

MAKING THE TRANSITION BETWEEN CHIP AND MEDICAID AS SEAMLESS AS POSSIBLE

Pennsylvania has an important task

Among the many changes to existing health care coverage programs, the Affordable Care Act sets a new Medicaid income eligibility threshold for children at or below 138% of the federal poverty guidelines.¹ Under current rules, these children are eligible for the CHIP program but beginning January 1, 2014, this new guideline requires children ages 6 to 19 whose family income is between 100 and 138% of poverty to move from CHIP to Medicaid. The federal government will continue to pay the enhanced CHIP federal matching rate of 67% for these children².

This change in the income eligibility *threshold* is distinct from the new Modified Adjusted Gross Income (MAGI) *income deeming* rules that will be used for Medicaid, CHIP and the Insurance Marketplace. It is our understanding that Pennsylvania, through an 1115 waiver, will begin utilizing the MAGI income rules beginning October 1, 2013 rather than operate two parallel income determination calculations in the period between October 1 and January 1, 2014 for children under 19, pregnant women, parents and caretakers and some adults.

Unlike most other states, Pennsylvania operates its CHIP and Medicaid programs through two different state departments. While this makes the transition of children between programs more challenging, it is possible to engineer the transfer in a careful, coordinated manner that will maintain continuity of care, preferred providers and a child's medical home. Pennsylvania's Departments of Insurance and Public Welfare have a long history of working collaboratively to assure children's easy and continuing access to health coverage. The Healthcare Handshake and COMPASS are but two examples of this coordination. In the time remaining between now and January 1, 2014, we urge the Departments of Insurance and Public Welfare to work collaboratively to assure a smooth transition.

The number of children likely to be affected by the change in eligibility criteria is estimated to be 50,000. However, it should be noted that even prior to the ACA children regularly moved between the Medicaid and CHIP programs due to changes in age, income, and family size that affect eligibility. In addition, children who develop serious illnesses or disabilities while enrolled in CHIP are routinely transferred to the Medicaid program through the children with disabilities category. These children also require close attention to preserve their continuity of care.

¹ Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010), § 2001(e), §1902(a)(10) (A) (ii), 42 U.S.C. § 1396a (a) (10) (A) (ii).

² 77 Fed Reg. 17,149 (March 23, 2012) (final rules and regulations).

The statutory MAGI rules and the increase of Medicaid eligibility to 138% of the federal poverty income guidelines are required by the ACA statute. As such they are independent of the Supreme Court imposed option to expand Medicaid to non-elderly, non-disabled adults under 138% of poverty income guidelines. The Secretary of Health and Human Services has no flexibility on this issue; as of January 1, 2014, children who are eligible for Medicaid due to these changes can no longer be enrolled in CHIP. The impact of the changes from current income eligibility rules to MAGI is likely to be relatively small, but should be included in planning processes nonetheless. These transitions must be managed carefully to ensure continuity of health care and avoid confusion and possible disruption in care.

There are multiple steps that Pennsylvania and the Departments of Insurance and Public Welfare can take to smooth the way.

Recommendations:

- 1. The Insurance Department should instruct the CHIP plans to take the necessary steps to correctly identify the children who must move from CHIP to Medicaid.**

This is essentially a three step process:

1. Obtain current household income information
2. Calculate countable income using the MAGI income rules
3. Apply the new eligibility guidelines for CHIP and Medicaid

The CHIP program currently allows 12-month continuous eligibility; this means that if a family's circumstances change during this time – such as a decrease in household income due to the loss of a job or a change in family size due to the birth of a new baby – the child retains her CHIP coverage. But it also means that the CHIP plans will not know if family circumstances have changed in the period since initial enrollment or the most recent renewal. Before communicating with families regarding a transition to Medicaid, MAGI income eligibility rules must be calculated using current household income. This should be relatively easy using the ACA-mandated federal data hub and other state data sources for most income verification.

