Briefing Book for Missouri Medicaid

Section 5: Benefits and Exchanges/Marketplaces

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Medicaid Benefits and Services

Background and Overview
Under federal law, if a state chooses to participate in Medicaid, every resident of the state who meets the state’s eligibility requirements is entitled to receive covered benefits and services. Within broad federal rules, states are allowed determine which categories of benefits their Medicaid programs will cover and define the specific features of each covered service. States also have the discretion to establish cost-sharing for certain groups and for certain benefits, and may choose different models for services delivery. As a result, Medicaid coverage and delivery of benefits and services varies from state to state. This section provides an overview of Medicaid benefits policy at the federal level and discusses some of the benefit design options for states.

Traditional Medicaid Benefits
Under traditional Medicaid, states are required to cover certain “mandatory benefits,” and can choose to provide other “optional benefits.” The traditional Medicaid program covers a variety of mandatory services, such as inpatient hospital services, lab/x-ray services, physician care, and nursing facility care for persons aged 21 and over. States may cover other optional services, which may include prescription drugs, physician directed clinic services, physical therapy, and prosthetic devices. In addition to traditional mandatory and optional benefits, most states also cover home- and community-based (HCBS) services for certain frail elderly or disabled individuals. Several states include HCBS services in their Medicaid state plans, and 47 States and DC are operating at least one 1915(c) HCBS waiver.

The scope of coverage for a given benefit can and does vary from state to state, even for mandatory benefits. In general, in defining a covered benefit, federal guidelines require that (1) services be sufficient in amount, duration and scope to reasonably achieve their purpose; (2) the amount, duration, and scope of services must be the same statewide; and (3) with some exceptions, beneficiaries must have the freedom of choice of providers among health care practitioners or managed care entities participating in Medicaid.

The MO HealthNet Division of the Missouri Department of Social Services (DSS) runs the Missouri Medicaid program and administers services covered under the Medicaid state plan, including all mandatory Medicaid covered services, as well as several optional services. A detailed list of mandatory and optional services covered under Missouri’s Medicaid program can be found below.
MO HealthNet Mandatory Services

- Inpatient hospital services
- Outpatient hospital services, including those delivered in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Physicians services, including psychiatry
- Family planning services and supplies
- Nursing facility services and home care
- Skilled home health services, including durable medical equipment
- Lab and x-ray services
- Nurse midwife, certified pediatric and family nurse practitioner services
- Medical and surgical services provided by a dentist
- Non-emergency medical transportation
- EPSDT services

MO HealthNet Optional Services

<table>
<thead>
<tr>
<th>Mandatory Services</th>
<th>Optional Services</th>
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<tbody>
<tr>
<td>Inpatient hospital services</td>
<td>Mental health rehabilitation services</td>
</tr>
<tr>
<td>Outpatient hospital services, including those delivered in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)</td>
<td>IMD services for participants over the age of 65 ICF/MR services</td>
</tr>
<tr>
<td>Physicians services, including psychiatry</td>
<td>Inpatient psychiatric services for children under age 21</td>
</tr>
<tr>
<td>Family planning services and supplies</td>
<td>Personal care services</td>
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<tr>
<td>Nursing facility services and home care</td>
<td>Targeted case management</td>
</tr>
<tr>
<td>Skilled home health services, including durable medical equipment</td>
<td>Primary care case management</td>
</tr>
<tr>
<td>Lab and x-ray services</td>
<td>Hospice care</td>
</tr>
<tr>
<td>Nurse midwife, certified pediatric and family nurse practitioner services</td>
<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
</tr>
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<td>Medical and surgical services provided by a dentist</td>
<td>Non-emergency medical transportation</td>
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<tr>
<td>Non-emergency medical transportation</td>
<td>Nursing facility services for participants under the age of 21</td>
</tr>
<tr>
<td>EPSDT services</td>
<td>Critical care hospital services</td>
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</tbody>
</table>

**Benchmark Benefit Packages**

As an alternative to providing mandatory and optional benefits under standard Medicaid, the Deficit Reduction Act of 2005 (DRA) gave states the opportunity to provide benefits specifically tailored to meet the needs of certain Medicaid population groups, to target residents in certain areas of the state, or to provide services through specific delivery systems. The DRA also allows states to impose more than nominal cost sharing for populations with incomes above 100 of the federal poverty level (FPL). These benefit packages are referred to as benchmark or benchmark-equivalent coverage, and they allow states to bypass requirements that have traditionally applied to Medicaid, such as statewideness, comparability, and freedom of choice.

States can generally choose which groups of people they will enroll in the benchmark/benchmark-equivalent benefit plan, but certain populations defined in statute are exempt from mandatory enrollment in a benchmark plan. States are allowed to require
mandatory enrollment in benchmark plans for full benefit eligibles. Medically needy and certain spend-down populations, such as individuals whose Medicaid eligibility is based on a reduction of countable income for costs incurred for medical or remedial care, are excluded from the definition of a full benefit eligible. Specific groups exempt from mandatory enrollment in benchmark benefit packages include those with special health care needs such as disabling mental disorders or serious and complex medical conditions. States can offer these groups voluntary enrollment in a benchmark/benchmark-equivalent benefit plan, but cannot require mandatory enrollment.

Under the DRA, Medicaid benchmark coverage is based on any one of the following plans:

- the Blue Cross/Blue Shield standard provider plan under the Federal Employees Health Benefits Program (FEHBP),
- a plan offered to state employees,
- the largest commercial health maintenance organization (HMO) in the state, and
- other Secretary-approved coverage appropriate for the targeted population.

Benchmark-equivalent coverage packages must have the same actuarial value as one of the benchmark plans identified above and must also include certain benefits: (1) inpatient and outpatient hospital services; (2) physician services; (3) lab and x-ray services; (4) emergency care; (5) well-child care, including immunizations; (6) prescribed drugs; (7) mental health services; and (8) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75 percent of the actuarial value of coverage under the applicable benchmark plan for vision care and hearing services (if any). For children under age 21 in one of the major mandatory and optional Medicaid eligibility groups, benchmark and benchmark-equivalent coverage must include Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The DRA further requires all benchmark and benchmark-equivalent packages to include access to rural health clinics and federally qualified health centers.

Cost-Sharing and Premiums
Under Medicaid, states may require certain beneficiaries to share in the cost of Medicaid services, by paying enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing amounts. There are, however, specific guidelines limiting who may be charged these fees, the services for which they may be charged, and the amount allowed. The DRA provided states with other options for beneficiary obligations for some populations, and the Affordable Care Act expands state authority to significantly increase cost-sharing (including both copayments and coinsurance). States are now permitted to establish higher cost sharing for prescription drugs, for nonemergency use of the emergency department and updates the maximum allowable cost-sharing levels to consolidate provisions. The final rule also creates one
streamlined set of rules for all Medicaid premiums and cost sharing. Specifically, the ACA and related federal provisions establish the following rules:

- Enables providers to deny services to patients with incomes above 100 percent FPL who are not members of exempted groups.
- Enables states to impose cost-sharing for non-emergency care furnished in emergency departments. Under these special rules, agencies may impose cost sharing for non-emergency services (no upper limit for families with incomes greater than 150 percent FPL, and $8 for families with incomes below 150 percent).
- Allows premiums in the case of individuals with family incomes over 150 percent FPL (certain groups are exempt); and
- Bars cost-sharing for certain specified services (emergency services, family planning services and supplies, preventive services that are essential health benefits, pregnancy related care, and “provider-preventable” services (i.e., treatments related to preventable errors).

**Alternative Benefit Plans under the ACA**

Under the ACA, states have the option to expand Medicaid to individuals with family incomes up to 133 percent FPL. This newly eligible group is required to enroll into benchmark or benchmark-equivalent benefit plans, which will now be known as Alternative Benefit Plans (ABP). Certain individuals who qualify for Medicaid under other eligibility categories will be exempt from mandatory enrollment and continue to be entitled to the traditional benefits package. Exempted groups consist of medically frail individuals or individuals with special medical needs, individuals with disabling mental disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their functional abilities, individuals with chronic substance abuse disorders, current and former foster care children, and individuals who meet Social Security Act disability criteria.

Starting in 2014, ABPs must cover at least the essential health benefits (EHBs) that will also apply to plans in the private individual and small group marketplaces. EHB categories include: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) lab services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. The ACA also expands the types of benefits covered under ABPs to include coverage for family planning services and supplies. ABPs that provide both medical and surgical benefits, and mental health or substance use disorder benefits, must also comply with the Mental Health Parity and Addiction Equity Act. To the extent states pay for covered outpatient drugs under their ABPs prescription drug coverage, states must comply with certain federal requirements.
States must define EHBs for Medicaid ABPs by selecting a reference plan from among the following three plans: the state’s largest non-Medicaid HMO; the state’s employee health plan; or the FEHBP BCBS plan. As part of its 2014 State Plan Amendments (SPA), states must identify an EHB reference plan for Medicaid ABPs and must indicate the populations eligible for the ABP, the benefits covered, and the reimbursement methodology. If the reference plan selected fails to cover all EHB categories, then the state must supplement the ABP plan by reference to another plan that does cover the service. As of July 2013, Missouri has not identified an EHB reference plan for MO HealthNet ABPs, as the state has not expanded Medicaid to the newly eligible group at this time.

Coordination between Medicaid and Insurance Marketplaces

The challenges for expanding coverage through Medicaid and the ACA exchanges, and understanding the implications for individuals and families who move between these two programs, are underscored by the fundamental differences between these two sources of coverage. To address this, the ACA allows for a bridge program between Medicaid and exchanges. The ACA requires the HHS Secretary to establish a basic health program (BHP) that meets certain statutorily specified requirements, which states may choose to implement. The purpose of the program is to provide federal funding to states to finance coverage for individuals with income between 133 percent and 200 percent FPL who are not eligible for Medicaid. BHP coverage would be offered in lieu of obtaining coverage through a health insurance exchange for this population. Because a majority of the newly eligible category is likely to churn between Medicaid and Insurance Marketplaces, it will be important for states to consider the BHP option, and look to best practices to coordinate eligibility determinations across insurance affordability programs.

Additional Resources

Coverage Alternatives for Low and Modest Income Consumers

Prepared by: Manatt Health Solutions

The Patient Protection and Affordable Care Act (ACA) describes a continuum of subsidized coverage for individuals with incomes below 400 percent of the Federal Poverty Level (FPL): Medicaid, the Children’s Health Insurance Program (CHIP), Basic Health Program (state option) and advanced premium tax credits (APTCs)/cost-sharing reductions (CSRs) — collectively, insurance affordability programs (IAPs). To ensure a seamless system of coverage, the ACA requires a single streamlined application for all IAPs and a coordinated process for IAP eligibility and enrollment. States are looking beyond the eligibility and enrollment process and are exploring different mechanisms to address the cost-sharing cliff in the Exchange and also to promote continuity of coverage and care as consumers transition across IAPs.

The ACA gives states the option to create a Basic Health Program (BHP), a state-run, subsidized coverage vehicle for individuals with incomes below 200 percent FPL who are eligible for a Qualified Health Plan (QHP) and federal tax subsidies.\(^1\) Some states, particularly those that have already expanded their Medicaid programs above 138 percent FPL, have expressed interest in pursuing a BHP in order to reduce premiums and cost-sharing that lower income families would otherwise have to pay for QHP coverage. In sub-regulatory guidance issued on February 6, 2013, the Centers for Medicare and Medicaid Services (CMS) indicated that it will issue BHP proposed rules for comment in 2013 and final guidance in 2014.\(^2\) Based on this timeline, BHP implementation in interested states cannot occur before the 2015 coverage year.

States have begun to explore coverage models in addition to or as alternatives to the BHP that address either or both affordability in the Exchange and continuity of health plans and providers across IAPs. CMS has expressed willingness to work with states to develop strategies to facilitate coverage continuity and reduce cost-sharing.\(^3\) The following chart, developed by Manatt Health Solutions, provides a side-by-side analysis of coverage alternatives under state and federal consideration including: the Basic Health Program; the Bridge Plan; QHP Premium and Cost-Sharing Support; maintaining existing Medicaid expansions above 133 percent FPL; and Premium Assistance. These options are compared against subsidized QHP coverage available under the ACA.

