CONTINUITY OF CARE ISSUES BETWEEN THE MARYLAND HEALTH BENEFIT EXCHANGE AND MARYLAND MEDICAID

Recommendations for further study by the Continuity of Care Committee

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

September 13, 2012

Table of Contents

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) ushered in a new age of health care reform in the United States that will open up health insurance coverage for millions of people. The law provides for tax credits and cost sharing subsidies to assist low-income individuals and families between 100 and 400 percent of the Federal Poverty Level (FPL) in purchasing insurance through the Health Benefit Exchange. It codifies strong rules to prevent insurance companies from denying coverage to individuals with preexisting conditions, ensuring access to affordable and comprehensive coverage. The ACA also expands Medicaid by raising the income limit for parents up to 138 percent of the FPL and – for the first time without a special waiver – allowing states to cover childless adults at the same income limits as parents.

The ACA determines eligibility for Medicaid and the Exchange principally on income. By definition, therefore, eligibility for these programs is sensitive to income fluctuations and changes in family composition. The result will be that a large number of individuals will move between Medicaid and the Exchange. This churning can impact the care that individuals receive, particularly individuals that are frequent users of health care services. Providers may participate in plans offered through the Exchange, but not always with Medicaid plans. The benefit packages between Medicaid and Exchange plans will be slightly different, causing individuals to lose or gain benefits as they cycle between the systems.

In light of these concerns, the General Assembly tasked the Maryland Health Benefit Exchange with drafting a report on continuity of care issues in the State of Maryland. The Exchange, in turn, has created a Continuity of Care committee (the Committee) to advise policymakers on solutions to minimize the negative impact of churning on individuals' health care. This paper is intended to help begin the Committee's discussion of the issues and to help Exchange staff design a Request For Proposal (RFP) for a vendor to complete a comprehensive study on continuity of care issues for the Exchange.

Summary of the Recommendations

This paper reviews broadly the major issues surrounding continuity of care, including: the size of churn and its effect on individuals in certain treatment plans; the possible use of covered transition periods and transition plans for individuals moving between plans; the ability of the Exchange to leverage existing programs to enhance continuity of care for everyone moving between systems; and how major changes in plan design and enrollment processes could impact care.

Recommendations for further study by the Continuity of Care Committee and the Exchange's vendor are provided throughout the text. They are neatly summarized as follows:

1) Exchange staff should ask the vendor to conduct an analysis of churn for the State of Maryland, including modeling different scenarios. If timeframes do not allow for a detailed analysis, the vendor should develop a number of different churn scenarios.

2) The Committee and vendor should make recommendations on what specific treatment plans warrant continuity of care protections.

3) The Committee and vendor should estimate the volume and costs of these treatment plans that warrant continuity of care protections. Specifically, the vendor should estimate the proportion of costs remaining when individuals are disenrolled from either the Medicaid program or a Qualified Health Plan. The vendor should work with the Committee to make recommendations concerning who pays for these costs.

4) The Committee and vendor must analyze the provider reimbursement rates across Medicaid and commercial payers, such as CareFirst. They must also analyze the financial impact of the provider reimbursement rates on providers or the Medicaid program as a result of any new requirements.

5) The Committee and the vendor should analyze whether the development and use of transition plans across MCOs and QHPs would be beneficial for individuals with certain treatment plans. The vendor should assess what the costs would be to implement such a system.

6) The Committee and vendor should conduct an analysis on how health information technology, electronic health records, and other information sharing processes could be integrated and leveraged into continuity of care policies.

INTRODUCTION

On January 1, 2014, Maryland will open up a system for universal health insurance coverage for virtually all of its residents. The state is taking full advantage of the opportunities under the Affordable Care Act (ACA), including building a state-based Exchange for the individual and small group markets and availing itself of federal funding for the expansion of Medicaid.

Universal coverage is not without potential stumbling blocks. One of the major concerns is continuity of care across systems. When Congress passed the ACA, it stipulated that several different health coverage systems would exist alongside one another. These systems include government-managed or overseen programs like Medicaid, Medicare, and the Exchange, as well as private sector systems like employer sponsored insurance. Universal coverage is comprised of the participation of all these different payers and many aspects of their coverage are not standardized.

