CMS Guidance Authorizes Medicaid Demonstration Applications That Cap Federal Funding: Implications for States

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I. Introduction

The Centers for Medicare & Medicaid Services (CMS) issued a long-anticipated State Medicaid Director Letter (SMDL)[1] on January 30, 2020 inviting states to apply for Section 1115 demonstration projects that would impose caps on federal Medicaid funding for the adult expansion and some other adult populations in exchange for new programmatic flexibility. Referred to as "Healthy Adult Opportunity" by CMS, these demonstrations would allow states to choose between two types of capped funding arrangements: a per capita cap or an aggregate cap (i.e., a block grant). CMS also released with the SMDL an application template[2] for use by states interested in requesting a capped funding demonstration.

The SMDL is a major shift from Medicaid's current structure as a statutory entitlement, in which the federal government matches all eligible state expenditures *without* any cap. Previous proposals to shift Medicaid federal funding models to a cap were included in the repeal and replace legislation of 2017, which were not passed by Congress. Those bills would have replaced traditional Medicaid spending for *all* states with a per capita cap, and some would have imposed a block grant for Affordable Care Act (ACA) expansion groups. Under CMS' new guidance, each state may decide for itself whether to apply for a Section 1115 demonstration that would cap federal financial participation (FFP) for certain Medicaid populations, subject to the parameters set out in the guidance.

As explained in the SMDL and application template, CMS uses "expenditure" authority under Section 1115(a)(2) to allow coverage that can be designed without regard to key provisions in the Medicaid statute, including certain standard beneficiary protections that today apply to all Section 1115 Medicaid demonstrations.[3] The capped funding model thus offers states new programmatic flexibility with respect to enrollment procedures, covered benefits, and federal oversight in exchange for reduced federal funding and substantial financial risk. Given the extent and nature of the financial and programmatic changes that would be permitted pursuant to

Key Considerations for States

As states weigh whether to pursue a capped funding demonstration, they will want to consider key features and implications of the guidance, as described in more detail throughout this issue brief:

- **Loss of Federal Funds.** Caps on federal funding shift financial risk to the states. That risk is particularly great under the model described in the SMDL, given that the caps are designed to constrain the growth in Medicaid spending.
- **Limited New Flexibilities.** The SMDL describes various forms of program flexibility that states may request, many of which are already available to states outside the context of a capped demonstration. Notable policy options that have not previously been approved include: access to "shared savings," some of which may be spent on services outside of Medicaid; eliminating hospital presumptive eligibility; implementing a closed prescription drug formulary for populations beyond the ACA expansion group; proposing alternative approaches to complying with federal standards for access and managed care oversight; and modifying certain program elements during the demonstration without the need for federal approval.

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1 Centers for Medicare & Medicaid Services. State Medicaid Director Letter, Healthy Adult Opportunity (SMDL # 20-001). Washington: Centers for Medicare & Medicaid Services; 2020. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf. Accessed January 30, 2020.

2 Centers for Medicare & Medicaid Services. Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application Guidance & Template. Washington: Centers for Medicare & Medicaid Services; 2020. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/how-states-apply/hao-application-template.docx. Accessed January 30, 2020.

3 Rather than using its traditional 1115(a)(1) "waiver" authority to construct capped funding allotments, CMS' new guidance relies heavily on 1115(a)(2) of the Social Security Act to grant expenditure authority for costs that are not otherwise matchable. By relying on this 1115(a)(2) authority, CMS asserts that otherwise applicable Medicaid requirements need not apply to the demonstration population.

the SMDL, demonstrations approved under the guidance are also at high risk of litigation.

This issue brief describes key features of the CMS guidance and provides an overview of potential implications for states that pursue these capped funding demonstrations. As discussed in greater detail below, CMS is open to approving certain new program flexibilities for states that accept a cap on their federal Medicaid funding. These capped funding arrangements will be designed to constrain federal Medicaid spending; states that adopt them will be subject to new pressure (in addition to the fiscal imperative to constrain Medicaid costs that states always face) to reduce Medicaid expenditures in order to keep spending below the self-imposed caps. Manatt Health is continuing to review the guidance, and an analysis of its fiscal impact on states is forthcoming. This analysis focuses on considerations for states rather than the potential implications for beneficiaries, Medicaid providers, and health plans that could result from these demonstrations.

