

Healthy Adult Opportunity

CMS guidance details new Medicaid program reform options for all states

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The Healthy Adult Opportunity offers states new flexibilities for their Medicaid programs in return for assuming the financial risk of block grants. State program directors face many complex considerations as they evaluate these options.

On January 30, the Centers for Medicare and Medicaid Services (CMS) introduced guidance¹ describing the new Healthy Adult Opportunity (HAO) 1115 waiver option, which outlines conditions under which a state might convert open-ended matching funding for expansion adults² into a block grant or per capita cap program.

While the HAO will clearly appeal to states that have previously considered requesting a block grant, the range of policy options made available under this initiative may bear consideration for states across the country.

As with earlier block grant proposals,³ the guidance was simultaneously lauded and met with critiques from all sides. Some stakeholders voiced concerns about potential loss of coverage, while others questioned why states would want to take on additional financial risk for a population already mostly covered by federal matching dollars. There are clearly many details still to be ironed out, with potential implications for all stakeholders.

For this paper, we identified the following 10 key topics that we believe states will want to evaluate first:

1. Prescription drug limited formulary.
2. Targeted expansion above 133% of the Federal Poverty Level (FPL).
3. Alignment with exchange products and Medicaid buy-in opportunities.
4. Benefit safeguards and eligibility for behavioral health services.
5. Alternative benefits and cost sharing.
6. Value-based payments.
7. Alternative provider access metrics.
8. CMS managed care rate approval process.
9. State-directed and pass-through payments.
10. Financing and shared savings.

States may pick and choose any combination of options—or what CMS refers to as “flexibilities”—under the HAO. CMS will review proposed programs individually.

How is the Healthy Adult Opportunity program different from earlier block grant proposals?

Limited to healthy adults

Lower expenditure base than the full program, with more flexibility to manage the program.

Rebase at renewal

Reduces divergence from projections.

Special circumstances adjustment

States may renegotiate caps for changes in the economy and population health events.

1. Prescription drug limited formulary

LIMITED FORMULARY

One of the most intriguing new options offered under the HAO is the option to limit the prescription drug formulary for HAO covered populations.⁴ Because the HAO uses 1115(a)(2) expenditure authority rather than the state plan, CMS has proposed waiving the open formulary requirements under Section 1927 of the Social Security Act (the Act). States may choose to exclude certain drugs; and may also negotiate supplemental rebates in exchange for including drugs on the formulary or for favorable tier placement.

Instead of covering all rebatable drugs, states will be expected to comply with essential health benefit (EHB) prescription drug requirements. In addition, CMS includes special protections to ensure states cover most mental health drugs, antiretroviral drugs, and opioid use disorder treatment drugs.

BUT STILL REBATES!

Despite the limited formulary, drug manufacturers will still be required to pay Medicaid rebates under Section 1927(b) of the Act. This is a notable departure from the status quo, under which states receive rebates in return for covering all approved drugs. A request from Massachusetts to limit its formulary was denied in 2018, with CMS previously commenting it would consider a closed formulary only if all of Section 1927 were waived, including both the open formulary and the required rebates.⁵ CMS appears to be carving out an exception to existing Medicaid drug rebate rules for the HAO.

POTENTIAL IMPACT

The ability to exclude certain drugs from the formulary or change tier placement, as well as subjecting certain drugs to prior authorization policies and/or greater cost sharing, provides states additional leverage to negotiate favorable financial arrangements with drug manufacturers. However, states pursuing this option may also need to invest in additional staff and other resources to support a closed formulary.

2. Targeted expansion above 133% FPL**FLEXIBLE INCOME STANDARD**

The HAO allows states flexibility on where to set the income standard for a coverage expansion. Consistent with prior guidance, states must set the income standard at or above 133% FPL and provide eligibility for all individuals described in the adult group to be eligible for enhanced federal financial participation (FFP).

For states that expand the income standard to above 133% FPL, an enhanced Federal Medical Assistance Percentage (FMAP) is only available for beneficiaries with incomes up to 133% FPL. CMS did not explicitly limit the income standard states may use, but from a practical standpoint, this will probably be limited by state funding.

ADDITIONAL ELIGIBILITY CRITERIA OPTIONS OVER 133% FPL

The HAO gives states the flexibility to apply additional eligibility requirements for beneficiaries above 133% FPL. CMS suggests states could prioritize eligibility for persons with targeted chronic conditions, such as serious mental illness (SMI), substance use disorder (SUD), or HIV/AIDS.⁶ States could also require asset testing to qualify for benefits.

POTENTIAL IMPACT

Several states already cover higher-income populations with targeted chronic conditions through a waiver or 1915(i) program.⁷ Other states cover these populations with state-only funding. The HAO allows for more income standard flexibility than a 1915(i) program, and it also allows states to consolidate these programs while receiving federal matching funds.

