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A Look at Section 1115 Medicaid Demonstration Waivers Under the ACA: A Focus on Childless Adults

EXECUTIVE SUMMARY

Prior to the Affordable Care Act (ACA), adults without dependent children were excluded from Medicaid coverage, unless states used Section 1115 waivers to extend coverage to this population. Moreover, since the enactment of the ACA, additional states have obtained these waivers to get an early start on the ACA's Medicaid expansion that will take effect in January 2014. This brief provides an overview of current Medicaid waivers that expand coverage to childless adults and implications for these waivers under the ACA. Key findings include:

One key reason states have obtained Section 1115 waivers to date is to expand coverage to childless adults. There are 24 states that provide coverage to adults without dependent children through waivers today.¹ The waivers vary significantly across states in terms of eligibility levels, benefits, and cost sharing requirements. The ACA provides new state plan authority for states to expand Medicaid to nearly all non-elderly adults with incomes up to 138% FPL as of January 2014, and provides an enhanced 100% federal matching rate for newly eligible adults that will phase down to 90% over time. The ACA also provided states with a new state plan option to get an early start on the expansion, effective April 2010 to December 2013, at their regular federal Medicaid matching rates. Seven states (California, Connecticut, Colorado, the District of Columbia, Minnesota, New Jersey, and Washington) expanded Medicaid coverage to adults after the enactment of the ACA to prepare for 2014. Connecticut uses the ACA's pre-2014 state plan option, while all of the other states use a waiver as a vehicle for all or some of their coverage expansion.

Most (18 of 24) states with waivers that cover childless adults are planning to transition this coverage by implementing the ACA's 2014 coverage expansion. Many of these states will need to make changes in their existing waiver coverage to meet the rules of the 2014 expansion, such as eliminating enrollment caps, expanding benefits, and reducing cost sharing requirements. Six states with waivers for childless adults (Idaho, Indiana, Maine, Oklahoma, Utah, and Wisconsin) are not planning to implement the Medicaid expansion at this time, although CMS recently approved one-year waiver extensions in Indiana and Oklahoma. In states that do not implement the ACA's 2014 Medicaid expansion through their state plans or a waiver extension, many adults covered by these waivers will likely lose coverage when the waivers expire at the end of 2013.

CMS has issued guidance related to the role of waivers in the 2014 Medicaid expansion, and several states are seeking waiver authority to implement the expansion in ways that differ from the new state plan authority. CMS has indicated that states cannot receive the enhanced 100% federal matching rate for partial expansions that do not extend up through 138% FPL (e.g., an expansion only to 100% FPL). However, CMS noted that it would consider section 1115 waivers for partial expansions at a state's regular Medicaid matching rate. In addition, CMS has specified that it will consider approving a limited number of section 1115 waivers to allow states to implement the 2014 Medicaid expansion through a premium assistance model, in which the state would use Medicaid funds to purchase coverage for the expansion population in the new Health Insurance Marketplaces established by the ACA. CMS has also identified at least one federal Medicaid requirement that it will not waive, specifying that it will not approve enrollment caps for the newly eligible population.

A number of states have waivers pending or in development. As of September 2013, Wisconsin has a waiver proposal to implement a partial expansion (coverage for childless adults up to 100% FPL) at its regular Medicaid matching rate. In addition, Arkansas received waiver approval to implement the expansion using a Marketplace premium assistance model to purchase coverage in the Marketplaces. Iowa also has a waiver request pending that would provide coverage for the ACA Medicaid expansion population through existing Medicaid delivery systems (but with a monthly premium contribution) and by using premium assistance to purchase coverage in the Marketplaces for those with incomes over from 101-138 percent FPL. Pennsylvania has also released a waiver concept paper with broad changes as well as some premium assistance and Michigan enacted state legislation to implement the expansion which would require a waiver.

CMS has also issued guidance to promote several strategies to facilitate enrollment in the Medicaid expansion that would require waiver authority. These include early adoption of Modified Adjusted Gross Income (MAGI)-based rules, which has been approved for 12 states; extending the Medicaid renewal period so that renewals that would otherwise occur during the first quarter of calendar year 2014 occur later, which has been approved for 19 states; enrolling individuals into Medicaid based on Supplemental Nutrition Assistance Program eligibility, which has been approved in 4 states; enrolling parents in Medicaid based on children's eligibility, which has been approved in 2 states, and adopting 12-month continuous eligibility for parents and other adults, which has not yet been adopted by any states.

Prior to the ACA, the only way to cover adults without dependent children and receive Medicaid matching funds was through a Section 1115 waiver. In providing coverage to those who would have otherwise been uninsured, CMS also has approved limits on this coverage such as limited benefits or enrollment caps. By expanding Medicaid coverage to childless adults through the ACA and providing states with significant amounts of federal funding to do so fundamentally changes the landscape. Given the ACA, the role and design of waivers for this population remains an open question. Which provisions of the Medicaid statute CMS will allow states to waive, how effective the ACA's new waiver approval processes will be at obtaining public input on waiver changes, and what the implications will be for individuals, providers, plans, and states, all remain important issues to watch.

INTRODUCTION

Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules (See Text Box 1 and Appendix A). Waivers can provide states with significant flexibility in how they operate their programs and can have a considerable impact on program financing. As such, waivers have important implications for beneficiaries, providers, and states. Section 1115 waivers play a notable role in the Medicaid program and have been used for a variety of purposes, including expanding coverage to populations who are not otherwise eligible, changing benefits packages, imposing different levels of cost sharing, and restructuring delivery and payment systems.^{2,3} Historically, one key purpose has been to expand coverage to childless adults, a group that was excluded from Medicaid prior to the Affordable Care Act (ACA). As of September 2013, nearly half of states (24) have a Medicaid Section 1115 waiver in place that expands coverage to childless adults. Many of these waivers have been in place for many years, while a number of states obtained these waivers more recently to get an early start on the ACA's Medicaid expansion. This brief provides an overview of Section 1115 waiver authority, describes major provisions of waivers that extend coverage to childless adults, and identifies key issues and implications of these waivers looking forward.