As individuals move between these systems, they may confront obstacles, as the systems will have different provider networks, benefit packages, and co-pay and cost-sharing requirements. As most of the Maryland Medicaid population is in the program's managed care system called HealthChoice, individuals will be cycling between Managed Care Organizations (MCOs) and the Qualified Health Plans (QHPs) in the Exchange.

For individuals in the middle of a course of treatment, these shifts could have significant consequences on their care. Maryland will need to plan effectively to ensure that transitions between systems do not negatively impact its residents and the quality of their care.

In order to design an effective continuity of care regime, it will be necessary for the Committee and the vendor to estimate the scale of churn for Maryland as well as to identify the subsets of the population that will be most affected by moving between plans. The Committee and the vendor must also review existing research on transition policies employed by other states for these special populations. The Committee and vendor should explore how using the patient navigator process and health information technology could enhance continuity of care for all individuals shifting between the Exchange and Medicaid. Finally, the Committee should be aware of the larger policy questions that the state will have to resolve that could impact continuity of care.

ESTIMATING CHURN

Eligibility for Medicaid and the Exchange is based on income. Individuals' financial circumstances can change frequently and shifts can cause them to either lose or gain eligibility for programs, often with very little advanced warning. Because eligibility for these systems is sensitive to individuals' economic circumstances, there will be various points of churn depending on the entry point of the various systems.

While the 138 percent of the FPL[1] line of churn is used as the fault line between Medicaid and Exchange eligibility, the reality is that Medicaid eligibility is not uniformly determined to be 138 percent of the FPL for all groups. Pregnant women are covered up to 250 percent of the FPL in Maryland, with an eligibility span that extends to two months after the birth of a child. Maryland could decide to lower the income thresholds for pregnant women, but only to 185 percent of the FPL. This creates a scenario where a

[1] While the ACA states that the income limit for Medicaid is set at 133 percent of the FPL, it also directs Medicaid programs to disregard 5 percent of an eligible person's income. This functionally raises the income limit to 138 percent.

woman would be eligible for Medicaid for less than a year even if her income remains steady because of the triggering event of pregnancy. Similarly, children under the age of 19 are covered from 0 to 300 percent of the FPL, making their entry point to the private market at a higher percent of the FPL than what an adult individual's will be.

Within academic circles, the scale of churn is still debated.[2] In a major and highly cited study, Benjamin Sommers and Sara Rosenbaum estimated churn would occur for the 0 to 200 percent of the FPL population at a high rate.[3] According to this study, for individuals between 19 to 60 years of age, at least 35 percent would have one shift at 138 percent of the FPL in the span of six months and 50 percent would have a fluctuation within a year. Compounding the issue will be individuals who churn twice in a short span of time, making them eligible for a program, then ineligible, then eligible again for the same program. Sommers and Rosenbaum found that 24 percent of the individuals in their study would churn in this manner in one year and 39 percent would churn like this in two years.[4]

The scale of churning will be large, but at this stage it has not been modeled for Maryland by a state agency or vendor. In State Fiscal Year 2015, Medicaid enrollment is expected to be over 1.1 million people,[5] while the Exchange is expected to cover close to 170,000 people.[6] Even a small fraction of that population moving between systems would be numerically significant.

> RECOMMENDATION**:** Exchange staff should ask the vendor to conduct an analysis of churn for the State of Maryland, including modeling different scenarios. If timeframes do not allow for a detailed analysis, the vendor should develop a number of different churn scenarios.

TARGETED TRANSITIONS FOR SELECT POPULATIONS

I. Identifying Populations with Critical Continuity of Care Issues

Certain individuals will be in the middle of health care treatment plans when they move between Medicaid and the Exchange. Disruptions in care for these individuals could be quite detrimental to their health status. The Committee should focus its efforts on improving or guaranteeing continuity of care for these individuals by identifying the population subsets, provider relationships, and key treatments most in need of special protection.

For instance, a pregnant woman may be disenrolled from her QHP under the Exchange, but her OB/GYN may not participate with any Medicaid MCO. The Committee will have to decide if protections should be built into the various health care insurance systems to allow the pregnant woman to maintain her provider relationship. This protection is already built into HealthChoice, the Medicaid managed care program, but not commercial insurance plans.

