WELCOME
November 13, 2014
This webinar will begin promptly at 1pm ET

LIVING AND WORKING IN THE COVERAGE GAP:
HOMELESS HEALTH CARE
IN STATES YET TO EXPAND MEDICAID

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PRESENTERS

• Host: Dan Rabbitt, MSW, Health Policy Organizer, National Health Care for the Homeless Council, Baltimore, MD

• Judy Solomon, JD, Vice President for Health Policy, Center on Budget and Policy Priorities, Washington, DC

• Jenn Hyvonen, MPC, HCH Director, Fourth Street Clinic, Salt Lake City, UT

• Monique Winters, Community Resource Specialist, St. Joseph’s Mercy Care, Atlanta, GA

• Jeff Driver, Consumer Advisory Board, Downtown Clinic, Nashville, TN
MEDICAID EXPANSION AND HOMELESS HEALTH CARE

• Most people experiencing homelessness were uninsured prior to the ACA
• Few earn enough to qualify for subsidized private insurance through the State/Federal Marketplace
• Medicaid expansion is the main opportunity for new coverage
PROJECT OVERVIEW:
LIVING AND WORKING IN THE COVERAGE GAP

• Interviewed HCH leadership, enrollment staff, and consumers in five cities:
  • Atlanta, GA
  • Houston, TX
  • Manchester, NH
  • Nashville, TN
  • Salt Lake City, UT
• 19 interviews total from May-September 2014
• Focused on finances, billing/enrollment capacity, clinical barriers, and consumer experience
Percent of Visits with Clients Who Have Comprehensive Health Insurance: January 2013 to July 2014

- Atlanta, GA
- Houston, TX
- Manchester, NH
- Salt Lake City, UT
Status of State Medicaid Expansion in 2014
Coverage Landscape in 2014

Medicaid and CHIP coverage, based on 2012 eligibility levels in a typical state
Source: Kaiser Commission on Medicaid and the Uninsured
“Waiver” is a Misnomer

• Section 1115 of the Social Security Act provides authority for demonstration projects

• Allows waivers of certain statutory provisions but only to the extent needed to further the objectives of the demonstration

• Budget neutrality required
  – Costs to federal government no more with the waiver than without

• Transparency requirements added in the ACA
Happening Now: The [State Name] Way to Expansion

• Approved demonstration projects
  – Arkansas Private Option
  – Iowa Marketplace Choice and Iowa Wellness Plan
  – Healthy Michigan Plan
  – Healthy PA

• Pending and forthcoming
  – Healthy Indiana Plan 2.0
  – Healthy Utah Plan
  – New Hampshire Health Protection Program
Common Themes of [Name of State] Approaches

- Use of “private coverage” via premium assistance
- “Personal responsibility” via cost-sharing and premiums
- Incentives for healthy behaviors
- Pushing the limits on waiver authority
  - Premiums and lock-outs for non-payment
  - Work requirements
Some Limits Have Been Set

- Partial expansions, including those with caps on enrollment, do not qualify for enhanced federal match (CMS 12/10/12 guidance)
- “Cost sharing for the expansion and current Medicaid populations. . .must conform to limits as established by statute and regulations.” (Letter from Cindy Mann to VA Secretary of Health and Human Resources)
- “HHS has not generally permitted premiums for populations with incomes below the poverty level.” (Letter from Cindy Mann to President of the Iowa Senate, April 23, 2013)
- Work requirements have never been approved
March 29, 2013 Guidance on Premium Assistance Demonstration Projects

• CMS will consider a “limited number” of premium assistance demonstrations
• Beneficiaries must have a choice of at least 2 Qualified Health Plans (QHPs)
• States must make arrangements with QHPs to “wrap around” Medicaid benefits and cost-sharing
• Demonstrations MUST end no later than 12/31/16
Correcting the Myths About Medicaid

• Opponents rely on a number of myths. Here’s some of the facts:
  – Medicaid is an efficient program.
  – States have a great deal of flexibility in the design of their Medicaid programs.
  – Medicaid expansion is a good deal for states. The federal government will pick up on average more than 95% of the cost over the next ten years.
  – The federal commitment to finance the expansion is stable.
  – Medicaid provides good access to care.
The Benefits of Medicaid Expansion Are Already Evident

• Uninsurance down sharply in expansion states
• Hospitals in expansion states have seen a 47% drop in admissions of uninsured patients
• State budgets
  – State Medicaid spending growing at a lower rate in expansion states
  – Savings in mental health, other areas showing up in state budgets
For More Information

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FOURTH STREET CLINIC

- Stand alone HCH, 25 years, AAAHC Medical Home
- 2013: 50 staff, 150 volunteers, 25,000 visits, 4,100 patients
- Medical, mental health, substance abuse, dental, pharmacy, case management
- 74% uninsured, 94-98% below 100% FPL
- 7.2 million with half in-kind and 20-25% private
- Operate in a Non-Expansion State
THEMES AMONG NON-EXPANSION STATES

• Appropriate care complicated by a lack of insurance
• Heavy reliance on HRSA grants, volunteers & fundraising
• Politicos favor expanding through private options
• Enrollment & billing processes take time/resources to develop
PRIOR TO O&E GRANT

