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The Healthy Adult Opportunity

Overview, Fiscal Impact, and Key Considerations

March 11, 2020

Cindy Mann

Developed with support from the Commonwealth Fund and the Robert Wood Johnson Foundation State Health & Value Strategies program.

Agenda

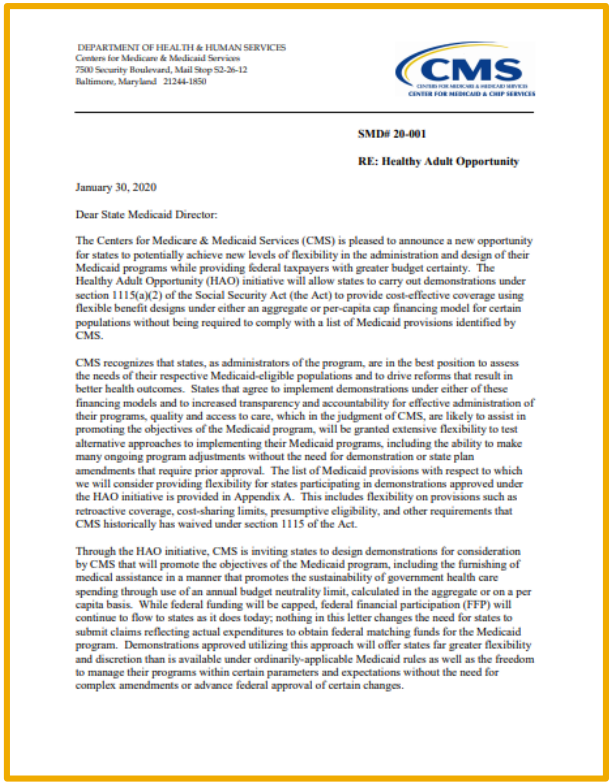
- Overview of Healthy Adult Opportunity Guidance
- Fiscal Impact
- Key Considerations
- Q & A

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

Overview of Healthy Adult Opportunity Guidance

Healthy Adult Opportunity Demonstration Guidance

On January 30th, CMS issued guidance inviting states to apply for Section 1115 "Healthy Adult Opportunity" demonstrations that would cap federal Medicaid funding in exchange for fewer federal rules.



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

CMS
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 have the opportunity to divert "unused" federal block grant funds to other purposes

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

Demonstration Focused on Expansion Adults

The guidance targets the Affordable Care Act adult expansion group, but some other populations may 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 income 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

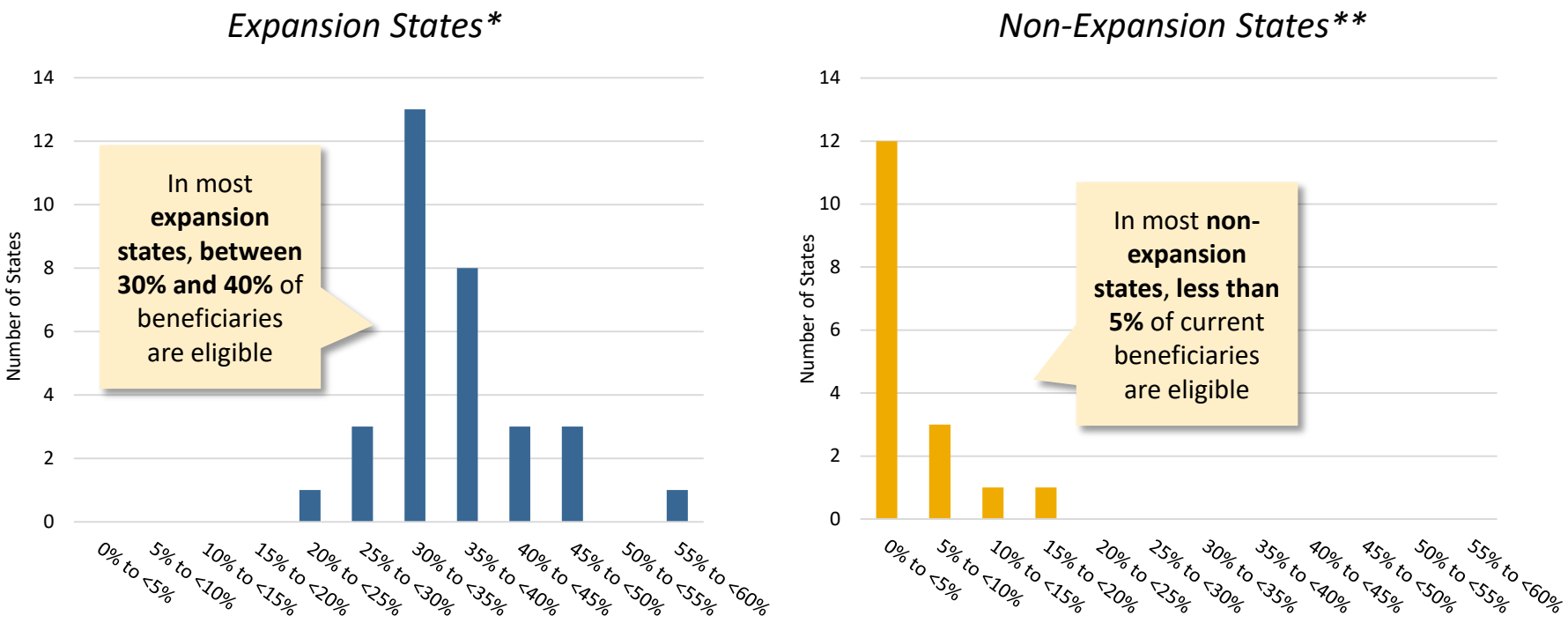
Ineligible Populations:

