American Academy of Pediatrics (AAP)
Principles on Waivers
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Preamble: 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 waivers—most frequently in the form of Medicaid Section 1115 and Affordable Care Act (ACA) Section 1332 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, the AAP adopts the following waiver principles, seeking to ensure that state waivers "first, do no harm" to current or future enrollees. The AAP affirms that state waivers must:

- **Ensure the full range of care, treatment, and services that would otherwise be provided is maintained and/or strengthened.**
    - For example, CMS should ensure that proposals:
        - Fully maintain the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit
        - Maintain the full scope of benefits currently offered through the state plan, in addition to protecting retroactive coverage, non-emergent medical transportation, and other services

- **Maintain and/or build upon existing efforts to make care more readily accessible, and not implement barriers to eligibility, enrollment, or continued coverage.**
    - For example, CMS should ensure that proposals:
        - Maintain statutory eligibility requirements and do not make Medicaid eligibility contingent on factors such as work requirements, drug screening/testing, or premium or health savings account (HSA) payments
        - Uphold the program's entitlement by rejecting proposals that include periods where individuals are "locked out" of coverage for failing to meet specific standards, or making coverage time limited (e.g., 5 years of lifetime Medicaid coverage)

- **Maintain and/or strengthen affordability protections for children and families**.
    - CMS should ensure that proposals:
        - Do not employ cost-sharing through copayments, health savings account contributions, deductibles, or premiums for the purpose of discouraging access to needed care and services, or effectively act as a de facto reduction in payment to providers.
        - Do not require asset tests
        - Do not eliminate or cut cost sharing reductions or premium tax credits

- **Preserve and enhance existing funding mechanisms.**
    - CMS should ensure that proposals:
        - Preserve health care program financing to states, families, or providers by limiting cost- or risk-shift significant funding of Medicaid.
        - Maintain or increase payment to pediatricians and other physicians to enhance access to care

- **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 levels
        - Properly evaluate waiver impact on enrollees, families, and providers