Medicaid Waiver Toolkit

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# Medicaid Waiver Toolkit

## Executive Summary

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**STATE POLICY NETWORK**

Executive Summary

Despite the transfer of power in Washington, many states remain understandably frustrated that so-called Washington solutions to the mounting healthcare crisis remain elusive and largely inadequate in their scope. While there may be cause for hope that more flexibility may be coming from a new administration, states must realize what opportunities already exist to begin immediately reclaiming control of their healthcare marketplaces.

Whether or not “Obamacare” stays or goes, this toolkit outlines twenty reforms that states can begin seeking immediately to flex their muscles against Washington’s bureaucratic red tape. By taking advantage of opportunities that already exist and demanding even greater flexibility through the process, states can innovate with more affordable, accessible, market-driven healthcare solutions whether or not Washington passes reforms dismantling Obamacare. The reforms envision a Medicaid program that has resources to help the truly needy and has transitioned healthy adults into the workforce where they can live better.

WHY NOW IS THE TIME TO USE WAIVERS

In March 2017, Secretary of Health and Human Services (HHS) Tom Price and Administrator of the Centers for Medicare and Medicaid Services (CMS) Seema Verna co-signed a letter to the nation’s governors. It called for federal-state collaboration in encouraging states to redesign their Medicaid programs. In the letter, they stated:

“Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid’s challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.”

This new approach is as critical as it is welcome. The Medicaid program was originally supposed to provide healthcare services to the poor and disadvantaged. Today, the program has grown far beyond that original mandate with negative implications for recipients, healthcare providers, policymakers, and taxpayers. Medicaid now accounts for more than one-quarter of state budgets (when counting federal and state funding) compared to 11 percent in 1988. This trend is unsustainable as Medicaid threatens to squeeze out spending for other state priorities such as education and transportation.

This signal from HHS encouraging state innovation in the Medicaid program, is a historic opportunity for states to reimagine Medicaid. Keeping in mind that legislative action aimed at repealing or replacing the Affordable Care Act (ACA) could soon provide additional opportunities; now is the time for states to begin crafting new approaches for delivering higher-quality care to our most vulnerable while at the same time effectively allocating taxpayers’ hard-earned dollars.

The proposed Medicaid reforms in this healthcare policy toolkit provide lawmakers and policy groups with a starting point to begin proposals for reforming the program. While this...
 toolkit is based on potential Section 1115 waivers and state plan amendments that states can now submit to HHS, these approaches can also be used as a framework for identifying statutory barriers to state flexibility under the proposed Block Grant Funding and Per Capita Cap proposals being considered in Washington.

In Section 1902 of the Social Security Act, states may seek to modify statutory requirements of the Medicaid program through a Section 1115 waiver. The HHS Secretary has enormous discretion over how and when these requirements can be waived or modified.

The current administration could provide more a more favorable response to many of the waiver applications that were denied in the previous administration.

States already have some discretion in how they implement their Medicaid programs. In some cases, states may only need to submit a state plan amendment, which describes how the state will administer its program.

This toolkit will focus primarily on these two implementation vehicles and is not intended to provide an exhaustive list of possible ways to improve the program in every state. It is a starting point to encourage states to look at ideas that have been submitted in past years and take the opportunity to tailor their Medicaid program to their state’s unique needs and populations.
Possible reforms for consideration include:

**TIER 1 REFORMS**
- Work Requirements and Activities
- Enrollment Freezes & Caps
- Eligibility Redetermination
- Direct Primary Care
- Health Savings Vehicles

**TIER 2 REFORMS**
- Lock-Out Periods
- Lifetime Time Limits
- Incentivize Lower Cost Surgical Options
- Eliminate Retroactive Eligibility
- Telehealth Medicine

**OTHER REFORMS**
- Medicaid Queues and Charity Days
- Benefit Flexibility
- Wellness Incentives
- Maintenance of Effort
- Use of Lower-Cost Transportation Options
- Premiums
- Copays for Missed Appointments and Unnecessary ER Visits
- Blend Funding Streams
- Consumer Driven Models
- Balance Billing
One in seven Medicaid recipients is an able-bodied adult above the poverty level who will lose 100 percent of their benefits if they increase their income by even $1. Bottom line? The current system is rigged to discourage work—and it works.

**The Solution:** States should take advantage of potentially newly granted flexibility from Washington to seek a waiver from this current approach and institute work requirements for able-bodied adults as a condition for their receipt of Medicaid benefits.

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**THE PROBLEM**

The Medicaid program was originally designed to provide a safety net of healthcare services for the poor and disadvantaged in society. Today, the program goes far beyond that. Of the 73 million people currently enrolled in the program, about one in seven is an able-bodied adult above the poverty level. These individuals lose 100 percent of their Medicaid benefits once their incomes rise above the income eligibility threshold (138 percent of poverty). In other words, if they earn 139 percent of the poverty level, they lose all Medicaid benefits.

This work disincentive creates a “welfare cliff” which discourages individuals from seeking additional work and earnings. Instead of serving as a safety net, the program has become a poverty trap that can discourage additional work, promotion, or transfer to a better opportunity for participants.

**THE SOLUTION**

States need tools that give them more discretion in prioritizing spending and directing it toward the highest priorities, including the most vulnerable Medicaid recipients. But the Medicaid expansion funding formula may encourage states to cut spending and services on the most vulnerable in times of budget crises.

For example, a state would need to cut about $2 in Medicaid spending on the traditional Medicaid population to save $1 of state spending. But because the federal government is picking up most of the tab for the expansion population, a state would need to cut up to $10 in Medicaid spending on the expansion population to save $1 in state spending.

Multiple states have previously sought to impose work requirements on able-bodied Medicaid recipients. Unfortunately, the Centers for Medicare and Medicaid Services (CMS) has never approved a waiver application that would make work a condition of Medicaid eligibility.

**IMPLEMENTATION VEHICLE**

States may seek a Section 1115 waiver authority under Section 1902(a)(10)(A) of the Social Security Act to seek to impose work requirements for “able-bodied adults.”
POTENTIAL IMPACT OF REFORM
A proposed work requirement shines a bright light on why the Medicaid expansion is, in some cases, counterproductive. States need the tools to ensure that limited resources are directed to the truly needy, operating as a temporary safety net for able-bodied adults.

Imposing work requirements for able-bodied adults as a condition of eligibility will not only ensure that recipients continue to engage in productive work activities, it will also add protections for the most vulnerable who rely on the program.