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ISSUE BRIEF
April 2013

1 Patient Protection and Affordable Care Act, P.L. 111-48, Section 1331.
<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Health Program (BHP)</th>
<th>Bridge Plan</th>
<th>QHP Premium &amp; Cost-Sharing Support</th>
<th>Maintain Existing Expansion</th>
<th>Premium Assistance</th>
<th>Subsidized QHP (Standard ACA)</th>
</tr>
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<tbody>
<tr>
<td>Section 1331 of the Patient Protection and Affordable Care Act (ACA) gives states the option to create a state-run, subsidized coverage vehicle for individuals with incomes below 200% FPL who are eligible for a Qualified Health Plan (QHP) with tax subsidies. The state receives 95% of the value of the advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) for each individual that enrolls in the BHP. By leveraging state purchasing and (presumably) lower than commercial level provider reimbursement, it is anticipated that states will be able to purchase coverage at rates lower than QHPs would otherwise charge, thereby reducing the premiums and cost-sharing obligations of eligible enrollees. In a February 6, 2013 FAQ, the federal government indicated that it will not issue BHP guidance until late 2013, and the program will not be implemented in states until 2015.3</td>
<td>The idea for the Bridge Plan was developed by the State of Tennessee. Bridge Plans are QHPs offered by Medicaid Managed Care (MMC) organizations. Enrollment is limited to consumers transitioning from MMC coverage to Exchange coverage or family members of consumers enrolled in or transitioning from MMC coverage. In a December 10, 2012 FAQ, CMS issued guidance allowing a State-Based Exchange to certify a Medicaid Bridge Plan as a Qualified Health Plan.6</td>
<td>Some states are considering offering subsidies to “wrap around” Exchange coverage, thereby reducing the premiums and cost-sharing obligations of low and modest income individuals purchasing coverage through the Exchange. States could use state-only dollars to wrap. States interested in using federal Medicaid dollars to fund a premium or cost-sharing wrap should contact CMS. States ability to use federal Medicaid funding may depend on whether they had previously expanded coverage under a waiver and have waiver savings.</td>
<td>Some states are contemplating maintaining their existing Medicaid coverage of expansion populations until BHP guidance is available and they are able to implement a BHP or pursue an alternative model.</td>
<td>The January 22, 2013 proposed regulations authorize states to use federal and state Medicaid or CHIP funds to purchase QHP coverage for otherwise Medicaid/CHIP eligible individuals. Some states are considering using premium assistance to buy QHP coverage for pregnant women with incomes above 138% FPL and below the state’s eligibility level for pregnant women; other states are looking at premium assistance to buy Medicaid or CHIP eligible children into the QHP in which their parents are enrolled; and, still others are looking at it for subgroups of their new adults population. All Medicaid rules continue to apply and among other things, the state must provide a cost-sharing and benefit wrap to the extent the QHP covers fewer benefits or imposes greater cost-sharing than is contemplated under federal Medicaid rules. The state must also demonstrate that the cost of premium assistance is comparable to the cost of purchasing Medicaid coverage directly.</td>
<td>As defined in the ACA, individuals with incomes between 100% and 400% FPL are eligible to purchase health insurance coverage through Exchanges with federal subsidies in the form of APTCs and CSRs.</td>
<td></td>
</tr>
<tr>
<td>Participating issuers</td>
<td>Medicaid Managed Care (MMC) plans</td>
<td>MMC plans certified as QHP issuers</td>
<td>QHP issuers</td>
<td>MMC plans (or Fee For Service Medicaid)</td>
<td>QHP issuers</td>
<td>QHP issuers</td>
</tr>
</tbody>
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4 Patient Protection and Affordable Care Act, P.L. 111-48, Section 1331.
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<tbody>
<tr>
<td>Funding</td>
<td>The state receives federal funding equal to 95% of the amount each BHP enrollee would have received through APTC/CSRs had they obtained coverage through the Exchange. Per enrollee amount is subject to year-end reconciliation and the state (not the enrollee) is at risk for over payment. Some limited consumer premium and cost-sharing are likely.</td>
<td>Federal APTC/CSR funding; minimal consumer cost sharing</td>
<td>Federal APTC/CSR funding plus state-only or federal Medicaid funding to wrap premium and cost-sharing obligations of enrollees</td>
<td>State and federal Medicaid dollars with the state’s standard federal match</td>
<td>State and federal Medicaid dollars. Enhanced match rate for &quot;newly eligible&quot; beneficiaries.</td>
</tr>
<tr>
<td>Eligibility Criteria</td>
<td>Individuals with incomes below 200% FPL who are not eligible for Medicaid and are eligible for QHP coverage</td>
<td>Individuals who are APTC eligible and transitioning from MMC, and family members of MMC enrolled or transitioning with income eligibility levels set by the state</td>
<td>Individuals who are APTC eligible likely with income eligibility limits set by the state</td>
<td>Individuals under age 65; not eligible for and enrolled in mandatory or optional Medicaid category; and have a household income above 138% FPL and below income standard established by the state</td>
<td>Medicaid or CHIP eligible individuals</td>
</tr>
<tr>
<td>Product Type</td>
<td>Basic Health Plan</td>
<td>QHP</td>
<td>QHP</td>
<td>Medicaid</td>
<td>QHP</td>
</tr>
<tr>
<td>Benefit Package</td>
<td>Essential Health Benefits (EHB)</td>
<td>EHB&lt;sup&gt;9&lt;/sup&gt;</td>
<td>EHB</td>
<td>Medicaid standard or other benefit design approved in state plan or waiver</td>
<td>EHB plus Medicaid benefit wrap to meet Medicaid coverage requirements</td>
</tr>
<tr>
<td>Rate Development</td>
<td>Unclear. Likely risk adjusted rates set by Exchange or state.</td>
<td>Unclear. Likely risk adjusted rates set by Exchange, state or plan.</td>
<td>Rate filing and prior approval</td>
<td>Medicaid FFS or MMC rate methodology apply</td>
<td>Rate filing and prior approval</td>
</tr>
<tr>
<td>Provider Network</td>
<td>Medicaid network</td>
<td>Medicaid network</td>
<td>QHP network</td>
<td>Medicaid network</td>
<td>QHP network</td>
</tr>
<tr>
<td>Consumer Continuity</td>
<td>Facilitates continuity of plans and providers for low-income individuals who experience income fluctuations up to 200% FPL. Promotes plan continuity for families with members eligible for different insurance products and subsidies (&quot;mixed families&quot;).</td>
<td>Facilitates continuity of plans and providers for some low-income individuals who experience income fluctuations up to income level set by state. Promotes plan continuity for families with members eligible for different insurance products and subsidies (&quot;mixed families&quot;).</td>
<td>No Impact</td>
<td>Facilitates continuity up to expanded Medicaid eligibility level.</td>
<td>Assures continuity of plans and providers as the same plans and provider networks will be available as individuals experience income fluctuations. Also permits pregnant women previously enrolled in a QHP to stay in the QHP while taking advantage of Medicaid's cost sharing and benefit rules.</td>
</tr>
</tbody>
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<sup>7</sup> Supra note 1 at § 1331(d)(3).
<sup>8</sup> Social Security Act § 1902(a)(1)(A)(ii)(XX); 42 CFR § 435.218.
<table>
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</thead>
<tbody>
<tr>
<td><strong>Consumer Affordability</strong></td>
<td>Mitigates cost-sharing “cliff” by offering consumers with incomes up to 200% FPL more affordable coverage than subsidized QHPs.</td>
<td>Mitigates cost-sharing “cliff” for eligible consumers transitioning from Medicaid and their families by offering more affordable coverage than if they transitioned to subsidized QHP coverage.</td>
<td>Mitigates cost-sharing “cliff” by offering low-income consumers more affordable coverage than if they received standard subsidized QHP coverage.</td>
<td>Mitigates cost-sharing “cliff” for consumers with incomes above 138% FPL up to the expanded eligibility level more affordable coverage than available through subsidized QHPs.</td>
<td>Does not address QHP cost-sharing cliff for consumers with incomes above 138% FPL. Consumers will experience an affordability “cliff” as they transition from Medicaid to a QHP.</td>
</tr>
<tr>
<td><strong>State Fiscal Impact</strong></td>
<td>Unclear/potential state funding obligation if cost of program exceeds federal funding.</td>
<td>Requires some state funding. States interested in using federal Medicaid funding should reach out and discuss with CMS.</td>
<td>State foregoes federal tax credit dollars by continuing state Medicaid funding for individuals who would otherwise be eligible to purchase coverage in the Exchange with federal funding.</td>
<td>Premium assistance may be somewhat more costly to state than directly under the state plan or waiver. However, states may find the costs comparable as other factors are considered (e.g. reduced churning, reduced cross subsidization and required increase in Medicaid rates to assure sufficient access).</td>
<td>No state funding obligation</td>
</tr>
<tr>
<td><strong>Provider Reimbursement Impact</strong></td>
<td>Expected to be higher than Medicaid rates but lower than commercial rates.</td>
<td>Commercial rates</td>
<td>Medicaid rates</td>
<td>Commercial rates</td>
<td>Commercial rates</td>
</tr>
<tr>
<td><strong>Exchange Assessments</strong></td>
<td>Do not apply</td>
<td>Apply</td>
<td>Apply</td>
<td>Do not apply</td>
<td>Apply</td>
</tr>
<tr>
<td><strong>Federal Authority</strong></td>
<td>ACA</td>
<td>ACA, Social Security Law, IRS</td>
<td>State Plan Amendment or Waiver</td>
<td>ACA, Social Security Law</td>
<td>ACA</td>
</tr>
<tr>
<td><strong>Issues/Considerations</strong></td>
<td>Federal guidance will not be finalized until 2014 and program may not be implemented until 2015.</td>
<td>Only addresses affordability and continuity for consumers transitioning from Medicaid and their families.</td>
<td>CMS may not approve use of federal Medicaid funding. One issue will be whether the state is able to demonstrate budget neutrality. Does not mitigate plan, benefit, provider continuity.</td>
<td>Leaves federal funding “on the table” for consumers otherwise eligible for tax subsidies. May ease transition burden on consumers and administrative burden on state associated with implementing different coverage models in 2014 and 2015.</td>
<td>Does not address issue of affordability of coverage; does address issues of continuity of coverage and care. May be operationally complicated. Does not mitigate concerns related to continuity, affordability, harm to existing Medicaid expansion populations.</td>
</tr>
</tbody>
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Update: Final Rule on Medicaid and CHIP, Including Essential Health Benefits in Alternative Benefit Plans; Eligibility Notices, Fair Hearings and Appeals Processes; Premiums and Cost Sharing; and Exchange Eligibility and Enrollment

By Sara Rosenbaum

Introduction

On July 5, 2013, the Obama Administration published final rules implementing various provisions of the Affordable Care Act related to Medicaid and CHIP, premiums and cost-sharing, and Exchange eligibility and enrollment. This Update discusses the highlights of this very long rule, which modifies final regulations published in March 2012 as well as previous proposed regulations. The final rule contains four major parts:

A. Medicaid Eligibility Part II Final Rule
B. Essential Health Benefits in Alternative Benefit Plans
C. Exchanges: Eligibility and Enrollment
D. Medicaid Premiums and Cost-sharing

In general, the final rule was adopted with very few changes. At the same time, CMS noted that certain aspects of the proposed rules remain un-finalized, pending additional implementation activities, including further changes necessitated by the Administration’s decision to delay employer compliance-related reporting requirements in connection with the Act’s employer responsibility provisions.

The rules are especially notable for the latitude they afford states to provide comprehensive coverage to newly eligible Medicaid beneficiaries through Secretarial-approved alternative benefit plans (ABPs) that can be significantly broader than the state’s base benchmark plan used to determine the scope of Qualified Health Plan (QHP) coverage through the Marketplace for health insurance. In other words, Medicaid programs can substitute a more generous benchmark for newly eligible beneficiaries, whose coverage by law is limited to benchmark coverage. These more generous benchmarks can essentially cover any type of medical, preventive, or remedial service recognized under federal Medicaid law.

Even as the rules broaden state flexibility to offer comprehensive benefits and extend full mental health and addiction parity to coverage under ABPs, they also preserve Medicaid’s longstanding exclusion of federal payments toward the cost of treatment for residents of institutions for mental diseases. This paradox, which leaves inpatient treatment effectively non-federally financeable, is discussed at the end of this Update.

The final rules also clarify states’ flexibility to significantly increase Medicaid cost-sharing obligations; the final rule estimates approximately $500 million in federal savings as a result of this broader flexibility.

Furthermore, the final rule allows states great latitude over prescription drug coverage through ABPs, with the option of offering narrower, and more tightly managed, coverage than that afforded under traditional Medicaid. At the same time, the final rule applies Medicaid’s drug rebate system to drugs covered under ABPs.
In addition, the final rule clarifies that CHIP funds can be used to extend coverage to children for whom employer-sponsored family coverage is unaffordable, thereby effectively compensating for previous rules issued by the IRS, which define affordability for purposes of premium tax credits and cost-sharing assistance only in relation to the cost of self-only coverage.

Finally, seemingly building on the Administration’s decision on July 2, 2013, to delay the reporting requirements related to the employer shared responsibility provisions of the Act, the final rule allows individuals to secure premium tax credits on the basis of an attestation that they do not have access to affordable employer coverage. In other words, the final rule does not require individuals to complete the worksheet contained in the single streamlined application appendix that enables documentary verification of either the existence of a plan or its cost for purposes of determining whether the individual in fact has access to an affordable employer plan that meets the law’s minimum value test. (Premium tax credits contain an anti-crowdout provision that bars the extension of credits to individuals with affordable employer coverage of minimum value or other form of insurance such as Medicaid.) Because attestation has proven an effective means of deterring fraud in numerous circumstances related to tax liability (individuals who attest to the lack of affordable coverage and are found to have misrepresented their situations face tax liability), the agencies have elected to rely on this approach as the broader issues associated with employer reporting are worked through.

