

A Review of the New Healthy Adult Opportunity Demonstration Guidance

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Patricia Boozang
Allison Orris
Adam Striar

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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Presentation Objectives

- **Overview: New Guidance Authorizing Caps on Federal Medicaid Funding**
- **Key Features of the New Guidance**
- **Financing Deep Dive**
- **Implications of Capped Funding for States**
- **Questions**

Overview: New Guidance Authorizing Caps on Federal Funding

Healthy Adult Opportunity Demonstration Guidance Overview

On Thursday, January 30, CMS issued an SMDL and corresponding template inviting states to apply for Section 1115 “Healthy Adult Opportunity Demonstration” projects 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 52-26-12
Baltimore, Maryland 21244-1850



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 Demonstration 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.



Eligible Populations. Populations that may be covered under the funding cap include the Affordable Care Act adult expansion group and “optional” non-elderly, non-disabled adults, whether or not the state currently covers them.



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

Why Some States Might Apply for Capped Funding Demonstrations



Program Flexibility

In exchange for capped funding, the federal government will allow some new policy options and reduce certain aspects of federal oversight.



Opportunity to Use Funds for Other Purposes

States that reduce program spending below the cap can potentially access some of these savings, which can be applied to subsequent years or shared with the state—subject to meeting certain performance benchmarks—to finance other state priorities.



Compromise

Some states may apply for these demonstrations as part of agreements with state legislatures to expand Medicaid.

Potential Risks to States that Opt to Pursue Capped Funding Demonstrations



Budget Risk. If capped funding falls short, states will need to either curtail spending or use state dollars to replace federal matching dollars for all spending above the cap.



Beneficiary and Stakeholder Risk. Budget constraints combined with new flexibilities are likely to reduce access to care, constrict provider reimbursement to unsustainable levels, or lower managed care capitation rates.



Quality and Monitoring Obligations. Since the demonstration imposes obligations that go beyond typical 1115 demonstrations, states may need to invest resources in implementing their quality strategy and satisfying reporting requirements.



Administrative Complexity. Under the demonstration, states will be running a separate program alongside existing coverage for mandatory populations; this will create different standards and requirements for states to administer.



Litigation Risks. States can expect implementation delays and costly and time-consuming legal challenges to any approved demonstration that includes capped federal funding.

Key Features of the New Guidance

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).

✗ Ineligible Populations:



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

States that have expanded Medicaid (or plan to do so) are most likely to propose a capped funding demonstration.

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.

States May Choose a Per Capita Cap or Aggregate Cap

Medicaid is an entitlement program and the federal government currently “matches” all eligible state expenditures without any cap; the new guidance eliminates the open-ended funding commitment.

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 <i>lower</i> 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 <i>lower</i> 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

While all 1115 demonstrations must be “budget neutral” to the federal government, the capped funding guidance takes a stricter approach to limiting federal spending. Caps apply on an annual basis rather than over the life of the demonstration. A state that exceeds its cap in any given year must repay the “excess” match.

Spending Included in and Excluded from the Cap

The capped funding demonstration guidance sets out the categories of spending that are included in the per capita and aggregate cap.



Included State Spending

- ✓ Almost all of a state's Medicaid spending on covered populations.
- ✓ Standard fee-for-service (FFS) supplemental payments.
- ✓ Managed care pass-through payments.

*This bucket of spending **will not be matched** once a state reaches the per capita or aggregate cap – representing a key difference from the current Medicaid financing structure.*



Excluded State Spending

- ✗ Administrative expenditures.
- ✗ Spending on public health emergencies.
- ✗ Spending on services “received through” Indian Health Service facilities.
- ✗ Spending not attributable to individual enrollees, including disproportionate share hospital (DSH) and demonstration payments [e.g., Designated State Health Program (DSHP), Delivery System Reform Incentive Payments (DSRIP)].

*This bucket of spending **will continue to be matched** regardless of state spending against the cap, in accordance with the current Medicaid financing structure.*

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

Provided states meet certain performance criteria, they may be eligible to access shared savings under the aggregate cap; this policy creates a strong pressure on states to spend below the cap.

