

Healthy Adult Opportunity: An Empty Promise from the Trump Administration

Introduction

On January 30, the Centers for Medicare & Medicaid Services (CMS) released its long-rumored guidance¹ on Medicaid block grants. This letter to state Medicaid directors invites states to restructure their Medicaid programs in a radical manner previously rejected by Congress, by capping federal funding at an artificially low level. This new effort from the Trump administration, misleadingly titled Healthy Adult Opportunity (HAO), ought to have little appeal to state governments for reasons of basic math that we detail below. The proposal is also in stark violation of Medicaid law, and it represents a major threat to tens of millions of Medicaid beneficiaries.

CMS wants to convince states to forgo federal financial support and take on considerable fiscal risk in exchange for “flexibilities” to cut Medicaid. Governors across the country should not be fooled: HAO is a bad deal, and it comes from an administration that has repeatedly tried to cut trillions of dollars in federal Medicaid funding to states by capping federal obligations.

Healthy Adult Opportunity (HAO) Overview

Medicaid’s financing is based on federal matching of state Medicaid costs. As states spend money paying for Medicaid services, the federal government pays for a portion of their costs ranging from 50% to 90%, depending on the nature of the cost and the state. State fiscal flexibility is therefore built into Medicaid: States can spend what is needed on Medicaid knowing that their match rate is fixed in statute and

not capped. The new HAO option creates a pathway for states to turn a portion of their Medicaid program into a block grant, meaning the federal government would cap the amount of money a state receives no matter the state’s actual spending. The fiscal parameters of this particular block grant structure are detailed below, but the basics of a Medicaid block grant are all too easy to understand: If a state’s Medicaid costs exceed the amount of the block grant, the state will have to use its own funds to make up the difference or, more likely, cut provider rates and/or services for low-income people or take away their Medicaid coverage. The risk to the state will compound year over year as the block grant amount fails to keep up with the real cost of health care. As this happens, funding for other state priorities like education, infrastructure, and law enforcement would all be threatened as more and more state dollars would be required to pay for health care services.

The Trump administration has sought to cap federal Medicaid spending from its first days in office as a mechanism to shift financial risk to the states and to cut Medicaid. In the 2017 bills to repeal and replace the Affordable Care Act and then in proposed budgets in 2018 and 2019, the administration has repeatedly proposed over \$1 trillion in Medicaid cuts, with much of the cut derived by imposing caps on federal Medicaid match to states that are set to grow more slowly than actual health care costs. The HAO option is an effort to achieve the same goal by using Medicaid waivers and — it appears — appealing to partisanship as a way to get states to sign on despite the obvious downsides.

The block grant approach follows a predictable playbook. States receive greater “flexibility” — meaning less oversight and transparency around proposed Medicaid cuts — in exchange for accepting less federal money. Under current law, federal support automatically changes to match a state’s spending and needs. Federal support increases if a state’s costs go up, like with an opioid epidemic, natural disaster, or in the event a state decides to cover new medical treatments for its residents. In contrast, a state that elects to block grant Medicaid would face an awful choice in the event of health care cost trends that exceed the capped amount or when facing a public health crisis. Once that happens, the state will probably start rolling back benefits or cutting Medicaid eligibility. And it will be doing so without normal federal oversight or public transparency.

This paper describes who is directly at risk under the HAO guidance, what Medicaid cuts the guidance authorizes states to make, and how the proposed financing structure makes little sense for states.

Who Is Directly at Risk?

Nearly all Medicaid-eligible adults, with few exceptions, are ultimately vulnerable. Under the HAO’s legal reasoning, states gain broad discretion to block grant non-mandatory populations. In the short term, the administration has said it is “focusing” on Medicaid expansion adults. The most likely group to be block granted under HAO in the next several months is therefore the Medicaid expansion population, composed of adults who are under 138% of the federal poverty level and do not otherwise qualify for Medicaid as disabled, as a very low-income parent, or as a pregnant woman. However, according to the guidance that CMS released, other groups of Medicaid beneficiaries are also vulnerable to a federal approval of a similar block grant if they are in any way optional for states to cover. Many adult Medicaid beneficiaries are technically optional for states to cover. These individuals include some seniors, pregnant women, children 19 and older, and young adults aging out of foster care. Although the administration has declared a short term focus on Medicaid expansion adults, the only optional populations definitively exempted from an HAO block grant in the guidance are those who qualify for Medicaid because of a disability or the need for long-term services and supports.

Furthermore, it must be emphasized that all Medicaid beneficiaries are ultimately at risk if a HAO block grant throws a state’s Medicaid budget into crisis. And, as mentioned above, such a crisis also would threaten other state priorities like education, infrastructure, and law enforcement.

