

STATE OPTIONS FOR MEDICAID EXPANSION

POLICY BRIEF

JULY 2011

POLICY BRIEF OVERVIEW

The Patient Protection and Affordable Care Act (ACA) expands the Medicaid program to include approximately 16 million individuals with incomes at or below 133% of the Federal Poverty Level (FPL) starting in 2014 (or earlier at state option). For this new population, states will initially receive 100% federal medical assistance percentage (FMAP), to be phased down to 90% by 2020. Currently, many of those experiencing homelessness are uninsured because Medicaid is generally not extended to childless adults. In 2009, about 827,000 individuals received health care and/or other services from Health Care for the Homeless federally qualified health centers and 70% of these patients were uninsured. Hence, the new Medicaid expansion is the largest benefit to very low-income adults contained in the ACA.

This policy brief will describe two different expansion options, detail several states that have already implemented these options, and provide a state-by-state chart indicating which states are currently operating Medicaid programs that implement these options.

Overview of Two Expansion Options

Many states view early expansion as a means of easing the transition of newly eligible individuals into the Medicaid program, thus minimizing the enrollment burden in 2014. States are authorized to carry out early expansion efforts under two different statutory provisions. One option is through Section 1902(k)(2) of the Affordable Care Act (ACA) and the second is through Section 1115 of the Social Security Act.

Under ACA Section 1902(k)(2), states may expand Medicaid to low-income single adults earlier than 2014. This option provides states with an opportunity to cover previously non-mandatory groups who will become eligible in 2014.

Under Section 1115 of the Social Security Act, states can apply for a waiver proposing demonstration projects and thereby waive certain federal Medicaid provisions. Section 1115 waivers are commonly used to expand coverage, increase benefits, and/or implement innovative models of care that often aim to reduce state costs.

1902(k)(2) State Plan Amendment

Section 1902(k)(2) of the ACA allows states to “phase-in” coverage for low-income childless adults at any time before 2014.¹ States that adopt the new 1902(k)(2) coverage option will receive federal matching payments at their regular FMAP rather than at the 100% rate, which will not be effective until 2014. States can set the income eligibility standard for the new group at any level up to 133% FPL.

In order to implement the 1902(k)(2) option, states must submit a state Medicaid plan amendment to the Centers for Medicare and Medicaid Services (CMS). Prior to this provision, states were required to submit an application for a waiver, a much more arduous process. At the time of this publication, two states (Connecticut and Minnesota) and the District of Columbia have taken advantage of early expansion under the 1902(k)(2) option. Connecticut and DC had previously been providing coverage to low-income childless adults using state/district-only funding. Since implementing early expansion, they are now able to offset expenses with federal funds.

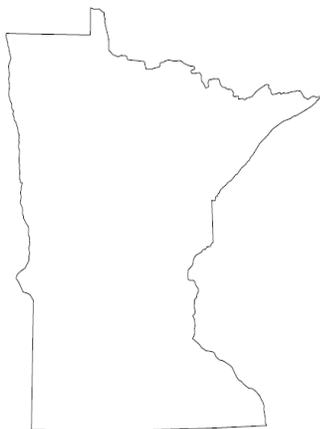
Section 1115 Demonstration Waivers

Under Section 1115 of the Social Security Act, the Secretary of HHS is permitted to waive certain provisions of the Act for states that wish to implement coverage initiatives for research and demonstration purposes. States may seek an 1115 waiver rather than making a state plan amendment in order to waive certain program requirements to test innovative models of care or payment systems. Waivers can provide states with more flexibility to tailor their Medicaid programs to local needs. Though not mandated by law, 1115 waivers must demonstrate budget neutrality under Medicaid policy requirements, meaning that federal Medicaid expenditures under the waiver must not exceed federal expenditures for a state in absence of the waiver. Further, 1115 demonstration waivers are subject to a cap on the amount of federal funding for the selected Medicaid expenditures during the waiver demonstration period; the state is responsible for any incurred costs that exceed the federal cap.²