Drawing Down Shared Savings

A state may convert unused spending into a shared savings payment.

- The federal government will designate 25 to 50% of unused federal matching dollars as shared savings, contingent upon a state meeting certain performance benchmarks.
- States may draw down shared savings at the applicable matching rate by spending state funds.
- States may reinvest savings into certain health-related state programs that have not traditionally been eligible for Medicaid funding.
- Federal shared savings may not supplant existing federal funding, but can replace existing state spending on health programs, thereby freeing state dollars for other uses.

Using Savings as a Cushion in Later Years

- A state that underspends in a given year may hold its unused spending for up to three years.
- If the state exceeds its cap during that three-year period, the state may offset the overspending in an amount equal to the unused funds.

“Program Flexibility” in Exchange for Capped Funding

- 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

In exchange for assuming additional financial risk, the guidance authorizes the federal government to approve “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	<input checked="" type="checkbox"/>
	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 (EHB) (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	■	

“Program Flexibility” in Exchange for Capped Funding (Continued)

- 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

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

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

✗ Partial expansion

✗ Enrollment caps

✗ Asset tests

Additional Monitoring and Reporting Obligations for States

The guidance imposes monitoring and reporting obligations for capped funding demonstrations, including requirements that extend beyond those of standard 1115 demonstrations.

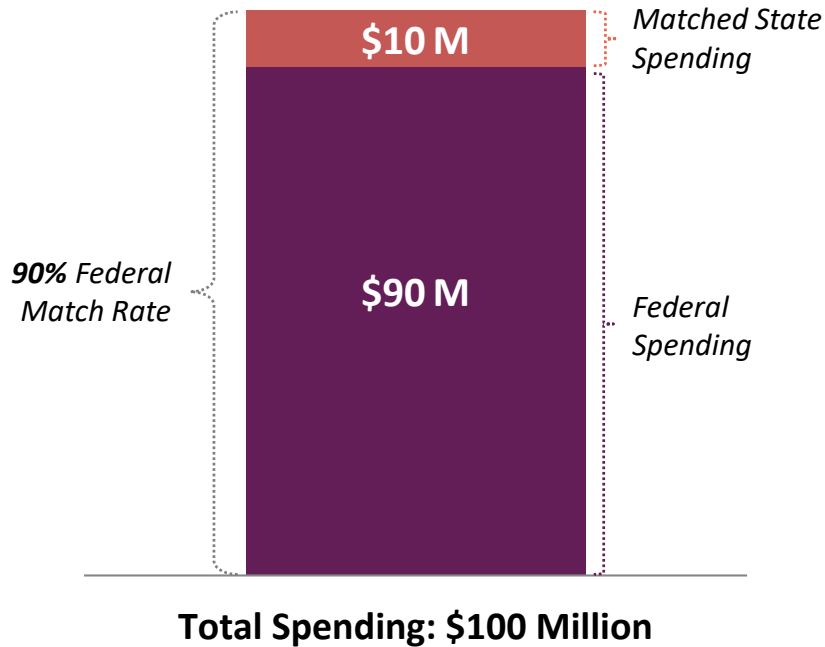
- States will need to develop and submit for federal approval their implementation plans with “detailed information” about the implementation approach; the federal government will provide a template.
- States may seek preapproval of policy changes that can later be implemented with no formal amendment, but states will need to update their implementation and monitoring plans, and also comply with procedures for public notice/comment and tribal consultation.
 - If a state implements a preapproved policy change that is likely to substantially impact enrollment, CMS will reexamine, and might adjust, the annual caps.
- States must implement demonstration-specific quality strategies and submit quarterly and annual reports to the federal government addressing:
 - 13 sets of continuous performance indicators
 - 25 quality and access measures from the Adult Core Set
 - Financial reporting to assess whether spending has reached the annual cap
 - Progress against the demonstration implementation plan
- Section 1115 demonstration evaluation requirements also apply.

