MEDICAID ADVISORY COMMITTEE

March 26th

10:00 a.m. – 1:00 p.m.

Portland State Office Building
800 NE Oregon St
Room 1E
Portland, OR 97232

Public listen - only conference line: 888.204.5984; Participant Code: 1277166
Webinar registration link

Time	Item	Presenter
10:00	Opening Remarks	Co-Chairs
10:05	Approval of Minutes – February 2014	Committee
10:10	2014 Legislative Update	Brian Nieubuurt, OHA
10:30	Overview of Churn	Deborah Bachrach & Kinda Serafi; Manatt Health Solutions
10:50	Strategies to Mitigate Disruptions as a Result of Churn - Including Discussion of Advantages/Disadvantages	
11:45	Break	
12:00	Strategies to Reduce or Avoid Churn Including Discussion of Advantages/Disadvantages – Special Considerations for Pregnant Women	
12:45	Public Comment or Testimony	
12:55	Closing comments	Co-Chairs; staff
1:00	Adjourn	

Next meeting:
April 23, 2014
9:00 a.m. to noon
General Services Building
Mazama Conference Room
1225 Ferry St. SE, Salem, Oregon

Introduction

It is estimated that the Oregon Health Plan (OHP), Oregon's Medicaid program will add up to 240,000 new Medicaid enrollees under expansion by 2016.[1] Overtime changes in income, employment status or family circumstances, so will their eligibility for coverage programs, creating movement or "churn." Individuals who receive coverage through Exchange offered plans may not receive the same benefits offered by OHP, and vice versa. To minimize the effects of churn that can results from benefit differences, which are important to the health coverage of affected individuals, a key consideration is for states to assess benefit differences between Medicaid and qualified health plans (QHPs).

Benefit Differences

The federal Affordable Care Act (ACA) mandates that people eligible for Medicaid expansion and those enrolling in QHPs, both inside and outside of the Exchange receive a comprehensive benefit package. Known as essential health benefits (EHBs) the EHBs must include items and services within 10 service categories. States are allowed to select from a set of benchmark plans and are not required to have the same benchmark plan for their Medicaid program and Exchange plans (i.e. Oregon's Medicaid Alternative Benefit Plan or ABP).[2] Plans offered through an Exchange reflects a "typical" health plan offered by employers, which generally do not have different benefit packages tailored to the specific health care needs of each individual seeking coverage. In Oregon, Medicaid or OHP covers more services than those offered in the 2nd lowest-cost silver QHP offered in the Exchange (see table 1).

Table 1: Potential Differences in Coverage between QHPs and Medicaid

Benefit	Qualified Health Plans	Medicaid
Naturopath	Not Required	Covered
Acupuncture	Not Required	Limited to specific conditions[3]
Chiropractic	Not Required	Limited to specific conditions (i.e., back pain with neurologic component)
Bariatric	Not Required	Limited to Type 2 diabetics
Massage Therapy	Not Required	Covered
Hearing Aids (Adults)	Not Required	Covered
Hospice/Respite care	Limited respite care - 5 consecutive days or 30 days/yr	Covered
Dental	Not Required	Limited major dental services for adults 21+
*Inpatient Mental/Behavioral Health	Limited to 45 days/yr for residential treatment	Covered
*Inpatient Rehabilitation	Limited to 30 days/yr with add. 30 days for head/spinal cord injury	Covered
*Outpatient Therapies	Limited to 30 days/yr with add. 30 days for specific conditions	Covered

*Indicates benefits that are key cost drivers.

[1] Estimated Financial Effects of Expanding Oregon's Medicaid Program under the Affordable Care Act (February 2013).

[2] Oregon's Medicaid program selected the Oregon Health Plan Plus (for nonpregnant adults) as its benchmark benefit package[2], while the PacificSource Preferred CoDeduct small group plan was selected as the benchmark for qualified health plans in the exchange.[2]

[3] Limited to chemical dependency, HIV, migraine, post-stroke depression, and some conditions during pregnancy.

