OCTOBER 2010

COORDINATING COVERAGE AND CARE IN MEDICAID AND HEALTH INSURANCE EXCHANGES

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) increases access to affordable coverage by creating a new continuum of coverage and providing assistance to individuals with incomes up to 400% of the federal poverty level (FPL). Medicaid eligibility is extended to a national floor of 133% FPL and subsidies are provided to individuals between 133%–400% FPL to purchase coverage through new Health Insurance Exchanges. The ACA also requires states to create a coordinated, simple, and technology-supported process through which individuals may obtain Medicaid, CHIP, and Exchange coverage. Further, coordinating delivery of care across these coverage types will be important. To explore key issues related to achieving coordinated and seamless enrollment and care in Medicaid and Exchange coverage the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened the second in a series of roundtables with national and state experts focused on health reform implementation on August 31, 2010. Key issues identified by participants during the roundtable include the following:

It is critical that states begin taking steps now to create an integrated and seamless eligibility and enrollment system for Medicaid and Exchange coverage that is supported by technology. While the Medicaid expansion and Exchange coverage will not go fully into effect until 2014, states face a long-lead time for system upgrades since they must go through formal procurement processes and many will need to make large-scale upgrades. One key decision states must address is to what extent they will build on existing Medicaid systems versus creating a new eligibility and enrollment system. Further, some states may want to consider restructuring where Medicaid eligibility is determined to facilitate integration with Exchange coverage, particularly those that currently determine eligibility through county-level social service agencies. Participants agreed that states need substantial and timely federal guidance and support to make the necessary upgrades by 2014. The Secretary of Health and Human Services (HHS) recently adopted a set of standards for interoperable electronic enrollment systems, and the ACA provides grants to states to assist in developing and implementing such systems. However, further federal guidance and support will be vital. States are specifically interested in having federal prototypes of systems and more federal financial support to enhance their capacity to upgrade systems.

The requirement to integrate Medicaid and Exchange enrollment systems, combined with simplified Medicaid eligibility criteria under reform, provide a valuable opportunity for states to vastly simplify Medicaid enrollment processes. Participants suggested that eliminating state procedural and documentation requirements in Medicaid that are not required by federal law would make it easier to coordinate Medicaid and Exchange coverage. However, it was noted that some states have concerns that doing so would increase their error rates during federal audits. It was noted that states that have already implemented significant Medicaid simplifications have some of the lowest error rates in the country and suggested that the focus of federal audits could be revisited so they are better aligned with the ACA goals of expanded coverage. Participants also commented that the ACA calls for uniformity of enrollment processes across Medicaid and subsidized coverage in the Exchange which may supersede state flexibility to impose certain enrollment requirements in Medicaid, such as face-to-face interviews.

It will be important to minimize burdens on individuals by utilizing technology and existing data sources to obtain information. There was consensus among participants that utilizing existing databases to support eligibility determination and automate enrollment would go a long way in simplifying the enrollment process. With regard to income, it was noted that although eligibility for Medicaid and subsidized Exchange coverage will be based on Modified Adjusted Gross Income (MAGI)—which is captured when individuals file taxes and available through the Internal Revenue Service—there will need to be processes to collect more current income to assure individuals are enrolled in the correct program and receive the correct amount of financial assistance. Tax data may be lagged by as long as two years and, over that period, individuals may have a change in income or circumstances that affects their Medicaid eligibility and/or the level of assistance they qualify for under Exchange coverage. Moreover, the law requires that Medicaid eligibility be based on current income and that HHS establish guidelines for Exchange coverage to gather more recent income information for people who have experienced a change in circumstances. Further, not all individuals will have filed taxes and, within Medicaid, there will remain some groups (including elderly and disabled individuals) whose eligibility will continue to be based on current Medicaid methodologies. Several participants also suggested that it will be important for individuals to be able purchase coverage through the Exchange without answering any income-related questions since some will not be eligible for or interested in receiving any assistance.