Though waivers can expand coverage, waivers can also be used to limit services or develop new payment and oversight mechanisms that may or may not be advantageous to vulnerable populations. Under the ACA, the waiver approval process will become more transparent, thereby allowing for increased public input. The new legislation also includes a Maintenance of Effort (MOE) component, which requires that states uphold any eligibility parameters that were in effect on March 23, 2010 when health reform was enacted.³ States that violate the MOE requirement will lose their federal match unless they can prove that they are facing a budget deficit. States that wish to expand using a Section 1115 waiver must submit a proposal to CMS detailing program objectives, eligibility requirements, projected budget neutrality, and funding streams.

State Examples

MINNESOTA: Expanded Coverage to State's Most Vulnerable



In February 2011, Minnesota gained approval to expand its Medicaid program to single adults with incomes at or below 75% FPL under Section 1902(k)(2) of the ACA.

Expansion officially began on March 1, 2011 and is expected to transition 12,000 uninsured individuals and approximately 83,000 enrollees from two state-funded programs – General Assistance Medical Care and MinnesotaCare – to Medical Assistance (MA), the state's Medicaid program.

Early Medicaid enrollment will bring in approximately \$1.1 billion in federal funds over the next two years.⁴ The newly expanded program provides more comprehensive benefits and requires lower co-pays than the two previous state-funded programs. Additionally, MA coverage may go back three months from when the MN Department of Human Services receives an individual's written request for coverage, in the case that s/he has acquired medical expenses during those prior months.

Co-pays are minimal under the MA program. For example, co-pays for nonemergency health care visits are \$3.50 and prescriptions are \$1 with no co-pay for some mental health prescriptions. In addition, monthly co-pays are limited to 5% of a family's monthly income for low-income families. While some MA enrollees are required to pay co-pays, individuals who are unable to pay may still receive services. Providers are not permitted to ask for an individual's proof of inability to pay.⁵

DISTRICT OF COLUMBIA: Hybrid Options Striving for Universal Coverage

The District of Columbia implemented the 1902(k)(2) option in 2010 when Medicaid coverage was expanded to childless adults with incomes at or below 133% FPL. Prior to this expansion, some low-income childless adults received limited health care benefits through the HealthCare Alliance program, which operated on District-only funds. A 2009 survey of uninsured adults in DC found 55% were not aware of public coverage options, and about 33% did not know how to enroll in the programs.⁶ Because of this, DC's Office of the Health Care Ombudsman and Bill of Rights plans to use funds to support aggressive education and outreach efforts.⁷ In July 2010, approximately 32,000 Alliance enrollees were transferred to the newly expanded Medicaid program. The District acknowledged, however, that covering individuals at or below 133% FPL was not sufficient to achieve its goal of universal coverage, which

led DC policymakers to pursue a Section 1115 waiver in order to expand Medicaid coverage to individuals with incomes between 134 and 200% FPL. On average, DC previously spent approximately \$200 per enrollee per month; however, with the combination of Medicaid expansion and adding an 1115 Waiver, DC's Medicaid expenditure is nearly cut in half, totaling about \$105 monthly per enrollee.⁸ Local savings are expected to total approximately \$66 million over the next four years, making this a cost-effective combination of expansion options.⁹

LOUISIANA: Filling Service Gaps in the Wake of Devastation

Prior to August 2005, the United Health Foundation ranked the state of Louisiana last in the nation for its health care based on a set of behavioral, clinical, community, and policy-related measures.¹⁰ In addition to poor health care, the city of New Orleans had one of the country's highest rates of uninsured individuals.¹¹ The majority of the uninsured in New Orleans relied on the public hospital system for provision of care. Inpatient and outpatient care in the public system was delivered almost entirely at a centralized complex in or associated with the large Charity Hospital. Following Hurricane Katrina, however, the health care system in the Greater New Orleans area was left in shambles. Charity Hospital permanently closed its doors and many health care workers were unable to return to New Orleans following the storm. Immediately following Hurricane Katrina, homelessness increased by 325 percent.¹²