States are also required to cover additional services through their Medicaid program (see below for list). Consequently, individuals who move from OHP to a QHP through Cover Oregon will likely experience a change in the scope of benefits covered.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Services provided in a Rural Health Clinic
- Services provided in a Federally Qualified Health Center
- Dental (routine and basic for 21 and over)
- 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

Oregon Considerations for Addressing Benefit Differences in Oregon

Disruptions in coverage and/or lack of care coordination across transitions could result in unmet needs or exacerbation of chronic conditions. The options highlighted are examples of approaches to minimize benefit differences for individuals that transition from OHP to QHPs.

- **Benefit alignment** between OHP and QHPs through Cover Oregon can be used as a mechanism to reduce the impact of churn on individuals transitioning from Medicaid to QHP-eligible tax subsidies or vice versa. Alignment efforts could focus on the benefit differences with higher cost implications or target specific benefits for certain population subsets such as pregnant women and individuals with multiple chronic conditions.
- **Provider network alignment** across coverage options and to ensure the appropriate mix of providers to meet patients' needs.
- **Contractual mechanisms** between Coordinated Care Organizations and QHPs, such as transition plans, readiness reviews, health information sharing and acceptance of prior authorizations and ongoing course of treatment.
- **Wrap-around benefits** allow individuals whose incomes increase beyond the Medicaid limit to retain certain benefits and thus continue to receive medically necessary services in their care plan for a fixed period of time when they move to a QHP.

DRAFT

Enrollment Dynamics Between the Oregon Health Plan and Commercial Qualified Health Plans

Introduction

Implementation of the Affordable Care Act (ACA) will have major impacts on Oregon, by establishing a continuum of subsidized coverage through programs referred to as insurance affordability programs (IAPS):

- Expansion of Medicaid eligibility to low income adults up to 138% of the federal poverty level (FPL),
- Extension of the Children's Health Insurance Program through 2019, and
- Establishment of a health insurance exchange that will provide access to premium tax credits and cost-sharing subsidies for adults with incomes up to 400% FPL.

It is estimated that the Oregon Health Plan (OHP) will add up to 240,000 new Medicaid enrollees under expansion by 2016.[1] Due to changes in income, employment status and family circumstances, some of these individuals will eventually experience shifts between Medicaid and commercial coverage. Nationally, it has been estimated that within a six month timeframe, more than 35% of adults below 200% of the FPL will experience a shift in eligibility from Medicaid to a health insurance exchange, or the reverse; that percentage jumps to 50% within 1 year.[2] To explore the potential magnitude of "churn" in Oregon, the Oregon Health Authority (OHA) collaborated with the Centers for Health Care Strategies (CHCS), the State Health Access Data Assistance Center (SHADAC), and Mercer on an analysis that estimated the number of individuals likely to "churn" between programs. This report identifies key differences between Medicaid and commercial coverage in terms of benefits, consumer premiums, and cost sharing responsibility.

The Issue

To ensure a seamless system of coverage, the ACA requires a single streamlined application for all IAPs and a coordinated process for IAP eligibility and enrollment. States are starting to look beyond eligibility and enrollment processes to explore different mechanisms to mitigate churn's most impactful effects: disruptions in coverage, care continuity and coordination. The underlying issues associated with the effects of churn include, but are not limited to:

- Differences in benefit coverage and provider networks, which can lead to fragmented, lower quality of health care and increased costs, e.g., duplication of diagnostic tests and the need to coordinate or renew treatment plans.
- Affordability of coverage (e.g. higher levels of cost-sharing including out-of-pocket caps for individuals and families particularly as they churn upward out of Medicaid into commercial coverage).
- Undermining of incentives for health plans and providers to invest in longer-term health improvements, because enrollment turnover means health plans cannot expect to benefit from such investments.