Seamless and automatic renewals of and transitions between coverage will be vital components of integrated enrollment systems. Assuring there are simple and effective processes to collect updated income and other eligibility information will be key for preventing disruptions in coverage and making sure that individuals receive the appropriate coverage and amount of financial assistance at the right time. It was recognized that, within Medicaid, utilizing electronic data exchanges to obtain updated information and automatically renew coverage has been an extremely effective and efficient way to help individuals maintain coverage. Further, experience with Medicaid and CHIP suggests that transitions between programs occur most seamlessly when a single agency handles eligibility determinations for both programs; however, using electronic data exchange can help smooth transitions between separate agencies. Participants also noted that allowing states to provide 12-month continuous eligibility to adults in Medicaid would help would help minimize the frequency of transitions in coverage and thereby reduce the risk of coverage gaps and/or disruptions in care.

Developing processes and systems that facilitate continuous care across coverage types will also be important. The legislative requirements to coordinate benefits and health plans between Medicaid and the Exchange are limited. The primary requirement is that an essential health benefits package be created for Exchange coverage and that benchmark coverage for "new eligibles" in Medicaid must, at a minimum, provide the essential health benefits. A few participants suggested that having similar benefit packages for plans in Medicaid and the Exchange would facilitate coordinated care. Further, the question of whether benchmark coverage for "new eligibles" in Medicaid should resemble commercial coverage was raised, although concerns were expressed as to how this would impact enrollees with significant health needs who require more services than typically included in a commercial plan. Another topic raised was to what extent states should work to ensure that some plans participate in both the Medicaid and Exchange markets, for example, by providing incentives or utilizing selective contracting processes. While not required by legislation, having some plans that are available through both markets could help facilitate continuity of care for people who transition between programs.

In conclusion, the ACA establishes requirements to create a continuum of coverage with a coordinated enrollment process supported by technology. It also will be important to assure that care is coordinated across coverage types. A number of challenges must be addressed to achieve these goals, but the requirements also provide an opportunity for states to greatly simplify their Medicaid enrollment processes and make large-scale upgrades to their eligibility systems. The discussion emphasized that it will be vital for states to begin taking steps now to have systems in place by 2014. Further, participants stressed the importance of immediate federal guidance and support to advance state efforts.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 with a number of broad goals, including increasing access to affordable health coverage and reducing the number of uninsured. To make coverage more affordable, the law creates a new continuum of coverage pathways and provides assistance to individuals with family incomes up to 400% of the federal poverty level (FPL). Medicaid eligibility is extended to a national floor of 133% FPL[1] and subsidies are provided to individuals between 133%–400% FPL to purchase coverage through new Health Insurance Exchanges. The Medicaid expansion and Exchange coverage will go fully into effect beginning in 2014.

Along with increasing affordability of coverage, the ACA includes provisions to make it easy for individuals to enroll in coverage by requiring states to create a coordinated, simple, and technology-supported process through which individuals may obtain coverage through Medicaid, CHIP, and the new Exchanges. Beyond coordinating eligibility and enrollment, it also will be important to coordinate delivery of care across these coverage types, particularly since low-income individuals often have fluctuating incomes and family circumstances that may cause their eligibility to shift over time.

To explore key issues related to achieving coordinated and seamless enrollment and care between Medicaid and the new Exchanges, the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened a roundtable with national and state experts on August 31, 2010. This report is based on the discussion during this roundtable, which is the second in a series of health reform roundtables focused on implementation issues related to Medicaid.[2]

