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| **Template for Chapters to Respond to Medicaid**  [Waiver Application](https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html)s | | |
|  | **Example of waiver proposal** | **Sample Language to Use in Chapter Comment Letter** |
| **Work Requirements** | [*Mississippi*](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa.pdf)sought to make Medicaid eligibility contingent on participation in job training, volunteer, work or other activities. Specifically, non-disabled adults over the age of 19 must complete 20 hours a week of eligible work activities to be eligible for Mississippi’s Medicaid program. This requirement will be implemented at least one year after approval of the waiver application by CMS. Those who fail to comply with the work requirement will lose their coverage on the first day of the month following noncompliance. Those who are terminated from the program can regain compliance and be reinstated if they are within their original time period of eligibility.  Qualifying work activities include paid employment, self-employment, participation with the Office of Employment Security, approved volunteer work, participation in an alcohol/drug treatment program, or other activities in compliance with SNAP and TANF work requirements.  The following groups of people are exempt from the work requirement: Native Americans; pregnant women; children under the age of 19; disabled individuals; individuals enrolled in 1915(c) waivers; individuals over 65 years of age; individuals residing in an institution; individuals diagnosed with a mental illness; SSDI or SSI recipients; individuals who are primary caregiver for one who cannot care for themselves; individuals physically or mentally unable to work; recipients or applicants of unemployment insurance; participants of alcohol/drug abuse treatment program; part-time students at institution of higher learning; part-time high school students over age of 19; and individuals being treated for cancer.  Other states are expected to seek the same. | ACP policy states that work-related or job search activities should not be a condition of eligibility for Medicaid. Assistance in obtaining employment, such as through voluntary enrollment in skills- and interview-training programs, can appropriately be made available provided that is not a requirement for Medicaid eligibility. Work or community engagement status should not be a condition of Medicaid eligibility for a variety of reasons. According to the [Kaiser Family Foundation](https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/), 60% of nonelderly adults are already working and 8 in 10 live in families with at least one person employed. Those who are not working often have a valid reason; they may be taking care of a loved one, going to school, unable to find employment, or are sick or disabled.  A [research letter](https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2664514?redirect=true) surveying people enrolled in Michigan’s Medicaid expansion program, the Healthy Michigan Plan, found that enrollees were “more likely to report being unable to work if they were older, male, or in fair or poor health or had chronic health conditions or functional limitations.” One [survey](http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches) found that 55% of people who were unemployed reported that enrolling in Medicaid enabled them to search for a job and those that were working said they were able to do their job better after they gained coverage. A [study](http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf) of Ohio Medicaid enrollees found that about 75% of unemployed people who were searching for a job reported that Medicaid coverage made it easier to search for employment and 52% of those currently employed said the coverage enabled them to continue working. If the sick and disabled are disenrolled from Medicaid, they will lose the health insurance that could empower them to work and further their engagement in the community.  Work requirements will impose an unnecessary and unjustified burden on patients to document that they fit into an eligible exemption and an unnecessary and unjustified burden on physicians who may be asked to attest that their patients have an exempted medical condition. For patients, work requirements will place an onerous reporting burden that may cause them to delay or forego care or leave the program altogether. [Evidence](https://academic.oup.com/ppar/article/25/2/52/1501759) [shows](https://www.gao.gov/assets/270/263053.pdf) [that](https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html) when Medicaid and other programs add paperwork and other administrative requirements, enrollees are less likely to participate. ACP greatly appreciates CMS’ initiative to reduce administrative burdens through its Patients Over Paperwork initiative, but work requirements could add substantial paperwork hassles that will reduce the amount of time physicians have to care for their patients. Further, work requirements may force physicians to make a choice between compromising their professional integrity and causing their patients to lose health coverage if a patient seeks a disability assessment to become exempt from the work requirement.  The state may have to make a substantial financial investment in systems to track work requirement compliance. The TANF program provides historical context. According to the [Medicaid and CHIP Payment and Access Commission](https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf), “monitoring beneficiary compliance with [TANF] work requirements has been complex for states, requiring significant staff time and coordination across agencies and with employers.” We believe that limited Medicaid dollars are best used to improve patient health outcomes, not to create wasteful bureaucratic administrative systems.  Most importantly, work requirements are inconsistent with the purpose of the Medicaid program because they impose harmful and unnecessary eligibility conditions and administrative burdens that will result in many of the most vulnerable people losing coverage. [We know](http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly) that uninsurance is associated with increases in mortality. Any policy that reverses the gains in health and well-being from being insured is unacceptable. |

**Other Common Waiver Proposals**

The following proposals are typical of Medicaid waiver applications.

