non-payment results in lesser benefit package. Enrollees at 101-138% FPL will be disenrolled for failure to make HSA contributions.	Approved 1/31/18
Iowa	Iowa Wellness Plan	Amendment in 2015	Adults ages 19-64 from 50-138% FPL. Exemptions: medically frail and American Indians/Alaska Natives	Yes for those below 100% FPL. No for those from 101-138% FPL	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 and premiums limited to 5% of quarterly income. Co-pay required for non-emergency use of the ER beginning in year two of enrollment.	Approved 2015

State	Waiver Name	Year	Population	Cost-sharing optional	Proposal	Status
Kentucky	Kentucky HEALTH	2017	All adult enrollees up to 138% FPL. Exceptions: pregnant women, children, section 1931 parents, and the medically frail.	No	Monthly premium payments of \$1-\$15/month for enrollees from 0-138% of FPL. Third-parties may assist members with monthly contributions. Failure to pay for those above 100% FPL will result in disenrollment from Kentucky HEALTH, with a waiting period of six months to re-enroll. Those at or below 100% FPL will be required to pay copayments for all services, \$25 will be deducted from My Rewards Account or suspension of My Rewards Account.	Approved 1/24/2018
Michigan	Healthy Michigan	2015	Working parents from 64-138% FPL, Jobless parents from 37-138% FPL, Childless adults from 0-138% FPL	No -failure to pay won't result in loss of Medicaid eligibility, but it's considered a debt to the state	Expansion adults with income from 100-138% FPL pay monthly premiums of 2% of income (~\$20-27/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 after six months of enrollment. Care is provided by health plans in exchange for capitation payments. 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.	Approved 8/18/17
Montana	Montana Additional Services and Populations	2016	Childless adults from 0-138% FPL and parents from 50-138% FPL	Yes for those at or below 100% FPL. No for those	State can charge enrollees monthly premiums of 2% aggregate household income. Enrollees with income at or below 100% FPL cannot be disenrolled	Approved 12/14/2017

State	Waiver Name	Year	Population	Cost-sharing optional	Proposal	Status
				from 101-138% FPL.	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 debt 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% of household income. Preventive health services, immunizations, and medically necessary health screenings exempt from copayments.	
Pending						
Maine	Maine Care	2017	Able bodied adults ages 19-64 (with same exemptions as community engagement and work requirements)	No	Premium: able bodied adults ages 19-64 (same exemptions as community engagement and work requirements). Participation in MaineCare will be terminated if payment is not made. Payments must be received by last day of final enrollment month or member will be disenrolled for 90 days or until any unpaid premiums are paid. Payments required: 51-10% FPL \$10/mo, 101-150% FPL \$20/mo, 151-200% FPL \$30, 201% FPL and above \$40. Copayments: non-emergency us of the ED \$10.	Pending - 8/2/2017

State	Waiver Name	Year	Population	Cost-sharing optional	Proposal	Status
New Mexico	Centennial Care	2017	Premiums: Adult expansion population with household income > 100% FPL. Native Americans exempt from premiums. Copayments: All except Native Americans; ICF-IID Individuals; QMB/SLIMB/QI1 Individuals; Individuals in Family Planning-Only, PACE, DD waiver, Hospice	No	Premiums: \$10/mo year 1, \$20/mo year 2. First month's premium must be paid before enrollment and services begin. Centennial Rewards program for healthy behavior. Rewards vendor will collect premiums. Rewards will go toward premium payments. Failure to pay will after three-month grace period will result in disenrollment and three-month lock out period. Copayments: \$10/rx for non-preferred rx drugs, \$25/visit for non-emergency ER visits.	Pending - 12/20/2017
Utah	Primary Care Network	2017	All enrollees	No	\$25 co-payment for non-emergent use of emergency department	Pending - 8/16/2017
Wisconsin	Badger Care	2017	Childless adult population with household income from 51%-100% FPL	No	Premium of at most \$8 per household which may vary based on level of income and results of health risk assessment. Limit of 48-months of continuous eligibility, must wait 6 months before re-enrolling. \$8 copay for nonemergent use of ED.	Pending - 6/15/2017

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