



# NAMD ACA IMPLEMENTATION SNAPSHOT – OPEN ENROLLMENT, WEEK 7

NOVEMBER 18<sup>TH</sup> – NOVEMBER 25<sup>TH</sup>, 2013

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THIS SNAPSHOT IS PART OF NAMD'S ONGOING PUBLICATION DESIGNED TO SUPPORT STATES THROUGHOUT AFFORDABLE CARE ACT IMPLEMENTATION PROCESS. THE FOLLOWING SUMMARY IS A QUALITATIVE WINDOW INTO STATE EXPERIENCES OVER THE LAST WEEK —DISCUSSING THE STATE PERSPECTIVE ON REPORTING REQUIREMENTS, EDUCATION AND OUTREACH EFFORTS, AND PLANNING FOR SERVICE AND CAPACITY NEEDS. THIS SUMMARY IS BASED ON OUR CONVERSATIONS WITH A REPRESENTATIVE SAMPLE OF STATES.

IN ORDER TO PROVIDE THE MOST TIMELY AND ACCURATE DATA AVAILABLE, NAMD PLANS TO CONTINUE TO PUBLISH A WEEKLY UPDATE, DESCRIBING STATE AND FEDERAL EFFORTS TO REFINE SYSTEMS AND CREATE A SMOOTH PROCESS FOR INDIVIDUALS INTERACTING WITH STATE MEDICAID PROGRAMS.

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## THE STATE EXPERIENCE

- ∴ States are continuously evaluating their timelines and strategies for complying with the Affordable Care Act's (ACA) Medicaid provisions and meeting other state-specific goals. States are at a critical point in their work to comply with the ACA's mandatory eligibility policy changes and optional income eligibility expansions that take effect January 1, 2014. If they haven't already, states will shortly finalize decisions for whether or not they will implement mitigation plans for January 1<sup>st</sup> activities until certain federal and state IT systems and services are functional.

In addition to IT systems, all states are preparing for some amount of enrollment growth in their Medicaid program. In some states this stems from individuals who are currently eligible but not enrolled (EBNE) while in others the program growth results from the combination of the EBNE population and newly eligible individuals whose coverage can start on January 1, 2014. This means states are taking this opportunity to improve the efficiency and effectiveness of their enrollment efforts.

## ENROLLMENT INTERPRETATIONS

- ∴ States reported they were continuing to work closely with CMS on the collection and interpretation of Medicaid agency data for the month of October, as well as data that CMS may use in making baseline comparisons. States have submitted performance indicator data to CMS, but the data reported vary in scope, frequency and type. Some state systems currently support data of only high-level summary information, while other state systems can now produce reports that meet many of CMS' more detailed specifications. This week states also continued to respond to CMS' follow-up questions about their data, and to adapt their data systems going forward.

State-specific Medicaid programs, policies and systems make understanding and interpreting cross-state data challenging. This is particularly true during this highly transitional period for the nation's Medicaid programs. States provided and continue to offer caveats and explanatory information in response to CMS' reporting requirement. This supporting information is intended to help ensure state Medicaid data is presented and interpreted as accurately as possible.

Further, states reported that the picture of Medicaid will likely be more fluid than that for the new health insurance marketplaces. One reason is that, unlike the marketplaces, Medicaid does not have a single open enrollment period. Rather, eligible individuals can enroll in Medicaid, and do, at any point in the year. For this and other reasons, states expect that application and enrollment numbers will continue to shift but not always in direct correlation with ACA implementation.

## SYSTEMS – TESTING AND TIMELINES

- ∴ All states continue to work on the enormous task of bringing their Medicaid systems into compliance with the ACA's statutory and regulatory requirements. This work has

many moving pieces and decision makers within the Medicaid agency and within other governmental entities at the state and federal levels. In some states, interagency coordination can be further complicated by the need to align multiple vendors responsible for different IT components. Medicaid agencies report they are continually updating project timelines to accommodate the fluid situation on the ground.

