FEDERAL APPROVAL REQUIREMENTS FOR MEDICAID EXPANSION THROUGH PLAN AMENDMENT OR A SECTION 1115 DEMONSTRATION

The U.S. Supreme Court decision regarding the Affordable Care Act (ACA) gave states the option to expand their state Medicaid programs to cover adults up to 133 percent of poverty (138 percent with an income disregard).

There are two ways that states can take action on this option: (1) a Medicaid state plan amendment, or (2) a Section 1115 demonstration.

States seeking to expand their current Medicaid program to 138 percent of poverty can do so simply by changing the eligibility provisions in their Medicaid plan amendment. If states seek to provide a set of benefits or a service delivery model for this population that is different from their current Medicaid system, depending on the changes, they also may be able to do so in a plan amendment. Once approved, the federal government will pick up 100 percent of the expansion costs for the first three years, phasing down to 90 percent of costs in the future. The Medicaid expansion plan outlined in the Senate version of Senate File 296 can be secured through a straightforward Medicaid plan amendment.

States seeking to expand their current Medicaid program to something less than 138 percent of poverty or seeking to test new approaches to their coverage systems under Medicaid can apply to do so through what are known as Section 1115 demonstrations. These demonstrations can be awarded for a five-year period and can be renewed, typically for an additional three years. They often are referred to as “1115 waivers,” as they enable states to test new approaches that are outside the overall rules governing Medicaid. They must meet specific parameters and their purpose must be to benefit those they cover. They now also require a structured public-comment process and transparent review process at both state and federal levels. The House version of SF 296 approaches Medicaid expansion through a Section 1115 demonstration.

Section 1115 demonstrations come with their own set of rules. While the Centers for Medicaid and Medicare Services (CMS) has not received and acted on any Section 1115 demonstration equivalent to that outlined in the House version of SF 296, CMS has provided some guidance regarding Section 1115 demonstrations that pertains to several of its features and CMS’s authority to approve it. This guidance covers:

- Expansion of Medicaid coverage to a level lower than 138 percent of poverty
- Provision of cost-sharing services (co-payments and deductibles) and more limited health benefits under a Section 1115 demonstration;
- The ability to establish caps or limits on enrollment within a Section 1115 demonstration; and
- The ability to require premiums as part of a Section 1115 demonstration to those under 150 percent of the federal poverty level.

The CMS statements regarding each of these areas are provided in the appendix.

Here is how the CMS describes the purpose of Section 1115 demonstrations on its website:

> *Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:*
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> - *Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible*
> - *Providing services not typically covered by Medicaid*
> - *Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.*
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> *In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver. …*
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> *The Affordable Care Act requires opportunity for public comment and greater transparency of the section 1115 demonstration projects. A final rule, effective on April 27, 2012, establishes a process for ensuring public input into the development and approval of new section 1115 demonstrations as well as extensions of existing demonstrations. This final rule sets standards for making information about Medicaid and CHIP demonstration applications and approved demonstration projects publicly available at the State and Federal levels. The rule ensures that the public will have an opportunity to provide comments on a demonstration while it is under review at CMS. At the same time, the final rule ensures that the development and review of demonstration applications will proceed in a timely and responsive manner.*

Prior to the ACA, Section 1115 demonstrations were used by a number of states (including Iowa, for IowaCare) to expand eligibility to individuals not otherwise eligible for Medicaid. Because these individuals would have had no Medicaid coverage without a demonstration, CMS approved some demonstrations that included expansions of eligibility with more limited benefits or greater cost-sharing and premiums than allowed under Medicaid law at that time. However, since enactment of the ACA and its eligibility expansions, the basis for providing more limited benefits or requiring greater cost-sharing for adults under 133 percent of poverty no longer applies—and Section 1115 demonstrations must meet one of the latter two objectives shown above.

The process the states must take to secure a Section 1115 demonstration, including public comments at both the state and federal levels, is also shown in the appendix. Indiana has started the process for a Section 1115 demonstration for its Healthy Indiana Plan, which has some features in common with the Healthy Iowa Plan in the House version. CMS will not issue any response, beyond the completeness of the application, until after the federal public comment period, which ends May 30.

For more information on Medicaid expansion in Iowa, contact Danielle Oswald-Thole (danielleot@cfpciowa.org) or Sheila Hansen (shansen@cfpciowa.org) or visit www.cfpciowa.org.

APPENDIX

CMS Guidance on Cost-Sharing and Monthly Payments or Premiums

Guidance from Deputy Administrator of CMS, Cindy Mann, to Virginia Secretary of Health and Human Resources, Dr. William Hazel, Jr.

