

FACT SHEET #8 - Summary

Medically Frail Status as an Exemption to Receiving Medicaid Alternative Benefit Plan with Essential Health Benefits.

This fact sheet is intended to help Navigators answer specific questions people with disabilities may call you with if their exchange application indicates that they potentially qualify for enrollment in their state's Medicaid expansion. These individuals may have health conditions that qualify them as "medically frail" or another category that is exempt from enrollment in the Alternative Benefit Plans (ABP) with essential health benefits that will be provided to individuals in the Medicaid expansion population. Fitting within an exemption category could be very important for some people with disabilities who would benefit from a potentially different array of services and treatments available under traditional Medicaid, and who may have not qualified for Medicaid before under traditional eligibility rules.

Q1. If my Marketplace application is returned to me saying that I may qualify for my state's newly expanded Medicaid program, what do I need to know about Medicaid coverage?

A. Traditional Medicaid has a coverage package that includes the benefits and conditions outlined in a given state's Medicaid state plan. The state plan is a written contract that establishes how Medicaid works in a state, and includes rules for such topics as provider qualifications, who is eligible, what benefits are included, and the amount, duration and scope of those benefits. Each State submits its state plan to the federal Centers for Medicare and Medicaid Services (CMS) for approval. Under the Affordable Care Act (ACA), states who choose to expand their Medicaid coverage must establish an "alternative benefit plan" for the new expansion Medicaid population

Q2. What does it mean to be "medically frail"?

A. Federal law gives individual states a lot of discretion to define what it means to be "medically frail or otherwise an individual with special medical needs," but it does establish a floor of individuals that must be covered. Medically frail persons include children with serious emotional disturbances, children in certain other circumstances such as those in foster care or receiving adoption assistance, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical or mental disabilities that significantly impair their ability to perform one or more activities of daily living. "Activities of daily living" are common tasks that people perform as part of their day and include things like eating, dressing, bathing, walking and transferring, and hygiene. In July 2013, the federal government made some additional rules concerning ABPs and also expanded the definition of "medically frail," notably including individuals with chronic substance use disorders.

Q3. How does qualifying for a "medically frail status" help me?

A. States that choose to expand their Medicaid program under the ACA can choose an ABP for the expansion Medicaid population that is equal to their full state plan Medicaid coverage, or is different. If you are eligible for expansion Medicaid in a state that offers the exact *same* benefits under the exact same terms, including Long-Term Services and Supports such as home and community-based services and nursing facility care, in its ABP expansion coverage as in its state plan Medicaid coverage, then whether a person is medically frail will make no difference regarding his or her benefit package. As of the date of this fact sheet, most states with an ABP that has been approved by CMS are offering an ABP that is equal to what is offered under the state plan to its traditional Medicaid population.

If you live in a state such as Arkansas or West Virginia that is offering an expansion Medicaid ABP that differs from its state Medicaid coverage, then you have a choice that is not available to those in the expansion population that do not qualify as medically frail. As someone who may be newly eligible for expansion Medicaid, you only have to meet the less stringent requirements of the new modified adjusted gross income test rules instead of the traditional Medicaid eligibility rules that require fitting in disability categories and usually include asset tests. But if you are identified as medically frail, you can *choose* to have a Medicaid ABP that is defined using the traditional state Medicaid plan instead of the Medicaid ABP package.

Q4. If I qualify as medically frail, is it always better to choose an ABP that is defined by the full Medicaid state plan?

A. The ACA provides some very important protections to expansion Medicaid ABPs. First of all, ABPs must include coverage of the ten “essential health benefit” (EHB) categories that are also required of Marketplace and state exchange plans. A full range of preventive tests within the EHB categories must be provided without cost sharing. ABPs must also be compliant with the Mental Health Parity and Addiction Equity Act. In addition, all children under 21, medically frail or not, who are enrolled in an ABP must receive “Early and Periodic Screening, Diagnostic and Treatment (EPSDT), including pediatric oral and vision services. ABPs must also offer family planning services and supplies, federally qualified health clinic and rural health clinic services, and the assurance of non-emergency medical transportation. These are significant protections, and you cannot automatically assume that your state’s traditional Medicaid coverage package is better than its Medicaid expansion coverage package.

You need to look carefully at your ABP coverage choices for the particular services and treatments that you anticipate needing. Any state that offers Medicaid ABP benefit packages that differ from their full state plan Medicaid package is required to provide assistance and advice to medically frail individuals, to assist them to make an informed choice. Take advantage of any individualized counseling that is available to you.

Q5. I have a fluctuating income and think that over time I may wind up having to jump back and forth between eligibility for Medicaid under the new modified adjusted income rules and eligibility for purchasing private insurance in the Marketplace with subsidies.

Will this have an impact on my choice of an expansion ABP or an ABP that is defined in terms of the full Medicaid state plan?

Commercial insurance plans are the underlying basis for ABPs, just as they are for Marketplace insurance, and they share EHB and MHPAEA protections in common. Since you anticipate “churning” between public and private insurance eligibility, you should consider whether choosing an ABP with essential health benefits may lead to greater provider and treatment continuity of care. Talk to your state’s Medicaid agency to see if they can clarify your choices and offer additional assistance.

Q6. If I need my non-generic prescriptions and treatment regimens to maintain a stable medical condition, how will this impact my choice of Medicaid coverage (expansion ABP or Medicaid state plan coverage)?

A. Under federal rules, ABPs must meet the prescription drug standards that apply through EHB protections, and not the more specific Medicaid drug coverage protections. Traditional Medicaid rules have special protections that address such topics as the scope of drug coverage, when utilization management is permitted, and an appeals process to gain access to medically necessary drugs that fall outside of Medicaid coverage. If a state’s expansion ABP prescription drug coverage does not align with its traditional Medicaid plan prescription drug coverage, you may want to consider the impact of the expansion ABP drug coverage on your condition, including an understanding of the possibly alternative procedures the expansion ABP has in place to gain access to clinically appropriate drugs.

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