

Medicaid Advisory Committee

February 26th, 2014

General Services Building
Salem, Oregon

Time	Item	Presenter
9:00	Opening Remarks	Co-Chairs
9:10	Approval of Minutes – January 2014	Committee
9:15	Oregon Health Authority - Standing update	Rhonda Busek, OHA
9:45	State of Washington: Apple Plus - WA’s Basic Health Plan - Churn assessment in WA	Washington Health Care Authority
10:30	Break	
10:45	Enrollment Dynamics Between OHP and Exchange Coverage - Assess differences in benefit coverage between OHP and Qualified Health Plans (QHPs) - State churn environmental assessment	Co-Chairs; staff
11:50	Public Comment or Testimony	
11:55	Closing comments	Co-Chairs: staff

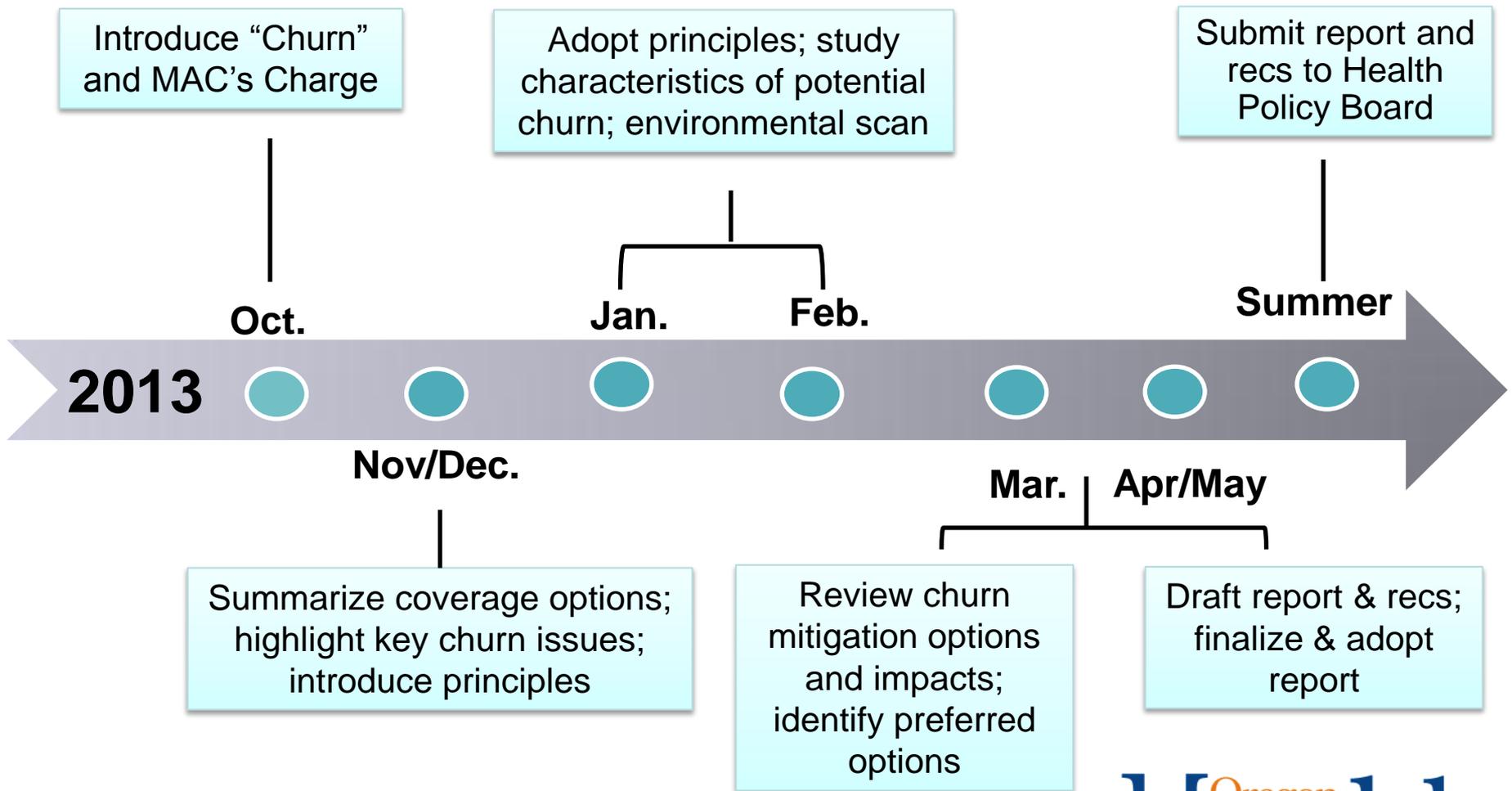
Committee Membership: Statutory Requirements