Financing Deep Dive

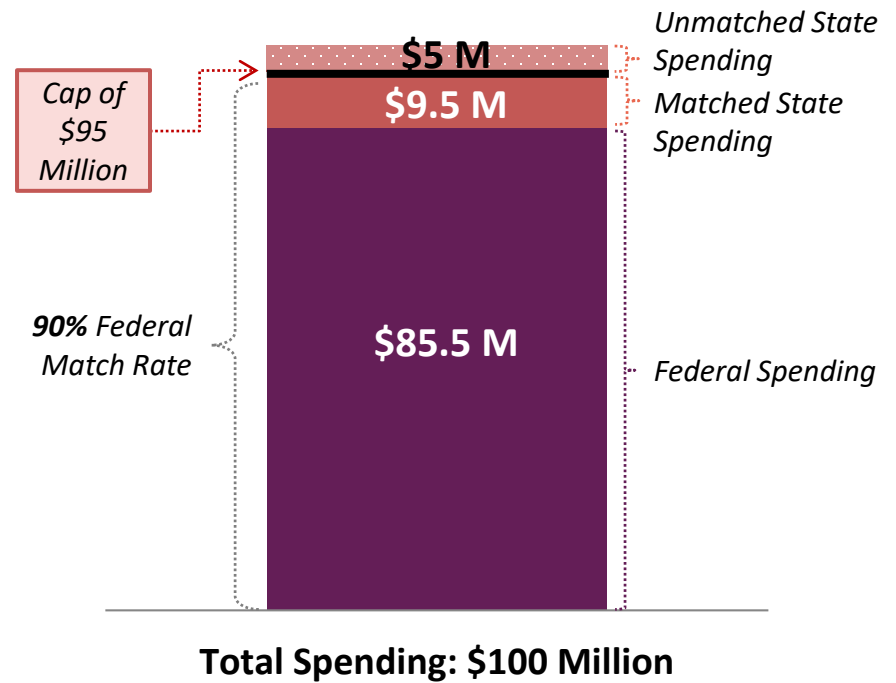
A Fundamental Change in Medicaid Financing

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

Medicaid Spending Without a Cap – Year 1



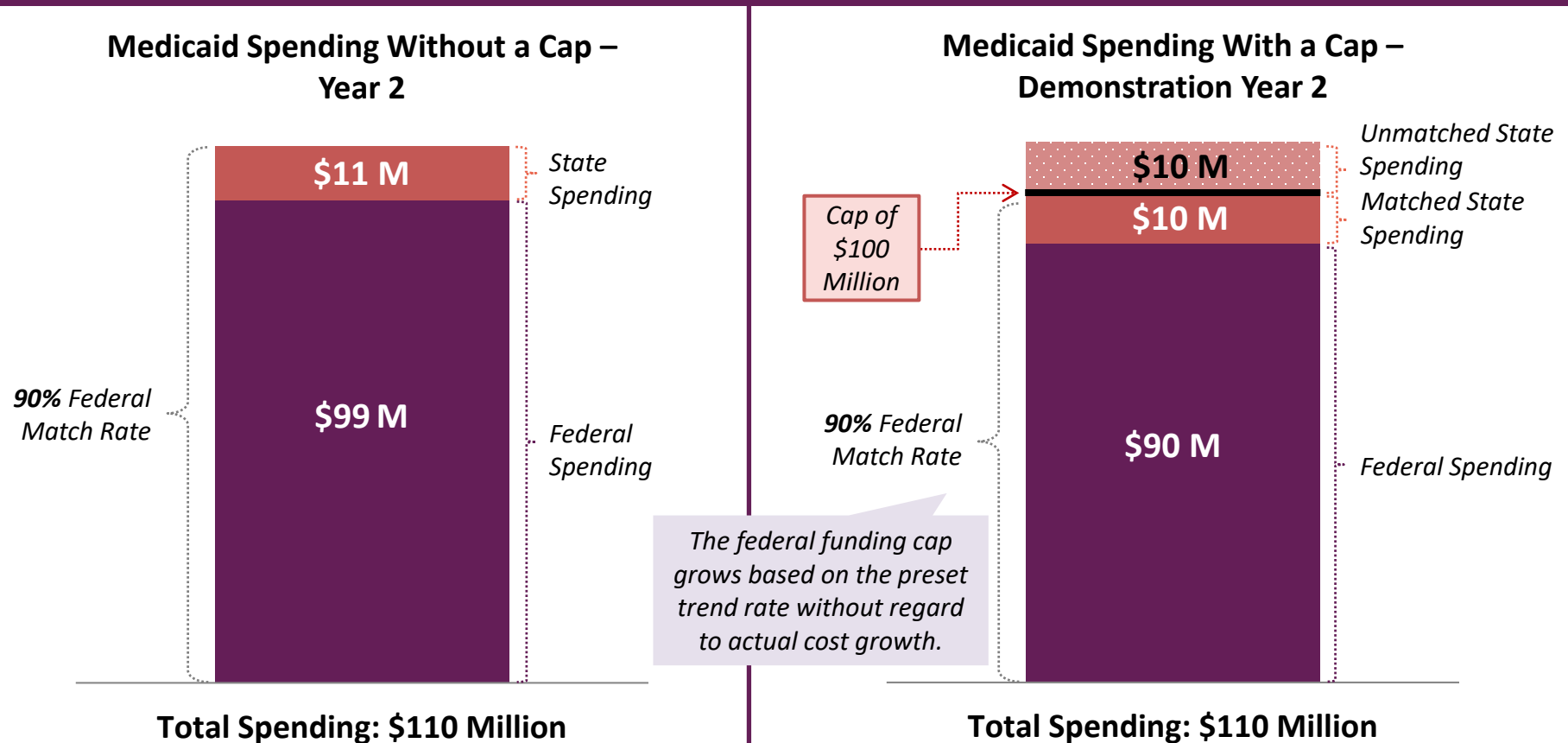
Medicaid Spending With a Cap – Demonstration Year 1