ADDITIONAL RESOURCES

2. Press to Freeze and Cap Your State Medicaid Program

THE PROBLEM
Medicaid is an entitlement program, meaning that someone can use the Medicaid program if they qualify for its coverage. States are required to accept all eligible recipients in the current Medicaid program.

THE SOLUTION
A Medicaid waiver that freezes or caps enrollment would change Medicaid from an open-ended entitlement program to a program with a budget. The Obama administration said that waivers that sought to limit Medicaid enrollment would not be allowed. A Medicaid freeze would violate an applicable maintenance of effort law as well.

States are required to accept all eligible applicants for Medicaid and the consequence is an unsustainable growth of a program that states can no longer afford.

The Solution: States should file waiver requests that press Washington for permission to freeze and cap enrollment to Medicaid at current levels. Such freezes and caps would slowly deflate the program as enrollees naturally cycle off and curtail ballooning costs.

The Medicaid freeze halts enrollment in the Medicaid program either permanently or for a specified period of time. As recipients find work and leave the program, the Medicaid rolls decrease. Medicaid freezes have been a valuable way to control a program that has grown too quickly.

IMPLEMENTATION VEHICLE
In 2011, Arizona allowed a Medicaid waiver to expire, and the expiration allowed the state to freeze the enrollment of the childless adult population in July 2011. As a result, the Arizona enrollment numbers drastically declined from almost 225,000 in the spring of 2011 to less than 68,000 by December 2013. HHS denied a waiver request to freeze enrollment for traditional Medicaid population. This waiver was for Section 1902(GG), which is the maintenance of effort enacted in the Affordable Care Act.

In 2005, Maine started an experimental expansion of the Medicaid program for childless adults called Mainecare. Enrollment surged, and Maine quickly froze enrollment. In nine months, enrollment in the program fell 40 percent. In 2012, Maine submitted a waiver from the ACA Maintenance of Effort on the grounds the state was running a deficit and Medicaid was not affordable.

After expanding their program to able-bodied, childless adults in 1994, Tennessee began disenrolling 170,000 from their expansion program in 2005 due to budget shortfalls. Economic researchers attributed a sudden increase in employment to those individuals re-entering the workforce.
POTENTIAL IMPACT OF REFORM
A Medicaid freeze would not harm current enrollees in the system, and it would re-emphasize private market alternatives. Many Medicaid recipients move in and out of the labor force and may not qualify for Medicaid for a period. This “churn” would mean that recipients would leave the Medicaid program and not return. This would encourage them to find alternative healthcare through either private coverage or charitable institutions. The rate of churn is significant, and one estimate is that almost all Medicaid expansion recipients would exit Medicaid for a short period of the next three years. This would effective-ly eliminate the expansion population and allow Medicaid to again focus on the truly needy.

ADDITIONAL RESOURCES
3. Re-determine Eligibility for Medicaid Recipients

**THE PROBLEM**
When an ineligible person is not removed from the managed care rolls, the state is essentially throwing away taxpayer money. Every dollar spent on an individual who is no longer eligible for the program—often not even living in the state or now covered through other insurance—is a dollar diverted away from other state priorities and taxpayers’ wallets.

The fiscal impact of the Medicaid expansion was already a concern in many states before the ACA became law. Now the dramatic increase in Medicaid rolls threatens to leave states stuck footing the bill for a larger-than-predicted number of enrollees with the prospect of doing so with fewer federal dollars in the coming years should there be additional reforms and/or federal spending limits imposed on the Medicaid program.

**States are increasingly shifting more of their Medicaid populations from a fee-for-services model, where the program pays for services used, to managed care, where the program pays a flat amount for each enrollee. That is why it is important for states to ensure that only eligible individuals participate in the program.**

It is a fact that there are ineligible people enrolled in Medicaid. While there are cases of intentional fraud, this situation frequently occurs for a variety of other reasons. For example, an enrollee may move out of state, obtain private health coverage, or may no longer be eligible due to income above the eligibility threshold.

**THE SOLUTION**
Federal law (42 CFR 431.10) requires that each state participating in the Medicaid program submits a state plan to CMS, setting many of the operational and policy parameters of their program. The state plan must include state-specific standards for determining Medicaid eligibility.

In 2012, Illinois lawmakers implemented the SMART Act (Save Medicaid Access and Resources Together) which required a systematic audit of Medicaid eligibility. They found that the Medicaid rolls contained more than 8,000 dead people and that 300,000 people no longer met the requirements for Medicaid eligibility.

**IMPLEMENTATION VEHICLE**
A state may revise its eligibility verification plan by filing a state plan amendment with CMS.
POTENTIAL IMPACT OF REFORM

Waste and fraud squeeze out spending in other priority areas while also diverting taxpayer resources away from the neediest patients. State lawmakers should ensure that taxpayer dollars are being spent wisely, ensuring that only those who are eligible are benefiting from the program.

ADDITIONAL RESOURCES

4. Embrace Direct Primary Care

THE PROBLEM
Traditional Medicaid is based on either the old fee for service system or managed care. Most Medicaid programs do not take advantage of innovations in the delivery of healthcare that lower overall costs. As a result, Medicaid recipients can have trouble finding doctors or getting effective care due to low reimbursement rates and lack of providers who accept Medicaid patients. Meanwhile Medicaid costs continue to grow while straining state budgets.

THE SOLUTION
Medicaid can use innovations in healthcare delivery, like direct primary care (DPC), to offer equal or better care for a lower price. In DPC, a patient pays a monthly fee directly to a provider in exchange for healthcare. The provider can then focus on medical care instead of worrying about billing or insurance companies. These savings can reduce the price of medical services by up to 20 percent. In some states, the Medicaid program can pay directly to a DPC provider network to allow Medicaid recipients to use DPC.

IMPLEMENTATION VEHICLE
Some states will need to change their laws to allow direct primary care providers to easily treat Medicaid recipients. States would also need to allow DPC companies to be paid by Medicaid. Funding could go directly to the DPC provider either from the state or in partnership with an existing Medicaid provider.

States should file a new State Plan Amendment to ensure federal approval for different payment rates to Medicaid providers.

ADDITIONAL RESOURCES

5. Incentivize Fiscal Responsibility Through Health Savings Accounts (HSAs)

Medicaid beneficiaries sometimes overpay or use unnecessary services because they have few incentives to be cost-conscious.

**The Solution:** Introducing Medicaid recipients to the same incentives of private coverage by encouraging (or requiring) contributions toward an HSA or allowing them to purchase private coverage with HSA dollars increases awareness of the costs of services and can help to ease transition from Medicaid to private plans.

