

# Health Care in Motion

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## Administration Releases a “Block”-headed Invitation to Dismantle Medicaid

The Trump Administration is back at it again with another attack on Medicaid. Yesterday, the [Centers for Medicare & Medicaid Services](#) (CMS) announced [new guidance](#) encouraging states to restructure their Medicaid programs as block grants.

Why is this so important? If implemented as proposed, this would represent a fundamental shift in the way the program works. Medicaid has always been an entitlement program that covers everyone who needs it, regardless of cost. With this change, CMS would permit states to transform their Medicaid funding from an open-ended source of federal money for all eligible people into a finite block grant that ends when the money runs out. If adopted, states will be incentivized to cut enrollment and benefits to save money. Back in December, we [explained](#) why block grants are so dangerous (and illegal).

Instead of calling this block grant proposal what it really is, the administration is dressing it up with the [Orwellian](#) label of “Healthy Adult Opportunity” (HAO) initiative. Whatever CMS calls it, the proposal represents a back door dismantling of the health care safety net that this Administration has repeatedly [failed to win in Congress](#). It is illegal, and advocates must do all they can to prevent its implementation.

As we saw with the Administration’s attempts to promote work requirements, this guidance is explicitly aimed at the [Medicaid expansion](#) population — adults that are not “categorically needy” under traditional Medicaid standards. While this may be the case, this change is likely to impact all enrollees as states shift their financing arrangements.

Here are the key points from yesterday’s guidance:

**Financing and Shared Savings:** Federal funding for the HAO population would be capped either as an aggregate amount (a block grant) or per enrollee (a per capita cap). If a state underspends its federal limit, it could share 25-50% of the savings and reinvest it in health programs not usually covered under Medicaid. Unspoken in the proposal is the stark incentive that this sets up for a state. Whether by limiting enrollment, cutting benefits, reducing doctor reimbursements, or limiting provider networks, the bottom line is that states that reduce their Medicaid spending get to [keep the change](#). Advocates should not have high expectations of how state governments will react to such an enticing offer.

**Prescription Drugs:** Among the most significant changes in this proposal is CMS’s new course with respect to prescription drug coverage. Under yesterday’s Guidance, States could enact a closed formulary limiting the number of

drugs available to the HAO population. This is a change from past policy. Advocates may [recall](#) this debate from 2018, when CMS [denied](#) Massachusetts' request to restrict access to prescription drugs.

**Premiums and Cost-Sharing:** States could impose premiums and cost-sharing without adhering to any statutory or regulatory protections, as long as the total cost doesn't exceed 5% of household income. CMS suggested, for example, that states could penalize patients with increased cost sharing for going to the emergency room during a non-emergency. CMS also proposed that states could kick people off Medicaid for failing to pay premiums on time.

**Benefits:** While noting that states would still be required to cover a baseline of essential health benefits (EHBs) for the HOA population, CMS also invited states to change benefits without meaningful review and approval. EHBs have already been [drastically weakened](#) under the Trump Administration.

CMS also re-iterated some of the draconian policies it has previously promoted. Under the guidance, states are once again invited to enact work requirements. We've [written before](#) about why these are dangerous and illegal. Work requirements have been repeatedly struck down by a federal court, and we're [still waiting](#) to hear how a higher court will rule on appeal. States could also get rid of retroactive eligibility for beneficiaries with paperwork processing delays. Such a change might prevent eligible people for gaining coverage in [emergency situations](#), and could inevitably lead to financial hardship or refused care.

## Conclusion

It's important to note that this is guidance, not rulemaking. So advocates don't have the opportunity to challenge it — yet. Once states apply for HAO demonstrations, there will be a 30-day [public comment](#) periods both at the state and federal levels. And if CMS does approve a state's HAO demonstration based on this guidance, advocates can challenge the approval in court (just like they did for work requirements).

Tennessee's block grant application is currently pending with CMS, but it is [quite different](#) from this guidance, so its fate is unclear. Oklahoma also seems [eager](#) to submit a HAO application.

Advocates must do all they can to stop the implementation of block grants. The Trump Administration cannot be allowed to re-write Medicaid law through the waiver process and destroy the health, rights, and dignity of millions of low-income Americans. Stay tuned to Health Care in Motion in the weeks to come for further updates and in-depth analysis as CMS tries to implement the block grant proposal.

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*Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Phil Waters, Clinical Fellow; Maryanne Tomazic, Clinical Fellow; and Rachel Landauer, Clinical Fellow;*

*This issue was also authored by Caroline Horrow, a clinical student in the Health Law and Policy Clinic of Harvard Law School.*

*For further questions or inquiries please contact us at [chlpil@law.harvard.edu](mailto:chlpil@law.harvard.edu).*