II. Key Features of Capped Funding Demonstrations

This section describes CMS' vision for capped funding demonstrations, as laid out in the SMDL. The demonstration's core features including the following:

- Populations that may be covered under the funding cap include the ACA adult expansion group as well as "optional" non-elderly, non-disabled adults, including groups that have not previously been covered in the state.[4]
- Federal funding caps may be imposed on either a per capita or an aggregate basis and will grow more slowly than projected Medicaid spending. States will continue to receive federal funding to match state spending but only up to the cap, leaving the state responsible for costs above the cap.
- Shared savings may be available under the aggregate cap model to a state that spends *less than* the annual cap and meets certain performance benchmarks. States that qualify can divert some of the unspent federal Medicaid funds to health-related initiatives outside the Medicaid program.
- Program flexibility articulated in the guidance includes changes that CMS has already permitted in demonstrations without funding caps as well as policies that CMS has not previously approved. The guidance does not, however, permit partial expansions [e.g., up to 100% of the Federal Poverty Level (FPL)] or enrollment caps for the expansion population.
- Federal oversight for capped demonstrations includes monitoring and reporting obligations beyond those typically required under an 1115 demonstration. Although CMS indicates it will loosen other forms of oversight (i.e., forgoing

Key Considerations for States

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- **Risks for Medicaid Beneficiaries and Other Stakeholders.** States that experiment with altering Medicaid program standards may end up reducing beneficiaries' access to care, constricting provider reimbursement to unsustainable levels, or squeezing managed care capitation rates to an extent that makes it unfeasible for plans to meet their obligations.
- **Quality and Monitoring Obligations.** A capped funding demonstration comes with monitoring and reporting obligations that go beyond the typical 1115 demonstration requirements.
- **Administrative Challenges.** A capped funding demonstration that departs substantially from the state's existing Medicaid coverage model will mean that the state is essentially running a new, separate program alongside existing coverage for other populations (such as children and disabled or elderly adults).
- **Litigation Risk.** States can expect legal challenges to any approved demonstration that includes capped federal funding.

4 The ACA required all states to expand their Medicaid programs to include all adults up to 133 percent of the FPL. The Supreme Court made this voluntary for states, however, with its 2012 decision in *National Federation of Independent Business v. Sebelius*.

prospective managed care contract review), CMS also acknowledges that it could require retrospective adjustments if it later deems a state to have been out of compliance.

A. Covered Populations

The SMDL states that the capped funding model is focused on "optional" nonelderly, nondisabled adults. States that apply for a capped funding demonstration may request to cover new populations for the first time, and also to transfer in some of their existing Medicaid populations, including adults currently covered as part of the Medicaid expansion, an "optional" state plan group, or an existing 1115 demonstration. At this time, states will not be permitted to pursue block grant demonstrations for children, the elderly, and people eligible based on a disability, nor for the lowest-income (i.e., "mandatory") parents and pregnant women. Note that many states have expanded coverage for low-income parents and pregnant women above the mandatory income levels and could apply for capped funding demonstrations that would cover optional parents and pregnant women, with or without adding the ACA expansion adult population.

B. Capped Funding Financing Models: Per Capita Cap and Aggregate Cap

The SMDL leaves Medicaid's federal matching structure in place; congressional action would be needed to convert Medicaid to a block grant model that provides lump-sum federal payments without a state match or state spending requirement, as exist in some block grant programs. Under a capped funding demonstration, the federal government would contribute FFP at the usual matching rate given the population and services covered until the cap is reached; at that point, the federal government would stop contributing a federal match, leaving the state solely responsible for all remaining program costs that year.

The guidance generally allows states to elect to cap their federal funding on either a per capita or an aggregate basis. If, however, a state uses a capped demonstration to extend coverage to a new population, the state must use a per capita cap until sufficient data is available to calculate an aggregate cap, as explained below. Under a per capita cap, the federal government will spend up to a certain amount *per enrolled beneficiary each year*. Under an aggregate cap, by contrast, the amount of the cap is fixed, meaning it is not adjusted to account for any changes in actual enrollment during the demonstration. Both types of caps shift financial risk to the states for unexpected increases in the cost per enrollee (due to, for example, an expensive new drug). The aggregate cap—but not the per capita cap—also shifts risk to the state for increased enrollment (due to, for example, an economic downturn).[5]

Calculating the Cap Amounts

For both the aggregate cap and the per capita cap models, CMS will calculate "base year" expenditures using the most recent two years of expenditures (state and federal) for the populations and services that will be covered under the demonstration.[6] If a proposed capped funding demonstration will extend coverage to new populations for the first time, the SMDL requires that the state start the demonstration period with a per capita cap for those populations,[7] with a base amount calculated using the best available state and national data. After two years—or once sufficient baseline data is available—states may transition to a rebased aggregate cap.