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

Non-Expansion States Have Few Eligible Enrollees

Most non-expansion states have very few optionally enrolled, non-aged, non-disabled adult enrollees; they can use the demonstration to expand

Projected Share of HAO-Eligible Enrollees by State, FY 2019



Source: The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative
*Excludes Maine and Virginia, which implemented expansions during 2019 but had not yet achieved steady-state enrollment
**Utah and Idaho are considered non-expansion states, since they did not open enrollment to childless adults until 2020

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States May Choose a Per Capita Cap or Aggregate Cap

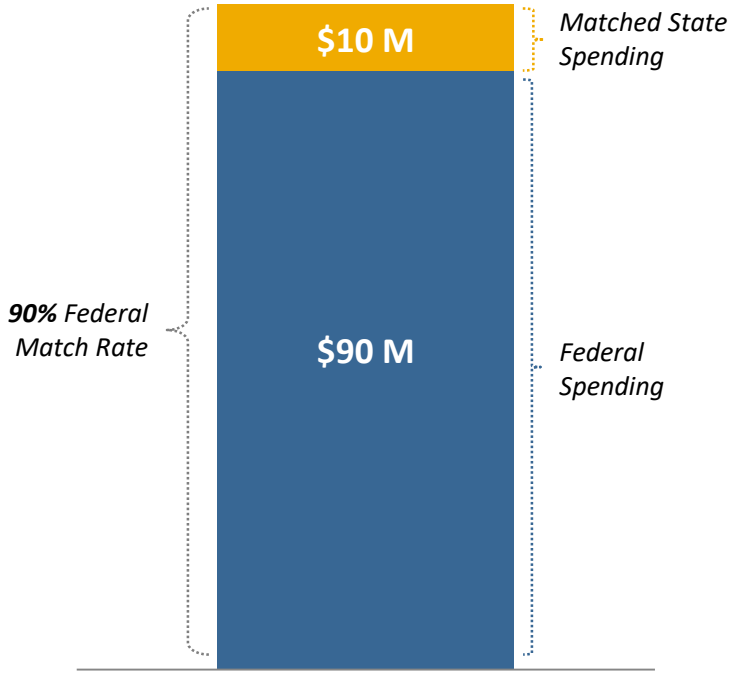
States covering new populations (e.g., a newly expanding state) must use a per capita cap for the first two years.

Cap Model	Base Payment	Trend Rate	Federal Matching	State At-Risk For…	Access to Shared Savings?
Per Capita Cap – Cap is set on a per person basis (i.e., adjusted for enrollment each year)	Based on historical spending per enrollee	Cap grows each year by pre-set trend rate: the *lower* of state historical spending growth or **medical CPI**	CMS matches state spending at the applicable match rate but only up to the cap	Increases in health costs but not enrollment	No
Aggregate Cap (Block Grant) – Cap is set for based on total demonstration spending (i.e., *not* adjusted for enrollment)	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 0.5 percentage points**		Increases in health costs ***and*** enrollment	Yes (contingent on quality performance and data availability)