Example is for illustrative purposes only.

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.



Example is for illustrative purposes only.

Calculating the Caps: Base Amounts

First, the federal government will calculate a base amount derived from historical expenditures; these amounts will serve as the basis for the cap in all years of a demonstration.



A

Per Capita Cap Base Amounts

- **Constructed as separate, per capita base amounts for each demonstration eligibility group, combined into an overall per capita cap.**
- Derived from most recent eight consecutive quarters of expenditure data or, for new populations, best available state and national data.
- Determined by dividing annualized expenditures by the actual number of enrolled individuals in each group.

B

Aggregate Cap Base Amount

- **Constructed as a single, aggregate base amount for the demonstration population.**
 - Derived from most recent eight consecutive quarters of expenditure data.
 - Determined by annualizing eight quarters of expenditure data.
- Exception: States covering new populations must start with a per capita cap.*

Calculating the Caps: Trend Rates

Next, the federal government will develop a trend rate(s) for inflating the base amount to the demonstration year.



A

Per Capita Trend Rates

Lesser of the following:

- Growth rate in state ***per capita expenditures*** for the demonstration population over the five years prior to the approval of the capped funding demonstration
- Medical CPI

B

Aggregate Trend Rates

Lesser of the following:

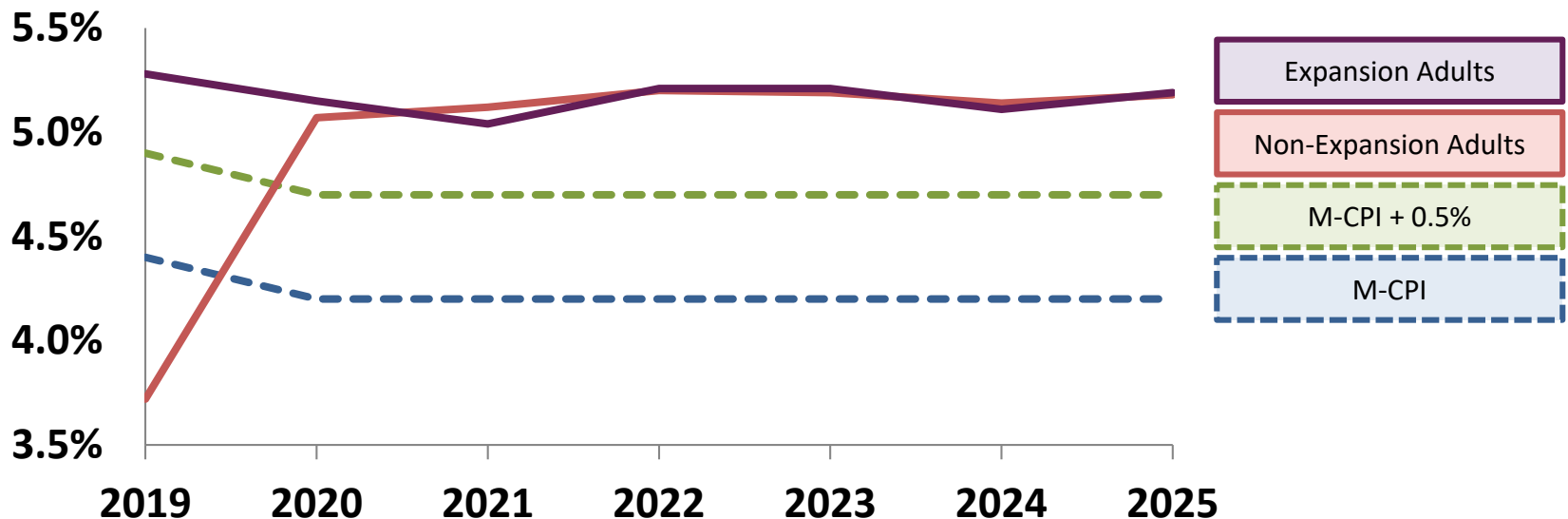
- Growth rate in state ***aggregate expenditures*** for the demonstration population over the five years prior to the approval of the capped funding demonstration
- Medical CPI + **0.5%**

Calculating the Caps: Trend Rates (Continued)

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)



Source: [OACT 2017 Actuarial Report on the Financial Outlook for Medicaid](#).

Calculating the Caps: Setting the Cap Amounts

To establish an overall cap in each year, the federal government will trend the base amount forward to the demonstration year; for the per capita cap model only, this amount will depend on actual enrollment.



A

Per Capita Cap

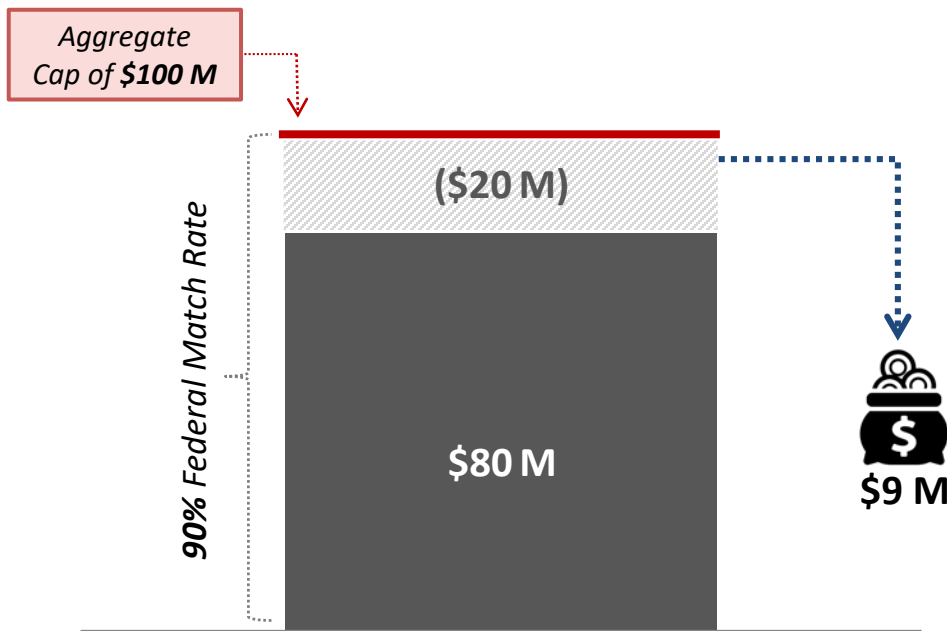
- Per capita base amounts are trended annually to the demonstration year to establish per capita caps.
- “Overall per capita cap” is set by multiplying per capita caps for each enrollment group by actual enrollment during the demonstration year.

