

Minimizing Care Gaps for Individuals Churning between the Marketplace and Medicaid: Key State Considerations

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Of the estimated 96 million Americans eligible to receive Medicaid or marketplace subsidies during any given year, up to 29 million are likely to “churn” between all coverage options, and seven million are likely to experience coverage shifts between Medicaid and marketplace policies annually.¹ Based on past experience, adults who change health insurance coverage are less likely to have a usual source of care and report delaying care during coverage transitions.² Those who churn between Medicaid and the newly established marketplace will, at a minimum, have different benefits and out-of-pocket expenses (e.g., premiums and cost-sharing). Further changes in plans, provider networks, and eligibility status could result in a lack of care coordination, unmet needs, and/or an exacerbation of chronic conditions.³ In addition, high rates of churn across the new array of Medicaid-marketplace coverage options will put an increased administrative burden on states and contracting health plans.

Given the likely churn between Medicaid and the marketplace, states can take steps to ensure coverage and care coordination so health status does not deteriorate during these transitions. A handful of states have begun to estimate the potential magnitude of churn on their current and newly eligible populations, and are exploring options to mitigate churn. This brief, made possible through the Robert Wood Johnson Foundation, outlines concrete strategies for states to mitigate the impact of coverage transitions.

1. Understand Demographics of the Churn Population

To develop strategies that effectively address churn, states will need to identify the individuals most likely to churn. To do this, states must develop an understanding of the demographics of the likely-to-churn population. Absent state administrative data about the population, states can use proxies such as the Survey of Income and Program Participation (SIPP) to develop an estimate of beneficiaries likely to shift between eligibility categories. Following are key variables for states to include in churn monitoring efforts:

- Age;
- Level of education;
- Household size;
- Marital status;
- Employment status and employment limitations due to physical or mental conditions;
- Income; and
- Program enrollment status.

If longitudinal data are available, states may want to determine the average variations in household income over 12 months and the characteristics of households experiencing greater variations. For example, those with chronic

IN BRIEF

The Affordable Care Act (ACA) has created new health insurance coverage opportunities for millions of low-income Americans. Many of these individuals, however, are likely to “churn” in and out of eligibility for Medicaid and marketplace coverage due to fluctuating income and changing family circumstances. While the phenomenon of churn is not new for state Medicaid agencies, it is complicated by the range of coverage options created through the ACA. This brief outlines key state considerations for mitigating potential gaps in coverage caused by churn. It highlights how select states have sought to avoid interruptions in care for beneficiaries who transition across the new array of coverage options.

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conditions and those with income between certain ranges might be more likely to churn. Depending on the direction of churn (greater percentage toward Medicaid or greater percentage toward marketplace/commercial), a state may decide to emphasize support for one or the other set of these individuals. For example, if individuals are likely to churn ‘upward’ from Medicaid to the marketplace, a state might develop mitigation options that support ongoing treatment episodes, care coordination, and subsidies for higher cost-sharing.

2. Using Navigators to Build Continuity of Coverage

Training of navigators, staff at community organizations, and in-person assisters is a crucial component in guiding individuals who transition between programs to obtain coverage. Although open enrollment should be the focus through the end of March 2014, navigators will be well-positioned to provide support thereafter, especially during renewal periods and when individuals experience income or life changes that impact eligibility.

Because changes in eligibility will result in coverage shifts, consumer education will be a critical element of a churn mitigation strategy to ensure that individuals remain enrolled in a health coverage option. Navigators or assisters should be at-the-ready to help consumers who are experiencing income and/or life changes enroll in, and understand the details of, another coverage option. Navigators can seek information during the initial enrollment period about future anticipated changes in income or circumstances to help consumers minimize coverage gaps.