- The committee shall be composed of:
 - A physician licensed under ORS chapter 677;
 - Two members of health care consumer groups that include Medicaid recipients;
 - Two Medicaid recipients, one of whom shall be a person with a disability;
 - The Director of the Oregon Health Authority or designee;
 - The Director of Human Services or designee;
 - Health care providers;
 - Persons associated with health care organizations, including but not limited to coordinated care organizations under contract to the Medicaid program; and
 - Members of the general public.

Oregon Health Authority Update

Rhonda Busek, OHA

Committee Timeline: Churn Recs





Washington State Medicaid – Churn Solutions

Oregon Medicaid Advisory Committee, February 26, 2014

Nathan Johnson - Director - Policy, Planning and Performance

Jenny Hamilton - Senior Policy Analyst - Policy, Planning and Performance

Topics for Today's Discussion

- Churn assessment
- Current coverage context
- Status of potential solutions

Churn Assessment

Is churn a problem?

Income at Initial Determination v. Actual Annual Income for Enrollment Year

Row Percent	[- Final FPL Range -]				
Initial FPL Range	<139% FPL	139%-400% FPL	>400% FPL	TOTAL	
<139% FPL	68.9%	23.7%	7.4%	100.0%	
139%-400% FPL	21.7%	65.5%	12.8%	100.0%	
>400% FPL	13.5%	46.1%	40.3%	100.0%	
TOTAL	47.0%	39.9%	13.1%	100.0%	
Initial FPL Range	<139% FPL	139%-200% FPL	201%-400% FPL	>400% FPL	TOTAL
<200% FPL	63.0%	13.3%	16.3%	7.3%	100.0%
139%-200% FPL	33.0%	24.2%	35.8%	unreliable	100.0%
201%-400% FPL	15.8%	14.2%	54.2%	15.7%	100.0%
>400% FPL	13.5%	8.1%	38.0%	40.3%	100.0%

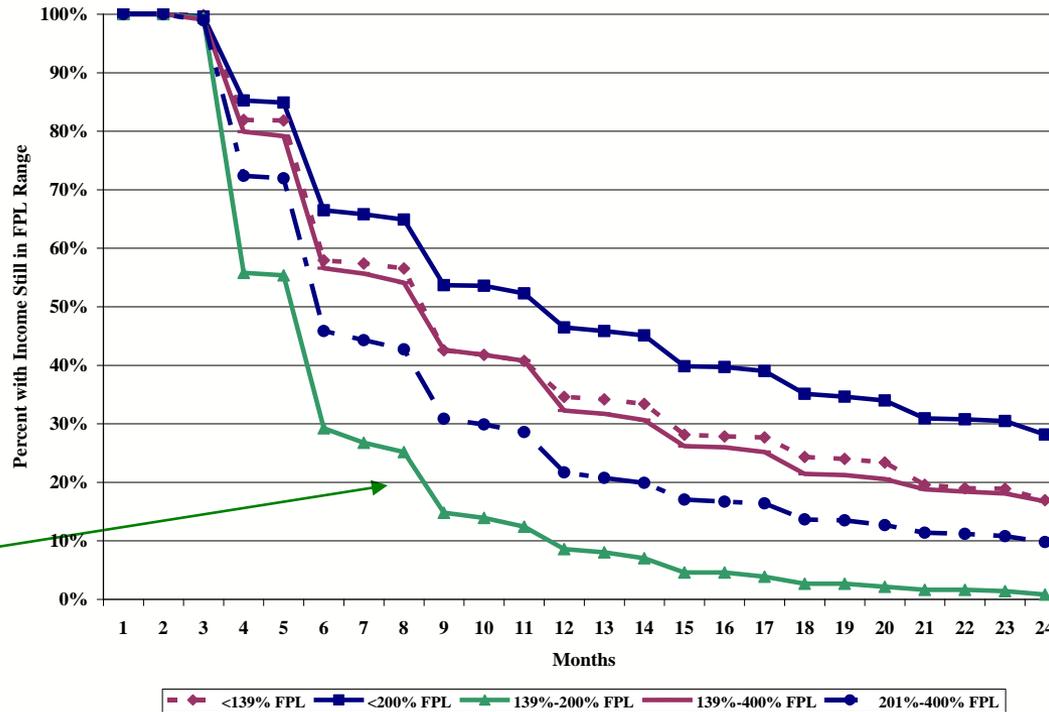
Notes: Based on Washington State adults age 19-64 without employer-sponsored insurance (ESI) at initial determination. FPL = federal poverty level. Source: SIPP analysis by John A. Graves, Ph.D.