Medicaid agencies also report they are squarely focused on testing, refining and launching those elements essential for system operation in a timely manner, including ensuring that sister agencies and entities such as counties are integrated into the system. In some cases, they have delayed auxiliary functions or system enhancements that could detract from this focus.

States with a Federally Facilitated Marketplace (FFM) model are in various stages of readiness and testing of the latest rules version of the account transfer service.<sup>1</sup> Testing is underway in some states, though no state reported that end-to-end, bi-directional testing was occurring. In other states, testing had not yet begun even if the state was ready.

These states also continued to raise questions about alignment of the account transfer service and new eligibility systems and policies, and, particularly in the near term, how CMS will work with states to reconcile reporting data for individuals that have applied through both the Medicaid and FFM. During this interim period when the account transfer service is not functional, some Medicaid agencies in FFM states are actively informing consumers they may re-apply through the Medicaid agency. This alternative can allow consumers to have their Medicaid determination processed in a more timely fashion.

## EXPANSIONS AND BENEFIT DESIGN

- ∴ As January 1<sup>st</sup> draws closer, states are prioritizing the “must do” items critical to launch systems and start coverage for new Medicaid enrollees. In particular, states expanding their income eligibility limits report they are working intensely with CMS to submit and receive approval on their state plan amendment (SPA) for the benefit package for this new group. They are also fleshing out FMAP Claiming SPAs, the development of screening tools to identify individuals who may need long-term services and supports, impact of pending asset test guidance, application of CMS’ payment policy for institutions for mental disease (IMD) for the newly eligible population, and other, relatively technical but impactful decisions.

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<sup>1</sup> See NAMD’s October 28, 2013 Snapshot for additional discussion about the account transfer challenges:  
[http://medicaiddirectors.org/sites/medicaidirectors.org/files/public/week\\_4\\_snapshot\\_final.pdf](http://medicaiddirectors.org/sites/medicaidirectors.org/files/public/week_4_snapshot_final.pdf)

## HEALTH SYSTEM CAPACITY AND PLANNING

- ∴ Medicaid agencies have been preparing for augmented demand for services, driven largely by changes to Medicaid eligibility and enrollment rules and the shifts in the healthcare marketplace generally. Medicaid agencies are employing a range of strategies to enhance delivery system capacity, where needed, and to ensure appropriate access to providers and care coordination services.

States' delivery system strategies align with their program design and population needs. Example approaches range from comprehensive changes to drive efficiency in the delivery system to more targeted approaches such as direct provider recruitment, modification of scope of practice rules, evaluation of targeted provider rates, and strengthening capacity and access requirements in procurements and contracts. Also, states with managed care programs continue to work with managed care entities to add staff on both the operational and clinical sides, again where needed. States have or will undergo network adequacy reviews of their plans to assure case management and clinical capacity.

## STAKEHOLDER COMMUNICATIONS

- ∴ States are conducting training and educational activities for stakeholders and members of the community that will be impacted by changes in Medicaid. They are using a range of strategies, including: public forums, webinars, stakeholder and state taskforces, informational sessions, and increased call center capacity.

As part of these Medicaid-focused sessions, states are also fielding many questions about the broader changes in public health care programs. Medicaid staff in FFM states report that they are receiving many questions from federally funded eligibility counselors, such as those certified as "Navigators". Medicaid staff are providing information to the best of their ability, and working to connect these individuals to guidance issued by the federal agencies responsible for the FFM.

## ON THE HORIZON

- ∴ *Primary care provider rate increase.* Separate from any state-specific strategies, Congress included in the ACA a temporary, federally-funded rate increase for certain Medicaid primary care physicians (PCP). This increase was intended to incentivize PCP participation. States report that delays in the regulatory approval processes and complexity of implementation slowed the start of enhanced payments. Although money is flowing to providers now in most states, at this time it is too early to draw conclusions about the effectiveness of the enhanced federal payments on provider retention and recruitment efforts.

The federal funds are scheduled to expire at the end of 2014 -- in the middle of many states' next fiscal year and provider contract periods. States are or will soon begin



to evaluate this issue more closely. States with biennial budgets or other issues may need to consider this issue sooner.

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