

# Issue brief: Medicaid expansion demonstration waivers *(updated December 6, 2016)*

## Introduction

Four years after the Supreme Court's decision that made Medicaid expansion a state option, policymakers continue to debate whether it is the right decision for their state. To date, 19 states have decided not to expand their Medicaid programs under the Affordable Care Act (ACA) to cover childless adults with incomes up to 133 percent of the federal poverty level (FPL).<sup>1</sup> Among the 31 states that have embraced the Medicaid expansion, most have expanded eligibility in existing Medicaid programs.<sup>2</sup> However, six states (AR, IA, IN, MI, MT and NH<sup>3</sup>) sought expansion under a Section 1115 Demonstration Waiver from the U.S. Department of Health and Human Services (HHS) to customize their Medicaid expansion plans in ways that would not otherwise be permitted under Medicaid rules.<sup>4</sup> In addition, three states (AZ, KY and OH) which had opted into Medicaid expansion as set forth in the ACA have recently sought to overhaul their expansion programs under the Section 1115 authority.

In general, Section 1115 Demonstration Waivers are common; the majority of states currently operate some part of their Medicaid program under a waiver. The waivers permit a state to put aside certain Medicaid requirements in order to test and evaluate a novel delivery model and also receive federal matching funds. Expanding Medicaid is one of the ways HHS has permitted states to employ demonstration waivers.

In states that are reluctant to expand Medicaid eligibility, demonstration waivers may provide a workable alternative, permitting states to increase coverage and receive increased federal funding while also addressing some of the perceived limitations of the program. States have sought waivers that require greater cost-sharing from some beneficiaries, mandate enrollment in private health plans and require contributions to health savings accounts. Some states have tied participation in wellness activities to beneficiaries' financial obligations. Others have introduced punitive measures to Medicaid like disenrolling beneficiaries who do not pay premiums and implementing lock-out periods.

Since there is no deadline for states to expand Medicaid eligibility, policymakers in non-expansion states are paying close attention to the experience of states that have sought and received federal approval to implement alternative expansion plans.

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<sup>1</sup> AL, FL, GA, ID, KS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI and WY have not expanded Medicaid.

<sup>2</sup> Thirty-one states and the District of Columbia have opted to expand Medicaid eligibility under the ACA. Those states include: AK, AR, AZ, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, LA, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA and WV.

<sup>3</sup> HHS approved a waiver for Pennsylvania from then-Governor Corbett to expand Medicaid using managed care organizations, following his election in 2014, Governor Wolf decided to instead adopt traditional Medicaid expansion.

<sup>4</sup> §1115 of the Social Security Act (42 U.S.C. § 1315).

## Federal guidance

HHS has said it will consider approving a "limited number" of demonstration waivers for Medicaid expansion, and in March 2013 the agency issued guidance to assist states designing premium assistance models.<sup>5</sup> As illustrated by state waiver activity, HHS has permitted some exceptions to its guidance.<sup>6</sup> The administration set the following parameters for premium assistance models in its 2013 guidance:

- **Partial expansion is not an option.** States must provide coverage to individuals with incomes up to 133 percent FPL to receive increased federal matching funds for the newly eligible population.<sup>7</sup>
- **Cost-sharing requirements must be consistent with current Medicaid rules.** Federal law limits a beneficiary's cost-sharing responsibility to five percent of the beneficiary's income and contains addition protections for children, pregnant women, and certain services such as family planning services. These protections may not be waived under Section 1115.
- **States must provide wraparound coverage for any mandatory Medicaid benefits not provided by a private plan.** Beneficiaries remain in Medicaid and continue to be entitled to all benefits provided under Medicaid.
- **Only populations which are "closely aligned" with the private plan's benefit package should be enrolled in private plans.** HHS cautioned that Marketplace plans were not designed to offer broader benefits and certain eligibility groups could experience unexpected adverse selection in private plans.
- **Individuals receiving premium assistance should have a choice between at least two plans.**
- **Waiver programs must be budget neutral.** Premium payments and other associated costs under a premium assistance model may not cost the federal government more than what it would otherwise pay for the same services.