---

[2] Analysts have reviewed churn and added to Sommers and Rosenbaum's seminal income fluctuation based analysis. In June 2012, for instance, the Urban Institute published an analysis that analyzed the effect of affordable offers of Employer Sponsored Insurance (ESI) on churn for both Medicaid and the Exchange. *See* Buettgens M, Nichols A, Dorn S. Churning Under the ACA and State Policy Options for Mitigation. (June 2012).

[3] Sommers B. D. and Rosenbaum S. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." Health Affairs, 30, no. 2 (2011): 228-236.

[4] Id.

[5] This is the entire Medicaid population, including children and those over the age of 65.

[6] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.

Another example of a treatment plan worth considering is behavioral health. Most likely, Medicaid will have a more comprehensive benefit package for behavioral health services than QHPs. Gaps in services for this population could have significant consequences for their care. The Committee will have to decide whether specific behavioral health services will have to be guaranteed across health insurance systems when individuals move between Medicaid and QHPs.

These are only two examples of the analysis that the Committee and vendor will have to do. The Center for Health Care Strategies (CHCS) has identified a number of treatments covered by transition policies: pregnancy; certain dental care such as orthodontia; hospitalizations; transplants; chemotherapy, radiation therapy and dialysis; individuals that are approved to receive expensive durable medical equipment that is not provided prior to a transition, home health services, or prescription medications; individuals with prior authorizations; and behavioral health and substance abuse services.[7] While this group may serve a base for the Committee's and vendor's analysis, it should not be treated as an exclusive list.

> RECOMMENDATION: The Committee and vendor should issue recommendations on what specific treatment plans warrant continuity of care protections.

II. Transition Periods for Individuals in Treatment

A common continuity of care provision employed by states for individuals transferring from one Medicaid plan to another is to have a predetermined period of time where individuals can continue to receive the same services, often with the same providers. These transition periods could be adopted for Medicaid-to-Exchange transitions through contracting or regulatory requirements. The CHCS has done an analysis on such state transition policies.[8]

There is wide variety of transition period policies. First, transition periods vary depending on the population served. For instance, New York has a 60-day transition period for individuals with a life-threatening disease or condition, but for women in the second trimester of a pregnancy, the transition period will last through the pregnancy and up to 60 days after the birth of the child.[9] Transition periods do not have to be uniform for all treatment plans.

Second, the care requirements in transition periods are different. Some transition periods require MCOs to allow new enrollees to have access to their previous providers even if those providers are out-of-network. On a national level, NCQA accredits managed care plans on whether the plans allow those undergoing active treatment for a chronic or acute medical condition to have access to their discontinued providers through their current period of active treatment or up to 90 days. Others require MCOs to continue with previous treatment plans, but with in-network providers. Some transition periods only require that prior authorizations be observed.[10]

Transition periods serve a valuable role as they allow individuals in the middle of treatment to continue to access services from their providers as they make adjustments to the new plan's benefit structure or provider network. Such periods permit the individual time to either complete treatment or to find a comparable service or provider.

---

[7] Ingram C., McMahon S. M., and Guerra V. "Creating Seamless Coverage Transitions Between Medicaid and the Exchanges." State Health Reform Assistance Network, April 2012.
[8] Id.
[9] Id.
[10] Id.

The Maryland HealthChoice program has self-referred services, which guarantee individuals the ability to go out-of-network for particular services.[11] The MCO pays its established reimbursement rate to the provider rendering the service. In New York, the provider must agree to accept the receiving Medicaid plan's rates, while other states, such as New Mexico, require Medicaid MCOs to pay Medicaid FFS rates for services provided outside of the MCOs' provider networks.[12]

There is an important caveat with the transition periods related to reimbursement that could be especially important in a Medicaid-to-Exchange context – different reimbursement rates. Transition regulations or contracting provisions have usually occurred inside a Medicaid marketplace, not across systems. Thus, providers have always agreed to Medicaid terms and conditions, including provider rates. This will not be the case when transition periods would have to cross systems and providers will be confronted with different reimbursement rates.[13]

The Committee and vendor should be aware that Medicaid reimbursements are determined based on budget allocations and raising the rates may be difficult to accomplish. Since 2007, the Medicaid program has grown over 50 percent by adding over 340,000 individuals across all programs. This sharp increase has been driven by the slow economic growth the United States has experienced since 2008. While rates in Medicaid have historically been below market rates, the effects of a lagging economy have added new pressures to the program.