BACKGROUND: ACA REQUIREMENTS FOR COORDINATING ENROLLMENT AND CARE

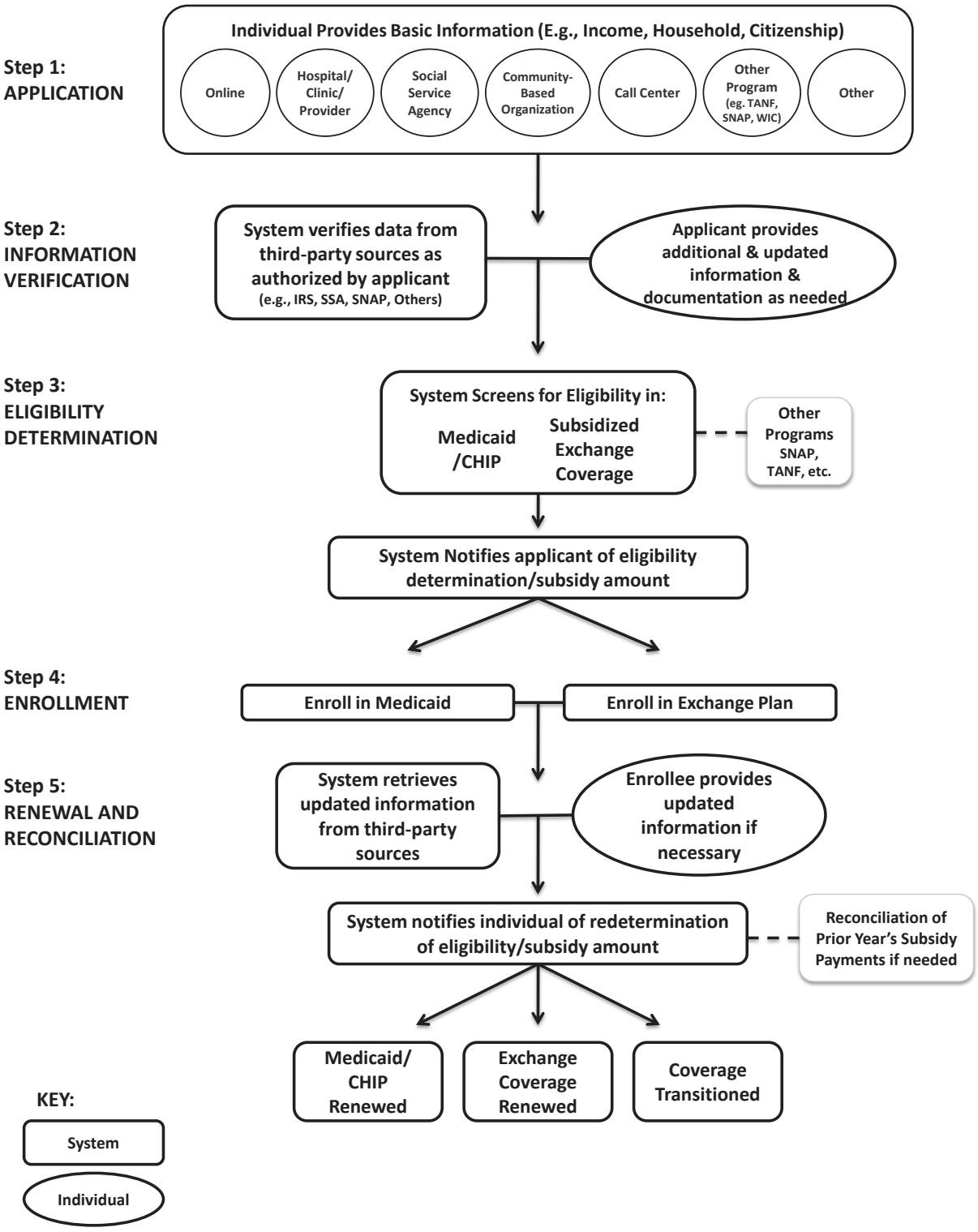
As noted, the ACA includes requirements focused on making sure enrollment and eligibility systems for Medicaid, CHIP, and Exchange coverage are streamlined and integrated and utilize technology to reduce burdens on individuals. More specifically, the law requires:

- **Web portals** through which individuals may obtain and compare information about coverage options and apply for coverage;
- **A single application form** that is available online and may be filed online as well as in-person, by mail, or by telephone and application support including "navigators" to provide education and facilitate enrollment;
- **"No wrong door"** for coverage, so that individuals are screened for all coverage options regardless of where they apply and enrolled without additional application forms or multiple eligibility determinations;
- **Standardized income rules using Modified Gross Income (MAGI)** to determine eligibility;
- **Secure electronic data exchange** that is utilized to the "maximum extent practicable" to establish, verify, and renew and update eligibility.[3]

Further, the ACA provides grants to states to support the development and implementation of these enrollment systems and the Secretary of HHS recently adopted a set of standards and protocols related to the development of these systems.[4]

The following flow chart (Figure 1) illustrates an example of key steps and processes that could be incorporated into an integrated and automated eligibility and enrollment system.

Figure 1:
Example of Key Steps and Processes in an Integrated Enrollment System for Medicaid and Subsidized Exchange Coverage



The requirements in the ACA for coordinating health plans and delivery systems across coverage types are more limited than those related to integrated eligibility and enrollment. Health plans in Exchanges must contract with essential community providers, who may serve as access points for the low-income population. There are also some requirements related to coordination of benefits. Namely, Exchange coverage must offer a specified "essential health benefits package" and benchmark coverage for new eligibles in Medicaid must, at a minimum, include the benefits in the "essential health benefits package."

