"Block Grant" Medicaid Waivers Would Pose Serious Risks to Beneficiaries, Providers, and States

Center on Budget and Policy Priorities

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma wants to use Medicaid waivers to let states ignore various federal standards and beneficiary protections — and avoid federal oversight — in exchange for agreeing to caps on the federal Medicaid funding they receive. As explained below, such "block grant" waivers would pose serious risks to beneficiaries, health providers, and states.[1]

CMS guidance that reportedly would provide a framework for states to seek and implement block grant waivers currently is under review at the federal Office of Management and Budget. Several states are also drafting or considering waivers along these lines.

The combination of eligibility restrictions, weaker beneficiary protections, greater financial risk for states, and reduced federal oversight threatens the well-being of both low-income and vulnerable Medicaid beneficiaries and those who provide their care. Medicaid's coverage guarantee means that coverage is there when it's needed: people who lose their jobs or get sick can enroll when they qualify and receive a core set of health care services that all states must cover. Ending that guarantee — or eliminating the federal oversight that ensures that states, health plans, and providers comply with it — would worsen access to care, health, and financial security for Medicaid enrollees and very likely increase uncompensated care costs for hospitals and other providers.

Guidance Will Likely Invite Waivers That Would Undermine Coverage, Wouldn't Improve Health Care

The guidance will likely invite waivers that undercut Medicaid's guarantee of comprehensive coverage to low-income people who meet the program's statutory eligibility criteria. Administrator Verma has described the forthcoming waiver policy as giving states capped federal funding "in exchange for more flexibility and less oversight." But Medicaid already provides states with numerous options to customize their programs, while requiring that states provide coverage that meets basic affordability and benefit standards to all low-income people who qualify under Medicaid eligibility criteria. "Flexibility" is likely code for allowing states to abrogate these standards.

Utah's recently approved Medicaid waiver suggests where some states and the Administration may be headed in exchanging caps on federal funding for authority to limit coverage. The waiver gives Utah unprecedented authority to flatly deny coverage to eligible low-income adults who apply, in order the keep the state's share of Medicaid costs for this group within a budget cap that the state sets. And extending such authority to other states or other groups of Medicaid enrollees would amount to ending Medicaid's coverage guarantee for many people in those states.

Capping enrollment is just one of the ways CMS could let states deviate from Medicaid rules in exchange for accepting caps on their federal funds. The Trump Administration has already approved waivers that lock people out of coverage if they don't meet work requirements, pay premiums that many Medicaid beneficiaries may have difficulty affording, or fill out paperwork on time, as well as approving waivers that erode Medicaid's affordability protections. New waiver guidance could allow states to impose still higher premiums and cost-sharing and lock out those unable to afford these costs, or simply invite more states to implement these harmful provisions.

Cutting Medicaid enrollment would also have a significant impact on providers, increasing uncompensated care costs. Research shows that the Affordable Care Act's Medicaid expansion has led to reductions in uncompensated care and improved operating margins in hospitals, especially rural hospitals, in states that have expanded Medicaid. Under the type of waivers CMS is now contemplating, the expanded flexibility and diminished federal oversight that states would receive in exchange for accepting capped federal funding would likely reverse some of this progress.

Guidance Will Likely Invite Waivers That Raise States' Financial Risk

While CMS can't require states to accept deep federal funding cuts, the guidance will likely invite waivers that put states at greater financial risk. Block grant waivers likely won't entail the deep cuts that were included in the legislative block

grants and per capita cap proposals Congress considered but failed to pass in 2017. That's because the Trump Administration can't force states to agree to a waiver, and states are unlikely to accept waivers with federal funding caps far below the level of federal Medicaid funding they otherwise expect to receive.

Nonetheless, any waiver that imposes a rigid cap on federal funding would shift significant risk to states, since it would put them on the hook for unexpected costs that the federal government otherwise would help pay. That could include costs for new drugs that represent health care breakthroughs but are expensive, a public health emergency like the opioid epidemic, or in the case of an aggregate cap on a state's total federal Medicaid funding, increases in Medicaid enrollment during a recession when people lose jobs and the health coverage that often comes with them.

Meanwhile, some state policymakers appear to be under the mistaken impression that under a block grant waiver, a state could receive a specified amount of federal funding *regardless* of its own level of Medicaid spending, or that a state could receive *more* federal dollars under such a waiver. But Medicaid's funding structure cannot be changed using waiver authority. That means states would still have to put up their own funds to draw down federal dollars. Meanwhile, Medicaid waivers can keep federal costs the same or reduce them, but waivers cannot increase federal costs. That means a waiver could not increase federal funding for a state.

Plan Won't Protect Beneficiaries

Administrator Verma has said the new waiver authority would substitute state accountability for health outcomes for state accountability for complying with Medicaid standards and CMS oversight of states' adherence to those standards. Yet measurement of health outcomes is no substitute for Medicaid standards and protections and CMS oversight of state programs.

In practice, it's very difficult to reliably establish whether Medicaid changes as a result of implementing a waiver are worsening health outcomes. And it's virtually impossible in a short period of time; it often takes many years for the loss of access to care to lead to measurable deterioration in a person's health. In addition, as a federal court recently reminded CMS, the purpose of health insurance is *both* to improve access to care and health outcomes *and* to improve households' financial security. Tracking health outcomes sheds no light on whether changes made under a waiver are making it harder for low-income families to pay rent or put food on the table or are leaving them burdened by medical debt.

Moreover, abundant evidence has already established that letting states take coverage away from eligible people or make coverage less affordable worsens access to care and health outcomes. Procedural protections for beneficiaries and federal oversight are key to ensuring that states actually meet eligibility, affordability, and benefit standards.

Guidance Likely to Raise Legal Issues

The only federal court that has ruled to date on the new types of restrictive waiver approvals that take coverage away from people who do not comply with work requirements, pay premiums, or renew their coverage on time has disagreed with the Trump Administration's attempt to justify coverage losses as being consistent with Medicaid's objectives.

Despite this ruling, the Administration has made clear that it plans to continue approving waivers that include restrictive policies that jeopardize Medicaid's coverage guarantee. Waivers that jeopardize Medicaid's coverage guarantee by denying coverage based on funding caps or targets, allow states to deny coverage or health benefits that federal Medicaid law mandates, or eliminate important beneficiary protections (as part of a deal to cap federal funds) almost certainly will also be subject to legal challenge.

While the Administration may still approve such waivers, states could expend substantial effort and resources developing them, negotiating them with the Administration, and redesigning eligibility or other systems around the new waiver authorities, only to have the waivers struck down in court (or reversed by a subsequent Administration).

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[1] For more on this topic, see Judith Solomon and Jessica Schubel, "'Block Grant' Guidance Will Likely Invite Medicaid Waivers That Pose Serious Risks to Beneficiaries, Providers, and States," CBPP, June 27, 2019, https://www.cbpp.org/research/health/block-grant-guidance-will-likely-invite-medicaid-waivers-that-pose-serious-risks-to.