To determine the cap amount for each year of the demonstration, CMS will trend the base amount forward. For a state with a per capita cap, the trend factor will be the lower of the medical care component of the Consumer Price

5 CMS has previously approved two demonstrations with aggregate caps, one in Vermont in 2005 and a second in Rhode Island in 2009. In contrast to the approach taken in the SMDL, both Vermont and Rhode Island secured generous federal caps and, so, received more federal dollars than their projected federal contributions without the demonstration. For more information on these waivers, see Jocelyn Guyer, *Vermont's Global Commitment Waiver: Implications for the Medicaid Program*, Kaiser Family Foundation (April 2006), https://www.kff.org/medicaid/issue-brief/vermonts-global-commitment-waiver-implications-for-the/, and Edward Alan Miller et al., *Medicaid Block Grants: Lessons from Rhode Island's Global Waiver*, State Health Access Reform Evaluation, Robert Wood Johnson Foundation (June 2013), https://www.shadac.org/sites/default/files/publications/RI_Global_Waiver_Brief_FINAL.pdf.

6 If the state's quarterly CMS-64 expenditure reports do not permit CMS to separate out the specific populations and services that will be covered under the demonstration, the state will need to submit two years' worth of auditable expenditure data that ties to the expenditures reported on the CMS-64.

7 The guidance is unclear about whether a state could request a demonstration that applies a per capita cap for newly covered populations while simultaneously applying a block grant for other populations that were already covered.

Index (CPI) or the state's historical spending growth rate over the past five years.[8] For aggregate caps, CMS will use the lower of the medical CPI plus half a percentage point or the average state growth rate.[9] Anchoring the trend rate in the medical CPI is designed to constrain state spending relative to current levels: A recent publication from the CMS Office of the Actuary estimated that average annual Medicaid spending growth for the period 2017 to 2026 will consistently exceed the medical CPI.[10]

The annual cap amounts will be set at the time the demonstration is approved (using projections of the medical CPI available at that time); however, certain circumstances may prompt CMS to adjust the cap amounts during the demonstration period. States may request to renegotiate the demonstration's terms and conditions to account for unforeseen circumstances outside the state's control, such as public health emergencies or major economic events. Meanwhile, CMS may adjust the cap if a state requests a policy change that "has the potential to substantially impact enrollment" (p.36). The SMDL does not define "substantial impact" or offer specific examples, but potentially applicable policies might include, for example, community engagement requirements (commonly referred to as work requirements).

If a state seeks to renew a capped funding demonstration at the end of the five-year demonstration period, CMS will rebase the caps using the same procedures outlined above.[11]

Included and Excluded Spending Under the Cap

The federal funding cap will apply to almost all of a state's Medicaid spending on covered populations. The SMDL defines a limited set of exclusions for administrative expenditures, spending on public health emergencies, spending on services received through the Indian Health Service, and spending that is not readily attributable to individual enrollees, such as Disproportionate Share Hospital (DSH) payments and certain temporary supplemental and pool payments made under 1115 authority.[12] The cap will, however, include standard fee-for-service (FFS) supplemental payments and managed care pass-through payments; these supplemental payments would be allocated to the demonstration population based on the population's share of *non*-supplemental payments.[13]

Consequences of Exceeding the Cap

As the capped funding methodology is designed to constrain spending, and given the projected growth rate in Medicaid costs, states may find it challenging to stay within their spending limits, and if a state spends above the cap in a given year, the excess payments are ineligible for FFP. Any FFP provided to a state based on spending above the cap will be disallowed using standard procedures.

8 Note that, although the per capita cap amount is calculated on a per-enrollee basis, CMS will not assess state spending at the enrollee level. Rather, after each year of the demonstration, CMS will calculate an overall spending cap by multiplying the predetermined per enrollee cap amount by the number of enrolled beneficiaries.

9 Basing the trend factor on the medical CPI raises a question about timing: The SMDL states that the cap amounts "will be determined prior to approval of the demonstration" (p.16), but the Bureau of Labor Statistics publishes CPI figures each month based on actual data and does not forecast the medical CPI for future years. CMS may thus intend to rely on the medical CPI projections issued by the CMS Office of the Actuary. Alternatively, CMS may intend to apply the current medical CPI at the time of demonstration approval, locking in that rate for the demonstration's entire five-year period.

10 CMS Office of the Actuary. *2017 Actuarial Report on the Financial Outlook for Medicaid*. Washington: CMS Office of the Actuary; 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf. Accessed January 30, 2020.

11 This approach is consistent with 2018 guidance preventing states from "rolling over" unlimited savings from one demonstration project to the next. Centers for Medicare & Medicaid Services. State Medicaid Director Letter, Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects (SMDL # 18-009). Washington: Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf. Accessed January 30, 2020. Under CMS' current approach to budget neutrality, states are permitted to roll over accumulated budget neutrality savings only from the most recently approved five-year demonstration period.

12 The SMDL lists examples of excluded payments including Designated State Health Program (DSHP) payments, Delivery System Reform Incentive Payments (DSRIP), and Uncompensated Care Cost (UCC) payments.