In addition to its guidance, the administration's response to and approval of proposals in Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire and Pennsylvania may illustrate the boundaries of the terms HHS is willing to accept. This should be instructive to states as they design their own waiver proposals.

- **States may require enrollment in Marketplace plans.** Arkansas and New Hampshire require beneficiaries to enroll in qualified health plans (QHPs) in the Marketplace and provide premium assistance to lower the cost sharing imposed on beneficiaries.<sup>8</sup>

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<sup>5</sup> Centers for Medicare & Medicaid Services, *Medicaid and the Affordable Care Act: Premium Assistance*, March 2013, available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

<sup>6</sup> Most notably, in its 2013 guidance, HHS said waivers should be of short duration and must end by December 31, 2016 because State Innovation Waiver authority, which allows a range of state-specific reforms, would begin in 2017. HHS has not held to this position.

<sup>7</sup> Demonstration waivers that increase eligibility to levels below 133 percent FPL may still be approved, but the federal government will not pay the enhanced matching rate available under the ACA. For example, Wisconsin amended its existing Section 1115 Demonstration Waiver and Medicaid state plan to cover eligible individuals up to 100 percent of the FPL, but did not adopt the expansion under the ACA.

<sup>8</sup> Iowa's first waiver also included a premium assistance model, but has since eliminated the program in favor of statewide managed care.

- **States may charge premiums to newly eligible beneficiaries.** Under federal Medicaid law, states may only impose premiums on individuals with incomes above 150 percent FPL; however, HHS permitted Arkansas, Indiana, Iowa, Michigan, Montana, and Pennsylvania to charge premiums to those with incomes up to 133 percent FPL.
- **Beneficiaries may lose coverage for non-payment of premiums.** In Montana, individuals with incomes above 100 percent FPL who stop paying premiums may be disenrolled after notice and a grace period. Unpaid premiums become a debt owed to the state. In Indiana, individuals with incomes above the poverty level who cease making health savings account (HSA) contributions after a 60-day grace period will be disenrolled and ineligible to re-enroll for six months. However, HHS denied a request from Indiana to add a six-month lock-out for beneficiaries who do not undergo an annual redetermination process.
- **States may use wellness programs to incent healthy behaviors and lower beneficiary cost-sharing.** Indiana, Iowa, Michigan and Pennsylvania permit beneficiaries to pay lower premiums and/or co-payments if they participate in wellness activities. In Michigan, participation in wellness activities is mandatory.
- **States may require contributions to health savings accounts.** In Arkansas, Indiana and Michigan, beneficiaries with incomes above the FPL contribute cost-sharing amounts to health savings accounts which may be used to pay for out-of-pocket medical expenses. In Indiana, beneficiaries with incomes below the FPL may opt to pay premiums into HSAs rather than copayments.
- **States may not severely limit the available benefit package.** Iowa initially proposed eliminating the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and Pennsylvania proposed restricting beneficiaries' freedom of choice of family planning providers. Neither proposal was accepted by HHS. Similarly, HHS denied Indiana's request to eliminate EPSDT vision and dental benefits for 19- and 20-year-old enrollees. As previously noted, states must provide wraparound coverage for any Medicaid benefits not provided by a beneficiary's private insurer. The administration has, however, permitted states to eliminate the non-emergency medical transportation benefit (NEMT).
- **Employment search activities may not be a condition of Medicaid eligibility.** Pennsylvania initially proposed that beneficiaries working less than 20 hours a week must participate in a job search program in order to remain eligible for Medicaid. The administration indicated it would be unlikely to approve any waiver application that tied eligibility to employment status. Pennsylvania subsequently revised its proposal to make the employment program voluntary. Similarly, Indiana sought a work referral requirement that was denied by HHS. Instead, Indiana provides a voluntary work search and job training program to beneficiaries, but health coverage is not affected by the work program.
- **States may eliminate retroactive eligibility; provide 12-month continuous eligibility.** In Indiana, coverage is not effective until the first premium is paid. Montana, in an effort to reduce churning between Medicaid and Marketplace plans, added 12-month continuous eligibility.