**THE PROBLEM**
Medicaid encourages beneficiaries to use medical services they may not need. In a fee for service system, providers can have an incentive to provide more expensive services. Medicaid epitomizes the problem of a healthcare system where neither the patient nor provider has an incentive to find the most efficient service.

**THE SOLUTION**
State Medicaid programs can use HSAs—a tool that is already available to the private sector. HSAs encourage savings for medical needs and smarter health spending by account holders. Several states have established forms of HSAs that use funds from the Medicaid program. Many states require or encourage enrollees to contribute to the savings account to ensure that enrollees have their money in their account. By “having skin in the game,” patients will have an additional incentive to find the most effective care.

Indiana obtained a waiver that expanded Medicaid and established a health savings vehicle. CMS waived Section 1902(A)(10)(B) to facilitate the creation of the health savings vehicle, to allow bonus contributions to an account and to alter the mix of benefits.

Kentucky’s proposed Medicaid plan would establish two saving vehicles. One of the savings programs could be used to purchase optional, additional benefits while the other account is used to pay for cost-sharing provisions such as deductibles. Kentucky would contribute toward the deductible account with half of the deductible balance being allowed to roll over into the optional benefits account. Kentucky will also pay money to the optional account if an enrollee performs certain healthy activities. In addition, Kentucky requested a waiver for 1902(A)(10)(B) to help create the savings vehicles.

**IMPLEMENTATION VEHICLE**
States are using a Section 1115 waiver from the federal government to establish HSAs. A state should submit a waiver for Section 1902(a)(10)(B) to help create the account and for Section 1902(A)(14) to implement cost sharing and contributions. The contributions to the health savings vehicles are not considered premiums, but rather savings that are available for qualified use by an enrollee. Some of the savings vehicles are designed to facilitate the transition from a Medicaid program to private coverage, and funds in a savings vehicle could be used to pay for private health premiums. The Healthy Indiana plan was innovative in its use of savings vehicles and led to similar plans in neighboring states.
POTENTIAL IMPACT OF REFORM
Private application of HSAs can lead to and has resulted in lower health spending. By adopting this reform, states could see lower Medicaid expenditures, especially in Fee-For-Service (FFS) states. As recipients build up health savings, it could be easier to transition them to private insurance coverage and use the savings account to pay for a premium. These accounts could also help reduce Medicaid enrollees and strengthen the private market.

ADDITIONAL RESOURCES

6. Impose Lockout Periods for Failure to Pay

Many states require Medicaid recipients to share some portion of the costs. However, few states have any enforcement mechanisms when recipients fail to pay their share of the costs.

The Solution: States should include a maximum 90-day lockout period in waiver requests for non-payment or missed appointments (consistent with the maximum lockout period already permitted by the feds for the CHIP program).

THE PROBLEM
States have few ways to encourage Medicaid recipients to follow Medicaid rules. As a result, recipients are not penalized when they miss medical appointments or fail to pay their share of costs. States need ways to encourage recipients to more effectively use the program and prevent waste.

THE SOLUTION
In the private sector, missed payments often result in the cancellation or suspension of a service or a good. A Medicaid lockout period would temporarily bar Medicaid recipients from Medicaid services as a result of missed payments.

More than half of states charge a type of premium for the Medicaid benefit, and over 20 states will cancel Medicaid benefits for non-payment after 60 days. Several states have proposed a lockout period, where Medicaid recipients are barred from benefits for a certain period or until they pay their share of costs. While there is no current lockout period in Medicaid, there is a lockout period for CHIP with a maximum of 90 days. A Medicaid waiver that institutes a lockout period would bring both programs into parity.

Lockout periods would encourage Medicaid enrollees to pay their premiums. Research on existing lockout periods found that enrollees were aware of the potential to lose benefits for non-payment. Over three-fourths of Healthy Indiana enrollees were aware of the consequence for premium nonpayment. Recipients who are locked out due to non-payment can re-enroll if they meet certain requirements.

Many states submitted waivers to the Obama administration that included lockout periods for either non-payment of premiums or failure to follow other rules such as enrollment renewals. The administration rejected some of these waivers while approving others in the context of Medicaid expansion.

In 2016, Indiana submitted a waiver that would create a six-month lockout for able-body recipients who did not re-enroll in Healthy Indiana during the enrollment period. The state wanted to institute this lockout period to simulate the private market and prepare recipients for private coverage. CMS rejected that element of the waiver, noting that no lockout had ever been allowed for things like missing enrollment deadlines. Indiana does have an income-based lockout approved that would affect Medicaid recipients who miss premium payments.
Kentucky submitted a waiver that seeks to duplicate Indiana’s six-month lockout for failure to pay premiums over a sixty-day period. Recipients who had a family income over 100 percent of federal poverty level would be disenrolled and locked out of Medicaid for six months. Recipients in poverty would have restricted benefits. Locked out recipients can re-enroll if they pay past due premiums, the current month’s premium, and attend a financial literacy class. The waiver is currently pending before CMS.

In 2015, Montana had a waiver approved that disenrolled recipients over 100 percent of federal poverty level for missed premiums. Under the proposed waiver, recipients were locked out of the Medicaid program until they had paid their arrears or a lien was collected against their income tax liability. The waiver application specified that section 1902 (a)(8) would be waived to allow disenrollments for non-payment. The final waiver modified the lock-out period to a ninety-day grace period for non-payment and allowed re-enrollment at the end of a quarter.

IMPLEMENTATION VEHICLE
States would submit a Section 1115 waiver seeking to impose a lockout period for failure to pay Medicaid premiums.

POTENTIAL IMPACT OF REFORM
Lockout periods would encourage Medicaid recipients to pay their share of a medical payment in a timely fashion. It would give them experience in handling payments in the private sector and make the transition to private coverage easier. A lockout period can also help to ensure that recipients are not abusing the system and preserve Medicaid for the truly needy.

ADDITIONAL RESOURCES
7. Impose Time or Cost Limits for Enrollment on Medicaid

**THE PROBLEM**

Medicaid is a means-tested program that provides benefits to eligible recipients below a certain income level. Means-tested programs provide an economic incentive for beneficiaries to reduce work effort in order to maintain their benefits. Many economic studies have found that beneficiaries do act rationally and work less when they receive means-tested benefits. A waiver that includes time limits seeks to reduce this type of moral hazard by encouraging able-bodied beneficiaries to return to the workforce.

**THE SOLUTION**

The Congressional Budget Office (CBO) examined the ACA’s effects on the labor market and estimated that it will result in a reduction in the total hours of work almost entirely driven by workers choosing to work less. Establishing time limits on dependency programs prevents recipients from becoming dependent on the program and choosing to reduce their hours worked or dropping out of the labor force.

