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State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update

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State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update

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RESEARCH OBJECTIVE

When the ACA first expanded Medicaid in 2014 to include childless adults earning below 138% of the poverty level, states had the option of expanding by offering full state plan Medicaid to the new population or formulating a coverage plan different from traditional Medicaid.

The original study examined how states undergoing Medicaid expansion differed in their treatment of the "medically frail" population. The medically frail are members of the expansion population who may need the full benefits offered by traditional Medicaid or who by policy are not subject to certain coverage requirements, e.g., premiums, assigned to the expansion population. The Centers for Medicare and Medicare Services (CMS) has provided definitions for medical frailty, but still has not directed states on the specific method used to determine if an individual meets criteria for medical frailty. In our last study, we found 11 states where the issue of medical frailty was salient because those states had Medicaid expansion, but did not provide traditional Medicaid to individuals in the expansion group.

Medical Frailty Definition:

CMS defines medical frailty as involving individuals who encompass having:

- Disabling mental disorders
- Chronic substance abuse disorders
- Serious and complex medical conditions
- Physical, intellectual, or developmental disability that impairs one or more activities of daily living
- Disability determination by Social Security criteria or state plan criteria

Our updated review (as of 4/12/2017) finds 14 states that have Medicaid expansion and offer an alternative benefit plan with lower benefits or higher costs than standard Medicaid. Of the original 11 medically frail states, Pennsylvania is no longer a medical frailty state having converted to traditional Medicaid for all beneficiaries. Ten of the original study states, including Arkansas, California, Iowa, Indiana, Massachusetts, New Hampshire, New Jersey, New Mexico, North Dakota, and West Virginia, retained their medical frailty status. Arizona, Kentucky, and Michigan, formerly full state plan expansion states, have more recently received waiver approval for alternative benefit coverage requiring identification of medically frail members. Finally, Montana's Medicaid expansion waiver, effective 1/1/2016, includes medical frailty. We further updated, where available, how these 14 states assess medical frailty, and the differences in covered services as they may have implications on access to services.

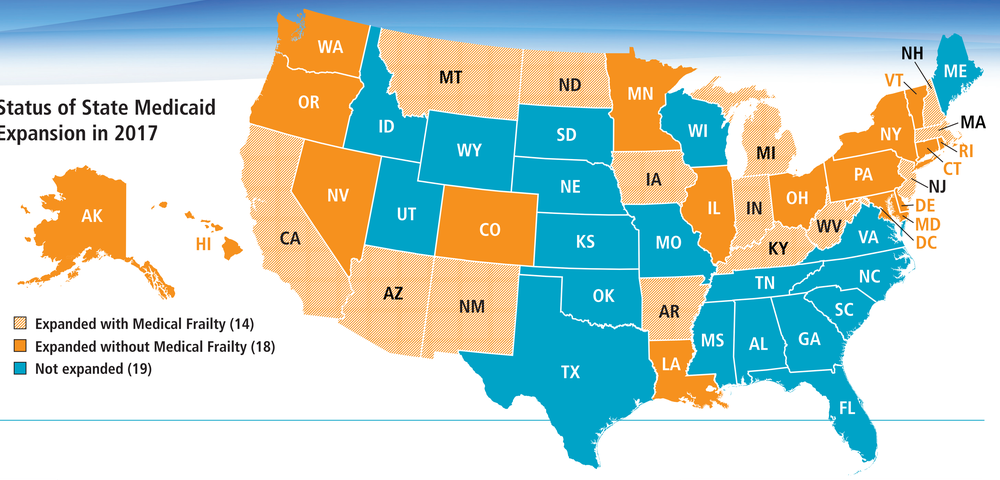
STUDY DESIGN

We examined states that previously had Medicaid expansion and noted if there were changes regarding coverage for the expansion population, i.e., if states were offering the expansion population an alternative benefit plan different from or the same as full state plan Medicaid. We further identified any newly expanded states with respect to the same factors. We examined state plan amendments, waiver materials submitted to CMS and primary documents from states, including client informational materials and policy documents, to understand the methodology used to assess medical frailty in each state, and to examine differences in covered services between the expansion and traditional Medicaid groups.

POPULATION STUDIED

The new population was the 14 states with Medicaid expansion with a difference in services between the alternative benefit plan and traditional Medicaid. These are states in which medical frailty applies.