Specific Provisions

Medicaid

Appeals and MAGI Income Calculations

The final rule:

- Retains the proposed rule’s state flexibility to delegate fair hearing authority to an Exchange or an Exchange appeals entity, in the case in which eligibility is denied based on the application of the ACA’s modified adjusted gross income standard (MAGI). The final rule, as with the proposed rule, restricts the power to delegate to situations in which the delegated Exchange is a “government agency which maintains personnel standards on a merit basis.”
- Retains the requirement that states give individuals the option of having their hearing conducted by the Medicaid agency.
- Retains the requirement that states reinstate benefits if a beneficiary requests a hearing within 10 days of being notified of the action.
- Clarifies the minimum Medicaid income standard for parents/caretakers and pregnant women as the state’s May 1, 1988, AFDC income standard, updated to conform to MAGI requirements.

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3 42 C.F.R. §431.11(d).
4 42 C.F.R. §431.205(b).
5 42 C.F.R. §431.231(c).
Clarifies, as in the proposed rule, that with limited exceptions, household income for purposes of eligibility determinations is the sum of MAGI-based income, of every individual included in the individual's household.\(^7\)

Provides for the reinstatement of an application submitted by an individual, as of the date that the application first is received by an Exchange, in situations in which individuals applied to the Exchange and either had withdrawn their application or were assessed by the Exchange as potentially eligible for Medicaid.\(^8\) (This is particularly important in situations in which Exchanges assess eligibility but do not make final determinations, and additional time is needed to determine eligibility via the Medicaid agency.)

**Application and renewal assistance**

The final rule:

- Retains application assistance as a state option, permitting states to certify staff and volunteers of “State-designated organizations” to act as application assisters, authorized to assist in applications and renewals.\(^9\)
- Defines assistance as including “providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, working with the individual to provide required documentation, submitting applications and renewals to the agency, interacting with the agency on the status of such applications and renewals, assisting individuals with responding to any request from the agency, and managing their case between the eligibility determination and regularly scheduled renewals.
  - Clarifies that assisters may be certified by the agency for one or more of these activities.\(^10\)
  - Requires notice of application assistance to applicants and beneficiaries and prohibits assisters from seeking compensation in any form from applicants or beneficiaries for their work.\(^11\)

**Electronic Notices**

The final rule:

- Requires that by January 1, 2015, agencies must give individuals a choice as to whether to receive required notices in electronic format and confirm the choice by regular mail.

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\(^6\) 42 C.F.R. §§435.110 and 116.
\(^7\) 42 C.F.R. §435.603(d).
\(^8\) 42 C.F.R. §435.907.
\(^9\) 42 C.F.R. §435.908(c).
\(^10\) 42 C.F.R. §435.908(c)(2).
\(^11\) *Id.*
Authorized representatives

The final rule:

- Requires agencies to permit applicants and beneficiaries to designate “an individual or organization to act responsibly on their behalf in assisting with the individual’s application and renewal of eligibility and other ongoing communications with the agency.”¹²
- Sets rules for authorized representatives related to fulfilling the scope of the authorization, maintaining confidentiality, and other matters.
- Does not impose minimum training or certification requirements on authorized representatives.

Premium Assistance

The final rule:

- Retains the January 2013 proposed rule, which authorizes Medicaid agencies to receive federal funding if they purchase QHPs sold in the individual Exchange market.¹³ (See earlier update on Medicaid premium assistance.)
  - Specifies that premium assistance programs must meet 4 conditions: the insurer is obligated to be the primary payer to Medicaid for all contractual services; the agency covers all Medicaid services not included in the contract; cost-sharing adheres to Medicaid rules; and the total cost of purchasing such coverage including administrative costs and the cost of the additional cost-sharing charges the agency must pay, is “comparable” to the cost of providing direct coverage under the state plan.
  - Prohibits states from requiring individuals to receive premium assistance or direct coverage.

Presumptive Eligibility

The final rule:

- Allows states to extend coverage to children, pregnant women, persons receiving family planning services, and breast and cervical cancer patients during a presumptive eligibility period.¹⁴
- Requires states to allow “qualified hospitals” to determine presumptive eligibility and defines qualified hospitals as any Medicaid participating hospital that opts to provide presumptive eligibility.¹⁵

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¹² 42 C.F.R. §435.923.
¹³ 42 C.F.R. §435.1015.
¹⁴ 42 C.F.R. §§435.1102 and 1103.
¹⁵ 42 C.F.R. §435.1110.
Coordinated Eligibility Across Insurance Affordability Programs

The final rule:

- Requires Medicaid agencies to begin accepting single streamlined applications during the initial open enrollment period commencing October 1, 2013, either directly or from another insurance affordability program (i.e., Exchanges),\textsuperscript{16} even though coverage for newly eligible adults as well as MAGI based coverage does not begin until January 2014.
- Requires agencies to begin making MAGI determinations and for applicants ineligible for Medicaid, electronically transfer files to other insurance affordability programs.\textsuperscript{17}
- Requires agencies to furnish Medicaid promptly to applicants who are eligible under 2013 standards.

Preventive Services

The final rule:

- Adopts as final the proposed expanded definition of preventive services, which allows coverage for preventive services (as defined) that are either furnished or recommended by a physician or other licensed health care provider.\textsuperscript{18}

Alternative Benefit Plans

The final rule:

- Adopts previously proposed rules that define "alternative benefit plans" (ABPs) for individuals enrolled in "benchmark" or "benchmark equivalent" coverage under §1937.\textsuperscript{19}
- Clarifies that beneficiaries who fall into the new eligibility category created by the ACA must enroll in ABPs as a condition of eligibility.\textsuperscript{20}
- Clarifies states’ option to require ABP enrollment for other eligibility groups that were eligible for Medicaid in 2006 and who could have been required to enroll in ABPs.
- Clarifies the groups that must be exempted from ABP enrollment requirements, while requiring that exempt groups must be given the option of an ABP “that includes all benefits available under the approved state plan.”\textsuperscript{21}
  - Exempted groups consist of medically frail individuals or individuals with special medical needs, individuals with “disabling mental disorders”, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that

\begin{footnotesize}
\footnote{16} 42 C.F.R. §435.1205. \\
\footnote{17} Id. \\
\footnote{18} 42 C.F.R. §440.130(c). \\
\footnote{19} 42 C.F.R. §435.305. \\
\footnote{20} Id. \\
\footnote{21} Id.
\end{footnotesize}
significantly impairs their functional abilities, individuals with chronic substance abuse disorders, current and former foster care children, and individuals who meet Social Security Act disability criteria.22

- Finalizes proposed rules providing that benchmark health benefits coverage offered under ABPs can consist of “any other health benefits coverage that the Secretary determines, upon application by a state, provides appropriate coverage to meet the needs of the population provided coverage.”23 Further clarifies that “benchmark equivalent coverage” may, at state option, include “coverage for any additional benefits of the type which are covered in 1 or more of the standard benefit coverage packages, or State Plan benefits described in law, and any other Medicaid state plan benefits enacted under Title XIX.”24

- Clarifies that ABPs must: (i) cover family planning services and supplies but does not specify how required Medicaid benefits may differ from the EHB requirements related to family planning; (ii) comply with mental health parity (as explained in a January 16, 2013 letter to state health officials on the Mental Health Parity and Addiction Equity Act);25 (iii) comply with §1927 of the Act (related to prescription drug coverage) “to the extent states pay for outpatient drugs under their ABP prescription drug coverage.”26

- In the preamble, clarifies that under §1937(b)(4) of the Act, states would be required to “assure access . . . to both rural health clinic and FQHC services, even if the state does not contract with an FQHC or rural health clinic” and that payment to both providers must be in accordance with Medicaid’s special payment methodologies.27

- Reiterates in the preamble that EPSDT for individuals under age 21 is a requirement for individuals enrolled in ABPs.28

**Essential Health Benefits**

The final rule:

- Specifies in the preamble that states have the flexibility to define habilitative services and devices for EHB purposes, as long as the definition is “at a minimum no or restrictive in terms of amount, duration, and scope than rehabilitative services and devices.”29

- Clarifies that prescription drug coverage in the case of ABPs is governed by the essential health benefit rules, which permit broad flexibility in drug coverage, rather than by the special Medicaid

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22 42 C.F.R. §440.315(f) and (h). See discussion of CMS decision to extend medically frail status to persons with substance use disorders in Preamble, Public View, pp. 257-260. The question of whether to include such individuals was raised in the proposed rule.
23 42 C.F.R. §440.330(c).
24 Specifically, benefits described in §§1905(a), 1915(i), 1915(j) and 1945. These sections describe all Medicaid state plan services as well as special waiver services for children and adults in need of home and community based care and independent living services.
25 CMS also clarifies in the Preamble that the Medicaid IMD exclusion extends to mental health benefits provided through an ABP. “Thus we clarify that the IMD payment exclusion applies to coverage offered through ABPs” (p. 139). As a result, while parity ostensibly applies, federal funding is not available for treatment for individuals who are residents of IMDs.
26 42 C.F.R. §440.345.
27 Preamble, public view, pp. 145-146.
28 Preamble, public view, p. 147.
29 Preamble, public view, p. 205.

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coverage standards established under §1927, which provide special rules regarding the scope of
drugs covered, the use of utilization management, drug benefit design, and emergency supplies.\textsuperscript{30}
As such, it would be acceptable to use private insurance utilization management techniques and
other techniques such as quantitative limits on the number of prescriptions.\textsuperscript{31} Thus, although in
CMS’ view, rebate rules apply, the §1927 protections do not.\textsuperscript{32} States may use a benchmark
equivalent benefit design that broadens coverage, but are not compelled to do so.

- Clarifies that states may select more than one base benchmark option for EHBs “in keeping with
  the flexibility for States to implement more than one ABP.”\textsuperscript{33}
- Bars EHB designs that discriminate based on disability, age, expected length of life, degree of
  medical dependency or other health condition but does not offer examples.\textsuperscript{34}
- Specifies that coverage for newly eligible beneficiaries is limited to the EHB categories, but also
  provides that states can design EHB categories that broaden coverage (through the use of
  benchmark-equivalent plans) within the categories to include the far broader range of benefits
  available under Medicaid.\textsuperscript{35}
- Clarifies (in the Preamble) that preventive services that are part of the EHB package must be
  covered without cost-sharing, but that state Medicaid agencies may apply cost-sharing
  requirements to other preventive services not identified as part of the EHB (i.e., not identified by
  the USPSTF, the ACIP, or by HRSA in its women’s and children’s preventive health guidelines).\textsuperscript{36}

Public Notice

The final rule:

- Retains the proposed rule, which requires that prior to submitting to CMS a state plan amendment
to establish or “substantially modify” an Alternative Benefit Plan, the state must provide the public
with advance notice and reasonable opportunity to comment, including commenting on the
requirement that states maintain a “method for assuring compliance with . . . full access to EPSDT
services” and changes related to premiums and cost-sharing.\textsuperscript{37}

\textsuperscript{30} Preamble, public view, p. 219.
\textsuperscript{31} Id. at 220.
\textsuperscript{32} Id. at 221-229.
\textsuperscript{33} 42 C.F.R. §440.347(c).
\textsuperscript{34} 42 C.F.R. §440.347(e).
\textsuperscript{35} 42 C.F.R. §440.360.
\textsuperscript{36} Preamble, public view, pp. 237-243.
\textsuperscript{37} 42 C.F.R. §440.386 Specifically, the final rule references §5006(e) of the American Recovery and Reinvestment Act of 2009,

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Cost-sharing and Premiums

The final rule:

- Retains the structure of the proposed rule, which expands states authority to significantly increase cost-sharing (including both copayments and coinsurance) and enables providers to deny services to patients with incomes above 100% FPL who are not members of exempted groups.
  - Exempt groups consist of most but not all infants and children, children receiving child welfare services, pregnant women, most individuals receiving home and community based care, individuals receiving hospice care, individuals being treated for breast or cervical cancer, and Indians.38
- Retains proposed rules enabling states to impose cost-sharing for non-emergency care furnished in emergency departments. Under these special rules, agencies may impost cost sharing for non-emergency services (no upper limit for families with incomes greater than 150% FPL, and $8 for families with incomes below 150%). Furthermore, agencies can impose cost-sharing for using the ED for non-ED purposes even on otherwise exempt groups such as infants and children.39 The final rule permits these policies as long as:
  - The hospital providing the care conducts an EMTALA-level screening in determining that no emergency condition exists.
  - Before providing non-emergency care, the hospital informs the patient of the charge, provides the name and location of an available and accessible alternative non-emergency services provider, determines that the provider can furnish care in a timely manner at lesser or no cost, and provides a referral to coordinate the care.40
- Specifies, as in the proposed rule, that premiums are permissible in the case of individuals with family incomes over 150% FPL, while recognizing certain exempt groups.41
- Adopts in final form proposed rules barring cost-sharing for certain specified services (emergency services, family planning services and supplies, preventive services that are essential health benefits, pregnancy related care, and “provider-preventable” services (i.e., treatments related to preventable errors).42

CHIP

The final rule:

- Limits the premium lock-out period (i.e., the period during which coverage can be denied for nonpayment of premiums) to 90 days.43

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38 42 C.F.R. §441.56.
39 42 C.F.R. §447.54.
40 Id.
41 42 C.F.R. §447.155.
42 42 C.F.R. §447.56(a)(2).
43 42 C.F.R. §457.10.
• Makes conforming amendments related to open enrollment, notice of agency determinations, and other application processes to align CHIP with Medicaid and Exchange processes.44
• Limits CHIP’s permissible period of exclusion following disenrollment from a group plan to 90 days.45
• Bars the use of waiting periods when the loss of coverage involves Medicaid or another insurance affordability program.46
• Prohibits the use of waiting periods if: (i) the amount charged for family coverage under a group health plan exceeds 5% of household income; (ii) the employer sponsored insurance for the parent is determined to be unaffordable and the parent thus becomes eligible for premium tax credits; (iii) the cost of family coverage exceeds 9.5% of household income; (iv) the employer stops offering dependent coverage; (v) a change in status results in the loss of employer coverage; (vi) the child has special health needs; and (vii) the child lost coverage due to the death of a parent.47

Issues

The final rule raises several issues related to state flexibility. It also contains areas of ambiguity.