[1] Estimated Financial Effects of Expanding Oregon's Medicaid Program under the Affordable Care Act (2014-2020). Manatt Health Solutions, State Health Access Data Center, and Oregon Health Sciences University. February 2013.

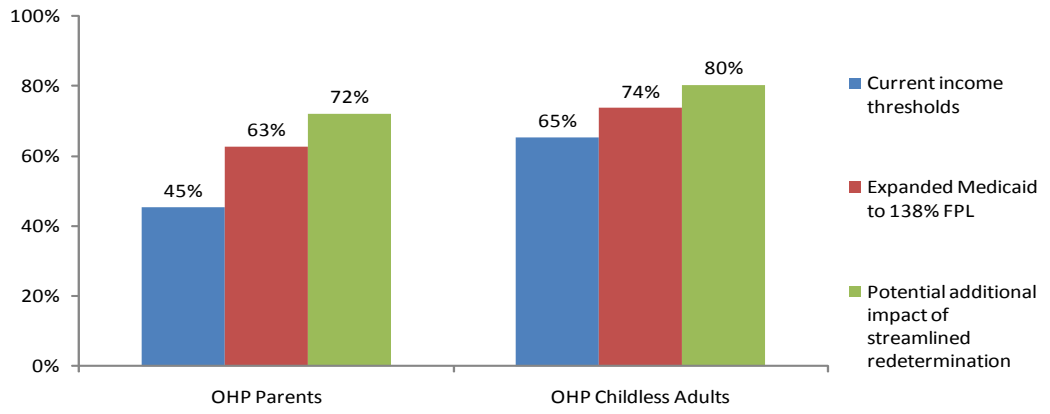
[2] B. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Health Affairs, February 2011,30:2, 228-236.

- Difficulty for the State to enforce benefit limits and limitation to measure and compare quality across health plans over time.
- Administrative expenses associated with enrollment turnover.

Initial Estimates of Churn

Eligibility changes in 2014 will likely result in increased retention of Medicaid enrollees as a wider income range up to 138% FPL will allow for more individuals to be continuously eligible over time. Oregon administrative data from November 2012 show that about 46% of OHP clients remained in the same eligibility group after 12 months (averaged across all eligibility groups). At new eligibility levels, at least 70% of adults are projected to remain income-eligible after 12 months. Based on Oregon's experience, streamlining redetermination procedures also improves retention. These comparisons are illustrated in Figure #1 below.

Figure #1: Current and Projected Medicaid Retention Rates for Adults



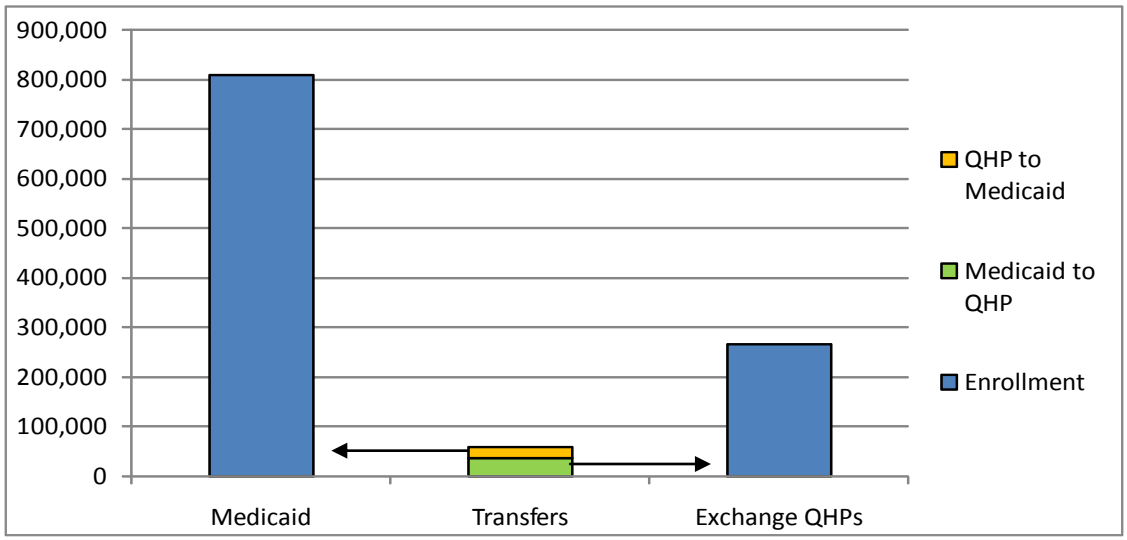
Source: SHADAC analysis of the Census Bureau's Survey of Income and Program Participation (SIPP) applied to Oregon Health Plan administrative data from November 2012 (percent of people who remain enrolled in the same eligibility category 12 months after initial enrollment or eligibility redetermination). March 2013.
Note: Additional impact of streamlined redetermination assumes that process-related terminations (currently around 50% of terminations) would be reduced by half.