In order to address the serious issues surrounding Louisiana's struggling health care system, the Department of Health & Hospitals obtained a Primary Care Access and Stabilization Grant (PCASG) from the US Department of Health and Human Services in 2006, which increased access to primary care to the four parishes of the Greater New Orleans area (Jefferson, Orleans, Plaquemines, & St. Bernard). The PCASG program saw tremendous success, facilitating the provision of services to approximately 175,000 people each year.¹³ The PCASG clinics have become important sources of care for a largely disadvantaged population that has historically relied on the public

hospital system and emergency rooms for primary care. As the September 2010 expiration date for the grant approached, Louisiana pursued an 1115 waiver.

Louisiana's 1115 waiver – the Greater New Orleans Community Health Connection (GNOCHC) – is effective through December 31, 2013. Under the GNOCHC program, coverage is extended to nonpregnant adults ages 19 to 64 who have been uninsured for at least six months, have incomes at or below 200% FPL, and live in the four parishes included in the Greater New Orleans area. This waiver is an opportunity to build upon the success of the federal PCASG program that has already resulted in a stronger, more efficient and coordinated healthcare delivery system. The state hopes that the waiver demonstration will generate valuable information and data that can be used to plan for and fully implement Medicaid expansion in 2014. Louisiana expects that the waiver will save up to \$30 million per year of the state's unspent Medicaid Disproportionate Share Hospital allotment.¹⁴

CALIFORNIA: Building a Bridge to Health Care Reform



Using an 1115 waiver in 2007, California implemented the Health Care Coverage Initiative (HCCI) in ten participating counties to increase coverage options for uninsured Californians. A subsequent 1115 waiver was approved in 2010 and acts as a bridge to full Medicaid expansion in 2014. Former Coverage Initiatives (CIs) are now Coverage Expansion and Enrollment Demonstration projects (CEEDs) and all counties are eligible for participation. The new waiver creates the Low-Income Health Program (LIHP) which permits coverage of childless adults up to 200% FPL; individuals with incomes at or below 133% FPL are covered under the Medicaid Coverage Expansion (MCE) program, and adults with incomes between 134% and 200% FPL may receive coverage under the remodeled Health Care Coverage Initiative.¹⁵ The new 1115 waiver mandates that California develop and implement a detailed plan to make a smooth transition into expanded Medicaid coverage in 2014. As such, the waiver includes action steps to expand the program to additional counties and to enroll newly eligible individuals in coverage programs.

Participation in the demonstration is open to all counties throughout the state, provided that there are sufficient county funds available to implement expanded coverage efforts (for the state-funded portion of Medicaid services). Initial approval has been granted to each of the state's 58 counties. As many as 455,000 uninsured individuals may be eligible for enrollment under the LIHP initiative. Participating counties have the option of providing coverage for MCE enrollees only or implementing both MCE and HCCI coverage.¹⁶ Unlike the HCCI program, however, federal match funds for covering MCE individuals are not subject to a cap. This is due to the new 1902(k)(2) state option, which allows states to cover adults with incomes at or below 133% FPL as an optional group without the use of a waiver. California expects to receive approximately \$8 billion in federal funds in order to implement the multifaceted demonstration project, making this the largest Section 1115 waiver in the nation.¹⁷

Discussion

As can be seen in **Table 1**, close to half of all states are using either 1902(k)(2) state plan amendments or Section 1115 waivers (or both, in the case of Washington DC) to provide care to additional vulnerable populations who are otherwise ineligible for coverage. While FPL standards vary considerably across states, a total of 14 states offer coverage for individuals between 100 and 150% FPL, and as many as eight states cover adults with incomes up to 200% FPL under certain circumstances.