KEY ISSUES IN ACHIEVING COORDINATED ENROLLMENT AND CARE

As discussed by roundtable participants and presented below, there are a number of key issues states will face in designing and implementing a system that coordinates eligibility and enrollment and delivery of care across Medicaid and Exchanges.

1. It is critical that states begin taking steps now to create an integrated and seamless eligibility and enrollment system for Medicaid and Exchange coverage that is supported by technology to be ready for 2014.

Importance of Federal Guidance and Support

States will play a key role in designing and implementing eligibility and enrollment systems that meet the ACA requirements. While the Medicaid expansion and subsidies for new Exchange coverage will not go fully into effect until 2014, states face a long lead-time associated with system upgrades, particularly since they must go through formal procurement processes. As such, participants commented that it is important for states to begin taking steps now to determine how they will integrate their Medicaid eligibility and enrollment systems with the new subsidized Exchange coverage and create a single, online application form that utilizes electronic data matching and verification.

A few states have already developed integrated, web-based enrollment systems—for example, Wisconsin has an online self-service tool that is fully integrated with its eligibility system and allows individuals to find out whether they may be eligible for Medicaid (and other assistance programs), apply for benefits, check the status of their benefits, renew their benefits, and report changes to keep their eligibility current.[5] The state also greatly streamlined its Medicaid eligibility rules, which helped support the simplicity and utility of the system.[6] While the state is a leader in developing an integrated, online system, it still faces some important limitations that prevent enrollment from being fully automated and slow application processing time. For example, because of a federal requirement that a public employee must verify eligibility, county or state workers must check each application.[7] Further, applicants must continue to submit any required documentation (e.g., paystubs) by scan, fax, mail, or in-person.[8]

Moreover, most states remain much farther behind in terms of their technology and have a long road to travel in terms of developing systems that will meet the requirements of the ACA. For example, while most states have their Medicaid and/or CHIP application available on-line, only a little more than half have the capability for it to be electronically submitted and, in most of these states, applicants still must provide paper documentation. Further, some states still rely on archaic, paper-based systems with very limited electronic capabilities.

Participants largely agreed that states will need substantial additional federal guidance and support to be able to make the necessary upgrades by 2014. It was noted that states are particularly interested in having access to federal templates or prototypes of systems that they could adopt. Under the ACA, the Federal government is required to build and provide a federal Exchange. The federal Exchange could help serve as a framework or reference model for states and could be built so that it could be adopted in whole or in part by states. This would promote increased consistency across states and reduce redundancies in terms of development efforts and costs.

Further, it was pointed out that although some grant funding is available to help support system development, current limitations and strains among state staffs make it challenging to apply for these grants. The federal government is considering whether a 90% federal match (as opposed to the traditional 50% administrative match) will be available to support eligibility system upgrades. This additional federal funding would enhance states' capacity to make eligibility system upgrades.

Determining Governance and Structure of Systems

In designing integrated systems, states will need to make decisions regarding where eligibility determinations for Medicaid and subsidies for Exchange coverage will be housed and which agencies, workers, and entities will be able to make eligibility determinations. While states already have eligibility and enrollment systems and processes in place for Medicaid, new systems and processes will need to be established to determine eligibility for premium and cost sharing subsidies for Exchange coverage. One key decision states will need to make is to what extent they will build on existing Medicaid eligibility systems to include Exchange coverage versus creating entirely new systems for Exchange coverage and Medicaid.

A number of participants commented that some states may want to consider restructuring where their Medicaid eligibility is determined to facilitate coordination and integration with new Exchange coverage. There is significant variation across states today in terms of where and how eligibility is determined for Medicaid and CHIP. For example, in some states, Medicaid eligibility is determined through a county-based system by county workers at a social services agency that also does eligibility determinations for other assistance programs, such as food stamps or Temporary Assistance for Needy Families. In other states, eligibility is determined at a centralized state office. Further, some states have state workers that conduct eligibility determinations in county offices. Still other states rely on private contractors to conduct key elements of enrollment activities, particularly for CHIP. And, some states have eligibility determined through a combination of these options.

