

Spotlight on the States #5

May 2013



Since the Supreme Court ruled that States could not be mandatorily obligated to expand Medicaid under the Affordable Care Act (“ACA”), both States and the Centers for Medicare & Medicaid Services (“CMS”) have contemplated options for expanding coverage in ways that were not necessarily anticipated under the ACA. The most prominent example of one such option is that being pursued by Arkansas<sup>i</sup>. In this model, Medicaid funding that attaches to an eligible individual would be used to purchase private health insurance coverage through a QHP offered on the Exchange. This mechanism is being referred to as “premium assistance”. While the State has not developed all of the details regarding the coverage expansion proposal as of the date of this paper, some parameters have been proposed through recently enacted legislation, which will be reviewed by CMS<sup>ii</sup>. It is important to note that the States and CMS continue to engage in discussions regarding these proposals, so future details and guidances may impact the analyses contained in this issue brief. Many stakeholders have raised important questions about how the proposal will work for Medicaid beneficiaries and providers. This issue brief will address some of the most common questions that have been raised in two parts: an overview of the different Medicaid eligibility groups and coverage and benefits they are entitled to and a discussion on how Exchanges will likely interact with Medicaid under the Arkansas proposal, which is being used as the model.

**Medicaid Populations: Differences Related to Entitled Benefits and Access to Coverage**

Because Arkansas has proposed to include “low-risk” adults whose income falls below 138% of the federal poverty line and potentially additional populations under the proposed coverage expansion, it is important to clarify that the proposal, and others that follow this model, will have different impacts on different Medicaid populations. These distinctions are identified and discussed below and summarized in the following table.

<b>Medicaid Populations: Differences Related to Entitled Benefits and Access to Coverage</b>			
	<b>Traditional Populations</b>	<b>Waiver Populations</b>	<b>Benchmark Populations</b>
<b>Eligibility</b>	Meet State-established categorical or medical requirements	Targeted populations established by waiver	Non-elderly, non-pregnant adults; up to 138% FPL under ACA
<b>Entitlement to FQHC Services</b>	FQHC services a mandatory benefit	As established under the waiver	SSA requires <u>access</u> to FQHC services
<b>Coverage Plan Options</b>	FFS; MCOs; Possibly QHPs	As established under the waiver	ABPs; QHPs
<b>Plan Access Standards</b>	FFS: State must enlist enough providers so that care and services are available at least to the extent that such care and services are available to	As established under the waiver	QHPs: must contract with Essential Community Providers (ECPs), which include FQHCs (number of FQHCs with which QHPs must contract not

	<p>general population</p> <p>MCOs: must make all services accessible to the same extent as such services are made accessible to FFS program beneficiaries</p>		<p>specified)</p>
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**What are the different eligibility groups?**

There are several different Medicaid eligibility groups: for this paper, we highlight “traditional populations”; “waiver populations”; and “benchmark populations.” Traditional Medicaid populations include individuals that meet current State requirements for Medicaid eligibility, which would include individuals who meet State-established income and asset tests, are pregnant, suffer a disability, are members of families with dependent children, and certain children and elderly individuals. Individuals may also qualify for limited Medicaid benefits, as discussed below, through 1115 Waiver programs established by the State, targeted at specific populations, and approved by the Federal government. Finally, there are individuals who are eligible for benchmark coverage under Medicaid. Under the ACA (as interpreted by the Supreme Court), States have the authority to expand Medicaid eligibility to all individuals with incomes up to 138% of the Federal Poverty Level (“FPL”). All individuals who become eligible for Medicaid through an expansion under the ACA must be covered under benchmark equivalent coverage<sup>iii</sup>. Therefore, these individuals are included in the “benchmark population” for purposes of determining what coverage and services they are entitled to.

**What Coverage and Services Are These Different Populations Entitled To?**

The kind of coverage and specific services to which a Medicaid-eligible individual is entitled is based on which eligibility group, or population, they fall into. Individuals in different populations will be eligible for different categories, types, and levels of services. For the purposes of this issue brief, we focus on how each population will be treated with respect to coverage of FQHC services.

