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A Review of the New Healthy Adult Opportunity Demonstration Guidance

Cindy Mann

February 7, 2020

Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter (SMDL) available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.

Agenda

- Overview of New Guidance Authorizing Caps on Federal Medicaid Funding
- Key Features of the New Guidance
- Q & A

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Overview of New Guidance Authorizing Caps on Federal Funding

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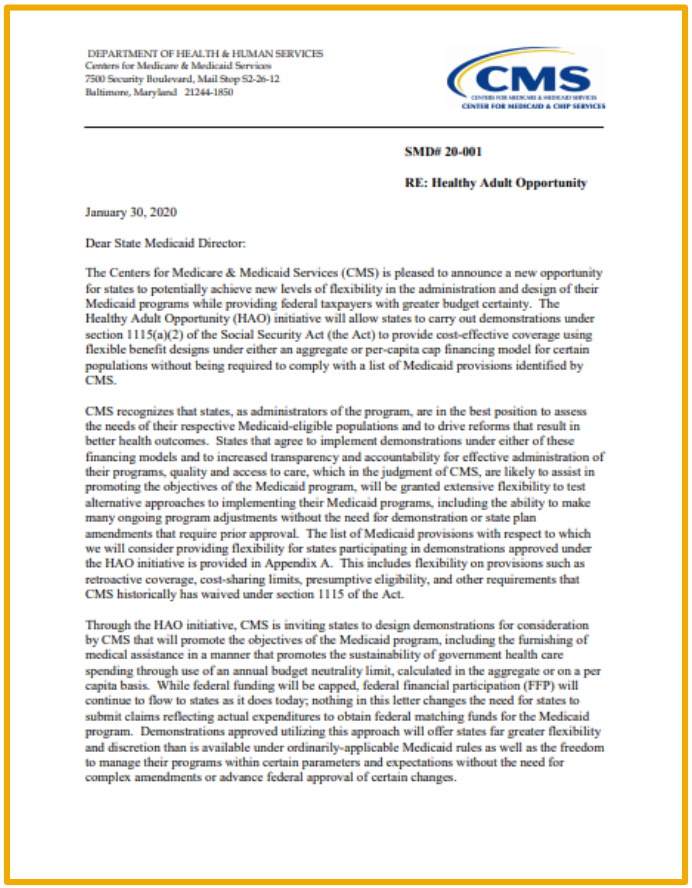
Healthy Adult Opportunity Demonstration Guidance

On January 30th, CMS issued an SMDL and template inviting states to apply for Section 1115 "Healthy Adult Opportunity" demonstrations that would cap federal Medicaid funding for a portion of their Medicaid population.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 20-001

RE: Healthy Adult Opportunity

January 30, 2020

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a new opportunity for states to potentially achieve new levels of flexibility in the administration and design of their Medicaid programs while providing federal taxpayers with greater budget certainty. The Healthy Adult Opportunity (HAO) initiative will allow states to carry out demonstrations under section 1115(a)(2) of the Social Security Act (the Act) to provide cost-effective coverage using flexible benefit designs under either an aggregate or per-capita cap financing model for certain populations without being required to comply with a list of Medicaid provisions identified by CMS.

CMS recognizes that states, as administrators of the program, are in the best position to assess the needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes. States that agree to implement demonstrations under either of these financing models and to increased transparency and accountability for effective administration of their programs, quality and access to care, which in the judgment of CMS, are likely to assist in promoting the objectives of the Medicaid program, will be granted extensive flexibility to test alternative approaches to implementing their Medicaid programs, including the ability to make many ongoing program adjustments without the need for demonstration or state plan amendments that require prior approval. The list of Medicaid provisions with respect to which we will consider providing flexibility for states participating in demonstrations approved under the HAO initiative is provided in Appendix A. This includes flexibility on provisions such as retroactive coverage, cost-sharing limits, presumptive eligibility, and other requirements that CMS historically has waived under section 1115 of the Act.

Through the HAO initiative, CMS is inviting states to design demonstrations for consideration by CMS that will promote the objectives of the Medicaid program, including the furnishing of medical assistance in a manner that promotes the sustainability of government health care spending through use of an annual budget neutrality limit, calculated in the aggregate or on a per capita basis. While federal funding will be capped, federal financial participation (FFP) will continue to flow to states as it does today; nothing in this letter changes the need for states to submit claims reflecting actual expenditures to obtain federal matching funds for the Medicaid program. Demonstrations approved utilizing this approach will offer states far greater flexibility and discretion than is available under ordinarily-applicable Medicaid rules as well as the freedom to manage their programs within certain parameters and expectations without the need for complex amendments or advance federal approval of certain changes.

