CMS's Healthy Adult Opportunity: What You Need to Know

On, January 30, 2020, the Centers for Medicare and Medicaid Services (CMS) released a State Medicaid Director (SMD) letter and fact sheet encouraging states to pursue block grant or per capita cap funding mechanisms through their Medicaid programs as part of the new Healthy Adult Opportunity (HAO). Under this initiative, states may submit a Section 1115 waiver to implement a block grant or per capita cap for certain Medicaid populations, and will be granted increased flexibility in administering the program.

The SMD letter is significantly more detailed than traditional SMD letters, which suggests that it initially may have been drafted as a regulation but later was transformed into a SMD.

The HAO is an option for states, not a mandate. States are not required to implement block grants or per capita caps when considering expanding Medicaid.

This initiative may represent an effort by the Republican Administration to facilitate coverage of the Affordable Care Act expansion population in red states. The top line financing numbers don't appear so punitive that the states are likely to reject this optional initiative. Notably, the Oklahoma governor has already announced that the state will pursue an HAO waiver.

Read on for key details of this new initiative.

Eligible Population

The SMD letter and fact sheet clarify that a state may not implement a block grant or per capita cap for its entire Medicaid population. Specifically, the initiative is targeted to "adult beneficiaries under age 65 who are not eligible for Medicaid on the basis of a disability or their need for long-term care and for whom Medicaid coverage is optional for states." CMS states that other low-income adults, children, pregnant women, elderly adults and people with disabilities will not be affected by this initiative. This appears to allow states to implement HAO for non-mandatory adult populations, but does have a clear focus on the expansion population.

States may impose conditions of eligibility on coverage under an HAO demonstration that do not generally apply to Medicaid coverage under state plans. CMS references work requirements as an example. CMS also notes that states can require an asset test for eligibility and can set the income standard for eligibility for coverage under an HAO demonstration. States also can limit coverage to a defined subset of individuals.

States using the HAO to expand Medicaid may access enhanced Federal Medical Assistance Percentages (FMAP) for the expansion population if the state fully expands Medicaid. CMS will not provide enhanced FMAP for partial Medicaid expansion, which includes implementing asset tests. This position is consistent with CMS's previous decisions regarding partial Medicaid expansions.

The focus on the adult expansion population raises the question: will the 14 non-expansion states pursue a block grant or per capita cap to expand Medicaid?

Additional Flexibilities and Benefit Coverage

The HAO initiative gives states additional flexibility in administering their Medicaid program if they pursue a block grant or per capita cap. Some areas of flexibility are the same as those implemented through 1115 waivers, such as Medicaid work requirements, premiums, cost-sharing and waiver of retroactive coverage periods.

Under the HAO, states are still required to cover the 10 essential health benefits (EHBs) established under the Affordable Care Act. States will "generally be expected to cover state-mandated benefits that are considered EHB as part their of benefit package," according to the SMD letter. States are not expected to cover Alternative Benefit Plan wrap-around service requirements, such as coverage of non-emergency medical transportation, and early and periodic screening, diagnostic and treatment services for individuals ages 19–20.

The SMD letter outlines additional flexibilities regarding housing support services, federally qualified health centers and prescription drug coverage under the HAO initiative.

Housing Supports

The HAO initiative grants states the "ability to pay for services that cannot traditionally be funded by Medicaid, including those designed to address certain health determinants, such as enhanced case management services that link individuals to housing or other supports." This coverage cannot extend to room and board, however.

Federally Qualified Health Centers

States may include coverage of services provided by a federally qualified health center as part of the state's value-based payment reform efforts.

Prescription Drug Coverage

States may adopt a closed formulary for prescription drug coverage in line with EHB requirements and may negotiate supplemental rebates with manufacturers in exchange for the inclusion of their drugs on the state's formulary. The HAO initiative thus appears to allow a state to adopt a closed formulary and still receive Medicaid drug rebates.