For traditional Medicaid populations, these services are a mandatorily covered benefit under Medicaid. *See* SSA § 1905(a)(2). Therefore, for these traditional populations, FQHC services must continue to be covered by the State, even if an individual is enrolled in a qualified health plan (“QHP”) through an Exchange (discussed further below). In a March 28 Q&A, however, CMS stated that if a State is implementing premium assistance through a demonstration waiver, the agency would only consider premium assistance proposals that are limited to individuals in the new Medicaid adult eligibility group – who fall into the “benchmark” populations – and not the pre-ACA, traditional populations. Again, however, CMS also reiterated that premium assistance may be implemented without a waiver as a State Plan Amendment.

Coverage of FQHC services for “benchmark populations” – including those newly eligible under a Medicaid expansion – may be different. Under the CMS proposed rule, all Medicaid benchmark coverage will be required to cover the ten categories of EHB (as required for QHPs), *plus* all existing Medicaid benchmark plan requirements. FQHC services are not listed as one of the EHB categories, but coverage of such services for Medicaid benchmark populations is discussed in the Social Security Act (“SSA”).

For benchmark populations in Medicaid, SSA § 1937(b)(4)(A) requires that these beneficiaries retain access to FQHC services. Because all Medicaid-eligible individuals must continue to receive all Medicaid benefits to which they are entitled, any individual in the benchmark population would still be required to have access to FQHC

services, even if they are covered under a premium assistance model and enrolled in a QHP. To date, no definitive “access” standard has been established. In other words, CMS has not defined what it means for an individual to actually *have* access to FQHC services. Therefore, the requirement that an individual retain access to FQHC services could be fully satisfied by QHPs as a byproduct of the above ECP requirements applicable to such plans – for example, it could be that if a QHP contracts with just one FQHC, this access standard will be considered by CMS to be met. It is NACHC’s interpretation that the “access” language in SSA § 1937(b)(4)(A) does not appear to be any more limiting than the statute and policy that CMS Medicaid currently applies for FQHC services in mandatory Medicaid managed care programs. Until further guidance is issued from CMS, some questions remain as to how States can or must ensure that benchmark populations retain access to FQHC services through a QHP, but it should be no more limiting than the position that CMS has taken with regard to current FQHC/MCO requirements.

**How Will These Populations Be Covered?**

Each type of Medicaid population may also be covered in different ways. For example, traditional populations can be covered under standard, State-run, fee-for-service (“FFS”) Medicaid; through a Managed Care Plan; or through Alternative Benefit Plans (ABPs). Newly eligible individuals must be covered under benchmark equivalent coverage, as noted above, which may include ABPs or QHPs. Just as each type of Medicaid population has certain requirements with respect to the covered benefits that they must be entitled to based on which population they fall into, each type of coverage is subject to different requirements with respect to services that they must cover. For purposes of this paper, we focus on how coverage of these populations through plans in the Exchange (QHPs) will likely function, what requirements will apply, and how this structure may impact FQHCs and their patients.

**Interaction Between Medicaid Expansion and the Exchange**

Under the proposed coverage expansion plan put forth by Arkansas, and potentially others, Medicaid funding that attaches to an eligible individual would be used to purchase private health insurance coverage through a QHP offered on the Exchange. This mechanism is being referred to as “premium assistance.” Because this is a new system of private insurance and a relatively uncommon approach to providing Medicaid coverage, a number of important questions have arisen, which are addressed below.

Key Takeaways: Medicaid Expansion Private Option
<ul style="list-style-type: none"> <li>• All Medicaid-eligible individuals, even those who participate in private plans through the Exchanges, will remain entitled to continued coverage of all Medicaid benefits.               <ul style="list-style-type: none"> <li>○ States must cover those services not covered by an Exchange plan through wrap-around benefits.</li> </ul> </li> <li>• Coverage of FQHC services may be impacted differently for different Medicaid populations.               <ul style="list-style-type: none"> <li>○ <b>Non-benchmark, or “Traditional,” populations.</b> For those individuals <u>not</u> covered under benchmark coverage today, FQHC services must continue to be covered by the State.</li> <li>○ <b>Benchmark and Expansion populations.</b> For those individuals who <u>are currently</u> covered under benchmark coverage, and for <u>all</u> individuals who become <u>newly</u> eligible for coverage through the expansion (even through a private option), the law requires that these populations have <u>access</u> to FQHC services. This may look different in each State.</li> </ul> </li> <li>• Payment for FQHC-provided services should continue to be the Medicaid PPS for all Medicaid populations, unless an FQHC negotiates a different rate with an Exchange plan.</li> </ul>

