
Extending Medicaid Coverage to Low-Income Childless Adults

Opportunities and Cautions for Managed Care Plans

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Introduction and Overview

- **Health care reform (P.L. 111-148 and P.L. 111-152) will increase Medicaid and CHIP enrollment by 16 to 20 million people by 2019**
 - **Starting in 2014, Medicaid will cover everyone below age 65 and 138% of poverty (\$15,030 for one person in 2011)**
 - 138% of poverty includes 5% MAGI income disregard

- **A large portion will be childless adults not previously covered by Medicaid in most states**
 - **Most states and managed care organizations (MCOs) have little experience in providing coverage and care for this population**
 - **States with existing or planned managed care programs will likely want to enroll this population in managed care**

Introduction and Overview *(Cont.)*

- **Major challenges for states and MCOs will include:**
 - **Determining appropriate “benchmark” benefit package**
 - **Conducting outreach and enrollment for a population with generally low levels of education and community ties**
 - **Developing appropriate provider networks for enrollees who are likely to have substantial behavioral and physical health care needs**
 - **Funding physician reimbursement for primary care services at 100% of Medicare after federal payment of extra costs for 2013 and 2014 ends**
 - **Developing appropriate care management and care coordination capabilities**
 - **Determining appropriate capitated rates for those who will enroll in capitated MCOs**
 - **Monitoring and evaluating the impact of this expanded coverage**

Introduction and Overview *(Cont.)*

- **Issues of special concern for MCOs**
 - **Capitated rates**
 - **Potential for adverse selection (only sickest may enroll)**
 - **Network development needs and requirements**
 - **Care management needs and requirements**

State Coverage of Low-Income Childless Adults

- **In the past, states have provided this coverage through Medicaid waivers or with state-only dollars**
 - **List of states, program features, and status as of 2009 is in a December 2009 Kaiser Commission fact sheet at: <http://www.kff.org/medicaid/7993.cfm>**
 - **Updated income eligibility limits for January 2011 are at:
<http://statehealthfacts.org/comparereport.jsp?rep=54&cat=4>**
 - **States that have been providing coverage equivalent to Medicaid will get a higher federal match rate between 2014 and 2018, but not as high as states that did not previously provide this coverage**
 - **Appears to include AZ, DE, HI, ME, MA, NY, and VT**

State Coverage of Low-Income Childless Adults *(Cont.)*

- **Health care reform requires coverage starting in 2014, with 100% federal match in 2014-2016, dropping to 90% by 2019**
- **States can cover this population starting April 2010 with regular federal match, and get the higher rate in 2014**
 - **Pre-2014 option will likely be of greatest interest to states now covering low-income childless adults with 100 percent state dollars (no federal match)**
 - **Examples include CT, DC, MN, WA**

Coverage Requirements Under Health Care Reform

- **For states that choose to enroll low-income childless adults under their Medicaid state plan now, and for all states starting in 2014**
 - **No enrollment caps or waiting lists**
 - **Benefit packages may be less than full Medicaid, but must meet “benchmark” or “benchmark equivalent” standards**
 - Comparable to FEHBP, state employee, or commercial coverage, or Secretary-approved
 - Must include hospital, physician, lab/x-ray, preventive, and – starting in 2014 – prescription drug and mental health services
 - **No beneficiary premiums and only “nominal” cost sharing (\$0.50 to \$3.00)**
 - **Immediate or retroactive (up to 90 days) enrollment**

Expansion Population Characteristics

- **Potential and likely enrollment**
 - **Initial enrollees will likely have high care needs**
 - Provider-stimulated enrollment
 - Retroactive Medicaid eligibility
 - Limited applicability of tax penalties for non-coverage
 - Transfers from state-funded health care programs

- **Care needs**
 - **Self-reported poor health**
 - **High use of inpatient, ER**
 - **Significant mental health/substance abuse problems**
 - **Pent-up demand**
 - **Low education levels**
 - **Limited family and community support**

Expansion Population Costs

■ Costs

- **Based on experience in nine states already covering low-income childless adults reviewed in 2010 by Center for Health Care Strategies and Mathematica**
 - Costs for those at lower income levels are likely to be similar to those of SSI/disabled adults in Medicaid
 - Costs for those closer to 138% of the FPL may be similar to those of TANF adult parents
- **Federal government will pay 100% of the costs in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter**
- **States using capitated MCOs to provide coverage must set capitated rates, but could share risk with MCOs in 2014-2016 until experience base develops**

Sources for Information on Characteristics and Costs

- **Stephen A. Somers, Allison Hamblin, James M. Verdier, and Vivian L.H. Byrd, “Covering Low-Income Childless Adults in Medicaid: Experience from Selected States,” Center for Health Care Strategies, Inc., August 2010**
 - Based on experiences in AZ, IN, ME, MN, NY, OR, PA, WA, and WI
 - Available at:
http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261143

- **Candace Natoli, Valerie Cheh, and Shinu Verghese, “Who Will Enroll in Medicaid in 2014: Lessons From Section 1115 Medicaid Waivers,” Mathematica Policy Research, Forthcoming**
 - Based on analysis of Medicaid Analytic eXtract (MAX) data for 2007 for AZ, DE, DC, ME, MI, OK, OR, UT, and VT
 - Compared to adults with dependent children, childless adults were:
 - Older and included more men
 - More likely to become Medicaid eligible due to disability
 - Likely to cost more

Care Management Options

- **States that already include Medicaid ABD/SSI/disabled populations in managed care should be able to include low-income childless adults with relatively little difficulty**
 - A number of states already include low-income childless adults in capitated Medicaid managed care programs, including AZ, MN, NY, OR, and WI
- **A new option provides enhanced federal funding for coordinated care for enrollees with chronic conditions**
 - Section 2703 of P.L. 111-148
 - Authorizes “health home” services for enrollees with mental health, substance abuse, asthma, diabetes, heart disease, obesity, and other chronic conditions
 - 90% federal match for first two years

Delivery System Design – Considerations for States

- **Delivery models**
 - **Build on what already exists in Medicaid in the state**
 - Capitated MCOs, PCCM, FFS
 - MCOs with only TANF experience may not be able to meet all the needs of lower-income childless adults

- **Relationship to health insurance exchanges**
 - **May be movement between Medicaid and private insurance for those near 138% of the FPL**
 - Need to facilitate continuity of care and smooth transitions, to the extent possible

Delivery System Design *(Cont.)*

- **Care management resources needed**
 - Stratification and triage by risk/need
 - Integration of health services, especially physical and behavioral health
 - Coordination with social services
 - Designated “health home” and personalized care plan
 - Consumer engagement strategies
 - Exchanges of relevant health information
 - Performance measurement and accountability
 - Financial incentives aligned with quality care

Delivery System Design *(Cont.)*

- **Treatment capacity needed**
 - **Ability to respond to high levels of pent-up demand, especially in initial months**
 - **Expanded primary and specialty care services**
 - Federal support for 100% of Medicare rates for primary care physician services will help in 2013-2014
 - **Expanded mental health and substance abuse services**
 - Better links with criminal justice system

Conclusions

- **Health care reform Medicaid expansion will result in many potential new enrollees for Medicaid MCOs**
- **High health care needs and costs for low-income childless adults will present significant challenges in terms of outreach, network development, care management, capitated rate setting, and quality monitoring**
- **Plans with experience covering ABD/SSI/disabled enrollees will have an initial advantage**
- **Plans that can develop improved care management and care coordination capabilities for enrollees with behavioral health and other chronic conditions will be especially attractive to states**