13 To allocate inpatient hospital supplemental payments, for example, CMS will examine the state's base payments for inpatient services and determine what percentage of those payments were attributable to services for the demonstration population.

Capped Funding Models Are More Restrictive than Standard 1115 Demonstration Budget Neutrality

CMS requires that all 1115 demonstrations be "budget neutral" to the federal government, meaning that federal spending under the demonstration must be no greater than what the federal government would have spent in the absence of the demonstration. As with a cap under the SMDL, CMS determines the budget neutrality limit by calculating the state's base year expenditures and trending that amount forward over the life of the demonstration. However, the SMDL takes a stricter approach to limiting federal spending.

- **Annual Spending Limits.** In a standard 1115 demonstration, the budget neutrality limit applies over the life of the entire demonstration. States can thus balance a budget overrun in one year against a surplus in the next, which allows for policy changes that may take upfront investment before generating longer-term savings. In a capped funding demonstration, by contrast, the caps apply on an annual basis. A state that exceeds its cap in any given year must repay the "excess" FFP the following quarter. (As discussed below, under an aggregate cap—but not a per capita cap—states may apply "unused" spending under the cap in one year against excess spending in future years; unlike budget neutrality, this rebalancing is limited to a *prospective* three-year period, so spending reductions late in the demonstration cannot make up for excess spending in the early years.)
- **Less Flexible Trend Factor.** When selecting a trend factor for budget neutrality in other Section 1115 demonstrations, CMS uses the lower of historical state spending or the President's Budget trend rate projections for Medicaid cost growth. Both figures are specific to Medicaid spending on populations covered by the demonstration. In a capped demonstration, by contrast, CMS will compare historical state spending against the medical CPI, a general inflation figure for people with all types of health coverage.

Provisions Specific to the Aggregate Cap: Retaining Unused Funding and Shared Savings

Certain additional financing features apply specifically to the aggregate cap model. The SMDL explains that these features, like the 0.5 percent boost to the trend rate, reflect the "added risk states will assume under an aggregate cap model" as compared with the per capita cap (p.18).

The aggregate cap itself creates strong pressure on states to keep total spending from exceeding the cap, but the SMDL goes a step further by defining two policies that could further drive states to reduce spending below the cap. First, a state that underspends in a given year may hold the "unused" spending for up to three years. If the state exceeds its cap during that three-year period, the state may offset the overspending in an amount equal to the unused funds.

Alternatively, a state may request to convert a portion of its unused spending into a "shared savings" payment. CMS will calculate the amount of potential FFP associated with the unused spending and will designate 25 to 50 percent of that unused FFP as shared savings that may be used by the state, contingent on the state maintaining or improving its performance on certain quality benchmarks.[14]

The shared savings are not returned to the state as a simple cash grant. Rather, shared savings payments operate as a form of flexible FFP, which the state may access by spending state funds, then drawing down the shared savings FFP at the state's usual federal match rate.[15] These shared savings may, at CMS' discretion, be spent on health-related state programs that are not otherwise FFP eligible but that promote Medicaid objectives. The SMDL lists potentially eligible initiatives such as prevocational services for Medicaid beneficiaries, a tobacco cessation program that serves (but is not limited to) Medicaid beneficiaries, or providing Medicaid services for populations not currently covered by the state's Medicaid program. The state spending required as a match does not have to

14 CMS will calculate shared savings as follows: First, a state must establish a comprehensive set of baseline quality metrics (tied to the CMS Adult Core Set metrics listed in SMDL Appendix D) for the demonstration population; thereafter, if the state maintains access and quality metrics at baseline levels, the state qualifies for shared savings consisting of 25 percent of unused FFP. The state may increase its shared savings percentage to 37.5 percent by showing either a 3 percent improvement or performance at the 75th percentile with respect to at least seven of the 25 Adult Core Set performance benchmarks. If the state can make that showing for 13 or more benchmarks, the savings percentage increases to 50 percent.

15 The match rate for these shared savings funds is likely to be lower than the block grant demonstration population match rate assuming the demonstration population includes the ACA expansion group.

be new state spending in all cases: up to 30 percent of a state's federal shared savings dollars may be spent on existing state programs, and although these dollars may not be used to supplant existing *federal* funding, they can replace existing *state* spending on health programs (as long as the match requirement is met), thereby freeing state dollars for other uses.

The SMDL combines these opportunities with a "maintenance of effort." Each year, states with an aggregate cap must spend at least 80 percent of their cap amount (combined state and federal shares) on Medicaid expenditures for the block grant population or CMS will reduce their cap amount going forward.

Limitations on Shared Savings

Although proponents of block grant models tout shared savings as a main selling point, a number of factors in the capped funding guidance may stand in the way of states qualifying for, or benefiting from, shared savings.