The “Flexibilities” — That Is, Medicaid Cuts — the Guidance Authorizes for States

The HAO guidance ostensibly offers states a quid pro quo: accept financial risk in return for new flexibility. But “flexibility” in this case is simply a euphemism for cuts to Medicaid that are not allowed under the Medicaid statute. As detailed below, HAO allows states to make otherwise disallowed cuts to Medicaid eligibility, benefits, and provider payment rates.

Cuts to Medicaid Eligibility

HAO provides states with an array of misguided and discredited mechanisms to make it harder for beneficiaries to stay enrolled. This includes both enrollment barriers previously promoted by the Trump administration and new potential barriers. The guidance reiterates the administration’s previously expressed interest in work reporting requirements and in eliminating statutory protections to improve continuity of coverage, like retroactive eligibility, beginning eligibility on the date of Medicaid application, and presumptive eligibility. The guidance allows block grant states to conduct more frequent eligibility redeterminations. The guidance also creates multiple new potential enrollment obstacles that include permitting states to target eligibility by geography, disease category, or by imposing asset tests. Finally, the guidance offers an open-ended authority to “impose additional conditions of eligibility.”

The connection between using tools like these and enrollment reductions is not theoretical. States have already used several of these tools to sharply reduce Medicaid enrollment and increase the number of uninsured under Medicaid policies the Trump

administration previously approved. In states that have pursued paperwork barriers like those in the HAO guidance, the subsequent enrollment reductions are quite stark.² In Arkansas³, 18,000 people lost coverage in just four months because of the work reporting requirement before the federal court blocked the program, and in Missouri⁴, arbitrary termination policies contributed to the highest rate of children’s coverage losses in the country. And — as emphasized throughout this analysis — the HAO caps on Medicaid funds will place enormous pressure on states to cut Medicaid enrollment.

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Cuts to Medicaid Benefits

As with Medicaid eligibility, the most important threat to Medicaid benefits in the HAO framework comes from the shift of risk and costs to states. HAO will create a strong incentive for states to eliminate numerous “optional” benefits to stay below their HAO cap. These optional services are actually critical for people’s health. They include dental benefits, hospice, and speech and physical therapy, among others.⁵

The guidance also offers to waive some mandatory Medicaid benefits in an unprecedented way — most notably prescription drug benefits. The Medicaid prescription drug benefit includes, by statute, all drugs approved by the Food and Drug Administration. The HAO framework would waive this benefit for every condition except HIV, opioid use, and mental illness, and it would allow states that accept block grants to significantly reduce drug coverage to as little as one drug in each clinical category. As many readers have likely experienced for themselves or for family members, there is often critical therapeutic value in having multiple drugs available for a given condition. Two drugs may have essentially the same effectiveness at a population level, but individual consumers may need to take one medication over another due to individual variations in their condition, side effects, interactions with other medications or health conditions, or ease of adherence. Additionally, there can be important differences in drug efficacy for white people and for people of color.

The guidance also allows states to circumvent Alternative Benefit Plan (ABP)⁶ requirements for beneficiaries block granted under HAO, instead allowing states to offer a benefits package that satisfies the essential health benefits (EHB) requirements for commercial plans on the exchange. There are several specific and important differences between these benefit packages. This means that HAO will effectively allow states to opt out of mandatory Medicaid benefits that are not EHBs, such as short-term skilled nursing facility services and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19- and 20-year-olds.

Payment and Provider Network Cuts

HAO offers states a pathway to cut provider reimbursement rates and managed care capitation rates, without going through federal review or oversight. States will have an overwhelming incentive to make these payment cuts, even though they could lead to huge access and quality concerns. Furthermore, the guidance invites states to propose alternative mechanisms to ensure that their Medicaid program has sufficient provider networks. In combination, these policies will allow states to cut the rates they pay providers and propose how they want to avoid federal mechanisms to ensure sufficient provider networks in Medicaid.

Block Grant Financing Models: A Detailed Summary and Implications for State Budgets

Any states that adopt HAO are offered one of two block grant financing approaches. Both involve the basic principle of capping federal matching. The first option, referred to as a per capita cap, establishes a cap on the funds available per enrolled person. The purpose of this approach is to account for fluctuations in enrollment. The second option, referred to as an aggregate cap, is a more traditional and even more rigid block grant. Under this approach, CMS establishes a hard financial cap regardless of changes in enrollment. While both options shift considerable financial risk to the states, according to CMS' HAO guidance, "states opting to implement an aggregate cap model assume greater risk due to the uncertainty in enrollment." In an effort to entice states to select the aggregate cap, CMS is offering states a "shared savings" option and a higher annual trend rate only

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available in the aggregate cap model. However, both models lace overwhelming fiscal pressure on states to cut back Medicaid benefits, payment, and/or enrollment. Ultimately, this pits a governor's interest in shared savings against the interests of the families who rely on Medicaid for their health care.