<http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#churn>

Who is likely to experience churn?

- Over several years, very few stay in the 139-200% FPL income range

Retention in Initial (Current) Income Level (WA Adults 19-64)



139%-200% FPL

Why is churn a problem?

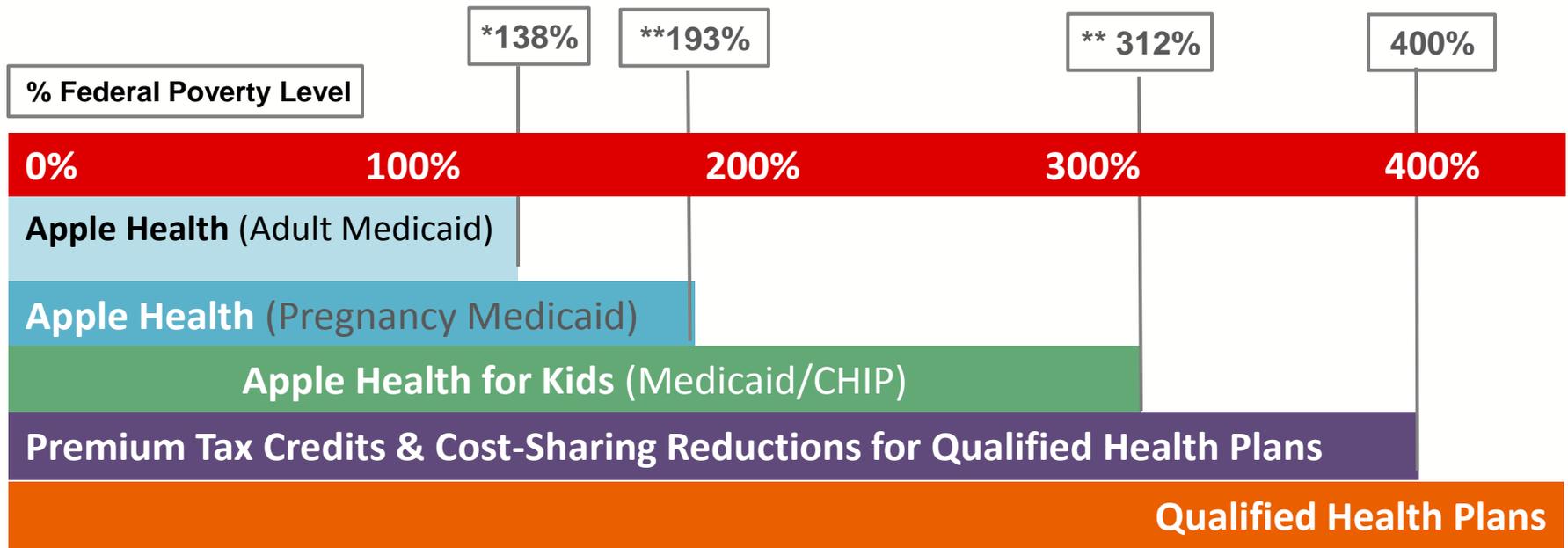
- Changing life circumstances & different Medicaid eligibility levels for children, parents & pregnant women result in:
 - ❖ Mixed family coverage from different plans in Medicaid (Apple Health) and Exchange (Qualified Health Plans)
 - ❖ Disruption of provider relationships and care during transition
 - ❖ Unnecessary duplication of tests and treatment plan revisions
 - ❖ Increased administrative expense for health plans
 - ❖ Decreased incentive for health plans/providers to invest in longer-term care management and coordination activities
 - ❖ Administrative difficulty in managing benefits /measuring quality when enrollees switch health plans frequently