Another factor influencing Medicaid rates is the ACA requirement for states to pay pediatricians, family practitioners, and internists for evaluation and management services at a rate that is equal to Medicare rates. The federal government will cover 100 percent of the increased costs for these providers and services for two years, starting January 1, 2013. Maryland's FY 2013 budget allows any physician to receive the enhanced rate when billing evaluation and management services. This federal support is only temporary and it does not include specialty services. Whether this continues beyond 2014 will be dependent on Maryland's decision on whether to continue funding the enhanced rate at its regular matching rate for the existing Medicaid populations and at the higher federal matching rates for the "newly eligible" individuals under the ACA.

> RECOMMENDATION: The Committee and vendor should estimate the volume and costs of these treatment plans that warrant continuity of care protections. Specifically, the vendor should estimate the proportion of costs remaining when the individuals are disenrolled from either the Medicaid program or the Qualified Health Plan. The vendor should work with the Committee to make recommendations on who pays for these costs.
>
> The Committee and vendor will need to analyze the provider reimbursement rates across Medicaid and commercial payers, such as CareFirst. They must also analyze the financial impact of the provider reimbursement rates on providers or the Medicaid program as a result of any new requirements.

[11] These services include: the initial medical exam for a child in state supervised care; emergency services; family planning services; an annual diagnostic and evaluation visit for a person living with HIV/AIDS; a newborn's initial medical examination in a hospital; pregnancy-related services initiated before an individual enrolls in a MCO; renal dialysis services in a Medicare-certified facility; school-based health center services; and, substance abuse treatment.

[12] Ingram et al.

[13] While there is often overlap between provider networks, official participation in the Medicaid program does not signal active participation. Some providers are enrolled in the program so that they can continue to provide care to established patients who have become eligible for Medicaid after being covered by private insurance.

III. Transition Plans

Transition plans may also facilitate continuity of care without shifting the financial burden from one payer to another. States have used transition plans to assist individuals moving between MCOs. Massachusetts requires receiving MCOs to prepare transition plans for pregnant women, individuals with significant health care needs or complex medical conditions, people receiving ongoing services or who are hospitalized at time of transition, and individuals who received prior authorization for services from the previous MCO. New Mexico requires relinquishing MCOs to complete a transition plan for transitioning members.[14]

Maryland Medicaid does not mandate transition plans, but it does impose a policy that serves a similar purpose. MCOs must conduct health risk assessments for all new incoming enrollees. These health risk assessments are used to identify individuals who have immediate care needs. The Committee may wish to explore greater use of health risk assessments or the development of detailed transition plans for certain populations and individuals in mid-treatment.

> RECOMMENDATION: The Committee and the vendor should analyze whether the development and use of transition plans across MCOs and QHPs would be beneficial for individuals with certain treatment plans. The vendor should assess what the costs would be to implement a system.

HEALTH CARE SYSTEM-WIDE PROGRAMS

Not all individuals will need transition periods or transition plans as they move across systems. But the experience of changing insurance plan coverage or changing doctors can be an administrative inconvenience for the individual, the provider, and the insurer. There are ways to minimize the administrative burden by leveraging already existing programs.

I. Patient Navigator Program

Continuity of care will be assisted through the Exchange's patient navigator program, as patient navigators should be equipped to assist individuals transitioning from one system to another. Patient navigators will be fluent in the options available to new Exchange enrollees and be able to guide them to the best insurance plans given their health status and circumstances.

The Exchange could augment the program by ensuring that patient navigators have access to detailed plan information. One example would be patient navigator familiarity with a consolidated provider directory. The Rutgers Center for State Health Policy notes that CMS regulations require that QHPs have a provider directory that states whether a provider is accepting new patients or not. Exchanges have the ability to consolidate these provider directories to build a master directory. Individuals transitioning between Medicaid and the Exchange could use a consumer-friendly version of the file to research whether their PCP or other preferred doctor participates in certain MCOs or QHPs.[15]

[14] Id.
[15] Cantor J., Gaboda D., Nova J., and Lloyd K., "Health Insurance Status in New Jersey After Implementation of the Affordable Care Act." Center for State Health Policy. Rutgers University. August 2011.

It would be in the best interest of the state if the provider file were able to adequately reflect the provider's participation in the various MCOs and QHPs. However, because providers change status frequently on whether they are open or closed to new patients, and because they do not update data files often, it will be difficult to ensure that the provider files are 100 percent accurate.