Healthy Adult Opportunity Guidance 101:

Capped Funding. States agree to accept caps on their federal matching dollars in one of two forms: a per capita cap or an aggregate cap

Flexibility. In exchange for accepting a cap, states can get pre-approved authorization to constrain eligibility, impose premiums/cost sharing, and modify benefits

"Shared Savings". States could divert "unused" federal block grant funds to other purposes

Timeframe. Demonstrations are authorized for a five-year demonstration period

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Implications

Reduced funding due to caps; cuts and level of risk grow over time

Harm to coverage and access to care; reductions in payments to plans/providers may be unsustainable

Opportunity to divert funds will deepen the cuts and add to access issues

Litigation risk is high

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Key Features of the New Guidance

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Demonstration Eligible Populations

The guidance targets the Affordable Care Act adult expansion group, but some other populations could be included.

Demonstration Eligible Populations:

Affordable Care Act adult expansion group

Optional populations of non-elderly, non-disabled adults (e.g., optional parents and pregnant women whose household income is above the federal mandatory threshold for these groups)

States may shift existing Medicaid populations (state plan or demonstration) to the capped funding demonstration, or use the demonstration to extend coverage to new populations

Ineligible Populations:

Children, elderly/disabled, and mandatory adults (e.g., mandatory parents and pregnant women)

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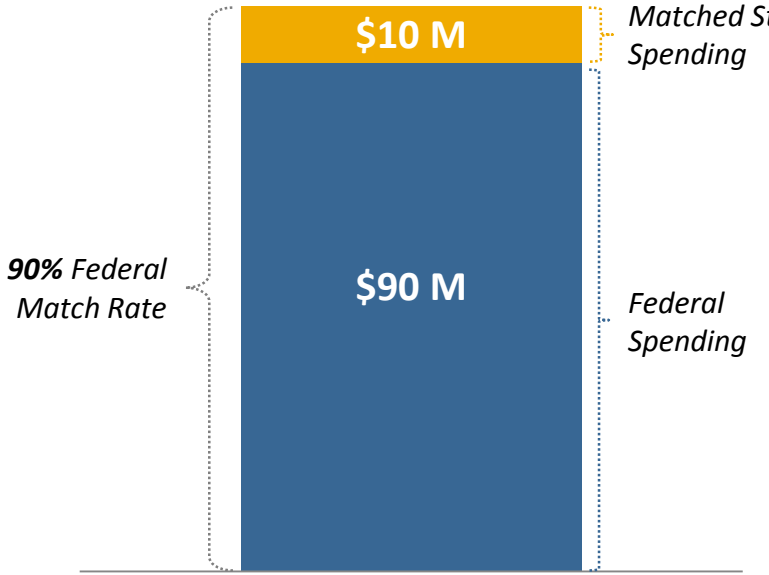
A Fundamental Change in Medicaid Financing

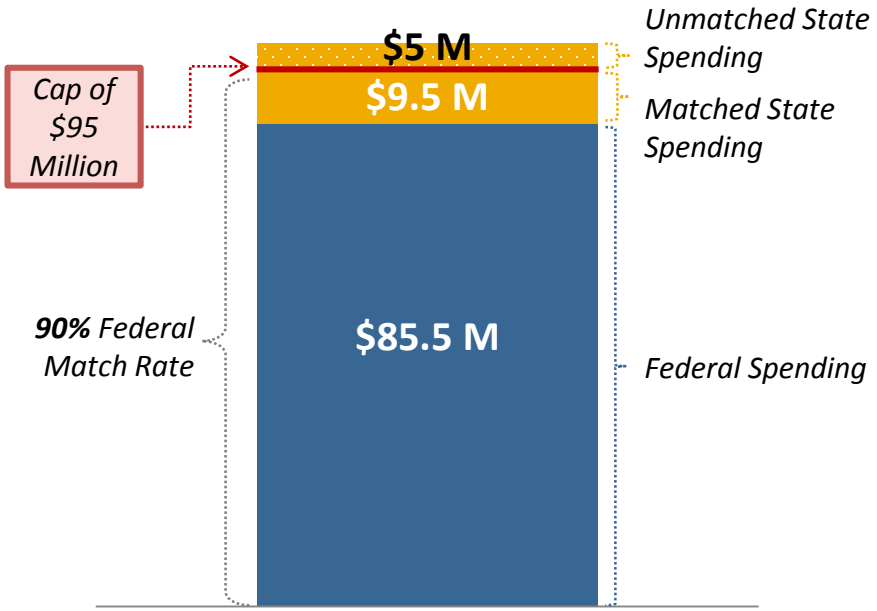
The federal government currently matches state expenditures without any cap. The new demonstration caps federal matching dollars.