Text Box 1: Key Elements of a Section 1115 Waiver

Section 1115 waiver authority is provided for “experimental, pilot, or demonstration projects...to assist in promoting the objectives of” the Medicaid program.

Section 1115 authorizes the HHS Secretary to:

- Waive state compliance with certain federal Medicaid requirements; and
- Provide federal matching funds for costs that would not otherwise be matched under Medicaid.

Section 1115 waivers are required to be budget neutral for the federal government.

- Under long-standing federal policy (not statute) federal spending under a state's waiver must not be more than projected federal spending would have been without the waiver.
- Budget neutrality is established using a cap on federal matching funds over the life of the waiver.

Waiver approval involves negotiations between a state and HHS and consideration of public comments.

- The approval process officially begins when a state submits a waiver application to CMS, which is subject to state and federal public notice and comment requirements.
- If a waiver is approved, CMS issues an award letter to the state specifying the sections of the Medicaid Act that are being waived or modified and the types of expenditures allowed as well as the “terms and conditions” of approval with which the state must comply.
- Waivers are typically approved for a 5 year period and can be extended, typically for 3 years.

MEDICAID COVERAGE OF CHILDLESS ADULTS

Prior to the enactment of the ACA, childless adults were excluded from the Medicaid program under federal rules. Before the ACA, Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, elderly individuals and people with disabilities. Adults without dependent children, often referred to as childless adults, who did not qualify for Medicaid based on age or disability were ineligible for coverage, and states could not receive federal Medicaid matching funds to cover these adults regardless of how low their incomes were. The only way a state could extend coverage to these adults was through a Section 1115 waiver. However, states could not receive additional federal funds to expand coverage to these adults through a waiver and, as such, needed to redirect existing federal funds or find offsetting program savings to finance such coverage.

In mid-1990s through the early part of 2000, a number of waivers were approved that focused on expanding coverage, often including childless adults. Many of these waivers also implemented broader managed care systems than were permitted under federal Medicaid law at the time. States used savings from mandatory managed care or redirected Disproportionate Share Hospital (DSH) funds to finance substantial coverage expansions for childless adults, and, in some cases, other groups, such as parents. These include waivers approved in Hawaii, Oregon, and Tennessee in 1994; waivers in Delaware and Vermont in 1996; waivers in Maryland and Massachusetts in 1997; and waivers in Arizona and New York in 2001.⁴ These waivers generally provided childless adults a comprehensive set of benefits that were equal or largely equivalent to the states' full Medicaid benefit package and had limited cost sharing requirements.

In 2001, the Bush Administration released a Health Insurance Flexibility and Accountability (HIFA) waiver initiative that provided a streamlined waiver approval process for states using waivers to expand coverage within their "current level" of resources and offered states increased flexibility to reduce benefits and charge higher cost sharing to help finance the expansion.⁵ During the 2001-2010 period, another eight states received waivers expanded coverage to childless adults under the HIFA initiative, including Maine,⁶ New Mexico, Michigan, Iowa, Indiana, Oklahoma, Utah, and Wisconsin.⁷ Many of these waivers provided these adults more limited benefits and charged them higher cost sharing than otherwise allowed in Medicaid. Moreover, some of these waivers covered these adults through a premium assistance model that allowed the state to use Medicaid funds to subsidize the purchase of private insurance that did not meet minimum Medicaid benefit or cost sharing rules without requiring the state to supplement that coverage with wraparound benefits or cost sharing.⁸ At the same time, some of the earlier managed care expansion waivers, such as in Oregon and Tennessee, began reducing coverage due to difficult budgetary environments. Coverage for childless adults in Tennessee through the TennCare Waiver expired in 2001 due to the fiscal situation in the state.

Currently, 24 states use waivers to provide Medicaid-funded coverage for childless adults. The eligibility levels, benefits, and cost sharing requirements for this waiver coverage vary significantly across states (See Appendix B). Only 9 states provide these adults with benefits that are comparable to the state's full Medicaid benefits package. The remaining states generally provide these adults with more limited benefits and charge them higher cost sharing than otherwise allowed under Medicaid. Enrollment data for these waivers is hard to capture because states often do not report data for just childless adults. For June 2012, 18 states were

able to report separate enrollment data for adults without dependent children; an additional three states reported data that included both parents and adults without dependent children. Of the 2.3 million low-income non-disabled adults covered under expansion programs in these states in June 2012, at least 1.77 million were adults without dependent children.⁹

One of the main ways the ACA seeks to reduce the number of uninsured individuals is by expanding Medicaid to nearly all adults under 138% of the federal poverty level (FPL) starting January 1, 2014. This expansion would make millions of adults newly eligible for the program. The federal government will fund 100% of the cost of covering newly eligible adults for the first three years of the expansion, phasing down to 90% over time. Under the ACA, the Medicaid expansion was intended to occur nationwide. However, the Supreme Court's ruling on the ACA effectively made the expansion a state option. As of September 2013, 25 states (including the District of Columbia) are moving forward with the expansion, 26 states are not moving forward at this time.¹⁰ There is no deadline for states to adopt the Medicaid expansion. If a state does not expand Medicaid, uninsured adults in that state with incomes at or below the federal poverty level will not gain a new coverage option and will likely remain uninsured. However, those with incomes above 100 percent FPL who are ineligible for Medicaid will have access to subsidies to purchase coverage in the new Marketplaces.

