American Hospital Association™

Advancing Health in America

Healthy Adult Opportunity Waivers: Talking Points

AHA Take: The AHA continues to support expansion of the Medicaid program, and states should have the flexibility to design their Medicaid programs to best meet the needs of their populations within appropriate safeguards. The guidance released today is expansive and will take some time to fully evaluate. However, we urge CMS to ensure critical safeguards are in place to prevent loss of coverage or access to care. This new authority should not be used as a pretext to strip coverage or benefits from any of the 75 million Americans who rely on the Medicaid program, nor should it be used to deny access to those who may become eligible in the future. Those who rely on the program today must be able to rely on the program tomorrow. In particular, a defined funding approach must not prevent states from meeting the coverage needs of vulnerable populations in times of economic fluctuation. Finally, we urge CMS to make certain that Medicaid funds are maintained for health care services and not diverted for other state spending priorities.

Key Points

- The AHA continues to support expansion of the Medicaid program.
- Medicaid is a lifeline for communities and vulnerable populations across the country,
- This is especially true in rural areas where 15 percent of hospital revenue depends on Medicaid funding.
- While the AHA does not support federal policy converting the Medicaid program to a block grant financing structure, we do not opine on policy decisions at the state level.
- States are in the best position to determine the right approach for their program based on local circumstances.
- The guidance released today is expansive and will take some time to fully evaluate.
- We urge CMS to ensure critical safeguards are put in place to prevent loss of coverage or access to critical benefits for patients.

Background

- CMS has released new guidance providing states with the opportunity to receive a “defined budget” to cover services for certain healthy adults using 1115 waiver authority.
- This approach is commonly referred to as a “block grant.”
- Generally, CMS will allow states to receive a defined amount of federal funding – on either an aggregate or per capita basis – annually to cover benefits for certain non-disabled adults under the age of 65 who do not need long-term care services and supports.

    - In other words, the agency is targeting what are referred to as “optional” adults, which includes the expansion population.
- States will be permitted, among other things, to:
    - Apply additional conditions of eligibility such as work requirements (referred to as “community engagement requirements”);
    - Apply higher beneficiary cost sharing than is currently allowed;
    - Tailor benefits to make them more in line with commercial coverage;
    - Restrict coverage of certain drugs through enhanced use of formularies; and
    - Eliminate retroactive coverage or presumptive eligibility.
- States would be permitted to make changes to provider payments without further approval by CMS, as well as to propose alternative approaches to managed care arrangements currently permitted in regulation.
- Budget targets will be negotiated between the state and CMS based on a state’s historic costs, as well as national and regional trends. These targets will be tied to inflation.
- States that receive an aggregate amount of funding may share in any savings accrued to the federal government by implementation of these approaches.
- States are not required to apply for block grants – or to apply for all of the available flexibilities; the decision to apply for such a waiver, and the specific requests within the waiver, are wholly within states’ discretion.
- The guidance is effective immediately, as is standard practice for CMS guidance to states on what the agency considers allowable uses of 1115 authority.