For children renewing their coverage during October, November, and December, the CHIP plans should use the CHIP renewal process to obtain current household income and calculate eligibility based on the MAGI rules. Approximately one quarter of children enrolled in CHIP will be due for yearly renewal in October, November or December. The CHIP plans can utilize the federal data hub and other state data sources to assess continuing eligibility for CHIP and to identify those children who

should move to Medicaid beginning January 1, 2014. Children who will move to Medicaid should continue to be covered by CHIP until December 31, 2013.

For the children whose renewals dates are on or after January 1, 2014, the CHIP plans will have to obtain current household income. The plans can use the federal data hub and other state data sources to obtain current income for the majority of the remaining three-quarters of those enrolled. Children whose family income is less than 138% using the MAGI rules should be moved to Medicaid effective January 1, 2014.

For children applying for the first time as of October 1, 2013 who qualify for CHIP using the MAGI rules and the current eligibility threshold, it will important to assess eligibility for Medicaid using the eligibility threshold that will be in effect on January 1, 2014. These children should be enrolled in CHIP prior to January 1, 2014 with notice to their parents/guardians that they will transfer to Medicaid effective the first of the year.

2. The Insurance Department should instruct the CHIP plans to reach out to affected families using Department approved messaging and the Department of Public Welfare should utilize the Enrollment Broker for outreach as well.

The most efficient method to successfully transfer children from CHIP to Medicaid while maintaining their medical home and specialty services is to engage their parents/caregivers in actively making decisions, rather than relying on default systems for automatic plan and Primary Care Provider (PCP) assignment. Parents and caregivers will need clear information and reminders to act developed by Insurance Department staff in consultation with advocacy groups. The child's current CHIP plan should be responsible for sending this information to parents well ahead of the deadlines to act. Contact with the parents/caregivers should include an initial letter, a reminder letter, and at least three attempts to make an outbound call from the CHIP plan to the child's household with at least one call after 5 pm.

Notices to parents and caregivers should be clear, written in low-literacy format, with multiple language banners on how to obtain the information in other languages. Letters and reminders should include information on:

- The income used to assess the child's eligibility for Medicaid under the new rules and how to correct information or appeal that decision.
- How to choose a Medicaid Managed Care Organization (MCO) and a Primary Care Provider (PCP) including the web site and phone number for the Medicaid enrollment broker.
- How to compare plans to best maintain a child's current health care providers, including behavioral health services.

- Continuity of on-going medical treatment, including prescription formulary, durable medical equipment benefits, behavioral services and dental care.
- Deadlines for choosing a plan and what happens if the family does not actively choose an MCO and PCP.

For families who do not actively choose a Medicaid MCO prior to the scheduled transfer to Medicaid, the Medicaid enrollment broker should make outbound calls during the 30-day choice period to avoid an auto-assignment to a Medicaid MCO. There should be at least three attempts, with at least one call after 5 pm.

3. The Insurance Department should engage the child’s health care provider in outreach efforts.

Primary care providers have a strong interest in maintaining their affiliations with patients. They also have strong relationships with parents and caregivers. Many patients are likely to follow directions from a trusted health care provider. The Insurance Department should provide information regarding which of their patients will be moving to Medicaid to individual health care providers no later than October 1, 2013 and update that information on a monthly basis as it becomes available. PID should encourage PCPs to reach out to their patients to inform them that if they want to keep their current PCP and/or other health care providers, they need to actively choose a Medicaid MCO that includes their chosen providers in its network.

4. The Departments of Insurance and Public Welfare should work together to use existing information to maintain child’s medical home.

If, despite substantial outreach efforts, a child’s family fails to choose a Medicaid MCO and PCP, the Departments of Insurance and Public Welfare can work together to identify the child’s current PCP and use that information to assign the child to a MCO with that PCP in its network. In the case of a child who has not used much medical care or where the PCP does not accept Medicaid, the child may have a younger sibling enrolled in Medicaid and the child should be enrolled in that sibling’s MCO and PCP. This would make a better “match” than a standard auto-assignment.

