

Exchanges and Medicaid: Key Issues for Implementing the ACA



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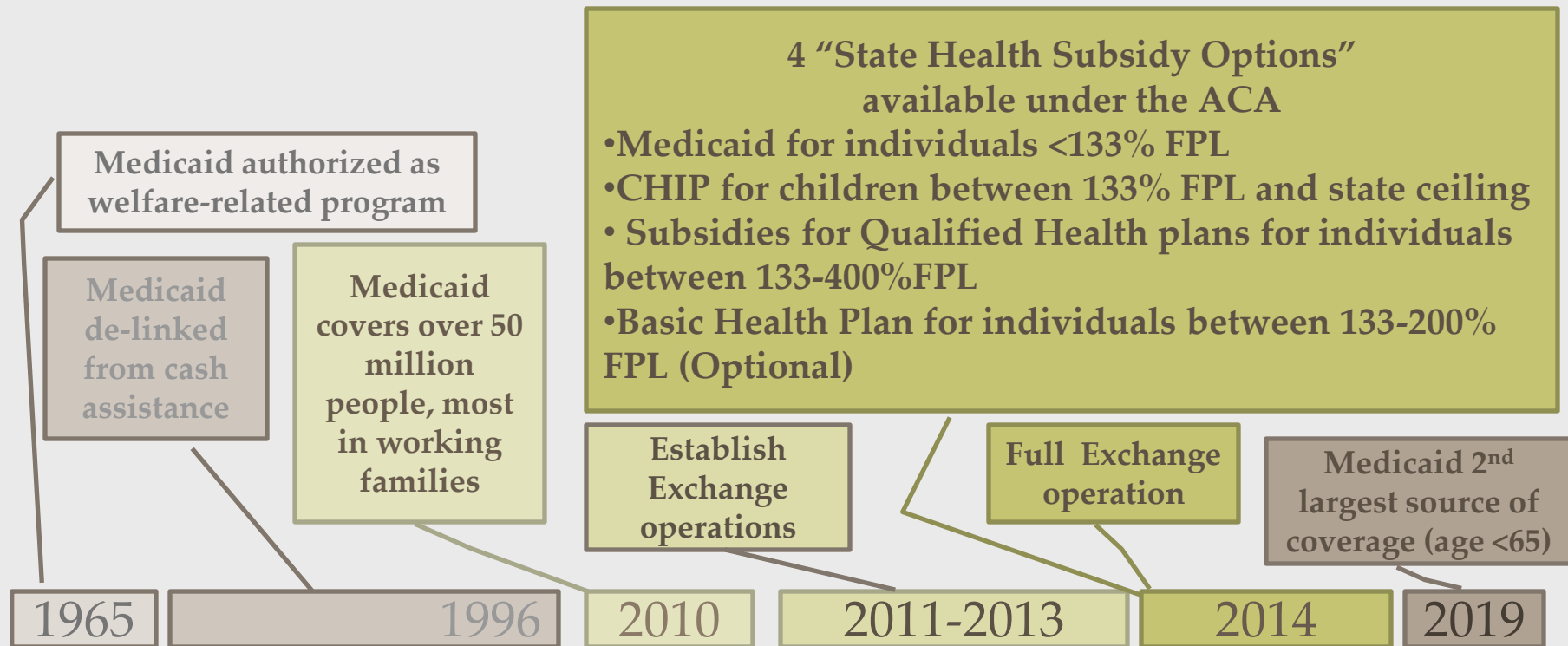
NATIONAL ACADEMY
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The 18th Princeton Conference: “Where Do We Go From Here:
The Future of Health Reform”
Princeton, NJ
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Overview

