State Health Reform Assistance Network
Charting the Road to Coverage

POLICY BRIEF
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Ten Considerations for States in Linking Medicaid and the Health Benefit Exchanges

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States face many challenges in addressing the Medicaid expansion provisions in the Affordable Care Act (ACA). Foremost among them is forging effective linkages between publicly funded programs and the newly established health benefit exchanges (HBEs). Creating seamless transitions for individuals who change eligibility status will require continuity of benefits, providers and health plans. Even further, consolidation of purchasing across Medicaid and HBEs could drive system-wide quality improvement efforts.

The route to creating a smooth relationship between Medicaid and HBEs is becoming clearer, though there remain a number of decisions for states to make leading up to 2014. States must first decide if they will have their own HBE or if they will rely on the federal government to implement an exchange or take a hybrid approach. States must also consider how to include public payers along with the individual and employer-based insurance markets. In addition, states have the opportunity to establish a Basic Health Plan (BHP) for individuals who are not eligible for Medicaid. This paper addresses issues that states pursuing a state-specific HBE will need to consider.

IN BRIEF:

One of the more complex challenges that states face in implementing the Affordable Care Act (ACA) is developing the relationship between Medicaid and the emerging health benefit exchanges (HBEs). The Department of Health and Human Services released proposed regulations on July 15, 2011 that begin to detail the route to creating relationships between state Medicaid programs and private health insurance coverage. This guidance while extensive, allows states flexibility to chart a course that best meets their unique needs as envisioned in the Affordable Care Act. One of the decisions states will have to make leading up to 2014 is whether to participate in the federal HBE, implement their own exchange, or partner with the federal government on some components and then establish their own exchange for others. Regardless, states will still need to determine how to align the exchange with public payers, how to streamline benefits, and how to align eligibility and enrollment to minimize churn. Guidance to assist states with these decision points are expected to be released at the end of the summer. Given this, states developing their own HBEs should regard this brief as early orientation to the principle issues.

1. What role should existing public programs play within a Health Benefit Exchange?

Most states will at least consider an HBE approach that leverages the role of publicly funded health care programs, such as Medicaid and the Children's Health Insurance Program (CHIP). Other states will use a more market-driven approach. The July 15, 2011 federal guidance[1] makes clear that state Medicaid agencies are among the entities eligible to conduct exchange operations. Additionally, states are authorized to work together and create subsidiary or regional exchanges, which can cross state boundaries. The proposed regulations also require exchanges to be in "ongoing consultation" with Medicaid/CHIP agencies, and must make information about public health care programs, including Medicaid and CHIP, available to consumers.

While the exchange regulations stop short of requiring full integration of Medicaid eligibility into the exchange, there are a number of options for states to consider that are designed to help improve access to public programs and minimize churn. These include requirements to:

- Offer online eligibility determination and to provide online enrollment options;
- Offer a "single streamlined application" encompassing Exchange Qualified Health Plans (QHPs) and Medicaid/CHIP; and
- Provide special enrollment periods and monthly eligibility reconciliation to help minimize the impact of coverage shifts between QHPs and Medicaid/CHIP.

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Proposed Exchange Regulations: Key Takeaways

The July 15, 2011 proposed exchange regulations provide one piece of the puzzle that states will need to assemble in order to implement key provisions of the ACA. Additional guidance on eligibility and enrollment, essential health benefits and the creation of the BHP are expected before the end of 2011. There are several key takeaways for states as they continue exchange implementation planning:

Federal-State Partnership
As required under the ACA, the proposed regulation allows for a federal-state partnership in the creation of the exchange. This is a clear recognition on the part of the Department of Health and Human Services that the implementation of an exchange requires significant planning and political will. As of July 2011, 10 states have enacted exchange legislation, and eight have signed legislation or executive actions that signal the intent to establish an exchange or to study the establishment of an exchange. This federal-state partnership allows states, during this rapid implementation period, to implement the most critical functions, leverage federal funding, and use the federal exchange elements for pieces of the exchange if needed.

Eligibility and Enrollment
The July 15, 2011 proposed regulations require the exchanges to evaluate and determine eligibility for applicants in Medicaid, CHIP and other health programs. An exchange is required to use a standardized form for eligibility determinations and to process enrollment in a Qualified Health Plan or Medicaid, CHIP and the BHP, if applicable. The regulation does not specifically address whether or how enrollment reports about Medicaid, CHIP or the BHP, if applicable, are required.

