



What Does CMS' New "Healthy Adult Opportunity" Guidance Mean for People with Disabilities?

On January 30, 2020, the Centers for Medicare and Medicaid Services (CMS) released its "Healthy Adult Opportunity" guidance to allow states, for the first time, to apply for waivers to use a capped amount of funding to finance part of their Medicaid programs. Specifically, the guidance encourages states to submit Medicaid Section 1115 waiver applications requesting to use a block grant (referred to in the guidance as an "aggregate cap") or per capita caps to fund Medicaid for adults under 65 who do not qualify for Medicaid on the basis of "disability or need for long-term care services and supports and who are not covered under the state plan."

This guidance allows states to fundamentally change how they finance their Medicaid programs in a way that will harm all Medicaid participants, including people with disabilities. Below, we break down the guidance and what it means for people with disabilities.

What are block grants and per capita caps?

Currently, states receive matching Medicaid funding from the federal government based on the actual cost of providing services to all their Medicaid participants. In contrast, block grants provide states a lump sum of funding, even if the state's actual cost of providing services is higher or more people enroll in the program. Similarly, per capita caps provide states a set amount of funding per participant regardless of the actual cost of providing services.

Both Block Grants and Per Capita Caps:

- Provide states with a preset amount of funding, which increases at set rate over time
 - Typically a lower rate than the rate at which actual health care costs increase
- Deprive states of federal matching funds for the actual costs of any services provided to Medicaid participants that go beyond the capped amount
 - Instead, states alone have to fund all costs above the cap
- Create pressure for states to address funding shortfalls by reducing costs, including by:
 - Cutting covered services
 - Limiting access to benefits
 - Setting stricter eligibility for enrollment in Medicaid or making it harder for people who are already enrolled to keep Medicaid

How will this guidance impact people with disabilities?

This guidance will impact many people with disabilities on Medicaid. It only excludes from capped funding people with disabilities who qualify for Medicaid on the basis of disability (for example, people who qualify because they receive Social Security Disability Insurance). Many people with disabilities do not qualify on that basis, including the millions of people with disabilities who have become eligible through the Affordable Care Act's Medicaid expansion.

By one estimate, five million people with disabilities on Medicaid could have their care threatened by the guidance. Moreover, when states face funding shortfalls from capped

funding, services for **all** Medicaid participants, including those who qualify on the basis of disability, may be cut.

Under this new guidance, states also can request to impose harmful policies not otherwise allowed in Medicaid programs that could lead to restrictions on services or loss of eligibility for the population covered in the waiver. These include:

- Conditioning eligibility on meeting work requirements
- Charging premiums and copayments beyond what Medicaid otherwise allows
- Restricting prescription drug coverage to as little as one drug per class for most conditions (other than HIV and behavioral health conditions)
- Eliminating non-emergency medical transportation
- Waiving managed care standards and oversight
- Eliminating retroactive coverage
 - Retroactive coverage allows people to get Medicaid coverage three months prior to when they applied if they would have been eligible at that time
 - Also protects hospitals and providers against uncompensated care costs

What could this guidance mean for the future of Medicaid?

This guidance is a first step that could open the door to broader Medicaid block grants. The Trump Administration has repeatedly put forth and supported proposals to allow states to block grant their entire Medicaid program. This guidance could lay the groundwork for future block granting of other Medicaid populations, including people who qualify on the basis of disability, along with the many people with disabilities already affected by this guidance.

Will this guidance be challenged in court?

The Administration, including CMS, cannot change the Medicaid statute— only Congress can. Disability and healthcare advocates successfully defeated attempts by Congress to allow block grants in Medicaid in 2017. CMS is now trying to reverse that outcome and change Medicaid's funding structure through this new guidance.

If CMS approves any state waivers under this new guidance, they will likely be challenged in court. Section 1115 waivers can only be used to waive requirements if doing so would promote the objectives of Medicaid, which are to provide low-income people with access to healthcare and services that help them gain or maintain independence and self-care. Courts have struck down as illegal other 1115 waivers approved by CMS that include policies (such as work requirements) that similarly could lead to loss of services or coverage.

For more information on the guidance, including media coverage and analyses, see: <https://medicaid.publicrep.org/feature/cms-block-grant-guidance-what-is-it-and-what-does-it-mean-for-people-with-disabilities>.

You can also find more information about how block grants work and what they could mean for the future of Medicaid here: <https://medicaid.publicrep.org/feature/what-could-block-grant-proposals-mean-for-medicaid>.