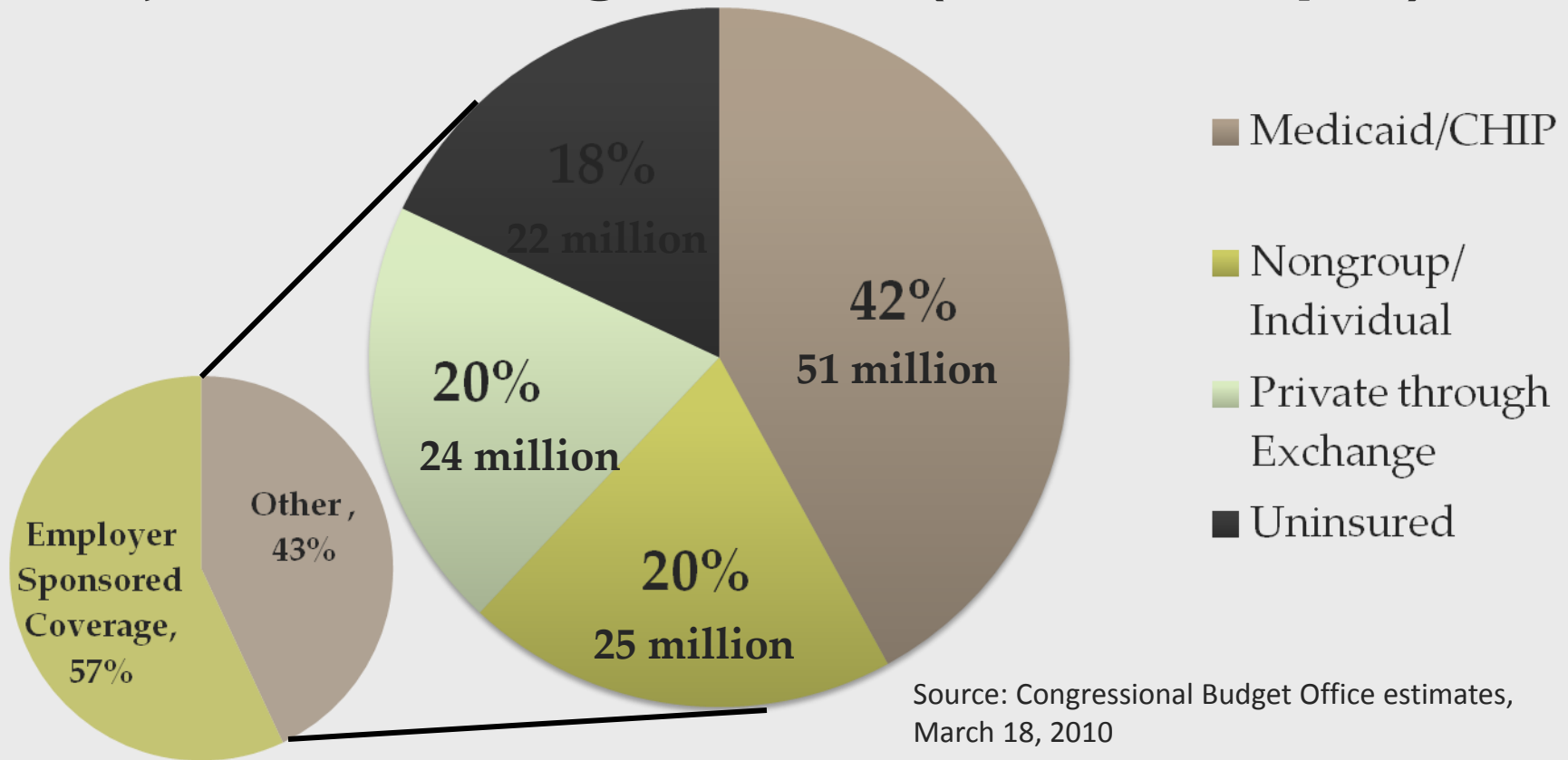
1. Context
2. Eligibility and Enrollment
3. Continuity of Coverage and Care
4. Purchasing/ Quality Strategy
5. Provider Payment and Supply
6. Governance and Infrastructure