A time limit is a restriction on how long a beneficiary can be on the Medicaid program before there is a change in their benefit structure or they are no longer eligible for benefits. A lifetime time limit is how long a beneficiary can be on Medicaid in their working life. Waivers for a restriction on lifetime benefits have always applied to only able-bodied working age adults. Able-bodied working age adults will lose Medicaid eligibility if they exceed their lifetime limits.

Lifetime benefit limits were a key piece of welfare reform that was enacted in a bipartisan fashion in 1996. Studies of welfare reform found that predictions of hardship and woe were inflated as recipients either found work or other forms of support. However, some lifetime benefit supporters are concerned that the time limit had limited impact on welfare recipients due to many loopholes in the welfare reform law.

**IMPLEMENTATION VEHICLE**

A state would need to submit a Section 1115 waiver and CMS would need to approve it before Medicaid time limits can be implemented by a state.

In recent years, many Medicaid waivers that have proposed time limits with a strict lifetime limit have been rejected.

Medicaid recipients stand to lose thousands of dollars in benefits if they earn just one dollar above the income eligibility requirement for the program thus discouraging them from bettering their circumstances and encouraging them to stay dependent on state benefits.

**The Solution:** States should submit a Section 1115 waiver to CMS seeking to impose limits to the costs a state can incur from an individual’s enrollment on Medicaid by limiting the number of years an individual can receive Medicaid, the total amount of dollars an individual receives, the total amount a state spends per person’s tenure on Medicaid, or other such reforms.
In 2016, the Obama administration rejected a waiver from Arizona that would have established a five-year lifetime benefit limit for Medicaid recipients. Arizona did not want Medicaid to increase dependency and adopted a lifetime limit similar to welfare programs. That administration believed that time limits do not contribute to healthy outcomes and are against the goal of the Medicaid program.

A 2008 Indiana waiver did not have a time limit but did have a dollar limit of $1 million. The more recent Healthy Indiana 2.0 did not have any time or dollar limits.

In 2015, Michigan submitted a waiver that changed benefits for recipients who exceeded 48 months. These recipients would face either higher cost sharing of 7 percent or could receive a subsidy to enroll in private coverage. A waiver of 7 percent cost sharing was needed since current law restricts cost sharing to 5 percent. CMS and Michigan agreed to a modified waiver concept that significantly weakened the time limits.

**POTENTIAL IMPACT OF REFORM**

Time limits implemented with welfare reform have demonstrated mixed results and very few welfare recipients have actually reached the end of their benefits. The impact of a Medicaid time limit will depend upon a limited number of exceptions to the time limit rule. This reform should help increase labor supply and productivity as Medicaid recipients will no longer have disincentives to work in order to remain in the Medicaid program.

**ADDITIONAL RESOURCES**

8. Incentivize Lower-Cost Surgical Options: Hospitals

Medicaid and Medicare patients who opt for ambulatory surgery centers (ASCs) over costlier hospital outpatient departments (HOPDs) can save money for themselves and the programs. Despite this fact, many states set up the wrong incentive by charging copays for use of ASCs but not for HOPDs.

The Solution: States operating fee-for-service Medicaid programs should eliminate copays for ASCs. All states should make ASCs preferred providers and require prior authorization for use of HOPDs.

THE PROBLEM
Ambulatory surgery centers (ASCs) are free-standing medical facilities that provide same-day surgical, preventive, and diagnostic procedures. They treat less-complicated medical cases than those that require overnight stays and are typically best performed in hospitals. ASCs also have a strong record of positive patient outcomes, high quality, and overall patient satisfaction—often at a fraction of the cost charged by hospitals. Today, Medicare-certified ASCs are in all 50 states.

Due to ASCs lower costs and high quality of care, employers and private insurance have been seeking ways to incentivize patient selection of ASCs over hospitals for routine surgical procedures. However, many states still incentivize Medicaid beneficiaries to choose HOPDs by imposing copays on ASCs and not for HOPDs.

THE SOLUTION
Given the cost savings that are already being realized by private insurers, the Medicare program, and employers, states should seek to incentivize the use of ASCs when available and appropriate for beneficiaries.

As a first step to incentivizing the use of ASCs, states should re-examine their copayment structure for the use of hospitals and ASCs. States operating Medicaid fee-for-service (FFS) programs should begin by eliminating copays for the use of ASCs over HOPDs and imposing prior authorization requirements on the use of HOPDs.

IMPLEMENTATION VEHICLE
Many states already impose copays for ASCs and HOPDs and use prior authorization. These systems should be aligned to ensure that ASCs are the preferred provider (when available and suitable for the patient).

States may impose copays that are below federal limits and use prior authorization. To make changes to their current system, states may file a state plan amendment with CMS.

POTENTIAL IMPACT OF REFORM
A 2013 study by researchers at the University of California, Berkeley found that ASCs saved the Medicare program $7.5 billion between 2008 and 2011. The researchers also found that ASCs have the potential to save the program $57.6 billion over the next decade. The same cost savings and health benefits from ASCs in the Medicare program should be available to states in the Medicaid program.
ADDITIONAL RESOURCES
Providers and some individuals eligible for Medicaid can request retroactive coverage for unpaid medical claims for the three months prior to enrollment applications. Consequences include incentives for providers to push patients to Medicaid enrollment to ensure payment for past services and for individuals with copays to delay enrollment—knowing they will be covered—to keep from paying their fair share.

**The Solution:** States should apply for a Section 1115 waiver to eliminate the three months of retroactive Medicaid eligibility. Additionally, states should also make benefits available only when individuals have begun contributing to their plan.

**THE PROBLEM**

In some cases, Medicaid provides retroactive coverage for up to three months for beneficiaries. To receive benefits, a recipient must be eligible for Medicaid during the retroactive period. This creates two incentive problems. The first problem is that some providers will want to enroll people into Medicaid to ensure payments of procedures up to three months in the past. The second problem is that if a patient knows he can be covered after the fact that patient may have an incentive to delay enrollment. This is particularly a problem with Medicaid programs that have cost-sharing provisions. A patient has an economic incentive not to enroll in Medicaid if they have to pay a premium since they can always be covered after they need medical care.

**THE SOLUTION**

Many states are moving toward cost sharing provisions. To make these Medicaid reforms work, states need Medicaid recipients to enroll prospectively. Several states either have received or are applying for waivers that would eliminate retroactive eligibility.