Exchange Composition, Consumer Interest and Stakeholder Engagement
The Department of Health and Human Services' proposed regulation includes substantial direction for states on consumer representation and exchange board composition. The proposed rule notes that if the exchange is a new independent state agency or not-for-profit entity established by the state and not an existing state agency, it must have a clearly defined governing board and must provide its accountability and governance structure in its exchange plan. Under the proposed regulation, a state Medicaid agency would be eligible to operate the exchange, and as expected, the proposed guidelines allow the exchange to contract with the state Medicaid agency, which would then determine eligibility on behalf of the exchange. The proposed regulation also makes clear that exchange boards must not have a majority of representation from health insurance issuers, brokers, or agents or any other individual licensed to sell health insurance. States are given flexibility on inclusion of additional members in the governing board as long as Federal requirements are met.

Resources and Operational Requirements
Resource constraints pose a major challenge for states in operationalizing and defining roles and responsibilities for the exchange. The July 15 proposed rules require states to ensure that the exchange has adequate resources to assist individuals and small employers, after federal funding for exchange operations ceases in 2015. An exchange will be deemed fully operational by January 1, 2014 if it is capable of beginning operations by October 1, 2013 to support the enrollment of individuals into coverage options.

There are critical advantages to linking the HBE and QHPs to existing public programs. These include:

- **Aligning eligibility and enrollment** processes to support smooth transitions when an individual's eligibility changes;
- **Coordinating plan and provider networks** across Medicaid and QHPs to facilitate transitions across programs and prevent gaps in coverage;
- **Leveraging Medicaid's influence** as a dominant purchaser in the health care market; Medicaid has substantial experience in developing and refining purchasing and delivery systems; and
- **Mandating common quality and reporting requirements** to reduce the administrative burden on health plans/providers and make it possible to compare quality indicators and monitor programs across the entire state.

At the same time, states may be concerned about the possibility of people avoiding the HBE because of a perceived "*welfare stigma*." State experience with CHIP could offer guidance in positioning these new programs. Some state officials attribute a portion of CHIP's success to its intentional separation from Medicaid and to the fact that CHIP is in part publically financed, in part

employer-based, and in part paid for by the beneficiary. This "three share" or "multi share" model used in some CHIP programs could be an important reference point in designing the array of state coverage options going forward.

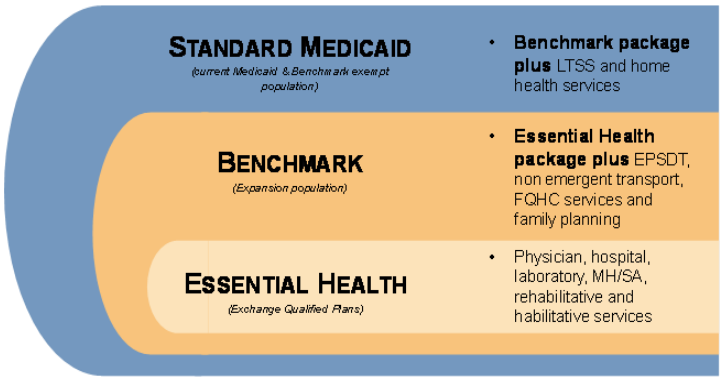
2. How will benefit packages be designed? What does this mean for Medicaid?

The ACA guides states toward three benefit tiers (see Figure 1) of publicly subsidized health care coverage.

- **Essential Health Benefits:** Individuals enrolling in QHPs must receive coverage that meets or exceeds the "Essential Health Benefits" standard. The Department of Health and Human Services will launch an effort this fall to collect public input on the Essential Health Benefits standard. Based on expectations in the ACA, that standard will offer robust coverage, including mental health and substance abuse services that are often excluded from commercial plans. It may also include some Medicaid-optional benefits that states have selected not to cover in order to make plans more affordable for certain populations.
- **Benchmark Benefits:** Individuals eligible through the Medicaid expansion mandate must receive coverage that meets or exceeds a "Benchmark Benefits" package. The Benchmark package includes the Essential Health Benefits package plus extra "Medicaid-based" services, such as EPSDT for children, non-emergent transportation, and family planning.
- **Standard Medicaid:** Benchmark exempt populations[2] will receive a benefit package that includes the Benchmark Benefits plus additional services such as long-term supports and services and home health care.

Figure 1:

Benefit Packages in the Affordable Care Act



In advance of future guidance, states can review the benefits currently offered in their public programs against those offered in the commercial market. Each state must also make sure that QHPs and the Medicaid expansion benefit package meet the state's own requirements for mandated insurance benefits. Differences between benefit sets in the various health programs may create perverse incentives for individuals with complex health needs to minimize their income to remain eligible for Medicaid. Future federal guidance on essential benefits will further guide these decision points for states.