State budgetary constraints and caps placed on federal funds for demonstrations have caused some states to stop enrolling new participants (e.g., Wisconsin) or temporarily implement wait lists (e.g., Indiana). For most states, eligibility is state-wide; however, some states (e.g., Louisiana, Missouri) have opted to expand coverage incrementally only to individuals living in certain cities and counties. In the case of California, the state's original Health Care Coverage Initiative expanded coverage only to adults living in one of 10 participating counties. However, the newest Section 1115 waiver deems all counties eligible for participation in the program.

While the majority of state expansion efforts do not expire until 2013, some states (e.g., Arizona, Maryland, Massachusetts) are nearing their waiver expiration dates. States renewing their waivers should include strategies to minimize costs and make the 2014 transition as smooth as possible. A few states have already incorporated detailed transitioning efforts into their most recent waiver renewals. These efforts include outreach initiatives and incremental coverage expansion for the state's most costly and vulnerable populations. Beginning in 2014, states will be allowed to use their federal match to conduct outreach in order to reach uninsured and underinsured individuals who are newly eligible for coverage. In order to lessen a potential enrollment burden in 2014, states should consider a 1902(k)(2) state plan amendment or 1115 waiver to expand Medicaid early and implement assertive outreach efforts prior to 2014. Vermont, California, and Iowa are just a few of the states that have incorporated outreach efforts into their Section 1115 waivers.

Upon expansion, states may see an increase in health care utilization particularly by those with complex chronic health conditions who have withheld seeking treatment for lack of insurance. Costs associated with increased health care utilization are likely to be offset by reduced hospitalizations as newly insured patients gain health stability.¹⁸ To further minimize costs, states should consider innovative and cost-efficient programs effective in meeting the needs of these groups. For people experiencing homelessness, such programs include permanent supportive housing and medical respite care. Permanent supportive housing is an approach to subsidized housing designed for people with very low incomes and chronic, disabling health conditions which provides access to a comprehensive array of supportive services. Studies on permanent supportive housing show up to a 62% decrease in hospitalizations after placement and a 50% decrease in nursing home days.¹⁹ Medical Respite care is acute and post-acute medical care for homeless persons who are too sick to be on the street but not sick enough to be in the hospital. Studies on medical respite care show homeless patients discharged to a medical respite program experienced a 50% decrease in hospital readmissions at 90 days and 12 months after program participation compared to patients discharged to their own care.²⁰

