Health Care Reform & Medicaid Expansion:

HCH Lessons Learned from Three States

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NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Today's Presenters

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Overview of Presentation

- Basics of Medicaid Expansion in Affordable Care Act
  - Eligibility
  - Enrollment
  - Current landscape
  - Opportunities and Challenges
- Massachusetts: Insurance Expansions Ahead of the Nation
- Colorado: Adults Without Dependent Children (AwDC)
- New York: Moving Homeless Populations from FFS to Managed Care
- Q&A

Medicaid Expansion: Who Is Eligible?

Currently eligible: children, pregnant women, disabled people, and parents

Newly eligible (starting January 1, 2014): Law expands Medicaid to non-disabled adults earning at or below 138% FPL:

- About $15,000/year for singles
- About $25,500/year for family of 3
- 65% of all HCH patients are uninsured

Also called "childless adults expansion" or "newly eligible group"

Must be a U.S. citizen, or legal resident at least 5 years

Medicaid Enrollment

Current enrollment: ~60 million (includes CHIP)

New enrollment:

Congressional Budget Office: 13 million

Centers for Medicare/Medicaid Services: 18 million

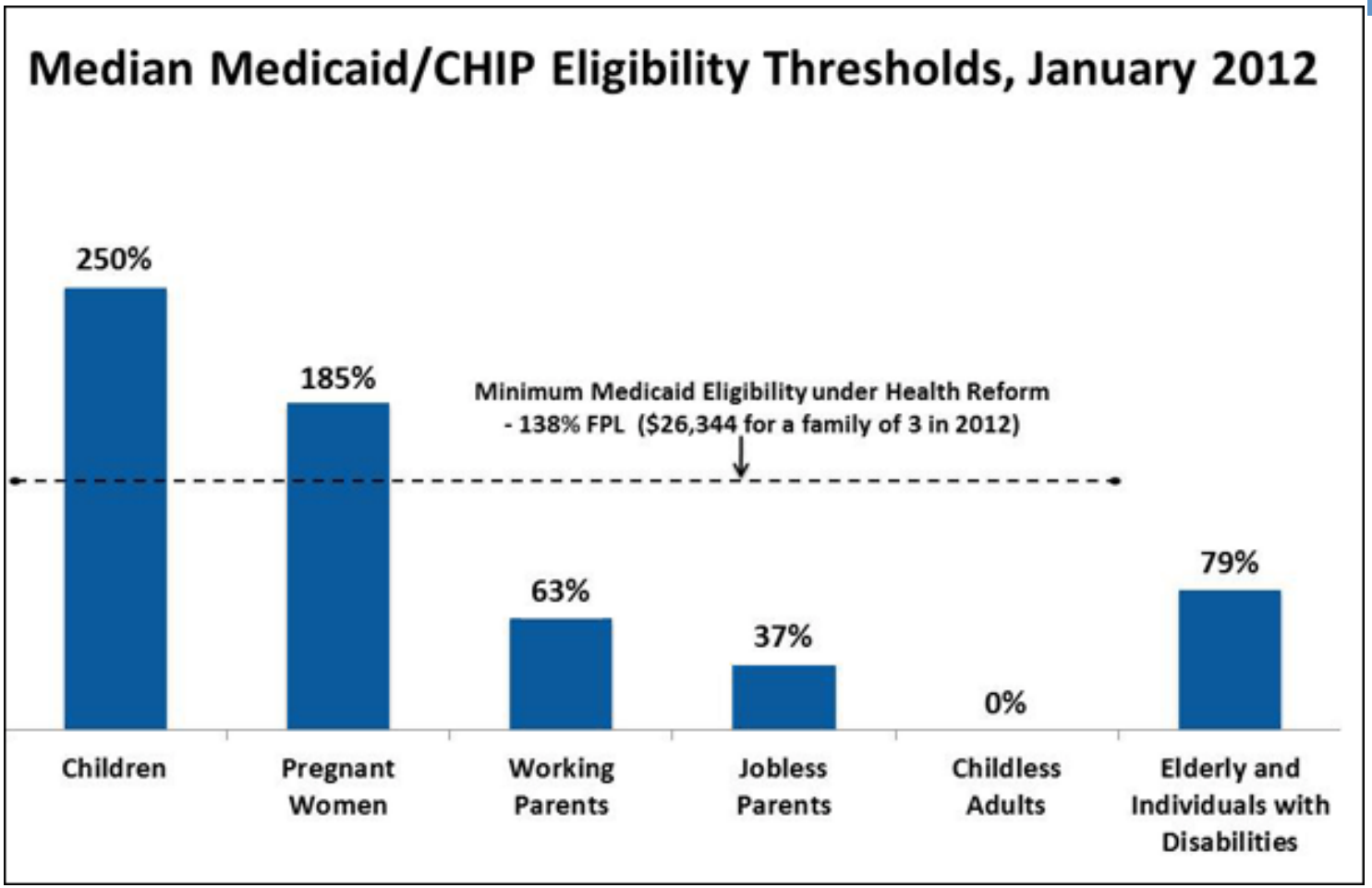
Likely scenario: 13.4 million (range: 8.5 million – 22.4 million)*