Some states have already begun thinking about changing where their Medicaid eligibility is determined in preparation for reform. For example, Washington is planning to move its Medicaid Administration out of the Department of Social and Health Services and merge it with its Health Care Authority, which administers its existing Basic Health coverage program for low-income adults.[9] Similarly, Michigan is considering moving eligibility determinations out of the Department of Human Services and into the Department of Community Health, which administers the Medicaid program, with a goal of simplifying the eligibility determination process and consolidating program administration.[10]

Moving health coverage eligibility determinations away from county-level social services agencies may be particularly important to consider, since using a centralized state eligibility system (vs. separate eligibility systems in each county) will facilitate integration with Exchange coverage and potentially reduce application processing time. For example, New York recently passed legislation to move administration of Medicaid eligibility determinations from the county to state level over a five-year implementation period, beginning on April 1, 2011.[11] However, it also was noted that, in some states, considering moving determinations away from the county-level may be met with tension and resistance among county workers.

Tracking "New vs. Current Eligibles" and Maintaining Current Medicaid Methodologies

A complicating factor in developing eligibility systems is that, under reform, states must track who is newly eligible for Medicaid (versus who was previously eligible) since the federal government will pay the majority of costs for newly eligible individuals. Further, whether an individual is considered "newly eligible" has implications for what benefits they will receive, as states can elect to provide newly eligible adults benchmark benefits that may differ from the traditional Medicaid benefit package.[12] Moreover, while most Medicaid eligibility groups will

have eligibility determined based on MAGI under reform, there are some groups, including elderly and disabled individuals, who will continue to rely on current Medicaid eligibility methodologies. Participants noted that there are a number of unanswered questions about how states will need to continue to track these distinctions and whether they will need to maintain dual eligibility systems to do so.

2. The requirement to integrate Medicaid and Exchange enrollment systems, combined with simplified Medicaid eligibility criteria under reform, provide a valuable opportunity for states to vastly simplify Medicaid enrollment processes.

Some states have already made significant strides forward in simplifying Medicaid enrollment, for example, by moving to data-matching and other electronic or automated means to verify information (rather than requiring paper documentation) and eliminating interview requirements that are not required by federal law. However, other states still maintain these types of requirements, particularly for parents. Participants suggested that it would be beneficial for states to consider greatly simplifying their Medicaid enrollment processes as they design new integrated systems since Medicaid simplifications would make it easier to coordinate with Exchange coverage and meet other ACA enrollment-related requirements.

Participants also commented that the ACA calls for uniformity of enrollment processes across Medicaid and subsidized coverage in the Exchange and specifically requires that individuals be screened for all coverage options regardless of where they apply and enrolled without additional application forms or multiple eligibility determinations. These requirements may supersede state flexibility to impose certain requirements in Medicaid, such as face-to-face interviews. However, it was also recognized that certain eligibility categories in Medicaid will continue to require different eligibility determination and enrollment procedures (such as individuals with disabilities or those requiring long-term care services).

It was noted that some states have concerns that simplifying the Medicaid eligibility and enrollment process would increase their error rates during federal audits. In response, it was pointed out that states such as Louisiana, which have implemented significant simplifications, have some of the lowest error rates in the country. It was also suggested that rethinking the focus of federal audits and performance measures so they are better aligned with the goals of the ACA could facilitate and encourage increased Medicaid streamlining efforts among states.

3. It will be important for systems to minimize burdens on individuals by utilizing technology and existing data sources to obtain information.

Consistent with the "no wrong door" requirement, it was noted that regardless of which avenue an individual comes through to seek coverage, the individual should be evaluated for Medicaid, CHIP, and subsidies for Exchange coverage. However, participants emphasized the need to strike a balance of asking enough information to determine eligibility without making the process complex, burdensome, or intrusive, particularly given the broad income range of people that will be seeking coverage through the Exchange. The Exchange will be utilized as an entry point to coverage for people at all income levels—some will be eligible for tax credits to offset premium and cost sharing amounts of Exchange coverage, some will be eligible for Medicaid or CHIP, and some won't be eligible for assistance but will still purchase coverage through the Exchange.

Overall, it was largely agreed that eligibility and enrollment systems should be designed to obtain enough information to determine eligibility for the "majority" of individuals applying for coverage, but that additional processes and enrollment supports will need to be in place for individuals with special circumstances. In fact, the legislation requires that individuals have access to meaningful application support and alternatives to the on-line application are available. Further, it was recognized that it will be important to make sure individuals are fully informed about and understand the determination process and final enrollment decisions to assure due

process requirements are met. Participants also highlighted the importance of enrolling individuals in the correct coverage category since a set of rights and their premium costs, benefits, and cost sharing will flow from their eligibility determination.