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| **Lifetime**  **Limits**  **On**  **Coverage** | [*Kansas*](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf) sought to limit the maximum length of Medicaid coverage for certain individuals to 36 months. Other states are expected to do the same. | ACP strongly opposes allowing lifetime limits on Medicaid coverage for certain individuals. This proposal would greatly harm patients with complex chronic care needs, including patients with diabetes, obesity, cardiovascular disease, and asthma, who require ongoing care management. Forcing enrollees off of Medicaid without providing a viable coverage alternative may lead to higher uninsurance rates and would deny patients the evidence-based benefits of Medicaid, including improved access to a usual source of care and being less likely to report an unmet need for medical care and prescription drugs. |
| **Premium Requirements** | [*New Mexico*](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf)proposed to implement premiums for the adult expansion population with household income above 100% of the federal poverty level. Other states are expected to seek the same. | [Evidence shows](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.0211) that applying premium increases and inflexible premium payment deadlines causes disenrollment from Medicaid. Although cost-sharing could be used to steer enrollees toward high-value care, an enrollee unable to pay an excessive premium may be more likely to go uninsured. One [study](https://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf) shows that a premium increase from zero to $10 a month reduces the length of enrollment by 1.4 fewer months. A comprehensive [literature review](http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations) on the effect of imposing premiums and cost-sharing on Medicaid beneficiaries found that “a large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.” |
| **Cost sharing for non-emergency use of the emergency department.** | New Mexico sought to require co-payments for non-emergency use of the emergency department. Other states are expected to seek the same. | ACP believes that Medicaid premiums and cost-sharing should be structured in a way that does not discourage enrollment or cause enrollees to disenroll or delay or forgo care due to cost, especially those with chronic disease. If cost sharing is applied it should be done in a manner that encourages enrollees to seek high-value services and health care physicians and other health care professionals. Further, ACP believes that Medicaid out-of-pocket costs should remain nominal and be subject to a cap (i.e., no higher than 5% of family income) for those with incomes above the poverty line.  ACP agrees that patients should receive care in the most appropriate health care setting. However, non-emergent use of the emergency department (ED) is minimal. The Medicaid and CHIP Payment and Access Commission, a federal legislative branch agency that studies and provides recommendations on Medicaid and Children’s Health Insurance Program, [found](https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-EDuse_2014-07.pdf) that only 10% of Medicaid-covered ED visits made by nonelderly patients were unnecessary. Evidence shows that patients use the ED for non-emergent care for a variety of reasons, including inability to access their regular primary care physician. Non-emergent use of ED may indicate that the patient cannot access the most appropriate clinician, such as a primary care physician or subspecialist. Patients may also be unable to determine if their symptoms, such as chest pain, require urgent attention, and such conclusions may only be possible with a physician evaluation. Further, evidence on whether copayments reduce non-emergent use of the ED is mixed. One [study](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4441261/) found that “granting states permission to collect copayments for non-urgent visits under the [Deficit Reduction Act of 2005] did not significantly change ED or outpatient medical provider use among Medicaid beneficiaries,” indicating that requiring cost-sharing may not effectively discourage unnecessary use of the ED. Requiring copayments will also create administrative burdens for physicians and other health care professionals who have to collect payments or provide information about alternative health care settings to enrollees who seek care in the ED. CMS should consider factors like primary care access and patient health literacy when deciding whether to require cost-sharing for nonemergency use of EDs and consider policy alternatives that better enable patients to visit the proper health care setting. |
| **Cost-sharing for non-preferred medications** | *New Mexico* sought to implement cost-sharing requirements for use of a non-preferred prescription drug when a preferred drug is available. Other states are expected to do the same. | ACP is concerned about the proposal to require a copayment for a non-preferred drug when a preferred drug is available. As previously stated, ACP can support cost-sharing if it is used to direct patients towards value-based services. This could be achieved with a properly-developed preferred drug list if inclusion is based upon a drug’s effectiveness, safety, and ease of administration rather than solely based on cost. ACP recommends that Pharmacy & Therapeutic Committees be representative of, and have the support of, the health care professionals that will utilize the preferred drug list. |

**Content for States that Are Considering Expanding Medicaid Eligibility**

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| **Expansion of Medicaid eligibility to 138% of the federal poverty level through a waiver that includes work requirements, benefit cuts, high cost-sharing, etc.** | Virginia is considering expanding its Medicaid program eligibility through a waiver that includes work requirements for enrollees. | Our chapter fully supports Medicaid expansion because it [increases patient access](https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/) to high-quality care and improves self-reported health status. We strongly urge that the state act (legislatively or administratively) to take advantage of this opportunity to expand coverage for the most vulnerable in our state. We understand that an agreement to expand Medicaid could be coupled with other changes, such as requirements that current enrollees, as well as those who would become eligible through expansion, be employed, looking for a job, participating in job training activities, or other community engagement activities.  We strongly prefer that the state move forward on expansion without including work requirements because they impose harmful and unnecessary eligibility conditions and administrative burdens that will result in many of the most vulnerable patients losing coverage.  The state should expand Medicaid without creating other barriers to enrollment, such as by requiring premium contributions or co-payments for services that most poor enrollees can't afford. We also strongly oppose including in such a package a cap on total Medicaid benefits. We believe that any Medicaid expansion agreement should ensure that the benefits of expansion, in terms of substantially increasing the number of low-income persons enrolled and who have affordable coverage, are greater than any losses of coverage that could result from tying expansion to other conditions that may make it more difficult for persons to enroll and maintain their coverage. |