Medicaid's Role in the Exchange

Making the Continuum of Coverage Meaningful

National Association of Medicaid Directors
Fall Meeting
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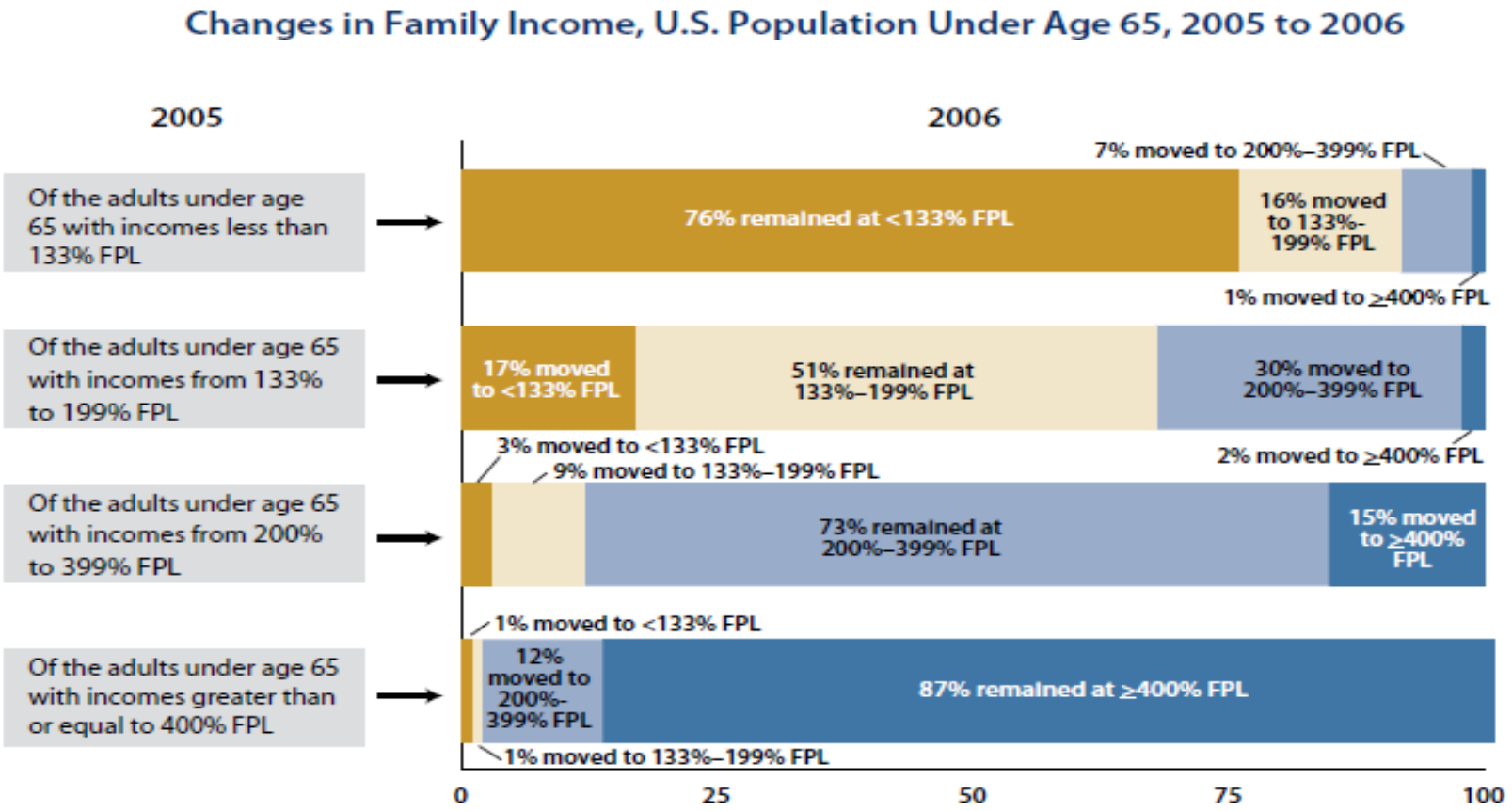
AGENDA

- Numbers of Eligibles
- Eligibility and Enrollment Rules & Processes
- Continuity of Coverage and Care
- Administration and Finance