A Fundamental Change in Medicaid Financing

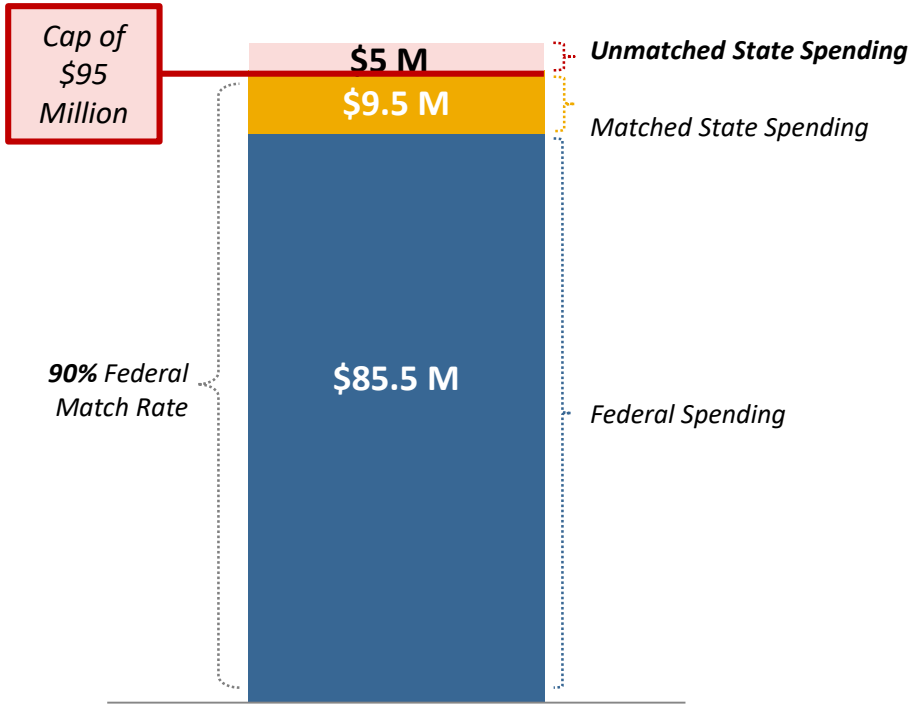
In Medicaid, the federal government matches state expenditures without any cap. The new demonstration caps federal matching dollars.

Medicaid Spending Without a Cap



Total Spending: $100 Million

Medicaid Spending With a Cap



Total Spending: $100 Million

"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 were already 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 (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	■

■ 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

**Although CMS has previously pre-approved a range of premium levels in a post-ACA demonstration without a cap, this program flexibility is designated as "newly available" because, under a capped funding demonstration, CMS is open to pre-approving a much broader range of policies.*

Fiscal Impact

Overview: Fiscal Impact Analysis

A recent report from the Commonwealth Fund and Manatt Health analyzed the fiscal impact of the block grant policy

ISSUE BRIEF
MARCH 2020

The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative

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ABSTRACT

ISSUE The Trump administration recently invited states to apply for the new Healthy Adult Opportunity Medicaid demonstration initiative, which lets states opt into a block grant funding model in exchange for fewer federal rules. By capping federal funding, the initiative exposes the Medicaid program to unprecedented financial risk.

GOALS To estimate the financial impact of the new block grant model.

METHODS Using historical data and projections of cost and enrollment growth, we estimate Medicaid expenditures under current law on a state-by-state basis and compare these to funding available under a block grant. We also demonstrate the sensitivity of our estimates to fluctuations in costs and enrollment.

KEY FINDINGS States that take up the block grant would see substantial reductions in Medicaid funding. Under our baseline scenario, the median state would face a reduction of 5.7 percent in fiscal year (FY) 2021; 14.6 percent in FY 2025; and 10.5 percent over the 2021–2025 period. The five-year median reduction in funding would be significantly larger if per enrollee spending growth is 1 percentage point above projections (13.9%), if enrollment grows at recent historical levels rather than projections (19.7%), or if a state reduces expenditures to capture "shared savings" (27.6%). Under all scenarios, the vast majority of Medicaid savings resulting from the funding reductions accrue to the federal government.

TOPLINES

- The Trump administration's new Medicaid block grant option will result in significantly less federal funding and greater financial risks for states that opt in.
- States that accept caps in federal Medicaid funding would need to cut coverage, reduce benefits, increase cost-sharing, lower provider payment rates, or otherwise steeply reduce their current Medicaid expenditures.
- Most of the savings from Medicaid spending reductions would accrue to the federal government, not the states.