By using targeted Medicaid eligibility rules, a state may try to shift high-risk/high-cost persons from the individual market into Medicaid, which could reduce individual market premium rates. Any federal savings generated could potentially be recaptured through a 1332 waiver.

3. Alignment with exchange products and Medicaid buy-in opportunities**PROGRAM OPTIONS**

Most healthy adult beneficiaries are gainfully employed⁸ and have some experience with commercial healthcare coverage. One of the stated objectives of the HAO guidance⁹ is to ease beneficiary transitions between commercial insurance and Medicaid by introducing some commercial market features:

1. Calendar year redeterminations.
2. Premiums and cost sharing.
3. EHB benefit design.
4. Option to eliminate retroactive¹⁰ and presumptive eligibility¹¹

Premiums and cost sharing continue to be limited to 5% of household income, with exceptions for tribal members and members with SMI, SUD, or HIV/AIDS.

MEDICAID BUY-IN

For states that have been considering a Medicaid buy-in program or Basic Health Program (BHP) for beneficiaries above 133% FPL, the HAO may be a convenient vehicle relative to options such as a 1115 demonstration. It explicitly allows for a higher income standard and for premiums and cost sharing to be applied to buy-in members, likely at a level slightly higher than that applied to the Medicaid expansion population. Also, as previously noted, states can restrict eligibility above 133% FPL to those with certain chronic conditions, those without affordable employer coverage, or to other populations based on state priorities.

RETROACTIVE AND PRESUMPTIVE ELIGIBILITY

Currently, states are required to offer retroactive eligibility and hospital presumptive eligibility. Eliminating these requirements exposes potential financial consequences for those who do not sign up for coverage (unaffordable or unpaid medical bills), which will impact both individuals and hospitals. In the short term, implementation of these provisions might increase charity care and medical debt. At some point, an evaluation of the HAO could provide information on whether changes to these enrollment rules cause consumer behavioral changes to occur.

4. Benefit safeguards and eligibility for behavioral health services

The HAO appears to offer some benefit protections and flexibility around behavioral health services, which is a hot topic across the entire healthcare system. HAO service flexibility may be integrated with widespread behavioral health redesign and benefit enhancement efforts taking place across the country to address the opioid crisis, behavioral health and physical health integration, housing, employment, and other social determinants.

BASIC SAFEGUARDS

The HAO includes several basic safeguards for persons with behavioral health conditions:

- The same required benefits as under the behavioral health EHB
- Compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Special protection for coverage of behavioral health drugs
- Premiums and cost sharing for individuals with SMI or SUD may not be required as a condition of eligibility and cannot be increased above amounts currently permitted in statute
- Any change to network participation that occurs from a value-based payment (VBP) strategy requires states to develop plans to prevent treatment disruptions
- CMS monitoring of performance metrics related to beneficiary access to care or other performance that may be impacted by the demonstration.

ENHANCEMENT OPTIONS

The HAO gives states options to change both benefits and eligibility for services. States also may expand Medicaid eligibility above 133% FPL, with the option to target individuals with SMI or SUD who often lack coverage¹² or are underserved.

CMS invites states to propose coverage of novel services that may improve health outcomes or address health determinants. Some states may use this flexibility to enhance benefits for members with SMI or SUD. This population is also likely to benefit from programs designed to address social determinants of health that may be partially funded with shared savings under the HAO.

5. Alternative benefits and cost sharing

NONTRADITIONAL DESIGN

For states that already have, or are considering, a nontraditional Medicaid expansion program, the HAO provides a streamlined preapproval process for most elements that have previously been allowed by CMS under 1115 authority,¹³ such as institution for mental diseases (IMD) expenditure authority and community engagement, along with new flexibility in several areas:

1. EHB design, aligning with standards for the individual and small group markets.¹⁴
2. Amount, duration, and scope of covered services.
3. Coverage of wraparound services such as nonemergency medical transportation or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19-year-olds and 20-year-olds.
4. Limited drug formulary option.¹⁵

States may pick and choose the elements they would like to incorporate. The IMD authority under the HAO appears similar to what is already available through 1115 expenditure authority.

6. Value-based payments

FEDERALLY QUALIFIED HEALTH CENTER PAYMENTS

The HAO includes new options for states to define their payment methodologies for federally qualified health centers (FQHCs). While some states have found creative ways to incentivize FQHCs to take risk, a limiting factor has been the requirement to pay the clinics under the Prospective Payment System (PPS), per Section 1902(bb) of the Social Security Act. Other areas of the HAO provide caution for this option, noting that measurements of access to FQHCs should assure the ongoing capacity of clinics to serve Medicaid beneficiaries.

