

# Medicaid Section 1115 Research and Demonstration Waivers



An increasing number of states are seeking greater flexibility in administering their Medicaid programs. The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) give states the opportunity to test innovative or alternative approaches to providing health care coverage to their Medicaid populations through Section 1115 Research and Demonstration Waivers (otherwise known as “1115 waivers”). States must demonstrate that their waivers promote the objectives of the Medicaid and Children’s Health Insurance Programs (CHIP) and CMS must use general criteria to determine whether the objectives of the Medicaid/CHIP programs are met. In November 2017, CMS updated these criteria and invited states to propose reforms to Medicaid, including reforms that would:<sup>1</sup>

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
2. Promote efficiencies that ensure Medicaid’s sustainability for beneficiaries over the long term;
3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
4. Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition;
6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid; and
7. Be budget neutral to the Federal government.

A public notice and comment period is required for an 1115 waiver application at both the state and federal levels. If approved, the waiver is carried out over a five-year period and states can apply for an additional three-year extension approval. Demonstrations with at least one full extension cycle without substantial program changes are eligible for a fast track review process. The fast track review process streamlines the extension application and review process for 1115 demonstrations, allowing states to receive up to a five-year extension.

## Implications for Cancer Patients, Survivors, and Those at Risk of Cancer – ACS CAN Position

The American Cancer Society Cancer Action Network (ACS CAN) actively reviews and submits written comments on 1115 waivers at both the state and federal levels. ACS CAN’s key concern in evaluating these waivers is the potential impact on cancer patients’, survivors’, and enrollees’ access to preventive services and treatment. Unfortunately, ACS CAN opposes many of the policies proposed in recent 1115 waivers, as data shows that they adversely affect efforts to fight cancer. They include:

- ✓ **Limiting or restricting eligibility (through work or community engagement requirements, waiving retroactive eligibility, or enrollment caps):** If work and community engagement is required as a condition of eligibility for Medicaid enrollees, many cancer patients, recent survivors, and those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the Medicaid program. Imposing work or community engagement requirements on lower income individuals as a condition of coverage could also impede individuals’ access to preventive care, including cancer screenings.

Under federal law, Medicaid programs must cover medical bills for up to three months prior to an individual's Medicaid application date (referred to as "retroactive eligibility"). Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and negatively impact patients with complex medical conditions that require frequent follow-up and maintenance visits to help control their disease process.

ACS CAN opposes any form of enrollment caps on Medicaid beneficiaries, as an enrollment limit or cap could prevent eligible individuals, such as cancer patients and survivors, from receiving critical health care and treatment services.

- ✓ **Imposing cost sharing (premiums, copayments):** Cost sharing and related lock-out periods for non-payment create administrative burdens for enrollees, will likely deter enrollment or result in a high number of disenrollment, and will cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums on low-income individuals is likely to deter enrollment in the Medicaid program.<sup>2,3,4</sup> Imposing cost sharing on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.<sup>5,6,7</sup> Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.<sup>8</sup>
- ✓ **Penalizing enrollees for non-compliance with various program or wellness requirements:** Proposals have included lock-out provisions that prohibit an individual from re-enrolling in the program for a given period of time for not meeting certain requirements or imposing higher cost sharing for those individuals who use tobacco. Lockout periods or any policies that would disrupt an individual's coverage can jeopardize access to lifesaving treatment and seriously jeopardize their chance of survival. Being denied access to one's cancer care team could have a significant impact on an individual's cancer prognosis and the financial toll that the lock-out would have on individuals and their families could be devastating.
- ✓ **Eliminating benefits/services:** States have gained approval to waive non-emergency medical transportation (NEMT) for its enrollees. NEMT is a critical service for many low-income Medicaid beneficiaries who do not have the financial means or the access to needed transportation services.<sup>9</sup> Without transportation benefits, chronically ill Medicaid beneficiaries may go without the lifesaving health services they need, leading to delayed care, an increase in avoidable hospitalizations, and poorer health outcomes.<sup>10</sup> Additionally, a lack of transportation to screening services hinders an individual's ability to obtain necessary cancer screenings and, for some individuals, could result in detection of tumors at a later stage.
- ✓ **Placing limits on the length of program eligibility:** Placing limits on the length of time an enrollee can use Medicaid could cause disruptions in care for individuals managing serious and complex chronic conditions, like cancer. Individuals are diagnosed with cancer at various stages and, depending on the type of cancer, the stage, and the necessary course of treatment, the patient could easily reach any proposed program eligibility limits. Similarly, cancer survivors often experience long-term side effects from their treatment, often requiring maintenance medication and frequent follow-up visits. Denying these individuals and others with complex, chronic medical conditions access to health care coverage through Medicaid would be devastating to the enrollee and their family and could significantly reduce their chances of surviving the disease.
- ✓ **Changes to financing structure (block grants or per-capita caps):** ACS CAN strongly opposes any proposals to change the funding structure of the Medicaid program. These proposals would fundamentally alter the Medicaid program, shifting the funding from a percentage match, whereby the program's funding adjusts automatically to account for the number of enrollees and rising health care costs, to one where funding for

the program would be capped. Block grants and per-capita caps could significantly reduce low-income cancer patients', survivors', and their families' access to affordable, comprehensive health care in their state.

Data indicates that these policy proposals, especially those that limit or restrict eligibility, will significantly reduce enrollment in the Medicaid program and deny access to preventive and treatment services for individuals and families enrolled in the Medicaid program.<sup>11,12,13</sup> Preservation of eligibility and access to health care coverage through state Medicaid programs is critical for continuing to make progress against cancer for those low-income Americans who depend on the program for cancer prevention, early detection, diagnostic, treatment and survivorship care services.

<sup>1</sup> Medicaid.gov. *About section 1115 demonstrations*. Accessed January 2020. <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.

<sup>2</sup> Hendryx M, Onizuka R, Wilson V, Ahern M. Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program. *Soc Work Public Health*. 2012; 27(7): 671-86.

<sup>3</sup> Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs*. 2010; 29(12):2311-16.

<sup>4</sup> Office of the Assistant Secretary for Planning and Evaluation. *Financial Condition and Health Care Burdens of People in Deep Poverty*. Published July 16, 2015. Accessed October 2019. <http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>.

<sup>5</sup> Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34: 1331-50.

<sup>6</sup> Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care*. 2011; 49: 865-71.

<sup>7</sup> Trivedi AN, Rakowski W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med*. 2008; 358: 375-83.

<sup>8</sup> American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2019-2020*. Atlanta: American Cancer Society; 2019.

<sup>9</sup> Rosenbaum S, Lopez N, Morris MJ, Simon M. Medicaid's medical transportation assurance: Origins, evolution, current trends, and implications for health reform. Washington, D.C.: Department of Health Policy, School of Public Health and Health Services, The George Washington University, 2009.

[https://hsr.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1035&context=sphhs\\_policy\\_briefs](https://hsr.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1035&context=sphhs_policy_briefs).

<sup>10</sup> Kim J, Norton EC, Stearns SC. Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care. *Health Serv Res*. 2009. 44(1):145-61. doi: 10.1111/j.1475-6773.2008.00907.x

<sup>11</sup> Wisconsin Badger Care Reform, June 7, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi-wi-badgercare-reform-pa.pdf>.

<sup>12</sup> Ohio Department of Medicaid Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver, <http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/GroupVIII/Detail-GroupVIII-021618.pdf?ver=2018-02-16-092910-683>.

<sup>13</sup> Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid work requirements – Results from the first year in Arkansas. *NEJM*. 2019; DOI: 10.1056/NEJMSr1901772.