II. Electronic Health Records and Health Information Technology

As mentioned in the preceding section, several states have policies governing transitions between MCOs requiring that relinquishing MCOs submit detailed case information of individuals in mid-treatment to receiving MCOs. For instance, if an individual is in treatment for substance abuse or cancer then that information, along with other medical information, is packaged and sent by the former MCO to the new receiving MCO.

While Maryland does not mandate the development of transition plans or their transfer, there is a proposal that demonstrates how health information technology could be used to send information automatically. The Maryland Health Information Exchange (HIE) is currently developing a proposal to send automatic patient case summaries to interested parties based on a triggering event, like a discharge from hospital or new eligibility with an insurer. When a triggering event occurs, the HIE generates a summary document from all of its hospital sources. The document will then be sent to the relevant care coordinator or provider entity.

Much of the focus of electronic health records and access has focused on the provider level. The continuing development of the HIE and the federal EHR incentive program will continue to facilitate the sharing of records between providers, which helps provide continuity of care. However, the Committee may wish to explore how to leverage this system for information sharing with payers as well.

> RECOMMENDATION: The Committee and vendor should conduct an analysis on how health information technology, electronic health records, and other information sharing processes could be integrated and leveraged into continuity of care policies.

OTHER OPPORTUNITIES TO MITIGATE CHURN

There are a number of larger policy issues that Maryland will have to resolve that could potentially mitigate the churn and transition issues between Medicaid and the Exchange. Those policies may be outside of the scope of the Committee, but advocates and analysts frequently cite continuity of care issues as a major reason influencing their views on the policies.

I. The Basic Health Program Option

Some studies have analyzed the Basic Health Program (BHP) as a possible means to alleviate churn.[16] The Basic Health Program is an option under the ACA in which the state could provide coverage for individuals between 138 percent and 200 percent of the FPL. The state would directly receive a high

[16] Boozang P and Lam A. New York State Foundation: Achieving Continuity of Insurance Coverage for Lower-Income New Yorkers in 2014 (2012); Hwang A., Rosenbaum S., and Sommers B. D. "Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges." Health Affairs, 31, no. 6 (2012): 1314-1320; Buettgens M, Nichols A, Dorn S. Churning Under the ACA and State Policy Options for Mitigation. (June 2012).

percentage of the tax credits and cost sharing subsidies that would have been allocated to the individuals receiving coverage in the Exchange, which it would then use to finance the coverage.

The BHP is intended to be beneficial for states, like Maryland, that have an established Medicaid managed care system which could be used to provide the same coverage to the 138 percent to 200 percent of the FPL cohort. For continuity of care, the appeal of a BHP would be that a potentially greater portion of low-income individuals would stay within the same network, therefore mitigating the service or provider gaps lower income individuals might face in transitioning between the Exchange and Medicaid.

Maryland Medicaid and The Hilltop Institute completed an introductory analysis of the BHP for Maryland in 2012. At that time, Medicaid determined that the lack of federal rulemaking on the option made it impossible to conduct a thorough analysis that would arrive at a recommendation for a decision by policymakers.[17]

During the 2012 session, the General Assembly tasked the Department of Health and Mental Hygiene (DHMH) with updating its analysis by December 1, 2012. Given the short timeframe remaining until DHMH updates its analysis, the Committee should await the results of the updated analysis. Absent a recommendation to pursue a BHP, the Committee should conduct and assess alternatives that include both a BHP option as well as a non-BHP option.

II. Aligning Plans Across Programs

Other studies propose that states either mandate or encourage MCO participation in the Exchange market and/or QHP participation in the Medicaid managed care market. The appeal of this policy for continuity of care purposes is that it could preserve provider networks across systems. Transitions could potentially be made even more seamless if a state were to allow auto-enrollment from a single entity's MCO plan to QHP plan when an individual moves from Medicaid to the Exchange.[18]

Maryland explored a precursor to this option in 2011 when DHMH released a white paper to solicit stakeholder feedback on contracting strategies. The white paper analyzed the benefits of changing the process of MCO entry into HealthChoice; specifically, from meeting a series of regulatory requirements to having Medicaid collect bids from health plans and selectively contracting with them. One of the objectives of selective contracting is to encourage continuity of care across systems by encouraging participation in both the Medicaid and Exchange markets. After conducting multiple public hearings across the state and studying considerable stakeholder feedback, DHMH decided based on that feedback to not pursue a selective contracting strategy. Many insurers and MCOs had expressed reservations about entering different markets.[19]

Notwithstanding the selective contracting hearing process, the requirements for QHP entry into the Exchange and the rules governing their participation are still being developed. It would be premature for the Committee and the vendor to begin assessing mandatory or incentivized cross-market participation.