- **Data Limitations.** To qualify for shared savings, states must establish a comprehensive set of baseline quality metrics for the demonstration population. States in the early phases of implementing data collection infrastructure may face challenges in establishing a quality baseline or demonstrating improvement. The variability in Medicaid data may complicate comparisons across state lines, which may hamper CMS' efforts to apply percentile-based performance benchmarks.
- **Timing Limitations.** States may be categorically ineligible in the early years of their demonstration, whether because of insufficient financial baseline data, as described above, or because they used the demonstration to cover a new population and were thus required to implement a per capita cap demonstration for at least two years before transitioning to a block grant. Moreover, states are not eligible for shared savings in the final year of a demonstration unless CMS approves a demonstration renewal.[16] Thus, some states may be eligible for shared savings in only two of the five demonstration years.
- **The Federal Government Will Retain the Majority of Shared Savings.** If a state qualifies for a portion of the shared savings, the state must spend its own funds to "draw down" the federal shared savings dollars. Even if a state uses a capped funding demonstration to cover the ACA expansion population, which carries an enhanced match rate of 90%, shared savings must be drawn down at the state's regular match rate; those rates currently range from 50% to 77%.

C. States Entering Capped Funding Demonstrations Will Trade Funding Reductions for Program Flexibility

The guidance proposes a trade-off for states: accept a cap on federal funding in exchange for flexibility in program design and administration. The per capita cap—unlike the aggregate cap—offers no opportunity for shared savings, such that program flexibility would be the primary benefit to states entering these arrangements. The SMDL "encourages states to apply for all flexibilities that have been previously approved in other demonstrations" with respect to program features such as eligibility, enrollment, covered benefits, and health system delivery reform (p.2). In addition, the SMDL expressly authorizes certain policy options that have not previously been approved and invites states to "request additional flexibilities" beyond those addressed in CMS' guidance (p.15). And as discussed in later sections of this issue brief, states may exercise these flexibilities in an environment of relaxed federal oversight. Consistent with current Section 1115 demonstration policy, states will have to develop, and submit for CMS approval, an implementation plan to provide "detailed information" about the state's approach to implementation; CMS will provide a template for the implementation plan, as the agency did for work requirement demonstrations (p.35).

16 As noted above, CMS intends to rebase the caps upon capped funding demonstration renewal. While the guidance is not clear about how spending reductions would factor into the baseline, a state that substantially reduces spending and qualifies for shared savings during an initial demonstration may, upon renewal, receive a reduced baseline cap for the new demonstration period.

Eligibility and Enrollment

As under existing Medicaid Section 1115 demonstrations, states may impose various restrictions on the demonstration population as well as on when and how they may enroll in Medicaid, including by:

- Imposing additional conditions on eligibility, such as work requirements or health assessments.
- Restricting the duration of effective Medicaid coverage by:
  - Eliminating retroactive eligibility; or
  - Imposing a waiting period (or payment of a premium) before enrollment becomes effective.
- Imposing coverage lockout periods for beneficiaries who fail to satisfy program requirements (such as work requirements or premiums).

The guidance also indicates openness to eliminating hospital presumptive eligibility (which CMS has not approved to date) as well as the prohibition on asset tests (subject to certain limitations with respect to the ACA expansion population).[17]

The SMDL specifies that the annual spending cap will take into account program features that "significantly affect enrollment" so that "states do not achieve savings from disenrolling individuals" (p.24). And the guidance notes that certain federal requirements for enrollment procedures will continue to apply, including rules regarding timely eligibility determinations, electronic verification, streamlined renewal, and coordination of eligibility determinations with the Marketplaces.

Covered Services

The SMDL explains that states will not be subject to the Alternative Benefit Plan (ABP) coverage requirements with respect to these demonstration populations. Rather, states will generally be expected to align capped funding demonstration coverage with the essential health benefits (EHB) available under private health plans in the Marketplace.[18] In this way, states will be able to opt out of otherwise mandatory Medicaid benefits such as:

- Nonemergency medical transportation (NEMT)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for individuals aged 19 or 20
- Medicaid's enhanced reimbursement rate and other provisions regarding Federally Qualified Health Centers (FQHCs) if in the context of a value-based payment arrangement[19]

In addition, states may request to add benefits under a capped funding demonstration, consistent with CMS' existing guidance and prior demonstration approvals. The SMDL lists examples including services to address social determinants of health, such as enhanced case management, and services provided at Institutions for Mental Diseases (IMDs) for substance use disorders or serious mental illness. Under a cap, however, new services may displace funding for traditional health care services. For example, if a state applies for a demonstration that adds housing supports not otherwise eligible for FFP, the state's historical expenditure data—and therefore the state's annual cap amount—would not reflect those services.