Medicaid Spending Without a Cap – Year 1



Total Spending: $100 Million

Medicaid Spending With a Cap – Demonstration Year 1



Total Spending: $100 Million

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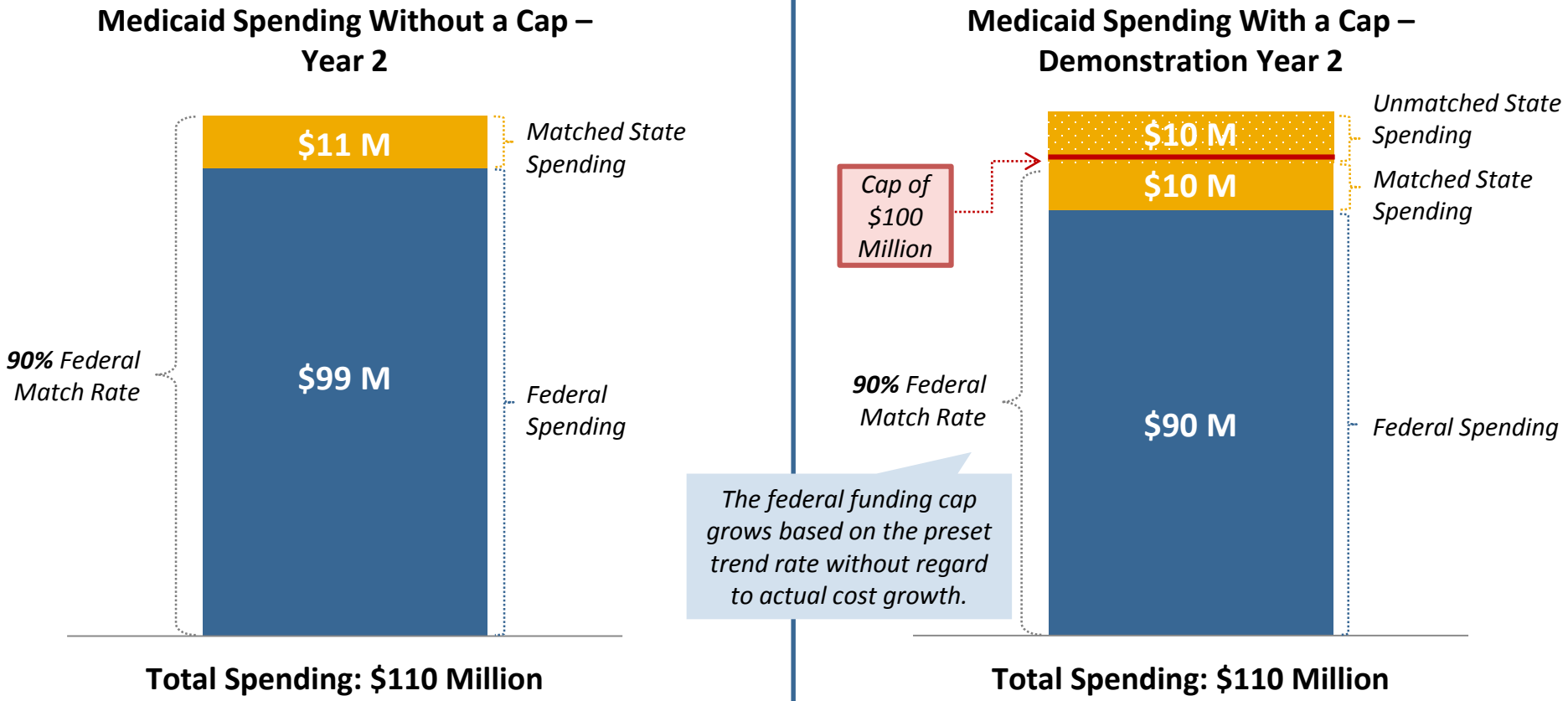
A Fundamental Change in Medicaid Financing (Continued)

When Medicaid costs go up under current law, federal funding increases proportionately. Under the demonstration, the cap limits federal spending regardless of actual costs.