## State waiver activity

To date, Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire and Pennsylvania have received approval from HHS to expand Medicaid eligibility under the Section 1115 waiver authority. Arizona, Ohio

and Kentucky had previously expanded Medicaid and have sought significant changes to their programs under Section 1115. Below is a summary of each state's demonstration.

### **Arizona Choice, Accountability, Responsibility, Engagement Program**

Arizona has long operated its Medicaid program under an 1115 waiver that utilizes managed care organizations and expanded Medicaid in 2013 as envisioned under the ACA. But the state has since developed a new waiver that incorporates the newly-eligible population, but does not rely on any waiver authority specifically related to Medicaid expansion under the ACA. HHS partially approved the waiver in September 2016. The agreed to portions of the waiver proposal were approved in conjunction with granting a five-year extension of the Arizona Health Care Cost Containment System (AHCCCS), the state's longstanding Medicaid managed care program.

The Choice, Accountability, Responsibility, and Engagement (CARE) program requires beneficiaries with incomes above the FPL to pay monthly contributions of two percent of income and copayments up to three percent of income. Participation in a healthy behavior incentive program lowers cost sharing obligations. Failure to make contributions may lead to disenrollment after a two month grace period. Beneficiaries pay a \$8 copay for non-emergent use of the emergency department, a \$4 copay for opioid prescriptions and for brand name drugs when a generic is available and a \$5-\$10 copay for specialist services without a referral from a primary care physician. The state also eliminated coverage of NEMT for beneficiaries above the FPL and introduced a voluntary work search and job training program.

The federal government rejected some of Arizona's controversial proposals, including monthly contributions for beneficiaries with incomes below the poverty line, a six-month lock-out period for nonpayment of monthly contributions, a work requirement, additional eligibility verification requirements, fees for missed appointments and a five year time limit on coverage. HHS said the rejected provisions could undermine access to care and do not support the objectives of the Medicaid program.

### **Arkansas Works**

In April 2013, the Arkansas General Assembly authorized the Department of Human Services to pursue the "private option" to allow newly eligible individuals to obtain coverage through the state's insurance marketplace with premiums paid by the state. The legislature must reauthorize the program each year with a three-fifths vote of the legislature. The program was reauthorized in 2014, 2015 and 2016. In 2015 the name of the program was changed from the Health Care Independence Program to Arkansas Works and a new waiver was submitted in 2016.

In September 2013, HHS approved Arkansas's waiver request for the Health Care Independence Program and in December 2014 approved changes to the waiver program. Childless adults with incomes up to 133 percent FPL and parents with incomes 17 to 133 percent FPL are the newly eligible beneficiaries. Beneficiaries choose a Silver QHP in the marketplace, or they are auto-assigned to a plan if no selection is made. Beneficiaries with incomes 50 to 133 percent of the FPL must pay \$5 to \$25 per month into HSAs. Beneficiaries who do not make the required HSA payments must pay the QHPs copayments at the point of service. Cost-sharing amounts cannot exceed five percent of a beneficiary's income. QHPs must cover all benefits in the state's Alternative Benefit Plan, which is the same as the Medicaid benefit package. Wrap-around coverage for all services mandatory under federal Medicaid law is provided on a fee-for-service (FFS) basis, except that the waiver approved in December 2014 waives coverage of NEMT.

In June 2016, the state submitted a new waiver request to HHS in accordance with the Arkansas Works Act of 2016 passed by the legislature. The new waiver would implement a new premium assistance program for

employer-sponsored insurance (ESI), charge premiums to beneficiaries above the FPL, terminate HSAs, incorporate wellness activities, eliminate retroactive coverage and provide work referrals. The waiver has not yet been approved.