• How will states use their flexibility? The final rule gives states broad flexibility over benefit design, including the scope of benefits extended to newly eligible beneficiaries as well as cost-sharing requirements. The rule also allows states to utilize a premium support approach to coverage. How will states utilize these areas of flexibility to shape coverage, align Medicaid and Exchange coverage, and potentially reduce the fall-out from coverage churn, that is, the problem of moving back and forth between sources of insurance affordability as a result of modest income fluctuations?

• Will the ambiguities in family planning coverage be resolved? The final rule underscores that ABPs for Medicaid beneficiaries are guided by the EHB requirements, which include all FDA-approved contraceptive services as well as other preventive services related to family planning. This definition of family planning is actually different from the family planning benefit under traditional Medicaid, which according to the rules, states also must comply with. Indeed, in some states the Medicaid family planning benefit may be narrower because not all FDA-approved contraceptive services are covered. CMS has promised to clarify the issue in future guidance.

44 42 C.F.R. §457.348 et seq.
45 42 C.F.R. §457.805(b).
46 42 C.F.R. §457.805(b)(2).
47 42 C.F.R. §57.805(b)(3). In other words, this provision compensates for the earlier decision by the Administration to define affordability in an employer coverage context only in relation to the cost of self-only coverage and not in relation to the cost of family coverage. Where coverage is affordable for the worker but unaffordable in terms of family coverage, the rule permits the family to enroll its children in CHIP. Furthermore, the rule permits CHIP as “wraparound” coverage to employer coverage for children with special needs.

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The tension between mental health parity and the Medicaid IMD exclusion. In what many may regard as a strange twist, CMS concluded – simultaneously – that both mental health parity and the Medicaid IMD exclusion apply to ABPs. How, might one wonder, could this be? According to CMS (final rule, public view, p. 139) the Mental Health Parity and Addiction Equity Act (MHPAEA) affects benefit design. The Medicaid IMD provision, by contrast, is a payment exclusion. Thus, while ABPs must offer parity of coverage, no federal financial participation is available to help defray the cost of treating persons who are considered residents of inpatients for mental diseases, meaning that while they may receive mental health or addiction treatment as inpatients, another source of funding will have to pay these costs. The simultaneous application of both parity and the IMD exclusion in the same rule underscores the many paradoxes that arise when a longstanding program such as Medicaid is re-tooled for the modern era. How states will respond to this paradox is of course not yet clear.
Getting into Gear for 2014:

Prepared by:

Martha Heberlein, Tricia Brooks, and Joan Alker
Georgetown Center for Children and Families

and

Samantha Artiga and Jessica Stephens
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

January 2013
The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid’s role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation’s Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission’s work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman
Diane Rowland, Sc.D.
Executive Director
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EXECUTIVE SUMMARY

As 2013 begins, implementation of the major provisions of the Affordable Care Act (ACA), including its coverage expansions, is less than a year away. Following the Supreme Court ruling to uphold the ACA and the 2012 elections, efforts to prepare for 2014 are moving into high gear in many states. During the past year, a number of states shifted focus to wide-ranging improvements in Medicaid enrollment processes and systems and a number continued to make more targeted eligibility or procedural improvements (Figure 1). Similar to recent years, Medicaid and the Children’s Health Insurance Program (CHIP) continued to be bedrock sources of coverage for children and, to a lesser degree, their parents, as the ACA requirement for states to maintain eligibility levels and enrollment and renewal procedures remained in place. Modest improvement in the economy curbed Medicaid enrollment growth and its impact on state budgets. Yet, continuing fiscal constraints prompted a number of states to increase cost-sharing and a handful eliminated coverage for adults under limited exceptions to the requirement for states to maintain eligibility.

At this pivotal time, this twelfth annual report provides a snapshot of current Medicaid eligibility and enrollment policies and procedures and highlights changes states will need to make in the coming year to implement the Medicaid provisions of the ACA. Conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, it provides results from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP, documenting changes made during 2012 and policies in place as of January 1, 2013.

Medicaid and CHIP Eligibility

Targeted improvements strengthened the role of Medicaid and CHIP as primary sources of coverage for low-income children and pregnant women. In 2012, eligibility levels for children and pregnant women remained stable, as intended by the ACA requirement to maintain coverage. The median eligibility level is 235 percent of the federal poverty level (FPL) for children and 185 percent of the FPL for pregnant women as of January 1, 2013 (Figure 2). Small improvements for children and pregnant women occurred in ten (10) states largely through continued state take-up of new options in the ACA and the 2009 CHIP Reauthorization Act (CHIPRA) to cover dependents of state employees and lawfully-residing immigrant children and pregnant women without a five-year waiting period.

![Figure 1: State Medicaid and CHIP Policy Actions for Low-Income Families, January 2012 – January 2013](image1)

![Figure 2: Median Medicaid/CHIP Eligibility Thresholds, January 2013](image2)
Adult eligibility continues to fall far short of that for children, and a few states scaled back coverage for parents and other adults during 2012. Parent eligibility levels remain very low, with the median level at just 61 percent of the FPL. Moreover, only nine (9) states provide full Medicaid coverage to other adults without dependent children. One state (CO) added coverage for adults to Medicaid through a limited expansion in 2012. In addition, Utah increased eligibility for its Section 1115 waiver premium assistance program for adults from 150 to 200 percent of the FPL. In contrast, three states (HI, IL, and MN) reduced eligibility for adults where it was not protected by the federal requirement to maintain eligibility.

The ACA Medicaid expansion would significantly increase eligibility for parents in many states, with even larger potential coverage gains for other adults. The ACA creates a new continuum of public and private coverage options, including extending Medicaid to a eligibility floor of 138 percent of the FPL in January 2014, with significant federal financing. This expansion would fill the substantial coverage gaps for low-income parents and other adults. Although the Supreme Court ruling upheld the Medicaid expansion, it limited the federal government’s ability to enforce it, effectively making implementation a state choice. If a state does not expand Medicaid, poor uninsured adults in that state will not gain a new affordable coverage option and likely remain uninsured. Currently, 33 states limit parent eligibility to less than 100 percent of the FPL, with 16 limiting eligibility to less than 50 percent of poverty (Figure 3). Moreover, the majority of states do not provide Medicaid coverage to low-income childless adults, regardless of how low their income is (Figures 4).

Use of Technology to Re-engineer Processes and Enhance Systems

States are pressing forward to develop high-performing eligibility and enrollment systems. During 2012, final regulations were released that outline new requirements for web-based, paperless, real-time eligibility and enrollment processes that will go into place in 2014. States also will need to coordinate closely with exchanges in implementing these processes to establish a “no wrong door” enrollment approach, so that, regardless of a person’s point of entry (i.e., the individual exchange or Medicaid), eligibility is determined for all insurance affordability programs. States must meet these new requirements regardless of whether they expand Medicaid. Many states have already harnessed technology to facilitate families’ access to coverage and gain administrative efficiencies. Moving forward, advanced use of technology holds the promise of further revolutionizing the Medicaid enrollment experience.
Taking advantage of a time-limited 90 percent federal matching rate available for systems development, almost all states are moving forward with major updates to their information technology (IT) infrastructure. As of January 1, 2013, 47 states have submitted or received approval for an advanced planning document (APD) to institute system upgrades, and 42 have already launched their system development work (Figure 5). In addition to this significant federal funding, CMS is providing technical assistance and has created a central repository for states to pool resources on IT development and reuse technology developed by leader states.

The majority of states are capitalizing on web-based tools to facilitate individuals’ access to coverage and ease administrative burdens. As of January 1, 2013, more than two-thirds (37) of states have an electronic online application in Medicaid or CHIP, an increase of four states over last year (Figure 6). Over half (28) of states allow families to renew online, including eight states that added this capability in 2012. Moreover, over two-thirds of states (36) provide online accounts. However, less than half of these accounts provide advanced features, such as the ability to receive paperless notices or upload electronic images of documents, which maximize the efficiency of online processes.

Illustrating the effectiveness of electronic verification, the large majority of states (45) have adopted a data match with the Social Security Administration (SSA) to verify citizenship in Medicaid or CHIP. States have quickly adopted the new option provided by CHIPRA to verify citizenship through an electronic data match with the SSA and have reported increased efficiency as well as highly successful match rates. This experience serves as a precursor to the new federal data hub established by the ACA to help states electronically confirm eligibility criteria as of 2014. State data sources can be tapped in a similar expedited fashion, and, as of January 1, 2013, 11 states report they have a state data hub that allows them to access multiple information sources at once. However, paper still remains the predominant method currently used by states to verify income. As such, movement to electronic verification under the ACA will represent a major procedural and cultural change for many states.
**Outreach, Enrollment, and Renewal Policies**

As the ACA is implemented, states will build on existing outreach and enrollment assistance resources to connect eligible people to coverage. As of January 1, 2013, a majority of states offers in-person assistance at eligibility offices, a toll-free assistance hotline, and/or provides assistance at the local level through out-stationed state eligibility workers or by funding community-based application assisters (Figure 7). Enrollment efforts under the ACA will extend this base through call centers, navigators, and other assistance programs.

Building on previous progress in streamlining enrollment and renewal processes, the ACA will continue to transform how families connect to coverage. For example, while most states have already eliminated asset tests and face-to-face interview requirements for children, a number will need to remove these barriers for parents in the coming year. States must also continue to expand the avenues available to families to apply for and renewal coverage to include online, telephone, in-person, and mail options. As of January 1, 2013, all states offer in-person and mail-in enrollment and renewal options. However, fewer states offer both online and telephone enrollment (16) and renewal (19). Moreover, beginning in 2014, states will be required to conduct annual renewals based on available information rather than requesting information and documentation from individuals. The vast majority of states (46) already have twelve-month renewal periods for both children and parents, but fewer states (22) seek to automatically renew coverage based on available information. As states move to these streamlined, data-driven procedures, they also will need to adjust eligibility worker roles and expectations to align with the new paradigm.

**Cost-Sharing**

During 2012, a majority of states did not impose additional cost-sharing requirements on families even though they continued to experience budget constraints. States generally cannot increase premiums under current federal requirements to maintain eligibility and enrollment policies. As such, premium changes were minimal and largely routine annual adjustments or modest increases to reflect inflation, as allowed under current requirements. States are not restricted from increasing co-payments within federal program limits, and nine (9) made such increases in 2012.

**Conclusion**

The ACA’s Medicaid expansion and requirements for a modern, simplified enrollment experience build on states’ accomplishments in covering children and accelerate the adoption of proven strategies. As states face a shrinking timeline to prepare for 2014, much work remains to be done and it will be important for states to leverage the experience of those leading the way. As they prepare for 2014, a key choice facing states is whether to expand Medicaid. If a state does not expand, poor uninsured adults in that state will not gain a new affordable coverage option and likely remain uninsured. Thus, 2013 will be a pivotal year as states weigh this decision and move into the final preparations for 2014.
Implementing the Alternative Benefit Plan

Carolyn Ingram, Senior Vice President
Shannon McMahon, Director of Coverage and Access

State Network Medicaid Small Group Convening
April 25, 2013
Agenda

• Alternative Benefit Plan (ABP) Overview
• Churn and Coverage Shifts
• Considerations for Selecting an ABP
• Benchmark Comparison
• Options and Next Steps
Benchmark Coverage Required for Adult Expansion Group

- Alternative Benefit Plan must:
  - Cover 10 essential health benefits (EHBs)
  - Meet mental health parity requirements
  - Provide EPSDT services for those under age 21
  - Assure non-emergency transportation
  - Cover prescription drugs

10 EHBs
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
# State Benefit Design Options

**Medicaid ABPs**

- Secretary-approved option
- Generally available and offered state employee coverage
- Standard Blue Cross Blue Shield Federal Employees Health Benefit Program package
- Commercial HMO with largest non-Medicaid enrollment

**EHB Benchmarks**

- The three largest plans by enrollment in the small-group insurance products
- The three largest state employee plans by enrollment
- The three largest national Federal Employees Health Benefit Program plan options by enrollment
- The largest fully insured commercial HMO product in the state
Individuals Exempt From Mandatory Enrollment in Benchmark/Expansion

- Pregnant women
- Individuals who qualify for Medicaid based on blindness or disability
- Dual eligibles
- Terminally ill hospice patients
- Inpatients in hospitals, nursing homes, and intermediate care facilities
- Children in foster care
- TANF/Section 1931 parents and caretakers
- Medically frail individuals
- Individuals who qualify for long-term care services based on their medical condition
- Individuals who only qualify for emergency care
- Individuals who qualify based on spend down
Considerations for States in Selecting ABPs

• Population
  ► Where will they seek care?
  ► What are their needs?
  ► Where do they live?