If a state accepts the aggregate cap and manages to cut enough to achieve a shared savings payment, the state will still need to provide matching funds to draw down the shared savings funds. States will be required to match those federal funds with state funds at the regular Federal Medical Assistance Percentage (FMAP) rate rather than the enhanced 90% rate associated with the Medicaid expansion population. This trade-off for states involves giving up certain Medicaid matching funds and taking on the risk of Medicaid costs growing faster than a block grant, in return for the possibility that a state can cut Medicaid sufficiently to earn back a small amount of shared savings. It's not a good trade for states.

It is even more fiscally irresponsible to apply this framework to Medicaid expansion, in which the federal matching rate is enhanced to 90%. As noted above, the Trump administration is targeting the Medicaid expansion population for HAO in the short term. We expect some governors in non-expansion states may see the block grant as a way to cover some or all of the Medicaid expansion in

a "conservative way," such as Oklahoma, whose governor joined Trump administration officials for the public announcement of the new block grant program. But even on purely fiscal terms, the deal offered to Oklahoma is all risk and no reward. There is very little fiscal risk to states in an uncapped 90% matched program. Yet the Trump administration asks states to give up a 90% match for costs above an artificially low cap, and to take on total risk for those costs, in return for a possible downstream shared savings payment at a regular Medicaid match.

Furthermore, for states like Oklahoma that have not implemented Medicaid expansion and are using HAO to implement partial or full expansion, the limited shared savings will likely not even become available until several years of capped federal funding. For a non-expansion state, which will not have historical claims data on the expansion population, CMS will require the state to spend at least two years in the per capita cap option before moving into an aggregate cap so the state can then create a baseline for any potential shared savings. After two years of generating historical data, the third year of the HAO waiver will be the aggregate cap baseline year. The state may not be eligible for shared savings in the third year either because that is the first year of the aggregate cap. It is unclear if CMS can evaluate the aggregate cap performance maintenance and improvement in

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the third year against per capita cap data from the second year. CMS also indicated that it may take an additional one or two years to evaluate data to determine performance scores.

The shared savings opportunity is highly uncertain. For a non-expansion state to access any of the shared savings funds, all of the following must take place:

1. The state must select the aggregate cap option to be eligible for shared savings. As described earlier, the aggregate option is the higher-risk financing option where the state relinquishes financial protections associated with upward fluctuations in enrollment.
2. The state must establish a baseline level of expenditures for a population it does not cover over the first and second years and possibly the third year under a capped model, initiating fiscal risk from the initial year of the demonstration.
3. CMS will then rebase the aggregate cap after two years of expansion experience under a per capita cap.
4. The state must then establish sufficient Medicaid benefits, eligibility, and cuts to generate savings off of this baseline. In order to receive the shared savings, the state will need to reduce overall costs dramatically and still meet or exceed certain quality benchmarks.
5. The fourth year may be the first and only potential shared savings year. CMS does not offer shared savings in the fifth and final year of the demonstration, unless the state renews its demonstration.

Clearly, the shared savings is not a guarantee. On Page 21 of the guidance, CMS offers an illustrative example of how this shared savings arrangement would work. Using CMS' own example, it is clear that the shared savings option under HAO is a poor option for states as compared to regular Medicaid expansion. As shown in Table 1 (page 7), CMS' example state had to reduce overall Medicaid expenditures by 16.67% and spend \$8 million in state funds to bring in \$49.5 million in federal funds. Yet if the same state expanded Medicaid and spent the same \$8 million in state funds on a simple, low-risk, and conventional implementation of Medicaid expansion, the state would bring \$72 million of federal funds into the state budget — a 45% increase in funds for the state compared to the HAO option with none of the risk associated with capping the program. And this example is the CMS best-case scenario. If the state fails to make these dramatic cuts, or even worse if costs escalate beyond the federal HAO cap, the state's liability is essentially unlimited.

Table 1. Medicaid Expansion a Better Deal Than HAO Shared Savings Even under the CMS Best-Case Scenario

	Total Computable Expenditures	State Share	Federal Share
Expenditures for Newly Eligible Adults ⁱ	\$50 million	\$5 million	\$45 million
Aggregate Cap (Based on State Baseline Spending)	\$60 million	N/A	N/A
CMS Assumed Budget Cuts Relative to Aggregate Cap	(\$10 million) ⁱⁱ	N/A	N/A
Shared Savings Percentage	N/A	N/A	50%
Eligible Shared Savings Amount ⁱⁱⁱ	\$7.5 million	\$3 million ^{iv}	\$4.5 million
Funding Flows under HAO Shared Savings	\$57.5 million	\$8 million	\$49.5 million
Funding Flows under Traditional Medicaid Expansion	\$80 million	\$8 million^v	\$72 million

ⁱ Ninety percent enhanced Federal Medical Assistance Percentage (FMAP) for the expansion population. A state that partially expands under HAO will not be eligible for the enhanced match, leaving even more federal funds unused as compared to a traditional Medicaid expansion.