The Commonwealth Fund

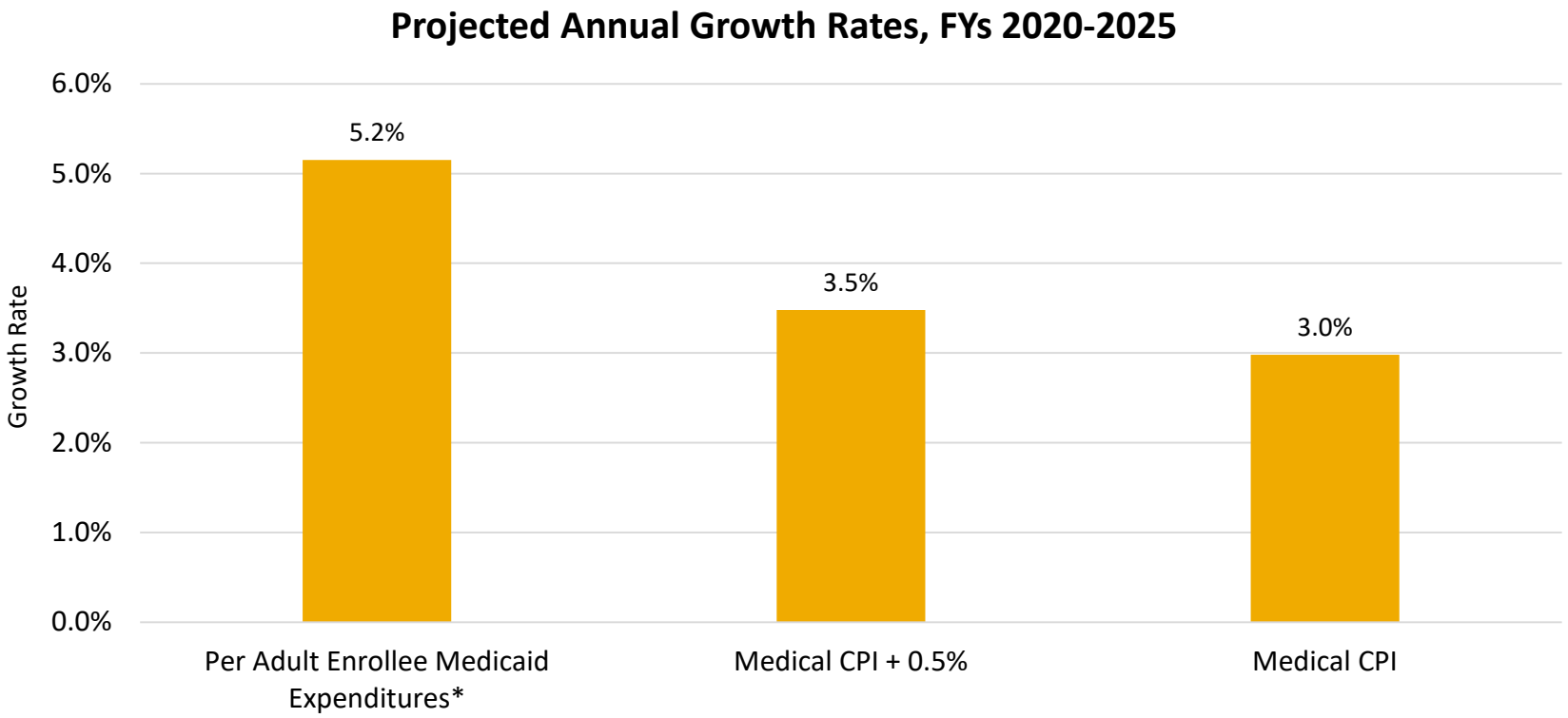
Methodology

- Analysis compares Medicaid spending under current law with spending under funding caps on a state-by-state basis
  - To calculate fiscal impact, analysis assumes non-expansion states expand Medicaid when taking up the block grant (since these states have few optional adults)
- Estimates developed using publicly available state-level historical spending and enrollment data and national projections of cost and enrollment growth
  - Estimates also provided across a range of real-world scenarios
- Analysis provides data-driven insight into the level of risk and the associated reduction in funding for states that take up the demonstration in Fys 2021-2025; actual impact will vary depending on a range of factors (e.g., timing of entering the model, etc.)
- For more information on the methodology and full state-by-state results, see the full report

Source: The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative

Low Trend Rates Could Constrain Medicaid Spending

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



Source: OACT 2017 Actuarial Report on the Financial Outlook for Medicaid; U.S. Bureau of Labor Statistics

* Reflects the average projected growth rate across expansion adults and non-expansion adults for FYs 2021-2025 as projected by the CMS Office of the Actuary.