---

[17] The paper may be accessed here: http://mmcp.dhmh.maryland.gov/SitePages/selective-contracting.aspx
[18] Office of Health Reform Integration. Amerigroup RealSolutions. Continuity of Care and Coverage in Health Insurance Exchanges. April 2011.
[19] The paper may be accessed here: http://dhmh.maryland.gov/docs/BHP%2001%2018%2012%20Report%20Analysis%20FINAL.pdf

III. Aligning Benefits Across Programs

A number of commentators note that benefits could be aligned across systems so that each program would be offering the same benefit package.[20] This could effectively remove the issue of varying benefits across systems, but it would not address provider network issues.

The ACA mandates that Medicaid and the Exchange both cover the Essential Health Benefits, which acts as a floor for covered benefit categories. The Exchange and Medicaid do have room for variation in their coverage. The Department of Health and Human Services (HHS) allows states to pick benchmark plans to serve as reference points for the coverage requirements for all plans. Medicaid programs and Exchanges are not required to have the same benchmark plan. Maryland Medicaid plans to offer its standard Medicaid benefit package as its benchmark plan, while the Maryland Health Care Reform Coordinating Council is still evaluating the options for the Exchange's benchmark.

In the Exchange, insurers will have further flexibility to set specific services and quantitative limits in plans so long as the plans track a baseline set of relevant benefits as reflected in the benchmark. There would be differences with Medicaid, which uses a medical necessity standard and does not have quantitative limits.

Just like mandating that plans operate in the Exchange and Medicaid is premature, an analysis on aligning benefits across programs is premature as many of the regulatory details on QHPs have yet to be issued.

IV. Presumptive Eligibility and 12-Month Continuous Eligibility

An important element of continuity of care is reducing the time people are out of coverage while transitioning from system to system as well as ensuring orderly transitions between health plans. Eligibility and enrollment issues can be described as continuity of coverage issues.

The ACA mandates that the Exchange's web portal (the HIX) serve as a no-wrong door entry point to receive coverage for Medicaid and the Exchange. It is intended that, in time, the HIX will serve as the principal, consumer-centric eligibility and enrollment system for both systems. In light of this mandate, Medicaid and the Exchange have been engaged in substantive discussions on the design of the portal and the process for eligibility determinations and enrollment in MCOs and QHPs. These discussions have and will continue to encompass care transitions.

Because Medicaid and the Exchange have implemented a process to resolve interoperability and eligibility issues between the systems, the Committee may not need to spend much time in devising eligibility- and enrollment-based solutions to coverage gaps between the systems. Nevertheless, the Committee should be aware of some of the policy proposals that have been raised by advocates, think tanks, and policymakers.

Some analysts recommend that presumptive eligibility be implemented to reduce coverage gaps. Presumptive eligibility allows faster determinations of eligibility to put individuals into coverage, and therefore care, more quickly. Under presumptive eligibility, a qualified provider can grant immediate, temporary Medicaid coverage for an individual if they believe the person is eligible for the program. Eligibility is confirmed at a later date with appropriate documentation. The ACA allows states that already allow presumptive eligibility determinations for children and pregnant women to extend presumptive eligibility to several new populations, including parents and childless adults. Currently,

[20] Boozang and Lam.

Maryland does not have a presumptive eligibility policy for children or pregnant women, although Maryland does expedite eligibility determinations for these populations.

Medicaid could also explore a twelve-month continuous eligibility period for children. Maryland requires annual renewals for Medicaid eligibility. But, by definition, eligibility for Medicaid is sensitive to income and can change over time with fluctuating income and changes in family composition. States have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP, even if the family experiences a change in income during the year. This may be a valuable tool to ensure that children have consistent access to health care services and their providers.