• Cost
Cost Considerations for ABP Selection

- Declining FMAP post-2016
- Cost-sharing options (maximum amount):
  - Outpatient: $4
  - Prescription drugs
    - Preferred drugs: $4
    - Non-preferred drugs: $8
  - Non-emergency ED: $8
  - Aggregate <5% family income

Enhanced FMAP
Newly Eligible Adults up to 133% FPL

<table>
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Selecting an ABP: Following CMS Guidance

1. Process for defining ABP
2. Targeting ABPs for specialized populations
3. Applicability of EPSDT services
4. Preventive services must be covered
5. State notice requirements
6. Medically frail exemption
7. Secretary-approved option flexibility
8. Benchmark equivalent coverage
35% Churn in **6 Months**
Adults < 200% FPL

**January 2014**
- 25 M Medicaid
- 0 M Churn
- 31M Exchange

**June 2014**
- 16 M Medicaid
- 20 M Churn
- 20 M Exchange

= 2 Million People
Using ABPs to Promote Seamlessness

• Alignment reduces service disruption:
  - Eligibility, providers, benefits

• “Secretary-approved” option gives flexibility, but requires greater administrative effort

• What happens if benchmark for EHBs is also used for Medicaid ABP?

**EXAMPLE**
Using commercial HMO (largest non-Medicaid enrollment) for EHB package for Medicaid, individual, and small group markets to build seamlessness example
State Considerations: Selecting a Commercial Plan for Medicaid ABP

- Often not covered in commercial benefits:
  - Dental (will require “wrap” for pediatric)
  - Vision (will require “wrap” for pediatric)
  - Bariatric surgery
  - Routine foot care
  - Habilitative services
  - Transportation

- Programming a new benefit into systems for different populations may be challenging, as states are rolling out new eligibility and enrollment systems.
Top of Mind for States: Mental Health Parity and Addiction Equity (MHPAEA) for Expansion Adults

- Current applicability to MCO vs. FFS
- CHIP vs. state plan Medicaid
- All ABPs, existing and future, must comply with MHPAEA
- Applicability to carve outs
States Should Seek Ease of Administration in Selecting ABP

☑ Reduce administrative burden for providers, clients, plans and Medicaid agency.
☑ Selecting delivery system (i.e., MCO)
☑ Assessing technology infrastructure
☑ Tracking and managing different eligibility groups for FFP claiming
States Should Require Input from Various Entities in Selecting ABP

- Conducting stakeholder engagement
- Determining approach for secretary approved option/comparison requirements
State Approaches to ABP Selection

- Secretary-approved option
  - **Washington**: Flexibility will help ensure alignment

- Suitability of commercial options for Medicaid beneficiary needs
  - **Oregon**: Marketplace small group benchmark plan selection is not rich enough for expansion population

- Using previous state experience with expansion
  - **New Mexico**: SCI expansion served as a pilot and provides valuable lessons learned
# Contact Information

<table>
<thead>
<tr>
<th>CONTACT</th>
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<tbody>
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Creating Seamless Coverage Transitions Between Medicaid and the Exchanges

Prepared by Carolyn Ingram, Shannon M. McMahon, MPA and Veronica Guerra, MPA, Center for Health Care Strategies, Inc.

IN BRIEF
Under health reform, Medicaid will expand in 2014 to cover an additional 16 to 20 million beneficiaries. This population will include a significant percentage of childless adults with urgent and complex health care needs, who are likely to shift between subsidy programs over time. This brief draws from current programs that have dealt with this challenge successfully, with the hope that their experience will help guide seamless coverage transitions between Medicaid managed care organizations and qualified health plans in the exchanges. A companion chart includes excerpts of sample contract language related to coverage transitions in existing programs.

INTRODUCTION
The 2014 expansion of Medicaid under the Affordable Care Act (ACA) will cover 16 to 20 million new beneficiaries, most of whom will be childless adults with incomes below 138 percent of the federal poverty level (FPL). Many of these individuals are likely to have complex health care needs and pent-up demand for care.\(^1\) Due to fluctuations in income, this population is also likely to “churn” between existing Medicaid programs, the new Medicaid expansion, subsidized exchange qualified health plans (QHPs), and possibly state-run basic health plans, creating a heightened need for seamless coverage transitions across state health care programs.\(^2\) While the Affordable Care Act (ACA) offers numerous opportunities to stabilize coverage for beneficiaries as their incomes rise and fall, the path is far less clear for creating continuous care.

This brief examines how seamless coverage transitions can be supported through policies designed to provide continuous care for individuals moving between health insurance products, plans, and providers. It reviews lessons from: (1) existing exchange programs in Massachusetts; (2) transition coverage policies within

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Tennessee’s proposed exchange model; and (3) current transition practices between Medicaid managed care organizations (MCOs) and other programs. These models offer insights to aid states in developing coverage linkages between current public programs, programs for the future Medicaid expansion population, and options provided by proposed insurance exchanges. A companion chart summarizes existing coverage transition practices from various sources, including: (1) state Medicaid managed care contracts; (2) the National Committee for Quality Assurance (NCQA); and (3) Medicare Part D. Sample contractual language related to coverage transitions is also provided. This preliminary review is not intended to be exhaustive; rather, it is meant to raise considerations for states as they develop coverage approaches between Medicaid and a state or federal exchange.

This analysis stems from work done to help the state of Maryland assess contractual requirements related to coverage transitions. As of early April 2012, the Maryland General Assembly was finalizing a bill to establish its health insurance exchange. Both the House and Senate versions of the bill include a provision that requires the state’s exchange to address coverage transitions across Medicaid and the future QHPs within the exchange. Although originally developed as a resource for Maryland, this brief offers value to all states in establishing provisions to preserve care continuity across health insurance coverage programs.

**UNDERSTANDING THE IMPORTANCE OF COVERAGE TRANSITIONS**

Within a six-month timeframe, it is projected that more than 35 percent of all adults with family incomes below 200 percent of FPL will experience a shift in eligibility from Medicaid to coverage provided by an insurance exchange. Additionally, within a year, an estimated 28 million individuals will transition from coverage through an exchange to Medicaid.³ For the population that will churn between Medicaid and QHPs, strategically designed coverage transitions can help ensure continuity of care with current providers or health care delivery systems. Smooth coverage transitions are particularly crucial to minimize disruptions in services for individuals who are in a prescribed course of treatment, e.g., radiation or chemotherapy, as well as those with special health care needs. This latter population includes those who have serious and chronic physical, developmental, and/or behavioral health conditions requiring medically necessary health and related services beyond those required by the typical beneficiary. Some states also include pregnant women, people who are hospitalized at time of transition, and individuals who received prior authorization for services from the relinquishing contractor in this higher-need subset of patients who require a more intense level of services over a short period of time. In other states, including Arizona, a beneficiary is considered to have special health care needs if a medical condition lasts, or is expected to last, one year or longer and requires ongoing care by a specialty provider.

In establishing the exchanges, states need to develop policies on how to transition coverage for individuals in a current course of treatment as well as for special needs populations as they churn beyond Medicaid into the exchange and vice versa. Of particular interest is how provider networks will be developed in QHPs to ensure access to essential community providers, such as federally qualified health centers (FQHC) or the Indian Health Service (IHS). Many low-income individuals with special health care needs will want to continue to see their existing providers, including safety-net providers, even as they move to a commercial network on the exchange. This raises a critical continuity of care issue. Indeed, recently issued regulations require QHPs to include in their provider networks a “sufficient number and geographic distribution of Essential Community Providers (ECPs) to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the QHP service areas,” yet do not mandate that all ECPs be included as enrolled providers.⁴ The regulation also allows flexibility for QHPs in how safety net providers are reimbursed. Specifically, the regulation does not require QHPs to contract with ECPs that refuse to accept “generally applicable payment rates.”⁵ However, the regulation requires QHPs to pay FQHCs the relevant Medicaid prospective payment system (PPS) rate. Alternatively, QHPs may pay a mutually agreed-upon rate to the FQHC provided that such rate is at least equal to the QHP issuer’s generally applicable rate.⁶

⁴ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers 77 FR 18470, page 18470.
⁵ Ibid.
⁶ Ibid.
Given the new federal contracting requirements for QHPs, states will need to examine policies that ensure provider continuity of care. In addition, beneficiaries may have an ongoing treatment cycle with a particular drug, e.g., a chemotherapy drug that may not be on the formularies held by the individual’s current health plan. To address such instances, states will need policies to ensure temporary access to drugs until prescriptions can be changed to conform to the receiving plan.

Transition of care issues may also be particularly important for individuals with jail involvement, whose eligibility may fluctuate between Medicaid and the exchanges following their incarceration and/or release. Jail-involved individuals have high rates of mental illness and substance use disorders, making coverage transitions particularly relevant for assuring them continued access to community-based behavioral health treatment.7 Accordingly, states may want to consider policies such as those described below to ensure that jail-involved individuals with behavioral health needs maintain access to providers and ongoing courses of treatment during these coverage transitions.

MEDICAID AND THE EXCHANGES

To understand how contracting provisions can support coverage transitions between Medicaid and the exchange, it is helpful to look at requirements in states with operational health insurance exchanges. Currently Massachusetts and Utah have health insurance exchanges. While cognizant of the need for seamless transitions between health insurance program options, Utah has not yet developed coverage transition requirements.

Massachusetts, on the other hand, has extensive contract language to help guide MCO coverage transitions between Medicaid and the state’s Health Connector program. The state’s MCO contractors must perform readiness reviews prior to enrolling new beneficiaries, then take steps to minimize disruptions in care and ensure uninterrupted access to medically necessary services. At a minimum, Massachusetts’ MCO contractors must provide transition plans for the following new enrollee subsets: (1) pregnant women; (2) individuals with significant health care needs or complex medical conditions; (3) people receiving ongoing services or who are hospitalized at time of transition; and (4) individuals who received prior authorization for services from the relinquishing MCO contractor. For individuals in each of these population subsets, Massachusetts requires receiving MCOs to complete a transition plan that is tailored to the new enrollee’s specific health care needs. An analysis of 2006 data found that although there are gaps in coverage, Massachusetts’ continuity ratio—the portion of the year during which the average Massachusetts Medicaid enrollee is continuously enrolled—is 82 percent, higher than the national average of 78 percent and among the highest in the nation.8

Moving forward with its exchange planning, Tennessee is proposing a policy to the Centers for Medicare & Medicaid Services (CMS) that allows family members who are enrolled in different Medicaid and exchange health insurance programs to receive coverage through a common carrier or provider network. This option would apply to families regardless of their eligibility status or the delivery system offered. In addition, Tennessee has requested CMS permission to provide continuity for beneficiaries by allowing them to retain coverage through the same insurer and provider network if their eligibility status changes (e.g., from Medicaid to premium tax credits or vice versa). Tennessee’s pending proposal to CMS would allow the state’s exchange to limit eligibility for bridge products to individuals who have a dependent in their immediate family who is enrolled in Medicaid or CHIP or has been enrolled in either program within the last six or 12 months.9 As a result, the bridge product may be available only to a subset of individuals of a particular age in a given rating area (depending on the issuer’s preference).

EXISTING MEDICAID BEST PRACTICES

To facilitate transitions between Medicaid MCOs, several states include coverage transition provisions in their MCO contracts that protect populations receiving certain types of care (see Managing Coverage Transitions: State and National Models appendix chart). In general, receiving MCOs are held responsible for continuing care previously provided by the

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relinquishing payer. Conversely, in some instances, the receiving MCO might allow transitioning beneficiaries to continue to obtain care from their previous provider for a specific timeframe. In addition, some states mandate that relinquishing MCOs be held financially responsible for provision of care to enrollees during the transition period. Specific transitional care issues addressed in state MCO contract language include:

1. Pregnancy;
2. Certain dental care, such as orthodontia;
3. Hospitalizations;
4. Transplants;
5. Chemotherapy, radiation therapy, and dialysis;
6. Individuals with ongoing needs such as durable medical equipment, home health services, or prescription medications;
7. Individuals with prior authorizations for procedures; and
8. Behavioral health and chemical dependency services.

In some cases, state contracts “protect” individuals receiving certain therapies by allowing them to continue treatment with current and non-participating providers. Many states require that both receiving and relinquishing MCOs coordinate coverage of individuals who are transitioning and jointly develop a transition plan to provide services within a defined timeframe, ranging anywhere from 90 to 120 days. Although timeframes for coordination of services are not always specified, MCO contractors are generally expected to coordinate transitional services, including necessary phase-in and phase-out strategies for individuals receiving critical care.