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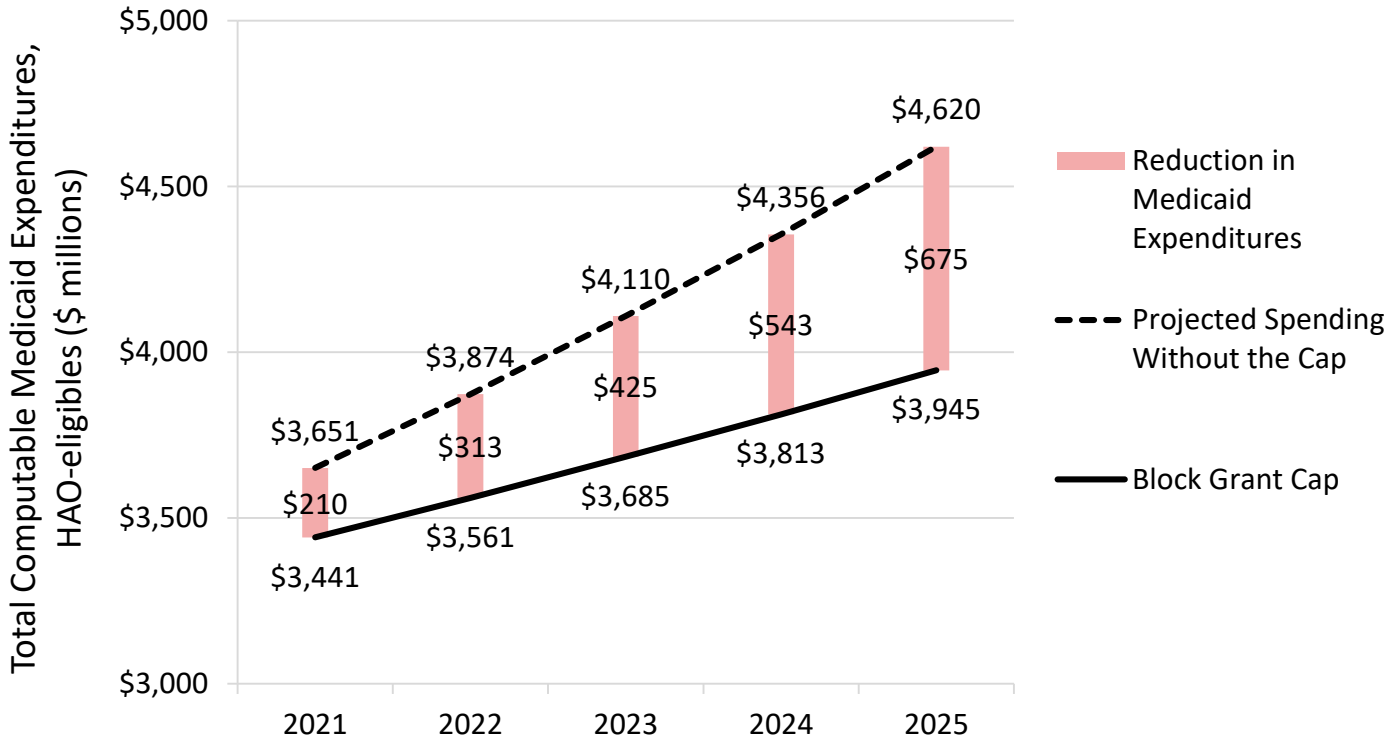
Caps Would Lead to Cuts in All States

States that adopt the block grant would see reductions in Medicaid expenditures that deepen over time

Median State Cut FYs 2021-2025

10.5%
($1.5 billion)

Projected Medicaid Expenditures vs. HAO Caps, Median State (Washington), FYs 2021 - 2025 ($ millions)



Source: The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative

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Most of the Savings from the Spending Reductions go to the Federal Government

States will have to cut spending to stay within the caps, but because of the 90% match rate, most of the savings would accrue to the federal government

States

- Average share of savings*: **17%**
- Share of savings (if states only cover expansion adults): **10%**