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States May Choose a Per Capita Cap or Aggregate Cap

States covering new populations (e.g., a newly expanding state) must use a per capita cap for the first two years.

Cap Model	Base Payment	Trend Rate	Federal Matches Up to the Cap	States At Risk For
Per Capita Cap – Cap is set per person	Based on historical spending per enrollee	Cap grows each year by pre-set trend rate: the *lower* of state historical spending growth or the **medical CPI**	CMS matches state spending at applicable match rate but only up to the cap	Increases in health costs but not enrollment
Aggregate Cap (Block Grant) – Cap is set for all spending under the demonstration	Based on historical spending and enrollment (total costs)	Cap grows each year by pre-set trend rate: the *lower* of state historical spending growth or **medical CPI plus .5**	CMS matches state spending at applicable match rate but only up to the cap	Increases in health costs and enrollment

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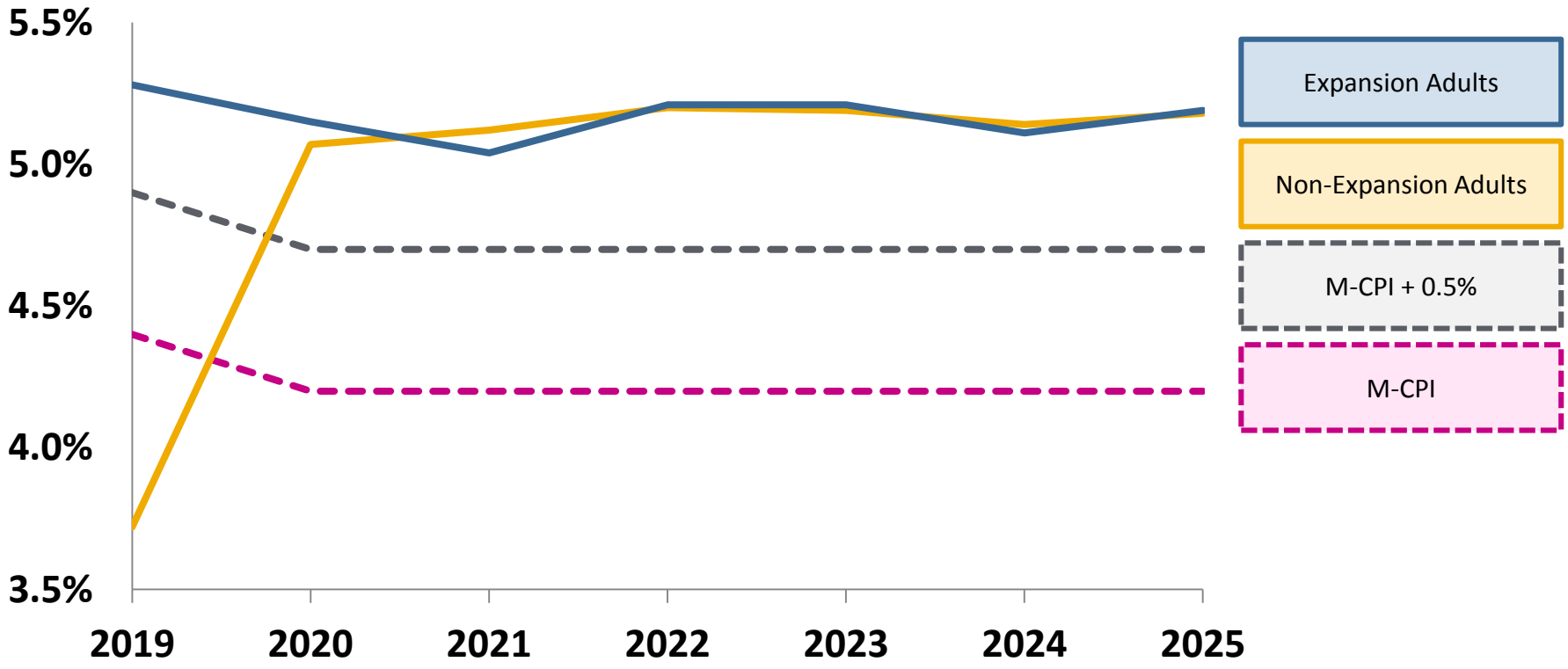
Capped Funding Demonstration Trend Rates

Medicaid expenditures are expected to grow more quickly than the allowable capped funding demonstration trend rates; over time, this will likely constrain state spending relative to current levels.

