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MEDICAID 1115 DEMONSTRATIONS

Wraparound Benefits in Premium Assistance Demonstrations

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Executive Summary

Arkansas, Iowa, and New Hampshire expanded Medicaid coverage to adults with incomes up to 138 percent of the federal poverty level using section 1115 authority to support beneficiaries' purchase of coverage from qualified health plans.[1] These premium assistance demonstrations must ensure that beneficiaries have access to certain Medicaid benefits not typically covered by qualified health plans, such as the Early and Periodic Screening, Diagnostic, and Treatment services for 19- and 20-year-olds and family planning services from any willing provider. In this brief, we review the requirements for these "wraparound" benefits, assess the status of their implementation, and discuss their implications for Medicaid beneficiaries' access to care.

All three states implemented wraparound benefits using procedures that are like the ones they use to administer wraparound benefits in their other premium assistance programs, notably their Health Insurance Premium Payment programs. All three states chose to give beneficiaries a Medicaid card to present to providers, who then bill the state for the wraparound benefits. States' demonstration monitoring reports to the Centers for Medicare & Medicaid Services do not provide sufficiently detailed data to assess wraparound benefit utilization and associated administrative costs, although the upcoming national evaluation of section 1115 demonstrations will include an analysis of wraparound benefit claims.

Introduction

Three states—Arkansas, Iowa, and New Hampshire—chose to implement Medicaid expansions using a premium assistance model authorized by section 1115 of the Social Security Act. These states support beneficiaries' purchase of coverage through qualified health plans (QHPs) based on those available in the Federally Facilitated Marketplace. States with premium assistance demonstrations must cover the insurance premium payments and other cost-sharing for adults with household incomes up to 138 percent of the federal poverty level.[1] These states can make enrollment in QHPs mandatory as long as beneficiaries are not medically frail and have a choice of QHPs from two or more issuers. Arkansas and Iowa implemented premium assistance demonstrations in January 2014, and New Hampshire implemented its demonstration in January 2016.[2] Arkansas and New Hampshire continue to operate their demonstrations, whereas Iowa suspended its program in December 2015.[3] In this issue brief, we discuss the experiences of all three states, focusing on the first year after implementation.

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some of these new approaches being tested under 1115 authority draw on established practices in commercial health insurance, such as cost-sharing at levels that exceed Medicaid limits and financial incentives for pursuing healthy behaviors. Other new approaches involve partnerships with private-sector entities, such as issuers that offer qualified health plans. However, Medicaid beneficiaries have lower incomes and poorer health status than most privately insured individuals and Medicaid expansion demonstrations have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

Benefits in states with premium assistance demonstrations. Because QHPs must include the 10 essential health benefits defined in federal regulation, beneficiaries in the new premium assistance demonstrations have access to a standard set of benefits on the Marketplace.[4] In addition, Medicaid-eligible beneficiaries may enroll only in specially designated, high-value "silver" plans that have lower cost-sharing than comparable silver plans available to individuals who are not eligible for Medicaid.[5] However, even high-value silver plans do not include all the benefits that federal law mandates for Medicaid beneficiaries.

Like all states that have expanded Medicaid to newly eligible adults, states with section 1115 authority for premium assistance demonstrations must develop an "Alternative Benefit Plan" for demonstration beneficiaries, and must specify these benefits in the state plan for medical assistance. Alternative Benefit Plans must cover the 10 essential health benefits as well as mandatory Medicaid benefits. For example, states must include family planning services and supplies from all willing providers and non-emergency medical transportation (NEMT), and must ensure access to federally qualified health centers (FQHCs) and rural health clinics. States may also extend optional benefits that are provided to traditional Medicaid beneficiaries, such as adult dental and vision benefits, to the new group of eligible adults. The Special Terms and Conditions for section 1115 demonstrations require states to provide or pay for benefits in their Alternative Benefit Plans that are not covered by QHPs, unless they are specifically waived by the Centers for Medicare & Medicaid Services (CMS).

Wraparound benefits in each state. Arkansas and New Hampshire offer Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for 19- and 20-year-olds, as did Iowa when its premium assistance demonstration was operational. This benefit must be made available to all children under age 21, although 19- and 20-year-olds are considered adults under the premium assistance programs. EPSDT includes coverage for dental and vision screening and treatment, as well as other preventive, mental health, developmental, and specialty services.

All three states also cover family planning services from all willing providers as a wraparound benefit. QHPs pay for covered family planning services when they are delivered by in-network providers; therefore, states only pay for family planning services as a wraparound benefit when they are delivered by an out-of-network provider. Officials in Arkansas anticipate, for example, that the state health department, which is the traditional provider of family planning services and is in-network for all Marketplace issuers, will continue to provide most family planning services. This means that Arkansas is unlikely to pay for most family planning services on a wraparound basis because these services will already be covered by QHPs.