Federal Government

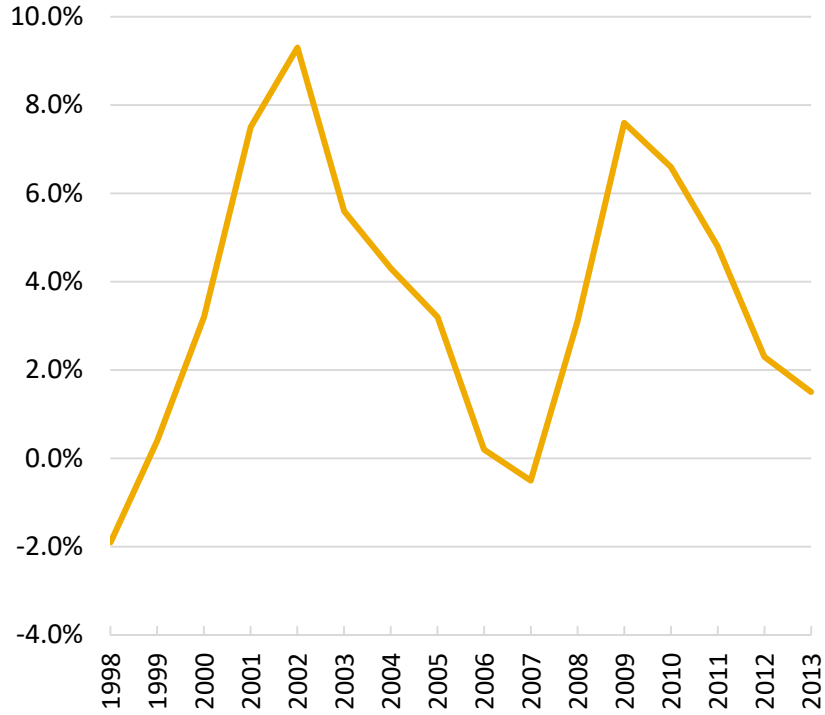
- Average share of savings*: **83%**
- Share of savings (if states only cover expansion adults): **90%**

Source: The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative
*Assumes all states take up the block grant and include all optional, non-aged, non-disabled adults in demonstration.

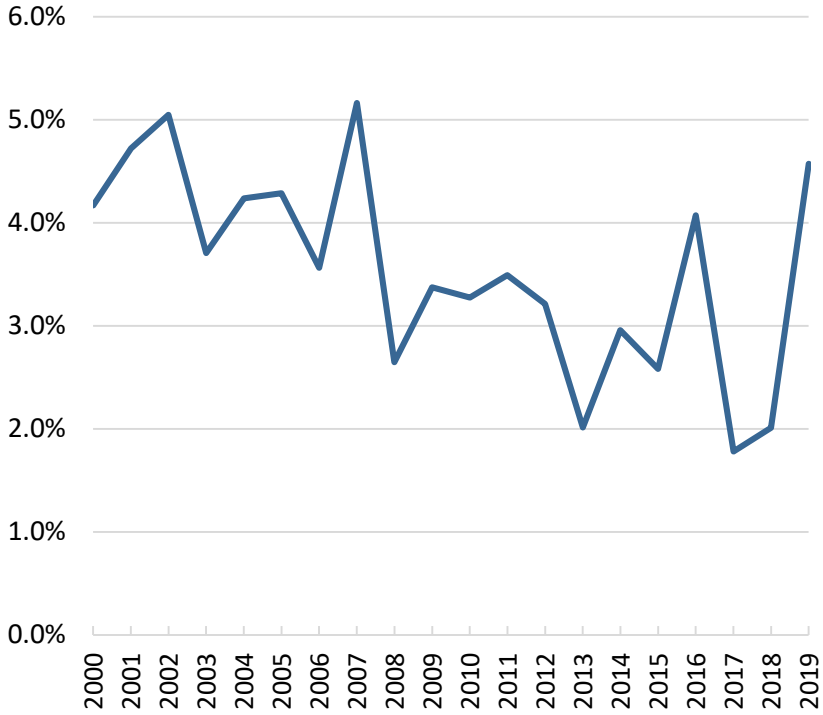
Changes in the Economy and Healthcare Landscape Make Funding Uncertain and Shift Risks to States

Factors outside of states' control can create uncertainty around whether funding will be adequate to cover program costs