Effective April 2010, the ACA also provided states with a new state plan option to expand coverage to childless adults at their regular federal Medicaid matching rates to get an early start on the expansion. States that expanded coverage through this option had to meet federal benefit and cost sharing requirements and could not cap enrollment. At the same time, subject to federal approval, states could still expand coverage to childless adults through a Section 1115 waiver and were no longer restricted from receiving additional federal matching funds for this population since these adults could now otherwise be covered through the state plan. A number of states received waivers to expand coverage through a Section 1115 waiver instead of the ACA state plan coverage group. The waivers deviated from the rules for the state plan group by providing a more limited benefits package, capping enrollment, or implementing on a county versus statewide basis. Since April 2010, seven states (California, Connecticut, Colorado, DC, Minnesota, New Jersey, and Washington) have expanded coverage to childless adults up to 133% FPL through the new ACA state plan option or a waiver to prepare for 2014. All of these states except Connecticut have used waivers as a vehicle for all or some of the coverage expansion.^{11,12}

MEDICAID EXPANSION DECISIONS IN STATES WITH EXPIRING CHILDLESS ADULT WAIVERS

Most (18 of 24) of the states that presently cover childless adults through waivers are moving forward with the Medicaid expansion in 2014, while 6 states are not moving forward at this time (See Appendix B). The 18 states moving forward include 12 states that have covered childless adults under Section 1115 waivers prior to the ACA, as well as six states that have obtained waivers after the enactment of the ACA's April 2010 state plan option to get an early start on the expansion. To implement the Medicaid expansion under the ACA's new state plan authority to cover childless adults in 2014, many of these states will need to make changes to their existing waiver coverage to meet the rules of the new state plan authority, such as eliminating enrollment caps, expanding benefits, and reducing cost sharing requirements. At least two of these states (Arkansas and Iowa) are seeking to move forward under new waivers that would implement the expansion in ways that would require a waiver.¹³

Six states (ID, IN, ME, OK, UT, and WI) with current Section 1115 waivers to cover childless adults have indicated that they are not moving forward with the ACA Medicaid expansion at this time. However, CMS recently approved one-year waiver extensions in Indiana¹⁴ and Oklahoma.¹⁵ In both of these states, the waiver coverage will continue, but coverage will be limited to individuals with incomes below 100% FPL. Current Medicaid beneficiaries with incomes above 100% FPL will be eligible for help purchasing coverage in the new Marketplaces. Indiana will maintain its enrollment cap and other core components of its waiver, which provides more limited benefits than the state's traditional Medicaid state plan benefits package. Oklahoma will continue to provide limited subsidized coverage under the Insure Oklahoma waiver. Consequently, the waiver coverage groups in Oklahoma and Indiana will not be eligible for the enhanced Medicaid financing available under the ACA Medicaid expansion. Wisconsin has a waiver proposal would reduce eligibility for childless adults in its existing waiver program from 200% to 100% FPL.¹⁶ Maine plans to let their current Section 1115 waiver for childless adults expire.¹⁷ In the remaining two states in this group, without the Medicaid expansion or a waiver renewal, childless adults covered under the waivers will lose eligibility and likely become uninsured when the waivers expire at the end of 2013.

PARAMETERS OF WAIVER AUTHORITY TO IMPLEMENT THE 2014 MEDICAID EXPANSION

Looking ahead to the ACA's 2014 Medicaid expansion, there are a number of key issues to consider regarding the role of Section 1115 waivers. While states have a range of options and flexibilities related to how they implement the expansion, such as how benefits are designed and care is delivered, some states have expressed interest in seeking additional flexibilities under Section 1115 waiver authority. However, now that adults without dependent children are covered under the ACA with significant amounts of federal funding to do so, the need for and role of waivers for this population fundamentally changes. Through new guidance, CMS has provided some indication of the types of flexibilities it might approve under waiver authority as well as those that the Secretary would not consider to be consistent with the objectives of the program (See Text Box 2). In addition to new guidance, experience with waivers prior to the ACA will inform waiver activity going forward with consideration of the new options and requirements in the ACA.

Text Box 2: Key CMS Guidance About the Use of Section 1115 Waivers for Coverage Expansions Post-ACA

Partial Coverage Expansions

States cannot receive the enhanced 100% federal matching rate for partial Medicaid coverage expansions that do not extend up to 138% FPL (e.g., an expansion only to 100% FPL).

CMS will consider partial expansion demonstration waivers at a state's regular Medicaid matching rate if the Secretary determines that the proposal would further the purposes of the program.

In 2017, when the 100% federal funding for newly eligible enrollees begins to reduce, further demonstration opportunities will become available to states under the ACA's new State Innovation Waiver authority, provided that waivers offer comparable coverage that is comprehensive and affordable at no additional cost to the federal government.

Enrollment Limits

- HHS will not authorize enrollment caps through Section 1115 demonstrations for the new adult group or similar populations (the Secretary has determined that these policies do not further the objectives of the Medicaid program).

Premium Assistance

HHS will consider approving a limited number of Section 1115 demonstrations to test using Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, provided that:

States ensure wrap-around coverage for benefits and cost sharing;

Beneficiaries have a choice of at least two Marketplace plans;

Demonstrations include only enrollees eligible for benefits that are closely aligned with Marketplace benefits packages (e.g., not medically frail); and

Demonstrations end by December 31, 2016.

Determining Matching Rates

The enhanced 100% federal matching rate for newly eligible enrollees applies to beneficiaries in the new adult eligibility group created by the ACA's Medicaid expansion who would not have been eligible for the full Medicaid state plan benefits package, benchmark benefits, or benchmark-equivalent benefits under the state's rules as of December 1, 2009. CMS is analyzing existing waiver coverage to determine whether the benefits provided through these waivers meet these standards.

States that provided coverage that is equivalent to traditional state plan or benchmark coverage will receive their regular matching rate for adults already covered under pre-existing waiver programs who transition to coverage under the 2014 Medicaid expansion, unless they qualify as an "expansion state."

Facilitated Enrollment Strategies

CMS will provide streamlined approval of waivers to implement targeted enrollment strategies including:

Early adoption of Modified Adjusted Gross Income (MAGI)-based rules;

Extending the Medicaid renewal period for scheduled renewals during the first quarter of CY 2014;

Using information from Supplemental Nutrition Assistance Program (SNAP) eligibility determinations to identify individuals potentially eligible for Medicaid;

Enrolling parents in Medicaid based on income information available from their already-eligible children; and

Adopting 12-month continuous eligibility for parents and other adults.

PARTIAL EXPANSIONS NOT ELIGIBLE FOR ENHANCED FEDERAL FUNDS

In guidance released in December 2012, CMS clarified that states cannot receive the enhanced 100% federal matching rate for partial coverage expansions that do not extend up to 138% FPL (e.g., an expansion only to 100% FPL). However, the guidance indicated that CMS would consider partial expansions through Section 1115 demonstration waivers at a state's regular Medicaid matching rate, if the Secretary determines that the proposal would further the purposes of the program.¹⁸ The guidance also stated that beginning in 2017, when the 100% federal funding for newly eligible enrollees begins to reduce, further demonstration opportunities will become available to states under the ACA's new State Innovation Waiver authority, which may be coupled with Section 1115 demonstrations. Under this authority, states would have additional flexibility so long as they offer the same level of coverage and affordability at no additional cost to the federal government.