Current Coverage Context

Washington's Policy Goals

- Optimize access to and use of needed services
- Maximize continuity of coverage as eligibility circumstances change
- Maximize continuity of care as eligibility circumstances change
- Make cost-effective use of federal, state and private dollars
- Identify and optimize administrative simplification opportunities
- Comply with or, seek waiver from, specific ACA coverage and eligibility requirements

2014 Continuum of Coverage



* The ACA's "133% of the FPL" is effectively 138% of the FPL because of a 5% across-the-board income disregard

** Based on a conversion of previous program eligibility standards converted to new MAGI income standards



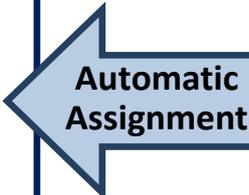
washington healthplanfinder

powered by the Washington Health Benefit Exchange

Medicaid Managed Care



Family Income (4):
~\$46,500 (195% FPL)



Qualified Health Plans



KEY GOALS:
Consumer Choice with
Whole-Family Coverage AND
Churn Reduction

Status of Potential “Solutions”

Overview

- What problem needs to be solved?
 - ❖ Coverage continuity
 - ❖ Care continuity
 - ❖ Affordability – cost-sharing cliff between Medicaid / QHPs
 - ❖ Whole family coverage

- Options proposed in Washington
 - ❖ Apple Health *Plus*
 - ❖ Federal Basic Health Option
 - ❖ Premium assistance in Exchange - for new Medicaid adults; CHIP children 215% -317% FPL
 - ❖ Alternatives – Bridge plan; Medicaid expansion

Apple Health *Plus* - Overview

- Intent for Exchange QHPs to participate in Medicaid on limited basis for adult churners and children of Exchange parents
 - ❖ Bridge to a more comprehensive churn/whole-family coverage solution or better marketplace alignment
 - ❖ All Medicaid contractual requirements apply to Apple Health *Plus* plans including full Medicaid benefits
 - ❖ Same provider network available between QHPs and Apple Health *Plus*
 - ❖ Plan participation solicited through an open application process – only 1 QHP responded
 - ❖ Original target January 1, 2014 start-up
 - ❖ Feb 2014 - Implementation challenges and anticipated Medicaid plan selection opportunity for January 2015 caused QHP to back out.

Federal Basic Health Option

- Pre-CMS guidance – <http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#federal>
 - ❖ Jun 2012 – State proposal based on historic Basic Health program
 - ❖ Dec 2012 – Report to Legislature confirms FBHO suspended (no DHHS guidance; fiscal impact to State unknown)
 - ❖ 2013 – Legislative study requested further analysis but didn't fund econometric modeling
- 2014 Legislative action to Feb 19, 2014
 - ❖ HB 2594/SB 6231 – Preliminary Blueprint, econometric modeling of enrollment and cost implications to state, enrollees & marketplace
 - ❖ SHB 2594 – added implementation for January 2016 coverage
 - ❖ ESHB 2594 – removed implementation, added report of modeling to include implications for provider reimbursement and Exchange stability, and comparison with insurance market for continuity of care, coverage affordability and access.