Medicaid, BHP & QHP Eligibles

Coverage Source	Population	
Newly Eligible Medicaid	16M	Medicaid total: 51M
Currently Eligible Medicaid	35M	
Basic Health Plan (133-200% FPL)	5.5M	BHP total: 5.5M
Subsidized Private Insurance through Exchange (201-400% FPL)	13.5M	Individual Coverage through QHPs total: 18.5M
Unsubsidized Private Insurance through Exchange	5M	

Individuals Will Move Between Income Bands & Coverage Options



Source: P. Short et al, *Realizing Health Reform's Potential: Maintaining Coverage, Affordability and Shared Responsibility When Income and Employment Change*, Commonwealth Fund, May 2011

Federal Law, Regulation & Policy

The Basics of Eligibility & Enrollment

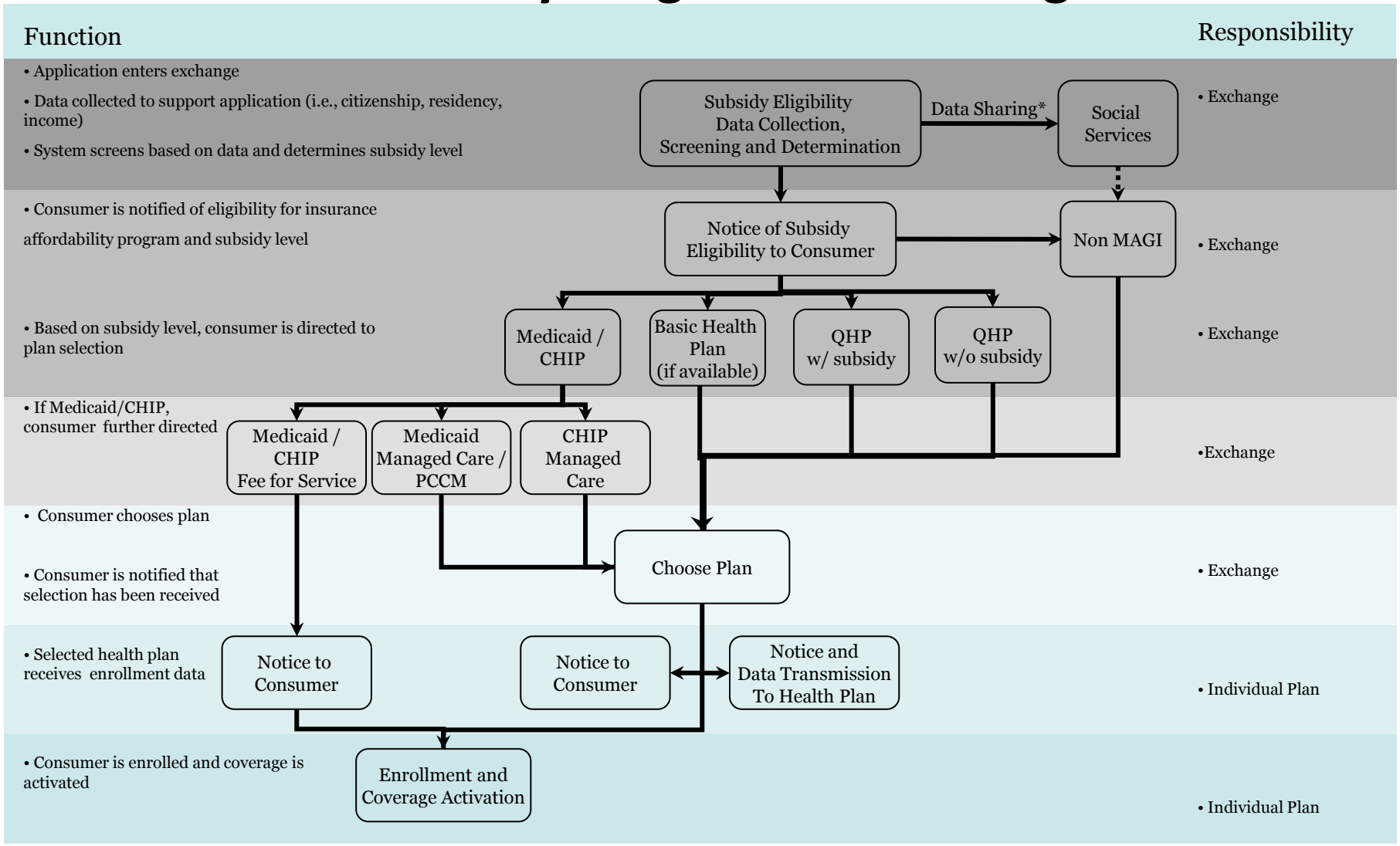
- Medicaid is an entity offering coverage options: MMC, FFS, PCCM
- The Exchange is an entity offering coverage options: Qualified Health Plans
- Both are responsible for eligibility determinations for QHPs and Insurance Affordability Programs (Medicaid, CHIP, BHP and advanced tax credits and cost-sharing 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



* Data sharing for the purposes of determining eligibility for additional benefits.