In August 2013, Wisconsin submitted a waiver application to CMS to implement a "partial expansion" at the regular federal Medicaid matching rate beginning in January 2014. Under the proposed waiver, the state would reduce eligibility for childless adults currently covered in its existing waiver program, BadgerCare, from 200% to 100% FPL.¹⁹ Under the ACA, if not eligible for Medicaid, individuals with incomes at or above 100% FPL will be eligible for subsidies to purchase coverage through the new Health Insurance Marketplaces created by the ACA. Wisconsin also plans to limit coverage for parents to 100% FPL (from 200% FPL). This change does not need waiver authority and was included in the state budget for 2013-2015.

ENROLLMENT LIMITS NOT PERMITTED

CMS has indicated that, given the significant amount of federal support now available to cover low-income adults under the ACA, it will not authorize enrollment caps or similar policies through Section 1115 demonstrations for the new adult group or similar populations.²⁰ Prior to the ACA when there was no coverage pathway or financing for childless adults in Medicaid, waiver for this population were approved. However, given the changes in the ACA, CMS noted that these policies do not further the objectives of the Medicaid program, which is the statutory requirement for allowing a Section 1115 demonstration. Some 10 of the 24 states that currently cover childless adults through a waiver, including 6 of the 18 states moving forward with the Medicaid expansion, currently have enrollment caps in place. As such, these caps would need to be eliminated to comply with the minimum federal standards for the ACA's new adult expansion coverage group in 2014.

IMPLEMENTING THE MEDICAID EXPANSION THROUGH A PREMIUM ASSISTANCE MODEL

CMS has noted that it will consider approving a limited number of Section 1115 waivers to implement the Medicaid expansion through a premium assistance model. CMS has issued regulations that provide a state plan option for states to implement the Medicaid expansion through a premium assistance model. CMS also indicated in guidance that it will consider approving a limited number of Section 1115 demonstrations that allow states to use Medicaid funds to purchase coverage for newly eligible Medicaid beneficiaries through the new Health Insurance Marketplaces. The waivers would only be required if a state wants to make premium assistance mandatory. The guidance related to Section 1115 demonstrations for premium assistance specifies that:²¹

- Premium assistance enrollees “remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections.”
- Beneficiaries have a choice of at least two Marketplace plans;
- Demonstrations include only enrollees eligible for benefits closely aligned with Marketplace packages (e.g., not medically frail); and
- Demonstrations end by December 31, 2016.

The guidance indicates that a state may increase the opportunity for a CMS approval of a demonstration by choosing to target premium assistance to individuals in the new adult group with incomes between 100% and 138% FPL, who are more likely to transition between Medicaid and Marketplace coverage over time due to fluctuations in income.

Arkansas has approval and Iowa submitted a waiver application to use premium assistance Section 1115 waiver authority to implement the Medicaid expansion. Currently, Arkansas and Iowa provide limited coverage for certain childless adults with incomes up to 200% FPL through the ARHealthNetworks waiver program and the IowaCare waiver program, respectively. Both states have plans to implement the ACA’s Medicaid expansion for some or all of those newly eligible for coverage by using premium assistance (See text box below for information on Premium Assistance).²² The Arkansas waiver was approved on September 27 and the Iowa proposal is still pending at CMS.²³ Under the plans, Medicaid funds would be used to purchase coverage for some or all newly eligible Medicaid beneficiaries in Marketplace Qualified Health Plans (QHPs).²⁴ Arkansas and Iowa need demonstration waiver authority primarily because their proposals would make premium assistance enrollment mandatory for affected beneficiaries. Iowa also proposes to impose premiums and to waive its obligation to provide wrap-around benefits. In addition, the Governor in Pennsylvania released a Medicaid reform plan that includes implementation of the Medicaid expansion using premium assistance. Some elements of Pennsylvania’s proposal appear to require waiver approval, including mandatory enrollment in premium assistance.²⁵ Key issues that CMS may consider in evaluating these waiver proposals include how they may affect continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from the demonstration, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective.²⁶

What is Premium Assistance in Medicaid?

The Medicaid statute provides several options for states to pay premiums for adults and children to purchase coverage through private group health plans. CMS recently issued regulations that outline the process for states to use Medicaid funds to pay individual market premiums to purchase coverage for beneficiaries. A state may pursue premium assistance as a state plan option without a waiver.²⁷ Under premium assistance arrangements, CMS has confirmed that enrollees remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections. This means that states must have mechanisms in place to “wrap-around” private coverage to the extent that the benefits provided in private plans supported by premium assistance are less extensive and cost-sharing requirements are greater than those in the state’s traditional Medicaid program. In addition, under the state plan option for premium assistance in the individual market, beneficiaries must be able to choose between receiving Medicaid benefits through the traditional Medicaid program or private insurance with premium assistance. The regulations also condition premium assistance arrangements on the determination that they are “cost effective.” Cost effectiveness generally means that the state Medicaid agency’s premium payment to private plans, plus the cost of any additional services required as wrap-around benefits, any required cost-sharing assistance to comply with Medicaid limits, and administrative costs, must be comparable to what the state would otherwise pay to cover beneficiaries through its traditional Medicaid program.

DETERMINING MATCHING RATES FOR ADULTS PREVIOUSLY COVERED BY WAIVERS

CMS has issued guidance and proposed regulations related to determining the applicable federal matching rate for enrollees currently covered under Section 1115 waivers who transition to a state plan or waiver coverage group under the ACA’s Medicaid expansion in 2014.²⁸ Specifically, the enhanced 100% federal matching rate for newly eligible enrollees applies to adults in the new coverage group for childless adults created by the ACA in 2014 who would not have been eligible for full Medicaid benefits, benchmark benefits, or benchmark-equivalent benefits under the state’s rules as of December 1, 2009. If a state’s December 2009 waiver benefits package was less comprehensive, adults previously covered by such a waiver are eligible for the 100% enhanced federal matching rate under the Medicaid expansion.