Status of State Medicaid Expansion in 2017



PRINCIPAL FINDINGS

There remain substantial differences in how the 14 states identify the medically frail population. In some states, such as Massachusetts, individuals who are applying for disability-based Medicaid simply "self-declare" that they have "special medical needs" (medically frail). In contrast, Arkansas has created a screening tool that identifies applicants as medically frail based on their diagnosis or medical utilization. North Dakota has developed a questionnaire to determine those likely to qualify as medically frail. Then a medical professional evaluates the questionnaire and, if the applicant is a possible candidate for medical frailty, they obtain additional medical information, which is then reviewed by the state Department of Human Services. Michigan and Arizona have approved waivers that include 'medical frailty' but neither of these states have yet fully developed their protocols for identification of the medically frail.

- **Self-Report**: Ten states (AR, IA, IN, KY, MA, MT, ND, NH, NM, WV)
- **Data Review**: Five states (AR, IA, KY, MI, MT)
- **Administrative Review**: Seven states (CA, IA, KY, MT, ND, NJ, NM)
- **Clinical Review**: Seven states (IA, IN, KY, MT, ND, NJ, NM)

Medical Frailty in ACA Expansion States

State	Self-Report	Data Review	Administrative Review	Clinical Review
Arizona	Pending development of an implementation protocol			
Arkansas	Online screening for conditions/service use predictive of exceptional needs in coming year	Claims monitoring to identify those no longer medically frail		
California			Criteria (Prior Authorization) for Medicaid Long Term Services and Supports (LTSS) are equivalent to 'medical frailty' — no separate assessment	
Iowa	If receive SSDI or assert ADL limitations, individual completes "Medically Exempt Member Survey"	Survey score determines assignment to Medicaid or ABP; retrospective claims analysis by IME on a quarterly basis	DHS employees, mental health regional designees, Iowa Department of Corrections employees may complete survey	Providers with current National Provider Identifier number may complete survey
Indiana	Application screens for qualifying conditions/medical frailty indicators			Managed Care Entity (MCE) verifies medically frail status using claims, lab results, etc., after enrollment; MCE also verifies annually after frailty established
Kentucky	Member self-identification captured by MCO	Health risk assessment results and claims data	Provider identification/referral to managed care organization (MCO); state approval based on evaluation of severity/assigned risk score (underwriting guidelines)	MCO identification via standardized health risk assessment
Massachusetts	Self-identification as having Special Health Care Needs (facilitated by informational materials)			
Michigan		Current health risk assessment identifies 'high utilizers' and may be used for medically frail when waiver amendment effective in 2018		
Montana	Self-attestation is acceptable verification of a special medical need/medical frailty to avoid premium payment; can attest at any time	Annual survey of beneficiaries to assess access to specialty care	Medicaid agency reviews third-party administrator (TPA) reports	TPA conducts risk assessment 90 days after enrollment; refers 'medically frail' to Department of Public Health and Human Services (DPHHS)
New Hampshire	Self-identify having ADL limitations or reside in medical facility or nursing home			
New Jersey			Review of eligibility criteria; hotline assistance by Medical Assistance Customer Center (MACC) staff	"Medically Exempt Attestation" form completed by providers
New Mexico	Self-identification facilitated by MCO counseling		Review of eligibility criteria	MCOs complete health risk assessment (in 30 days)
North Dakota	Medically frail questionnaire		Medical professional review of responses	Client must be examined and submit report by physician
West Virginia	Self-identification facilitated by informational materials			

CONCLUSIONS

The updated investigation found that there remain substantial differences in how states with Medicaid expansion identify their medically frail populations. The findings suggest that these differences may result in state-to-state variation in access to needed services among persons with high levels of medical need. Early data in two states finds that 7% (Arkansas) and 10% (Montana) of the expansion population have status as medically frail and receive full state plan Medicaid instead of the alternative benefit plan.

IMPLICATIONS FOR POLICY OR PRACTICE

The results provide needed information to policymakers in states that have not implemented Medicaid expansion or that want to modify alternative benefit plans while assuring access among vulnerable populations. The picture is complicated by the likelihood that there will be significant legislative changes in the ACA in the near future. If some form of Medicaid expansion still prevails, the likelihood of more state flexibility may well increase the probability that states will implement medically frail provisions. There remains a need for ongoing study of whether medical frailty policies, especially as they differ in application among states, effectively address issues of access for persons with high medical need.