3. Use Health Plan Contracting and Joint Purchasing to Mitigate Churn

There are a range of purchasing and contracting mechanisms that states can consider to lessen the impact of churn on individuals moving between Medicaid and the marketplace. For future open enrollment periods, states can use state law or managed care contracting provisions to require or provide incentives for cross-market participation of plans and providers to ensure smooth transitions between coverage options. In the absence of cross-market plan participation, states can use a variety of mechanisms to minimize the occurrence and impact of churn, including:

- a. Requiring transition plans, readiness reviews, and health information sharing to ensure continuity of coverage between *relinquishing* and *receiving* Medicaid managed care organizations (MCOs) and marketplace qualified health plans (QHPs);
- b. Encouraging plan acceptance of prior authorizations and ongoing course of treatment through contract provisions to avoid disruptions in care; and
- c. Aligning provider and payer incentives between Medicaid and the marketplaces.

Each of these options is discussed below.

- a. ***Require transition plans, readiness reviews, and health information sharing to ensure continuity of coverage between relinquishing and receiving Medicaid MCOs and QHPs***

States interested in better managing coverage and care transitions can look to similar practices in other states’ managed care contracts. For example, Massachusetts has extensive MCO contract language to help guide transitions between Medicaid and the state’s Health Connector program. At a minimum, Massachusetts’ MCOs must provide transition plans for: (1) pregnant women; (2) individuals with significant health care needs or complex medical conditions; (3) people receiving ongoing services or who are hospitalized at time of transition; and (4) individuals who received prior authorization for services from the relinquishing MCO.

Although Arizona ultimately opted for the Federally Facilitated Marketplace (FFM), it began planning for a state-based marketplace approach and intended to include guidelines for sharing information to coordinate care for individuals transitioning between Medicaid MCOs and QHPs. The state's proposed policy outlined *relinquishing* and *receiving* MCO responsibilities that require sharing of diagnoses, utilization data, and authorized service information.⁴ A number of additional states, including Indiana, New Mexico, and New York, require that relinquishing and receiving MCOs develop shared transition plans to coordinate services within a defined timeframe of 90 and 120 days.

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b. Encourage plan acceptance of prior authorizations and ongoing course of treatment to avoid disruptions in care

Smooth coverage transitions are particularly crucial to minimize disruptions in services for individuals who are in a prescribed course of treatment. Several states include coverage transition provisions in their MCO contracts to protect individuals receiving certain types of care (e.g., complex cancer treatment, mental health and substance abuse treatment). In general, these provisions require receiving plans to maintain care previously provided by the relinquishing plan. In some cases, the receiving plan might allow transitioning beneficiaries to continue to obtain care from their previous providers for a specific timeframe. In addition, some states require relinquishing plans to be financially responsible for provision of care to enrollees during a specified transition period. Some state Medicaid MCO contracts allow individuals receiving certain therapies to continue treatment with current and non-participating providers to avoid disruptions in care.⁵ As noted earlier, MCO contractors in Massachusetts must take steps to minimize care disruptions and ensure uninterrupted access to medically necessary services.

Maryland law explicitly requires Medicaid MCOs and QHPs to provide continuity of care for enrolled individuals. Plans in Maryland must:

1. Accept prior authorization determinations from relinquishing plans for a specified time period—the lesser of the course of treatment or 90 days, or through delivery and the postpartum visit for pregnant women;
2. Allow new enrollees within a specified course of treatment to receive care from out-of-network providers for 90 days or through delivery and the postpartum visit for pregnant women; and
3. Collect data during open enrollment and develop a process to evaluate and monitor continuity of care on an ongoing basis.⁶

c. Aligning provider and payer incentives between Medicaid and the marketplaces

Some states are encouraging cross-market participation of plans and providers to minimize health plan changes for individuals moving between coverage options. As an example, New York has decided that plans participating in Medicaid and Child Health Plus must also offer marketplace coverage. A cross-market mandate has the potential to facilitate moves between Medicaid and the marketplace, since it allows individuals shifting between coverage options to stay with the same health plan. To achieve this cross-market continuity, states must ensure that plans are willing to participate in both markets and that regulations accommodate licensure across markets. However, this strategy will only have an impact on churn if there is extensive provider network overlap with health plans participating as both Medicaid MCOs and marketplace QHPs. Colorado, Oregon, and Rhode Island have decided to allow Medicaid managed care plans to offer QHP coverage.