Federal Law, Regulation & Policy

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

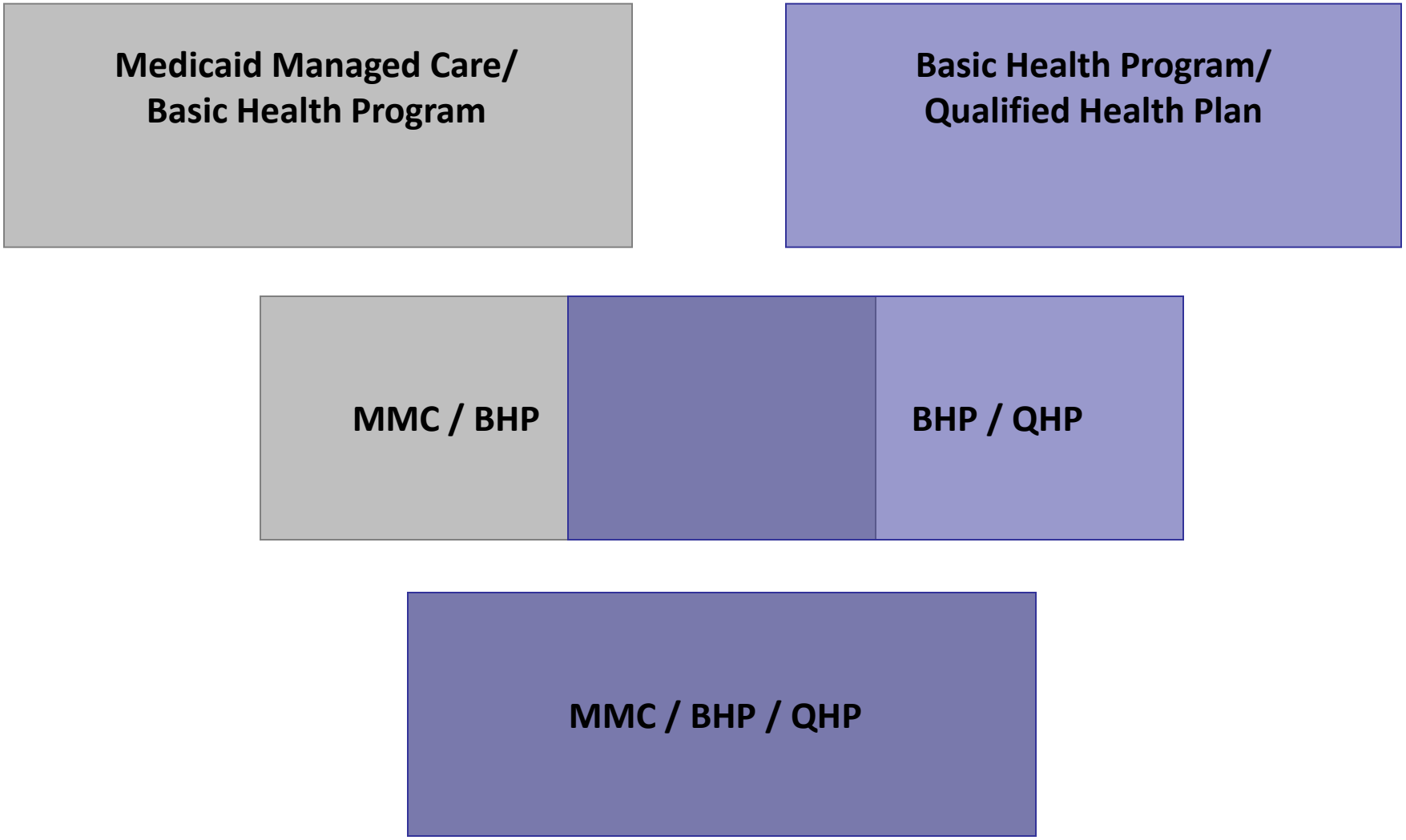
Integration Goals

- Facilitating transitions
- Leveraging buying power

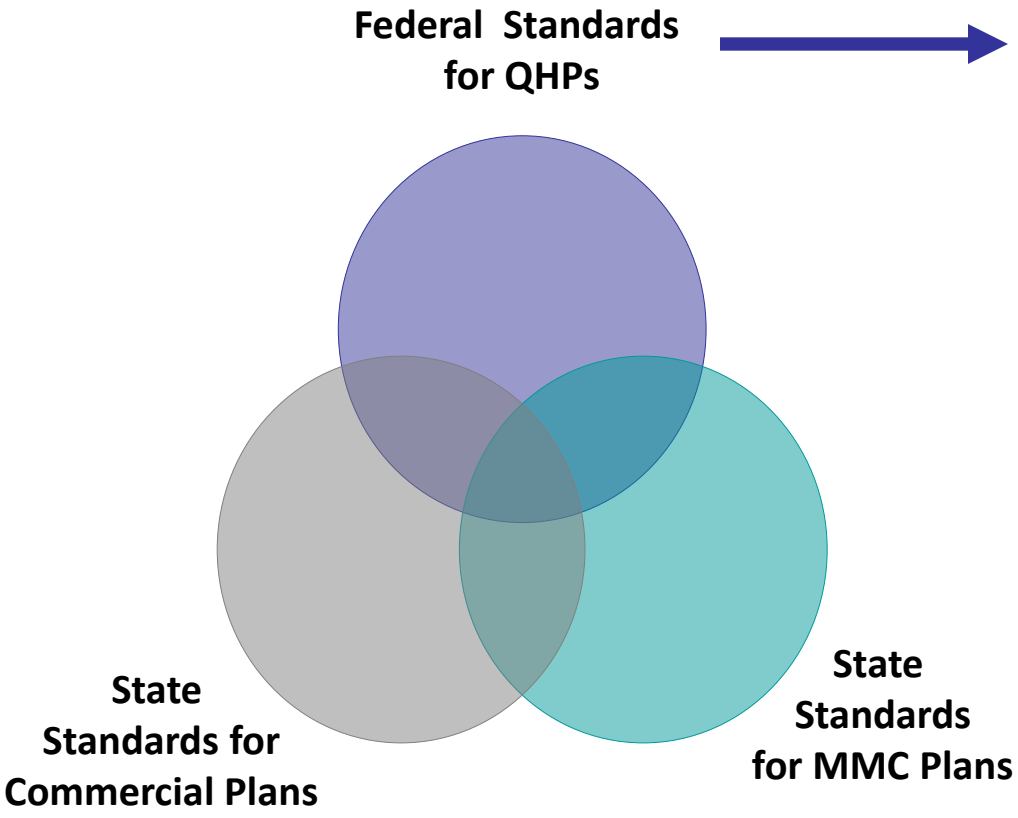
Integration Strategies

- Plans
- Providers
- Standards
- Benefits/Cost Sharing
- Basic Health Program

Exchange Contracting Options



Certification of QHPs, BHPs & Medicaid Managed Care Plans

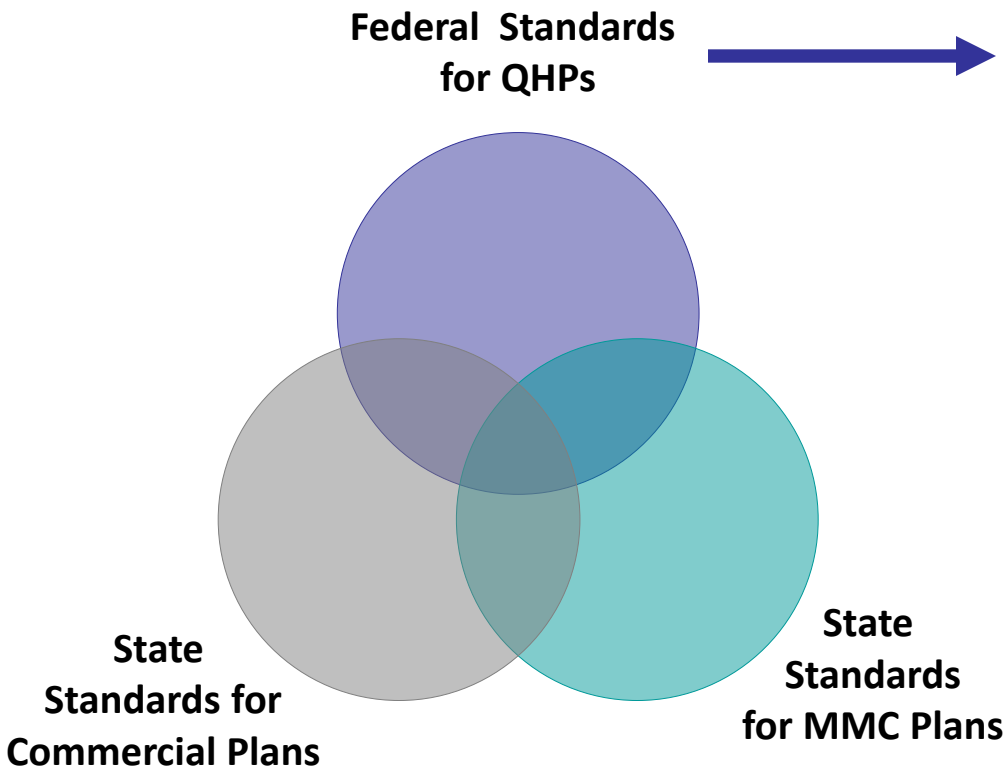


