



Section 1115 Demonstration Waivers and Other Proposals to Change Medicaid Benefits, Financing and Cost-sharing: *Ensuring Access and Affordability Must be Paramount*

Joint principles of the following organizations representing front-line physicians:

American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Osteopathic Association
American Psychiatric Association

On behalf of the more than 560,000 physicians and medical students represented by the combined memberships of the above organizations, we have adopted the following principles for designing, evaluating, reviewing and approving proposals to change Medicaid benefits, financing and cost sharing through Section 1115 demonstration waivers or other legislative or regulatory policies. Our members are the frontline physicians who care for patients in rural, urban, wealthy and low-income communities, and are the foundation of the American health care system.

States have historically utilized waivers of federal Medicaid law to create or test innovative demonstration programs to expand care to new populations, offer new services, and deliver care in new and different settings. Waivers have been both broad, affecting large segments of the Medicaid program, and narrow, focused on specific populations or services.

Recently, states have contemplated Medicaid Section 1115 waivers that would have the effect of restricting or limiting access, conditioning the receipt of care on meeting standards outside of the objectives of the Medicaid program, and/or altering the underlying financing of care itself, shifting financial risk to enrollees.

Given the broad array of current and possible future state waiver proposals, our organizations adopt the following waiver principles, seeking to ensure that state waivers “first, do no harm” to current or future enrollees. Earlier this year, we issued joint recommendations on Priorities for Coverage, Benefits and

Consumer Protections Changes [Priorities for Coverage, Benefits and Consumer Protections Changes](#). Consistent with those recommendations, we now offer the following principles to guide decisions by state and federal authorities on proposals to change Medicaid benefits, financing and cost sharing. The group of 6 frontline physician organizations affirms that state waivers must:

1. *Maintain and/or strengthen affordability protections: CMS should ensure that waivers and other proposed changes to Medicaid do not create barriers to coverage and care by requiring enrollees to pay significantly higher premiums, deductibles, co-payments and other out-of-pocket costs for Medicaid enrollees compared to current federal and state requirements and/or by establishing time limits on eligibility.* Studies show higher premiums and relatively small increases in cost-sharing creates barriers to coverage and access to care, especially for those with the lowest incomes:
 - Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty line. Some individuals losing Medicaid or CHIP coverage move to other, less comprehensive and more expensive coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
 - Even relatively small levels of cost sharing in the range of \$1 to \$5 are associated with reduced use of care, including necessary services. Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research shows that cost sharing increases financial burdens for families, causing some to cut back on necessities or incur debt to pay for care.ⁱ
 - State savings from premiums and cost sharing in Medicaid and CHIP are limited. Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses.ⁱ Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.ⁱⁱ
2. *Maintain/and or strengthen benefits: CMS should ensure that the full range of care, treatment, and services that would otherwise be provided is maintained and/or strengthened. CMS should ensure that waivers and other proposed changes to Medicaid do not reduce coverage of essential benefits, maternity care, substance use disorder treatment, mental health services, immunizations, and for children, services covered under the federal Early Periodic Screening, Diagnosis and Treatment*

(EPSDT) program, which mandates basic preventive and therapeutic health services that are deemed medically appropriate and necessary for children.

- Coverage of family planning and other women’s preventive services should not be eroded. Every \$1 spent on publicly funded family planning saves more than \$7 in Medicaid expenditures on pregnancy, delivery, and early childhood care.ⁱⁱⁱ Ensuring the availability of preventive services, maternity care, and contraceptive services and supplies means not only good health for mothers and their children, but is also fiscally responsible.

3. *Limiting Barriers to Eligibility and Coverage: CMS should ensure that waivers and other proposed changes to Medicaid do not impose punitive requirements that individuals be employed, be actively seeking a job, or be enrolled in a job training or job recruitment program and/or impose mandatory drug testing as a condition of eligibility.*

- Imposing work requirements, lock-outs, premiums, and other out-of-pocket costs will limit access to preventive and primary care services and inhibit Medicaid beneficiaries from seeking care that helps them avoid costlier health conditions and maintain wellness. While we support voluntary programs to assist Medicaid enrollees in obtaining a job or gaining job skills, as well as voluntary access to treatment for substance use disorders, we are concerned that making participation in such programs a mandatory condition of eligibility would create unacceptable barriers to care, especially for the most vulnerable persons. Studies show 8 out of 10 Medicaid enrollees are in working families and 59% are working themselves; “even when excluding SSI beneficiaries, most Medicaid adults who are not working report a major impediment in their ability to work, with 35% citing an illness or disability that prevents them from work. Others are taking care of home or family (28%), in school (18%), looking for work (8%), or retired (8%).”^{iv} Additionally, drug testing can be both financially and administratively burdensome on states, yielding minimum results. While currently no state Medicaid programs require beneficiaries be tested, several states do require this for public assistance programs. These programs, while expensive to administer, have resulted in small numbers of beneficiaries testing positive. For example, in 2014 Missouri appropriated \$336,000 to drug test applicants for the Temporary Assistance for Needy Families (TANF) program. That year, of 38,970 applicants, 446 were referred to follow-up testing and only 48 tested positive.^v