• Eligibility on back end of patient flow
• Provider and MA driven
• High application denial rates
• Long wait times
• High claim denial rates
DEVELOPING ENROLLMENT PROCESSES

• Resourced O&E Supervisor, manages front desk & hired CACs

• Incorporated eligibility screening into patient registration

• DWS Outreach worker office next to O&E Supervisor

• Ready for MedEx due to PCA Database
DEVELOPING BILLING PROCESSES

• Revamped Credentialing Process
• Medicaid Coding Audit
• Training CFO and billers
• 1.5 billers
• Operate multiple sites & use volunteers
NEXT STEPS

• O&E beyond clinic walls
• Coding training for providers
• Feedback loop for from billing to providers
• Licensed Substance Abuse Outpatient Treatment
• Medicaid Pharmacy and Dental
UT MEDEX WAIVER

• Pro that homeless will have access to health insurance

• Pro if Medically frail includes a homeless definition

• Work requirement is now work option

• No Expansion combined with Fiscal Cliff
MONIQUE WINTERS

Community Resource Specialist
THEMES AMONG ENROLLMENT STAFF IN NON-EXPANSION STATES

• Very few individuals experiencing homelessness are found eligible for new coverage options
• Outreach strategies varied; some targeted everyone, some targeted higher income people
• Provided other benefit enrollment assistance
• Provided education on the ACA
• Provided counseling and managed expectations
• Previously eligible but unenrolled consumers still needed a great deal of assistance
MERCY CARE

• Serving Atlanta’s underserved and underinsured since 1985
• 15 Satellite Clinics
• 2 Mobile Coach
• Services Offered:
  Comprehensive Primary Care
  Preventive Care
  Infectious Disease
  Recuperative Care
  Dental Services
  Vision Services
  Diagnostics - X-ray/ultrasound
  Behavioral Health
PATIENTS BY THE NUMBERS

Across all sites in 2013:
12,796 Clinic patients
24,575 Medical visits
8,359 Dental visits
5,229 Mental health encounters
786 Vision encounters
7,972 Enabling service encounters

67% Homeless
83% At or below federal poverty line
95% Uninsured
28% Best served in language other than English
53% Male
OVERVIEW OF O/E PLAN

• 3 Full Time staff members
• Outreach conducted at different partner sites and health fairs
• Community partners; Enroll America, social services agencies, faith based organizations, health departments, etc.
• All individuals lacking health coverage
GEORGIA ACA FACTS

- 316,543 selected Marketplace plans
- #5 in enrollments (Federally Facilitated Marketplace)
- 2\textsuperscript{ND} lowest premiums (Average $54/ with tax credits)
- 87\% of Georgians selected plans w/ tax credit
- 71\% selected Silver plan

SOURCE: HHS, JUNE 2014
MERCY CARE ACA FACTS

• Assisted: 6,418
• Enrolled: 1146 (QHP and Medicaid)
• Out of 5,272 not enrolled, the majority fell into the gap or
  → A select few opted to pay the penalty
  → Employer Coverage
  → Few (3) did not want Medicaid
CHALLENGES AND BARRIERS

• License Requirements
• Lack of Medicaid Expansion
• Website
• Lack of trust in government
• Misconceptions about “Obamacare”
INELIGIBLE CONSUMERS

• Education about the impact of Medicaid expansion

• Emphasizing what services are available to them even without insurance, and emphasizing the low or no copay
SECOND OPEN ENROLLMENT AND FUTURE FOR GEORGIA

- Reaching eligible consumers who did not access coverage last year
- Helping consumers keep and use their coverage appropriately
- Outreach and education throughout local community
- Promoting social change through advocacy opportunities, and safety net partnerships
JEFFREY DRIVER

Member, Consumer Advisory Board
THEMES AMONG HCH CONSUMERS IN NON-EXPANSION STATES

• Very few individuals experiencing homelessness are found eligible for new coverage options
• Some consumers are angry, but more are resigned that they will not receive help
• Misinformation and rumor about the ACA
• Concern about current safety net services continuing
• Maintaining strong relationship with HCH
DOWNTOWN CLINIC

• 4,500 Unique Patients in 2013
• Approximately 16,000 patient visits
• “Typical” Patient has 5 or 6 chronic health conditions and as many as 10 to 12 prescriptions (i.e., Hypertension, Diabetes, COPD, co-occurring addiction and mental health disorders)
• Services: Primary Care, Behavioral Health, Dental, Health Education, Transportation and Case Management, Labs and Referrals to Specialty Care
JEFF’S CHALLENGES GETTING NEEDED HEALTH CARE

- Formulary Issues
- Lengthy process of SSI/TennCare approval
- Long waiting lists for housing/lack of affordable housing stock in Nashville
- Legal Issues/Accessing Legal Aid
- Long waits for specialty care
JEFF’S EXPERIENCE APPLYING FOR HEALTH COVERAGE

• Medicaid (TennCare) tied to SSI in Tennessee (requires legal representation or SOAR)

• Don’t Earn Enough to Qualify for an Insurance Plan through the Exchange.

• Feelings of frustration and marginalization
QUESTIONS AND ANSWERS

For more information

www.nhchc.org
www.cbpp.org
www.kff.org
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