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4. Align Provider Networks to Support Uninterrupted Care Coordination

To ensure continuity of coverage for individuals transitioning between programs, Medicaid and the marketplace can develop coordinated policies to align providers across coverage options and ensure the right mix of providers. For example, prior state experience in enrolling “optional” adult populations into Medicaid suggest that the expansion population will have a greater need for mental health and substance abuse services and will be more likely to have had prior involvement with the criminal justice system. Given this, it will be critical to include a sufficient number of substance abuse and mental health providers to ensure continuity of care.⁷

Federal law requires states to ensure that each contracted MCO: (1) maintains and monitors a network that provides adequate and timely access to all services covered under the contract; and (2) refers enrollees out of network in an adequate and timely manner if the available in-network providers are unable to cover certain services.⁸ In addition to the federal requirements, some states have imposed other network adequacy requirements on MCOs to operate within their insurance markets.

Marketplace QHP guidelines require plans to assure that provider networks include essential community providers in sufficient numbers and geographic areas to meet the needs of low-income, medically underserved populations.⁹ Notably, marketplace QHP requirements emphasize the need for mental health and substance abuse providers. The marketplace must implement an evaluation process to assess the service areas of QHPs and ensure adequate geographic coverage in a non-discriminatory manner. Conversely, federal Medicaid requirements currently only stipulate considerations for establishing provider networks and ensuring timely access to care.

Given the difference between QHP and Medicaid MCO network adequacy requirements, when possible, states may wish to align requirements across markets to ensure adequate number and types of providers, especially in mental health and substance abuse services. States seeking to minimize the impact of churn should consider a review of network adequacy requirements for QHPs and Medicaid MCOs that compares the state’s provider network to the capacity of the network for each city and county. States can look at measures such as the actual capacity of each provider office, based on: (1) age of the patients that providers will accept; (2) number of practitioners in the office; (3) the ability to see new patients; (4) the total number of enrollees attributed to the office; (5) hours of operation; (6) proximity to public transportation; (7) linguistic accommodations; and (8) accessibility for people with physical disabilities. Developing procedures to monitor compliance with access standards will decrease the administrative burden both for states and for health plans that are participating across Medicaid and the marketplace.

5. Develop Benefit Connections to Assure Continuity of Coverage and Care

Beginning in 2014, the ACA requires individual and small group health plans to include an essential health benefits (EHB) package in all products offered both inside and outside the marketplace. States were required to select an EHB package for plans using one of several benchmark options allowed under federal guidance.¹⁰ Medicaid expansion states must identify an alternative benefit plan (ABP) from four benchmark plans similar to those available for the individual and small group market and also have the option of using a secretary-approved option that includes all 10 EHBs.

Although EHB benchmark and ABP selections are, for the most part, set for the first two years, states will be able to reevaluate and adjust their benchmark and ABP selection for

the small group and individual market and newly eligible Medicaid population beginning in 2016. States can use the next two years to measure service utilization among Medicaid populations covered under an ABP, particularly targeting utilization trends for newly enrolled adult beneficiaries. The information gathered can help states strategically design and align benefits for future enrollees.

Alignment of the Medicaid and marketplace benefit sets can minimize the potential disruption of churn. Although those moving between coverage options will face some differences in scope, quantity, and duration of benefits, inclusion of similar benefits across markets will reduce interruptions in care.

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6. Adopt Eligibility and Enrollment Policies to Minimize Churn

Eligibility changes can cause severe disruptions in continuity of coverage and care among individuals with fluctuating income. States can monitor reported income changes to inform strategies that will support coordinated coverage transitions, including:

- a. Ensuring continuous eligibility and extending Medicaid coverage prior to termination; and
- b. Adopting presumptive eligibility (PE) policies for adults.