In addition to ensuring seamless coverage transitions through contracting, states can use eligibility tools to keep individuals covered during transitional periods. The eligibility regulations released by CMS in March 2012 note that while states are not required to extend Medicaid eligibility through the end of the month in which an individual is no longer eligible, they are encouraged to do so. To reduce coverage gaps as individuals transition between Medicaid and QHPs, CMS authorizes federal funding to states that extend coverage to the end of the month at the applicable match rate for that extended period.

While Massachusetts is currently the only exchange-to-Medicaid example, the most longstanding examples of transition policies for individuals with special health care needs can be found in existing state requirements for coverage transitions between Medicaid and expansion populations as well as between Medicaid MCOs. States that have existing low-cost health insurance programs offer valuable guidance on how to facilitate smooth coverage transitions for beneficiaries. New Mexico’s State Coverage Insurance (SCI) program provides an example that demonstrates how transitions can be handled between Medicaid programs and the future Medicaid expansion population. When women who are covered under SCI become pregnant, they are allowed to stay on SCI and are able to retain the same MCO and providers. Upon birth, the infant is screened and enrolled into Medicaid or SCHIP and is assigned to the mother’s MCO. In this way, the mother and baby are able to keep the same MCO and provider throughout this process. New Mexico’s SCI program also carefully coordinates necessary coverage transitions for individuals who are transplant candidates. In order to keep SCI affordable to small businesses, the program was designed with a limited benefit package. If someone covered by SCI needs a transplant, the SCI benefit package will not address all of their needs. Thus, once a beneficiary is identified as a transplant candidate, the individual is transitioned into the state’s high-risk option, the New Mexico Medical Insurance Pool, so that transplant-related care can continue seamlessly.

New York also offers an existing model for coverage transitions between traditional Medicaid and expansion programs—via a waiver or other Medicaid State Plan option. Because New York has multiple waiver programs allowing the state to expand coverage broadly to parents, children, and individuals with complex needs, the state has specific transition requirements in its health plan contracts to address the care needs of beneficiaries. These contractual obligations balance the needs of the beneficiary with the health plan’s need to exercise its care manager role. For example, the contract addresses transitions for

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11 Social Services, State Coverage Insurance, Member Transition of Care, Section 8.306.16.9 New Mexico Administrative Code.
12 New York State Department of Health Office of Health Insurance Programs, Division of Managed Care, Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract. August 1, 2011.
individuals moving between Medicaid managed care and Family Health Plus—the state’s insurance program for adults with income too high for Medicaid eligibility. In such cases, a new enrollee with an existing provider who is not within the new plan’s provider network is able to continue an ongoing course of treatment by their non-participating provider for up to 60 days from enrollment. In addition, New York’s health plan contracts require transitional care for new enrollees undergoing treatment with a participating provider until the health plan’s approved treatment plan is in place.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE COVERAGE TRANSITION STANDARDS

The NCQA has established coverage transition standards for Medicaid and private market MCOs that must be met in order for plans to receive NCQA accreditation. Many states require accreditation to license MCOs, and in many cases, NCQA accreditation fulfills state MCO licensing requirements. However, the extent to which NCQA accreditation meets state requirements varies from state to state. NCQA’s standards focus on quality improvement and continuity of care in transitions between managed care plans for enrollees with specific conditions. For example, the NCQA standards require plans to allow pregnant women in their second or third trimester whose practitioners are discontinued from a network to obtain care from their previous practitioner through the post-partum period. NCQA standards also specify that individuals undergoing active treatment for a chronic or acute medical condition should be allowed to continue prescribed treatment for a defined period of time in the event that coverage changes. An active course of treatment, e.g., for cancer, typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. A discontinuation of such treatment could worsen health outcomes.

MEDICARE PART D CARE TRANSITION REQUIREMENTS

Medicare established a transition process for all Part D plans to ensure continuity of care for eligible individuals. Plans must ensure that new members, newly eligible beneficiaries, individuals transitioning from one Part D plan to another, and individuals in long-term care facilities have access to non-formulary medications during their first 90 days in a plan. If medically necessary, the transition period may be extended beyond 90 days. Plans are expected to provide transition fills of non-formulary prescriptions and a written transition notice to enrollees. CMS also requires that plan sponsors ensure that reasonable efforts are made to notify prescribers of enrollees who receive a transition notice after a temporary fill. In addition, plan sponsors are expected to determine the best way to expedite transitions to formulary drugs for enrollees who change treatment settings due to changes in level of care.

POTENTIAL CONTRACTUAL AND TECHNOLOGY SOLUTIONS TO MANAGE COVERAGE TRANSITIONS

State Medicaid agencies may wish to consider developing contractual requirements that call for direct transfer of clinical information to facilitate care coordination between health plans in the post-exchange environment. Such electronic transfer capabilities were envisioned for the statewide Health Information Exchanges, as detailed in the ACA. Health plans could potentially share information to facilitate care coordination for members transitioning to a new health plan. The Office of the National Coordinator for Health Information Technology (ONC) has started the Direct Project, an initiative to develop a secure, scalable, standards-based mechanism for encrypted data transfer of health information directly to payers, providers, and governmental entities over the Internet. Pilot projects in nine states—California, Connecticut, Minnesota, Missouri, New York, Oregon, Rhode Island, Tennessee, and Texas—are currently underway. This project, along with other state-initiated efforts, can support sharing of the following types of secure health information between exchange plans and Medicaid plans:

- Chronic disease diagnoses;
- Emergency room visits with diagnosis;
- Hospital admissions with admitting diagnosis;
- Prescription drug utilization; and

13 National Committee for Quality Assurance. Standards and Guidelines for the Accreditation of Health Plans. 2011
Current open care authorizations.

Electronic information transfer requirements could be placed on contractors when members moved to another Medicaid plan or to a commercial exchange plan, to facilitate care coordination.

CONCLUSION

With the implementation of health reform, up to 20 million Americans will be eligible for Medicaid in 2014. A majority of these newly eligible individuals are likely to churn on and off Medicaid rolls based on irregular and unpredictable income status, and many are also likely to have chronic and unmet health care needs. Establishing policies to support effective coverage transitions is an important step in ensuring seamless delivery of services across publicly subsidized health insurance options.

Smooth transitions across coverage options will help minimize disruptions in care and promote high-quality and consistent services for beneficiaries. States exploring strategies to address coverage transitions can look to Massachusetts, to existing state MCO contract language, and to NCQA standards for insights on managing shifts in eligibility across Medicaid, the basic health plan option, and the exchange.

The authors wish to acknowledge the thoughtful review provided by Barbara Edwards and Peter Nakahata of the Centers for Medicare & Medicaid Services.
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<thead>
<tr>
<th>States/ Agencies</th>
<th>General</th>
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<th>Special Populations: Chronic or Acute Medical Conditions</th>
<th>Hospital Stays</th>
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<tr>
<td>NCQA</td>
<td>NCQA requires transition of care standards for certain conditions.</td>
<td>Members in their second or third trimester of pregnancy have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the post-partum period.</td>
<td>Enrollees undergoing active treatment for a chronic or acute medical condition have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the current active treatment period or for up to 90 calendar days, whichever is shorter.</td>
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<tr>
<td>Medicare Part D</td>
<td>All Part D sponsors must have a transition process to ensure that newly enrolled members, and other individuals described below, have access to non-formulary medications during their first 90 days in a plan. (For transition purposes, formulary drugs that are subject to prior authorization or step therapy are treated as non-formulary drugs.) The transition process applies to: 1. New members who enroll during the annual coordinated election period (or, depending upon the plan’s declared transition policy, current enrollees affected by a formulary change from one contract year to the next); 2. Newly eligible Medicare enrollees who previously had other coverage; 3. Individuals who transition from one Part D plan to another during the year (as through a Special Enrollment Period); and 4. Enrollees in long-term care (LTC) facilities. The transition process requires Part D plans to allow a one-time temporary supply of a non-</td>
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### Managing Coverage Transitions: State and National Models (effective April 2012)

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<td><strong>Formulary Drug</strong></td>
<td>formulary drug, during which time the member, his/her physician, and the plan can work out an appropriate change to another drug or start an exception request to obtain the non-formulary drug. The plan must provide a written notice to all members who receive a transition fill within three business days of the temporary fill. For members living in the community, the temporary supply is a one-time fill for at least 30 days (unless the script is written for fewer days). For members living in LTC facilities, the temporary supply may be for up to 31 days, and may be renewed as necessary during the 90-day transition period. Depending on the individual's circumstances, the transition period may be extended beyond 90 days.</td>
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<td><strong>Maryland</strong></td>
<td>1. Health Choice regulations require Medicaid MCOs to pay for certain services without any requirement of referral by the PCP or MCO when the enrollee accesses the service through an out-of-network provider. 2. In general, enrollment brokers and providers are responsible for care continuity during transitions. There is no language requiring care coordination between MCOs and commercial carriers.</td>
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<td><strong>Arizona</strong></td>
<td><a href="http://www.azahc.ccs.gov/commercial/Purchasing/contracts.aspx">http://www.azahc.ccs.gov/commercial/Purchasing/contracts.aspx</a></td>
<td>Obligations of relinquishing MCO: 1. Provide relevant information and submit the Enrollment Transition Information (ETI) for those members with special circumstances. 2. Cover the member's care for up to 30 days in the case of failure to provide relevant high-risk pregnancy: Receiving MCO must allow beneficiary to stay with PCP. High-risk pregnancy: Receiving MCO must allow beneficiary to stay with PCP.</td>
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<td>1. Transplantation services in process: Relinquishing MCO will be responsible for the cost of all ongoing care at the time of transition. 2. Chronic illness: Receiving and Relinquishing contractor will be financially responsible for all hospital services demanded during a transition to the receiving contractor.</td>
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<td><a href="http://www.azahccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx">http://www.azahccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx</a></td>
<td>information to the receiving MCO. 3. Transfer medical records to receiving MCO. 4. Identify a transition coordinator to coordinate the transition of beneficiaries.</td>
<td>relinquishing MCOs must coordinate care. 3. <strong>Medical conditions that require ongoing care from a specialist:</strong> Receiving and relinquishing MCOs must coordinate care for patients with diabetes, hypertension, pain control, and orthopedic conditions. 4. <strong>Those being treated with chemotherapy/radiation therapy and/or dialysis:</strong> Receiving and relinquishing MCOs must coordinate care. 5. <strong>Those with ongoing needs</strong> such as DME (relinquishing MCO provides up to 15 days after switch), home health (relinquishing MCO must have procedure in place), medically necessary transport (relinquishing MCO must have procedure in place), prescription meds (relinquishing MCO provides up to 15 days after switch), and EPSDT benefits for qualified members (relinquishing MCO must have procedure in place). 6. <strong>Those who have received prior authorization for:</strong> procedures/therapies to be provided after the date of transition; sterilization for which consent form has been signed; specialist appointments outside the contractor service area; or nursing facility admission: authorized treatments must be honored by the receiving MCO.</td>
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| **Indiana**      | Hoosier Healthwise requirements:  
Relinquishing MCO agrees to:  
1. Provide phase-in/phase-out training.  
2. Coordinate an orderly transition for beneficiary to coverage through the receiving MCO.  

Care Select requirements:  
Upon notice from the state, the relinquishing MCO will:  
1. Provide phase-in and phase-out services for up to 120 days.  
2. Negotiate a plan with a successor to determine the type of phase-in and phase-out services required.  

Plan will outline a training program and provide experienced personnel to assist with phase-in/phase-out process. Personnel are allowed to leave the relinquishing MCO to work with the receiving MCO if mutually agreeable. The relinquishing MCO will transfer all of an employee’s fringe benefits to the receiving MCO.  