Currently, prescription drugs are an optional Medicaid benefit that all states cover. Medicaid prescription drug coverage generally operates under the Medicaid Drug Rebate Program constructs, which require participating manufacturers to enter into a rebate agreement with the US Department of Health and Human Services. A manufacturer provides the state rebate for the drug. In exchange, Medicaid programs cover almost all of the manufacturer's US Food and Drug Administration-approved drugs, and the drugs are eligible for federal matching funds.

That the HAO appears to allow states to have a limited formulary but also receive rebates is notable. Massachusetts previously submitted a 1115 waiver to implement a closed formulary and

still receive rebates through the Medicaid Drug Rebate Program, but CMS (under the current Administration) ruled that the state could not operate both. The HAO initiative thus appears to be either a deviation from CMS's previous decision, or a means by which CMS will allow states to operate the Medicaid Drug Rebate Drug alongside a closed formulary. Regardless, this likely will be an area of legal action.

Fee-for-Service and Managed Care

States may implement the HAO initiative through either fee-for-service or Medicaid managed care delivery systems. The initiative appears to provide additional flexibility for states that implement HAO through managed care. The SMD letter notes that states are expected to have actuarially sound rates but are not required to undergo review of those rates.

States also appear to have additional flexibility in managed care regarding network adequacy and access to care. The SMD letter indicates that states can "adopt alternative approaches to network adequacy, access to care, and availability of services." As a result, states might choose to cut payment rates and reduce network adequacy and access to services through the HAO initiative.

Medicaid Financing

An important component of the initiative is its financing structure.

Block Grant Financing

The SMD letter refers to block grant financing as the "aggregated" approach. If a state pursues a block grant model, CMS will calculate the base using the total computable amount of prior year expenditures attributable to populations and services included in the state's demonstration. CMS will calculate an annual base amount by annualizing the most recently available eight consecutive quarters after December 31, 2016, of finalized CMS-64 expenditure data. (CMS-64 expenditure data is a quarterly report submitted by states that details program benefit costs and administrative expenses.) CMS will trend this amount forward to the demonstration year annually *without* regard to changes in Medicaid enrollment. The annual aggregate cap determined for the base year will be increased by either the growth rate in the state over the prior five years, or CPI-M plus one-half of a percentage point (CPI-M + .5%), whichever is lower.

If a state's total computable demonstration expenditures are less than the annual aggregate cap, the state may qualify for shared savings reinvestment opportunities. Specifically, the state may qualify to receive between 25% and 50% of the federal savings in the form of federal financial participation for specified Medicaid reinvestment expenditures. Per CMS, "states must spend (combined federal and state share) a minimum of 80% of their aggregate cap annually or they will have their aggregate cap reduced for subsequent demonstration years."

Per Capita Cap Financing

If a state pursues a per capita cap model, CMS will determine a per capita base amount for each eligibility group included in the demonstration by dividing the total amount of prior year expenditures for each group by the actual number of enrolled individuals for that group. CMS

will calculate an annual base amount by annualizing the most recently available eight consecutive quarters after December 31, 2016, of finalized CMS-64 expenditure data.

CMS will trend each base amount forward to the demonstration year by multiplying each trended base amount by the number of respective enrollees for the applicable demonstration year, then adding these amounts to create an overall per capita cap. For per capita cap models, the base amount will be increased by a growth factor based on the lesser of the growth rate in the state over the prior five years and the medical care component of the consumer price index for all urban consumers (CPI-M).

Potential Legal Challenges

There likely will be legal challenges arguing that all or parts of the HAO initiative are illegal. In particular, stakeholders may argue that CMS does not have the authority to change Medicaid's financing structure to a block grant or a per capita cap.

The HAO initiative explicitly allows states to implement Medicaid work requirements. Some states, such as Kentucky and New Hampshire, previously tried to implement Medicaid work requirements and faced legal challenges that halted implementation.

Pharmaceutical manufacturers may also challenge the changes that allow for Medicaid prescription drug coverage, particularly the allowance of a closed or limited formulary in conjunction with Medicaid rebates.