Estimated Medicaid-commercial Transfers

For Medicaid adults under 139% FPL who experience an increase in income, projections suggest that about 19% will gain commercial coverage through the Qualified Health Plans (QHPs) through Cover Oregon, the state's health insurance exchange. [3] Income changes are expected to result in approximately 60,000 individuals (adults and children) moving between Medicaid and QHPs in 2016.[4] Approximately 60% of this movement (about 35,500 individuals) will be individuals moving from Medicaid to QHPs in Cover Oregon.[5] However, the portion of individuals moving or "transferring" between Medicaid and QHPs is a relatively small portion of total enrollment, as illustrated in Figure #2.

[3] SHADAC analysis of SIPP data applied to Oregon Health Plan administrative data. March 2013.
[4] Ibid.
[5] Ibid.

Figure #2: Transfers Between Markets



Source: SHADAC analysis of SIPP data applied to Oregon Health Plan administrative data from November 2012. March 2013.

Cost Sharing Implications

Once in the commercial market, an individual's responsibility for paying part of the premium and for cost sharing increases by graduated income levels at several key thresholds (138%, 150%, 200%, 250% FPL). There are premiums for all metal plan tiers offered through Cover Oregon, but these are increasingly subsidized at lower income levels. Out-of-pocket caps will apply so that low-income individuals' out-of-pocket costs are capped at lower levels than for higher income individuals purchasing QHPs through Cover Oregon. For individuals and families between 139-200%, out of pocket caps are $2,250 for an individual and $4,500 for a family. Table #1 identifies these cost differentials by FPL.

Table #1: Cost Sharing by FPL

FPL*	Annual Income	Max. premium as % of income	Average member cost-sharing	Out-of-pocket cap
Under 139%	<$15,971	2%	6% (100-150% FPL)	One-third of maximum
139-150%	$15,971-$17,253	3 - 4%		
150-200%	$17,253-$22,980	4 - 6.3%	13%	
200-250%	$22,980-$28,725	6.3 – 8.1%	27%	One half of maximum
250-300%	$28,725-$34,470	8.1 - 9.5%	30%	
300-400%	$34,470-$45,960	9.5%		Maximum** ($6,450 in 2013)

*Based on 2013 Poverty Guidelines.

** ACA section 1402 specifies a reduction in out-of-pocket maximum for these groups, but CMS recognizes it is not practical to reduce out-of-pocket max and maintain the statutory targets for actuarial value.

For example, a single individual with an annual income of $15,410 ($1,284 per month/ just under 139% FPL) might experience an increase in income to $16,755 per year ($1,396 per month/150% FPL). Monthly premiums for such an individual would jump from zero to $56 ($672/year). If this individual had health expenses of $1,250 per year, he or she might be responsible for $178 per year in out-of-pocket expenses. Similar increases in exposure would occur when an individual's income crosses the 200% and 300% of poverty level thresholds, whether due to decreased household size or increased income. While most individuals will have a low or medium level of health needs and service utilization, some individuals will have high needs and utilization.[6] Consequently, mitigating the impact of program transitions may benefit from better understanding those with high needs and what services they use most frequently in Medicaid.

