Marketplace Community Conversations

Medicaid Migration to the Marketplace

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Marketplace Administrator

Agenda

- Introduction
  - What is the Marketplace?
  - What is the HIMAC?
- Oregon Health Plan redeterminations
- Medicaid migration to the Marketplace
- Discussion about OHP redeterminations and Medicaid migration project
- Closing thoughts

What is the Marketplace?

- Part of state government
- State-based exchange that uses federal platform (HealthCare.gov)
- Oversee plans sold to Oregonians on HealthCare.gov
- Assist with enrollment, and support agents and partners who also provide assistance
- Conduct outreach and education about health coverage and financial assistance

What is the Health Insurance Marketplace Advisory Committee?

- Formally the Health Insurance Exchange Advisory Committee
- Advises in the governance and operation of the Oregon Health Insurance Marketplace
- Focus of the HIMAC:
    - Plan affordability
    - Accessibility of coverage in the individual market, including access through the Marketplace

OHP Redeterminations

Unwinding emergency policies when the public health emergency formally ends

HEALTH SYSTEMS DIVISION, Medicaid Policy

HEALTH POLICY AND ANALYTICS DIVISION, Oregon Health Insurance Marketplace

The federal government declared a public health emergency (PHE) effective March 18, 2020.

In response to the Families First Coronavirus Relief Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Oregon implemented emergency policies:

- OHP recipients eligible on March 18, 2020, and any individuals who gained eligibility after that date, will maintain coverage through the end of the PHE.

  Oregonians remain enrolled regardless of changes in circumstances, with few exceptions; death, confirmed out-of-state residency, incarceration, and voluntary request. This includes individuals who may have otherwise lost eligibility due to income, or because the agency received returned mail.

- Applicant attestation of most eligibility criteria is accepted for initial and ongoing eligibility determinations.

  Oregonians are not required to provide proof of reported information, except for their citizenship/immigration status.

Current federal guidance

The Centers for Medicare & Medicaid Services (CMS) will provide states with 60 days advance notice of the PHE end date.

Work has already begun to plan and prepare for this transition. When the PHE end date is confirmed, OHA will begin updating the ONE eligibility system to end the PHE-related rules.

CMS expects states to review eligibility for all recipients within 12 months following the PHE end-date. States are required to perform a full renewal and consider all programs before ending coverage.

Easing the transition

Once the PHE has ended, Oregon will begin re-evaluating eligibility for all OHP members.

- The agency will avoid significant surges and lags in renewal volume by 'balancing' the OHP caseload over the 12 months following the PHE.
- To avoid coverage loss among eligible individuals, the agency is planning outreach and communications efforts to let OHP members know what to expect, and to gain current contact information.
- The agency will coordinate with the health insurance Marketplace to support individuals transitioning from OHP to a Marketplace Qualified Health Plan.

What to expect once post-PHE renewals begin

- The agency will process renewals via existing methods. Automated Renewal (the agency confirms/verifies eligibility criteria without requiring action from the recipient) will be attempted. If coverage cannot be automatically renewed, members receive a pre-populated renewal notice that they must sign and return.
- Renewals are initiated ~90 days prior to the renewal deadline – this means that results of renewal batches will begin to be observed about 3 months after the PHE ends.
- The agency will share reports of cases being targeted for renewal ahead of time so that CCOs can reach out to their members.

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Background

- At the end of the Public Health Emergency (PHE) for COVID-19, Medicaid enrollment will resume its regular process of redetermining eligibility and terminating Medicaid coverage for those members no longer eligible.
  - Up to 300,000 Oregonians enrolled in OHP will no longer be eligible after the PHE.
  - Can lead to a large influx of new QHP-eligible enrollees over the following year.

Project updates

- Receiving data lists of OHP ineligible individuals from OHA to start reaching out to consumers prior to the start of Medicaid redeterminations
- Completed pilots with test data to determine time needed to process CCO to Marketplace crosswalk
- Analyzing data to determine potential call center staffing needs

Project updates

- Looking at manual crosswalk option for outreach, which will crosswalk a consumer to from a CCO to a corresponding Marketplace plan.
  - Looking at crosswalk criteria:
    - The networks used by a member while on OHP do not necessarily sync up to the networks used by commercial carriers.
    - We may be able to look at the provider(s) most used by the member, then identify the plans that most closely match the member’s CCO network.

Project engagement

- Survey sent to community partners and agents:
  - What are OHP members saying is important to them with respect to redeterminations and continuing care and coverage.
    - Update plans to increase benefits.
      - For example: add vision or offer plans that have alternative care options such as naturopathic therapies

Project engagement updates

Top 3 concerns:

- Affordability
- Understanding how to navigate Marketplace plans with respect to out-of-pocket costs
- Maintaining continuity of care
- Maintaining continuity of coverage

Project engagement updates

- Continued collaboration with Marketplace insurance carriers and CCOs to identify gaps where a complete crosswalk may not be available.
- Continued collaboration with OHP on data, timelines and potential IT updates.

Project engagement updates

- Collaboration with other state exchanges
  - Outreach tactics
  - Technology barriers
  - Staffing and funding to support Medicaid migration
  - Additional call center support needed and what that may look like
  - Best practices for migrating a consumer from OHP to a QHP

Current path

- Targeted outreach by:
  - Income
    - Metal level options based on the member's likely FPL.
  - OHP Network
    - Match consumer to plans that most closely match the consumer's OHP. Which providers should be given the most weight?
  - County
    - Cost of certain plans based on their county, options for other plans if the CCO matching plan is at a higher price point.

Current path

- Tribal status
  - Ensuring tribal members are aware of the no-cost sharing plan options.
- By current associated community partner
- Outreach will be determined based on the consumer’s contact preference and the contact information we receive for the consumer.
  - Initial outreach: Via mail or email.
  - Follow up options: via text message (if the consumer authorizes), calls from the call center or calls/texts from Agent or CP of record.

Challenges to current path

- Individuals will need to take the additional step of enrolling through HealthCare.gov on their own or with the help of a health insurance expert

Challenges to current path

- Member data accuracy:
  - Not all FPLs and member contact data will be 100% accurate due to potential life changes that have not been processed.
    - If a consumer has other qualifying coverage such as employer sponsored coverage that is affordable, they are not eligible for tax credits.
    - Some consumers may need to reconcile taxes before PTC eligible.
    - The typical complexities to deal with when trying to conduct outreach at the member level.

Discussion questions

Outreach and engagement

- What do you think the newly determined ineligible OHP enrollees will need to see and/or have in hand to take action?
- What will community partners and agents want to have in place to help with the caseload?

Discussion questions

Aligning provider networks and benefits

- What should be prioritized in a private plan network to display in consumer specific outreach?
  - Examples may be: provider network/usage, total providers from CCO in network, etc…

Discussion questions

Timing of transition

- When should redeterminations begin for people enrolled in OHP?
- When should outreach and messaging begin for people determined newly ineligible for OHP?

Closing thoughts

- Public Comments
  - Submit the form at https://go.usa.gov/xtxt6
  - Public comments are due Friday, Jan. 21 at 11:59 p.m.
- Questions
  - Email us at info.marketplace@dcbs.oregon.gov