Contact Information

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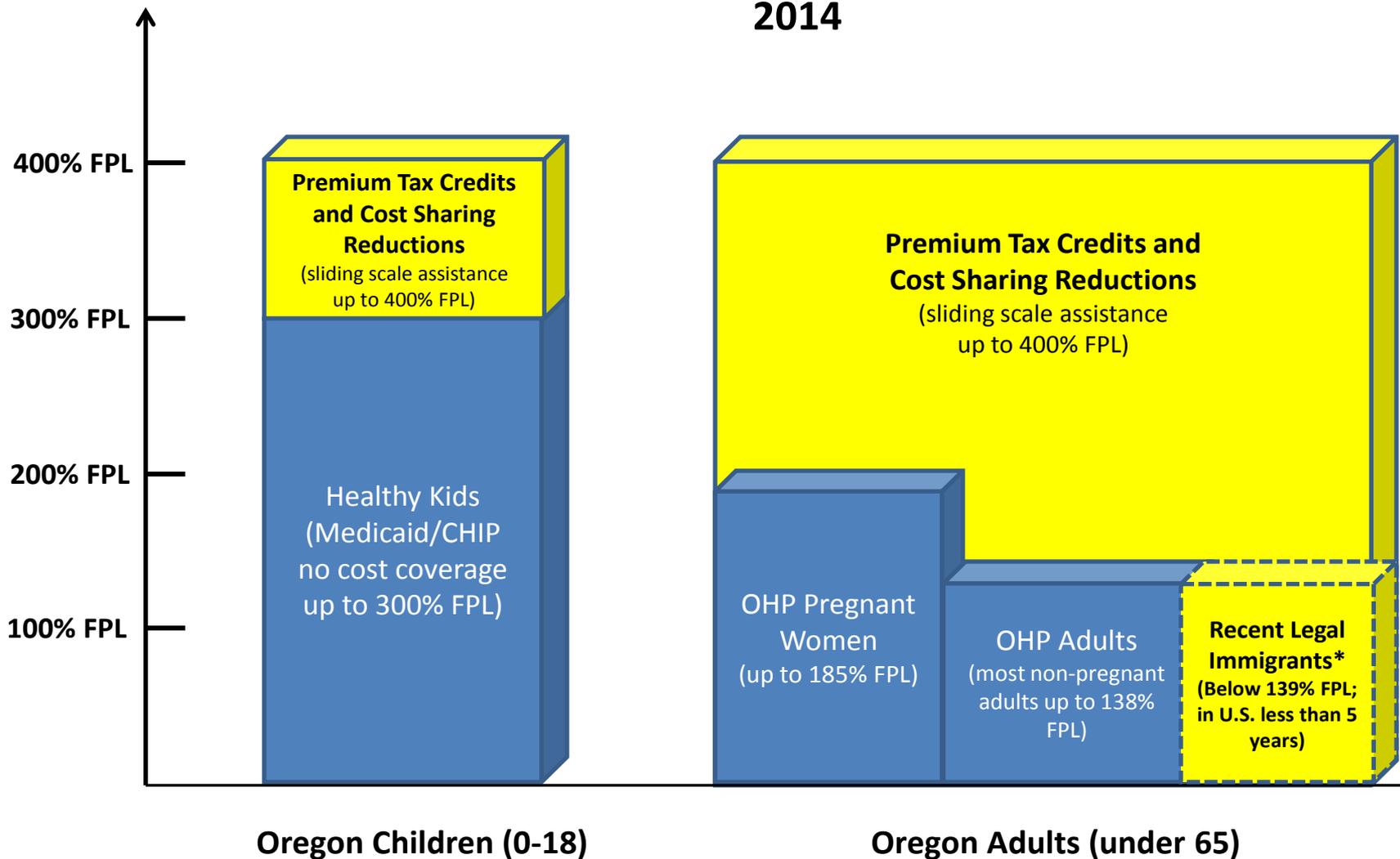
Enrollment Dynamics Between the OHP and Commercial Qualified Health Plans

Decision-making Criteria for Oregon's Churn Mitigation Options

Principles for Evaluation of Churn Mitigation Strategies

- Maximize affordability, benefit coverage, and continuity of care for individuals and families
- Consider the health and *support needs* of diverse subpopulations, parents, women, children, persons with disabilities, and residents in rural and frontier areas, among others served by OHP
- Balance consumer needs with the need for financial viability and operational self-sufficiency in the state Medicaid program, the health insurance exchange, and the *health care delivery system*
- Promote coverage options that ensure access and continuity to comprehensive health services and result in the lowest net level of churn