Projected Annual Per Enrollee Spending Growth Rates (2019 – 2025)



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Source: OACT 2017 Actuarial Report on the Financial Outlook for Medicaid.

"Shared Savings" May be Available to States That Opt for an Aggregate Cap

Provided states meet certain performance criteria, they could divert federal block grant funds; creates a strong incentive for states to spend well below the cap.

Drawing Down "Shared Savings"

A state may convert unused federal spending into a "shared savings" payment

- 25 – 50% of unused federal matching dollars can be drawn down as "shared savings," if state meets certain performance benchmarks
- States must draw down "shared savings" at the applicable matching rate by spending state funds; lower match rate than for the demonstration assuming the demonstration covers the expansion group
- States can divert the federal funds into state-funded health-related state programs
- Federal "shared savings" may not supplant existing federal funding, but can replace existing state spending on health programs as long as state match requirement is met, thereby freeing state dollars for other uses (e.g., roads and infrastructure)

Alternatively States Could Use Savings as a Cushion in Later Years

- A state that underspends in a given year may apply unused federal funds to offset overspending in any of the next three years

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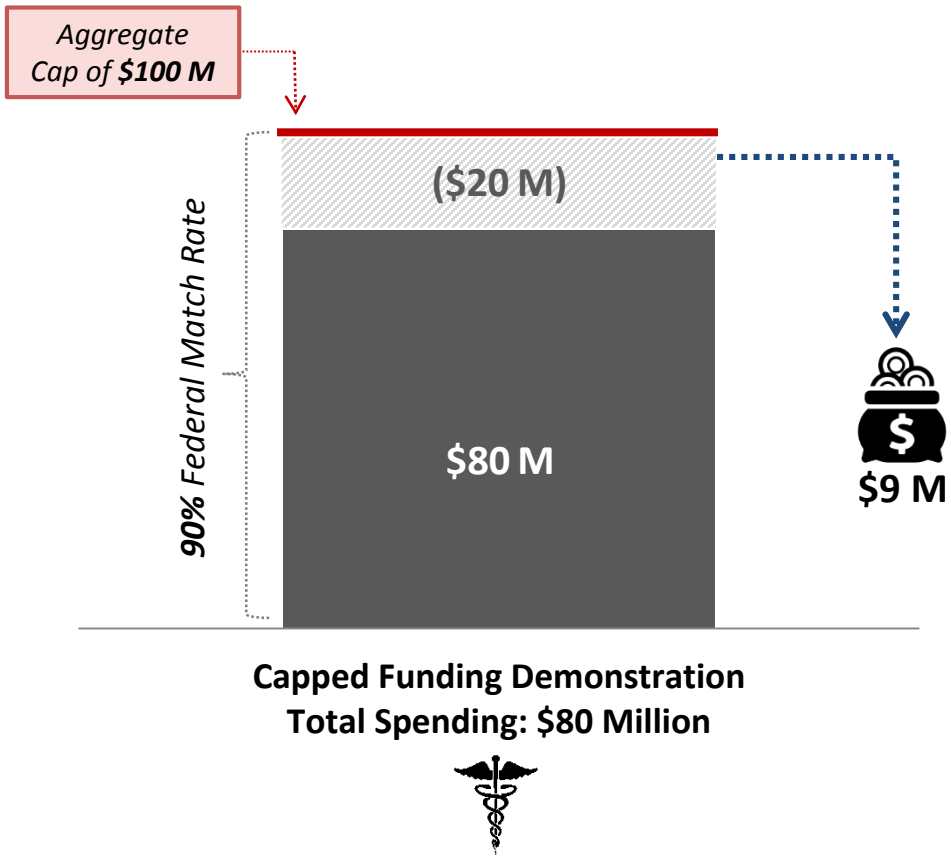
“Shared Savings” Illustrative Example



- State limits demonstration spending to 80% of the aggregate cap.
- Spending below the cap generates $20M in total savings ($18M federal/$2M state per the 90% match).
- State’s performance enables the state to draw down **$9M** (or 50% of the federal share of $18 M).

