could significantly alter coverage and care for children

OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) has signaled its intention to provide states flexibility through the administrative process to facilitate changes to Medicaid. CMS is positioned to work with states to try to achieve some of the aims of 2017 federal legislation to “repeal and replace” the Affordable Care Act (ACA) and make significant changes to Medicaid via the waiver process. The AAP is concerned that, in the name of “state flexibility,” CMS may approve waivers that exceed previously-approved authority, affect benefits and financing, and run counter to Medicaid program objectives. Such waivers could include provisions that directly affect care for children or the financing structure of Medicaid itself.

CMS issued 2 letters to states in March 2017 on Medicaid Section 1115 waivers and Affordable Care Act (ACA) Section 1332 waivers. Additionally, on January 11, 2018, CMS issued guidelines allowing states to impose work requirements in Medicaid, a fundamental change to the 50 plus year history of the program. Some states have already begun working on Medicaid 1115 waivers that may limit care in the program. The AAP urges chapters to be vigilant with respect to state waiver plans that may affect children’s care. Advocating for children and families insured by Medicaid when waivers are being crafted is vital.

WHICH WAIVERS ARE OUR FOCUS?

Section 1115 waivers, as created by the Social Security Act, provide states the ability to create experimental, pilot, or demonstration projects that promote the objectives of Medicaid and the Children’s Health Insurance Program (CHIP).

- Section 1115 waivers allow programmatic Medicaid changes to design and evaluate new eligibility, services, or delivery system reforms with the goal of improving care, increasing efficiency, and reducing costs.
- States can waive Medicaid requirements related to “statewideness;” amount, duration, and scope of services; cost-sharing; and grievances and appeals, among many others.
- Section 1115 waivers are approved at the discretion of the Secretary of Health and Human Services (HHS), are generally for a 5-year period, and must be budget neutral.
- As of September 2017, 33 states had 41 active 1115 waivers, to achieve numerous disparate state Medicaid aims.

Section 1332 waivers were created by the ACA to allow states to implement innovative methods of providing access to quality health care that are at least as comprehensive and affordable as provided under the ACA, to a comparable number of state residents, without increasing the federal deficit.

- To apply for a 1332 waiver, states must first pass enabling state legislation.
- States can waive ACA provisions related to private insurance benefits, subsidies, marketplaces, and the individual and employer mandates.
In December 2015, CMS issued guidance that put significant guardrails on how flexible and expansive 1332 waivers could be.

However, the current administration could revisit this guidance and expand the use of 1332 waivers. State ACA 1332 waivers became available January 1, 2017, and a small number of states have sought Section 1332 waivers to date. Section 1332 waivers must be approved by the Secretary of HHS and the Secretary of the Treasury.

Both Section 1115 and 1332 waivers have transparency requirements, and must allow for public comment both at the state and federal levels during different stages of the waiver approval process.

A CLOSER LOOK AT WAIVERS

Section 1115 Waivers

In its Section 1115 waiver letter, CMS notes it is “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.” In doing so, CMS highlights several recent reform proposals sought by states, often through proposed Section 1115 waivers to expand Medicaid to the adult population.

Many of these highlighted provisions mirror those of the Healthy Indiana Plan (HIP) 2.0, which was created by CMS Administrator Seema Verma when she was previously working in Indiana with then-Governor Mike Pence on HIP 2.0 development. These provisions included the following:

- Tied Medicaid coverage to work/employment or job training
- Created alternative benefit plans
- Used health savings account (HSA)-like structures with required premium payments and penalties for nonpayment; including for those below 100% of the federal poverty level (FPL) (this provision exceeded statutory limits)
- Used Medicaid to help finance employer-sponsored insurance (ESI) (also known as premium assistance)
- Created initiatives to keep families on the same plan
- Waived non-emergent medical transportation coverage
- Increased copayments for non-emergent use of the emergency department
- Waived retroactive eligibility

Concepts highlighted in the CMS letter are similar to others recently found in some state Medicaid expansion proposals, which have sought to expand coverage to adults, or alter existing adult expansions, through 1115 waivers that would also have the following effects:

- Waive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 to 20 year-olds.
- Establish a lifetime cap or time-limited cap on Medicaid coverage for adults, which may be also tied to a work requirement
- Implement a drug screening, testing, and/or treatment requirement as a condition of enrollment.
- Waive presumptive eligibility and/or hospital presumptive eligibility
- Implement an asset test
- Move to an “open enrollment” period and lockout coverage for failure to reenroll during that time window.
- Include incentives for healthy behaviors
- Make Medicaid coverage effective with the date of a first premium payment
- Require specific penalties for adults who fail to make premium payments, such as a reduced benefit package or a coverage lock-out period
- Waive choice of providers for those seeking family planning services
CMS is interested in broadening the reach of policy change through the waiver process, and it is likely that the Administration will respond favorably to waiver proposals with these and similar provisions. To that end, CMS notes that it intends to facilitate “fast track” approval of waivers and streamline the approval of state plan amendments (SPAs).

Section 1332 Waivers
In its Section 1332 waiver letter, CMS highlights the Alaska 1332 waiver application aimed at implementing a high-risk pool/state operated reinsurance program to bring down the cost of individual insurance premiums. In doing so, CMS encourages other states to pursue 1332 waivers that include high-risk pools/state-operated reinsurance programs. The Alaska waiver application was approved in July 2017, and other states have since expressed interest in similar reinsurance programs through the 1332 waiver process.

Within existing guidance, states may also seek broader ACA reforms through the 1332 waiver process—CMS indicates it will work with states on their innovation plans and encourages states to reach out to HHS and the Department of Treasury as they develop them. Of note in 2017, Iowa proposed a 1332 waiver that would make substantive changes to the ACA’s cost sharing reductions and premium tax credits, among other changes.

In May 2017, CMS announced the release of a Section 1332 waiver checklist for states that focuses on state 1332 proposals to support development of state high-risk pools or reinsurance programs.

The recent Better Care Reconciliation Act (BCRA) would have significantly expanded the ability of states to use the 1332 waiver process to alter existing coverage, and lawmakers may again seek to expand use of 1332 waivers in the future. The AAP will apprise chapters of any changes to 1332 guidance or related developments.

WHAT CAN AAP CHAPTERS AND ADVOCATES DO?

- The CMS letters to governors raise concerns that the Administration is inclined to allow states to implement previously-denied or new proposals, even if these create barriers to care in the Medicaid program.

- While recent waiver proposals have largely focused on the Medicaid adult expansion population, such proposals could impact care for young adults 19 to 20-years of age and could be expanded to include children’s coverage.

- The AAP is concerned that states may use Medicaid 1115 waivers to weaken the guarantee of EPSDT for children, limit specific benefits, and/or create burdensome eligibility or cost sharing requirements that would lead to barriers to care.

- The AAP is also concerned that CMS may work with states to limit overall funding to the Medicaid program through the waiver process.

- It is critical that AAP chapters advocate that such waivers must not negatively affect care for children and/or limit federal funding.

- Chapters should actively monitor state waiver plans and advocate that they “first, do no harm to children.” Chapters can investigate waiver plans with their state Medicaid office and other advocates.

- Chapters are also encouraged to call attention to the effects any such waiver proposals may have on families and access to care for low-income adults by threatening coverage, creating onerous barriers to care, or in any way limiting funding to the state.

- Chapters are also encouraged to remain abreast of required public input opportunities during the waiver process and to exercise their voice for children by submitting commentary.

We’re here to help. For consultation and technical assistance on state waivers, please contact the AAP at stgov@aap.org.