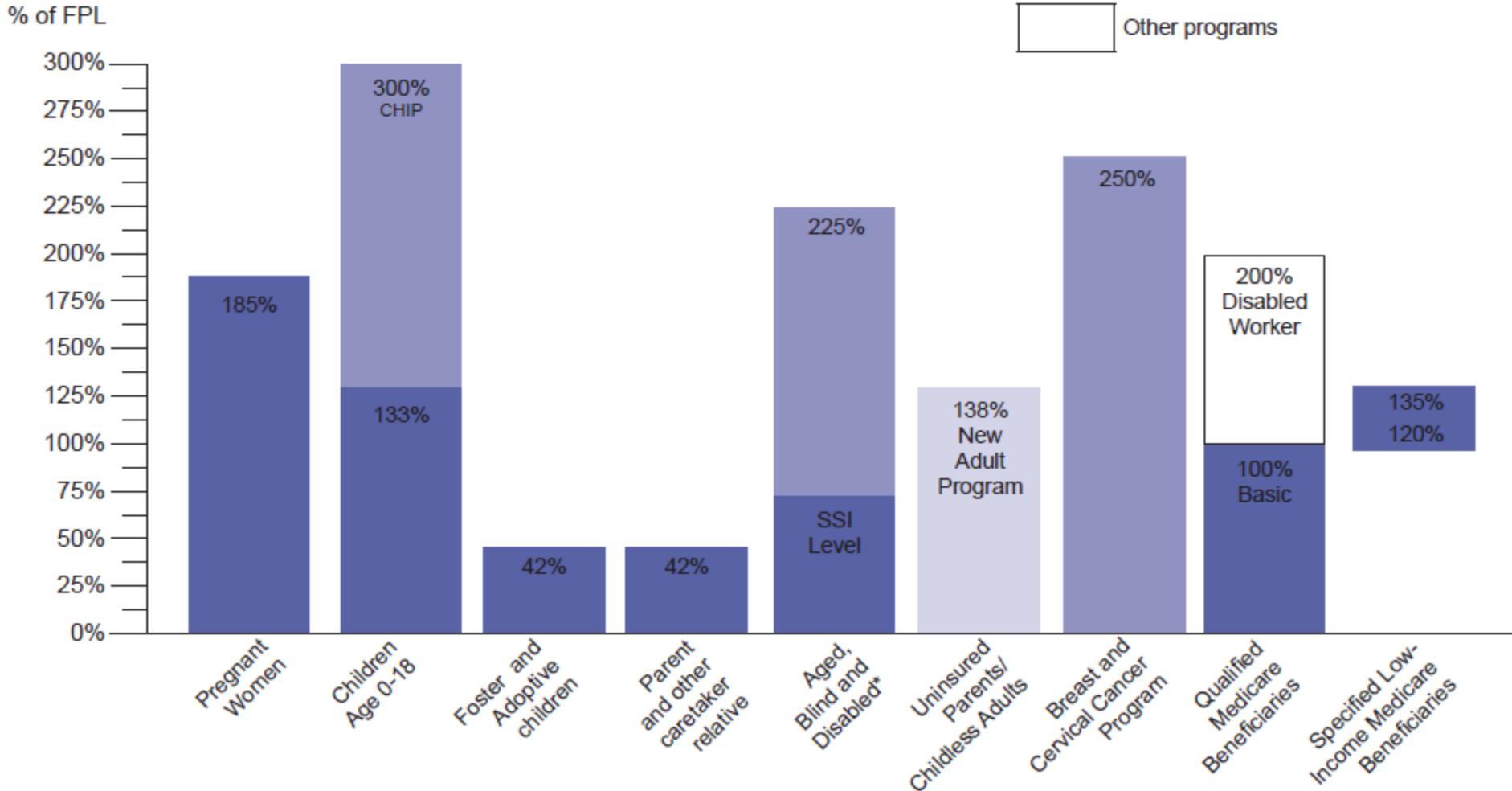
Insurance Affordability Programs in Oregon through the Affordable Care Act: 2014



*Lawfully residing immigrants in the US for 5 years or less will have access to coverage through the health insurance marketplaces and to premium and cost sharing subsidies based on income. Generally, will not be eligible for Medicaid and CHIP.

Medicaid Eligibility 2014

Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups



Differences in Commercial EHB Benchmark and Medicaid ABP (OHP+)

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management;
- and pediatric services, including oral and vision care.

Differences in Commercial EHB Benchmark and Medicaid ABP (OHP+)

- ✓ ambulatory patient services;
- emergency services;
- ✓ hospitalization;
- maternity and newborn care;
- ✓ mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- ✓ rehabilitative and habilitative services and devices;
- laboratory services;
- ✓ preventive and wellness services and chronic disease management;
- ✓ Pediatric services, including oral and vision care.