17 Federal law generally prohibits states from applying asset tests to populations that qualify for Medicaid eligibility based on modified adjusted gross income. This prohibition is not waivable under Section 1115(a)(1), but the SMDL indicates that CMS may use its 1115(a)(2) expenditure authority to permit otherwise unallowable asset tests. The SMDL cautions, however, that the enhanced federal match rate for the expansion population is available only if the state expands coverage all the way to 133 percent of the FPL *without* imposing an asset test.

18 Marketplace plans must cover services in each of the 10 categories of EHB: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, behavioral health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.

19 If a state elects to cover FQHC services as part of a value-based payment reform, the state may opt out of the Medicaid requirements for FQHC prospective payment or alternative payment methodologies, and may instead comply with the "Essential Community Provider" requirements at 45 C.F.R. § 156.235. This authority is precedent-setting as CMS has generally declined to waive FQHC requirements.

Implications of Importing the Essential Health Benefits (EHB) Standard into Medicaid

- The ability to align Medicaid benefits with EHB coverage magnifies the impact of recent federal efforts to relax the EHB standard by, for example, allowing states to incorporate elements of other states' EHB standards or limiting states' ability to supplement the EHB standards with benefits that were not already included as of the 2017 plan year.[20] In some states, these dynamics may contribute to a more limited benefit for Medicaid beneficiaries covered under capped funding demonstrations.
- The SMDL does not discuss "medically frail" individuals, who are currently exempt from being placed in the ABP applicable to the adult exchange group. Unlike Medicaid, the EHB standard does not require coverage of nursing homes and certain other options for long-term care. It thus appears that states may require medically frail individuals to enroll in the ABP with no right to opt in to comprehensive Medicaid coverage. A decision along these lines may drive an increase in the number of medically frail individuals who seek a disability determination,[21] which would likely remove them from the population targeted by the SMDL (in addition to qualifying them for other benefits and safeguards).

Prescription Drugs

The SMDL authorizes states to implement a closed prescription drug formulary without sacrificing manufacturer rebates under the Medicaid Drug Rebate Program (MDRP). Although CMS frames this policy as a major new flexibility, states have had similar authority to limit covered prescription drugs (while retaining MDRP rebates) for the ACA expansion population under the ABP. Relatively few states have pursued this approach. The key change, then, seems to be for medically frail individuals in the expansion population (who currently have a right to opt out of ABP coverage, as explained in the text box), as well as optional, nondisabled adult populations (who are currently covered under the state plan). For their state plan populations, states may already implement preferred drug lists that trigger a prior approval process for drugs not on the list, but CMS has been unwilling to approve a true closed formulary unless a state agreed to give up MDRP rebates.

Under a capped funding demonstration, however, a state may implement a closed formulary (in accordance with the EHB requirements that already apply to the ACA expansion population), retain MDRP rebates, and negotiate supplemental rebates with manufacturers as long as the state:

- Covers substantially all antiretroviral drugs and drugs for mental health, consistent with Medicare Part D coverage.
- Covers all FDA-approved drugs to treat opioid use disorders for which there are MDRP rebate agreements in place.
- Adheres to requirements for drug utilization review, state reporting, and program integrity "generally consistent" with Section 1927 of the Social Security Act (p.9).

Because these protections apply over and above EHB prescription drug requirements, states designing a closed formulary under a capped funding demonstration may need to cover more drugs than would otherwise be required under ABP rules for the expansion population.

20 These and other EHB details are discussed in SMDL Appendix C, and also in 2019 guidance from CMS that discusses the relationship between the ABP and EHB standards. Centers for Medicare & Medicaid Services. New State Flexibilities and Requirements regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB), CMCS Info. Bulletin. Washington: Centers for Medicare & Medicaid Services; 2019. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib080819-1.pdf. Accessed January 30, 2020.

21 Following passage of the ACA, studies have observed a decline, in expansion states, in the number of low-income non-elderly adults seeking disability determinations through the Supplemental Security Income (SSI) program. See, e.g., A. Soni, et al., *Medicaid Expansion and State Trends in Supplemental Security Income Program Participation*, Health Affairs 36, No. 8 (2017): 1485-1488. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1632. Accessed January 30, 2020.

Premiums and Cost Sharing

States will be able to increase premiums and cost-sharing fees under a capped funding demonstration, subject to certain limitations. The authority relating to copayments is new; CMS is offering this option notwithstanding a provision in federal law that constrains CMS' waiver authority relating to copayments.[22] States must continue to limit beneficiaries' aggregate out-of-pocket costs to 5 percent of the beneficiary's household income, and must retain current protections for beneficiaries who qualify for services through the Indian Health Service, or who are receiving treatment for mental health conditions, substance use disorders, or HIV. Although not specifically noted, CMS' broad statement (p.10) that current regulatory and statutory restrictions on premiums and cost sharing need not apply suggests that CMS would entertain states' requests to deny services to individuals below 100 percent of the FPL who cannot pay required copayments.