As states work to expand their value-based payment (VBP) strategies, this option may be of particular interest where FQHCs form the backbone of a state's Medicaid provider system and states cannot achieve their VBP goals without inclusion of FQHCs. States will want to consider broad application of new VBP programs, because FQHC arrangements will be reviewed by CMS in comparison to other VBP reforms in the state.

ALIGNMENT WITH CMMI

States are also encouraged to think about how their VBP initiatives may align with Medicare and commercial models, similar to initiatives promoted by the CMS Center for Medicare and Medicaid Innovation (CMMI). Taking a step to further align VBP and quality, the HAO also encourages states' quality strategy programs to apply the quality and cost measures that are used in the CMMI models.

7. Alternative provider access metrics

FEE-FOR-SERVICE

Under fee-for-service (FFS), beneficiaries have generally had access to any qualified and willing provider. The HAO would allow states to narrow networks (in nonemergency circumstances) based on written state standards. The standards must be consistent with accessibility, high-quality delivery, and efficient and economic provision of services.

MANAGED CARE

Under 42 CFR 438, managed care plans are currently required to document compliance with provider network standards and capacity. The HAO guidelines suggest CMS would also accept more direct measures of access, such as wait times or utilization metrics.

PERFORMANCE

As part of its HAO implementation plan, a state is expected to review and assess the current provider competitive landscape to determine whether "anti-competitive barriers" in the state have impeded access or increased costs. The implementation plan must address any identified issues.

A big change for fee-for-service Medicaid programs, if included in an HAO, is the additional accountability associated with mandatory reporting on Adult Quality Core Set measures (as referenced in the CMS State Scorecard¹⁶) and other performance indicators selected by CMS based on the state program. Quality strategy programs are often limited to managed care programs, so this change may require states to create new quality infrastructure, as well as monitoring and evaluation mechanisms for their fee-for-service programs. The ability to earn shared savings on this population, in addition to managed care programs, will need to be weighed against this administrative requirement.

8. CMS managed care rate approval process

The HAO offers states two options for approval of managed care capitation rates. Under Option 1, states may continue to follow the current managed care rate certification approval process. Under this option, CMS will impose additional requirements compared to the current environment; the rate certification must be submitted at least 30 days prior to the start of the rating period and retrospective rate adjustments will not be allowed (which could impact states with legislative cycles that require retroactive rate amendments).

Under Option 2, CMS will waive the requirement for prospective review of capitation rate certifications. In return, CMS will require more transparency, medical loss ratio (MLR) remittances, and enhanced audits. States should evaluate the relative workload and other differences between the two options.

TRANSPARENCY

Under Option 2, capitation rate certifications must follow an enhanced rate development guide, with additional tables and data. The rate certification must be publicly posted 60 days prior to the start of the annual rating period, with notification sent to CMS. Amendments must be posted 30 days prior to the effective date.

MEDICAL LOSS RATIOS WITH REMITTANCES

Under Option 2, state contracts with managed care plans must require remittances for MLRs below 85%. While MLR reporting requirements also exist under Option 1, CMS does not mandate MLR remittances in managed care contracts. New guidelines are two-sided and require payments back to the plans for MLRs above 95%. All remittances must be calculated and reconciled within 12 months of the rating period.

AUDITS

Under Option 2, managed care plans will need to provide enhanced audited financial reports, which must be reconciled to MLR calculations and submitted to CMS within 12 months of the rating period.

9. State-directed and pass-through payments

In general, state-directed payments would be expected to continue to comply with 42 CFR 438.6(c). However, pass-through payments may be allowed for the HAO under certain circumstances, if preapproved. CMS does not specify what circumstances might qualify. Any enhanced reimbursement for providers would be limited by approved aggregate or per capita caps.

10. Financing and shared savings

AGGREGATE OR PER CAPITA CAPS

The HAO requires states to assume risk for program costs. Aggregate or per capita caps will be determined prior to the approval of the demonstration, and expenditures over the cap will not be eligible for FFP.

States with an aggregate cap that generates savings may either use the savings to offset excess expenditures that may occur in the three subsequent demonstration years, or use the savings to reinvest in their health programs.

REINVESTMENT OF SHARED SAVINGS

To qualify for shared savings, a state must:

- Have an aggregate cap (not per capita)
- Generate savings
- Maintain or improve performance on a set of 25 mandatory quality and access metrics
- Contribute the state share (standard FMAP) of total costs for the initiative(s)
- Not be in the final year of the HAO demonstration (unless a renewal has been approved)

States that maintain base year performance against all metrics are eligible for 25% shared savings. States that additionally either perform at the 75th percentile or improve by at least 3% on seven to 12 of the 25 measures may earn 37.5% shared savings. Improving on 13 measures or more may earn 50% shared savings.