3. How can states ensure seamless eligibility and enrollment?

As states plan for expanded Medicaid enrollment, whether through early expansion or in 2014, they must also reexamine eligibility and enrollment processes. The ACA mandates a series of provisions that are designed to potentially simplify eligibility determination and enrollment in Medicaid. States are required to implement these changes by January 1, 2014, or risk losing federal financial participation. To meet these requirements, states must implement a single application form for Medicaid and QHPs,[3] and prospective beneficiaries must be referred to the appropriate program without having to submit an additional application.[4]

The July 15, 2011 regulations require the exchanges to evaluate and determine eligibility for applicants in Medicaid, CHIP and other health programs; however, these responsibilities can be delegated to the Medicaid agency. One key element of this seamlessness is the requirement for the exchange to use a single, streamlined application to collect information necessary for QHP enrollment, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and the BHP. HHS specifically

noted that this single application is designed to limit the amount of information an applicant has to provide and to reduce the number of times an individual must make submissions to receive an eligibility determination and complete the enrollment process.

The July 15 regulations also provide details on the creation of exchange-based Navigator programs and define criteria for selecting and duties pertaining to Navigators. The regulations allow state-based exchanges to award grants to organizations, public and private, to provide assistance to consumers.

Future regulations expected in the early fall of 2011 will provide greater detail on how eligibility requirements for public programs will be integrated into the exchange. Prior to receiving this guidance, states can begin to assess their readiness for streamlining eligibility. Before enrollment in any program or health plan, four distinct processes must take place: (1) outreach; (2) screening; (3) eligibility/subsidy determination; and (4) enrollment. Streamlining eligibility is inextricably linked to information technology (IT) systems, the overhaul of which will be an enormous challenge for most states. States may first opt to streamline the outreach and screening process in the short term, then re-do the actual eligibility determination and enrollment processes in the longer term.

4. What should states do to minimize the impact of individuals moving between programs?

Churning is not a new phenomenon in Medicaid, especially in states with coverage programs for low-income single adults. States will need to consider strategies for rate-setting and managing this churn within the HBE structure. Minimizing the "cliff" of program eligibility shifts can be achieved by providing a continuum of core benefits and cost-sharing structures.

Employment instability is a frequent challenge for many people, especially lower-income workers, so having Medicaid and CHIP linked to and available through the Small Business Health Option Programs (SHOP) Exchanges would be another way to help individuals maintain coverage. States focused on minimizing churn, however, should consider operating the two exchanges under a single governance or administrative structure, as allowed under the July 15 proposed exchange rule.

QHP enrollees are also likely to move between programs. Under the ACA, states can consider procurement requirements such as: (a) requiring health plans participating in Medicaid to offer HBE products; (b) mandating that managed care plans provide coverage statewide; and (c) developing provider panels that are consistent throughout the public and private products offered in the HBE. States with primary care case management or fee-for-service structures can achieve a similar goal by establishing these types of requirements for their statewide provider network.

5. What delivery system should a state use to cover the Medicaid Expansion Population?

Many states will experience a significant influx of new adults into Medicaid in 2014 – or even sooner in the case of states with early expansion plans. Prior state initiatives to expand coverage to uninsured populations indicate that many of these new beneficiaries can be expected to have relatively complex needs. A state's existing provider network may not be sufficient to meet those increased needs. In addition, many newly eligible beneficiaries with multiple complex care needs will likely have pent-up demand for physical and behavioral health care services. States, particularly those with behavioral health carve-outs, will need to consider mechanisms to foster integration across the continuum of care to effectively manage and care for this incoming population.

The significant increase in the Medicaid population coupled with the additional population in the QHPs will give states new purchasing powers in contracting with health plans. The ACA also provides opportunities for states to transform their payment and delivery systems through the creation of accountable care organizations (ACOs) and health homes for individuals with multiple chronic illnesses. This may involve adding new services such as transitional care, care coordination, and referrals to community and social support services, including supportive housing. But dramatic redesign takes time, and states may decide to start with existing delivery models and consider broader redesign in the future once the needs, demographics and service utilization patterns of the new beneficiary population are better defined.