Remaining uninsured: 26 million

Medicaid-eligible but un-enrolled: ~30-50%

Undocumented: ~30%

* *Source:* Sommers, B., Swartz, K., and Epstein, A. (November 2011.) Policy makers should prepare for major uncertainties in Medicaid enrollment, costs and needs for physicians under health reform. *Health Affairs* 30:11.



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Improved Enrollment Process

- Move to modified adjusted gross income (MAGI)
  - No asset tests, IRS definition of "household"
- Improved timeliness of determinations
- Electronic verification of income & identity (no paperwork!)
- Permanent address not required
- 12-month automatic renewal
- Application assistance

Current Landscape

- Range of responses at state level
  - 10 Governors pledge not to expand (to date)
  - Medicaid as a political statement
  - November elections
- Series of questions related to SCOTUS decision
  - Impact on current state programs?
  - Phased expansions in 2014?
- State budget constraints
- Proposed Federal policy changes

Opportunities

- Access to health care in community
- Access to specialty care & other needed services
- Enhanced reimbursement
  - Core services
  - Medical respite & PSH
- Coordinated care
- Better health, stability

Challenges

- Outreach & enrollment
- Engagement in services
- Available venues of care
- Adequate service capacity
- Sufficient workforce development
  - Clinical
  - Non-clinical
- Bridging gaps in coverage