Delivery System and Managed Care

Under a capped funding demonstration, states would continue to have the flexibility they do today to deploy a combination of FFS and managed care delivery system structures. They may also use Medicaid dollars to assist beneficiaries in securing private coverage or propose other coverage arrangements in connection with a State Innovation Waiver under Section 1332 of the ACA.

Although states with capped funding demonstrations will be required to monitor and report on beneficiaries' access to care, CMS will allow states to opt out of the current federal access standards in both FFS and managed care; states may propose alternative approaches to defining and measuring access to care and other standards for managed care contracts.[23] With respect to the requirement that managed care capitation rates be actuarially sound, for example, the guidance notes that states may forgo CMS review and instead submit their own independent actuarial certifications. In addition, although states must continue to submit managed care contracts for CMS review and approval, a state need not seek CMS approval for contract *amendments* that are consistent with the demonstration special terms and conditions (STCs).[24] The guidance cautions that if a state forgoes prior review and approval for amendments or rates, the state might be at risk if CMS later determines it is out of compliance.

D. CMS Oversight of Capped Funding Demonstrations

The guidance imposes a number of monitoring and reporting obligations for capped funding demonstrations that are over and above the standard monitoring, evaluation, and oversight requirements for 1115 demonstrations.

Preapproval for Mid-Demonstration Policy Changes

States that apply for a capped funding demonstration can seek approval of potential policy changes that may then be adopted at a later time during the course of the demonstration. States may propose, for example, a range of potential cost-sharing levels or a list of optional benefits that the state may or may not cover. CMS will incorporate all approved options into the STCs, allowing states to exercise those policy options as they see fit to manage costs during the demonstration period, with minimal CMS oversight.

During the demonstration period, the state would need to provide CMS with at least 60 days' advance notice before implementing a preapproved policy, but need not submit a formal demonstration amendment or wait for

22 Section 1916(f) of the Social Security Act establishes that the Secretary of Health and Human Services cannot waive cost-sharing requirements otherwise established by federal law unless multiple criteria are met, including that the waiver will test a unique and previously untested use of copayments; is limited to a period of not more than two years; will provide benefits to recipients of medical assistance that can reasonably be expected to be equivalent to the risks to the recipients; is based on a reasonable hypothesis that the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and is voluntary or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation. States have not typically pursued cost-sharing waivers and CMS has granted only one such waiver, which the state opted not to renew.

23 States remain obligated to meet the *statutory* requirements in sections 1903(m) and 1932 of the Social Security Act, but may propose alternatives to CMS' more detailed *regulatory* standards at 42 C.F.R. Part 438.

24 The SMDL does not address a scenario in which a state hopes to rely on managed care models for both demonstration and non-demonstration populations. It is not clear, for example, whether a state would need to execute separate contracts with separate managed care entities or whether the state could have a single managed care contract that defines separate rates and standards for each population, and where the amendment process would perhaps vary depending on which populations would be affected by the amendment.

federal approval. The state would need to reflect any such changes in the state's implementation plan. The state would, in addition, need to comply with procedures for public notice and comment and for tribal consultation, except with respect to administrative changes with only a minimal impact on Medicaid beneficiaries, providers, and plans. If a state opts to adopt a preapproved policy change that is likely to substantially impact enrollment, CMS would reexamine, and might adjust, the annual caps.

Additional Reporting Obligations

As compared with other 1115 demonstrations, these new capped funding demonstrations would require states to monitor and report on a greater array of quality and spending metrics, as described in SMDL Appendices D through H. The state must implement a demonstration-specific quality strategy and submit quarterly and annual reports addressing, among other things, 13 sets of continuous performance indicators regarding access, enrollment, appeals, and financing elements; 25 quality and access measures drawn from the Adult Core Set; financial reporting to assess whether spending has reached the annual cap; and the state's progress against the demonstration implementation plan.

These additional monitoring and reporting obligations suggest CMS' awareness that the capped funding model, with its incentives to reduce spending, may have an adverse effect on beneficiaries' access to high-quality care. The SMDL cautions that a change in the reported metrics "signals the need for CMS to engage with the state to determine the cause(s) of the change and whether corrective action is needed" (p.32). These reporting requirements are likely to prove significantly more burdensome for states as compared with existing procedures.