CONCLUSION

The implementation of universal health coverage in January 2014 will create great opportunities for low-income individuals to receive affordable and comprehensive health care coverage. But universal coverage creates challenges as well. One of the chief challenges will be continuity of care across systems.

As the Exchange, Medicaid, and its partners move forward, it will be important to recognize the differences between systems and to be able to address them with strong policy solutions. In doing so, Maryland should be aware that such differences affect plan benefits and services, provider networks, eligibility and enrollment systems, business practices, and technological capability.

WORKS CITED AND CONSULTED

Policy Papers, Studies and Academic Literature

Association of Community Affiliated Plans. "Millions Will Lose Coverage from Churning Between Medicaid and Exchanges." February 9, 2011. *Accessed at* http://communityplans.net.dnnmax.com/Portals/0/ACAP%20Docs/Press%20Releases/Release%20Medicaid%20Churning%20Hurts%20Millions%20FINAL%20020911.pdf

Boozang P and Lam A. "New York State Foundation: Achieving Continuity of Insurance Coverage for Lower-Income New Yorkers in 2014." (2012). *Accessed at* http://nyshealthfoundation.org/uploads/resources/Coverage-Continuity-for-Lower-Income-New-Yorkers.pdf

Buettgens M, Nichols A, Dorn S. "Churning Under the ACA and State Policy Options for Mitigation." (June 2012). *Accessed at* http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf

Buettgens, M. and Nichols, A. "Washington State Solutions for Churning." FamiliesUSA. Health Action 2012: Conference Materials. *Accessed at* http://www.familiesusa.org/conference/health-action-2012/conference-materials/WAChurning.pdf

Cantor J., Gaboda D., Nova J., and Lloyd K., "Health Insurance Status in New Jersey After Implementation of the Affordable Care Act." Center for State Health Policy. Rutgers University. August 2011. *Accessed at* http://www.cshp.rutgers.edu/Downloads/8970.pdf

Department of Health and Mental Hygiene. Maryland HealthChoice Program: Should Maryland Move to a Selective Contracting Strategy? 2011. *Accessed at* http://mmcp.dhmh.maryland.gov/SitePages/selective-contracting.aspx

Department of Health and Mental Hygiene, Medicaid Office of Planning & The Hilltop Institute. Analysis of the Basic Health Program. January 17, 2012. *Accessed at:* http://dhmh.maryland.gov/docs/BHP%2001%2018%2012%20Report%20Analysis%20FINAL.pdf

Fakhraei, S. H. (2012). Maryland health care reform simulation model: Detailed analysis and methodology. Baltimore, MD: The Hilltop Institute, UMBC. *Accessed at* http://hilltopinstitute.org/publications/MarylandHealthCareReformSimulationModel-July2012.pdf

Fakhraei, S. H. (2012). Simulation Model Projections. Baltimore, MD: The Hilltop Institute, UMBC. *Accessed at* http://hilltopinstitute.org/publications/SimulationModelProjections-July2012.pdf

Hwang A., Rosenbaum S., and Sommers B. D. "Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges." Health Affairs, 31, no. 6 (2012): 1314-1320. *Accessed at* http://content.healthaffairs.org/content/31/6/1314

Ingram C., McMahon S. M., and Guerra V. "Creating Seamless Coverage Transitions Between Medicaid and the Exchanges." State Health Reform Assistance Network, April 2012. *Accessed at* http://www.statenetwork.org/resource/creating-seamless-coverage-transitions-between-medicaid-and-the-exchanges/

Ingram C., Gore, S. and McMahon S. M. "Ten Considerations for States in Linking Medicaid and the Health Benefit Exchanges." State Health Reform Assistance Network, August 2011. *Accessed at* http://www.rwjf.org/files/research/20110812chcsbrief.pdf

Ku L., MacTaggart, P., Pervez, F. and Rosenbaum, S. "Improving Medicaid's Continuity of Coverage and Quality of Care." Prepared for the Association for Community Affiliated Plans. July 2009. *Accessed at* http://ahcahp.org/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf

Medicaid Health Plans of America. Letter to the Office of Consumer Information and Insurance Oversight. October 4, 2010. *Accessed at* http://www.mhpa.org/_upload/10-4-10%20MHPA%20Exchange%20Comments%20(2).pdf