6. How does a state decide whether a Basic Health Plan is a good fit?

The Basic Health Plan (BHP) is a new coverage vehicle established under the ACA for individuals with incomes between 139 percent and 200 percent of the federal poverty level. This option allows states to provide low-income residents who are ineligible for Medicaid benefits with coverage that is potentially more affordable than that provided by QHPs. If a state pursues this option, individuals would select a plan under contract with the state. The population that could receive coverage through a BHP is a population that is expected to frequently churn in and out of eligibility categories. A BHP would enable states to minimize the loss of coverage and smooth out program eligibility and enrollment for providers and health plans. For states interested in this option, it will be important to conduct an actuarial analysis regarding its financial viability and to determine whether the state can support the additional administrative and contracting requirements that a BHP would require. States will also need to consider the implication of pulling the BHP population out of the pool of prospective enrollees in QHPs.

7. Once the HBE is launched in 2014, what will happen to the state's safety-net providers and plans?

It is expected that 8.7 percent of the national population will remain uninsured once the ACA is fully implemented, though some will only be uninsured for short periods, e.g., between jobs.[5] For others, however – especially for individuals who are not citizens – the lack of health insurance will remain a chronic problem. For that reason alone, most states will have an interest in preserving safety-net providers.

Many patients who seek services from safety-net providers are currently uninsured. After 2014, a substantial number of these patients will be eligible for coverage through the Medicaid expansion or QHPs. The proposed exchange regulation makes clear that QHPs do not have to contract with essential community providers if the provider does not accept the generally applicable payment rate for the plan. However, the regulations require QHPs to reimburse Federally Qualified Health Centers (FQHCs) at the facilities' Medicaid prospective payment (PPS) rate. The FQHC PPS rates are facility-specific rates paid on a per encounter basis, and may be higher than the rates that QHP issuers pay to other contracted providers for similar services.

If QHP issuers are required to pay at least the Medicaid PPS rates to each FQHC that participates in the issuer's QHP network, the costs of QHPs with larger numbers of enrollees receiving care at FQHCs will be greater than the costs of QHPs with fewer enrollees seen at FQHCs. Furthermore, requiring QHP issuers to pay the full FQHC Medicaid PPS rate could lead insurers to minimally contract with FQHCs. On the other hand, if QHP issuers are permitted to negotiate mutually agreed upon payment rates with FQHCs, this would decrease the incentive to drive patients away from providers that may be best suited to meet their needs, while providing FQHCs leverage to negotiate payments that will allow them to continue providing comprehensive services, although payments may be less than Medicaid PPS rates.

Safety-net providers may want to contract with QHPs, but the rate complexity coupled with many state efforts to develop payment structures that pay for effective and efficient care may present a challenge to these provider types. HHS is seeking input from states, providers and insurers on how to move forward with these requirements in an effort to provide continued access to care.

States should also examine the impact of reduced Disproportionate Share Hospital (DSH) funding for hospitals that offer services to a large number of Medicaid beneficiaries and the uninsured. Under the ACA, these payments will dramatically decrease over the next several years.[6] Some DSH funding recipients will not be detrimentally impacted by the decrease in DSH funding. In fact, the ACA's expansion of the Medicaid program will bolster revenues for some current DSH recipients, particularly those that currently provide a significant amount of uncompensated care for the uninsured. Other safety-net providers, however, will continue to serve a large percentage of undocumented and uninsured patients, and the remaining DSH funds should be targeted accordingly.

8. How can Medicaid and the exchanges drive quality improvements in health care?

The July 15, 2011 proposed regulation clarifies that states have the flexibility to take advantage of the tremendous combined purchasing power that they will have through their HBEs. Efficiencies gained through common performance metrics, tracking tools and monitoring processes could help them achieve statewide quality improvement goals. However, HHS does request feedback on whether there should be minimum federal standards for network adequacy.

One option for states to consider is mandated, consistent performance and quality measures for QHPs, Medicaid and state employee plans. If provider or plan performance is not satisfactory, their contracts could be terminated. States may wish to consider social challenges such as poverty, housing and child care affordability, when developing performance expectations and outcomes for Medicaid plans. States can also consider releasing consumer-focused performance data so consumers are better informed during the plan selection process.

9. What role does the HBE play in ensuring program integrity?

Over the past several years, new federal program integrity efforts such as the Payment Error Rate Measurement (PERM) program have been a focus for state Medicaid officials. ACA program integrity mandates will need to be considered by states as they develop their HBEs. The ACA mandates states to contract with Recovery Audit Contractors to audit payments to providers.[7] In addition, the ACA requires Medicaid agencies to terminate providers who have been terminated by Medicare or another state's Medicaid program.[8]

The July 15 exchange regulations require the exchange to perform certain financial and program integrity evaluations including: evaluation of quality improvement strategies; overseeing implementation of enrollee satisfaction surveys; assessment and ratings of health care quality and outcomes; information disclosures; and data reporting. The regulation also notes that states may want to evaluate QHPs on past performance; quality improvement activities; enhancement of provider networks; service areas; and premium rate increases.