4. *Maintaining and/or strengthening access to any qualified provider: CMS should ensure that waivers and other proposed changes to Medicaid do not discriminate against otherwise qualified providers of women’s health services by denying state or federal funding to them.*

- Medicaid waivers should not be used to prohibit qualified providers from participating in the Medicaid program. Specifically, the services a provider performs or “promotes,” should not be the basis for exclusion from the Medicaid program. These actions violate Medicaid’s federal “any willing provider” and “freedom of choice” protections. These protections were enshrined in law in order to ensure that all Medicaid beneficiaries have the right to choose the providers and the treatments that best suit their needs, without outside interference. Such actions also adversely impact women’s health. Proponents who advocate denying Medicaid coverage for

primary and preventive care delivered at qualified providers often assert that other providers will fill the gap. However, it is evident that, in many states, the health care system is unprepared to meet current needs. Both obstetrician-gynecologists (ob-gyns) and primary care physicians face workforce shortages.^{vi} When Texas opted to end its 1115 demonstration waiver and excluded qualified providers from its state-funded family planning program, one in four women enrolled in the program was never seen by a health care provider for covered family planning services.^{vii} In addition, enrollment dropped 14 percent over four years, the number of contraceptives provided dropped 40 percent, and there was a major decline in providers who saw large numbers of program beneficiaries.^{viii} State waiver requests that discriminate against otherwise qualified providers of women’s health services by denying them funding should not be approved.

5. *Preserve and enhance existing funding mechanisms:*

- CMS should ensure that proposals preserve health care program financing to states, and limit cost- or risk-shifting to families or providers. In addition, CMS should ensure that Medicaid reimbursements to physicians are no lower than Medicare’s payment rates for comparable services. Studies show that higher state Medicaid-to-Medicare reimbursement ratios correlate with greater acceptance of new Medicaid patients. Finally, CMS should promote innovative models of health care delivery that can improve access, quality and effectiveness of care, such as Patient-Centered Medical Homes, Patient-Centered Medical Homes for Women, the integration of behavioral health and primary care, including the Collaborative Care Model, and expansion of telemedicine services that are supportive of the patient-physician relationship.

6. *Sustain and strengthen waiver transparency, stakeholder engagement, and evaluation: CMS should ensure states and the federal government include stakeholders in waiver development, follow required comment periods at both the state and federal level, and properly evaluate waiver impact on enrollees, families, and providers.*

ⁱ Artiga, S., Ubri, P., & Zur, J. (2017) *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*. The Henry Kaiser Foundation

ⁱⁱ Artiga, Ubri, and Zure. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings, Kaiser Family Foundation, June 1, 2017. Accessed 7th of September 2017 at <http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

ⁱⁱⁱ Frost JJ et al., Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, *Milbank Quarterly*, 92(4):696–749

^{iv} Garfield, R., Rudowitz, R., & Damico, A. (2017) *Understanding the Intersection of Medicaid and Work*. The Henry J. Kaiser Family Foundation, February 2017. Accessed Dec. 7, 2017 at <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>
Hall, Randi. *Drug Testing and Public Assistance*. Center for Law and Social Policy. Updated October 2016. <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2016.02.04-Drug-Testing-and-Public-Assistance-Brief-FINAL.pdf>

^{vi} Lawrence, H. C. and Ness, D. L. (2017). Planned Parenthood provides essential services that improve women’s health. *Ann Intern Med*.

^{vii} Texas Health and Human Services. *HHS Women’s Health Update*, May 15, 2017, Slide 13. Available at <https://hhs.texas.gov/sites/default/files//documents/about-hhs/leadership/ advisory-committees/whac/zika-may-15-2017/whac-women-health-updatemay-15-2017.pdf>. Last retrieved Aug. 15, 2017. (the number of clients accessing health care for FY 2016 equals the unduplicated

client counts for women enrolled and clients served in FY 2016 through the Texas Women’s Health Program (54,756 women) and Health Texas Women (15,580 women). The unduplicated client count for both programs and the total number served in FY 2016 was 94,851 women.).

^{viii} Texas Health and Human Services Commission. (2017). Final report of the former Texas Women’s Health Program: Fiscal Year 2015 Savings and Performance.