Determining Income

Under health reform, assistance will be available to individuals with income up to 400% FPL and eligibility for both Medicaid and subsidies in the Exchange will be based on MAGI, which is defined by the Internal Revenue Code and captured through the Internal Revenue Service when individuals file income taxes. Moving to MAGI standardizes and simplifies income eligibility across states and between Medicaid and subsidized Exchange coverage. However, tax data may be lagged by as long as two years and, over that period, individuals may have a change in income or circumstances that affects their Medicaid eligibility and/or the level of financial assistance they qualify for under Exchange coverage. Further, not all individuals will have filed taxes and, within Medicaid, there will remain some non-MAGI groups (including elderly and disabled individuals) whose eligibility will continue to be based on current Medicaid methodologies.

Given these issues and that the law requires Medicaid eligibility to be based on current income and HHS to establish guidelines for Exchange coverage to gather more recent income information for people who have experienced a change in circumstances, participants noted that processes will need to be established to collect more current information from applicants. Doing so will be vital for assuring that individuals can be screened for Medicaid eligibility and that they receive the appropriate level of subsidies and/or cost-sharing reductions for Exchange coverage. Participants cautioned that it will be important for this process to remain simple and for any documentation requirements to be clearly specified to the applicant in an easily understood manner.

Moving to MAGI also changes how households are defined and family size is calculated. For example, today, Medicaid often excludes step-parent and grandparent income that would be counted in the MAGI household definition of income. Further, participants pointed out that individuals generally perceive their household as all individuals with whom they live, which is very different from the tax definition of household used for MAGI. As such, it was noted that it will be important to clearly communicate to individuals who can be counted as part of their household and collect the necessary information to determine their household size and income.

Several participants commented that not every person coming to the Exchange to purchase coverage would be eligible for or interested in receiving assistance, and some of these individuals might find any income-related questions to be intrusive or off-putting. A suggestion was made to create an initial screening question or process that would enable individuals to purchase coverage through the Exchange without having to answer any income-related questions if they were not interested in applying for a subsidy. It was further noted that if any of these individuals are eligible for premium subsidies, they would receive credits after filing their tax return.

Automating Data Collection and Express Lane Eligibility

There was consensus among participants that utilizing existing federal and state databases to obtain and verify as much eligibility information as possible and automate enrollment would go a long way in simplifying the process and making it easier for individuals. It also reduces burdens on eligibility workers and can speed up the processing time of applications.

It was recognized that states can already move forward with developing these processes for children, since, under the Children's Health Insurance Program Reauthorization Act, they can implement "Express Lane Eligibility" initiatives that draw on other data sources to identify and automatically enroll eligible but uninsured children in Medicaid and CHIP. However, this authority does not currently extend to adults. It was noted that it would likely

be advantageous to expand Express Lane Eligibility authority to include adults since adults will comprise the bulk of those newly eligible for Medicaid and many states will be faced with processing a large volume of new adult enrollees following implementation of the expansion. Further, many of the adults who will become newly eligible for Medicaid are likely enrolled in the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps). As such, providing Express Lane Eligibility authority that would allow states to borrow data from SNAP to conduct Medicaid eligibility determinations for adults could offer a highly effective and efficient strategy for states to reach and enroll newly eligible adults.

4. Seamless and automatic renewals of and transitions between coverage will be vital components of integrated eligibility and enrollment systems.

Beyond issues associated with establishing income and eligibility when individuals initially apply for coverage, participants also noted that there are questions that need to be addressed with regard to capturing and managing changes in income and eligibility over time, including when and how changes in income will be collected. Assuring there are simple and effective processes to collect updated income and other eligibility information will be key for preventing disruptions in coverage and making sure that individuals receive the appropriate coverage and amount of financial assistance at the right time.