Conversely, in states that provided coverage that was equivalent to Medicaid or benchmark coverage, adults transitioning to the newly eligible coverage group are eligible for the state’s regular matching rate, unless the state qualifies as an “expansion state” (described below). Among the states planning to move forward with the 2014 expansion, adults in existing waiver programs in Arkansas, Iowa, Maryland, Michigan, New Mexico, and Oregon would likely receive the 100% enhanced federal matching rate, since these states provide a more limited benefit package compared to their traditional Medicaid programs.

Moreover, expansion states will receive a special matching rate that is higher than the state’s current matching rate and will gradually increase to 90% by 2020 (and which will equal the enhanced federal matching rate available to non-“expansion states” that implement the ACA’s 2014 Medicaid expansion).²⁹ A state qualifies as an “expansion state” if it covered parents and childless adults with incomes up to 100% FPL as of March 23, 2010, and provided coverage that included inpatient hospital care, was not limited to people with employer-

based coverage, and was not hospital-only benefits or a high-deductible health plan. The expansion state matching rate could apply to Delaware, Hawaii, Massachusetts, New York, and Vermont. CMS is analyzing the benefits in existing waiver programs to determine which matching rate will apply to adults currently covered by waivers who transition to the Medicaid expansion new adult group beginning in 2014.

SOME NEW PROPOSALS ARE SEEKING AUTHORITY TO WAIVE PREMIUM AND COST-SHARING RULES

Some proposed waivers include broader program changes that would also require waiver approval. In addition to the premium assistance provisions for those with incomes between 101-138 percent FPL, Iowa also is seeking waiver authority to impose a monthly premium contribution for enrollees with incomes over 50 percent and emergency room copayments. The waiver proposal in Wisconsin would also impose premiums (on a sliding scale) for individuals who qualify through the Transitional Medical Assistance (TMA) program (currently premiums apply for those who qualify through TMA with incomes greater than 133% FPL). The concept paper, released by Governor Corbett in Pennsylvania, calls for premium contributions that could be reduced if individuals participate in health and wellness appointments and actively engage in job search and training programs.³⁰ Michigan enacted legislation to implement that Medicaid expansion that would need waiver approval to impose copays and other contribution requirements for persons between 100 and 133 percent FPL.³¹

CMS would likely consider statutory and regulatory requirements as well as court decisions related to cost-sharing in reviewing new waivers of this authority. On August 24, 2011, the U.S. Ninth Circuit Court of Appeals ruled in *Newton-Nations et al. v. Betlach and Sebelius*, a case that involves the authority to impose heightened, mandatory copays on waiver expansion populations. The Secretary had approved the changes under a Section 1115 Waiver. The Court rejected the copay changes ruling that the Secretary's review did not satisfy the obligation under the Social Security Act to determine whether the proposal was likely to further the goals of the Medicaid Act and that the review did not adequately "consider the impact of the project on the" persons the Medicaid Act "was enacted to protect." The Court also questioned whether the project could have an experimental, pilot or demonstration value, expressing doubt that the copayments could "demonstrate something different than the last 35 years' worth of health policy research" (which consistently concludes that copayments cause low-income people to forego even medically necessary care).

In July 2013, CMS released final rules that streamlined and simplified existing regulations around premiums and cost-sharing while also making some changes to regulations for cost sharing. These regulations maintained the prohibition to charge premiums in Medicaid to individuals with incomes below 150 percent FPL.³² The rules increased the nominal rate for cost-sharing and increased allowable cost-sharing amounts for non-preferred drugs and non-emergency use of the emergency room. In order to impose higher cost sharing than otherwise allowed a state would need to meet the separate cost sharing waiver requirements under Section 1916(f). Under Section 1916(f), a state may seek a demonstration waiver to charge cost sharing above allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years.

NEW STRATEGIES TO FACILITATE ENROLLMENT IN THE MEDICAID EXPANSION AVAILABLE THROUGH WAIVERS

CMS has also issued guidance to promote several strategies, which require waiver authority, to facilitate Medicaid enrollment when the ACA's new streamlined eligibility and enrollment provisions take effect in 2014. Under the ACA, all states must implement changes to streamline, simplify, and coordinate enrollment processes across health coverage programs. These requirements apply to states moving forward and those not moving forward with the Medicaid coverage expansion. CMS's May 2013 guidance indicates that it will streamline approval of Section 1115 waiver applications that adopt certain targeted strategies to facilitate enrollment. The strategies proposed by CMS are listed below, along with the states that have adopted each option as of September 2013.³³ Both states moving forward and those not moving forward with the Medicaid expansion have adopted these strategies:³⁴

Targeted Enrollment Strategies and States with Approved Plans		
Enrollment Strategy	# of States	List of States
Early Adoption of Modified Adjusted Gross Income (MAGI) Rules	13	Colorado, DC, Hawaii, Illinois, Kansas, Louisiana, Missouri, Nevada, New Jersey, Oklahoma, Oregon, Virginia and Washington
Extension of Medicaid Renewals That Would Otherwise Occur in Quarter 1 of CY 2014	23	Alaska, Arkansas, Connecticut, DC, Florida, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Montana, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, and Vermont
Enrollment in Medicaid Using SNAP	4	Arkansas, Illinois, Oregon, and West Virginia
Parent Enrollment in Medicaid Based on Children's Eligibility	2	Oregon and West Virginia
12-Month Continuous Eligibility For Adults	0	No States Approved as of 9/15/2013

CONCLUSION

Today, a total of 24 states cover childless adults through Section 1115 waivers. These include some waivers that pre-dated the ACA, and others that were approved after enactment of the ACA to get a jump start on the ACA Medicaid expansion. Most of these waivers are set to expire at the end of 2013, when the expansion will take effect in states that decide to move forward with it. While the majority of states with waivers that cover childless adults are moving forward with the expansion, six of these states are not moving forward. In states that do not move forward, adults currently covered by expiring waivers may lose coverage, and there could be gaps in coverage.