B

Aggregate Cap

- Aggregate cap base amount is trended to demonstration year to establish a single aggregate cap for the demonstration population.
- Cap is generally NOT adjusted based on actual enrollment (except in special circumstances at discretion of the federal government, such as public health emergencies or major economic events).

Shared Savings Illustrative Example



Capped Funding Demonstration
Total Spending: \$80 Million



- 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).

- Total Computable Spending
- Unspent Block Grant Funds

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.

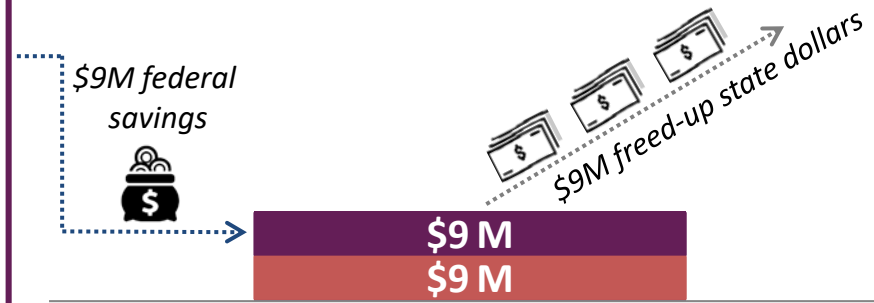
Without Shared Savings

\$18 M

Infectious Disease Prevention
Total Spending: \$18 Million



With Shared Savings



Infectious Disease Prevention
Total Spending: \$18 Million



Unmatched State Spending Matched State Spending Federal Spending

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.

- To access any federal savings, **states must reduce their total Medicaid expenditures beyond what is required to simply live within the cap.**
- 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 the expansion group under the demonstration).
- Newly expanding states would **not be eligible for shared savings 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.

Implications of Capped Funding for States

Reminder: Potential Risks to States that Opt for a Capped Funding Demonstration



Budget Risk. If capped funding falls short, states will need to either curtail spending or use state dollars to replace federal matching dollars for all spending above the cap.



Beneficiary and Stakeholder Risk. Budget constraints combined with new flexibilities are likely to reduce access to care, constrict provider reimbursement to unsustainable levels, or lower managed care capitation rates.



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Litigation Risks. States can expect implementation delays and costly and time-consuming legal challenges to any approved demonstration that includes capped federal funding.

Next Steps for States

The capped funding demonstration is far-reaching and complex; many provisions beyond capped funding will impact state health care policy, delivery, and financing. Necessary next steps for understanding implications include:

Getting Questions Answered

States will want additional clarity from the federal government to ensure they can evaluate their options before requesting/implementing the demonstration.

Financial Modeling

Given state-specific characteristics, it will be essential for states interested in the demonstration to leverage financial modeling to fully comprehend the impact on states over time.*

Engaging Key Stakeholders

States can engage key stakeholders (e.g., state legislatures) to clearly and effectively communicate the capped funding demonstration provisions and corresponding consequences and risks.

Learning from Other Actors

A few states (e.g., Alaska, Oklahoma, Tennessee, and Utah) have already expressed interest in capping funding through a demonstration. Other states can learn from them as they apply for and negotiate a capped funding demonstration.

**Manatt webinar on capped funding demonstration financial modeling coming soon.*

Questions

The slides and a recording of the webinar will be available at www.shvs.org after the webinar.

Thank You

Patricia Boozang
Senior Managing Director
Manatt Health
pboozang@manatt.com
212-790-4523
www.manatt.com/Health

Allison Orris
Counsel
Manatt Health
aorris@manatt.com
202-585-6561
www.manatt.com/Health

Adam Striar
Manager
Manatt Health
astriar@manatt.com
202-585-6512
www.manatt.com/Health

Heather Howard
Director
State Health and Value Strategies
heatherh@Princeton.edu
609-258-9709
www.shvs.org