Benefit Differences

Disruptions in coverage and/or lack of care coordination for individuals who transition between Medicaid and the commercial market may result in unmet needs or exacerbation of various health conditions including chronic diseases. As shown in Table #2 below, benefits covered in the commercial essential health benefits (EHB) benchmark are more limited than those covered in Medicaid through the Alternative Benefit Plan (ABP) for the OHP expansion population. Individuals who move from OHP to a commercial plan through Cover Oregon will experience a more limited scope of benefits. Benefit alignment between Medicaid/CHIP and QHPs through Cover Oregon can be used as a mechanism to reduce the impact of churn on individuals transitioning from Medicaid to QHP-eligible tax subsidies or vice versa. Alignment efforts could focus on the benefit differences with higher cost implications (*), which include inpatient hospital mental/behavioral health, inpatient rehabilitation, outpatient therapies and adult dental.

Table #2: Differences in Commercial EHBs and Medicaid ABPs

Benefit	Commercial	Medicaid
Acupuncture	Not Covered	Limited to specific conditions (i.e., chemical dependency, HIV, migraine, post-stroke depression, and some conditions during pregnancy)
*Adult Dental	Not Covered	Limited major dental services
Bariatric	Not Covered	Limited to Type 2 diabetics
Chiropractic	Not Covered	Limited to specific conditions (i.e., back pain with neurologic component)
Hearing Aids (Adults)	Not Covered	Covered
Hospice/Respite care	Limited respite care - 5 consecutive days or 30 days/yr	Covered

[6] These estimates are results from Mercer's utilization modeling applied to hypothetical plan designs. If a person had health expenses of $1,250 per year (50th percentile; the median range), he or she might be responsible for $178 per year in out-of-pocket expenses.

*Inpatient Hospital Mental/Behavioral Health	Limited to 45 days/yr for residential treatment	Covered
*Inpatient Rehabilitation	Limited to 30 days/yr with add. 30 days for head/spinal cord injury	Covered
Massage Therapy	Not Covered	Covered
Naturopath	Not Covered	Covered
*Outpatient Therapies	Limited to 30 days/yr with add. 30 days for specific conditions	Covered

Options to Minimize the Impact of Program Transitions

CHCS identified several options for states to consider in an effort to promote continuity of care and minimize the impact of plan, benefit, and cost sharing differences. These options include implementing contractual mechanisms to encourage plan and network alignment across markets, developing transitional programs to ensure necessary benefit coverage, and using administrative tools to ensure seamless transitions. The options are highlighted below:

Contractual mechanisms can include coverage transition requirements such as:

- Coordinated care transition teams
- Acceptance of prior authorization determinations for transitions
- Option to receive care from out-of-network providers during transition periods
- Agreements between QHP carriers and Coordinated Care Organizations (CCOs) to retain certain benefits for a transition period to complete treatments
- Alignment of quality metrics for CCOs and QHPs

Wrap-Around Programs can include wraparound benefits or premiums and cost sharing, or both, for those who transition from Medicaid to Exchange coverage during a fixed period of time.

- ***Wrap-around benefits***: allow individuals whose incomes increase beyond the Medicaid limit to retain certain benefits and thus continue to receive medically necessary services[7] in their care plan for a fixed period of time when they move to a QHP.
- ***Premium and cost sharing assistance***: offer additional premium and cost sharing subsidies to former Medicaid enrollees selecting the lowest price QHPs, making plans more affordable for individuals and potentially encouraging competitive pricing.
- ***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.