Shared savings may be reinvested in existing state-funded health programs or new health-related initiatives not otherwise eligible for federal funding. These restrictions may reduce the value of shared savings to many states.

Next steps and consideration of risk

The HAO appears to offer many options for states and careful study is necessary to understand those choices in the context of each state's objectives and priorities.

Compared with a block grant for the entire Medicaid program, the HAO reduces financial risk for states by limiting the reform options to the healthy adult population. At the same time, potential financial savings and reinvestment options are limited because the bulk of Medicaid program expenditures lie with other, more complex population groups.

The HAO provides states with many policy options that may be used to manage cost for the healthy adult population, including flexibility on cost sharing and the amount, duration, and scope of covered services. Other levers include community engagement requirements and excluding both retroactive and presumptive eligibility.

States that wish to enhance benefits, either for the expansion population or for mandatory groups, can implement cautiously, expanding in stages, with an eye on expenditures and value.

An interesting note is the encouragement of CMS for states to consider collaboration with other agencies (e.g., public health and mental health are both mentioned), both in identifying quality strategies¹⁷ and as a place to use shared savings once earned.¹⁸ With a whole-person approach considering multiple agencies serving the same Medicaid recipient, CMS suggests that by using HAO savings to pay for currently state-funded programs, states could free up resources for expanded services or benefits to Medicaid enrollees. Because these non-Medicaid programs may exist in unrelated agency budgets, this kind of braided or blended funding strategy would require active cross-agency coordination and budget planning to become reality.

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Endnotes

- ¹ CMS (January 30, 2020). SMD# 20-001: RE: Health Adult Opportunity (HAO guidance). Retrieved February 7, 2020, from <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>.
- ² Includes other non-mandatory healthy adult populations.
- ³ There have been several proposals, none of which have been implemented. Most recently, the State of Tennessee proposed TennCare II under 1115 waiver authority. See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn-tenncare-ii-pa10.pdf>. CMS was widely believed to be preparing guidance that was ultimately withdrawn in November 2019. See <https://www.beckershospitalreview.com/finance/cms-withdraws-guidance-on-medicaid-block-grants-from-omb-website.html>. Finally, in 2017, two proposals were passed by the U.S. House of Representatives but not the U.S. Senate. They were the American Health Care Act (AHCA, see <https://www.congress.gov/bill/115th-congress/house-bill/1628>) and Better Care Reconciliation Act (BCRA, see <https://www.congress.gov/congressional-record/2017/06/22/house-section/article/H5095-2>).
- ⁴ HAO guidance, p. 9.
- ⁵ Dickson, V. (June 27, 2018). CMS denies Massachusetts' request to choose which drugs Medicaid covers. Modern Healthcare. Retrieved February 7, 2020, from <https://www.modernhealthcare.com/article/20180627/NEWS/180629925/cms-denies-massachusetts-request-to-choose-which-drugs-medicaid-covers>.
- ⁶ HAO guidance, bottom of p. 5.
- ⁷ For more information on the 1915(i) program, please see <http://in.milliman.com/uploadedFiles/insight/2015/Medicaid-ACA.pdf>.
- ⁸ Garfield, R. et al. (August 8, 2019). Understanding the Intersection of Medicaid and Work: What Does the Data Say? Retrieved February 7, 2020, from <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/>.
- ⁹ HAO guidance, p. 6.
- ¹⁰ Musumeci, M. & Rudowitz, R. (November 10, 2017). Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States. Retrieved February 7, 2020, from <https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/>.
- ¹¹ CDC. Public Health Law: Hospital Presumptive Eligibility. Retrieved February 7, 2020, from <https://www.cdc.gov/phlp/docs/hospitalpe-brief.pdf>.
- ¹² McLaughlin, C.G. (April 2004). Delays in Treatment for Mental Disorders and Health Insurance Coverage. Health Research Services. Retrieved February 7, 2020, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361004/>.
- ¹³ For more information, please see https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2018/medicaids_winding_path_through_institutions_of_mental_disease.ashx.
- ¹⁴ Flexibility is consistent with 2019 final payment and benefit parameters. See <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>.
- ¹⁵ In general, Section 1927 requires coverage of all FDA-approved drugs for which the manufacturer has entered into a rebate agreement with the Secretary of HHS. The HAO waives the coverage requirement.
- ¹⁶ For more information on the CMS State Scorecard, please see <https://www.milliman.com/insight/evaluation-of-state-medicaid-scorecard-data>.
- ¹⁷ For instance, the CDC's 6|18 Initiative is referenced, which promotes a variety of public health-Medicaid joint interventions. See HAO guidance, p. 50.
- ¹⁸ HAO guidance, p. 20.



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