III. Conclusion: Key Considerations for States

The new capped funding model may hold interest for states that seek particular types of program flexibility that have not previously been approved, notably including the ability to:

- Qualify for shared savings if the state underspends its block grant while maintaining or improving quality. These shared savings payments can potentially be spent on services outside the capped funding demonstration or outside the Medicaid program (subject to a state match requirement).
- Eliminate hospital presumptive eligibility.
- Implement a closed prescription drug formulary even for optional non-expansion populations previously covered under the Medicaid state plan.
- Propose alternative approaches to complying with federal standards for access and managed care oversight.
- Modify certain program elements during the demonstration without the need for federal approval.

At the same time, the capped funding demonstration model also presents a number of potential drawbacks for states, including the following:

- **Loss of Federal Funds.** Caps on federal funding shift financial risk to the states. That risk is particularly great under the model described in the SMDL, given that the caps are designed to constrain the growth in Medicaid spending.
  - States would face difficult choices if capped funding falls short of actual need: either further curtail demonstration spending or use state dollars to replace FFP for all spending above the cap, thereby displacing other state spending (potentially including spending on Medicaid populations outside the demonstration).
  - Because the penalty for exceeding the cap means a loss of FFP, the consequences for exceeding the cap are most acute for states with high federal match rates. As compared with a state with a 50 percent match rate, a state with a 75 percent rate will lose an extra 25 cents of FFP on each dollar above the cap. The ACA expansion population, moreover, receives a 90 percent federal match rate (as long as the state covers the

entire expansion population up to 133 percent of the FPL). A state that exceeds its spending cap for this population could suddenly face a tenfold increase in its financial liability for each dollar spent.[25]

- Although the guidance offers the opportunity for shared savings under the aggregate cap model, this opportunity may not be meaningful in practice, given the various limitations in terms of timing, data, and program quality.

› **Risks for Medicaid Beneficiaries and Other Stakeholders.** CMS' guidance indicates that it will generally allow states that adopt a capped funding demonstration to remove or reduce current federal protections. States that experiment with altering Medicaid program standards may end up reducing beneficiaries' access to care, constricting provider reimbursement to unsustainable levels, or squeezing managed care capitation rates to an extent that makes it unfeasible for plans to meet their obligations.

› **Quality and Monitoring Obligations.** A capped funding demonstration comes with monitoring and reporting obligations that go beyond the typical 1115 demonstration requirements. States that pursue these demonstrations may need to invest considerable resources in implementing their quality strategies and satisfying reporting requirements.

› **Administrative Challenges.** In addition to the administrative burden associated with monitoring and reporting, as discussed above, states that implement a capped funding demonstration with significant new program flexibility will essentially be running a separate program alongside existing coverage for other populations such as children and disabled or elderly adults. States will need to remain cognizant of differing substantive standards and procedural requirements with respect to, for example, managed care contracting or beneficiary cost sharing. It remains to be seen how much of a lure the promise of somewhat reduced oversight will be, given that states will still be subject to standard Medicaid rules for the bulk of their Medicaid population and enhanced reporting requirements for their capped funding demonstration population. The financial risk of assuming a cap on federal Medicaid funding thus may not be outweighed by promised flexibilities.

› **Litigation Risk.** States can expect legal challenges to any approved demonstration that includes capped federal funding. The recent litigation around work requirements has shown that these types of legal challenges can be costly and time consuming, and can introduce uncertainty into states' implementation efforts. Legal challenges may take several forms, potentially including arguments such as:

- The Secretary of Health and Human Services lacks the authority to alter Medicaid's financing structure in this way, either under Social Security Act Section 1115(a)(1) (because the financing provisions are not listed among the provisions that may be "waived" in a demonstration project) or under Section 1115(a)(2) (because the Secretary's so-called expenditure authority does not permit changes in the financing structure itself).
- Particular changes that disregard fundamental Medicaid protections—such as cost sharing or drug formularies—may be found to exceed statutory authority under 1115(a)(2).
- A demonstration that restricts enrollment or benefits may not meet the requirement that demonstration projects be "likely to assist in promoting the objectives" of the Medicaid program.
- A change of this magnitude should be effectuated through formal rulemaking—which affords opportunities for public comment—rather than through guidance documents or ad hoc demonstration approvals.

25 The guidance does not explain how CMS will assess excess spending in a demonstration that covers multiple populations subject to *different* matching rates—for example, covering the expansion population at a 90 percent match rate as well as certain optional populations at the state's standard rate. The SMDL suggests that CMS will apply a single overall cap by blending weighted spending projections for all covered groups, and so CMS will perhaps take a similar approach with respect to allocating excess spending above the cap (based on, for example, each population's share of *overall* spending that year). Alternatively, CMS could attempt to allocate spending chronologically by determining the point in time at which spending hit the cap amount and disallowing FFP for all expenditures after that date.

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