



Healthy Adult Opportunity (HAO)



*Center for
Medicaid &
CHIP Services*

January 2020

Overview

- **The Health Adult Opportunity (HAO) is designed to provide states:**
 - **Greater flexibility to improve the health of their Medicaid populations while holding states accountable for a defined budget, the quality of care provided to beneficiaries, and providing access to high quality health care services**
 - **An opportunity to access a full array of waivers that historically have been provided by CMS**
 - Benefits, cost sharing, retroactive eligibility, social determinants of health, additional conditions of eligibility
 - **New opportunities for state innovation**
 - Formulary opportunity to reduce drug costs
 - Inclusion of FQHC services in value-based payment reform efforts
 - Shared savings opportunity

Eligible Populations

- HAO is available to all states and is focused on coverage for adults under age 65 who are not eligible for Medicaid on the basis of disability or need for long term care services and supports, and who are not eligible under a state plan.
- **State Will Have the Opportunity to:**
 - Set additional conditions of eligibility that promote state and federal program objectives, like community engagement
 - Establish flexible cost-sharing structure within broader federal limits
 - Choose a lower income standard or limit to a subset of individuals (e.g., individuals with substance use disorder) at the regular federal match
 - States must cover full new adult group to claim enhanced federal match

Key Beneficiary Protections

- The guidance also clearly articulates the key beneficiary protections to which states will be expected to adhere, including:
 - Following all federal disability and civil rights laws,
 - Following a public and beneficiary notice process, and providing for fair hearing rights,
 - Providing key statutory protections for tribal beneficiaries,
 - Following all public notice requirements when making benefit changes,
 - Maintaining benefits that at a minimum meet the Essential Health Benefits (EHB) standard, and
 - Ensuring that the aggregate limit on premiums and cost sharing of 5% of family income is met.

Eligibility and Enrollment Processes

- **State Will Have the Opportunity:**
 - Not to be required to provide for retroactive coverage or hospital presumptive eligibility
 - To align initial coverage date and renewal with managed care or Exchange enrollment
- **Key Protections/Requirements:**
 - States will still be expected to:
 - Use MAGI and a single streamlined application (with necessary revisions to accommodate HAO), and
 - Meet eligibility standards like electronic verifications, data-driven renewals, timely eligibility determinations, and adequate beneficiary notices and due process protections.

Benefit Package

- All HAO demonstrations are expected to guarantee beneficiaries benefit coverage consistent with private coverage, based on essential health benefits (EHB).
- **States Will Have the Opportunity:**
 - Consistent with Exchange requirements, to align coverage with the EHB benchmark in their state or another state, or propose a set of benefits consistent with EHB policy, and may cover additional benefits at state discretion
 - To cover FQHC services consistent with QHP regulations, as part of value-based payment strategy
 - To provide a drug formulary similar to those in commercial health insurance markets (while still collecting federal drug rebates), allowing for greater negotiating power
- **Key Expectations:**
 - Formulary would cover all drug classes consistent with EHB requirements, with special protections added for behavioral health and HIV
 - Coverage would still meet mental health parity and non-discrimination regulatory standards

Premiums and Cost Sharing

- **States Will Have the Opportunity:**
 - To establish premiums and cost sharing premiums and cost sharing within certain statutory limits
- **Key Protections/Requirements:**
 - Aggregate out of pocket costs still may not exceed 5% of household income
 - Statutory protections for tribal beneficiaries, individuals needing treatment for substance use disorder, and individuals living with HIV and for prescription drugs needed to treat mental health conditions

Delivery System & Payment Models

- **States Will Have the Opportunity:**
 - To determine type of delivery and payment models used under HAO, including fee-for-service, managed care, and premium assistance
 - Separate waivers and authorities to operate these models not required
- **Key Protections/Expectations:**
 - States using managed care would still need to meet certain statutory and managed care regulatory requirements for beneficiary access, quality, and actuarial soundness requirements, even if using alternative approaches

Simplified Application Process

- **Application template:** CMS is providing an HAO application template to facilitate approval of HAO demonstrations. The application will:
 - Help facilitate timely development and review of state proposals
 - Guide states on the full range of policy flexibility available
 - Maximize use of state attestation of compliance instead of extensive narrative
 - Ensure that the necessary information for robust public input is collected
 - Provides for post-approval submission of implementation plan to detail operational plans, with public notice requirements
 - Offer a clear approach to oversight requirements and specifications for which financial and program performance baselines are required as part of the application

Simplified Process for Changes

- CMS will offer flexibility to states to manage their programs with reduced need for further federal approval for administrative and programmatic changes.
- States will still be required to:
 - Comply with approved terms and conditions,
 - Provide advance public notice of any change to the policy, design, or operation of the demonstration
 - Comply with the state's tribal consultation process, and
 - Provide a copy of the public notice to CMS.
- In cases where CMS finds that a planned change is inconsistent with the state's approved demonstration terms and conditions, CMS will have the ability to require the state to seek an amendment.
- States will provide a quarterly update to CMS to summarize any changes that have occurred or attest that no such changes have occurred.