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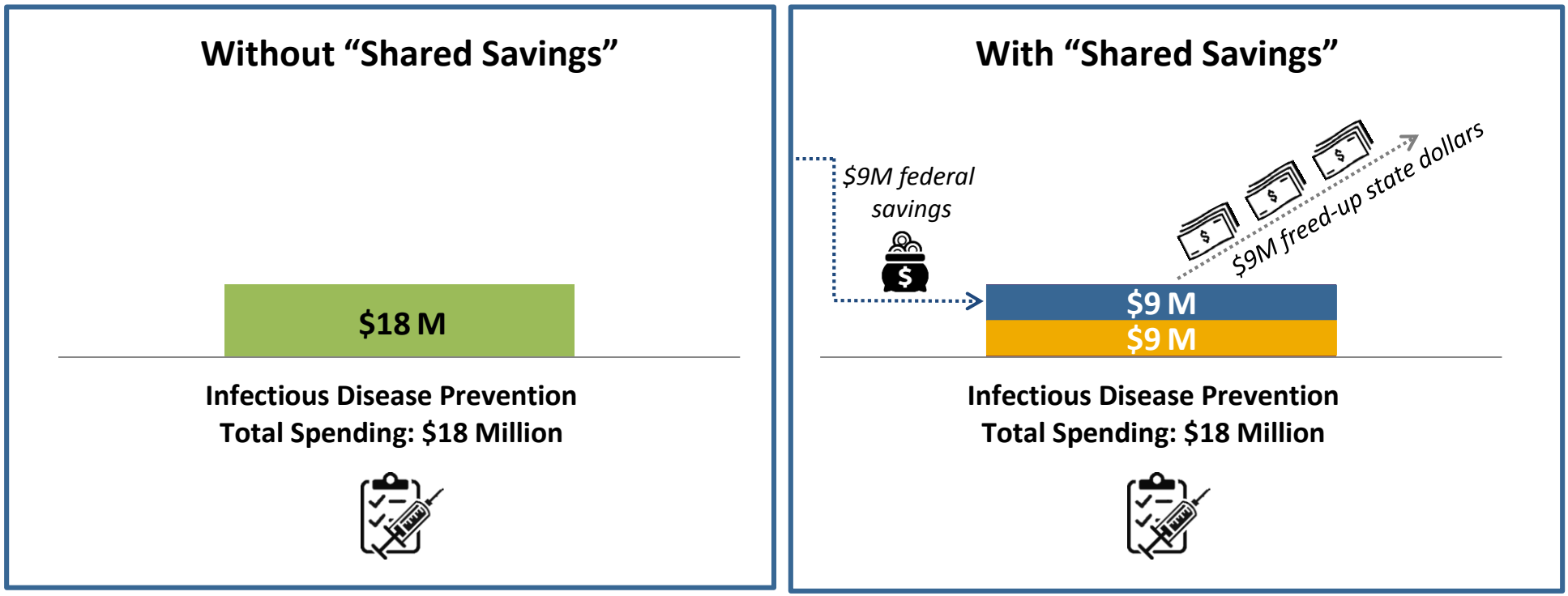
“Shared Savings” Illustrative Example (Continued)

- To draw down all of the $9 M in federal funds available to the state at its regular Federal Medical Assistance Percentage (FMAP) of 50%, the state would need to spend $9 M in state funds.
- The state could meet the state match requirement as long as it kept $9M of the state funding in the infectious disease prevention program.
- The other $9M of state funds previously spent on infectious disease prevention could be freed-up for other uses.



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Considerations for "Shared Savings"

While "shared savings" and the ability to divert federal dollars may sound initially appealing, a number of factors limit their appeal.

Looking Under the Hood

- ✕ To access any federal savings, **states must reduce their total Medicaid expenditures beyond what is required to simply live within the caps**
- ✕ States still must provide matching dollars to draw down "shared savings" **at the regular match rate, which is likely below the demonstration match rate** (if state is covering expansion group under the demonstration)
- ✕ Newly expanding states would **not be eligible for "shared savings" in in the first two years when they are under a per capita cap; other limitations may apply in later years** (e.g., data limitations; last year of demonstration)
- ✕ States must **establish a comprehensive set of baseline quality metrics for the demonstration population,** which may prove challenging in some states

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“Program Flexibility” in Exchange for Capped Funding

In exchange for assuming additional financial risk, the guidance authorizes CMS to approve new “program flexibilities” for demonstration populations, many of which are currently available.