Medicaid Enrollment Growth, SFYs 1998-2013



Medical CPI, CYs 2000-2019

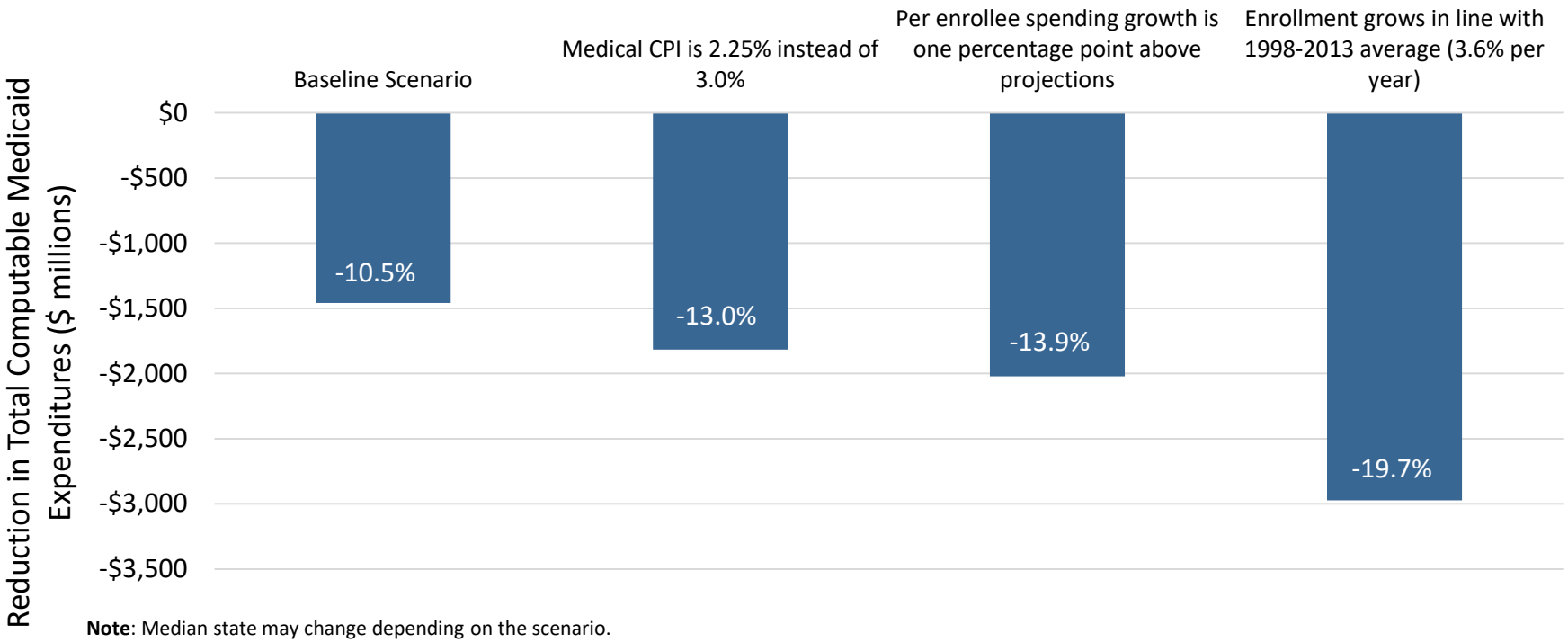


Sources: Medicaid Enrollment & Spending Growth: FY 2019 & 2020, Kaiser Family Foundation
U.S. Bureau of Labor Statistics

Real-World Circumstances Could Make Cuts Much Larger

Small changes (e.g., the rate of cost or enrollment growth) driven by real-world circumstances could deepen cuts

Change in Total Medicaid Expenditures in Median State Under HAO Demonstrations, Selected Scenarios, FYs 2021-2025 ($ millions and % of baseline)



Note: Median state may change depending on the scenario.

Source: The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative

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

States with an aggregate cap may be able to divert federal block grant funds to other purposes

Drawing Down "Shared Savings"

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

- States that spend below the caps can divert 25 – 50% of unused federal Medicaid dollars to other programs if state meets certain performance benchmarks
- To draw down federal funds the applicable matching rate; shared savings will generally be matched at a lower rate, assuming the demonstration covers the expansion group
- States can divert the federal funds into state-funded health-related 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

