Healthy Adult Opportunity Waivers

Proposal

On January 30, 2020, CMS issued a State Medicaid Director (SMD) guidance letter announcing a new Healthy Adult Opportunity (HAO) initiative allowing states to apply for federal waivers that establish defined budget targets or "block grants" for federal spending programs covering adults, including the adult expansion population under the Affordable Care Act. Established through either 1) an aggregate cap based on prior year spending for covered populations trended forward without taking into account changes in enrollment; or 2) per capita caps calculated for the total covered population(s) based on prior year spending for covered groups trended forward that also reflect growth in enrollment, these limits will limit overall federal financial participation (FFP), though still require states to match federal funding.

While federal funding will be capped, states will not be able to cap enrollment for the adult expansion population up to 133% of the federal poverty line if they choose this waiver option and want to receive the enhanced Federal Medical Assistance Percentage (FMAP). The guidance letter also stipulates that CMS will provide states an opportunity to propose updates to an approved HAO demonstration to account for changes in projected expenditures or enrollment resulting from "unforeseen circumstances out of the state's control, such as a public health crisis or major economic event." Expenditures excluded from the budget caps include state administrative costs, Disproportionate Share Hospital (DSH) payments, expenditures for public health emergencies (not defined), and most Indian Health Service (HIS) related costs.

States choosing this option will have more flexibility to align benefits with commercial insurance and will not be required to wrap additional Medicaid services, such as non-emergency medical transportation (NEMT) around such coverage. States may also charge premiums and copays equivalent to up to 5% of annual household income, adopt additional eligibility requirements, including community engagement, adopt closed formularies, and set rates for managed care plans without prior CMS approval.

States assuming greater risk by adopting an aggregate cap will be able to reinvest up to 50% of federal savings achieved from spending less than the total capped allotment for each year. They can also use a portion of any savings to offset expenditures that exceed the cap for up to three years. To be eligible to receive shared savings, a state must meet "performance maintenance criterion" (access and quality of care remain at or above levels established in the base year) for the first 25%, and "performance improvement criterion" (states perform above certain performance benchmarks established by using mandatory CMS quality and access to care measures) for an additional 25%. These federal savings can be reinvested in existing state-funded health programs (but limited to 30% of total savings) or new health-related initiatives that "promote the objectives of the Medicaid program" over a three-year period. States will be required to match the reinvested federal savings at their regular FMAP rate. However, if a state spends less than 80% of its total capped budget in any given year, this shortfall will be deducted from the subsequent year's allotment.

Managed Care Flexibilities

The HAO guidance letter provides states a number of flexibilities related to managed care:

- While expected to meet statutory requirements for actuarial soundness, states will not be required to submit capitation rates for prospective review, but will instead be subject to retrospective audits. They will also have more flexibility to make retroactive adjustments.

- States can propose alternative approaches to meeting network adequacy, access to care, and availability of services requirements included under 42 CFR 438.68.

- States can adopt managed care contract amendments without needing the approval of CMS so long as they are consistent with the terms of the HAO demonstration as well as applicable Medicaid statutory and regulatory requirements.

- States can make directed payments through managed care plans under 42 CFR 438.6(c) without CMS's prior approval so long as such payments are based on delivery and utilization of services to Medicaid beneficiaries covered under the contract or outcomes and quality of the delivered services during the rating period associated with the direct payment. (If a state intends to make pass-through payments or supplemental payments to providers instead of directed payments, these need to be explicitly authorized in the state's HAO demonstration and paid outside of the managed care capitation rates.)

Questions and Issues for Consideration

- Will the calculations used to establish an initial aggregate budget cap or the per capita cap limits for the base year, including for newly covered populations, provide sufficient funding to cover the services needed for the population(s) included in the HAO demonstration?

- Are the growth rates under both options adequate?

- Should CMS consider providing additional guidance that includes criteria for changed circumstances that would trigger adjustment of states' overall budget caps?

- Will the option for states to forgo prospective rate review by CMS by adopting alternative requirements for rate transparency, rate development, medical loss ratios (MLR) with remittance, and retroactive MCO audits be workable and ensure that payment rates are actuarially sound?

- Under this option, required remittances to MCOs that exceed the annual budget cap are not eligible for FFP. Does this create an unreasonable risk for MCOs?

- Are there specific changes that should be made to the CMS Managed Care Capitation Rate Development Guide referenced in the SMD guidance letter to better ensure that rates are actuarially sound?

- Will the ability of states to implement closed formularies impact managed care capitation rates?