### *Where is the Authority for this System found in Law?*

Section §1905 of the Social Security Act permits Medicaid payments to “include expenditures for Medicare cost-sharing and for [Medicare] premiums . . . and [except in the case of elderly or disabled Medicare beneficiaries] other insurance premiums for medical or any other type of remedial care or the cost thereof.” Additionally, SSA §1906A, requires that States, under certain circumstances, provide premium assistance subsidies to cover “qualified employer-sponsored coverage” in the case of Medicaid beneficiaries who are eligible for enrollment in such plans.

CMS also addressed the issue of how States can use premium assistance in Medicaid in order to purchase private coverage through an Exchange in a Q&A released on December 10, 2012<sup>iv</sup>. According to CMS, States have used premium assistance “to help Medicaid/CHIP eligible families pay for available employer-based coverage that the State determines is cost effective.”<sup>v</sup> CMS further acknowledged that, under premium assistance, there are “cost sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid and/or CHIP funds does not meet Medicaid or CHIP standards.”<sup>vi</sup>

The Q&A provides the following example: When a child is eligible for Medicaid/CHIP and the parent is enrolled in a qualified health plan through the Exchange, a State Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible child through that qualified health plan. With respect to the children – the Medicaid-eligible individuals – CMS indicates that the State must adhere to federal standards for premium assistance, “including providing wrap-around benefits, cost sharing assistance, and demonstrating cost-effectiveness, as appropriate.”<sup>vii</sup> The Q&A specifically contemplates that “a State-Based Exchange may be able to support such an option, and in States where a Federally-Facilitated Exchange is operating, a State Medicaid or CHIP agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals.”<sup>viii</sup>

On March 29, 2013, CMS issued another Q&A document regarding the use of premium assistance in Medicaid<sup>ix</sup>. In this Q&A, CMS reiterates that under premium assistance arrangements, the Medicaid beneficiaries continue to be enrolled in Medicaid and are therefore entitled to all benefits and cost-sharing provisions under the federal Medicaid statute. CMS further makes clear that under a premium assistance model, States “must have mechanisms in place to ‘wrap-around’ private coverage to the extent that benefits are less and cost sharing requirements are greater than those in Medicaid.” In addition, the Q&A indicates that States may pursue premium assistance as a State plan option and that a waiver is not required. However, the Q&A also states that individual market beneficiaries must be able to choose an alternative to private insurance to receive Medicaid benefits.

### *How Would This Work on a Practical Level?*

From a practical standpoint, an individual otherwise eligible for Medicaid would enroll or be enrolled in a QHP through the Exchange. The mechanisms for enrollment have not yet been explained in detail and, unless the State obtains a waiver, no Medicaid beneficiary could be required to obtain their coverage through a QHP as their only option for obtaining Medicaid benefits. However, once enrolled in a QHP, an individual’s QHP would be the primary payer for services received. Medicaid would be a secondary payor, effectively providing “wraparound” coverage for services and for lower cost sharing that the Medicaid enrollee is entitled to, but which are not provided under the QHP. CMS has clarified through these guidances that such enrollees are still Medicaid beneficiaries and still subject to all Medicaid requirements. Furthermore, it would appear that States that elect to

use this model must follow current law in order to receive the enhanced match rate for Medicaid expansion populations (which is 100% in 2014 through 2016, and gradually decreases to 90% by 2020) rather than implement such an arrangement through a waiver, although this is not entirely clear. It is clear that a State must take up the full expansion of coverage in order to receive the enhanced match for the expansion population but CMS has also provided guidance to consider premium assistance options as a demonstration in the individual market.