Table 1. Wraparound benefits by state

Wraparound benefit	Arkansas	Iowa[a]	New Hampshire
EPSDT services for those under age 21	✔	✔	✔
Family planning services	✔	✔	✔
Non-emergency medical transportation	✔[b]		✔
Adult dental		✔[c]	✔[d]
Adult vision			✔

Source: Mathematica review of Special Terms and Conditions for each section 1115 demonstration.
Note: "EPSDT" is Early and Periodic Screening, Diagnostic, and Treatment. EPSDT includes coverage for dental and vision screening and treatment, as well as other preventive, mental health, developmental, and specialty services.
[a] Iowa's premium assistance program closed at the end of 2015 and beneficiaries were moved to the state's other section 1115 demonstration, the Iowa Wellness Plan.
[b] With prior authorization only.
[c] Dental Wellness Plan benefits include emergency, basic, and preventive dental care. Beneficiaries can earn enhanced dental benefits, such as restoration, by completing a first dental exam and timely follow-up exam.
[d] Dental benefits for beneficiaries age 21 and older are limited to treatment of acute pain or infection.

Differences among these states in the offer of NEMT, dental, and vision services result from state-specific demonstration authority and existing Medicaid policy. First, NEMT is a wraparound benefit in New Hampshire and Arkansas. Arkansas has a prior authorization requirement; after eight trip legs (transportation between two stops), beneficiaries must call the state's utilization review vendor to be authorized for another block of trips to obtain health care services. NEMT was waived entirely in Iowa's premium assistance program.

New Hampshire includes adult dental benefits as a wraparound benefit, as did Iowa, and New Hampshire includes adult vision benefits as well. These dental and vision benefits are separate from those provided to beneficiaries under age 21 as part of EPSDT benefits. Dental benefits in Iowa were part of a new Dental Wellness Plan created as part of both the premium assistance demonstration and Iowa's ongoing section 1115 demonstration, the Iowa Wellness Plan. Dental Wellness Plan beneficiaries receive a set of core dental benefits under

this plan. Those who complete an initial dental exam and a follow-up visit within 6 to 12 months can receive enhanced benefits such as restorations and root canals. If beneficiaries complete a second follow-up dental visit, they can receive additional benefits such as crowns and tooth replacements. In New Hampshire, dental and vision benefits are more limited, but match what is available to adult beneficiaries covered through the state's traditional Medicaid program.

Comparisons with other premium assistance programs. Since 1990, states have had the option to provide premium assistance to certain Medicaid beneficiaries, and could do so by filing a state plan amendment rather than obtaining section 1115 demonstration authority. Section 1906 of the Social Security Act authorizes the Health Insurance Premium Payment (HIPP) program, through which states pay Medicaid-eligible employees' share of the premiums for employer-sponsored insurance when it is available and cost-effective.[6] In addition, section 2015(c)(3) of the Social Security Act enables states to purchase private group or non-group coverage for CHIP-eligible children and their families. In terms of benefit requirements, HIPP is most comparable to the new premium assistance demonstrations in that states must provide mandatory Medicaid benefits as wraparound coverage when they are not covered through employer-sponsored insurance (GAO 2010).[7]

Arkansas and New Hampshire operate preexisting HIPP programs alongside their section 1115 demonstrations, as did Iowa. As of 2010, there were approximately 3,000 Medicaid- or CHIP-eligible individuals enrolled in HIPP in Iowa, where the program was mandatory for Medicaid-eligible beneficiaries with access to employer-sponsored insurance, and 127 in New Hampshire, where the program was optional for Medicaid beneficiaries (GAO 2010). Data are not available for Arkansas.

Under the premium assistance demonstration in Iowa, HIPP took precedence over Marketplace premium assistance: adults eligible for premium assistance could only enroll in Marketplace coverage if they did not have access to cost-effective employer-sponsored insurance. New Hampshire planned a similar exclusion from Marketplace premium assistance for people with offers of cost-effective employer-sponsored insurance, but did not implement it. The state determined that the process of assessing cost-effectiveness and subsequently imposing the exclusion was not worthwhile because very few adults eligible for premium assistance had offers of cost-effective employer-sponsored insurance. Most HIPP participants in New Hampshire are children. In general, New Hampshire administers wraparound benefits the same way for people enrolled in QHPs and HIPP, as did Iowa when its premium assistance program was operational.

How has the implementation of wrap-around benefits worked in practice?

