NAMD ACA IMPLEMENTATION SNAPSHOT – OPEN ENROLLMENT, WEEK 3

OCTOBER 14th – OCTOBER 21st, 2013

THIS SNAPSHOT IS PART OF NAMD'S ONGOING SERIES OF REPORTS DESIGNED TO SUPPORT STATES THROUGHOUT THE AFFORDABLE CARE ACT (ACA) IMPLEMENTATION PROCESS. THE FOLLOWING SUMMARY IS A QUALITATIVE DISCUSSION OF STATE EXPERIENCES IN WEEK 3 OF OPEN ENROLLMENT, THE LAUNCH AND REFINEMENT OF MEDICAID AGENCIES' NEW ELIGIBILITY SYSTEMS, AND OTHER TASKS LEADING UP TO THE JANUARY 1, 2014 START OF NEW COVERAGE PROGRAMS. THE SUMMARY IS BASED ON OUR CONVERSATIONS WITH A REPRESENTATIVE SAMPLE OF STATES.

HEADING INTO THE THIRD WEEK OF OCTOBER, CHALLENGES STEMMING FROM THE PARTIAL FEDERAL GOVERNMENT SHUTDOWN WERE GROWING IN SCOPE AND BREADTH ACROSS STATES.[1] NAMD NOTES THE NOW RESOLVED FEDERAL GOVERNMENT SHUTDOWN SLOWED STATE WORK WITH FEDERAL PARTNERS TO THE POINT THAT IT MAY HAVE DOWNSTREAM IMPLICATIONS ON PROJECT PLANNING AND TIMELINES FOR LAUNCHING CERTAIN FUNCTIONALITIES AND PROGRAMS IN SOME STATES. THIS REPORT REFLECTS STATE PROGRESS DESPITE THE DELAYS AND ADJUSTMENTS TO PROJECT PLANS.

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 THE NATION'S MEDICAID PROGRAMS.

[1] NAMD's conversations with states largely occurred before federal policymakers resolved fiscal year 2014 funding for federal agencies and before CMS staff returned to work on October 17th, 2013.

THE STATE EXPERIENCE

∴ As states work through ACA-related operations and policy changes to their Medicaid programs, the dynamics of these changes take a unique form in each state. Variation exists in all aspects of implementation, including the experience with IT systems and vendors, consistency of communication between different state entities and with federal entities, and the design and timelines for each stage of progress. Regardless of these variations, every state is engaged in quality improvement and assurance activities. This includes improving system integrity, quickening responses to constituents, and preparing for higher utilization across all aspects of their Medicaid program.

CMS INTERACTIONS

∴ During the third week of open enrollment, states continued to report that they were in regular communication with CMS staff on a limited set of ACA-related issues. Some states are conducting daily check-in calls with their federal partners. Other states have a schedule of calls based on the intensity of their implementation activities. These interactions mean that day-to-day operational issues are being addressed. However, state-federal discussion and resolution on longer-term or more complicated policy issues seemed to have slowed.

DATA REPORTING

∴ States began reporting almost immediately on a number of data points, with weekly and eventually monthly reporting to CMS being set in motion. This week, states raised concerns with CMS' baseline and ongoing performance indicator reporting requirements. Reporting frequency, data definitions and the reporting process were all identified challenges, primarily caused by the "late-in-the-day" establishment of the reporting requirements. Although CMS and states had expected challenges, the number and breadth of these concerns were growing during this week.

First, states reported that they need more time to re-program their systems to accommodate CMS' new reporting requirements. While some states are already collecting a subset of the new indicators, no state is collecting all of the indicators in the way CMS has defined them, Also, in some instances states noted they cannot retroactively adapt their legacy systems to submit baseline data fields to accommodate CMS definitions. Generally states are making progress with new processes and incorporating the multiple federal data fields into their reporting procedures, but most cannot immediately fulfill all of the CMS requests and have to conduct numerous manual processes in the interim.

This retrofitting process and the wide-variation of data definitions will make it extremely difficult to support comparisons across states. There is even concern that

interpretation of state-specific data in the early phases of implementation will be challenging. Many states have listed detailed caveats to the data they can transmit, and worry that CMS efforts to report across the states will misrepresent conditions "on the ground." For example, many states have combined call centers for multiple human services programs, while others have Medicaid specific, or health care specific call centers. This is just one example of the challenges of nationwide measures of ACA implementation.

States recognize the need to track consumer support issues, and detail the performance of the eligibility and enrollment processes. To ensure there is a clear understanding by all stakeholders about these issues, states stressed the importance of working closely with CMS on a process to validate the information the federal agency plans to release with regard to state data.

Interfacing with Eligibility Systems

∴ States continue to closely monitor eligibility systems and application processing. At this time, states reported there is a manageable volume of inquiries and applications.

On October 16, CMS sent states some very limited data about individuals the FFM was referring to each state's Medicaid agency. Weekly transmission of the so-called "flat file" is a mitigation strategy that CMS is employing until the FFM's real-time electronic account transfer functionality is launched (scheduled for November 1st). States are still processing the flat file data, but initially were struggling to interpret the universe of individuals included in the transmission. States hope to use to data to prepare for CMS to "go-live" with the account transfer process.

Marketplace and Medicaid Relationships

∴ Communication between states and marketplaces continue to contain challenges in the initial weeks of open enrollment. Coordination of information between the two entities is complex. This is particularly true in states where an FFM is operating. Several states are reporting disconnects surrounding the process through which consumers are directed to the Medicaid agency. This week CMS began sending notices to individuals who applied through the FFM and were determined eligible for Medicaid. A few states reported this led to spikes in call volume and considerable confusion among applicants about their eligibility for Medicaid.

Hub Connectivity

∴ States report consistent improvement in federal hub connectivity. Most states are experiencing a "real-time" exchange of data with the hub. Specifically, states that are obtaining information about an individual's "lawful presence" are experiencing real

time responses from the hub. Also, some states are newly reporting that the Minimum Essential Coverage (MEC) data service is now operational.

ON THE HORIZON

∴ New challenges are unfolding as states continue to refine systems and prepare for new Medicaid enrollees to access services. NAMD expects these 'horizon' issues will evolve over time as CMS addresses outstanding issues and approves state plan amendments, and as states implement innovative approaches to meet the needs of their enrollees.

Health Insurer Fee – States continue to evaluate how to reflect the ACA's new fee on all insurance providers. This fee applies to certain Medicaid managed care plans and will impact their cost for doing business. States must determine whether this requires adjustments in the capitation rate for affected Medicaid managed care entities. Some states have proposed to include the fee into their capitation payments, others have inserted a placeholder in their budgets until more information is available about the fee's impact, and a number of states are still evaluating their options and have sought guidance from CMS.

The Medically Frail Population – The transition to using an individual's modified gross adjusted income (MAGI) to determine Medicaid eligibility has created new ambiguities surrounding the population deemed medically frail. States identified a complex set of outstanding policy and operational questions relative to handling this population going forward. Depending on the answers, these could have significant implications for this population, for other low-income individuals, and for federal and state budgets.

While there remains a fair amount of confusion, the key outstanding questions are tied to whether and when certain individuals are eligible for Medicaid long-term care services and supports, and whether these individuals will be required to meet pre-requisites (such as a review of their existing assets) or without "spending-down" to begin receiving long-term care benefits. Under current eligibility rules, asset tests and "spend-down" requirements are applied to most individuals that are deemed eligible for Medicaid LTC services. NAMD and individual states have stressed the pressing need for CMS to help states develop a framework to identify the medically frail population, and to clarify the federal policy on these requirements. CMS has responded that guidance will come soon.