Prior to the ACA, the only way to cover adults without dependent children and receive Medicaid matching funds was through a Section 1115 waiver. In providing coverage to those who would have otherwise been uninsured, CMS also has approved limits on this coverage such as limited benefits or enrollment caps. By expanding Medicaid coverage to childless adults through the ACA and providing states with significant amounts of federal funding to do so fundamentally changes the landscape. Given the ACA, the role and design of waivers for this population remains an open question. Which provisions of the Medicaid statute CMS will allow states to waive, how effective the ACA's new waiver approval processes will be at obtaining public input on waiver changes, and what the implications will be for individuals, providers, plans, and states, all remain important issues to watch.

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APPENDIX A: OVERVIEW OF SECTION 1115 WAIVER AUTHORITY, FINANCING, AND APPLICATIONS

Section 1115 Medicaid Waiver Authority. Section 1115 of the Social Security Act (SSA) gives the Secretary of Health and Human Services (HHS) authority to waive provisions of major health and welfare programs authorized under the Act, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. This authority is provided for “experimental, pilot, or demonstration” projects which, in the view of the Secretary, are “likely to assist in promoting the objectives of” the program. Although the Secretary’s waiver authority is broad, it is not unlimited. There are some program elements the Secretary does not have authority to waive, such as the federal matching payment formula. States have obtained “comprehensive” Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost sharing, and provider payments. There also are narrower Section 1115 waivers that focus on specific services, such as family planning services, or populations, such as people with HIV.³⁵

Section 1115 Waiver Financing. Although not required by statute or regulation, under longstanding administrative policy, Section 1115 waivers have been required to be budget neutral to the federal government. This means that federal spending under a state’s waiver must not exceed projected federal spending for that state without the waiver. The federal government establishes budget neutrality by placing a cap on federal matching funds over the life of a waiver, putting the state at risk for all waiver costs that exceed the cap. To date, most Section 1115 waivers have utilized a per capita cap for groups covered under the waiver, which puts the state at risk for higher than anticipated per person costs but not higher than expected enrollment. However, a June 2013 Government Accountability Office (GAO) report found that budget neutrality is not always met, citing for example four states (Arizona, Indiana, Rhode Island, and Texas) in which HHS approved higher-than-benchmark spending limits.³⁶ Section 1115 waivers do not change the federal Medicaid matching payment structure. A state must pay its share of costs for services and populations allowable under the waiver, as determined by the Medicaid matching rate formula in federal law. The federal government then matches the state’s expenditures up to the established budget neutrality cap.

Section 1115 Waiver Approval Process. Waivers are subject to approval by the HHS Secretary. The process officially begins when a state submits an application to the CMS, although states generally have discussions with CMS or submit a concept paper before submitting an official application. Significant negotiation about aspects of the waiver may take place between the state and HHS throughout the waiver approval process. Section 1115 waivers generally are approved for an initial five-year period. At the end of the initial approval period, waiver extensions may be approved, typically for a three-year period. Some waivers have been extended repeatedly, allowing them to remain in place for many years. In addition to federal approval, some states require authorizing legislation for waivers. In response to concerns about the lack of public input and transparency in the Section 1115 waiver approval process, the ACA established new provisions designed to ensure meaningful opportunities for public input into the Section 1115 waiver process, including public hearings as well as notice and comment periods at the state and federal levels. These regulations went into effect April 27, 2012 and apply to all new Section 1115 Medicaid and CHIP waiver proposals as well as extensions of existing waivers; they do not apply to waiver amendments.³⁷

**Appendix B:
Waivers for Childless Adults: Income Eligibility Limits as a Percent of the FPL, Waiver Timing and Medicaid Expansion Status**