ⁱⁱ The example state needs to cut \$10 million in Medicaid expenditures, or 16.67%, to receive up to \$7.5 million in shared savings.

ⁱⁱⁱ The shared savings reinvestment expenditures are matched at the state's regular FMAP rate. In CMS' illustrative example, CMS demonstrates this using a 60% FMAP rate.

^{iv} For a state to access the full \$4.5 million in shared savings, it will have to expend \$3 million in state funds.

^v This illustrative example assumes that both the HAO shared savings option and traditional expansion option have the same state share (\$8 million).

Governors have the difficult task of financing competing priorities in their state. The current state-federal Medicaid partnership provides states with a dependable source of federal funds amidst constrained budgets. This guarantee is even more compelling for Medicaid expansion adults

whose costs are matched at 90 cents on the dollar. Rejecting the federal guarantee to match a state's actual Medicaid spending has major implications. Before even considering HAO, states should understand all the ways in which the deal being offered is a poor one.

CMS' Approach Is Illegal and Likely Will Be Challenged and Blocked in Court

The HAO guidance is illegal and runs afoul of Medicaid law in five distinct ways:

1. The federal courts have found that Medicaid waivers, limited to “promoting the objectives” of Medicaid in Section 1115 of the Social Security Act, must actually promote Medicaid coverage to be approvable under the statutory waiver authority. A policy that imposes funding cuts on states in return for new extra-statutory state authorities to cut Medicaid benefits and eligibility manifestly fails to meet that standard.
2. The Medicaid waiver authority only allows waivers of some provisions of Medicaid law (that is, Title XIX of the Social Security Act). Section 1115 waivers cannot extend to the statutory sections governing federal match to states. The principle that CMS can't waive federal match has always been a fundamental guardrail for Medicaid waivers.
3. The administration tries to get out of these difficulties by relying on a different waiver authority — Section 1115(a)2, which allows CMS to find some non-Medicaid expenditures eligible for Medicaid match if they promote the objectives of the program. But this provision is clearly intended to allow CMS to add new Medicaid benefits and programs. It is absurd to use this provision to move swathes of the program into a block grant by cynically calling them “non-Medicaid.”
4. The HAO effort is also an attempt to circumvent Congress. The effort to block grant Medicaid via waiver comes after the administration's 2017 legislative attempt to block grant Medicaid failed. Changing the financing structure of Medicaid requires congressional authority.
5. In addition to subverting Congress, the administration has also subverted the American public by skipping a public comment process mandatory for any significant change in administration policy under the Administrative Procedures Act.

Conclusion

Cutting Medicaid via block grants has been a cornerstone of this administration's agenda. As noted above, the Trump administration tried and failed to have Congress create a similar structure for Medicaid in 2017 as part of the effort to repeal the Affordable Care Act and then proposed a draconian mandatory Medicaid funding cap in subsequent budgets. The American people — and a bipartisan Senate majority in 2017 — have strongly rejected these Medicaid cuts.

To this point, a small number of states have signaled interest in the HAO waiver approach. Other states will likely confront the issue during their state legislative session this winter. While inevitable legal battles wage on, it will be important that advocates in the states unmask the HAO for what is really is — a misguided ideological boondoggle that puts both state taxpayer dollars and constituent lives at risk.

¹ Centers for Medicare & Medicaid Services, State Medicaid Director Letter #20-001, January 30, 2020, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>.

² Emmett Ruff and Eliot Fishman, “The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018,” Families USA, April 2019, https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.

³ Emmett Ruff and Joe Weissfeld, “The Results Are In: Medicaid Work Requirements Don’t Work,” Families USA, August 20, 2019, <https://familiesusa.org/resources/the-results-are-in-medicaid-work-requirements-dont-work/>.

⁴ Stan Dorn, Joe Weissfeld, and Emmett Ruff, “America’s Children Are Losing Health Insurance, Putting Their Futures at Risk: How National Lawmakers Can Help,” October 4, 2019, <https://familiesusa.org/resources/americas-children-losing-health-care/>.

⁵ Centers for Medicare & Medicaid Services, “Mandatory & Optional Medicaid Benefits,” <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>.

⁶ Medicaid and CHIP Payment and Access Commission, “Alternative Benefit Plans,” <https://www.macpac.gov/subtopic/alternative-benefits-packages/>.

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