- *Virginia inquired about cost-sharing for a possible expansion population and the current Medicaid population that would exceed what is permitted under section 1916A of the Social Security Act and in CMS' January 22, 2013, Notice of Proposed Rule Making. CMS explained and Virginia agreed that the federal cost-sharing rules permit significantly higher cost-sharing for adults with incomes above 100% of the federal poverty line than for those with lower incomes, and new opportunities to use cost-sharing to reduce unnecessary emergency room care and to promote use of preferred drugs.* ***CMS and Virginia further agree that the federal government has very limited flexibility under the statute to waive statutory cost-sharing requirements for the expansion population, or for the existing lowest income Medicaid population. Cost-sharing for the expansion and current Medicaid populations, therefore, must conform to limits as established by statute and regulation.*** *However, within those parameters states have flexibility to vary cost-sharing across groups and for services including for appropriate pilot projects to test payment and delivery reforms. Virginia has various options for designing the benefit package benchmarked to a commercial product for the adult expansion population (including newly eligible adults with incomes below the federal poverty line).*

Guidance from Deputy Administrator of CMS, Cindy Mann, to Sen. Pam Jochum (04.23.2013)

- *To what extent may HHS approve section 1115 demonstrations that incorporate cost-sharing, including monthly payments or premiums on the part of enrollees?*

  The Medicaid statute provides considerable flexibility (no waiver is required) with respect to cost-sharing in the form of copayments and similar fees for individuals with incomes above 100% of the federal poverty level ($11,490 for a single person in 2013), and we have recently proposed additional flexibility for lower income individuals with respect to copayments imposed for nonemergency use of emergency room services and for non-preferred drugs. In addition, I would also note that states may structure their copayments to provide incentives for individuals to meet state-designed activities designed to promote better health.

  *To the extent a state is seeking a waiver to impose copayments beyond the levels permitted by statue, federal law specifies conditions under which such waivers be granted (see section 1916(f) of the Social Security Act****). In general, the statute does not permit premiums for beneficiaries whose incomes are below 150% of the poverty level. Prior to the Affordable Care Act, HHS approved the use of premiums in some section 1115 demonstrations, but has not generally permitted premiums for populations with incomes below the poverty level.***

CMS Guidance on Essential Health Benefits Plans

Guidance from Deputy Administrator of CMS, Cindy Mann, to Sen. Pam Jochum (04.23.2013)

- *To what extent can a state, through a section 1115 demonstration, adopt benefits below what constitutes an essential health benefits plan?*

  There is considerable flexibility in the statute for a state to design its benefit package for the newly eligible adults benchmarked to commercial plans as long as individuals have access to a core set of "essential health benefits"—the same set of benefits that will be assured to individuals purchasing coverage in the small and individual group markets in the new Marketplace… However, ***given the focus in the Affordable Care Act on ensuring the essential health benefits are to available across all programs as well as the individual and small group markets, we do not anticipate approval of a benefit package that would provide less than the essential health benefits for the lowest income Americans.***

CMS Guidance on Enrollment Caps and Periods of Ineligibility

Guidance from CMS (issued 04.25.2013)

- *Will CMS approve enrollment caps or periods of ineligibility in section 1115 demonstrations?*

  The Affordable Care Act provides significant federal support to ensure the availability of coverage to low-income adults. Enrollment caps limit enrollment in coverage on a first come, first serve basis. Periods of ineligibility delay or deny coverage for otherwise eligible individuals. These policies do not further the objectives of the Medicaid program, which is the statutory requirement for allowing section 1115 demonstrations. ***As such, we do not anticipate that we would authorize enrollment caps or similar policies through section 1115 demonstrations for the new adult group or similar populations.***

CMS Guidance on Partial Expansion and Federal Matching Funds

Guidance from CMS (issued 12.10.2012)

- *Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?*

  No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. ***If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate.***

CMS Process and Timeline for Submission of 1115 Demonstration Project

Guidance from CMS (issued 04.27.2012)

At a minimum, from the time of development of the application materials there is at least a three-month period for securing approval. The following outlines the required application process and its public input involvement provisions.

1. *Standardized Application Materials.* State develops and posts 1115 demonstration proposal.
2. *Public Input at the State Level.* State solicits meaningful public input from the public regarding the proposal, **with at least a 30-day period for response and two public hearings** occurring at least twenty days before submission of the 1115 demonstration proposal.
3. *Formal Submission to CMS.* **State submits 1115 demonstration to CMS, including "a report of the issues raised through the public comment period** and…how the State considered those comments when developing its application for submission to CMS."
4. *Assessment of Completeness of Application.* **Within 15 days of the submission of the application, CMS will report to the state whether the application is complete** or whether additional information is needed.
5. *Public Input at the Federal Level.* Once CMS notifies the state of the completeness of the 1115 demonstration application, the **demonstration request will be posted for a 30-day national public comment period**, with comments published, reviewed and considered.
6. *Earliest Federal Action.* No sooner than 45 days after the posting for public comment, CMS will render a final decision.
7. *Post Implementation Public Forum.* At least six months after approval, the state must convene a post-award forum to solicit public comment.