Medicaid’s Role in the Exchange
Making the Continuum of Coverage Meaningful

National Association of Medicaid Directors
Fall Meeting
November 9, 2011
AGENDA

Numbers of Eligibles
Eligibility and Enrollment Rules & Processes
Continuity of Coverage and Care
Administration and Finance
# Medicaid, BHP & QHP Eligibles

<table>
<thead>
<tr>
<th>Coverage Source</th>
<th>Population</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly Eligible Medicaid</td>
<td>16M</td>
<td>Medicaid total: 51M</td>
</tr>
<tr>
<td>Currently Eligible Medicaid</td>
<td>35M</td>
<td></td>
</tr>
<tr>
<td>Basic Health Plan (133-200% FPL)</td>
<td>5.5M</td>
<td>BHP total: 5.5M</td>
</tr>
<tr>
<td>Subsidized Private Insurance through Exchange (201-400% FPL)</td>
<td>13.5M</td>
<td>Individual Coverage through QHPs total: 18.5M</td>
</tr>
<tr>
<td>Unsubsidized Private Insurance through Exchange</td>
<td>5M</td>
<td></td>
</tr>
</tbody>
</table>
Individuals Will Move Between Income Bands & Coverage Options

Changes in Family Income, U.S. Population Under Age 65, 2005 to 2006

The Basics of Eligibility & Enrollment

- Medicaid is an entity offering coverage options: MMC, FFS, PCCM
- The Exchange is an entity offering coverage options: Qualified Health Plans
- Both are responsible for eligibility determinations for QHPs and Insurance Affordability Programs (Medicaid, CHIP, BHP and advanced tax credits and cost-sharing reductions)
  - State’s Medicaid eligibility and enrollment rules apply
- Integrated or coordinated eligibility and enrollment systems
- Consumers have the same first-class shopping experience regardless of door they come in through or whether or not they are eligible for an insurance affordability program
Federal Law, Regulation & Policy
A Simple, Seamless Path to Affordable Coverage

- Streamlined eligibility and enrollment processes
  - Use of electronic data and individual attestation to verify eligibility
  - If information provided by individual is “reasonably compatible” with electronic data no further information may be requested
- Eligibility rules are generally aligned with respect to all four insurance affordability programs
- Real-time eligibility determinations
- Prompt enrollment into QHPs
- Prompt enrollment into appropriate insurance affordability programs
Eligibility & Enrollment Workflow for Insurance Affordability Programs in Exchange

Function

- Application enters exchange
- Data collected to support application (i.e., citizenship, residency, income)
- System screens based on data and determines subsidy level

Responsibility

- Exchange

• Consumer is notified of eligibility for insurance affordability program and subsidy level

• Based on subsidy level, consumer is directed to plan selection

• If Medicaid/CHIP, consumer further directed

  - Medicaid / CHIP
  - Medicaid Managed Care / PCCM
  - Basic Health Plan (if available)
  - QHP w/ subsidy
  - QHP w/o subsidy

• Consumer chooses plan

• Consumer is notified that selection has been received

• Selected health plan receives enrollment data

• Consumer is enrolled and coverage is activated

* Data sharing for the purposes of determining eligibility for additional benefits.
Redetermination Process Emphasizes Continuous Coverage

- Electronic data primary source for initial redetermination reviews
- Exchange sends pre-populated form to enrollee to verify
  - If enrollee fails to sign and return, Exchange determines eligibility based on available data
- Medicaid reviews available electronic information; if data sufficient Medicaid enrollment continues
  - If data not sufficient, pre-populated form sent to enrollee with request for additional information
- Both Exchange and Medicaid must determine enrollee’s eligibility for other insurance affordability programs when income changes
Plan Integration or Alignment

Key to Continuity of Coverage

- Income mobility
- Medicaid, CHIP, Basic Health Program and advanced tax credits have specific income eligibility bands
- No guaranteed eligibility periods
- Continuous coverage is the foundation of continuous care and improved outcomes for the individual and system wide improvements in efficiency and quality
Achieving Continuity of Coverage

Integration Goals
- Facilitating transitions
- Leveraging buying power

Integration Strategies
- Plans
- Providers
- Standards
- Benefits/Cost Sharing
- Basic Health Program
Exchange Contracting Options

- Medicaid Managed Care / Basic Health Program
- Basic Health Program / Qualified Health Plan
- MMC / BHP
- BHP / QHP
- MMC / BHP / QHP
Certification of QHPs, BHPs & Medicaid Managed Care Plans

