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Preparing for Medicaid Expansion

Planning to help state Medicaid agencies prepare for health reform implementation in 2014

SUMMARY

According to expectations, the federal Patient Protection and Affordable Care Act (ACA) of 2010 will provide health insurance to an additional 32 million people nationwide. Much of the new coverage will come from expansions to Medicaid that will make the states the single largest purchasers of health care.

The Center for Health Care Strategies, a nonprofit health policy resource center located in Hamilton, N.J., calls the new law "the biggest policy change to Medicaid since its inception." Between October 2010 and December 2011, the center identified and analyzed some of the major issues the states will face as they prepare for this expansion as part of implementing health reform in 2014. While highlighting the opportunities for innovation and cost-effective care delivery, the center also noted that if state Medicaid capacity is not strengthened, a key pillar of universal coverage "could crumble."

This project was part of the planning prior to the launch of a new Robert Wood Johnson Foundation (RWJF) national program, the *State Health Reform Assistance Network*. The network provides technical assistance to states in order to maximize the expansion of cost-effective, high-quality health care under the ACA.

Results

Meetings

The center convened two meetings of health policy experts from government, health plans, and nonprofit organizations (December 2010 and November 2011) to discuss Medicaid expansion and the needs of the states. "At the end of the day, the largest chunk of the expansion [in coverage] is happening because of the Medicaid expansion. We were trying to shine a light on that," states Shannon McMahon, MPA, director for coverage and access at the center and project director of the grant.

Of particular concern was how best to align Medicaid benefits with benefits to be available through state health insurance exchanges. Created under the ACA, exchanges

will provide a marketplace for quality, affordable insurance to individuals otherwise unable to obtain group coverage; subsidies are available to qualified participants.

Meeting attendees also discussed the health benefits essential in any plan, eligibility issues, and how best to provide seamless benefits to participants who may cycle through Medicaid and the exchanges.

The second meeting included staff from the federal Centers for Medicare & Medicaid Services (CMS). "We wanted to have CMS in the room for part of the discussion to figure out what they were thinking, where they were going. States could ask questions, CMS could ask questions of the states," said McMahon.

Policy Briefs

The center produced three policy briefs focused on issues facing the states as they prepare to implement the ACA in 2014.

- ***Strategies for Building Seamless Health Systems for Low-Income Populations***[1] **examined ways that states can provide stable, affordable, and high-quality coverage and care as recipients' incomes fluctuate.**

  Under the ACA, Medicaid will cover people with incomes up to 133 percent of the federal poverty level; those with incomes between 133 and 400 percent of poverty will be eligible for subsidies so they can receive coverage through the insurance exchanges. Studies suggest that a large proportion of low-income families will move between these eligibility categories (a phenomenon known as "churning") as family income changes.

  States can reduce the impact of churn and create seamless health care through appropriate designs that include:

  — Managing subsidy fluctuations through eligibility, enrollment, and reenrollment strategies. The infrastructure should allow eligibility to be determined efficiently and enrollment to proceed promptly.

  — Ensuring stable coverage and care by providing continuity of coverage and offering similar benefits and providers across plans

- ***Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?***[2] **examined how federal supplemental payments influence efforts to reform Medicaid's payment and purchasing strategies.** Hospitals serving large numbers of Medicaid and uninsured patients receive significant revenue through two federal payment programs: the Disproportionate Share Hospital and Upper Payment Limit programs.

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[1] Center for Health Care Strategies, Policy Brief, February 2012. Available online.

[2] Center for Health Care Strategies, Policy Brief, August 2011. Available online.

— While these payments help subsidize the costs of uncompensated care and supplement low reimbursement rates, they are not connected to specific services for specific patients. Nor do they reward efficiency or quality of care. As a result, they may undermine the new emphasis on value-based purchasing at the federal and state levels.

— Supplemental payments should be aligned with the broader payment reform objectives of improving access to cost-efficient, high-quality care. "The imperative to reform Medicaid payment policies and ensure maximum value for Medicaid spending has never been greater," declares the brief.

- ***Medicaid Managed Care: How States' Experience Can Inform Exchange Qualified Health Plan Standards***[3] **analyzed Medicaid managed care in six states in order to inform the design of the new health insurance exchanges**.

  — State Medicaid managed care plans vary from highly regulated models to free market systems, but all set minimum standards their plans must meet. This diversity in approach is likely to be mirrored in state exchanges.

  — States can use, adopt, or modify their Medicaid managed care experiences as they design the exchanges. Existing programs may provide the expertise and infrastructure to address issues relating to provider networks, quality of care, accreditation, marketing, information, and data disclosure, as well as plan selection.

"All of the policy briefs really were laying the groundwork. As more federal guidance came out and states began to get more organized, these tools have served as first step to take things to the next level, which is step by step, technical assistance," explains McMahon.

Lesson Learned

1. **Provide opportunities for states to learn from other states, from policy experts, and from regulatory officials.** Peer-to-peer exchange is beneficial for everyone involved. (Project Director/McMahon)

Funding

RWJF provided a grant of $385,596 to support this work.

Afterward

The Center for Health Care Strategies has received an additional grant[4] from RWJF under its *State Health Reform Assistance Network* national program to provide in-depth

[3] Center for Health Care Strategies, Policy Brief, November 2011. Available online.

[4] ID# 68871 ($1.2 million, June 2011–May 2012).

technical assistance to selected states on Medicaid expansion and state exchanges. This work includes developing high-level policy briefs, state-specific strategic Medicaid planning, assisting with purchasing and payment models, and determining benchmark benefits.

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