5. The Department of Public Welfare should remove barriers to parents’ choices of health plans and PCPs.

The children moving from CHIP to Medicaid should receive special handling by the Medicaid enrollment broker. The enrollment broker should identify parents and caregivers making this transition either through the interview questions posed by the broker or, better yet, in the information the broker receives from DPW about each child.

MCOs that are closed to new enrollees should be required to enroll a child if that is the parent/caregiver's choice or if the auto-assignment rules mentioned above apply. Similarly, PCP practices closed to new patients generally would not and should not exclude existing patients. (The argument that physicians are reimbursed at a lower rate should not come into play given the Medicare payment parity requirements under the ACA.)³

6. The Department of Public Welfare should assure continuity of health care services.

Some children who transition from CHIP into Medicaid will be in the midst of ongoing medical or dental treatment. In order to assure continuity of care for these children, in accordance with Act 68 of 1998 under certain conditions, ongoing treatment must be covered by the Medicaid managed care plan.

Medicaid is required to pay for an ongoing course of treatment⁴ with a nonparticipating health care provider for a period of up to 60 days from the date a new enrollee is signed up with the managed care plan. If it is clinically appropriate to do so, this 60 day period may be extended after consultation between the managed care plan, the health care provider, and the enrollee.⁵ This coverage must be provided under the same terms and conditions that apply for health care providers who do participate in Medicaid, as long as the services are otherwise provided under the plan.⁶

For those children who are in ongoing orthodontic treatment at the time they are transferred from CHIP into Medicaid, Medicaid will pay for continuing orthodontic treatment under certain conditions.⁷ Children who began orthodontic treatment prior to becoming eligible for Medicaid will be covered for eight quarters of care minus the number of quarters of care received prior to the child's enrollment in Medicaid.⁸ For example, a child who had been receiving orthodontic treatment for three quarters before becoming eligible for Medicaid would be covered for an additional five quarters of orthodontic treatment under Medicaid, provided that the care meets the criteria laid out in the Medicaid regulations. These rules should be made known to parents at the time of the transfer and reminders should be sent to the plans.

Finally, it is important to note that in 2011 and 2012, for some enrollees CHIP prospectively paid providers for the entire course of orthodontia. On a case-by-case basis, MCO case managers or relevant staff should verify whether or not an enrollee's entire orthodontic regimen has already been paid for up front, in which case Medicaid

³ 42 CFR 447.400

⁴ 31 Pa. Code §154.2

⁵ 31 Pa Code §154.15(a), (c), (e)

⁶ 40 P.S. § 991.2117(d) and (f)

⁷ 55 Pa.Code § 1149.54 (9)

⁸ 55 Pa.Code § 1149.56 (5)

will not need to provide additional compensation to the provider. Parents should be advised of the responsibility of the orthodontic provider to continue to provide care.

7. The Departments of Insurance and Public Welfare should work together to address the gaps in provider networks.

With two separate programs and separate managed care organizations for each program, there is not 100% alignment of provider networks between Medicaid and CHIP. This is particularly true for behavioral health services, for dental care and for some pediatric specialty care. A child moving between Medicaid and CHIP may not be able to continue to see their current providers beyond the transition period covered by Act 68. (See above.)

There are multiple reasons for these gaps, many of which can and should be addressed: perceived lower reimbursement rates in Medicaid, provider contracting issues with plans, provider credentialing requirements by the managed care plans that take months and months to process, hospital or health system-determined non-participation in certain plans, differing covered benefits and perceived differences in the enrolled population.

Solutions could include:

- Informing primary care providers about the increase in Medicaid primary care reimbursement to Medicare levels and recruiting their participation in Medicaid provider networks.
- “Grandfathering” willing CHIP-only or Medicaid-only providers into the other program’s managed care provider networks.
- Further aligning health benefits between Medicaid and CHIP so the benefit packages are similar, particularly behavioral health benefits, such as family-based mental health services in CHIP.
- Concerted outreach by plans and encouragement of insurance providers to make CHIP and MA panels identical.