Using Data Exchange to Automate Renewals and Coverage Transitions

It was recognized that, within Medicaid, utilizing electronic data exchanges to obtain updated information and automatically renew coverage has been an extremely effective and efficient way to help individuals maintain coverage. For example, in Louisiana, children are automatically renewed for coverage based on information available through other programs and data sources (e.g., SNAP, child support, tax information) or if their case meets specified criteria.[13] As a result of this initiative, the state has almost completely eliminated losses in coverage at renewal due to procedural reasons.[14]

It also was stressed that it will be important to develop a process that facilitates seamless, automatic transitions between coverage, particularly since a number of low-income individuals have changing circumstances and income that may cause their eligibility to shift over time. Past experience with Medicaid and CHIP suggests that transitions in coverage work best when a single, unified agency conducts eligibility determinations for both coverage programs. When transitions occur across different agencies, there is a risk that people will lose coverage during the transition.

Although transitions work best when eligibility for both programs is housed within a single agency, participants noted that there are some best practices that can be drawn on from Medicaid and CHIP for transitioning coverage between agencies. For example, in Alabama, the Department of Public Health, which administers its separate CHIP program "ALL Kids," and the Alabama Medicaid Agency have created a collaborative working relationship and taken steps to align eligibility rules, although some important differences remain.[15] The state facilitates coordination and transfers of coverage between Medicaid and ALL Kids through an electronic data exchange system that passes applications back and forth between the two programs on a nightly basis.[16] (However, a signed paper for must also be transferred before eligibility can be determined, which adds to the processing time for referred applications.)[17] Further, each agency has staff devoted to processing cases transferred from the other program.[18]

Similarly, Pennsylvania has an online application system, COMPASS, that provides a bridge between Medicaid, CHIP, and its state-funded adultBasic program for low-income adults by transferring data between the Department of Public Welfare, which administers Medicaid, and the state Insurance Department, which administers CHIP and adultBasic. This "Healthcare Handshake" automatically transfers data not only at the point

of application but also when an enrollee loses eligibility in one program but may qualify for another.[19] As part of the Handshake, the "losing agency" provides a fully populated application with all the information needed to make an eligibility determination to the "gaining agency," without requiring any action by the individual or family.[20] The transaction takes seconds and the individual is enrolled in the new program at the earliest date possible.[21]

As part of a process of transitioning individuals between coverage programs, it will be important for states to track the success of their transitions or referrals between programs. It also will be imperative to incorporate processes to educate individuals about their coverage changes, for example, by informing them about why and how their coverage changed and how their premium and cost sharing amounts, covered benefits, and health plan and provider networks are affected.

Another issue that was raised was that Medicaid provides retroactive coverage (i.e., covering health costs for the three months prior to the date of enrollment), while Exchange coverage is provided on a prospective basis (i.e., beginning on the first of the month following enrollment). It will be important to address this timing issue so that it does not create gaps in coverage as a person moves from Medicaid to Exchange coverage. Extending Medicaid through the end of the month after disenrollment was one suggestion made to prevent such gaps.

Stabilizing Coverage for Adults in Medicaid by Allowing Continuous Eligibility

Similar to employer-sponsored coverage today, enrollment in Exchange coverage will be based on an annual open enrollment period, although eligibility for premium and cost sharing subsidies may vary throughout the year based on any changes in income or family circumstances. However, currently, there is significant variation across states and population groups in terms of enrollment periods for Medicaid. Many states have a 12-month enrollment period for their Medicaid program, meaning that applicants only need to renew coverage annually. However, if enrollees experience a change in income or circumstances within that period they would be expected to report that change and would be disenrolled if the change made them ineligible. Further, some states require more frequent (e.g., 6-month) Medicaid redeterminations, particularly for parents.

States have the option to provide 12-month continuous eligibility to children in Medicaid and CHIP, meaning that children remain eligible for an entire year regardless of changes in income. However, states do not have an option to provide this continuous eligibility to adults after 2014. Participants generally concurred that providing continuous eligibility would help would minimize the frequency and burden of reporting income data and frequent transitions in coverage that increase risks of coverage gaps or disruptions in access to care. Minimizing transitions in coverage through continuous eligibility would also enhance the ability of health plans to manage and coordinate care for enrollees.

5. Developing processes and systems that facilitate continuous care across coverage types will also be important.

As noted, the legislative requirements around coordinating benefits and health plans between Medicaid and the Exchange are limited. The primary requirement is that an essential health benefits package be created for Exchange coverage and that benchmark coverage for "new eligibles" in Medicaid must, at a minimum, provide the essential health benefits.

