



Medicaid Eligibility: Enrollment Pathway Considerations for Vulnerable Populations

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Part of a series of briefs developed by the Technical Assistance Collaborative, Inc. (TAC) to assist policy makers, providers, and advocates to understand and capitalize upon opportunities in the Affordable Care Act (ACA) to help improve the lives of people with disabilities.

On March 23, 2012, the Centers for Medicare and Medicaid Services (CMS) issued final regulations codifying changes made by the Affordable Care Act (ACA) to Medicaid and Children's Health Insurance Program (CHIP) eligibility, enrollment, and renewal processes. These changes are due to take effect in January 2014. The [final regulations](#) also outline how Medicaid and CHIP must coordinate with Affordable Insurance Exchanges. Specific highlights of the final regulations include:

- **Applies a new national methodology for calculation of income for most Medicaid and CHIP enrollees,¹ using the Modified Adjusted Gross Income (MAGI) standard.** The simplified rules for calculating income also eliminate the use of an asset test for making eligibility determinations under the MAGI standard.
- Extends Medicaid to people aged 19-64 with incomes up to 133%² of the federal poverty level (FPL)³ through the creation of a new adult eligibility category.⁴ **This expansion of Medicaid eligibility criteria includes childless adults without disabilities who have been excluded from participation in Medicaid in many states.**
- Adopts new standards for applying and renewing eligibility to make it easier and more straightforward for people to apply for Medicaid including:
 - **Requires use of a single, streamlined application that can be used to apply for all insurance affordability programs** (e.g., Medicaid, CHIP, a state's Basic Health Plan, etc.). In-person interviews cannot be required for applicants applying (or renewing) under the MAGI standard. For people applying based on disability or others for whom the MAGI criteria do not apply, states can develop a modified application form but it must, "minimize burden" on applicants.
 - Individuals must be able to **apply via the Web, by phone, mail, or in-person.**
 - Reduces paperwork burden by creating a system where states can verify information used to make eligibility determinations using electronic data available from Social Security, the Department of Treasury (IRS), and Homeland Security. This will help minimize documentation requirements and allow for more timely eligibility reviews.
 - **Limits renewals for people enrolled using MAGI income standards to once every 12 months**, unless the agency has information that would affect the individual's eligibility (e.g., change in income). This is positive because the more frequent the renewal cycle the greater the likelihood that someone will lose eligibility. Currently states can conduct eligibility renewals more frequently than once per year.
 - **Allows people to apply for and be determined eligible for (or preliminarily eligible for) Medicaid or CHIP through a state's Affordable Insurance Exchange.** An Exchange is a virtual marketplace where individuals can go to enroll in public or private health insurance. Under the ACA every state must operate an Exchange or defer to

¹ MAGI based income calculations do not apply to certain eligibility groups such as those receiving SSI, people over age 65, or people requesting coverage for long-term care services.

² The MAGI calculation includes a 5% income disregard which effectively raises the income eligibility threshold to 138% of FPL or \$15,414 for an individual in 2012.

³ The recent U.S. Supreme Court decision now makes coverage of this population optional for the states.

⁴ Federal and state residency, immigration and documentation of U.S. citizenship requirements still apply.

the Federal government to operate their state's Exchange.

As a result of the changes to Medicaid eligibility rules, an estimated 16-22 million new individuals across the country will become eligible for Medicaid.⁵ It is also thought that many people, who were eligible for Medicaid based on existing eligibility criteria but never enrolled, will apply for Medicaid. However, not all Medicaid enrollees will have access to the same benefit package. This paper will briefly review enrollment pathway considerations for people with disabilities and identify ways that advocates and others interested in Medicaid benefit design and enrollment issues can help ensure that people with disabilities have the information they need to make an informed decision about the enrollment pathway that will lead to the benefit plan best suited to their needs.