State payments for wraparound benefits. States pay providers for all wraparound benefits in Table 1 as fee-for-service Medicaid benefits. Dental benefits in Iowa were an exception, as they were provided to premium assistance beneficiaries under a stand-alone dental managed care plan with a separate network. Iowa continues to offer the Dental Wellness Plan to beneficiaries in its ongoing section 1115 demonstration. The Dental Wellness Plan issues a membership card that beneficiaries use to access dental services, and the state pays the plan a monthly capitation rate for each beneficiary. Iowa also considered payments to FQHCs to be a wraparound benefit, although technically these are supplemental payments. Federal regulations do not require QHPs (or Medicaid managed care organizations) to pay FQHCs the full amount required by the FQHC prospective payment system,[8,9] so state Medicaid programs must pay FQHCs the difference between the reimbursement received from health plans and the prospective payment rate. Neither Arkansas nor New Hampshire reports supplemental payments to FQHCs as a wraparound benefit. New Hampshire officials noted that state statute requires QHPs to pay FQHCs 133 percent of Medicaid rates.

Process for beneficiary access. Arkansas and New Hampshire provide beneficiaries in premium assistance demonstrations with a Medicaid card that providers can use to bill Medicaid for wraparound benefits, as did Iowa. This means that beneficiaries receive up-front coverage for wraparound benefits, rather than paying for services and being reimbursed later by the state. State officials emphasize the seamless nature of this up-front coverage for beneficiaries. However, beneficiaries must also carry two insurance cards with them. If it is not clear to beneficiaries which card to use, or if providers do not ask to check both cards, this system has the potential to be confusing for beneficiaries and possibly reduce their access to care.

State notification of wraparound benefits. The Special Terms and Conditions for premium assistance demonstrations require states to provide beneficiaries with a notice detailing wraparound benefits, along with phone numbers or web sites that provide information on how to access them. In Arkansas, for example, these notices describe the availability of EPSDT benefits and provide a toll-free number to call to arrange for non-emergency medical transportation. Likewise, the New Hampshire Department of Health and Human Services provides multiple notices aimed at both beneficiaries and providers that explain which benefits are available through QHPs and which are available through Medicaid.

How did states determine the design of the wraparound benefits, and what implementation challenges have there been?

When designing the delivery of the wraparound benefits, state officials sought to minimize administrative complexity. New Hampshire and Iowa designed wraparound benefits procedures to match those used for other programs. Using existing procedures to administer wraparound benefits simplifies demonstration implementation, although any existing implementation difficulties would also be replicated for the premium assistance population. In New Hampshire, the Medicaid agency administers wraparound benefits in the demonstration in the same way it administers them in its HIPP program. State officials were cautious about designing a potentially complex new approach when the demonstration started, because the legislature initially authorized the premium assistance program for a single year. New Hampshire officials also felt that implementing wraparound benefits on a fee-for-service basis would minimize administrative burden on QHPs, relative to alternative approaches such as paying QHPs to provide, coordinate, and bill the state for services that are not included in standard QHP benefit packages. Similarly, in Iowa, the wraparound benefits process for the demonstration was similar to both the process for children and families enrolled in Medicaid managed care plans as well as for adults enrolled in the HIPP program. Arkansas officials, in contrast, did not emulate HIPP in the state's process for administering wraparound benefits, but officials commented that keeping costs low is a priority. Therefore the state did not create a separate payment system for these benefits or push for them to be administered directly through QHP issuers.

Few implementation challenges. As noted, all three states designed administration methods that either replicate those used in existing programs or that they believe are more straightforward than potential alternatives. Arkansas and Iowa did not report difficulties with wraparound benefit administration or implementation. New Hampshire reported that administering NEMT was a challenge in the first year of its premium assistance program but the state is working with the vendor to manage NEMT utilization and costs.

What are the implications of wraparound benefits for evaluations of premium assistance programs?

The existence of wraparound benefits has the potential to create barriers to care and to care coordination that may result in under-utilization of benefits. For example, in a preliminary analysis of dental service utilization, New Hampshire found that there was lower utilization of dental services provided on a wraparound basis in the year after premium assistance was implemented compared to the year before, although the exact cause of this pattern is not clear (New Hampshire is unique among the premium assistance states in that it expanded Medicaid prior to implementing its demonstration).[10] More data are needed to assess whether this is a long-term trend, and how utilization of wraparound benefits compares to utilization in other premium assistance states and in states that have implemented traditional Medicaid expansions. The upcoming national evaluation of section 1115 demonstrations will include such comparisons (Irvin et al. 2015). These analyses may illuminate whether beneficiaries have more difficulty obtaining services when benefits are accessed and paid for through different systems than when benefits are provided through a single provider network. Such difficulties might result from integration or coordination issues related to separate payment systems.