Federal Standards for QHPs
- Marketing requirements
- Network requirements
- Inclusion of “essential community providers”
- Accreditation on quality measures
- Implementation of QI strategies
- Uniform enrollment form
- Standard format for presentation of benefits
- Information on quality measures

State Standards for Commercial Plans

State Standards for MMC Plans

*State may supplement
Quality Strategies and Reporting

Federal Standards for QHPs*

- Increased reimbursement or other incentives for and reporting of
  - Activities to improve health outcomes, including use of medical homes
  - Implementing activities to prevent readmissions
  - Implementing activities to improve patient safety and reduce medical errors
  - Promotion of wellness and health
  - Reduction of disparities

As of Jan. 2015, a QHP may only contract with a hospital that
  - Utilizes a patient safety evaluation system
  - Assures patients receive comprehensive plan for hospital discharge
  - Implements a health care QI program

*State may supplement
Consumer Information and Reporting Requirements

Federal Standards for QHPs

- Provide information in plain language on:
  - Claims payment policies
  - Periodic financial disclosures
  - Data on enrollment and disenrollment
  - Data on denied claims
  - Data on rating policies
  - Information on cost sharing
  - Information on enrollee rights

*State may supplement

State Standards for Commercial Plans

State Standards for MMC Plans
Basic Health Plan: The Basics

- Enrollee eligibility
  - Income between 133% and 200% FPL and ineligible for Medicaid
  - Lawfully present immigrants below 133% of FPL; ineligible for Medicaid
  - Under age 65
  - No access to employer- or government-sponsored “minimum essential coverage”
- In lieu of coverage through Exchange
- Reduced cost-sharing and expanded benefits
- Funded with tax credits and cost sharing reductions
- Delivery system
  - Licensed HMO
  - Licensed Insurer
  - Network of health care provider
- State must do competitive procurement
### Basic Health Plan

**Supporting or Hindering Continuity?**

<table>
<thead>
<tr>
<th><strong>BENEFITS</strong></th>
<th><strong>RISKS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>More affordable for consumers between 133 - 200% FPL</td>
<td>New transition at 200% FPL</td>
</tr>
<tr>
<td>Smoothes transition at 133% FPL</td>
<td>– Cost-sharing</td>
</tr>
<tr>
<td>– Cost-sharing</td>
<td>– Benefits</td>
</tr>
<tr>
<td>– Benefits</td>
<td>– Plans</td>
</tr>
<tr>
<td>– Plans</td>
<td>– Providers</td>
</tr>
<tr>
<td>– Providers</td>
<td>May weaken Exchange</td>
</tr>
<tr>
<td></td>
<td>– Leverage</td>
</tr>
<tr>
<td></td>
<td>– Sustainability</td>
</tr>
</tbody>
</table>
Evaluating the BHP Option

- Are there sufficient federal dollars to fund in 2014? Beyond 2014?
- What is the state’s reconciliation exposure?
  - Risk adjustment
  - Tax credit and cost-sharing adjustments
- How will the administration of the BHP be financed?
- How to address the cost-sharing cliff at 200% FPL?
- How will continuity of coverage and providers be addressed at both 133% FPL and 200% FPL?
- What is the impact on the Exchange? Can it be addressed?
- Are there alternatives to reduce cost sharing for the BHP-eligible population?
Achieving Continuity of Care as well as Coverage

- Goal: continuity of providers across plans
- Challenge: Medicaid managed care plans and commercial plans tend to contract with different providers
- Potential Strategies:
  - ACA requires QHPs to contract with “essential community providers; should Exchanges go further?
  - How can the Exchange, Medicaid and plans facilitate provider transitions?
  - Should plan be required to allow new enrollees to access out-of-network providers for limited time?
  - Is transparent consumer information on plan provider networks sufficient?
Administration & Operations
Integration, Coordination or Duplication?

- Eligibility processes and systems
  - MAGI
  - Non MAGI
- Enrollment processes
- Plan procurement
- Plan oversight (network, marketing, quality etc)
- Premium collection
- Website
- Call Centers
- Navigators
Federal Financing

**Supports Integration**

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ 50 percent for administration</td>
<td>▪ 100 percent for systems build</td>
</tr>
<tr>
<td>▪ 90 percent for systems build</td>
<td>▪ 100 percent for 2014 operating costs</td>
</tr>
<tr>
<td>▪ 75 percent for system operations</td>
<td></td>
</tr>
</tbody>
</table>
For More Information

Contact:

Deborah Bachrach
Special Counsel
Manatt Health Solutions
DBachrach@Manatt.com
212-790-4594