Federal Standards for QHPs*

- 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 may supplement

Quality Strategies and Reporting

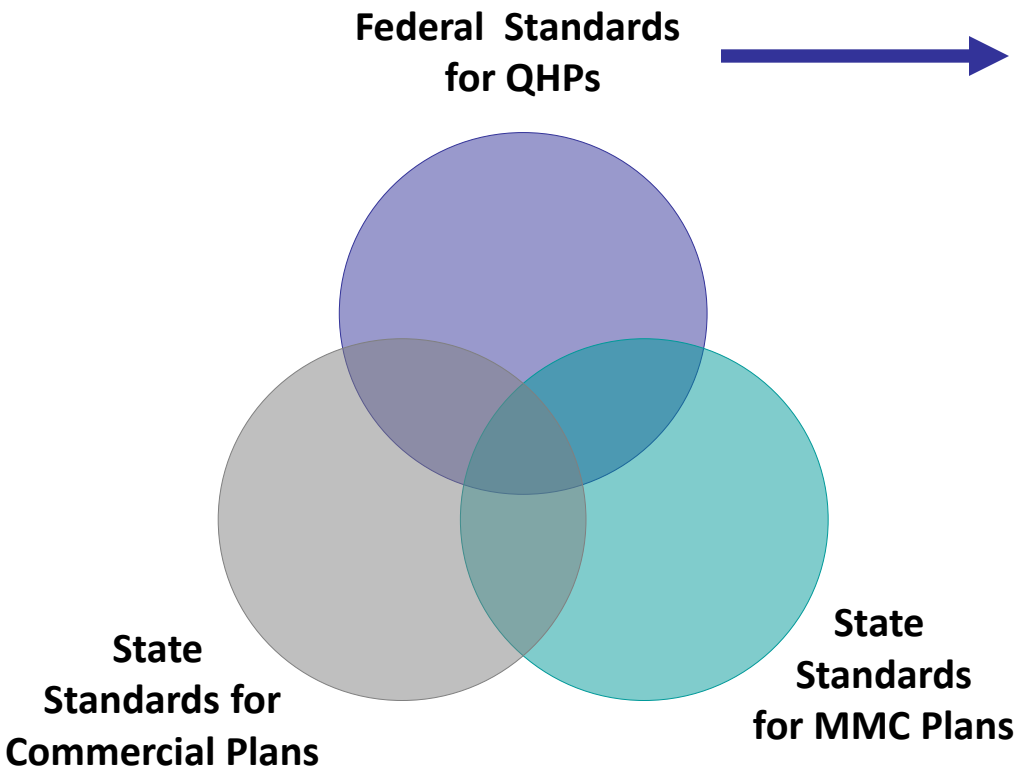


Federal Standards for QHPs*

- 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

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?

BENEFITS

- More affordable for consumers between 133 - 200% FPL
- Smoothes transition at 133% FPL
  - Cost-sharing
  - Benefits
  - Plans
  - Providers

RISKS

- New transition at 200% FPL
  - Cost-sharing
  - Benefits
  - Plans
  - Providers
- May weaken Exchange
  - Leverage
  - Sustainability

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

Medicaid	Exchange
▪ 50 percent for administration ▪ 90 percent for systems build ▪ 75 percent for system operations	▪ 100 percent for systems build ▪ 100 percent for 2014 operating costs

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