State	Medicaid Benefits		More Limited Coverage		Explanation of Current Coverage	Waiver Initiated
	Jobless	Working	Jobless	Working		
MOVING FORWARD WITH MEDICAID EXPANSION AT THIS TIME						
Arizona	100% <i>(closed)</i>	100% <i>(closed)</i>			Arizona froze enrollment in its waiver coverage for childless adults on July 8, 2011.	Pre ACA
Arkansas*			200%		In Arkansas, adults up to 200% FPL are eligible for more limited subsidized coverage under the ARHealthNetworks waiver program; individuals must have income below the eligibility threshold and work for a qualifying, participating employer.	Pre ACA
California			200%	210%	California extends coverage for adults through two programs: the Medicaid Coverage Expansion (MCE) up to 133% FPL and the Health Care Coverage Initiative (HCCI) between 133% and 200% FPL. While both coverage options offer more limited benefits than full Medicaid, the MCE benefit package is more comprehensive. Fifty out of 58 counties are participating in MCE; 5 counties are participating in HCCI.	Post ACA
Colorado	10% <i>(closed)</i>	20% <i>(closed)</i>			Colorado extended Medicaid coverage to a limited number (10,000) of adults with income up to 10% FPL through a waiver as of May 2012.	Post ACA
Delaware	100%	110%			In Delaware, adults with incomes up to 100% FPL are eligible for Medicaid benefits through the Diamond State Health Plan.	Pre ACA
District of Columbia	200%	211%			The District of Columbia took up the new ACA early expansion option and obtained a waiver to cover adults up to 200% in 2010, transferring adults from a previously locally-funded program to Medicaid.	Post ACA
Hawaii	133%	133%			Hawaii covers adults up to 100% FPL under its QUEST Medicaid managed care waiver program; enrollment in QUEST is closed except for certain groups including individuals receiving Section 1931 Medicaid coverage or General Assistance or those below the old AFDC standards. The state's QUEST-ACE waiver program provides Medicaid coverage to adults with incomes up to 133% FPL that are not eligible for QUEST. Further, adults previously enrolled in Medicaid with incomes up to 133% FPL can purchase QUEST-NET waiver coverage by paying a monthly premium.	Pre ACA
Iowa*			200%	250%	In Iowa, adults up to 200% FPL are eligible for more limited coverage under the IowaCare waiver program.	Pre ACA
Maryland			116%	128%	In Maryland, childless adults are eligible for primary care services under the Primary Adult Care waiver program.	Pre ACA
Massachusetts			300%	300%	In Massachusetts, childless adults who are long-term unemployed or a client of the Department of Mental Health with income below 100% FPL can receive more limited benefits under the MassHealth waiver program through MassHealth Basic or Essential. Additionally, adults up to 300% FPL are eligible for more limited subsidized coverage under the Commonwealth Care waiver program.	Pre ACA
Michigan*			35% <i>(closed)</i>	45% <i>(closed)</i>	In Michigan, childless adults are eligible for more limited coverage under the Adult Benefit Waiver program; enrollment is closed.	Pre ACA
Minnesota	75%	75%	200%	200%	Childless adults receive a more limited benefit package that has a \$10,000 annual limit on inpatient hospital care. Minnesota decreased eligibility for childless adults in its 1115 and state-funded coverage from 250% to 200% of the FPL in 2012.	Post ACA
New Jersey			23%	23%	In April 2011, New Jersey obtained a waiver to expand coverage to childless adults who had previously been covered through the state's general assistance program. For those who are unemployable, the limit is \$210 per individual; for those who are employable the limit is \$140 per individual.	Post ACA
New Mexico			200% <i>(closed)</i>	414% <i>(closed)</i>	In New Mexico, adults up to 200% FPL are eligible for more limited subsidized coverage under the State Coverage Insurance waiver program. Individuals must have income below the eligibility threshold and work for a participating employer; if they do not work for a participating employer, they can obtain coverage by paying both the employer and employee share of premium costs. Enrollment is closed.	Pre ACA
New York	100%	100%			In New York, childless adults up to 78% FPL are eligible for the Medicaid (Home Relief) waiver program and parents up to 150% FPL and childless adults up to 100% FPL are eligible for the Family Health Plus waiver program.	Pre ACA
Oregon			100% <i>(closed)</i>	201% <i>(closed)</i>	In Oregon, adults up to 100% FPL are eligible for more limited coverage under the OHP Standard waiver program; enrollment in OHP Standard is closed. The state provides premium assistance to adults up to 201% FPL under its Family Health Insurance Assistance Program waiver program. Enrollment in FHIAP is open to children only.	Pre ACA
Vermont	150%	160%	300%	353%	In Vermont, 1931 coverage is available up to 77% FPL in urban areas and 73% FPL in rural areas; parents up to 185% FPL and childless adults up to 150% FPL are eligible for the Vermont Health Access Plan waiver program. Additionally, the state offers more limited subsidized coverage to adults up to 300% FPL under its Catamount Health waiver program.	Pre ACA
Washington			133% <i>(closed)</i>	200% <i>(closed)</i>	In Washington, adults up to 133% FPL are eligible for more limited coverage under the state's Basic Health waiver. Enrollment is closed.	Post ACA

State	Medicaid Benefits		More Limited Coverage		Explanation of Current Coverage	Waiver Initiated
	Jobless	Working	Jobless	Working		
NOT MOVING FORWARD WITH MEDICAID EXPANSION AT THIS TIME						
Idaho			185%		Idaho provides premium assistance to adults up to 185% FPL under a waiver; individuals must have income below the eligibility threshold and work for a qualified small employer.	Pre ACA
Indiana			200% <i>(closed)</i>	210% <i>(closed)</i>	In Indiana, adults up to 200% FPL are eligible for limited coverage under the Healthy Indiana waiver program. Enrollment is closed for childless adults. A one-year waiver renewal was approved in September 2013 that would limit coverage to 100% FPL beginning January 2014.	Pre ACA
Maine			100% <i>(closed)</i>	100% <i>(closed)</i>	Childless adults up to 100% FPL are eligible for more limited coverage under the MaineCare waiver program; enrollment is closed.	Pre ACA
Oklahoma				200%	In Oklahoma, adults up to 200% FPL are eligible for more limited subsidized coverage under the Insure Oklahoma waiver program. Individuals must have income below eligibility threshold and also work for a small employer, be self-employed, be unemployed and seeking work, be working disabled, be a full-time college student, or be the spouse of a qualified worker. A one-year waiver renewal was approved in September 2013 that would limit coverage to 100% FPL beginning January 2014.	Pre ACA
Utah			150% <i>(closed)</i>	200%	In Utah, adults up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults under the Utah Premium Partnership (UPP) Health Insurance waiver program. Eligibility in UPP increased from 150% to 200% in October 2012.	Pre ACA
Wisconsin*			200% <i>(closed)</i>	200% <i>(closed)</i>	In Wisconsin, childless adults up to 200% FPL are eligible for more limited coverage under the BadgerCare Plus Core Plan waiver program. Enrollment for childless adults is closed. In 2012, the state changed its crowd-out policy for parents and adults; if health insurance costs 9.5% or less of income, they are excluded from coverage.	Pre ACA

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013, updated to reflect eligibility restrictions in Maine as of March 2013.

*AR recieved CMS approval to implement the Medicaid expansion using premium assistance; IA submitted a waiver proposal to CMS that would make program changes related to cost-sharing and premiums and also use premium assistance for populations with incomes between 100-133% FPL; WI has a waiver proposal that would cover childless adults to 100% FPL with no cap (and would be eligible for the regular state FMAP because it is a partial expansion of coverage). MI passed legislation to implement the Medicaid expansion that would require a waiver to implement.