Benefit Differences

Differences in Commercial EHBs and Medicaid ABPs		
Benefit	Commercial	Medicaid
Naturopath	Not Covered	Covered
Acupuncture	Not Covered	Limited
Chiropractic	Not Covered	Limited
Bariatric	Not Covered	Limited (T2 diabetics)
Massage Therapy	Not Covered	Covered
Hearing Aids (Adults)	Not Covered	Covered
Hospice/Respite care	Limited respite care	Covered
Inpatient Hospital Mental/Behavioral Health*	Limited residential treatment	Covered
Inpatient Rehabilitation*	Limited	Covered
Outpatient Therapies*	Limited	Covered

*Benefits that are key cost drivers

Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
<i>Ambulatory patient services</i>			
Acupuncture	Not Covered	√ chemical dependency, HIV, migraine, post- stroke depression, limited medical conditions during pregnancy	Non EHB
Chiropractic	Not Covered	√ certain conditions only (including back pain with neurologic component, not muscular)	
Naturopath	Not Covered	√	
Routine vision care	Not Covered	Not Covered for adults 21 and over	Limited to <21
Dental - diagnostic & preventive	Not Covered	√ (for all ages)	Non EHB
Dental - basic	Not Covered	√ (for all ages)	
Dental - dentures	Not Covered	limited	

Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
<i>Hospitalization</i>			
Organ & tissue transplants	√ limited to organs specified \$5000 limit for travel expenses \$8000 limit for donor expenses lodging for caregiver	√ limited to organs specified	Limit Expenses
Bariatric surgery	Not Covered	√ limited to patients w/ type 2 diabetes	Non EHB
Hospice / respite care	√ respite limit 5 consecutive days / 30 days	√	Limit Benefit

Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
<i>Mental health and substance use disorder services, including behavioral health treatment</i>			
Inpatient hospital - mental/behavioral health	√ limit 45 days / yr. for residential treatment	√	Limit Benefit Quantity

Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
<i>Rehabilitative and habilitative services and devices</i>			
Inpatient rehabilitation	√ limit 30 days / yr. additional 30 days for head/spinal cord injury	√ No limits when in skilled nursing, IP hospital or IP rehab	Limit Benefit Quantity
Physical, speech & occupational therapy (outpatient)	√ limit 30 visits / yr. additional 30 visits / condition for specified conditions	√ No limits for 3 mos. After 3 mos. stabilization, 2 visits per year (PT/OT/ST) Change of status triggers an additional 6 visits/year for ST/OT/PT	Limit Benefit Quantity
Massage therapy	Not Covered	√ as part of PT	Non EHB

Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
<i>Rehabilitative and habilitative services and devices (cont.)</i>			
Durable medical equipment (DME)	√ limit \$5000 for non-essential DME	√ Per Administrative Rules	Limited Benefit
Vision hardware	Not Covered	NC for adults 21 and over Covered for ages 19 and 20	OHP Coverage only 19-21
Hearing aids – adults	√ \$4,000 every 48 months for certain people under age 25	√ 1 hearing aid every 5 years	Age limit
Skilled nursing	√ limit 60 days / yr.	√	Limited Benefit
Home based habilitative services per state plan	Not Covered	√	Not Covered

Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
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Preventive and wellness services and chronic disease management

Nutritional counseling	√ limit 5 visits / lifetime	√	Exclusion/ Limitation
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Benefit	EHB Benchmark/ QHP	Alternative Benefit Plan (OHP+)	Difference
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Pediatric services, including oral and vision care (19-20 year olds)

Hearing aids	√ limit \$4000+CPI / 4 yrs.	√	Limitation
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Non-EHB Services (Medicaid specific)

Benefit	Alternative Benefit Plan (OHP+)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	√
Services provided in a Rural Health Clinic	√
Services provided in a Federally Qualified Health Center	√
Dental (excluding major, e.g. crowns, etc.)	√
Nursing facility services	√
Targeted case management	√
non-emergency medical transportation	√
Private duty nursing services	√
Intermediate care services	√
Extended services for pregnant women	√
Personal care services	√

STATE CHURN ENVIRONMENTAL ASSESSMENT

State Options to Mitigate Churn

- Contractual Mechanisms
- Basic Health Plan
- Bridge Plan(s)
- Wraparound
- Premium Assistance
- Other strategies to reduce the impact of coverage transitions

Contractual Mechanisms

- Coverage transitions encourage plan acceptance of prior authorizations and ongoing course of treatment through contract provisions to avoid disruptions in care
- Transition plans, readiness reviews, and health information sharing ensure continuity of coverage between relinquishing and receiving Medicaid managed care organizations (MCOs) and marketplace qualified health plans (QHPs)

Basic Health Plan: What Is It?

