Manatt on Medicaid:
New Strategy for Financing 12 Months of Continuous Coverage for Newly Eligible Adults

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The federal government recently issued sub-regulatory guidance that will allow states to receive 98.7 percent to 99.3 percent of the cost of providing 12-month continuous coverage to adults newly eligible for Medicaid in expansion states. In states that adopt the option, not only will consumers benefit, but issuers and providers can expect greater stability in their revenue streams and a greater return on investments in preventive services and care management.

Background

In May of 2013, the Centers for Medicare & Medicaid Services (CMS) issued guidance to states on strategies available to facilitate the enrollment and renewal of eligible people into Medicaid coverage. One strategy provides states the option to seek a Section 1115 waiver to provide 12 months of continuous Medicaid eligibility for adults regardless of changes in circumstances that occur during the year. The option is designed to minimize "churning," where low- and moderate-income people move back and forth between eligibility for Medicaid and Marketplaces as they gain or lose employment, get married or divorced or experience other changes in circumstances.[1] States have had this option for children since 1997. As of January 2013, 32 states provided it for children in Medicaid or CHIP, and 23 provided it in both programs. However, the May 2013 guidance represents the first time that CMS has offered states the opportunity to implement 12 months of continuous eligibility for adults.

Until recently, however, no state had implemented 12 months of continuous eligibility for newly eligible adults under the May 2013 guidance, largely due to financing barriers. CMS informed interested states that they could not receive the 100 percent matching rate for 12-month continuous eligibility, but did not yet have details on what the available matching rate would be.

Enhanced Federal Medical Assistance Program (FMAP)

Recently, CMS announced a new, simplified formula for establishing the appropriate matching rate. Drawing on research conducted by George Washington University, CMS determined that 97.4 percent of the cost should be financed at the enhanced matching rate available for newly eligible adults and the remaining 2.6 percent at a state's regular Medicaid matching rate. As a result, states will receive a matching rate between 98.7 percent and 99.3 percent for the cost of 12-month continuous eligibility for

[1] Summers and Rosenbaum have estimated that more than one-third of adults with incomes below 200 percent of the federal poverty level will experience a shift from Medicaid to Marketplace coverage or vice versa in the first six months of ACA implementation. See "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs*, February 2011, vol. 30, no. 2, pp. 228-236.

newly eligible adults in 2014.[2] See the attached table for state-specific data on the matching rate applicable to newly eligible adults in states that elect this option.

Implications for Stakeholders

The new option offers the possibility of greater continuity of coverage for consumers, administrative simplicity for states and enhanced opportunities for issuers and providers to develop and take advantage of stable relationships with enrollees and patients. The potential advantages include:

- **Greater continuity of coverage for consumers.** In states that implement the option, consumers will be able to rely on a consistent source of coverage, allowing them to develop stronger relationships with their providers and preventing disruptions in their care. In the absence of the option, consumers must report changes to the Medicaid agency (or Marketplace in some states) and may be required to select a new plan, find new providers, and switch medications or otherwise develop new care plans.
- **More reliable source of revenue for plans and providers.** The new option offers health plan issuers and providers a more reliable source of revenue and greater certainty about the population they will be serving. They can be assured that newly eligible adults will be enrolled for at least a year, making it easier to estimate and plan for a steady stream of premium dollars and provider payments.
- **Greater potential returns on investments in prevention and care management.** In the past, Medicaid managed care plans and individual providers have raised the concern that investing in prevention and care management does not pay off for people enrolled in coverage on a sporadic or short-term basis. With 12-month continuous eligibility, plans and providers are more likely to be able to see returns on upfront investments in immunizations and care management for asthma, diabetes and other chronic conditions.
- **A greater capacity to measure quality.** On a related note, issuers, states and others have long noted the challenge of measuring the quality of Medicaid managed care plans and care delivery initiatives when enrollees churn in and out of coverage in short periods of time. As a result, 12-month continuous eligibility could open the door to better and more accurate measures of the quality of care provided to Medicaid enrollees.
- **Administrative savings for states, issuers and providers.** States, health plans and providers also may see reduced administrative costs if there are fewer transitions in coverage among newly eligible adults. States and issuers, for example, will not need to process as many enrollments and disenrollments, while providers who have formed relationships with patients will not need to update insurance coverage information and cost-sharing policies with the same frequency in states that adopt 12-month continuous eligibility.

Ultimately, however, it is the states that must decide whether or not to pursue the option. They are likely to consider the fiscal impact on their budgets, as well as the implications for their eligibility workers and other staff. States that adopt the option will see a marginal increase in the cost of care, although for no state will the state's share exceed 1.3 percent.

On the other hand, states are likely to see potentially significant administrative savings as fewer people churn in and out of Medicaid eligibility, reducing the need for eligibility workers to take action, for notices to be sent to consumers, and for enrollment data to be exchanged between the state's eligibility

[2] In future years, a state's matching rate for continuous eligibility will continue to depend on its regular Medicaid rate and on the enhanced matching rate for newly eligible adults, which remains at 100 percent through the end of 2016, but then declines modestly in 2017 and future years until it reaches 90 percent in 2020.

system and its claims system. In the months ahead, as renewal activity ramps up, states and stakeholders may find the 12-month continuous eligibility option to be of increasing interest.

Implementation Procedures

To take up this policy option, states must submit aSection 1115 waiver to CMS or, if they already have a waiver, they must submit an amendment. As with all Section 1115 waivers, those aimed at the 12 month continuous eligibility option are subject to transparency requirements and so must be made available for public comment. However, CMS has advised that it will review these waivers expeditiously and assist states in developing and submitting their applications (or amendments to existing 1115 waivers). Issuers and providers may want to check with their state Medicaid agency to see if their state plans to take up this option.