Indiana’s waiver plan disallowed retroactive eligibility. Instead, benefits would commence when a potential recipient had enrolled in a Healthy Indiana plan. The state also wanted to disallow benefits until some enrollees had started to contribute to the savings plan. New Hampshire received a similar waiver for their premium assistance program.

Arkansas also sought a waiver to eliminate retroactive eligibility. Arkansas wants to move enrollees from Medicaid to private coverage, and retroactive eligibility makes this transition harder since there is not a comparable eligibility requirement in private coverage. This waiver was conditionally approved by CMS in 2016.

With the goal of cost savings, this reform helps make some Medicaid behave more like its private market counterparts.
Kentucky made a similar waiver request where coverage would begin when a premium was paid instead of retroactive coverage. Again, the goal is to align the Medicaid program with private coverage that does not begin until the first premium is paid.

**IMPLEMENTATION VEHICLE**

States will need to apply for a Section 1115 waiver and have CMS approve the waiver. States wishing to change the period in which retroactive benefits are allowed will need to waive Section 1902(a)(34).

**POTENTIAL IMPACT OF REFORM**

With the goal of cost savings, this reform helps make some Medicaid behave more like its private market counterparts. It encourages potential Medicaid recipients to enroll in the program before they need coverage. If Medicaid recipients do not enroll, then they cannot accrue savings in a savings vehicle or use private coverage. Eliminating retroactive eligibility strengthens many other Medicaid reform ideas.

**ADDITIONAL RESOURCES**

THE PROBLEM
Many healthcare providers do not see Medicaid recipients due to low reimbursement rates. Additionally, many rural areas lack access to health providers.

The federal government is now using distance to a healthcare provider as a way to monitor states’ Medicaid programs. States need creative and efficient new solutions to provide healthcare to Medicaid recipients.

THE SOLUTION
Telemedicine is a type of medical care where healthcare providers are not physically present while providing medical services to a patient. Almost every state now includes some form of telemedicine in its Medicaid program. There is still room for growth where more states can use this innovation more broadly. Telemedicine allows health providers to see patients through electronic services. Providers can make a diagnosis and issue prescriptions. Costs of telemedicine services are lower than traditional medical care and can help lower overall costs and stabilize state budgets.

Telemedicine can allow patients to see providers from their own homes—an especially important feature for rural and elderly patients who may need to travel great distances to see providers. Originally, many telemedicine services were restricted to rural Medicaid recipients but, over time, states have gradually increased the areas telemedicine providers can serve.

IMPLEMENTATION VEHICLE
States will need to examine their own laws to ensure healthcare regulations allow broad use of telemedicine. For example, some scope of practice laws may restrict Medicaid services from being offered via telemedicine. Other laws may bar medical providers from using telemedicine to practice across state lines.

If a state takes advantage of telemedicine being cheaper than face-to-face coverage, the state will need to submit a different State Plan Amendment (SPA) in order to pay a different reimbursement amount. In the SPA, the state may also want to describe what coverage is available under the telemedicine services.

A Section 1115 waiver may be necessary if a state is changing some of the fundamental federal rules regarding Medicaid services. There are examples of states, like Illinois, incorporating a Section 1115 waiver with a SPA to expand telemedicine.
ADDITIONAL RESOURCES
11. Consider Medicaid Queues and Charity Days to Address Provider Shortage

THE PROBLEM
A majority of states report difficulty in ensuring an adequate number of healthcare providers participate in their Medicaid programs. This finding has been confirmed, repeatedly, by the U.S. Government Accountability Office (GAO). Not only is patient access far more limited under Medicaid than under private coverage, but Medicaid patients in some states may now be facing, even more difficulty in obtaining care as Medicaid enrollment has dramatically increased while the number of providers has not.

Increasingly, healthcare providers are choosing not to accept Medicaid patients due to diminishing reimbursement rates and missed appointments (among other reasons). Medicaid beneficiaries face long lines or a total dearth of Medicaid providers.

The Solution: Rather than allowing medical providers to heavily restrict the amount of Medicaid patients they will treat, states should allow providers to set a limited number of dates and times during which they will see Medicaid patients. This solution limits providers’ financial liability while making caregivers more accessible to Medicaid patients.

While low reimbursement is certainly an important factor in providers not accepting Medicaid patients, it is not the only one. A variety of other factors, such as missed appointments, also contribute to the shortage of providers.

THE SOLUTION
To increase access to healthcare providers, states should allow “Medicaid and charity care days” where providers could offer patients queued for service care under Medicaid. States could set parameters when this could be allowed, such as a limited number of days per week.

While a handful of states require equal treatment between Medicaid beneficiaries and the general public as part of their administrative regulations or contractual provisions, there is no explicit federal requirement. In fact, states seem to have their interpretations of federal law and judicial holdings surrounding this issue. As a result, interpretations vary widely.

Most Medicaid providers already restrict the number of Medicaid patients they treat. According to a Goldwater Institute legal analysis, “limiting the days or times for which Medicaid beneficiaries may schedule appointments is far less restrictive than only allowing a certain amount of Medicaid patients overall. Therefore, although there may be potential violations of Title VI by restricting scheduling times, it seems more likely to pass the court’s scrutiny than not.”

Federal law (42 CFR 447.20) sets out state plan requirements for providers, such as parameters and rules for Medicaid reimbursement.
IMPLEMENTATION VEHICLE
While Medicaid patient queueing has not yet been pursued, states should seek to revise their provider provisions to allow for it. As a first step, a state might limit this approach to medical specialties where there is an acute shortage of Medicaid providers. A state plan amendment could accomplish this reform.

POTENTIAL IMPACT OF REFORM
The Medicaid patient high “no-show” rate is a contributing factor for physicians when limiting the number of Medicaid patients that they are willing to treat (even if they participate in the program). That is because a provider can lose the potential Medicaid payment, which is almost always well below private coverage reimbursement and sometimes below the actual cost of providing care. By allowing providers more (even if limited) flexibility in scheduling, this reform could increase the number of willing providers for medically underserved Medicaid populations.
12. Increase Medicaid Benefit Flexibility to Focus on Truly Vulnerable

**THE PROBLEM**
States are required to provide comparable services to both their mandatory and optional populations. This requirement forces states to provide the same comprehensive benefits package to a severely disabled Medicaid recipient as to an able-bodied adult.

This requirement has the potential to misallocate resources by possibly limiting needed resources for the most medically vulnerable while providing nonessential benefits to others. In recent years, there have been more incidents of states placing developmentally disabled recipients on waiting lists for care. Realizing that some individuals in the optional Medicaid population have significant medical needs, this approach should focus on the able-bodied, optional beneficiaries.