Relinquishing MCOs will be reimbursed for all phase-in/phase-out costs. | Hoosier Healthwise requirement:  
A receiving contractor must reimburse for and honor request of a pregnant woman in her third trimester to continue to receive care from current physician. | Hoosier Healthwise requirement:  
Receiving MCOs must honor previous care authorizations for a minimum of 30 calendar days. | Hoosier Healthwise requirements:  
Relinquishing MCO responsible for care coordination after the member has disenrolled if disenrollment occurs during an inpatient stay.  
1. Relinquishing MCO financially responsible for the hospital DRG payment and outlier payments.  
2. Relinquishing MCO must coordinate discharge plans with the receiving MCO. |
| **Massachusetts** | MCO transition and contract readiness:  
Review conducted of the following elements:  
1. Network provider composition and access;  
2. Staffing;  
3. Marketing materials;  
4. Capabilities of material subcontractors;  
5. Care management capabilities;  
6. Content of provider contracts;  
7. Enrollee services capabilities; | Pregnant women:  
1. If a pregnant enrollee enrolls with the contractor during the transition period, she may choose to remain with her current provider of obstetrical and | Behavioral health provider network:  
If there are significant changes, the contractor will determine the number of affected enrollees and the specific steps taken to assure that enrollees continue to have access to medically necessary services. | Special health care needs enrollees: |
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<tbody>
<tr>
<td><strong>8.</strong> Comprehensiveness of quality management/quality improvement and utilization management strategies;<strong>&lt;br&gt;9. Internal grievance and appeal policies and procedures;</strong>&lt;br&gt;10. Fraud and abuse and program integrity;<strong>&lt;br&gt;11. Financial solvency; and</strong>&lt;br&gt;12. Information systems.</td>
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<td>The contractor will implement policies and procedures to ensure continuity of care for new enrollees:</td>
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<td>1. For the purpose of minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary Services.</td>
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<td>2. At a minimum, will address the following:</td>
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<td>a) Pregnant women;</td>
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<td>b) Those with significant health care needs or complex medical conditions;</td>
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<td>c) Those receiving ongoing services such as dialysis, home health, or chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition; and</td>
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<td>d) Those who received prior authorization for services such as scheduled surgeries, out-of-area specialty services, or nursing home admission from the relinquishing contractor.</td>
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<td>gynecological services, even if that provider is not in-network.</td>
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<td>Transition plan must be completed no later than 10 business days from when contractor becomes aware of enrollee’s health status but no later than 45 days after enrollment. Transition plan should be specific to health needs and at a minimum should include:</td>
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<tr>
<td>2. Contractor is required to cover all medically necessary obstetrical and gynecological services through delivery of the child, post-partum care, and follow-up appointments within the first six weeks of delivery.</td>
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<td>1. Medical record documentation;</td>
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<td>If the enrollee would like to select a new provider within the network, she may do so.</td>
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<td>2. HRA completion;</td>
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<td>3. Evaluation for care management;</td>
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<td>4. Coordination and consultation with existing providers;</td>
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<td>5. Review of existing prior authorizations and prescriptions; and</td>
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<td>6. Coordination and consultation with other state agencies, if needed.</td>
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<td>Transition from another MassHealth-contracted MCO:</td>
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<td>The contractor will honor all prior authorizations and prior approvals. If the contractor chooses to modify or terminate a prior authorization, they must treat as an Adverse Action.</td>
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<tr>
<td>Minnesota</td>
<td>Receiving MCO must cover previously authorized services, but it can require that the beneficiary see an in-network provider, if this stipulation does not create undue burden.</td>
<td>Pregnancy: Cases in which pregnancy services are covered by receiving MCO: At-risk pregnancy:</td>
<td>Chemical dependency and mental health: Both treatment and treatment-related room and board must be covered by the relinquishing MCO. The relinquishing MCO must develop a</td>
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<tr>
<td>States/Agencies</td>
<td>General</td>
<td>Special Populations: Maternity Care</td>
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<tr>
<td>New Mexico</td>
<td>1. Relinquishing MCO expected to develop a detailed plan addressing clinical transition issues and transfer of potentially large numbers of members.</td>
<td>1. If in third trimester; and 2. If PC reports the pregnancy is high-risk. May continue to see an out-of-network provider. The receiving MCO is not responsible for out-of-network care after the hospital discharge of the mother and child.</td>
<td>transition plan for the beneficiary receiving mental health services. <strong>Orthodontia:</strong> Cases in which orthodontia is covered by the receiving MCO: 1. If authorized; 2. Necessary under an established plan of care; and 3. Care plan has a definitive end date. MCO must pay the orthodontia provider at minimum the state Medical Assistance fee-for-service rate. <strong>Pharmaceuticals:</strong> The receiving MCO must pay for all drugs currently taken by the beneficiary, except for those covered by Medicare Part D.</td>
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<td>2. Relinquishing MCO will develop a detailed plan for transitions of individual members. The relinquishing MCO must also be able to provide data and clinical information to receiving MCO. Extends to transitions between Salud!, State Coverage Insurance (SCI), Coordination of Long Term Services (CoLTS), and Fee-for-Service (FFS) programs including Premium Assistance programs.</td>
<td>Pregnant women: In the third trimester, women enrolled in a new MCO may stay with the same obstetrical provider, whether contracted or out-of-network.</td>
<td><strong>Salud! member requirements:</strong> Prior authorization and provider payment requirements: 1. Receiving MCO must honor prior authorizations for 30 days or until it arranges for a transition of services. 2. Receiving MCO must pay for prescription drugs for the first 30 days or until it has made other arrangements. <strong>CoLTS requirements:</strong> The relinquishing MCO must: 1. Honor all prior authorizations for</td>
<td><strong>Hospital stays:</strong> <strong>Salud! members</strong> Relinquishing MCO must cover all hospital expenses provided by a general acute-care or rehabilitation hospital until discharge from the hospital if the member is hospitalized at the time the member becomes exempt. If member disenrolled from Salud! because they have become eligible for and enrolled in the CoLTS program, the relinquishing contractor will be responsible for the payment for the initial</td>
</tr>
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</table>
### Managing Coverage Transitions: State and National Models (effective April 2012)

<table>
<thead>
<tr>
<th>States/ Agencies</th>
<th>General</th>
<th>Special Populations: Maternity Care</th>
<th>Special Populations: Chronic or Acute Medical Conditions</th>
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<tbody>
<tr>
<td>New York</td>
<td></td>
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<td>the first 60 calendar days of enrollment or until other arrangements for transition of services are made.</td>
<td>hospital stay, including professional services through the last day of the month of the last capitation payment.</td>
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<td>2. Pay for prescription drugs for the first 90 days or until it has made other arrangements.</td>
<td><strong>SCI member requirements:</strong> The contractor will track members who are nearing the annual claims benefit maximum or annual bed-day maximum by:</td>
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<td>3. Accept prior authorization for long-term nursing facility placement and DME, personal care services.</td>
<td>1. Tracking dollars paid for claims and hospital inpatient days and identifying those who have utilized a large portion of their inpatient resources.</td>
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<td>4. Reimburse non-network providers at Medicaid FFS rate.</td>
<td>2. Providing care coordination to high utilizers to prevent members from reaching benefit claims and/or hospital day maximums.</td>
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<td><strong>Salud! and CoLTS requirement:</strong> Receiving MCO must pay for up to $2,000 of DME for equipment approved but not received by member until after disenrollment from the relinquishing MCO.</td>
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<td>If enrollee has a life-threatening disease or condition, the receiving MCO will permit the enrollee to continue treatment with a non-participating provider during a 60-day period from enrollment.</td>
<td><strong>Hospital Stays:</strong> Relinquishing MCO must pay for a beneficiary’s hospital stay if she is hospitalized on the day of disenrollment. UNLESS she is transferred to a different hospital OR is transferred to a different unit in the same hospital and method of payment changes from DRG-based to per diem OR per diem to DRG-based.</td>
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<td>Transitional period will continue for remainder of pregnancy up to 60 days after delivery if the enrollee is in second trimester at time of enrollment.</td>
<td>1. Care with non-participating provider will be authorized by receiving MCO for transitional period if non-participating provider adheres to contractor’s policies, procedures, and quality assurance requirements, and accepts contractor-defined reimbursement rates.</td>
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<td>For enrollees whose provider has left</td>
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<td>Pennsylvania</td>
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<td>the network, the receiving MCO should allow member to continue course of treatment with current provider for up to 90 days.</td>
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1. Daily and Monthly Membership Files with changes to membership are provided to each physical health (PH) MCO. PH-MCO must provide the same level of coverage for each member in the file, from the first day of the month or the PH-MCO coverage start date (whichever is later) through the last day of the month or the PH-MCO end-date.
2. Those who move out of the PH-MCO’s service area may still be covered by their PH-MCO, pursuant to review by County Assistance Office (CAO).
3. Members who become ineligible for Medicaid retain coverage with their PH-MCO for six months. If they requalify for Medicaid within those six months, they again become the responsibility of the PH-MCO.

**Dual Eligibles:**
Dual eligibles enrolled in Medicare Part D who turn 21 will be identified on the first Friday of every month and disenrolled from their PH-MCO. Newly identified dual eligibles will be disenrolled from their PH-MCO at the end of the month in which Medicare Part D is posted to their eligibility record.

**Newborns:**
Should be covered by PH-MCO covering mother, unless Children and Youth assumes custody of the newborn.

**Medical Necessity:**
State may require continuation of care by relinquishing PH-MCO for cases in which there is medical necessity.

**Change in coverage while in hospital:**
1. **FFS to PH-MCO:** PH-MCO becomes responsible for expenses at the begin date of PH-MCO coverage.
2. **PH-MCO:** PH-MCO is responsible for coverage unless the recipient is still in the hospital during the FFS begin date, in which case FFS begins to pay.
3. **Transfer between PH-MCOs:** The relinquishing PH-MCO is responsible for coverage up until the receiving PH-MCO’s begin date, unless the begin date is not the first of the month.
4. **Recipient loses and regains Medicaid eligibility while in hospital:** PH-MCO coverage will extend retroactively to cover the lapse in coverage due to ineligibility.
5. **Recipient loses and regains Medicaid eligibility once discharged from the hospital:** PH-MCO covers through the end of the month and FFS kicks in until the date of discharge.
6. **Recipient never regains Medicaid eligibility:** PH-MCO only responsible for coverage until the end of the month.
Basic Health Program. The Affordable Care Act offers states another option besides Medicaid and the exchanges for health coverage for low-income residents.

WHAT’S THE ISSUE?
The Affordable Care Act employs two main strategies for expanding health insurance coverage—first, by extending Medicaid to millions of additional low-income people, and second, by allowing better-off people to purchase private health insurance with federal subsidies through new state-based health insurance exchanges. But the law also provides for additional means of expanding coverage, including allowing states to run a so-called Basic Health Program beginning in 2014.

Under such a program, states could offer public health insurance to people whose incomes are too high to qualify for Medicaid but are also below 200 percent of the federal poverty level (in 2012, that means less than $46,100 for a family of four).

To help pay for this program, which would probably resemble Medicaid, states could draw on a portion of the federal dollars that would otherwise go to subsidizing the purchase of private insurance coverage for those people through exchanges.

Proponents of the Basic Health Program idea maintain that having such a plan would make coverage more affordable for low-income people and save money for some states. But others worry that the program could undermine the viability of the new state insurance exchanges and, rather than saving money, expose states to financial risk. Meanwhile, federal officials have not yet provided many details for states about how the program will be operated.

This policy brief explores the issues surrounding the Basic Health Program and outlines options for states.

WHAT’S THE BACKGROUND?
To understand how the Basic Health Program could fit into the continuum of coverage provided by the Affordable Care Act—and why advocates believe the program is a necessary option for states—it is useful to recall key elements of the law and the complex structure of the nation’s different health insurance programs.

MAIN AVENUES OF COVERAGE: The Affordable Care Act requires most people to have health insurance coverage beginning in 2014 or pay a financial penalty. As noted, the law provides for two main avenues for expanded coverage, the first through Medicaid for adults having incomes up to 138 percent of the federal poverty level, which in 2012 is about $15,415 for an individual and $31,810 for family of four. The second avenue is through private coverage purchased from new state-based health insurance exchanges, along with federal subsidies to lower premium costs and coinsurance for people with incomes between 100 percent and 400 percent of the federal poverty level.
The Basic Health Program is aimed in part at giving states a way to mitigate these ill effects of churning, if only somewhat. One analysis by Ann Hwang and coauthors published in *Health Affairs* estimated that the effect of a Basic Health Program would be to reduce the number of adults who would churn between Medicaid and coverage obtained through exchanges.

Without a Basic Health Program, the authors estimated, 58.2 percent of people with incomes below 400 percent of the federal poverty level would not experience an income-related eligibility change for a full year. By contrast, with a Basic Health Program, 62.5 percent of people would have stable income eligibility. Those percentages mean that, in numerical terms, 1.8 million fewer US adults would churn between coverage programs if all states had Basic Health Programs.

A second analysis, by Matthew Buettgens, Austin Nichols, and Stan Dorn of the Urban Institute, estimated a comparable effect. If states set up a Basic Health Program and jointly administered it with Medicaid, churning between Medicaid plans and exchange plans for those below 200 percent of poverty would effectively be eliminated, this study said. Although there would still be churning for people whose incomes rose above 200 percent of the federal poverty level, and who then had to purchase coverage through exchanges, the total number of those churning between Medicaid and exchanges would fall from 6.9 million to 5.8 million annually—or about 1.1 million fewer people per year.

**WHAT’S IN THE LAW?**

To create a Basic Health Program, the Affordable Care Act allows a state to contract with one or more managed care plans or other organizations to offer insurance coverage. This coverage must include at least the state’s minimum essential health benefits, which consist of a required package of services, including hospitalization; treatment for physical and mental health conditions; maternity,
newborn, and pediatric care; and prescription
drugs. (See the Health Policy Brief published
on April 25, 2012, for more information on es-
sential health benefits.)

Maximum premiums and cost-sharing ex-
penses for Basic Health Program coverage are
linked to the private coverage available in a
state’s health insurance exchange. For exam-
ple, the enrollee’s monthly premium cannot
exceed what it would have been if the enroll-
ee purchased the second-lowest cost “silver”
plan in the insurance exchange. If a state’s
Basic Health Program is run by an insurance
company, its plan will be required to spend a
greater percentage (85 percent) of premium
dollars on clinical services and quality im-
provement compared to plans offered through
an exchange (80 percent).