Following are descriptions of each of these areas to help inform state strategies.

a. Ensure continuous eligibility and extend Medicaid coverage prior to termination

Health services research has found that administrative barriers are a key reason why many individuals fall off the Medicaid program at redetermination.¹¹ Under the ACA, states have the opportunity to mitigate this problem by reducing the number of renewals and allowing for 12-month continuous coverage for parents and other adults.¹² States can also extend Medicaid coverage to the end of the month or the end of the next month when an individual is found ineligible and then disenrolled.¹³ Going forward, state Medicaid agencies are expected to make redeterminations based on information available to the state and to pre-populate forms with available information.¹⁴ The streamlined redetermination processes that will be implemented under the ACA are likely to reduce this source of churn.

b. Adopt presumptive eligibility for adults

Beginning in 2014, the ACA extends states' ability to use PE for newly eligible adults and creates an option for hospitals to make presumptive eligibility decisions.¹⁵ These options allow states and certain providers to provide temporary coverage under Medicaid to children, pregnant women, parents, and single adults even if the state has not adopted the policy.¹⁶ One key feature of the ACA's PE requirement is that states are required to develop performance standards for providers making PE determinations. Given this, states can use PE as a lever to minimize churn, since it can have the immediate effect of minimizing lapses in care, but can also connect individuals who 'fell off' coverage back to the most appropriate program for which they qualify. Under these new options, states are required to ensure that: (1) the income determination process for PE is simplified; (2) those determined presumptively eligible receive immediate access to care and temporary coverage; and (3) state standards for oversight of PE providers are robust.

Federal regulations allow Medicaid MCOs to offer bridge QHPs in the marketplace on a limited enrollment basis to certain populations.

7. Use Benefit Wraparound, Premium Assistance, and Bridge Plans to Promote Coverage and Continuity of Care

States can provide additional benefits or “wraparound benefits” for select populations. In addition, states can offer premium and cost-sharing subsidies, beyond federal subsidies, to help individuals moving from Medicaid to the marketplace afford costlier coverage. Federal law authorizes state use of federal Medicaid and CHIP funds for premium assistance for health plans in the individual market, including QHPs in the marketplaces.¹⁷ Depending on the benefits offered and program structure, states may face increased costs for providing wraparound benefits to meet federal Medicaid benefit and cost-sharing requirements.¹⁸ Despite increased cost, these wraparound benefits can help mitigate churn by allowing individuals to retain certain benefits, including services that are medically necessary.

Premium assistance programs are another option that states are using to extend coverage and minimize churn. To date, three states – Arkansas, Iowa, and Pennsylvania – have submitted waivers to create Medicaid premium assistance programs, allowing the state to use Medicaid funds to purchase private health insurance via insurance marketplaces. The Centers for Medicare & Medicaid Services (CMS) has indicated that states can use a state plan amendment or an 1115 waiver demonstration to set up a premium assistance program for the Medicaid expansion. Using a premium assistance program would allow people to keep the same health coverage if their income fluctuates and they move in and out of Medicaid.¹⁹

For state-based marketplaces, federal regulations allow Medicaid MCOs to offer bridge QHPs in the marketplace on a limited enrollment basis to certain populations. According to federal guidance, the bridge plan must meet QHP certification requirements within the marketplace, and would need to demonstrate that the provider network has sufficient capacity to provide adequate services.²⁰ The plan would serve as a bridge for those who move from Medicaid or CHIP to the marketplace and allow them to stay with the same insurer and provider network. This option would allow families that have split coverage across the marketplace, Medicaid, and CHIP, to obtain coverage under one issuer, enroll in the same plans, and maintain the same providers. For example, beginning April 1, 2014, California will implement a bridge plan option for individuals and household members transitioning from Medicaid and CHIP coverage.²¹ In future years, the state is interested in allowing marketplace-eligible individuals up to 200 percent FPL to participate in a broader bridge model.

Conclusion

Although income and household changes will impact individual coverage options, states can take a number of steps to minimize the impact of churn for individuals transitioning between Medicaid and the marketplace. Strategies will likely vary from state-to-state, but common elements outlined in this brief will guide states in devising a comprehensive strategy to address the potential downsides of churn.

Coordination and open communication between Medicaid and the marketplace – whether state-run or the federal marketplace – is crucial to ensure a standardized, consumer-oriented eligibility process and achieve CMS’ goal of a “no-wrong door” approach for consumers.²² Providing insurance coverage is just the first step toward ensuring adequate health care access for Americans enrolled in Medicaid or marketplace coverage. Making certain that continuity of care is addressed through smooth transitions across coverage options will be a critical component of the nation’s reformed health care system.

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 access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

Endnotes

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