Benchmark plans and enrollment pathway considerations

The ACA requires states to offer benchmark or benchmark equivalent⁶ benefits to the newly eligible "expansion population". Medicaid benchmark coverage includes any one of the following as outlined in 42 CFR 440:

- The standard Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefit Plan
- The HMO plan with the largest commercial, non-Medicaid enrollment in the state
- Any generally available state employee plan (regardless of whether any state employees select the plan)
- Any plan that the Secretary of HHS determines to be appropriate⁷

⁵ Holahan, J., Headen, I. (2010, May). Medicaid coverage and spending in health reform: National and state by state results for adults at or below 133% FPL (Kaiser Commission on Medicaid and the Uninsured Report No. 8076). Washington, DC: Henry J. Kaiser Family Foundation.

⁶ Benchmark equivalent benefits must have an actuarial value that is at least equivalent to coverage under one of the benchmark coverage outlined above.

⁷ This coverage could be the state's standard Medicaid plan as long as it covers services within the 10 required categories.

The ACA requires that these benchmark plans include at least the ten categories of "essential" benefits which are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- **Mental health and substance use disorder services, including behavioral health treatment⁸**
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Of course the above categories do not detail the services included within that category (e.g. the scope or continuum of services within a category). Recently, the United States Department of Health and Human Services (HHS) determined that the services included in the state's selected benchmark plan would become the essential health benefit (EHB) package. For example, if a state selects the HMO plan as their "benchmark" then the services covered by that plan within the 10-required categories become the EHB package.

If the state's selected benchmark plan does not include benefits under one of the 10-required categories, then the plan must be supplemented to ensure coverage. Thus, depending on the plan selected by the state, the benefits that a single non-disabled adult with an income at or below 138% of FPL would be eligible for will more closely resemble benefits and services covered in the commercial insurance market than those benefits available under a state's "standard" Medicaid plan.

While states can require members of the newly eligible expansion population to enroll in a benchmark plan, certain categories of individuals cannot be required to enroll in a benchmark plan and must be able to enroll in

⁸ Mental health and substance use services must be provided at "parity" in compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA). This means that coverage limitations that apply to MH and SUD services cannot be any more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.

the state's traditional or standard Medicaid plan. People who are exempted from mandatory enrollment in a benchmark plan include:⁹

- Pregnant women
- Blind and disabled people regardless if the person is eligible for Supplemental Security Income (SSI)
- People who are eligible for Medicare
- Terminally ill individuals
- People residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), or other medical institutions
- Medically frail or people with special needs which includes:
 - youth in foster care or receiving adoption assistance
 - people dually eligible for Medicare and Medicaid
 - youth with serious emotional disturbance (SED)
 - people with disabling mental disorders
 - individuals with serious and complex medical conditions
 - individuals with physical and/or mental disabilities that significantly prevent them from performing one or more activities of daily living

States that elect to offer a benchmark benefit can choose to allow the exempt populations the option to enroll in a benchmark plan. If they offer them the option to enroll in the benchmark, states must provide information to enrollees which compare the benchmark to the standard benefit plan. States must also offer exempt populations the option to revert back to traditional Medicaid at any time.

Benefits for vulnerable populations

For enrollees with mental health issues or substance use disorders, an important question is what enrollment pathway will lead to the most “robust” benefit to meet their needs, the benchmark plan or a state's standard Medicaid plan? The answer ultimately will depend on how a state's standard Medicaid plan compares with that of the benchmark plan. While states vary considerably as to the range of benefits and services available

through their standard Medicaid plan, the inclusion of services intended to help people with serious mental illness such as Assertive Community Treatment (ACT), Supported Employment, or peer support, that may be available under a state's standard Medicaid benefit, are not likely to be included in a state's benchmark plan; thus pursuing enrollment through the non-MAGI eligibility pathway is likely (but not always) the route to the “best benefit.” In states with a limited standard benefit that includes few services for people with mental health or substance use needs, enrollment in a benchmark plan might offer more comprehensive coverage. Understanding how benefits are delivered (under managed care or fee-for-service) in the state is also important. This is because the MHPAEA (e.g., the parity law) **does not** apply to fee-for-service Medicaid but **does** apply to services offered as part of a benchmark plan and to Medicaid managed care plans. Ultimately a state-specific analysis and comparison of the benchmark plan with the standard plan will be required in order to make the most informed decision.