ENDNOTES

- ¹ In addition, Connecticut provides coverage for childless adults through the ACA's 2010 state plan option to expand coverage to childless adults up to 133% FPL prior to January 2014.
- ² Samantha Artiga. *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, May 2012), <http://kff.org/medicaid/issue-brief/an-overview-of-recent-section-1115-medicaid/>.
- ³ Samantha Artiga and Cindy Mann. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2005), <http://kff.org/medicaid/issue-brief/new-directions-for-medicaid-section-1115-waivers/>.
- ⁴ Cindy Mann. *The New Medicaid and CHIP Waiver Initiatives* (Kaiser Commission on Medicaid and the Uninsured, February 2002), <http://www.kff.org/medicaid/report/the-new-medicaid-and-chip-waiver-initiatives/>.
- ⁵ Samantha Artiga and Cindy Mann. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Kaiser Commission on Medicaid and the Uninsured, 2005), <http://www.kff.org/medicaid/issue-brief/new-directions-for-medicaid-section-1115-waivers/>.
- ⁶ Maine's waiver was retro-active to October 2001.
- ⁷ Mann (2002) and Teresa Coughlin, et al, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs*. 25:2 (April 2006), doi: 10.1377/hlthaff.25.w204.
- ⁸ All HIFA waivers are required to include at least a feasibility study of premium assistance.
- ⁹ Laura Snyder and Robin Rudowitz. *Medicaid Enrollment: June 2012 Data Snapshot* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, August 2013), <http://www.kff.org/medicaid/issue-brief/medicaid-enrollment-june-2012-data-snapshot/>.
- ¹⁰ State Medicaid Decisions as of September 30, 2013. Centers for Medicare & Medicaid Services (CMS). *State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014* (September 30, 2013), <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html>.
- ¹¹ A few states have county specific waiver coverage for childless adults including Cook County, Illinois; Cayahoga County, Ohio; and St. Louis, Missouri.
- ¹² Washington, DC uses SPA and waiver for its childless adult coverage expansion.
- ¹³ Waivers will be required to implement both the proposed expansion passed by the Michigan legislature and Pennsylvania governor's proposal.
- ¹⁴ CMS. *2014 Healthy Indiana Plan Extension Approval Letter* (September 3, 2013), <http://www.in.gov/fssa/hip/2429.htm>.
- ¹⁵ CMS. "SoonerCare" Program Extension Approval Letter (September 3, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/ok-soonercare-ca.pdf>.
- ¹⁶ Wisconsin Department of Health Services. *BadgerCare+ Demonstration Project Waiver* (August 15, 2013), <http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm>.
- ¹⁷ Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder. *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2013), <http://kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014>.
- ¹⁸ CMS. *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid* (December 10, 2012), <http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>.
- ¹⁹ BadgerCare+ Demonstration Project Waiver (August 15, 2013).
- ²⁰ CMS. *Affordable Care Act: State Resources FAQ* (April 25, 2013), <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Affordable-Care-Act-Newest-Version.pdf>.
- ²¹ 42 C.F.R. § 1015, 78 Fed. Reg. 42160-42322 (July 15, 2013), <https://www.federalregister.gov/articles/2013/07/15/2013-16271/essential-health-benefits-in-alternative-benefit-plans-eligibility-notice-fair-hearing-and-appeal>; HHS, Medicaid and the Affordable Care Act: Premium Assistance (March 2013), <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-PremiumAssistance.pdf>.
- ²² Note that Iowa's premium assistance application is for 100-133% FPL while Arkansas' waiver is for all newly eligible adults (Iowa is proposing to cover newly eligible (and existing) adults under 100% FPL through Medicaid managed care through a separate waiver application).
- ²³ Letter from Marilyn Tavenner, Dep't of Health & Human Servs., to Andy Allison, Ark. Dep't of Human Servs. (Sept. 27, 2013), <http://posting.arktimes.com/media/pdf/arkansassignedapprovaltr.pdf>.
- ²⁴ MaryBeth Musumeci. *Medicaid Expansion Through Premium Assistance: Arkansas and Iowa's Section 1115 Demonstration Waiver Applications Compared* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September, 2013),

<http://www.kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/>.

²⁵ Office of Governor Tom Corbett. *Healthy Pennsylvania: Reforming Medicaid and Health Pennsylvania* (September 17, 2013), <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=1598151&parentname=ObjMgr&parentid=2&mode=2>.

²⁶ MaryBeth Musumeci. *Medicaid Expansion Through Marketplace Premium Assistance* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2013), <http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>.

²⁷ Joan Alker. *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (Kaiser Family Foundation, March 2013), <http://www.kff.org/medicaid/issue-brief/premium-assistance-in-medicaid-and-chip-an-overview-of-current-options-and-implications-of-the-affordable-care-act/>.

²⁸ CMS. *Questions and Answers: Medicaid and the Affordable Care Act* (February 2013), <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/ACA-FAQ-BHP.pdf>.

²⁹ Robin Rudowitz. *Financing Medicaid Coverage Under Health Reform: What is in the Law and the New FMAP Rules* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, May 2013), <http://www.kff.org/health-reform/issue-brief/financing-medicaid-coverage-under-health-reform-the-role-of-the-federal-government-and-states/>.

³⁰ Office of Governor Tom Corbett (September 17, 2013).

³¹ Act No. 107, Public Acts of 2013. Approved by the Governor, September 16, 2013 [http://www.legislature.mi.gov/\(S\(a1hxol55sxpai453ukfwq55\)\)/mileg.aspx?page=getObject&objectName=2013-HB-4714](http://www.legislature.mi.gov/(S(a1hxol55sxpai453ukfwq55))/mileg.aspx?page=getObject&objectName=2013-HB-4714).

³² Federal Register Vol. 78, No. 135, July 15, 2013, pp. 42307-42310.

³³ CMS. *State Health Official/State Medicaid Director Letter: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014* (May 17, 2013), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>.

³⁴ Targeted Enrollment Strategies Approved by CMS as of October 1, 2103. <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html>.

³⁵ There are additional Medicaid waiver authorities outside of Section 1115. The Affordable Care Act (ACA) created a new Center for Medicare and Medicaid Innovation (CMMI) which is provided waiver authority under Section 1115A to test, evaluate, and expand different service delivery and payment methodology demonstrations to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid, and CHIP. Further, Medicaid waivers may be authorized under Section 1915(b) to permit states to enroll most Medicaid beneficiaries in mandatory managed care and under Section 1915(c) to provide home and community-based services to people who would otherwise need institutional care. In addition, Section 1916(f) provides authority for the Secretary to approve higher cost sharing than otherwise allowed if a demonstration meets specified requirements.

³⁶ U.S. Government Accountability Office. *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency* (GAO-13-384) (June 2013), <http://www.gao.gov/assets/660/655483.pdf>.

³⁷ CMS. *Improved Review and Approval Process for Section 1115 Medicaid Demonstration Projects* (February 22, 2012), <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4284>. The regulations do not apply to amendments to existing Section 115 waivers or Section 1915 waivers.