**THE SOLUTION**
States should have the flexibility to determine the benefits and services that are available to optional individuals. This frees up limited resources for those with the greatest medical needs and encourages innovation in a variety of plan benefit designs including consumer-driven approaches to coverage.

**IMPLEMENTATION VEHICLE**
States will need to seek a Section 1115 waiver (1902(a)(10)(B)) to provide alternative benefit packages to their optional Medicaid populations.

**POTENTIAL IMPACT OF REFORM**
Allowing states to vary the Medicaid benefits package based on the recipient’s eligibility group, will provide states the flexibility—and incentives—to better tailor their Medicaid health benefit plans to the needs of varying populations.

**ADDITIONAL RESOURCES**
13. Introduce Wellness Incentives with a Health Savings Account

Traditionally, Medicaid patients have been insulated from understanding the true costs of care and lack exposure to managing popular private plan components such as wellness incentives. This experience could also make it easier for them to smoothly transition to private coverage.

The Solution: File a Section 1115 waiver to introduce a health savings account (HSAs) vehicle to beneficiaries, allowing funds to roll over from year-to-year with a sliding scale for premium contributions that could be spent on enhanced programs such as job and training activities, as well as cover copays and any fees for non-emergency use of the emergency room.

THE PROBLEM
Too often, Medicaid recipients are disconnected from program costs, incentives for wellness, and other obstacles that hinder their long-term self-sufficiency.

THE SOLUTION
A Medicaid version of the popular employee wellness incentive is now being considered in one state. Kentucky is proposing to establish My Rewards Account which would be a health savings vehicle that would include deposits from the previous year’s deductible funds, sliding scale premium contributions, participation in disease management, community engagement, job training activities, and GED programs. Funds would be deducted from the account for inappropriate emergency room use and routine copays.

The waiver proposal excludes some groups such as pregnant women, children, and the “medically frail.”

IMPLEMENTATION VEHICLE
Kentucky is applying for a Section 1115 waiver. The waiver is currently under consideration and could be approved or partially approved at any moment.

POTENTIAL IMPACT OF REFORM
Kentucky’s waiver is a strong example of reimagining the Medicaid program. This proposal, if approved, would take an important step toward infusing the Medicaid program with patient empowerment and consumer engagement as well as put it on a path toward long-term self-sufficiency.

ADDITIONAL RESOURCES
THE PROBLEM
States are greatly restricted in setting eligibility rules for Medicaid enrollment, making it difficult to keep costs under control. Maintenance of effort rules require that states keep their Medicaid eligibility requirements the same for a certain period. States are also barred from implementing a new enrollment or otherwise restricting the number of recipients.

These requirements are instituted when the federal government is worried about states trying to reduce Medicaid rolls or changing rules regarding eligibility or cost sharing. The federal government has made federal funds to the states contingent upon a state agreeing to the maintenance of effort.

The Obama administration implemented two laws with the maintenance of effort rules. One was under the 2009 stimulus and the other with the Affordable Care Act. The Obama-era rules have expired except for one concerning children under 19 in Medicaid and CHIP.

THE SOLUTION
States could use a waiver to avoid maintenance of effort to regain control of their eligibility requirements. This would allow states to manage their Medicaid enrollment population to protect recipients and the budget. Under maintenance of effort rules, states will not be able to innovate or make changes to the Medicaid program that could adjust the level of benefits.

In 2011, 33 governors wrote a letter to the Obama administration asking for relief from the federal requirements. The Obama administration responded by saying the maintenance of effort would be not changed, and states would not receive the sought after flexibility. While some states tried to use the waiver process for relief, no state was successfully able to use a waiver to avoid the Obama administration maintenance of effort restrictions.

IMPLEMENTATION VEHICLE
A state must seek a Section 1115 waiver from the federal government. Some states have used Section 1902 (GG) for their waiver.

POTENTIAL IMPACT OF REFORM
A state would be able to make substantial changes to its Medicaid program with regard to eligibility and cost sharing. This reform should be paired with other reforms that seek more significant, fundamental changes since maintenance of effort primarily deals with enrollment numbers.
ADDITIONAL RESOURCES


15. Consider Allowance for Provider-Covered Transportation

Medicaid patients can have difficulty finding proper transportation to and from physician visits leading to millions of missed appointments each year and potentially higher cost treatment. Yet providers lack the flexibility to provide free transportation to address the issue due to bureaucratic restrictions.

**The Solution:** While certain patients must already have non-emergency transportation costs covered by states, states should explore whether they will need to file a state plan amendment to expand this option for providers to offer to more Medicaid patients.

**THE PROBLEM**
Medicaid patients, especially those with chronic conditions, sometimes face transportation challenges that lead to no-shows and delay in care. Given the effect this has on patient well being and provider reimbursements, healthcare providers have sought to cover Medicaid patients’ transportation costs.

While Medicaid does require states to provide non-emergency transportation for some patients, these policies are directed toward eligible individuals that meet certain qualifications. Whether or not other healthcare providers could provide transportation was not clear.

Until recently, there had been concern that allowing healthcare providers to provide free transportation would be a violation of federal anti-kickback statutes. An HHS rule that went into effect in January 2017 exempts free and discounted rides that meet certain criteria from these laws.

This HHS ruling that exempts some free rides from healthcare anti-kickback statutes is expected to increase the growth of on-demand ride-sharing for patients. The rule clarified that hospitals and clinics may offer free rides to patients and that such an offering would not violate federal law.

**THE SOLUTION**
According to the Community Transportation Association, 3.6 million Medicaid patients miss at least one appointment per year because of transportation problems. Some providers believe that missed appointments can contribute to delayed care which contributes to unnecessary hospitalizations and higher spending for those patients. The hope is that by providing transportation services, providers will be able to cut down on missed appointments, eliminate unnecessary hospitalizations, and reduce overall healthcare spending.

**IMPLEMENTATION VEHICLE**
States may need to file a state plan amendment to allow providers to offer this benefit.

**POTENTIAL IMPACT OF REFORM**
Reliable transportation is frequently reported as a cause of missed appointments which, for some patients, contributes to additional healthcare problems and costs. By allowing providers and health plans to cover patients’ transportation costs through low-cost alternatives, such as Uber and Lyft, the hope...
is that providers and health plans can more effectively manage patients’ care and contribute to better patient outcomes.

Ascension, the nation’s largest non-profit health system with 2,500 care sites across the country, recently announced that it is partnering with Lyft to provide non-emergency transportation to its most vulnerable patients.