Among advocates for vulnerable populations such as people with mental health or substance use disorders, there has been legitimate concern that a state's benchmark benefit plan may not offer the types of services and supports that these groups may need. There is also worry that the enhanced federal match states will receive for the “expansion population”, will provide a major incentive for states to enroll people in the adult MAGI-based group regardless if they might also be eligible under an existing eligibility group.

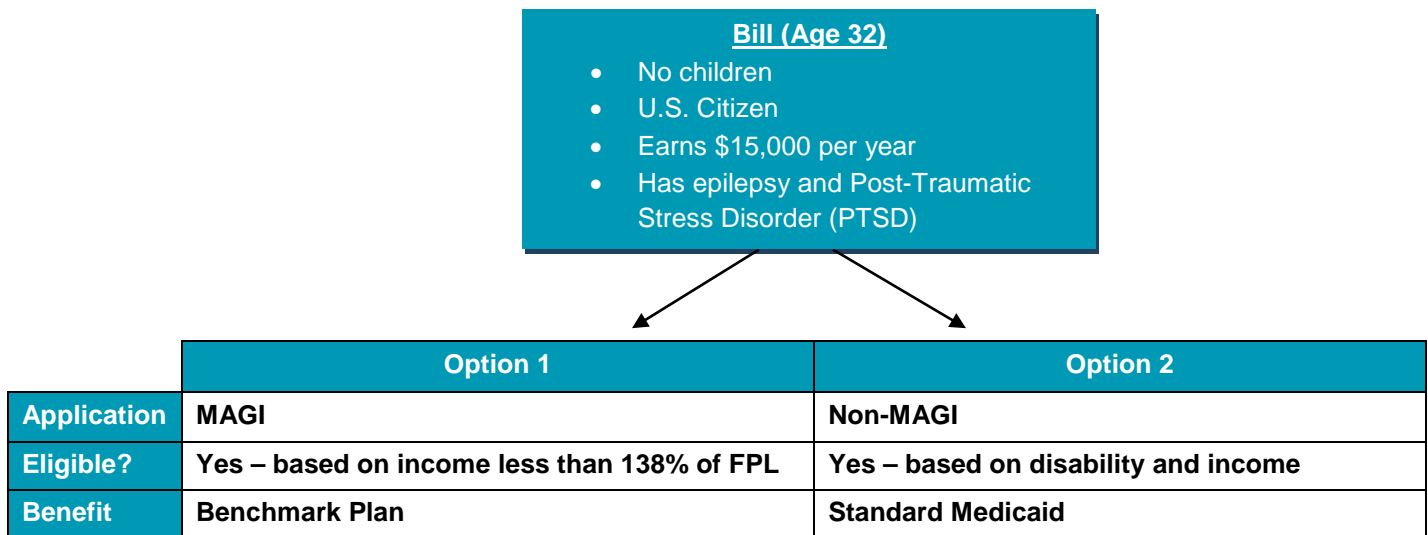
In order to assist states with paying for the expansion of their Medicaid program, the federal government will pay 100% of the medical costs associated with the expansion for the first three years, with the percentage gradually decreasing through 2020 to 90%. This enhanced federal match however only applies to those people who enroll under the expansion, not to people who enroll under one of the existing Medicaid categories. For example, a childless adult with a disability making \$15,000 per year from a part-time job living in a state that has a Medicaid Buy-In Program for Working People with Disabilities, could qualify for Medicaid under the new MAGI-based eligibility standard

⁹ A complete listing of populations who are exempt from inclusion in a benchmark plan can be found at 42 CFR Part 440.

AND the state’s Medicaid Buy-In program (see Figure 1). If that individual enrolls under the MAGI pathway, he/she could receive the state’s benchmark benefit plan with the state receiving the enhanced Federal match for medical services provided to that individual. If that same individual applies through the non-MAGI pathway and is found eligible based on disability, he/she cannot be required to enroll in a benchmark plan, and the state would receive reimbursement under their usual Federal

matching rate for services delivered to that individual. Advocates and others worry that because of this incentive states will not be as judicious as they should be in ensuring that people with disabilities who would otherwise qualify under an existing eligibility category (and therefore are not eligible for the enhanced federal match) are informed about and enrolled in the enrollment pathway that will allow them access to the benefit package that will best meet their needs.

