A Review of the New Healthy Adult Opportunity Demonstration Guidance

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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
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.

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)

**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
- Matched State Spending: $10 M
- Federal Spending: $90 M
- Total Spending: $100 Million

Medicaid Spending With a Cap – Demonstration Year 1
- Unmatched State Spending: $5 M
- Matched State Spending: $9.5 M
- Federal Spending: $85.5 M
- Cap of $95 Million
- 90% Federal Match Rate
- 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.

Medicaid Spending Without a Cap – Year 2

- Matched State Spending: $11 M
- Federal Spending: $99 M
- Total Spending: $110 Million

90% Federal Match Rate

Medicaid Spending With a Cap – Demonstration Year 2

- Unmatched State Spending: $10 M
- Matched State Spending: $10 M
- Federal Spending: $90 M
- Cap of $100 Million
- Total Spending: $110 Million

90% Federal Match Rate

The federal funding cap grows based on the preset trend rate without regard to actual cost growth.

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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.

<table>
<thead>
<tr>
<th>Cap Model</th>
<th>Base Payment</th>
<th>Trend Rate</th>
<th>Federal Matches Up to the Cap</th>
<th>States At Risk For</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per Capita Cap</strong> – Cap is set per person</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 the medical CPI</td>
<td>CMS matches state spending at applicable match rate but only up to the cap</td>
<td>Increases in health costs but not enrollment</td>
</tr>
<tr>
<td><strong>Aggregate Cap (Block Grant)</strong> – Cap is set for all spending under the demonstration</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 .5</td>
<td>CMS matches state spending at applicable match rate but only up to the cap</td>
<td>Increases in health costs and enrollment</td>
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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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“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

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 $18M).

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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 $9 M of the state funding in the infectious disease prevention program.
- The other $9 M of state funds previously spent on infectious disease prevention could be freed-up for other uses.

With and Without “Shared Savings”

**Without “Shared Savings”**

- Infectious Disease Prevention Total Spending: $18 Million
- $18 M

**With “Shared Savings”**

- Infectious Disease Prevention Total Spending: $18 Million
- $9 M federal savings
- $9 M freed-up state dollars
- $9 M

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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 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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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.

<table>
<thead>
<tr>
<th>ELIGIBILITY &amp; ENROLLMENT</th>
<th>Work requirements</th>
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<tbody>
<tr>
<td>Prospective enrollment (i.e., delay before coverage becomes effective)</td>
<td></td>
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<tr>
<td>Eliminate retroactive eligibility</td>
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<td>Eliminate hospital presumptive eligibility</td>
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<td>Lock-out periods</td>
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<td>Health risk assessment</td>
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<td>Healthy behavior incentives</td>
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<tr>
<td>Align renewal cycle with Marketplace (i.e., reduce first coverage period)</td>
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<tr>
<td>Continuous eligibility up to 12 months</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED BENEFITS</th>
<th>Align benefits with Essential Health Benefits (EHBs) (incl. mandatory plan and ABP) by eliminating:</th>
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</thead>
<tbody>
<tr>
<td>Non-Emergency Medical Transportation (NEMT)</td>
<td></td>
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<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for 19 &amp; 20 yo</td>
<td></td>
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<tr>
<td>Long-term care</td>
<td></td>
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<tr>
<td>Closed prescription drug formulary while retaining Medicaid Drug Rebate Program (MDRP)</td>
<td></td>
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<tr>
<td>rebates</td>
<td></td>
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<tr>
<td>Vary amount, duration, and scope of covered benefits</td>
<td></td>
</tr>
<tr>
<td>Lifetime/annual treatment limits on non-EHB services</td>
<td></td>
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<tr>
<td>Coverage of additional items and services beyond EHB standard</td>
<td></td>
</tr>
</tbody>
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- 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)

<table>
<thead>
<tr>
<th>PREMIUMS &amp; COST SHARING</th>
<th>Charge premiums at all income levels</th>
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<tbody>
<tr>
<td></td>
<td>Impose cost sharing in excess of statutory limits</td>
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</table>

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<thead>
<tr>
<th>DELIVERY SYSTEM &amp; FEDERAL OVERSIGHT</th>
<th>Flexibility in delivery system</th>
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<tbody>
<tr>
<td></td>
<td>Pre-approval of policies that may be implemented during demo</td>
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<tr>
<td></td>
<td>Eliminate CMS pre-approval of managed care rates &amp; retro adjustments, contract amendments, directed payments, provider payment methods</td>
</tr>
<tr>
<td></td>
<td>Depart from managed care rules on actuarial soundness, network adequacy</td>
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<tr>
<td></td>
<td>Depart from FFS access standards (rate setting, payment methods)</td>
</tr>
<tr>
<td></td>
<td>Reimburse Federally Qualified Health Centers (FQHCs) through value-based purchasing rather than enhanced FQHC rates</td>
</tr>
</tbody>
</table>

| 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

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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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