Massachusetts

Insurance Expansions Ahead of the Nation

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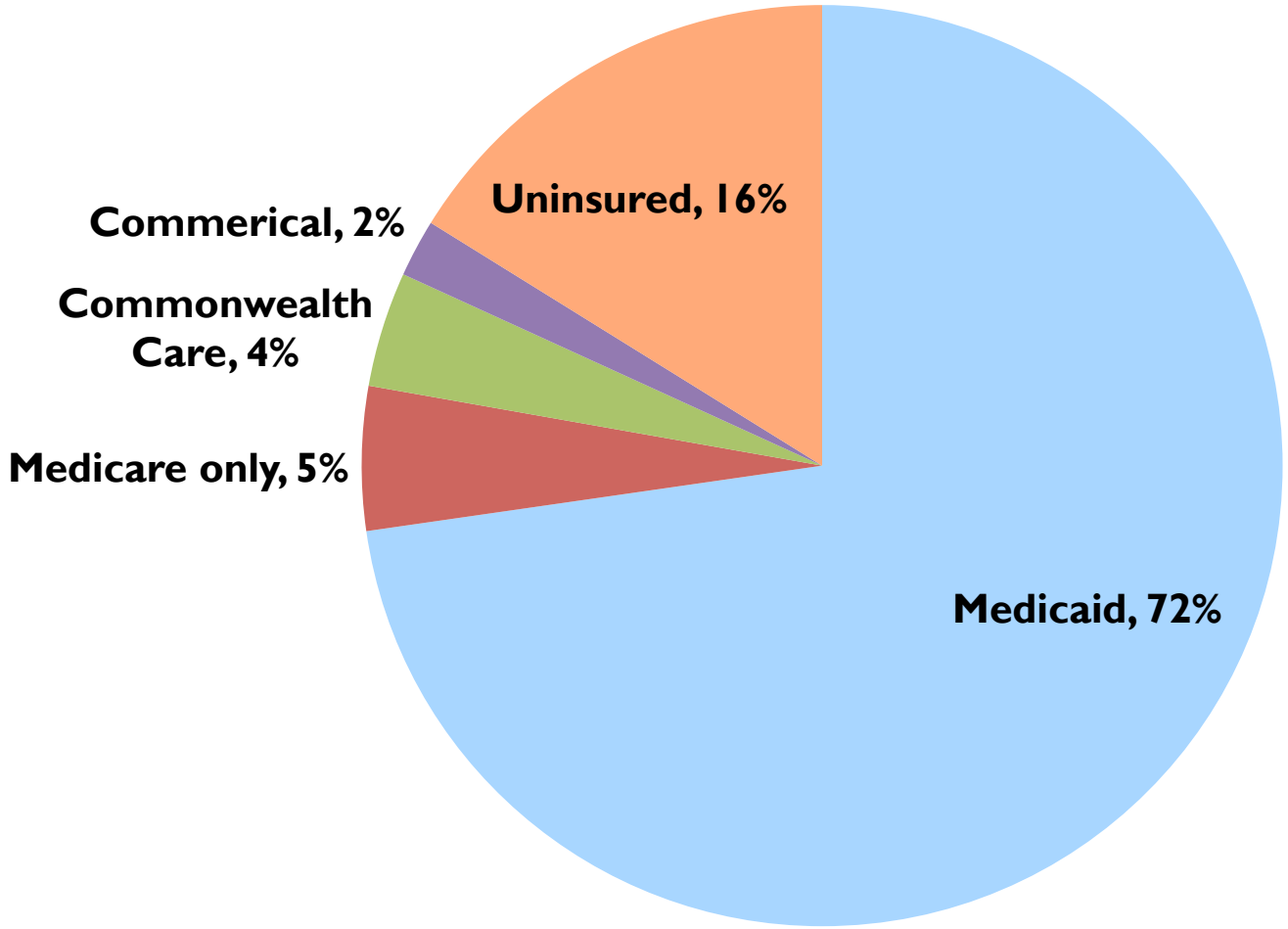
Homeless People Have Had Remarkable Success in Getting and Keeping Medicaid Benefits: CY 2011



It Happened Incrementally In Massachusetts: 1996 – 2006

- **1996:** 1115 waiver expansion
  - Doubled enrolled homeless adults from 30% to 65%
- **2004:** State electronic application portal
  - Faster, simpler application process
  - Single pathway to the highest eligible benefit
- **2006:** "RomneyCare"
  - Replaced categorical requirement for Medicaid with simpler income threshold
  - Further increased enrolled homeless adults fom 65% to 75%

Pre-conditions for Success in Massachusetts Partnership with Medicaid

- **Attitude:** Shared goal to make it easy to enroll people if they're eligible & eliminate barriers
  - Historically at Massachusetts Medicaid
  - Appears to be true at CMS at this time
- **Awareness:** Understand that homeless people are at risk of disparities in enrollment *just because they are homeless*
  - Enrollment system accommodation to homelessness is necessary
- **Partnership:** Medicaid operations leaders and advocates tracked outcomes; identified and fixed problems