Medicaid: From Welfare Program to Health Insurer



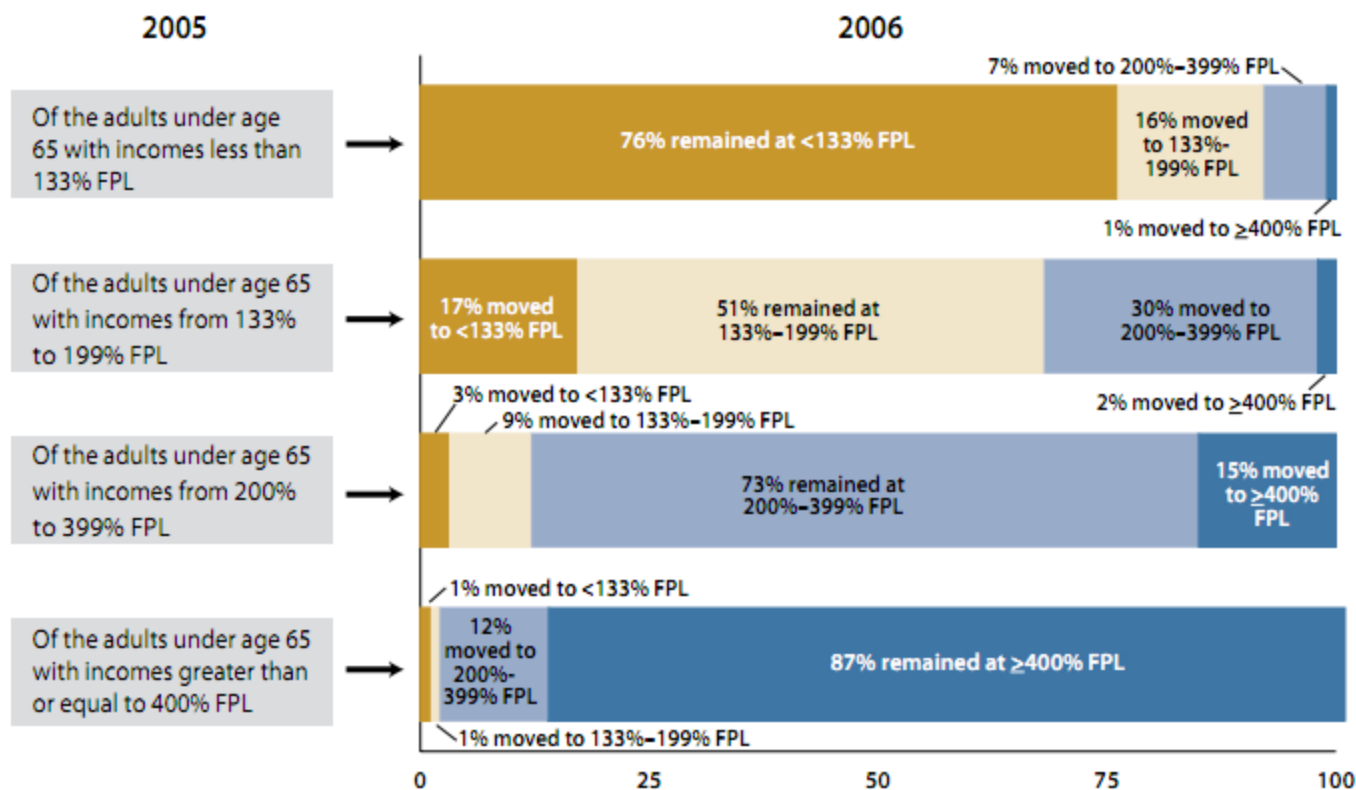
Medicaid and the Health Insurance Market

Projected Coverage in 2019 (People < 65 yrs.)



Income Fluctuations Among Those Below 400% FPL

Exhibit 4. Changes in Family Income, U.S. Population Under Age 65, 2005 to 2006



Source: Farley, P., Swartz, K., Uberoi, N., et al. *Realizing Health Reform's Potential:*

Maintaining Coverage, Affordability, and Shared Responsibility when Income and Employment Change. (New York, NY: The Commonwealth Fund, 2011)

Eligibility and Enrollment

- Exchanges are required to determine eligibility for and coordinate enrollment in Medicaid, CHIP, and state health subsidy programs using: (ACA §1413)
 - A single, streamlined eligibility form for all programs
 - A “secure, electronic interface”
 - Multiple access points: internet, mail, phone, in person
- New MAGI standard for Medicaid and subsidies
 - Point-in-time vs. income tax return eligibility determinations

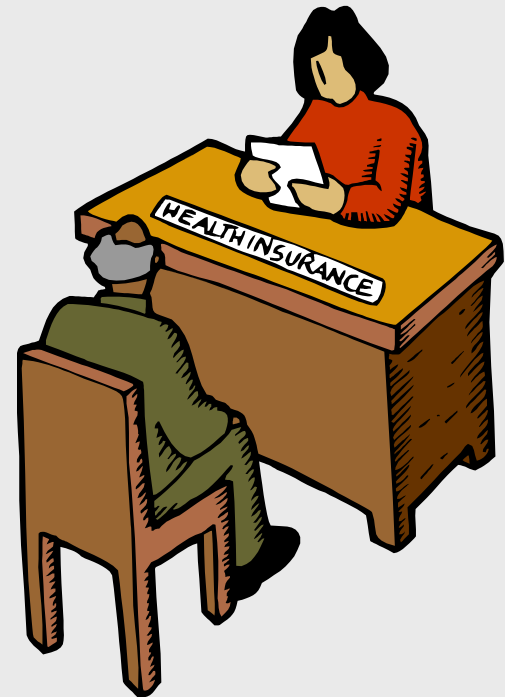
“...[S]ystem transformations should be undertaken in full partnership with Exchanges ... Extensive coordination and collaboration would be required between Exchanges and Medicaid.” NPR for Federal Funding for Medicaid Eligibility Determination & Enrollment Activities, 11/8/10

Eligibility and Enrollment

- Key eligibility considerations for states:
 - Data gathering/ sharing
 - Verification through state and federal databases
 - Information sharing vs. full process integration between Medicaid/CHIP and Exchange
 - Additional state eligibility regulations
 - Elimination of excessive requirements (ex. fingerprinting)
 - Continuous eligibility standards
 - Coordination with current public programs
 - Use of current applications and processes
 - Coordination with other public benefit programs (ex. Food Stamps)
 - Screen for non-MAGI populations