Enhanced Accountability

- HAO envisions enhanced accountability for effectively managing state programs and producing positive health outcomes.
- This will be demonstrated through program integrity requirements, development of a quality strategy, robust monitoring and evaluation, and submission of regular and ongoing key performance metrics and indicators.
 - Program Integrity Strategy: All program integrity requirements like PERM will still apply. States will be required to ensure they continue to make accurate eligibility determinations and receive appropriate federal funds for covered populations.
 - Monitoring and Evaluation: States will be subject to robust monitoring and evaluation requirements similar to all demonstrations, including:
 - Monthly T-MSIS data submissions,
 - Quarterly and annual monitoring reports, and
 - Interim and final evaluations.

Improving Quality of Care

- States will be required to annually report on certain Adult Core Set measures that currently are optional to ensure that beneficiary access to and quality of care is preserved and promoted by the demonstration, including the following examples:
 - Flu vaccinations
 - Screening for depression and follow-up care
 - Controlling high blood pressure
 - Comprehensive diabetes care
 - HIV viral load suppression
 - Follow-up after hospitalization for mental illness
- States also will be required to develop a quality strategy identifying measurable goals and interventions to achieve them.

Real-time Performance Indicators

- CMS has selected metrics that participating states will report to CMS and publicly on a quarterly basis.
- The metrics are intended to provide CMS and states with an early indicator of potential issues impacting access to care so corrective action can be quickly taken, if necessary.
- These measures include, but are not limited to:
 - Number of providers actively enrolled and seeing patients
 - Complaints regarding difficulty in accessing timely services
 - Total emergency department visits per month
 - Retention of beneficiaries at renewal
 - Number of appeals for eligibility or service denials
 - Number of grievances filed, by health plan
 - Claims processing timeliness and rate of denials

Demonstration Financing

- Participating states will be subject to defined spending targets set on either:
 - Annual total expenses, or
 - A per-enrollee basis.
- Spending targets may be adjusted in unforeseen circumstances beyond the state's control.
- States will not be able to claim federal funds for expenditures that exceed their annual spending target.
- The spending targets will be based on the state's historical spending with potential adjustments including factors like regional and national averages.
- Spending targets will be trended forward on a basis tied to the state's historical growth or medical inflation.

Total Expenses Model

- **Base Calculation:** CMS will calculate a base year amount using the prior year expenditures attributable to the populations and benefits included in the state's demonstration.
- **Trend:** The growth rate will be the lesser of the historic growth rate in the state over the prior five years and CPI-M plus one-half of a percentage point (CPI-M + 0.5%).
- **Maintenance of Effort:** To promote program investment, adequate provider rates, and an accurate annual cap amount, states must spend a minimum of 80% of their total spending target annually or they will have their target reduced.
- **Shared Savings:** If a state's annual expenditures are less than the annual limit, the state may qualify for shared savings for reinvestment in their Medicaid program.
- **Rebasing:** If a state seeks to extend an approved HAO demonstration, CMS would re-calculate the base period expenditures needed to establish a new aggregate or per capita cap associated with the new demonstration period.

Shared Savings

- **Allocation of Shared Federal Savings**
 - Between 25 and 50% of any federal savings achieved may be made available to states electing the total expenses model in the form of additional federal matching funds that states must use to reinvest in their Medicaid programs.
- **To receive shared savings, states need to meet certain quality and reporting requirements, including that they:**
 - Demonstrate no declines in access to and quality of care based on required reporting metrics, and
 - Achieve certain performance improvement benchmarks on a set of mandatory quality and access to care measures.

Per Enrollee Model

- **Base Calculation:** Under this option, CMS will determine a per enrollee base amount for each eligibility group included in the demonstration, similar to the per member per month calculations for other section 1115 demonstrations.
- **Trend:** The growth rate will be based on the lesser of the historical growth rate in the state over the previous five years and the medical care component of the consumer price index for all urban consumers (CPI-M).
- **Setting the Target:** The totals for each group will be added together to create an overall target amount.

What HAO is *not*

- **A mandatory change in the program's structure or financing**
 - *This is an optional demonstration opportunity. No state is under any obligation to participate.*
- **Permission for states to strip benefits or limit eligibility**
 - *Participating states must meet minimum benefit requirements and cannot cap or limit adult enrollment while still receiving enhanced federal funding.*
- **A change in coverage for Medicaid's most vulnerable populations**
 - *HAO is limited to adults who are not eligible on the basis of a disability and for whom state coverage is optional.*

Questions?

Questions may also be submitted to:

- Press inquiries: press@cms.hhs.gov
- Other: haodemonstrations@cms.hhs.gov



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