Enrollment and Plan Assignment
Two Separate but Related Processes

- **Enrollment:** Getting eligible people approved for entitled benefits
- **Assignment to Health Plans:** Getting people who are approved for benefits enrolled with the health plan that can best serve them
- **Two separate processes in Massachusetts:** A response to earlier abuses reported in other places

Successful Enrollment Strategies: Not Rocket Science

- Boston HCH Actions
  - Submitted initial applications for our patients all sites with front desks when patients came to us for care
  - Worked with shelters to publicize new eligibility
  - Sent enrollment specialists to shelters in the evening and enrolled anyone who wanted our help
  - Listed ourselves as the person assisting in the application for follow-up and got copies of follow-up correspondence from Medicaid
  - Built a tracking system and entered information to track our applications

Successful Enrollment Strategies (cont' d): Not Rocket Science

- Workgroup from Medicaid Customer Service Operations Staff (authorized/mandated) and Advocates:
  - Met monthly and conducted a number of PDSA Cycles
  - Talked through expected problems and needed accommodations
  - Tracked results to get baselines and measure progress
  - Identified and drilled down on unexpected results

Successful Plan Assignment Strategies

- HCH staff educate patients in understanding the limitations and differences between different plans.
  - Clinical staff must understand and assist
- Allowing/Protecting maximum freedom for enrollees to switch out of plans that do not serve their needs well

Summary: Massachusetts Lessons Learned

- Expansions have been successful, but disparities remain
- It happens best with a willing Medicaid partner – invest in partnership building
- It requires HCH staff to roll up their sleeves.
  - Our deep involvement is both necessary for success and a good investment of our resources
- Success in enrolling patients in Medicaid provides a significant revenue stream to expand HCH capacity and services
  - And being able to continue to serve them through Medicaid plans
- It matters
  - It's good for patients
    - It moves us closer to health care justice
      - It doesn't require a negative change in clinical practice

Colorado

Adults Without Dependent Children Medicaid Expansion in April 2012

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Background

Colorado Health Care Affordability Act, 2009

- Charges 6.0% of net patient revenues to hospitals
- $50 million in fees offset General Fund expenditures for Medicaid
- Increases Medicaid inpatient hospital payments to 100% Medicare rates
- Increases Medicaid outpatient hospital payments to 100% of costs

Background

Colorado Health Care Affordability Act, 2009

- Establishes quality incentive payments to improve quality of care
- Expands coverage to low-income children and pregnant women
- Provides health care coverage for low-income, uninsured adults (AwDC)
- Provides Medicaid Buy-In Program for persons with disabilities

Background Prep

- 15 stakeholder meetings in 2009 & 2010
- 5 client focus groups in 2010
- 1 official stakeholder advisory committee

"Clients will have high needs and require case management"

Lessons from Other States

- More applicants than expected
  - *Oregon Lottery 2008: 90,000 for 10,000 slots*
- Likely to have multiple chronic conditions
- Needs and costs "are more like adults with disabilities than parents," particularly at the lowest income levels
  - *Oregon: 33% reported a disability prevented job access vs. 11% of parents*
  - *2x hospital admissions and ER visits*
  - *3x the mental health/STS visits*

Colorado Target Population*

	Estimate of Uninsured ≤ 100% FPL	Estimate of Uninsured ≤ 10% FPL
2009	143,191 people	49,511 people
2008	117,475 people	na

* 3-year-old data; estimates expected to be lower than need

Cost Estimates & Total Funding

- 2011/2012 & 2012/2013: $190 million
  - $95 million in hospital provider fees
  - $900 per month, per person
- To 10% FPL (without enrollment cap): $770 million
- To 100% FPL: $1.75 billion
- January 1, 2014: all those eligible under 133% FPL at 100% federal funds

CMS Waiver

- 1115 Demonstration Waiver through 12/31/2013
  - Income limit ≤ 10% FPL
  - Enrollment cap and waitlist
  - Flexibility to expand income limit and enrollment cap if budget allows