ADDITIONAL RESOURCES
16. Create “Skin in the Game” for Able Medicaid Beneficiaries

**THE PROBLEM**

Medicaid recipients often do not fully value the services they receive because beneficiaries bear little of the cost. This contributes to a relatively high rate of missed appointments. If patients share in the costs, they are more likely to obey guidelines and rules.

Currently, states have limited ability to charge premiums to Medicaid recipients. Federal rules bar states from cost-sharing plans, like premiums, for Medicaid recipients under 150 percent of the federal poverty level (FPL).

**THE SOLUTION**

Without a waiver, states cannot charge a premium to Medicaid enrollees below 150 percent of FPL. Some states have used the waiver process to implement premiums or a different cost sharing arrangement for Medicaid. Many of these premiums are voluntary and only used by recipients who wish to enroll in a different program like a health savings account (HSA). States use premiums to encourage recipients to enroll in nontraditional programs with the belief that these programs can help transition people to private coverage. Premiums can also be used to enforce some discipline in the program by pairing premiums with lockout periods for failure to pay.

Several states that expanded Medicaid under the ACA enacted premiums, particularly for the expansion population. States argue that premiums encourage enrollees to take better care of their health because they have “skin in the game.” Premiums can also promote more savings by beneficiaries. CMS approved some restrictions on premiums such as a minimum grace period.

Montana enacted some premiums when it expanded Medicaid. The state waived Section 19 (A)(17) and Section 19 (A)(14) to create a 2 percent premium for the expansion population. A 2 percent premium is comparable to the amount recipients might pay with a healthcare exchange subsidy. Montana also received permission to impose a lockout period for non-payment of premiums.

Arkansas’s “Arkansas works” waiver was approved and established a premium for recipients over 100 percent FPL. Arkansas also waived Section 19 (A)(14) to allow the implementation of
premiums. The premium is for 2 percent of household income. Arkansas successfully argued that the premium encourages personal responsibility and with people using private coverage there are fewer people quickly transitioning in and out of the Medicaid program.

Indiana created a plan that established contributions to an HSA instead of premiums. Like other states, the contribution is 2 percent of household income. A key difference is that the contribution is savings, with enrollees eventually able to spend their contribution on approved health goods and services. Current CMS Director Seema Verma is one of the key designers of the Indiana plan and believes that it can fundamentally change the Medicaid program.

IMPLEMENTATION VEHICLE
States would need to have a Section 1115 Medicaid waiver approved by CMS in order to implement premium cost sharing for recipients below 150 percent of FPL or protected from cost sharing arrangements under current federal rules.

POTENTIAL IMPACT OF REFORM
Premiums can decrease no-shows at healthcare providers, which can help lower costs. Some premiums are collected as enforced contributions to a savings account, which can be later used for private coverage or non-covered benefits. Premiums also help prepare Medicaid recipients for private coverage by giving them experience with traditional healthcare that requires monthly premium payments.

ADDITIONAL RESOURCES
THE PROBLEM

The Affordable Care Act (ACA) was supposed to reduce unnecessary emergency room (ER) visits through the expansion of private and Medicaid coverage. But instead of reducing these costly and often unnecessary visits, ER use by Medicaid patients has significantly increased. This seems to be holding true for non-emergency ailments or conditions that could have been prevented with primary care, as well as visits during both normal and after office hours.

Meanwhile, the seemingly intractable problem of Medicaid patients not showing up for scheduled appointments remains. This problem is partially responsible for the low number of providers able and willing to accept new Medicaid patients.

Some providers estimate that up to half of their Medicaid appointments are no-shows leading to an increasing numbers of doctors refusing Medicaid patients. Non-emergent use of emergency rooms is also on the rise. Both issues waste taxpayer dollars and reduce access to care.

The Solution: States should file a Section 1115 waiver under Section 1916 of the Social Security Act to impose copays above the current federal limitations for missed appointments and non-emergent use of the emergency room.

Some providers estimate that up to half of their Medicaid appointments are no-shows. That leaves providers without reimbursement from Medicaid, which is already low and sometimes below the actual cost of providing that care, and means that left unchanged, the provider will be even less likely to accept new Medicaid patients.

THE SOLUTION

Arizona previously applied for a Section 1115 waiver to impose copays above federal limits for non-emergent ER use and fees for missed appointments on the Medicaid expansion population.

In September 2016, CMS approved of copays above federal limits for non-emergent ER visits for childless adults with incomes

The Affordable Care Act (ACA) was supposed to reduce unnecessary emergency room (ER) visits through the expansion of private and Medicaid coverage. But instead of reducing these costly and often unnecessary visits, ER use by Medicaid patients has significantly increased.
from 100 to 138 percent of the Federal Poverty Line (FPL), but total cost sharing could not exceed 5 percent of the total household income. CMS rejected the request to impose fees for missed appointments.

States should ensure that they have a rate structure in place that would incentivize patients to choose office visits for non-emergent care instead of the ER.

**IMPLEMENTATION VEHICLE**

States may seek a Section 1115 waiver authority under Section 1916 of the Social Security Act to seek to impose copays above federal limits for non-emergent ER use and fees for missed appointments on the Medicaid expansion population.

**POTENTIAL IMPACT OF REFORM**

While Medicaid patients do not have the financial means to pay the full cost of unnecessary ER visits and missed appointments, they should bear some financial responsibility for these situations. After all, taxpayers are footing the bill for these services that not only increase program costs but are also impose costs on providers and other patients who will have a more difficult time accessing care.

**ADDITIONAL RESOURCES**

Kaiser Family Foundation, “Medicaid Benefits: Inpatient Hospital Services, Other Than in an Institution for Mental Diseases,” State Health Facts at [http://kff.org/Medicaid/state-indicator/inpatient-hospital-services-other-than-in-an-institution-for-mental-diseases/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.](http://kff.org/Medicaid/state-indicator/inpatient-hospital-services-other-than-in-an-institution-for-mental-diseases/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)
18. Blend and Braid Funding Streams from Multiple Programs

THE PROBLEM
Numerous duplicative and overlapping federal and state programs aim to address the issue of healthcare. The ACA added yet another layer of bureaucracy without requiring accountability or evaluating the current programs’ effectiveness.

That is why state lawmakers should audit current healthcare programs with the goal of identifying ineffective, inefficient, and duplicative programs so that they can redirect resources to better address the needs of the poor and vulnerable.

THE SOLUTION
Section 3021 of the Affordable Care Act (ACA) amends the Social Security Act by adding Section 1115A to the law. This provision of the ACA establishes the Centers for Medicare and Medicaid Innovation (CMI).