## Healthy Indiana Plan 2.0

In January 2015, HHS approved Governor Pence’s Section 1115 Demonstration Waiver request that builds on the state’s existing Healthy Indiana Plan (HIP), which initially passed the Indiana General Assembly in 2007. Enrollment in the program began on February 1, 2015.

HIP 2.0 establishes two paths to coverage for beneficiaries: HIP Plus and HIP Basic. HIP Plus pairs high deductible health plans with HSAs, called Personal Wellness and Responsibility (POWER) accounts. Participation in HIP Plus is required for individuals with incomes above the FPL. Those who do not make HSA contributions may be disenrolled and locked out of coverage for six months. Beneficiaries with incomes below the FPL are enrolled in HIP Basic if they do not make HSA contributions.

The state and beneficiaries jointly fund the \$2,500 HAS in HIP Plus, which is used to pay the plan’s deductible. Beneficiaries make a monthly contribution, not to exceed two percent of household income, to the HSA and only have cost-sharing obligations for non-emergent use of the emergency department after the deductible is met. Co-payments are graduated for non-emergent use of the emergency department: \$8 for the first instance and \$25 for recurring use. Coverage is effective after the first contribution payment, rather than on the date of enrollment. Beneficiaries can “earn” additional dollars for their HSAs by participating in wellness activities.

Beneficiaries with incomes below the FPL have a choice between HIP Plus, as described above, and HIP Basic. HIP Basic requires co-payments for most services in amounts not to exceed five percent of a beneficiary’s income, in accordance with existing Medicaid rules.

Both options cover all the benefits in the state’s Alternative Benefit Plan. HIP Plus also includes enhanced benefits – vision and dental coverage – that HIP Basic does not. HHS allowed the state to waive the NEMT benefit. Indiana also offers optional premium assistance to beneficiaries with access to ESI and a voluntary work search and job training program, called Gateway to Work.

## Iowa Health and Wellness Plan

In June 2013, the Iowa legislature approved the Iowa Health and Wellness Plan which provided managed care and premium assistance to the newly eligible population. The premium assistance program was subsequently terminated. The legislature conditioned the program’s administration on continued federal funding at the currently prescribed levels.

In December 2013, HHS approved Iowa’s two waiver requests. The Iowa Wellness plan provides coverage for those living under the FPL through Medicaid managed care plans. HHS also approved the Iowa Marketplace Choice Plan, which provided premium assistance to those with incomes 101 to 133 percent FPL, but Iowa ended the program in September 2015 and moved beneficiaries with incomes above the FPL into managed care. Beneficiaries pay up to \$10 monthly premiums, which can be reduced through participation in wellness activities. In accordance with federal Medicaid law, cost-sharing cannot exceed five percent of a beneficiary’s income. Plans must cover all benefits in the state’s Alternative Benefit Plan, which is the same as the state employee benefits package. Wrap-around coverage is provided for all services mandated under federal Medicaid law and not provided through a managed care plan. HHS allowed the state to waive the NEMT benefit.



## Kentucky HEALTH

In August 2016, Governor Bevin submitted a Section 1115 demonstration waiver proposal, called Kentucky Helping to Engage and Achieve Long Term Health (HEALTH), as an alternative to the existing Medicaid expansion which is being implemented through a state plan amendment. HHS has not yet approved or denied the application.

Kentucky HEALTH proposes to add a state-funded high deductible health plan and savings account to the existing Medicaid managed care program. Dental, vision and over-the-counter medications would be categorized as “enhanced” benefits and only covered after a beneficiary completes certain wellness or employment incentives. NEMT would not be covered. Premiums would be based on family income on a sliding scale up to \$15 per month and would increase based on the length of time in the program. Beneficiaries with incomes above the FPL could be disenrolled for nonpayment of premiums after a 60-day grace period and would face a six month lock-out period. The program would also require most beneficiaries to participate in up to 20 hours per week community engagement. Eligible community engagement activities include working, volunteering, job searching, job training, and attending school.

