The Healthy Adult Opportunity
Overview, Fiscal Impact, and Key Considerations

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Agenda

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

Overview of Healthy Adult Opportunity 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.

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)

- **Ineligible Populations:**
  - Children, elderly/disabled, and mandatory adults (e.g., mandatory parents and pregnant women)

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.
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

**Expansion States**

- In most expansion states, between 30% and 40% of beneficiaries are eligible.

**Non-Expansion States**

- In most non-expansion states, less than 5% of current beneficiaries are eligible.

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
**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.

<table>
<thead>
<tr>
<th>Cap Model</th>
<th>Base Payment</th>
<th>Trend Rate</th>
<th>Federal Matching</th>
<th>State At-Risk For...</th>
<th>Access to Shared Savings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Cap – Cap is set on a per person basis (i.e., adjusted for enrollment each year)</td>
<td>Based on historical spending per enrollee</td>
<td>Cap grows each year by pre-set trend rate: the lower of state historical spending growth or medical CPI</td>
<td>CMS matches state spending at the applicable match rate but only up to the cap</td>
<td>Increases in health costs but not enrollment</td>
<td>No</td>
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<tr>
<td>Aggregate Cap (Block Grant) – Cap is set for based on total demonstration spending (i.e., not adjusted for enrollment)</td>
<td>Based on historical spending and enrollment (total costs)</td>
<td>Cap grows each year by pre-set trend rate: the lower of state historical spending growth or medical CPI plus 0.5 percentage points</td>
<td>Increases in health costs and enrollment</td>
<td>Yes (contingent on quality performance and data availability)</td>
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</table>
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**
- Matched State Spending: $90 M
- $10 M
- Federal Spending: $90 M
- Total Spending: $100 Million
- 90% Federal Match Rate

**Medicaid Spending With a Cap**
- Matched State Spending: $9.5 M
- Unmatched State Spending: $5 M
- Cap of $95 Million
- Federal Spending: $85.5 M
- Total Spending: $100 Million
- 90% Federal Match Rate
"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.

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

<table>
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<tr>
<th>PREMIUMS &amp; COST SHARING</th>
<th>Charge premiums at all income levels</th>
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<td></td>
<td>Impose cost sharing in excess of statutory limits</td>
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<tr>
<th>DELIVERY SYSTEM &amp; FEDERAL OVERSIGHT</th>
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<td>Flexibility in delivery system</td>
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</table>
| 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 | ✓

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<th>FINANCING</th>
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| Shared savings based on “unused” federal financial participation (FFP) under aggregate cap | ✓

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<th>APPEALS</th>
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| Modify fair hearing processes | ✓

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

- ✗ Partial expansion
- ✗ Enrollment caps
- ✗ Asset tests

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

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
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.

Projected Annual Growth Rates, FYs 2020-2025

- Per Adult Enrollee Medicaid Expenditures*: 5.2%
- Medical CPI + 0.5%: 3.5%
- Medical CPI: 3.0%

* 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.
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
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)

- Baseline Scenario: -10.5%
- Medical CPI is 2.25% instead of 3.0%: -13.0%
- Per enrollee spending growth is one percentage point above projections: -13.9%
- Enrollment grows in line with 1998-2013 average (3.6% per year): -19.7%

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

Baseline Scenario

States Spend 80% of Caps

Reduction in Total Computable Medicaid Expenditures ($ millions)

<table>
<thead>
<tr>
<th>Reduction in Total Computable Medicaid Expenditures ($ millions)</th>
<th>Baseline Scenario</th>
<th>States Spend 80% of Caps</th>
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<tbody>
<tr>
<td>$0</td>
<td>-10.5%</td>
<td>-27.6%</td>
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*Assumes all states spend 80% of their caps and capture the maximum possible shared savings.

Note: Median state may change depending on the scenario.

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