Figure 1: Enrollment Pathways



Due to the numerous comments CMS received about the potential for people with disabilities not being able to access the benefits they might need if enrolled through the MAGI eligibility pathway, changes were made to the final regulations. The final regulations make clear that if an individual indicates on their application that they are disabled (or otherwise requests a non-MAGI based eligibility determination or if the state has information from some other source that the individual is disabled), the state must determine eligibility based on the applicable non-MAGI criteria. States must also provide information to potential enrollees about the different eligibility options and benefit packages to help people make an informed choice about the eligibility pathway that will best meet their needs. In addition, because the time to make an eligibility determination based on disability may take longer, if the person is deemed eligible based on MAGI financial criteria, he/she will be

able to receive benchmark coverage while awaiting final determination based on disability or need for long-term care services. The regulations also clarify that people who enroll via the MAGI pathway but whose circumstances change (e.g., they need long-term care services) can move to coverage under another eligibility group if deemed eligible as part of that group. It is also important to keep in mind that while anyone who wants to apply for Medicaid via the non-MAGI pathway can, not everyone will necessarily be found eligible for Medicaid under an eligibility group that will allow them access to standard Medicaid benefits. For example, as many states use SSI criteria to determine if someone is disabled for the purposes of Medicaid eligibility, a childless adult with a sole substance use disorder would not qualify as disabled and therefore would only be able to access benchmark benefits.

Conclusion

States are developing their enrollment processes, outreach activities, and planning for benefit design now; participating in your state's stakeholder process will be the best way to ensure that the needs of vulnerable groups are considered in the planning and implementation process. The following are some key areas to consider and influence as state's move forward with implementing key ACA provisions:

- **What are your state's plans for outreach and enrollment of vulnerable populations?** Section 2201 of the ACA requires states to establish procedures for reaching out to and enrolling vulnerable and underserved populations including youth, unaccompanied homeless youth, racial and ethnic minorities, and individuals with mental health or substance-related disorders. Many of these vulnerable populations will be exempt from enrollment in a benchmark plan and are likely to qualify for Medicaid under one of the existing eligibility groups. **How will your state ensure that vulnerable populations who are exempt from enrollment in a benchmark plan are made aware of the enrollment pathway that will allow them to access the benefit that will best meet their needs?**
- **What benefit package will your state offer the newly eligible expansion population?** States are currently selecting the benchmark plan they will offer to the newly eligible Medicaid expansion population as well as the benchmark plan they will offer people who will receive insurance through a state's Affordable Insurance Exchange. An Exchange is a

virtual marketplace where individuals can go to enroll in public or private health insurance. It is possible that a state could select a benchmark plan for the Medicaid program that differs from the one offered through the Exchange program. Given the expected high rate of transition of adults between Medicaid and the Exchange, aligning coverage between the two programs will provide better continuity of care for people who may move back and forth between insurance coverage types.¹⁰

- States must provide information to potential enrollees about the different eligibility options and benefit packages to help people make an informed choice about the eligibility pathway that will best meet their needs. The strategies used to educate and inform vulnerable populations about the different enrollment pathways and benefit packages will be critically important to arming people with the information needed to make an informed decision about which enrollment pathway to pursue. **Learn about how your state will include people with disabilities in the development and review of educational materials to help ensure they are clear and provide the appropriate information to assist people in making an informed decision.**
- Advocates, service providers, and other stakeholders who work with people with disabilities can play an important part in educating potential enrollees about the benefits of enrolling in Medicaid and the various pathways and procedures for doing so. **Educating staff persons who are in frequent contact with enrollees about how to navigate the Medicaid enrollment system** should be an important staff training activity.

This brief was prepared by Kelly English of the Technical Assistance Collaborative. Editorial assistance was provided by Steve Day, Suzanne Fields, Marie Herb, and Jenny Chan. For additional information and related resources, visit www.tacinc.org.

¹⁰ Sommers, B.D. & Rosenbaum, S. (2011). Issues in health care reform: How changes in eligibility may move millions back and forth between Medicaid and the insurance exchanges. *Health Affairs*, 30, 228-236.