Eligibility and Enrollment

- Key enrollment considerations for states
 - Administrative efficiency
 - Coverage continuity
 - Consumer education
 - Household variability
 - Overlap between QHPs and Medicaid managed care plans



Achieving Continuity of Coverage & Care

- States may investigate the degree to which Medicaid with their Exchanges could and should interact
 - Through integration of Medicaid in the Exchange, states can:
 - Facilitate transitions
 - Leveraging buying power
 - Facilitate other policy goals (i.e. quality improvement)
- Continuum of integration strategies
 - Contracted plans
 - Provider networks
 - Basic health plan
 - Benefits



Achieving Continuity of Coverage & Care

□ Benefit Design

- Health needs of covered populations
- Enhanced FMAP
- Ease of administration
- “Essential benefits package” vs. Medicaid “benchmark” coverage

□ Risk Adjustment

- The Secretary will develop, a risk adjustment program that will apply to all plans in the individual and small group market both inside and outside of the Exchange (ACA §1343)
- States may consider using a similar adjustment program for Medicaid

Purchasing/ Quality Strategy

- States may use their power as purchasers in Medicaid and the Exchange to achieve critical policy goals
 - Alignment of standards and requirements across the “continuum of coverage”
- Plan contracting
 - Managed care plans – contracting through Medicaid agencies or purchasing through the Exchange?
 - Incentives for QHPs to offer Medicaid/CHIP and/or for Medicaid-only plans to become QHPs?
- Health plan certification
 - Standardization of all Exchange plans including Medicaid?
 - Application of current Medicaid plan requirements/ certification processes to QHPs?

Purchasing/ Quality Strategy

□ Quality and Reporting

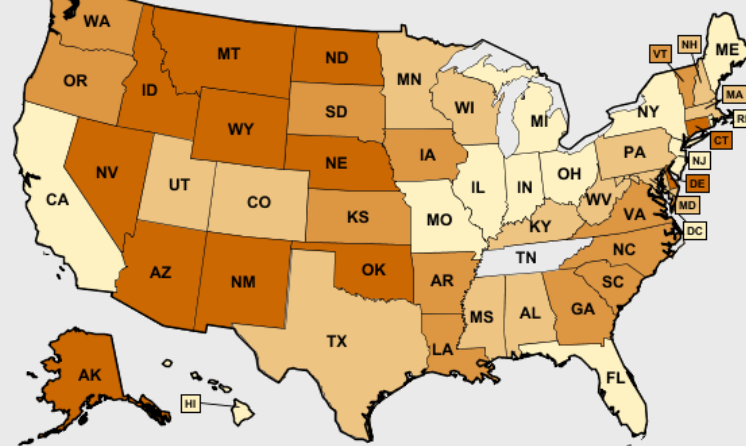
- The Secretary will develop guidelines for payment structures that incentivize quality improvement strategies (ACA §1311(g))
 - QHPs must report to Exchange plans on activities they have conducted to implement these strategies
- QHPs may only contract with hospitals that utilize patient safety evaluation systems and a comprehensive discharge program (ACA §1311(h))
- States may strategize on how best to leverage these requirements and develop a multi-payer approach to quality improvement in the Exchange that includes Medicaid/CHIP and QHPs



Provider Supply and Payment—Two Different Worlds?

- ❑ 32 million “newly insured” individuals competing for strained provider supply
- ❑ Low Medicaid reimbursement
- ❑ State range in degree to which Medicaid and commercial networks are separate
 - Incentives for providers and plans that participate in both Medicaid and commercial insurance plans?

Medicaid-to-Medicare Physician Fee Index, 2008



0.37 - 0.73

0.73 - 0.89

0.89 - 0.96

0.99 - 1.43

Physician fees relative to the national average.

Source: Statehelfacts.org

Governance & Infrastructure

- Exchange governance: What should be the role of the Medicaid and insurance agencies?
 - Different capabilities of each (ex. plan contracting)
 - To what degree would a contractual relationship promote administrative efficiency?
- Systems and administration
 - Facilitated integration with eligibility and enrollment functions
 - Determination of the extent to which Medicaid/CHIP infrastructure can be a platform for Exchange development
 - Realization of efficiencies through integration
- Federal funding opportunities
 - 90% Medicaid match for enhancement of eligibility systems
 - 75% match for Exchange operations

Resources and Contact

<http://www.nashp.org>

<http://www.staterereform.org/>

<http://www.maxenroll.org/>



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Thanks to:

Bachrach, D., Boozang, P., Dutton, M., *Medicaid's Role in the Health Benefits Exchange: A Road Map for States*. (Portland, ME: National Academy for State Health Policy, 2011)

Holahan, D., *Coordinating Medicaid and the Exchange in New York*. (New York, NY: United Hospital Fund, 2011)