Although the law gives states considerable
leeway in designing a Basic Health Program,
most approaches under consideration build on
existing state programs. The Urban Institute
estimates that at least 600,000 more people
would have health insurance if all states of-
fered a Basic Health Program because such in-
surance coverage is likely to be decidedly less
costly than private coverage available through
insurance exchanges.

According to the analysis, an adult having
income between 138 percent and 200 percent
of poverty would pay an average monthly pre-
mium of about $102 for a private insurance
plan obtained through an exchange, plus $36
in monthly out-of-pocket costs. Under a Basic
Health Program with premium and cost-shar-
ing charges similar to those in Medicaid and
the Children’s Health Insurance Plan—which
are likely to be the models many states use to
devise their Basic Health Program coverage—
monthly premiums and out-of-pocket costs
would each average only about $8 (Exhibit 1).

ELIGIBILITY REQUIREMENTS: To qualify for
the Basic Health Program, a state resident
must be under age 65, cannot be eligible for
Medicaid, and cannot be offered employer-
sponsored coverage that is considered afford-
able under the law (that is, costing no more
than 9.5 percent of household income). As
noted, the person’s income must be greater
than 138 percent of poverty but less than 200
percent. (Legal immigrants who have incomes
below 138 percent of poverty but who do not
have the five-year lawful residency required
for Medicaid are eligible for the Basic Health
Program.)

To fund the Basic Health Program, the fed-
eral government will give states 95 percent of
the federal premium tax credits and cost-shar-
ing subsidies that would have been spent on
individuals had they been enrolled in a private
health insurance plan purchased through a
state exchange. If these federal dollars exceed
a state’s costs for its Basic Health Program,
any surplus funds must be used to reduce pre-
miums and cost sharing for eligible people or
to provide additional benefits.

The federal government is supposed to
make a determination before the fiscal year
begins about how much money it should give
the state, based on projected enrollment and
other factors. Then, when the year is over, pay-
ments to the state may be adjusted if it turns
out that the initial estimates were incorrect.

Although states have the option to offer a
Basic Health Program, they are not required
under the law to do so. At least eight states
have conducted analyses to explore creating
the programs. Washington, which already
had a similar state program in place, passed
legislation to enact a Basic Health Program
that complies with the terms of the Afford-
able Care Act. Massachusetts also passed such
“enabling” legislation, and California will
consider a bill to establish one during a forth-
coming special session of the state legislature
beginning in December 2012 or January 2013.
Seven other states have passed legislation re-
quiring an analysis of the prospect.

EXHIBIT 1

Estimated Average Annual Costs for Insurance Coverage for
Low-Income Adults

<table>
<thead>
<tr>
<th></th>
<th>Basic health program</th>
<th>Subsidized coverage in exchanges</th>
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<tbody>
<tr>
<td>Premiums</td>
<td>$1,500</td>
<td>$1,200</td>
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<tr>
<td>Out-of-pocket costs</td>
<td>$1,200</td>
<td>$900</td>
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<td></td>
<td>$900</td>
<td>$600</td>
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<td>$300</td>
<td>$0</td>
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</tbody>
</table>

SOURCE: Stan Dorn, Matthew Buettgens, and Caitlin Carroll, “Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States,” Urban Institute, September 2011. NOTES: Results show effects as if policies were fully implemented in 2011. Results were derived from the Health Insurance Policy Simulation Model developed by the Health Policy Center and the Urban-Brookings Tax Policy Center at the Urban Institute.
Most approaches under consideration build on existing state programs.

600,000

More people insured
The Urban Institute estimates that at least 600,000 more people would have health insurance if all states offered a Basic Health Program.

WHAT ARE THE ISSUES?

Although the Basic Health Program offers potential benefits to both the state and to its residents, the calculation as to whether a state should establish one is complicated. Here are some of the issues involved.

IMPACT ON EXCHANGES: The interaction between a Basic Health Program and the state health insurance exchange created in a given state is likely to be complex. If a state sets up a Basic Health Program, some people will obtain coverage through that program rather than by purchasing subsidized private health insurance coverage through the state exchange. That, in turn, will mean that fewer people will receive coverage through an exchange.

In fact, nationwide, a third of the people expected to be eligible to purchase private health coverage through exchanges, and receive federal subsidies to do so, have incomes below 200 percent of the poverty. This large group of people—an estimated 7.5 million—could thus be eligible for a Basic Health Program if their states set them up.

VIABILITY THREATENED: If the result of creating a Basic Health Program is that the population of people buying coverage through a given state’s insurance exchange is too small, the exchange’s viability could be threatened. For the exchange concept to work financially, there needs to be a broad pool of people purchasing coverage through the exchange, in part so insurers can spread the risks and costs of covering a relatively small group of very sick people across a broader group of healthier people.

States that have explored creation of the Basic Health Program option have generally found that the remaining pool of people buying coverage through exchanges will still be large enough for the exchange market to work. However, it’s not certain that this would be the case in all states.

There are other concerns about the existence of a Basic Health Program cutting into the size of the population that would buy coverage through exchanges. Under the law, states have the option of running their exchanges in an “active purchaser” model that allows them to negotiate with health plans to obtain the most affordable premiums. However, if fewer people will be covered through a state’s exchange because of the existence of a Basic Health Program, the state may have less negotiating power with health plans.

The prospect that people eligible for a state’s Basic Health Program could be subtracted from the population of people eligible to purchase coverage through the state’s health insurance exchange could also affect the overall health status of the pool of people buying coverage through the exchange in a way that might or might not affect the level of their health insurance premiums.

The size and extent of any impact is difficult to predict because the population of people likely to be eligible for the Basic Health Program is expected to be generally younger and poorer than the population that would still be buying coverage through exchanges. These two characteristics work in opposite directions on risk and premiums: lower income is associated with poorer health status and higher risk, while younger age is associated with better health status and lower risk. Until a given state has actually operated both programs for a while, it might be impossible to know what the effect of premiums would be.

Officials in some states have considered ways to mitigate problems related to shifting health status and risks, including having risk adjustment mechanisms that apply not just to coverage purchased through exchanges but also to the Basic Health Program. (See the Health Policy Brief published on August 30, 2012, for more information on risk adjustment.) Another option might be to consider all enrollees in the Basic Health Program and the exchanges as a common pool, and thus have premiums level across the two groups.

IMPACT ON BASIC HEALTH PROGRAM: There are also concerns about the impact flowing the other way—from a state’s exchange to its Basic Health Program. Since the federal government will give states 95 percent of the premium and coinsurance subsidies that it would provide if the population were enrolled in plans under the insurance exchanges, that means that the premiums charged through the exchange will determine the amount of federal funding provided to the Basic Health Program. Thus, the lower the premiums on policies sold through the exchange, the lower the dollar value of the subsidies and the less federal funding available to the state for its Basic Health Program.

Most analyses assume that the Basic Health Program will utilize a benefit design and payment structure similar to that of Medicaid.
One reason is that the Affordable Care Act requires close coordination between Basic Health Programs and Medicaid. It is also likely that states electing to set up Basic Health Programs would sign contracts with Medicaid managed care organizations to supply services to the people who will enroll in these plans.

**Continuity of Care:** Such a close alignment with Medicaid would provide the greatest continuity of care to people churning between Medicaid and the Basic Health Program as their income and eligibility shifted. Under such an arrangement, a Medicaid enrollee who shifted into his or her state’s Basic Health Program at some point would be highly likely to be able to keep the same doctors, rather than having to switch to a new group of providers contracted to work with the exchange plans but not with Medicaid.

A related issue is how much health care providers would be paid to see and treat patients in a Basic Health Program. Medicaid programs have typically paid providers less money for their services than private insurance plans or even Medicare, so that the groups of physicians who will agree to see and treat patients on Medicaid are typically smaller than networks serving other insured groups. It is possible that the rates that a Basic Health Program would pay providers would fall somewhere above Medicaid rates but less than those of private plans, but at this point, no one really knows.

If providers are paid at rates comparable to those of Medicaid to see and treat Basic Health Program patients, some observers question whether there will be enough interest on the part of providers to participate. If there isn’t, it’s not clear that the existing corps of safety-net providers who serve the current Medicaid population will have enough additional capacity to serve the Basic Health Program enrollees as well.

**Effect on Churning:** As previously noted, if a state creates a Basic Health Program, it is likely that there will be many occasions when incomes fluctuate and people move from Medicaid coverage into coverage under the Basic Health Program. Such a circumstance represents churning at the lower bound of income.

However, it is also true that if a state creates a Basic Health Program, it will create a new opportunity for people to move from that program into a health insurance exchange, if and when an individual’s or family’s income shifts such that it exceeds 200 percent of the federal poverty level. This circumstance represents churning at the upper bound—in other words, at a higher level of income. It is also possible that such people could move from the Basic Health Program to obtaining coverage through an employer. In either case, these people will most likely face higher premiums and cost sharing as they move into this new type of coverage. The evidence suggests that the number of people losing coverage at 200 percent of the federal poverty level may be greater than the number who lose coverage under Medicaid when their incomes exceed 138 percent of the federal poverty level.

Whether or not this additional churning occurs may be influenced by the structure of the Basic Health Program. The law does not require cost sharing or benefits to be constant for all enrollees in the Basic Health Program, regardless of their level of income. If states gradually increase cost sharing as enrollees’ income increases, then the contrast between the Basic Health Program and the exchange plans may not be as significant, making it easier for people to transition to obtaining coverage through an exchange and to handle any additional costs.

On the other hand, if states do not gradually increase cost sharing as income increases, then the contrast between the out-of-pocket costs of enrolling in a Basic Health Plan and an exchange plan may be significant and make it difficult for individuals to maintain coverage.

**Fiscal Benefits and Risks to States:** The Basic Health Program presents both potential financial advantages as well as financial risks to states. Some states have already chosen to enroll the same populations who would be eligible for the Basic Health Program in Medicaid instead. For example, in 2011, California spent $225 million to provide Medicaid coverage to recent legal immigrants who did not qualify for receiving Medicaid coverage that would be paid for in part with federal matching funds.

In addition, some states have programs that provide direct services to uninsured residents at considerable costs. Reducing the number of these uninsured people, or shifting populations from Medicaid to a Basic Health Program that could be supported with even more generous federal subsidies, could reduce state expenditures for providing health services for these types of populations.
However, it is also possible that states could face additional expenditures as a consequence of setting up a Basic Health Program. Such a situation would arise if federal funding did not cover the costs. This situation could occur if the reconciliation process that adjusts federal funding based on the actual income of enrollees reduces the amount of money available to the state from the federal government. It is also possible that premiums charged in the exchange—the basis of determining the amount of federal subsidies—will be too low to create a Basic Health Program that is attractive to both enrollees and providers. States may find it necessary to contribute state money to improve the product.

INTERFACE WITH MEDICAID EXPANSION: The June 2012 Supreme Court decision largely upheld the Affordable Care Act in effect gave states the option of declining to expand their Medicaid programs as the law envisioned. Many states have signaled that they may decline to proceed with the Medicaid expansion. If so, in these states, residents with incomes between 100 and 138 percent of poverty would qualify to purchase coverage through exchanges with the aid of federal subsidies but would not be eligible for Medicaid coverage.

It is unlikely that states in this situation would pursue creation of a Basic Health Program, since doing so would create a patchwork system in which individuals or families between 100 and 133 percent of poverty would participate in exchanges; individuals and families between 134 to 200 percent of poverty would be in the Basic Health Program; and then individuals or families with incomes above 200 percent of poverty would also be purchasing subsidized coverage through exchanges.

OTHER PROGRAM UNCERTAINTIES: States do not know at this point how the federal Department of Health and Human Services (HHS) is likely to implement the Basic Health Program, including in particular how the federal government intends to determine available funding, what the review and reconciliation processes will involve, and how states can cover administrative costs. To date, HHS has not released any guidance to help states decide whether or not to pursue a Basic Health Program. With President Barack Obama’s reelection, these regulations may be issued, but no specific timeline has been given.

WHAT’S NEXT?

Currently, only a few states—including Washington, Massachusetts, and California—are taking steps to implement a Basic Health Program. A number of states appear to have held back for the time being, as they await clarification from federal regulators on specific details of the program. More broadly, decisions that states may make about setting up a Basic Health Program will clearly be linked to their plans for expanding Medicaid coverage and establishing health insurance exchanges, which are likely to crystallize now that the elections are over.

The absence of federal guidance also means that time is running out to implement a program to coincide with the launch of the exchanges in 2014. Presumably, states could implement a Basic Health Program at a later date. HHS may also allow states to implement alternative programs to reduce churning.

RESOURCES

Bachrach, Deborah, Melinda Dutton, Jennifer Tolbert, and Julia Harris, “The Role of the Basic Health Program in the Coverage Continuum,” Kaiser Family Foundation, March 2012.

Buettgens, Matthew, Austin Nichols, and Stan Dorn, “Churning under the ACA and State Policy Options for Mitigation,” Urban Institute, June 2012.