In states that run other premium assistance programs, such as HIPP, it might be useful to compare wraparound benefit costs among adults enrolled in QHPs and employer-sponsored insurance. To the extent that claims data from employer-sponsored plans are available, evaluators may also be able to assess differences in the types of wraparound benefits accessed by beneficiaries. HIPP enrollment has historically been very low, primarily because so few parents in families with incomes at or below 100 percent of poverty are offered insurance by their employers. Even when employers offer insurance, it often has relatively high employee cost-sharing requirements, making it less affordable for low-income families (Goodwin and Tobler 2009). But increased income thresholds in Medicaid expansion states mean that more Medicaid-eligible adults may have access to cost-effective employer-sponsored insurance (Bachrach and Osius 2014). As enrollment in both HIPP and section 1115 premium assistance demonstrations grows, comparing the costs and use of wraparound benefits among beneficiaries enrolled in these programs may yield information about how Medicaid agencies can ensure access to needed care as they support enrollment in commercial coverage.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

METHODS AND DATA SOURCES

Information for this issue brief is based on Mathematica's analysis of section 1115 demonstration documents for Arkansas, Iowa, and New Hampshire, as listed below.

- Arkansas Special Terms and Conditions, Approval Period: September 27, 2013 – December 31, 2016; as amended January 1, 2015.
- Iowa Marketplace Choice Plan Special Terms and Conditions, Approval Period: January 1, 2014 – December 31, 2016; as amended December 31, 2014.
- New Hampshire Special Terms and Conditions, Approval Period: March 4, 2015 – December 31, 2018.

We also conducted key informant interviews with Medicaid officials in all three states in May, June, and July 2015, and we spoke with New Hampshire Medicaid again in June 2017 to discuss implementation experiences . We designed interview protocols to clarify information in the Special Terms and Conditions and monitoring reports for each demonstration and to assess the implementation of demonstration policies. Each interview included a lead interviewer and a note taker.

References

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Government Accountability Office. "Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs." 2010. Available at http://www.gao.gov/assets/100/96518.pdf. Accessed June 27, 2015.

Irvin, Carol V., Debra Lipson, Carey Appold, Maggie Colby, Katharine Bradley, Jessica Heeringa, Jenna Libersky, Vivian Byrd, and Julia Baller. Medicaid 1115 Demonstration Evaluation Design Plan. Final report to the Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, May 2015.

Endnotes

[1] The Affordable Care Act established a 5 percent income disregard that increases the effective income limit from 133 to 138 percent of the federal poverty level.

[2] Michigan received approval in December 2015 to amend its demonstration to include a premium assistance program. The premium assistance phase of the demonstration is scheduled to begin in April 2018.

[3] Iowa's premium assistance demonstration was effectively closed on December 31, 2015, although the state retained its authority to operate the program through December 2016. One of Iowa's two participating QHP carriers became insolvent in late 2014 and the other stopped accepting new Medicaid beneficiaries in 2015. The state received approval in January 2016 to modify eligibility for the other component of its 1115 demonstration, the Iowa Wellness Plan, to include the population formerly enrolled in premium assistance.

[4] The Essential Health Benefits categories, set forth in 42 U.S. Code § 18022, include ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The law does not specify which benefits QHPs must provide in each category, although it requires that the scope of benefits must be equal to that of a typical employer plan. For more information on Essential Health Benefits standards, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html.

[5] Throughout this document, we use the terms "qualified health plan" and "QHP" to denote the plans in which Medicaid premium assistance beneficiaries enroll. These premium assistance QHPs are technically off-Marketplace products that are exact duplicates of Marketplace QHPs, except for their higher actuarial value (94 or 100 percent). Medicaid beneficiaries cannot buy regular QHPs in the Marketplace, and consumers who are not Medicaid beneficiaries may not apply tax credits to obtain the QHP look-alikes available through the Medicaid premium assistance programs.

[6] Section 1906 was enacted in the Omnibus Budget Reconciliation Act of 1990 and amended by the Balanced Budget Act of 1997.

[7] As a 2010 report by the Government Accountability Office (GAO) notes, states that implemented CHIP as a Medicaid expansion program can operate premium assistance programs that are funded by CHIP but come under Medicaid authority, which means they must follow Medicaid rules, including rules for mandatory benefits.

[8] The prospective payment system gives FQHCs a fixed per-visit fee for Medicaid patients, regardless of the length or intensity of the visit. For more information on the prospective payment system, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html.

[9] Medicaid managed care organizations are legally obligated to pay FQHCs/RHCs at least as much as they would pay different providers for the same services (42 U.S.C. § 1396a(bb)(5)(A)), but this amount may not fulfill Medicaid agencies' obligations to pay the prospective payment rate.

[10] Email communication with New Hampshire Medicaid officials, July 19, 2017.