Optional coverage program under ACA that allows states to use federal funding to offer subsidized coverage for individuals with incomes below 200% FPL

Eligibility: Individuals 139% - 200% FPL and recent legal immigrants <138% FPL (in US <5 years), under age 65, and who meet all other eligibility requirements for Qualified Health Plans

Benefits and Cost:

- Requires "essential health benefits" at a minimum and a medical-loss ratio of at least 85%
- Premiums/cost sharing no more than what enrollees would pay in QHP
- State must offer a choice of at least two plans and plan selection must use a competitive bidding process

Funding and Administration:

- Federal government pays state 95% of value for premium tax credits and cost sharing reductions it would have provided to eligible individuals enrolled in the Marketplace.
- State must establish a BHP trust fund to receive funding

Basic Health Plan

Minnesota*

- BHP is a particularly beneficial for MN as they already cover adults from 138%-200% FPL under MinnesotaCare, a jointly funded, federal-state program
- Estimate savings from \$100 to \$300 million under BHP compared with MinnesotaCare

BHP Learning Collaborative

- Eight states joined a federal BHP Learning Collaborative with CMS
- States are in different places for considering BHP implementation

* Source: Information from Minnesota's Health Insurance Exchange Advisory Task Force.

Medicaid Bridge Plan: What Is It?

- Allows Medicaid MCOs to offer QHPs in exchange on limited enrollment basis to:
 - Individuals transitioning from Medicaid/CHIP to Exchange, or
 - Family members of consumers enrolled in or transitioning from Medicaid/CHIP
- Allows individuals transitioning from Medicaid/CHIP to exchange based QHPs to:
 - Stay with the same issuer and provider network
 - Offer family members to be covered by a single issuer and provider network
- Potential for greater consumer affordability

Bridge Plan: Examples

California Bridge Plan

- First known state to pursue a Medicaid bridge plan

WA Apple Health Plus

- Permits health plans participating as QHPs in the exchange to also participate in the Medicaid managed care delivery system by offering an Apple Health Plus (AHP) product on a limited basis:
 - Medicaid/CHIP-eligible children of parents enrolled in a QHP
 - Women enrolled in a QHP who become Medicaid-eligible due to pregnancy
 - QHP enrollees who become Medicaid eligible due to income fluctuations

Wraparound: What Is It?

- **Premium and cost-sharing wrap:** Offer additional premium and cost-sharing subsidies to former Medicaid enrollees selecting the lowest price QHPs, making plans more affordable for individuals and possibly encouraging competitive pricing.
- **Benefit wrap:** Allow individuals whose income increases beyond the Medicaid limit to retain certain benefits or continue to receive *medically necessary services* in their care plan for a fixed period of time when they move to a QHP.
- **Combination:** With federal approval, move individuals *near* the Medicaid income limit to a QHP (with financial support for premiums and cost sharing) to minimize disruptions if income does increase; would have to include wrap-around coverage for Medicaid benefits not included in QHP.

Premium Assistance: What Is It?

- Enables individuals to stay with the same health plan and provider network as their income fluctuates above and below Medicaid eligibility levels
- Provides Medicaid beneficiaries the same access to providers as privately insured patients, as required by federal Medicaid law
- Enables “whole family” coverage, i.e. Medicaid/CHIP eligible children can enroll in the same health plans as their parents who are eligible for tax credits through QHPs.

Medicaid Health Insurance Premium Payment (HIPP)

- Medicaid/CHIP funds help pay for employer-sponsored insurance (ESI) using employer or enrollee fees to help pay premium costs
- Operates under Medicaid §1906 authority
- Benefits must be “cost-effective” to state, i.e. must cost less than enrolling eligible individuals into public programs
- Ensure same package of benefits at the same cost as they would under traditional Medicaid.

Additionally, states have multiple other options to provide premium assistance through Medicaid and CHIP

Other strategies to mitigate coverage transitions

Examples include:

- Eligibility and enrollment policies to minimize churn such as 12-months continuous eligibility, extending Medicaid coverage prior to termination, and adopting presumptive eligibility for adults.
- Align benefits and provider networks between Medicaid and the exchange to support uninterrupted care coordination.
- Align provider and payer incentives between Medicaid and the exchange.
 - E.g. New York decided that its Medicaid and Child Health Plus plans must also offer exchange coverage.

Public Comment

Next Meeting

- March 26th
- **Different time: 10-1pm*
- **Location:*
 - Portland State Office Building
 - 800 NE Oregon Street
 - Portland, OR