ELIGIBILITY & ENROLLMENT	Work requirements	■
	Prospective enrollment (i.e., delay before coverage becomes effective)	■
	Eliminate retroactive eligibility	■
	Eliminate hospital presumptive eligibility	☑
	Lock-out periods	■
	Health risk assessment	■
	Healthy behavior incentives	■
	Align renewal cycle with Marketplace (i.e., reduce first coverage period)	■
	Continuous eligibility up to 12 months	■
COVERED BENEFITS	Align benefits with Essential Health Benefits (EHBs) (incl. mandatory plan and ABP) by eliminating:	
	Non-Emergency Medical Transportation (NEMT)	■
	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for 19 & 20 yo	■
	Long-term care	■
	Closed prescription drug formulary while retaining Medicaid Drug Rebate Program (MDRP) rebates	■
	Vary amount, duration, and scope of covered benefits	■
	Lifetime/annual treatment limits on non-EHB services	■
	Coverage of additional items and services beyond EHB standard	■

■ Approved under demonstrations without a cap (post ACA)

■ Approved/permitted under rules for ACA expansion population (except medically frail)

☑ Newly available under capped funding demonstration

"Program Flexibility" in Exchange for Capped Funding (Continued)

PREMIUMS & COST SHARING	Charge premiums at all income levels	■
	Impose cost sharing in excess of statutory limits	☑
DELIVERY SYSTEM & FEDERAL OVERSIGHT	Flexibility in delivery system	■
	Pre-approval of policies that may be implemented during demo	☑
	Eliminate CMS pre-approval of managed care rates & retro adjustments, contract amendments, directed payments, provider payment methods	☑
	Depart from managed care rules on actuarial soundness, network adequacy	☑
	Depart from FFS access standards (rate setting, payment methods)	☑
	Reimburse Federally Qualified Health Centers (FQHCs) through value-based purchasing rather than enhanced FQHC rates	☑
FINANCING	Shared savings based on "unused" federal financial participation (FFP) under aggregate cap	☑
APPEALS	Modify fair hearing processes	☑

Unavailable under capped funding demonstration if state seeks 90% enhanced match rate:

- ✕ **Partial expansion**
- ✕ **Enrollment caps**
- ✕ **Asset tests**

■ Approved under demonstrations without a cap (post ACA)

■ Approved/permitted under rules for ACA expansion population (except medically frail)

☑ Newly available under capped funding demonstration

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Implications for Beneficiaries

Funding cuts and level of risk grow over time

Funding cuts plus flexibilities will result in coverage losses and reduced access to care

Opportunity to divert funds will deepen the cuts and add to access issues

Litigation risk is high; new expansions relying on these waivers may be stopped by the courts.

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A Bad Deal for States

Potential Appeal for Some States

✓ **Reduces Medicaid spending** on the demonstration population

But…

✕ Because of the 90/10 match, **most of the reductions in spending for the expansion population accrue to the federal government**, not the state

State Share of the Reduction in Spending (10%)

Federal Share of the Reduction in Spending (90%)

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Bad Deal for States (Continued)

Potential Appeal for Some States

- ✓ If a state spends well below the cap some of the Federal savings can be reinvested through the **"shared savings" option**
- ✓ In exchange for less federal funds, the federal government will **allow certain policy options/program changes**
- ✓ **Relaxed federal oversight** (e.g., prior approval from CMS not required for certain actions)
- ✓ More politically acceptable **pathway to expansion?**

But…

- ✕ It will be **hard to cut that deeply**; state match still required, time frame is limited particularly for newly expanding states, and data may be an issue
- ✕ Why take the risk; **many of the policy options/program changes offered have been approved in other waivers without caps on federal Medicaid funding**
- ✕ **CMS will still monitor** and may require retrospective adjustments for states deemed out of compliance; guidance imposes **new monitoring and reporting obligations on states**
- ✕ **Legal challenges** are highly likely, with associated costs and uncertainty

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Thank You

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