The purpose of the CMI is “to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles.” In other words, the CMI is supposed to foster changes in the delivery of healthcare through experimentation and innovation primarily through the Medicare and Medicaid programs.

IMPLEMENTATION VEHICLE
Title XXV of the Cures Act includes Social Impact Partnership opportunities (“pay after performance”). States may apply (once the RFP is issued) for a demonstration allowing SSI participants to substitute a work incentive benefit for a trust benefit.

POTENTIAL IMPACT OF REFORM
This approach has the potential to consolidate duplicative and overlapping bureaucracies and activities while improving healthcare quality and reducing taxpayers’ costs. By consolidating multiple funding streams and disparate government efforts, more of every taxpayer dollar spent not only has the potential to reach the intended recipient; it has the potential to give states more flexibility in how they address the needs of their unique and diverse communities.
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ADDITIONAL RESOURCES
19. Explore a More Immediate Consumer-Driven Model in Non-Expansion States

State policymakers that did not expand Medicaid under the ACA have paid a high political price. Their leaders have faced sharp criticisms and stinging political attacks for not expanding in their state.

Non-expansion states are poised to pivot more quickly toward consumer-driven reforms and take advantage of the new administration’s demonstrated eagerness to fund state-based efforts to support low-income access to care. The Trump administration’s funding of Florida’s Low Income Pool (LIP) should inspire confidence in other states looking for assistance in advancing innovative solutions at home.

**The Solution:** States (like Kansas, Tennessee, and Texas) that previously maintained low income pools, should examine whether to revamp these programs—a significantly less costly approach when compared to funding individuals through Medicaid. This tactic can free up state dollars to be reinvested into indigent care or directed toward community health facilities.

**The Problem**

State policymakers that did not expand Medicaid under the ACA have paid a high political price. Their leaders have faced sharp criticisms and stinging political attacks for not expanding in their state.

But as evidence mounts about the lack of quality care and access under the Medicaid program and the potential budget shortfalls some states may face as the result of taking the so-called “free” federal money, states and the new administration may be looking for alternative options.

**THE SOLUTION**

The federal government recently granted the state of Florida funding for its Low Income Pool (LIP). The program began as a demonstration pilot program in 2006 and morphed into a backstop to pay for the uninsured.

Fast-forwarding to today, the Trump administration has provided Florida, a non-expansion state, an infusion of money for this program. This signals the new administration’s willingness to support state efforts to support low-income healthcare outside of the Medicaid expansion.

The reality for states is that the Medicaid program is expensive and does not deliver high-quality and accessible care. For the same money that is spent on an expansion participant, the participant could have received primary care plus hospital care and still had extra money left over to deposit in a health savings account, to pay for indigent care, or to direct toward community healthcare facilities.

**IMPLEMENTATION VEHICLE**

Kansas, Tennessee, and Texas are already well-positioned to replicate this approach. These three states plus Florida are the four non-expansion states that previously participated in the demonstration. These states could move forward with revamping their healthcare safety net using a significant portion of funds that would not be subject to Medicaid program rules.
POTENTIAL IMPACT OF REFORM

The ACA never addressed the important issues of healthcare costs or access. Rather than attempt to expand a Medicaid program to fit Washington dictates, these select states should seek to redesign their healthcare safety net into an innovative, consumer-driven program that aims to transition enrollees into private coverage.

ADDITIONAL RESOURCES


Medicaid reimbursement rates barely reach two-thirds of the amount providers get from the private market, creating a disincentive for them to continue seeing Medicaid patients and leading to diminished access to care.

The Solution: States should file a state plan amendment and waiver (ensuring no state statutes need to be addressed) from payment limitations to providers for Medicaid and Medicare enrollees, allowing patients the choice of “making up the difference” by paying providers on top of the reimbursement for the difference in cost of care.

THE PROBLEM
According to a 2014 report by the Government Accountability Office, Medicaid pays between one-fourth and two-thirds the amount of the private sector in fee for service. Medicaid managed care pays a third to two-thirds less than the private sector. Lower reimbursement rates are a major reason why Medicaid recipients can have problems finding medical providers.

Survey results show that healthcare providers are less interested in taking new Medicaid patients even as the number of Medicaid enrollees has increased under the Affordable Care Act. Research finds that the majority of states limit provider reimbursement for their state and the federal government also limits provider reimbursement at the national level. The federal government established an upper payment limit (UPL) for Medicaid fee for service providers, where Medicaid cannot exceed Medicare prices.

THE SOLUTION
Balance billing is a payment method where the patient makes up the balance between the prescribed rate and the billed rate. Current law makes it illegal for Medicaid and Medicare providers to accept payment other than government billed rates for Medicare services; having a direct impact on those individuals who qualify for both Medicare and Medicaid (often referred to as “dual eligibles”). This restriction on balance billing has been in place for decades as an attempt to control cost in health entitlement programs.

But states may have far more discretion in determining payment methods and amounts for their Medicaid-only populations. No states are currently seeking such waivers. There have been arguments from free market policy groups that balance billing should be pursued for Medicaid beneficiaries. If a patient wants to pay more to a preferred provider, they should have that right instead of having to abide by government price controls.

POTENTIAL IMPACT OF REFORM
States would need to file a state plan amendment and a Section 1115 waiver from the federal government to exceed the upper payment limits. For many states, balance billing is also illegal under state law. States would have to change state laws, if applicable, to be able to implement a balance bill waiver properly.
POTENTIAL IMPACT OF REFORM

A waiver for balance billing could allow patients to have more access to doctors. It is likely that health providers would be willing to see more Medicaid patients as payments increase and they are able to receive immediate payment for a portion of their charges instead of waiting for the Medicaid reimbursement process.

ADDITIONAL RESOURCES

Conclusion

There is no need for states to wait on Washington to move forward with Medicaid reforms that improve patient access to care while reining in costs. As states begin to consider their options and next steps, they must be prepared to:

1. **ACT NOW.** The application process for a waiver can be extensive. States should begin working immediately.

2. **THINK BIG.** New leadership at HHS and CMS has indicated enthusiasm and support for state-based solutions to address healthcare needs. States should not shy away from seeking innovative, bold approaches that can increase quality of care while stewarding taxpayer resources.

3. **APPLY.** The HHS secretary cannot approve a waiver that is not requested by a state. States must examine every opportunity to press Washington for flexibility—whether by applying for Section 1115 and 1332 waivers or by looking at Social Security laws and state plan amendments. States that try innovative ideas and creative vehicles for reform can clear the path for others to follow in their footsteps.