States will need to consider how provider enrollment is handled through payment and eligibility systems, and how these systems are tied into the HBE in order to facilitate audit reporting requirements. States will also want to consider how Medicaid provider audits and terminations will impact provider networks of other programs in the HBE.

10. How will the state pay for the HBE? Can Medicaid help?

In January 2011, CMS announced several new state funding opportunities for HBE planning.[9] Exchange establishment grants allow states flexibility as they are developing their exchange infrastructure. These grants also allow states that are moving faster to receive multi-year funding, which others can choose to apply annually. Indiana, Rhode Island and Washington have already been awarded these grants, and it is expected that many other states will apply this year.

In May 2011, CMS issued *Guidance for Medicaid and Information Technology (IT) Systems* to help guide states' planning for HBE implementation.[10] This guidance reiterates that states can use the exchange establishment grants for activities including:

- Program integrity enhancements;
- Policy and systems research;
- Stakeholder engagement;
- Financial management; and
- IT systems changes.

States may also wish to take advantage of the recently announced 90-10 match to build the eligibility system, as well as other enhanced funding to support state development of electronic health records in order to help fund the needed IT infrastructure in the state.[11,12]

Although initially funded by the federal government, by January 1, 2015, HBEs must be self-funded.[13] Most HBEs will charge participating health plans a fee or percentage of premiums to participate in the HBE. States will want to evaluate the flow of federal versus state dollars into programs offered through the HBE:

- QHPs will be paid using a combination of federal funds (through subsidies) and individual premium payments in excess of the subsidized amount. Therefore, if a state's HBE charges these plans to support itself, funds will be pulled from federal and personal dollars – no state resources would be involved.
- Medicaid payments to providers and health plans consist of a combination of federal and state dollars. Therefore, if a state's HBE charges these providers or plans to support itself, these funds will come from provider reimbursements or plan capitation rates.
- Part of the administrative fee would come from federal dollars via federal financial participation for Medicaid – so by including Medicaid plans and providers, the state would be bringing in more federal dollars to support the HBE. Budget-strapped states may want to optimize the flow of federal funds coming into the state.

Conclusion

States face enormous challenges as they begin the process of mapping out the development of their HBEs, and the July 15 proposed rule on exchange operations provides them with preliminary direction. Opportunities for linkages between public and private coverage abound. Such linkages should seek to: (a) streamline administration across programs; and (b) facilitate seamless transitions for individuals. Continuity of benefits, providers, and health plans is critical to developing a smooth roadmap for their HBEs.

ADDITIONAL RESROUCES

This brief is one in a series of resources that the Center for Health Care Strategies (CHCS), a national nonprofit health policy resource center, is developing to help states establish effective relationships between Medicaid and the emerging Health Benefits Exchanges. Future papers, made possible by the Robert Wood Johnson Foundation, will discuss: (1) the opportunities under the ACA to build stable health systems for low-income individuals; and (2) Medicaid benefit design options and considerations to facilitate continuity of care across eligibility levels.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS' work with state and federal agencies, health plans, providers and consumer groups focuses on: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.

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[1] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans Proposed Rule, 76 Fed. Reg. 41866, (July 15, 2011). Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf.

[2] Benchmark exempt populations include individuals below the state's 1996 welfare level; seniors and persons with disabilities; some pregnant women; and the medically frail.

[3] Affordable Care Act §1413(b).

[4] Affordable Care Act §2201.

[5] M. Buettgens and M. Hall. *Who Will be Uninsured After Health Insurance Reform?* (Washington, DC: Urban Institute, 2011) 1-13.

[6] Affordable Care Act §2551 as amended by §1203 of the Reconciliation Bill.

[7] Affordable Care Act §6411.

[8] Affordable Care Act §6501.

[9] U.S. Department of Health and Human Services, "HHS Announces New Resources to Help States Implement the Affordable Care Act," http://www.hhs.gov/news/press/2011pres/01/20110120b.html.

[10] Centers for Medicare & Medicaid Services, "Guidance for Medicaid and Information Technology (IT) Systems," http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/exchangemedicaiditguidance.pdf.

[11] Centers for Medicare & Medicaid Services, "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf.

[12] Centers for Medicare & Medicaid Services, "EHR Meaningful Use Overview," http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.

[13] U.S. Department of Health and Human Services, "Initial Guidance to States on Exchanges," U.S. Department of Health and Human Services, "Initial Guidance to States on Exchanges." http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html