## Healthy Michigan Plan

In September 2013, the Michigan legislature approved the Healthy Michigan plan. Michigan’s Section 1115 Demonstration Waiver was approved by HHS in December 2013 to mandatorily enroll adults with incomes up to 133 percent FPL into the existing managed care delivery system. The waiver was amended in 2015.

Under the initial waiver, beneficiaries with incomes above the FPL were expected to pay premiums amounts up to two percent of income and pay co-payment amounts up to five percent of income. The Michigan waiver was notable because it was the first to require beneficiaries to contribute cost-sharing amounts to HSAs. Premiums and co-payments can be reduced by participation in wellness activities. The managed care plans cover all benefits in the state’s Alternative Benefit Plan.

HHS approved an amended waiver in December 2015. The amended waiver reflects state legislation passed in 2013 to require individuals enrolled in Healthy Michigan for 48 cumulative months to either enroll in a QHP on the Marketplace using premium assistance or stay in Healthy Michigan with cost-sharing that could total seven percent of income. However, the seven percent cost-sharing will be reduced for beneficiaries that participate in wellness activities, which are mandatory. All beneficiaries, except the medically frail, with incomes above the poverty level must work with their physicians on certain wellness goals or enroll in a QHP. Thus, few, if any, beneficiaries will face cost-sharing amounts in excess of five percent of income.

## Montana Health and Economic Livelihood Partnership Program

In April 2015, the Montana legislature passed the Health and Economic Livelihood Partnership (HELP) Act to expand Medicaid eligibility to 133 percent FPL. HHS approved Montana’s waiver proposal in November 2015. Coverage became effective on January 1, 2016.

Under the approved waiver, the state contracts with a third party administrator to manage the delivery of healthcare services to the newly eligible population, payment to providers, and collection of premiums. Newly eligible individuals with incomes between 50 percent and 133 percent FPL are required to pay the maximum copayment amounts permitted by federal law and premium amounts of two percent of monthly income. In accordance with federal law, premiums and copayments may not exceed five percent of family income. Individuals with incomes above the poverty level can be disenrolled for non-payment of premiums after 90 days and re-enrolled only after the premiums have been repaid to the state. Individuals who

participate in certain wellness activities cannot be disenrolled for nonpayment of premiums. Under the legislation, newly eligible individuals have access to a voluntary workforce development program and the state will charge a \$100 monthly fee on enrollees with assets exceeding certain limits. The waiver also implements twelve-month continuous eligibility for all newly eligible adults.

## **New Hampshire Health Protection Program**

In March 2014, the New Hampshire legislature approved the Health Protection Plan to expand Medicaid eligibility to 133 percent FPL using premium assistance, a managed care bridge program, and a premium assistance program. In March 2015, HHS approved the state's waiver proposal to implement a premium assistance model. In 2016, the legislature reauthorized the program through 2020.

Under the approved waiver, New Hampshire provides a premium assistance program for individuals with access to ESI. Newly eligible beneficiaries without access to ESI remained in a managed care bridge program through the end of 2015 and then most transitioned to a mandatory QHP premium assistance program. Under the QHP premium assistance program, childless adults with incomes up to 133 percent FPL and parents with incomes 38 to 133 percent FPL must choose a QHP in the marketplace or they will be auto-enrolled if no selection is made. Beneficiaries with incomes below the poverty level will not have cost-sharing obligations. Beneficiaries with incomes above the poverty level face the same cost-sharing responsibilities as required under the state plan. QHPs must cover all benefits in the state's Alternative Benefit Plan. Wrap-around coverage for all other services provided under the state plan will be provided on a fee-for-service basis.

In 2016, the legislature passed a bill instructing the state to submit a waiver to require, among other things, that able-bodied, childless adults engage in at least 30 hours of work-related activity each week in order to maintain Medicaid eligibility. However, an amendment was added to the bill that allowed expansion to continue if HHS denied the request, and, in November 2016, HHS rejected the waiver request. In addition to the work requirement, HHS also rejected new citizenship verification requirements, higher cost sharing for non-emergent use of the emergency department and a requirement that hospitals caring for Medicaid patients must also provide services to patients in veteran's health programs. HHS said the rejected components could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program.