- Applicant to receive:
  - Regular Medicaid benefits
  - Mandatory managed care enrollment in a Behavioral Health Organization and the Accountable Care Collaborative

Eligibility

- Adults (19 to 64) who do not have a Medicaid-dependent child
- Must be at or below 10% of the Federal Poverty Level
  - $90 per month per individual
  - No resource limit
  - Some unearned income excluded: SNAP & temporary disability (AND)
- Cannot be eligible for other Medicaid program or Medicare

Benefits, Co-Pays & Care Management

- Benefits begin on the first day of the enrollment month
- Beneficiaries receive the same regular Medicaid benefits as other Medicaid clients
  - Mental health services delivered through a Behavioral Health Organization
- Pay the same co-pay as current Medicaid beneficiaries
- Are mandatorily enrolled into a Regional Care Collaborative Organization

Benefit Package

- Comparable to private insurance
- Includes physician care, hospitalization, emergency care, radiology, lab, medications, mental health services and substance abuse services
- Excludes services provided through home and community-based (HCBS) waivers
- Redetermination, Reassessment and Recertification (RRR) done one year from enrollment date

Selection Process

- Limited to 10,000 eligible individuals
- Applications accepted April 1, 2012 and placed on a wait list through May 15, 2012
- Randomized member selection process identifies new AwDC enrollees on May 15, 2012
- Process continues each month to reach and sustain a total of 10,000 enrollees

Selection Process

- Current enrollment at about 8,000 *(as of July 11, 2012)*
- Wait list is unlimited – individuals remain on list until position opens
- All waitlisted applicants to be enrolled January 1, 2014

Concerns

- Inappropriate denials
- Electronic benefits management system programming
- Data entry errors (transmitting content from paper applications)
- Physical correspondence to applicants
- Co-pays
- Medications
- Client fears

Policy Outlook

"The court's decision simply keeps Colorado on the path toward reform we've been on since the Affordable Care Act became law." – *Colorado Governor John Hickenlooper*

"The only bright spot in the ruling was the edict that states can't be forced to go along with the Medicaid eligibility expansions." - *Colorado Attorney General John Suthers, one of 26 AGs losing their suit to overturn the Act*

New York

Moving Homeless Populations from FFS to Managed Care

Debbian Fletcher-Blake, APRN, FNP; Assistant Executive Director, Care for the Homeless, New York

Doug Berman, MS; Senior Vice President of Policy, Harlem United, New York

NYC Homeless Population & Managed Care

- **42,986** homeless persons in the NYC shelter system on July 16, 2012; **110,112** unduplicated homeless persons in NYC for FY2011
- Population Breakdown as of July 12, 2012:
  - Families with Children: 30,457
  - Single Adults: 8,949
  - Adult Families: 3,453
- Over 215 shelter facilities in the Department of Homeless Services (DHS) system
- NYC Providers of Health Care for the Homeless (PHCH) serves approximately 85% of the homeless population
- All homeless persons eligible for Medicaid, but exempt from managed care
  - 60% of patients enrolled in Medicaid
- Fee for service preserved a flexibility that dealt with transience

Managed care potentially beneficial for transient population:

- Continuity of care across the patients' life span and range of supportive services
- Avoid duplication of diagnostic services
- Avoid Rx contraindications
- Access to patient medical history, especially for people who may not be medically fluent or are cognitively dysfunctional and highly transient
- Homeless population known as high cost/high use population, targeted for health home participation
- NYS had a 10 year history with Medicaid Managed Care

Policy vs. Experience:
How to ameliorate operational restrictions, reduce access barriers and ensure provision of necessary care?