#### *What Happens to an Individual Who Receives Medicaid Benefits that are Beyond the EHB?*

All Medicaid enrollees will continue to be entitled to Medicaid benefits under Federal law, regardless of whether their coverage is obtained through a QHP or not. Benefits to which Medicaid-eligible individuals are entitled may extend beyond those that are required to be offered by QHPs. These benefits must remain available to Medicaid-eligible individuals receiving coverage through a QHP. CMS made this expressly clear in the recent proposed rule, stating that “Medicaid-eligible individuals enrolled in a private health plan would remain qualified for all benefits for which the individual is covered under the State plan.”<sup>x</sup>

#### *How Would This Plan Impact Coverage of FQHC Services for Different Medicaid Populations?*

As mentioned above, for traditional, non-benchmark (non-expansion) populations, FQHC services are a mandatorily covered benefit under Medicaid. See SSA § 1905(a)(2). Therefore, for these populations, FQHC services must continue to be covered by the State, even if an individual is enrolled in a QHP through an Exchange. For benchmark populations in Medicaid, SSA § 1937(b)(4)(A) requires that these beneficiaries retain access to FQHC services. Because there is no definitive “access” standard to date, the requirement that an individual retain access to FQHC services could potentially be satisfied by QHPs as a byproduct of the above ECP requirements applicable to such plans.

Because these requirements attach to an individual based on their eligibility for Medicaid, and not based on what kind of Medicaid program or plan they actually enroll in, even if a QHP does not contract with *any* FQHC to participate in its network, these FQHC services coverage and access requirements would still apply to both traditional and non-benchmark Medicaid populations. The Medicaid standard attaches to the individual by virtue of their eligibility for Medicaid and is not altered by the fact that they are enrolled in a QHP. As a result, if the QHP does not provide access to FQHC services, the State would presumably be required to do so through some other means. For example, the individual could obtain FQHC services out-of-network and the State could be liable for covering any out-of-pocket expenses incurred as a result of any such visit through a wrap-around benefit. Again, the level of coverage of or access to FQHC services that will be required will vary across these populations.

For States pursuing premium assistance under a demonstration waiver, CMS provided guidance on the mechanism through which wrap-around benefits would be provided. In the March 28 Q&A, CMS says that under a demonstration waiver states would be required to make arrangements with the QHPs to provide the necessary wrap around benefits and cost sharing reductions through the QHP, and the State, as an example, would provide a supplemental premium payment to the QHP for the provision of these wrap-around benefits.

#### *How Would This Plan Impact Payments Made to FQHCs?*

For traditional Medicaid populations, SSA § 1902(bb) requires that FQHCs be paid the Medicaid PPS rate. With respect to Medicaid benchmark (e.g., expansion) populations, § 1937(b)(4)(B) further requires that payment for

FQHC services be made in accordance with the Medicaid PPS payment. Therefore, under current law and absent a waiver, for the Medicaid population, it would appear that the FQHC PPS payment rate would continue to apply to payments made for FQHC services provided to Medicaid beneficiaries enrolled in a QHP through a premium support mechanism.

Furthermore, given that Federal law imposes cost-sharing limitations with respect to Medicaid beneficiaries, it would appear that a State must ensure these individuals remain subject to the cost-sharing protections of the Medicaid program. This protection may extend regardless of whether an FQHC is out of network with respect to a given QHP.

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<sup>i</sup> Reports indicate that New York, Texas, Florida, and Ohio have also expressed interest in this proposal, though possibly with differences.

<sup>ii</sup> *Arkansas' Approach to Low Income Premium Assistance*, March 13, 2013, is available at:

<http://humanservices.arkansas.gov/director/Documents/Arkansas%20Medicaid%20Private%20option%20letter%203.13.13.pdf>; The legislation implementing this proposal is at: <http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/HB1219.pdf>.

<sup>iii</sup> See 78 Fed. Reg. at 4629.

<sup>iv</sup> See Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, December 10, 2012, available at: [ccio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf](http://ccio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf).

<sup>v</sup> *Id.* at 16 – 17.

<sup>vi</sup> *Id.* at 17.

<sup>vii</sup> *Id.*

<sup>viii</sup> *Id.*

<sup>ix</sup> See Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Reuse of Exchange for Ancillary Products*, March 29, 2013, available at: <http://ccio.cms.gov/resources/files/ancillary-product-faq-03-29-2013.pdf>.

<sup>x</sup> *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals etc.*, 78 Fed. Reg. 4594, at 4624 (Jan. 22, 2013) (to be codified at 42 CFR Parts 430, 431, 433, et al.; 45 CFR Part 155).

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**Medicaid Premium Assistance and Health Insurance Exchanges**

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