## **Healthy Ohio**

Ohio expanded Medicaid under the terms of the ACA in January 2014. In June 2016, Ohio submitted a Section 1115 Demonstration Waiver request to make significant changes to the program as required by the operating budget approved by the legislature. Ohio sought changes to Medicaid for the newly-eligible population as well as other categories of Medicaid beneficiaries, including parents and pregnant women. The waiver was not approved, but the details of the proposal are included below.

The Healthy Ohio program would have required all newly eligible adult Medicaid enrollees, as well as some low-income parents, foster care youth, and beneficiaries with breast and cervical cancer, to pay monthly fees into HSAs with a state-funded annual deductible of \$1,000. Beneficiaries would have paid copays into the HSA at maximum state plan amounts and monthly premiums up to two percent of income. Pregnant women and people with no income were exempt from premium requirements. Coverage would not begin until a premium payment was made, and the state would have disenrolled beneficiaries for non-payment of premiums after a 60-day grace period or failure to provide renewal documentation. Notably, Ohio also sought to eliminate the state's obligation to provide a fair hearing to those who become ineligible for coverage because of non-payment of premiums. Beneficiaries would have been able to lessen financial obligations by participating in healthy behaviors and carry over HSA contributions to the subsequent year. Healthy Ohio

would have permitted beneficiaries who lose eligibility because of rising income to keep HSA funds to pay for private coverage.

In September 2016, HHS denied the state's waiver request citing concerns that the monthly financial obligation would undermine access to coverage and affordability of care and that the plan to exclude individuals indefinitely until debts are paid is inconsistent with the objectives of the Medicaid program. Ohio estimated that over 125,000 people would likely lose coverage each year for non-payment.

## Healthy Pennsylvania Plan

In August 2014, HHS approved then-Governor Corbett's Section 1115 Demonstration Waiver request to cover the newly eligible population under contracts with private managed care organizations. However, following the election of Governor Wolf, the state decided to replace the waiver program with traditional Medicaid expansion.

Though not being implemented, the HHS-approved features of the Healthy Pennsylvania Plan were as follows: The waiver program would have enrolled adults with incomes up to 133 percent FPL in their choice of an approved managed care plan in their region. Beneficiaries with incomes below the poverty level would not pay premiums, but would pay copayments consistent with the state plan. Beneficiaries with incomes above the poverty level would pay premium amounts up to two percent of household income, but would not otherwise be responsible for cost-sharing except for an \$8 copayment for non-emergency use of the emergency room. Enrollees could be disenrolled for non-payment of premiums after a 90-day grace period, but could reenroll without a waiting period. All newly eligible beneficiaries could reduce cost-sharing by participating in wellness activities. The managed care plans would have covered all benefits in the state's Alternative Benefit Plan; however, the state was permitted to eliminate the NEMT benefit for the first year of the demonstration. In addition to health care coverage, the state would have encouraged employment through a voluntary job training program. Medicaid coverage would not have been affected by participation in the job training program.

## AMA policy

### D-290.979 Medicaid Expansion

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. (Res. 809, I-12)

### H-290.966 Medicaid Expansion Options and Alternatives

1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such



waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.

4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site. (CMS Rep. 5, I-14; Reaffirmed: CMS Rep. 02, A-16)

#### **H-290.965 Affordable Care Act Medicaid Expansion**

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits. (CMS Rep. 2, A-16)

#### **Health Savings Accounts in the Medicaid Program H-290.972**

It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:

- A. Make beneficiary participation voluntary;
- B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
- C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
- D. Set deductibles at 100% of account contributions, but no higher;

- E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
- F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
- G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
- H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages;
- I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
- J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
- K. Monitor the impact on utilization and beneficiary financial burden;
- L. Test broadening of eligibility to include currently ineligible beneficiary groups; and
- M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian. (CMS Rep. 1, I-06 Modified: CMS Rep. 01, A-16)

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