- Even before initial stages of state process, PHCH engaged key stakeholders from state and city agencies and educated them on the practice of HCH clinics
- Examined how managed care contract terms did not align with HCH experience
- Compiled these issues in a single document that outlined potential problems and suggested modifications to ensure access, comprehensive services, and smooth enrollment into new care delivery system
- Widely disseminated PHCH document to all stakeholders
- Collaborative process resulted in State Department of Health guidance for homeless patients attached to MCO contracts

Recommendations: Enrollment/Disenrollment and Phase-In

- Phase in by borough and subpopulation
  - Begin in boroughs with smallest homeless populations to spread out the financial burden of the transition
  - By subpopulations with the most managed care experience
- Cultivate alternative mechanisms for outreach and communication
- Match patient Medicaid data with Department of Homeless Services, Human Resources Administration and NY Medicaid Choice data
- Allow HCH providers to be designated representatives for patient enrollment
- Include HCH providers in outreach and education activities
- Allow for easy switch of plans to accommodate transience
  - Broaden definition of "Good Cause Disenrollment"
  - Eliminate post 90 day "lock-in period"

Recommendations: Access to Services

- Suggested accommodations that allow clients to be enrolled at point of care
  - Allow for presumptive authorization of initial visit and urgent care
  - Bill patients as Fee-For-Service during initial visit (or new provider) and early follow up – until patient more permanently sheltered
  - Reimburse provider for initial services even if he/she does not participate in the patient's MCO
- Allow patients to change their PCP as often as necessary by removing limitations
  - Plans should effectuate changes immediately to allow for reimbursement for service at point of care

Recommendations: Contracting and Credentialing

- Require MCOs to contract with all 330(h) agencies and expedite process
- Expedite the credentialing of HCH providers to ensure preparedness for April 1 implementation
- Concurrent to NYS Department of Health process, PHCH monitored the readiness of plans and providers
  - Measured readiness by the number of fully executed contracts and the number of providers credentialed

Pre-conversion Process

- Educate Shareholders
  - Managed care plans do not understand the complexities in health care for homeless people
  - The States mandate, but do not have the expertise or knowledge about health care for homeless people
  - Patients view these changes as working against their needs if they are not properly informed and may not participate fully
  - The staff must be engaged early in the process and be fully educated to disseminate and execute the changes
    - This will yield staff buy-in

Collaboration

- Healthcare Providers cannot succeed alone.
- Must engage State Officials, community partners and Medicaid officials
- The importance of culturally competent healthcare for homeless and indigent populations must be realized at high levels.
- Get to know the people you are working with and collaborate with them

Advocacy

- This is constant
- Work with MCO's and Medicaid officials as advocates not adversaries.
- Be clear what the expectations are and advocate fiercely

Follow up

- Make this a priority
- As problems are identified, it is imperative to follow up immediately with the right people.
- Develop strategies for immediate follow up early in the process

Problem solve

- Look for solutions/work around to ease your operational burdens (staffing, training, work force development, workflows, contracting, credentialing, etc.)

CONVERSION PROCESS

- Continue the pre-conversion process
- Corrective action for pre-conversion problems
- Get involved in patient benefits enrollment
  - Work with enrollers when available, or directly work with patients to enroll them in managed care plans
- Continue to meet and discuss issues with stakeholders for extended period of time

Lessons Learned

- Reach out to everyone who will be involved
- Educate early and FOLLOW UP
  - Know exactly what is needed
  - Make yourself the centerpiece of these operations
- Be the ones to drive the process
- Readiness is key for a successful implementation
- Monitor implementation on a weekly basis

Questions?

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More Information on the Council

The National Health Care for the Homeless Council is a membership organization for those who work to improve the health of homeless people and who seek housing, health care, and adequate incomes for everyone.

- www.nhchc.org
- Health reform materials: http://www.nhchc.org/policy-advocacy/reform/
- *Forthcoming:* Policy Brief related to Medicaid expansion
- Free individual memberships at: http://www.nhchc.org/council.html#membership
- Technical assistance available
- Other resource: www.healthcare.gov