Office of Health Reform Integration. Amerigroup RealSolutions. Continuity of Care and Coverage in Health Insurance Exchanges. April 2011. *Accessed at* http://hcr.amerigroupcorp.com/wp-content/uploads/2011/06/Special-Focus-Edition-Continuity-of-Care-and-Coverage.pdf

Seifert, R., Kirk, G., and Oakes, M. "Enrollment and Disenrollment in MassHealth and Commonwealth Care. Prepared for Massachusetts Medicaid Policy Institute. April 2010. *Accessed at* http://www.massmedicaid.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf

Sommers B. D. and Rosenbaum S. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." Health Affairs, 30, no. 2 (2011): 228-236. *Accessed at* http://content.healthaffairs.org/content/30/2/228.abstract

Maryland Regulations Furthering Continuity of Care

Maryland Medicaid Managed Care Program: Eligibility and Enrollment – Disenrollment COMAR 10.09.63.06. (If family members are enrolled in different MCOs then an adult enrollee may request that other family members be enrolled in one of the MCOs in which another family member is currently enrolled. Enrollees may also request enrollment into the MCO that contracts with the PCP of any other family member who is not a HealthChoice enrollee.) *Accessed at* http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.63.06.htm

Maryland Medicaid Managed Care Program: Managed Care Organizations: Special Needs Populations – Children with Special Health Care Needs. COMAR 10.09.65.05. (If a child MCO enrollee is diagnosed with a special healthcare need requiring a plan of care that includes specialty services, approval may be requested for an out-of-network specialist in the instance that the MCO does not have a comparable available provider.) *Accessed at* http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.65.05.htm

Maryland Medicaid Managed Care Program: Benefits – Self-Referral Services. COMAR 10.09.67.28. (Describes Medicaid's self-referred services which allow MCO enrollees to pick out-of-network providers for certain specified services). *Accessed at* http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.67.28.htm

Maryland Medicaid Managed Care Program: Rare and Expensive Case Management – Benefits. COMAR 10.09.69.05. (Individuals who qualify for Medicaid managed care and rare and expensive case management (REM) are eligible for coverage that gives preference to any pre-established relationships between the participant and the primary care provider.) *Accessed at* http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.69.05.htm

Maryland Medical Assistance Program. HealthChoice Transmittal No. 1. December 17, 1997. (Describes MCO responsibilities to new enrollees before the MCO completes its initial evaluation and plan of care for the enrollee). *Accessed at* http://www.emdhealthchoice.org/trans/FY98/PT11-98.pdf

Contractual Language for Care Transitions (as compiled by the Center for Health Care Strategies for the "Creating Seamless Coverage Transitions between Medicaid and the Exchanges" paper)

Arizona Health Care Cost Containment System (AHCCCS) Contract Amendments. *Accessed at* http://www.azahcccs.gov/commercial/Purchasing/contracts.aspx

Indiana. Contract Between the Family and Social Services Administration, Office of Medicaid Policy and Planning and _____. *Accessed at* http://www.docstoc.com/docs/25848527/RFS-7-62-ATTACHMENT-B-SAMPLE-CONTRACT

Medicare Part D (Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4). *Accessed at* http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter6.pdf

Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare Medical Care Services. 2012 Families and Children Contract. *Accessed at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_166537

National Committee for Quality Assurance (Standards and Guidelines for the Accreditation of Health Plans). *Accessed at* https://inetshop01.pub.ncqa.org/Publications/deptCate.asp?dept_id=2&cateID=100&sortOrder=175&msclkid=#100175

State of New Mexico Human Services Department. Medicaid Managed Care Services Agreement Between New Mexico Human Services Department and Lovlace Community Health Plan. July 1 2012 – December 31, 2013. *Accessed at* http://www.hsd.state.nm.us/mad/pdf_files/salud/Lovelace%20Community%20Health%20Plan%20FINAL%20%20Contract%20July%202012.pdf

Agreement Between the New Mexico Human Services Department and Amerigroup Community Care of New Mexico. September 30, 2009. *Accessed at* http://www.hsd.state.nm.us/mad/pdf_files/AMERIGROUP%20CONTRACT.PDF

New York State Department of Health Office of Health Insurance Programs, Division of Managed Care. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract. August 1, 2011. *Accessed at* http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

Pennsylvania Department of Welfare. Healthchoices Agreement. *Accessed at* http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002105.pdf