[7] CMS defines medically necessary services as health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Alternative Coverage Plans refer to plans that cover specific populations in an effort to facilitate care coordination and reduce financial burden on individuals moving from Medicaid to subsidized coverage in the Exchange.

- ***Basic Health Plan:*** optional coverage program provided under Section 1331 of the ACA that allows states to use federal tax subsidy dollars to offer subsidized coverage for individuals with incomes between 139-200% FPL who would otherwise be eligible to purchase coverage through the Exchanges.
- ***Medicaid Bridge Plan:*** CCOs could offer QHPs with enrollment limited to previously eligible Medicaid individuals, which would allow those individuals to remain with the same carrier and provider network and might help families split among different products to obtain coverage under one issuer and enroll in the same plans.

Additional Alignment Tools some of which Oregon already has in place or is developing, such as 12-month continuous coverage, streamlined eligibility determination processes, and coordinated outreach for Medicaid and QHP enrollment. Information technology strategies to link provider networks and facilitate information sharing could also enhance the coordination of care during program transitions.

For each of these options, additional analyses may help Oregon understand the potential financial and administration implications for Oregon's Medicaid program and Cover Oregon, as well as the impacts among individuals and families. It is important to assess the needs of the estimated 60,000 who would be most likely churn. For a Medicaid bridge plan specifically, the Exchange should ensure that eligible individuals are not disadvantaged in buying power of tax credits and the state must ensure that mechanisms are in place to prevent cost shifting to Medicaid.

Summary

Expanding Medicaid eligibility to 138% FPL is likely to increase continuous enrollment. Some churn will always occur but initial estimates identify 60,000 likely shifts between Medicaid and commercial coverage annually by 2016. Taking steps to minimize care disruptions when individuals transition between the OHP and QHPs can benefit both individuals and systems, helping lead to better care, better health, and lower costs. While a variety of policy options and operational strategies should be considered in a coordinated effort to reduce disruptions, Oregon will need to better understand each option, including feasibility for implementation, potential financial implications for both consumers and the state, and the impact on the financial viability of the Exchange.

Medicaid Advisory Committee
Decision-making Criteria for Oregon's Churn Mitigation Options

When fully implemented by January 1, 2014, the federal Affordable Care Act (ACA) will increase the number of insured Oregonians through two primary strategies – expanding Medicaid and providing insurance through a state-based insurance exchange. As an individual's household income exceeds the maximum for Medicaid eligibility, he or she will be eligible for subsidies to buy coverage through an exchange, up to a household income of 400 percent of the federal poverty level (FPL). This switch in eligibility also works in reverse. If an individual's household income falls at or below 138% FPL, he or she will become eligible for Medicaid. A key design challenge for those tasked with implementing the reform law is how to manage this "churning" phenomenon – when individuals cycle in and out of public programs as their incomes fluctuate – so that disruptions in care and other adverse impacts are minimized. To address this issue, Oregon's Medicaid Advisory Committee (MAC) will carefully examine the issue of churn and put forth a set of proposed policy options intended to mitigate its effects among Oregonians. The Committee will make recommendations to the Oregon Health Policy Board that seek to mitigate the impacts for individuals and families that transition between the Oregon Health Plan (OHP) and qualified health plans (QHPs) in the Exchange.

The Medicaid Advisory Committee is charged with advising the Oregon Health Authority (OHA) and the Oregon Health Policy Board on the operation of Oregon's Medicaid program, the Oregon Health Plan (OHP) (ORS 414.221). The committee is composed of consumers, providers serving OHP members, representatives of health care organizations and Coordinated Care Organizations (CCOs), and advocates familiar with the needs among individuals and families served by OHP. Consequently the MAC assumes a special responsibility to speak on behalf of the Medicaid population and how they experience the health care system. As the MAC considers options to mitigate the effects of churn between Medicaid and commercial coverage, the committee elected to adopt a set of decision-making criteria or "principles" to guide their work.

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**