A few participants suggested that having similar benefit packages for plans in Medicaid and the Exchange would help facilitate coordinated care. Further, the question of whether benchmark coverage for "new eligibles" in Medicaid should look more like commercial coverage was raised, although concerns were expressed as to how this would impact individuals with significant health needs who may not qualify as disabled but still require more services than those typically included in a commercial plan. Also, it was noted that the more significant the

differences are for benefits for "new eligibles" versus "current eligibles," the more important it will be for a state to continue to make the distinction as to which individuals are "newly eligible." Another topic raised was to what extent states should work to ensure that some plans participate in both the Medicaid and Exchange markets, for example, by providing incentives or utilizing selective contracting processes. However, it was noted that many Medicaid managed care plans may find it difficult to operate in the Exchange since they are smaller and/or are not set up to operate in a commercial market.

The discussion also included broader questions about whether it would be advisable to group the Small Business Heath Options Program (SHOP) and individual Exchange markets together along with the Medicaid population. While some cautioned that this would be difficult and cause complexities, others commented that it will be important to think about creating and utilizing purchasing power by combining groups under a single governance.

CONCLUSION

In conclusion, beyond expanding coverage to millions of currently uninsured, the ACA envisions and establishes requirements to create a continuum of coverage with a coordinated and seamless enrollment process supported by technology. It also will be important to assure that care is coordinated and continuous across coverage types. To achieve the goal of coordinated coverage and care, a number of challenges must be addressed, but the requirement to create modernized and integrated systems provides an important opportunity for states to greatly simplify their Medicaid eligibility and enrollment processes and make large-scale system upgrades that make better use of technology and reduce burdens for both individuals and eligibility workers. The roundtable discussion emphasized that it will be important for states to begin taking steps now to have systems in place by 2014. Further, participants stressed the importance of immediate federal guidance and increased federal financial support to advance state efforts.

ENDNOTES

[1] A standard 5% of income disregard will be used to determine Medicaid eligibility, raising the effective income limit to 138% FPL.

[2] Artiga, S., Rudowitz, R., and B. Lyons, "Expanding Coverage to Adults through Medicaid Under Health Reform," Health Reform Roundtables: Charting a Course Forward," The Kaiser Commission on Medicaid and the Uninsured, September 2010.

[3] Morrow, M. and J. Paradise, "Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act," The Henry J. Kaiser Family Foundation, October 2010.

[4] These standards focus on creating an eligibility and enrollment system that features a transparent, understandable and easy to use online process that enables consumers to make informed decisions about applying for and managing benefits; accommodates a range of user capabilities, languages, and access considerations; offers seamless integration between private and public insurance options; also connects individuals with other services and need-based programs (e.g., SNAP, TANF); and provides strong privacy and security protections. "Patient Protection and Affordable Care Act, Section 1561 Recommendations," The Office of the National Coordinator for Health Information Technology, September 17, 2010, http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

[5] "Wisconsin's ACCESS Internet Portal," Optimizing Medicaid Enrollment: Spotlight on Technology, The Kaiser Commission on Medicaid and the Uninsured, forthcoming.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Kellar, E., et al, "Staying on Top of Health Reform: An Early Look at Workforce Challenges in Five States," The Henry J. Kaiser Family Foundation, September 2010.

[10] Ibid.

[11] "Lieutenant Governor's Report on Controlling Increases in the Cost of New York Medicaid," September 20, 2010; "Right Dose of Oversight Needed to Control N.Y.'s Medicaid Costs," Observations, The Nelson A. Rockefeller Institute of Government, October 2010, http://www.rockinst.org/observations/burkec/2010-10-right_dose_oversight.aspx

[12] Essential health benefits are the benefits that must be provided to people signing up for Exchange plans or coverage in the individual or small group insurance market, beginning in 2014. The Secretary of Health and Human Services is charged with defining essential health benefits.

[13] Brooks, T., "The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP," The Georgetown University Health Policy Institute Center for Children and Families, February 2009.

[14] Ibid.

[15] Kellenberg, R., Duchan, L., and E. Ellis, "Maximizing Enrollment in Alabama: Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids," A Maximizing Enrollment for Kids Diagnostic Assessment Series, National Academy for State Health Policy and the Robert Wood Johnson Foundation, February 2010.

[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] Morrow, B., "Emerging Health Information Technology for Children in Medicaid and SCHIP Programs," E-health Snapshot, The Kaiser Commission on Medicaid and the Uninsured and The Children's Partnership, November 2008.

[20] Ibid.

[21] Ibid.

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