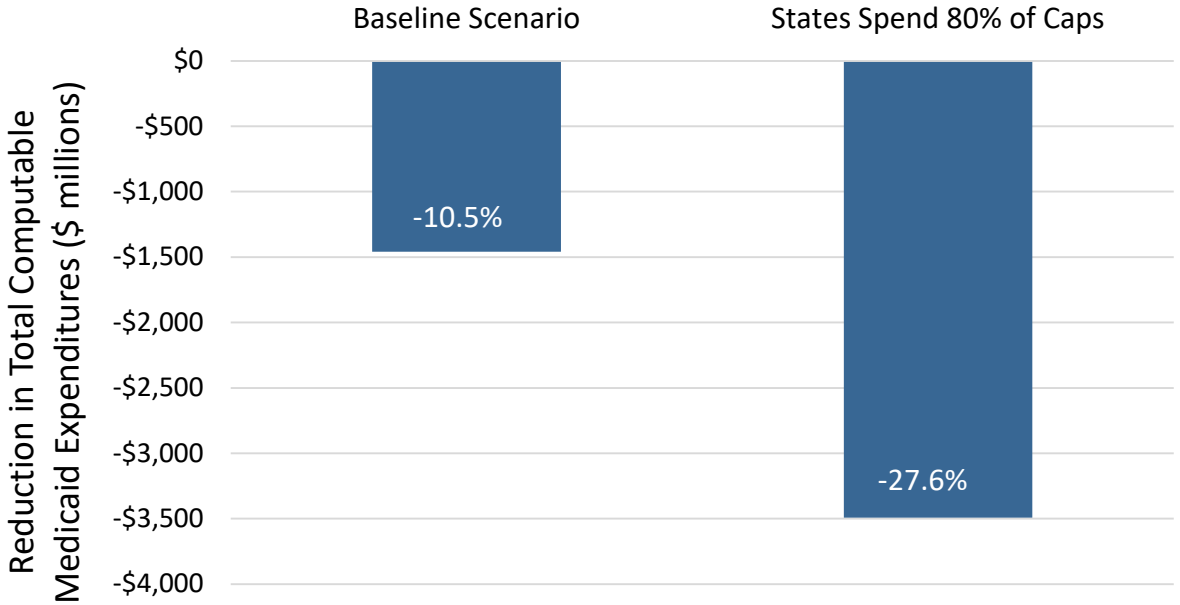
Alternatively, States Could Use Savings as a Cushion in Later Years

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

“Shared Savings” Policy Could Induce Further Cuts

The “shared savings” policy would deepen Medicaid cuts, but the federal government would retain the vast majority of savings

Change in Total Medicaid Expenditures in Median State Under HAO Demonstrations, Selected Scenarios, FYs 2021-2025 ($ millions and % of baseline)



Note: Median state may change depending on the scenario.

*Share of Cuts Retained by the Federal Government**

76.9 percent

*Assumes all states spend 80% of their caps and capture the maximum possible shared savings.

Source: The Fiscal Impact of the Trump Administration’s Medicaid Block Grant Initiative

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Key Considerations

Policy Will Lead to Cuts and Shift Risk to States

Capped funding will require states to make cuts and bear unprecedented financial risk; this could have substantial implications for beneficiary access to care and provider reimbursement

Policy Will Lead to Cuts

- To stay below the caps, States will need to **reduce coverage, skinny benefits, increase cost sharing**, **reduce payment rates** or take other measures to cut spending
- **Expansion states** will be required to make **cuts that grow over time** relative to current Medicaid spending levels
- **Non-expansion states** that decide to expand through capped funding demonstrations will be **leaving substantial federal dollars on the table** relative to traditional expansions; the median non-expansion state would see **11.3% fewer federal dollars** if they expanded through a block grant

Increased Risk for States

- Under current law, states receive **federal matching funds on a dollar-for-dollar basis** with no limit; this protects states against increases in Medicaid spending
- **States would be on the hook for increased expenditures** resulting from new breakthrough technologies, economic downturns, or other factors
- The guidance states that **CMS will consider adjustments** for “public health crises” and “major economic events”, but **such occurrences are not defined and adjustments are not guaranteed**

Are Block Grants a Good Deal?

Potential Appeal for Some States

- ✓ **Reduces Medicaid spending** on the demonstration population
- ✓ 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 funding, the federal government will **allow certain policy changes**
- ✓ **Relaxed federal oversight** (e.g., prior approval from CMS not required for certain actions)
- ✓ More politically acceptable **pathway to expansion?**

But…

- ✕ The **majority of reductions accrue to the federal government**
- ✕ It will be **hard to make big enough cuts** and **non-expansion states will not have access to this provision until year 4**
- ✕ Many of the policy 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, bringing associated costs and uncertainty

Q&A

Thank You

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