8. The Departments should create a realistic timeline for these activities and hold the CHIP plans and the enrollment broker accountable for meeting the benchmarks.

With the deadline of January 1, 2014, these outreach activities should begin no later than August 15, 2013.

Based on the recommendations for identifying those children who will transition from CHIP to Medicaid, once identification is completed:

The CHIP plans' role:

- Within 5 days of identification, the CHIP plans should send a written notice to the family.
- Within 30 days of identification, the CHIP plans should complete their outreach efforts, including outbound calls.
- Within 30 days of identification, the CHIP plans should share the information with the child's current Primary Care Provider.

Following the initial 30 day period, those families who have not yet made a choice of Medicaid plans should be transferred to the Enrollment Broker.

The Enrollment Broker's role:

- Within 5 days of the transfer, the Enrollment Broker should send out a written notice to families.
- Within 30 days, the Enrollment Broker should complete their outreach efforts, including the outbound calls.

Following that second 30 day outreach period, the Enrollment Broker should initiate a second round of outreach efforts. These should not be a repetition of the first outreach messaging and tactics but a revision of those strategies that may include coordinating with the child's primary care provider, or previous CHIP plan.

- Within an additional 30 days, the Enrollment Broker should complete their second outreach efforts.

Auto-assignment:

If, at the end of the 90-day outreach period, the family has not chosen a Medicaid plan and Primary Care Provider, the Enrollment Broker and DPW will be faced with making an auto-assignment. Any auto-assignment should be completed within a 30 day period, following the recommendations above.

Monitoring the outreach efforts

To measure the impact of the outreach efforts, it will be important to set benchmarks and ask the vendors to report on their efforts.

The CHIP plans should report to the Departments of Insurance and Public Welfare on the number of:

- Enrollees identified as having income between 100 and 138% of income guidelines

- Letters sent to those households (the number of enrollees and the number of households will differ due to multiple children in the same household)
- Responses to the letters where the family made a choice of Medicaid plans and PCP
- Outbound calls made to households (including number of attempts, number of messages left, number of completed calls, and time of day for each)
- Responses to outbound calls where the family made a choice of Medicaid plans and PCP
- Households transferred to the broker

The Enrollment Broker should report to the Departments of Insurance and Public Welfare on the number of:

- Households transferred from each CHIP plan
- Letters sent to those households (the number of enrollees and the number of households will differ due to multiple children in the same household)
- Responses to the letters where the family made a choice of Medicaid plans and PCP
- Outbound calls made to households (including number of attempts, number of messages left, number of completed calls, and time of day for each)
- Responses to outbound calls where the family made a choice of Medicaid plans and PCP
- Households that have not made a choice of Medicaid plans and PCPs at the end of round one of the outreach effort
- Letters sent to those households in round two (the number of enrollees and the number of households will differ due to multiple children in the same household)
- Responses to the letters where the family made a choice of Medicaid plans and PCP
- Outbound calls made to households in round two (including number of attempts, number of messages left, number of completed calls, and time of day for each)
- Responses to outbound calls where the family made a choice of Medicaid plans and PCP
- Households where there has been no choice made

Pennsylvania has a unique opportunity and a serious obligation.

Smoothly transferring children from one health care coverage program to another is important. We strongly believe that these recommendations, if implemented, can provide needed information to families, encourage their engagement and participation in choosing a managed care plan and health care providers, minimize disruptions in health care services, and assure children maintain a medical home.

We are certain that the Departments of Insurance and Public Welfare are equally committed to these goals. Thank you for your consideration of these suggestions. We would like to meet with you and your staff to discuss the detailed recommendations and to further describe our suggestions. We will contact your staff to schedule a meeting.

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