Table 1: Overview of state expansion programs

State	Program Name	Expires	1115	1902(k)(2)	Group Coverage Parameters
Arizona	Arizona Health Care Cost Containment System	9/30/2011	X		Individuals with adjusted net countable income at or below 100% FPL who are not otherwise eligible for Medicaid
California ²¹	Bridge to Reform	12/31/2013	X		<i>Medicaid Coverage Expansion:</i> Non-pregnant adults ages 19 to 64 with incomes at or below 133% FPL; <i>Health Care Coverage Initiative:</i> Non-pregnant adults 134-200% FPL (or less based on participating county income standards) otherwise ineligible for Medicaid
Connecticut	Medicaid for Low-Income Adults			X	Single adults and married couples whose income does not exceed 56% FPL; for individuals living in Region A (mostly Southwestern CT), income-eligibility limit is 68% FPL
Delaware	Diamond State Health Plan	12/31/2013	X		"Uninsured Adults Expansion" group: Aged 19 and older with incomes up to 100% FPL
District of Columbia	District of Columbia Childless Adults	12/31/2013	X		Low-income adults with incomes between 134-200% FPL who live in DC, have no other health insurance, cannot get Medicaid or Medicare, and have belongings and savings of less than \$4,000 for 1 person or \$6,000 for couples or families
	Medicaid Expansion			X	Medicaid expansion newly eligible adults ages 19 to 64 with incomes at or below 133% FPL
Hawaii	Hawaii QUEST	6/30/2013	X		Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid with incomes at or below 100% FPL; Childless adults who meet Medicaid asset limits with incomes at or below 100% FPL
Indiana	Healthy Indiana Plan	12/31/2012	X		Non-custodial parents and childless adults (19-64) with incomes below 200% FPL who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare
Iowa	IowaCare	12/31/2013	X		Adults (age 19-64) between 0% and 200% FPL who are not eligible under Medicaid State Plan
Louisiana	Greater New Orleans Community Health Connection	12/31/2013	X		Individuals who are uninsured for at least 6 months, not pregnant, between 19 and 64 years old, not eligible for Medicaid, CHIP, or Medicare, reside in one of 4 participating parishes, and have a family income up to 200% FPL
Maine	MaineCare for Childless Adults	12/31/2013	X		19- and 20-year-olds at or below 150% FPL with assets no more than \$2,000; Childless adults (ages 21-64) up to 100% FPL who are not disabled and whose assets don't exceed \$2,000 for individual, \$3,000 for couple
Maryland	Primary Adult Care Program	6/30/2011	X		Childless & non-custodial adults ages 19 and above, not otherwise eligible for Medicaid, Medicare or SCHIP, with incomes at or below 116% FPL
Massachusetts	MassHealth	6/30/2011	X		Adults who are long-term unemployed with incomes at or below 100% FPL and who are not eligible for MassHealth Basic
Michigan	Medicaid Nonpregnant Childless Adults Waiver	9/30/2014	X		Childless adults with incomes at or below 35% FPL who are not otherwise eligible for Medicaid or Medicare
Minnesota	Medical Assistance			X	Adults ages 21-64 without children who have incomes at or below 75% FPL

State	Program Name	Expires	1115	1902(k)(2)	Group Coverage Parameters
Missouri	Gateway to Better Health	12/31/2013	X		Uninsured individuals, ages 19 through 64, residing in St. Louis City or St. Louis County, with family incomes between 0 and 133% FPL who do not meet eligibility requirements of the Medicaid State plan
New Jersey	New Jersey Childless Adult Expansion	12/31/2013	X		Low-income adults aged 19-64 who are not eligible for traditional Medicaid and who may not be able to get private coverage
New Mexico	New Mexico State Coverage Insurance	9/30/2014	X		Uninsured, low-income adults, ages 19 to 64, with countable family incomes of up to 200% FPL, who are not eligible for other public or private health insurance programs such as Medicaid, Medicare, and TRICARE
New York	NY Partnership Plan	4/30/2010	X		Uninsured childless adults with gross incomes at or below 100% FPL and resources not exceeding 150% of the medically needy Medicaid income standard
Oregon	Oregon Health Plan 2	10/31/2013	X		Population 11: Childless adults ages 19 through 64 with incomes up to 100% FPL will be enrolled in OHP Standard; Population 18: Uninsured childless adults who are not eligible for Medicaid/Medicare with incomes from 0 to 200% FPL who are enrolled in FHIAP
Rhode Island	Global Consumer Choice Demonstration	12/31/2013	X		Services for uninsured adults with mental illness or substance abuse problems not eligible for Medicaid; Limited benefit package for low-income adults eligible for the state's General Public Assistance program, ages 19-64 who are unable to work due to a variety of health conditions, but don't qualify for disability benefits
Utah	Utah Primary Care Network	6/30/2013	X		Adults ages 19 through 64 who are U.S. citizens or legal residents, are not covered by other health insurance, not qualified for Medicaid, and do not have access to student health insurance, Medicare or Veterans benefits
Vermont	Vermont Global Commitment to Health	12/31/2013	X		Demonstration Population 5: Childless adults with income up to and including 150% FPL
Washington	Transitional Bridge Demonstration	12/31/2013	X		Non-pregnant individuals ages 19 through 64 who have countable incomes up to and including 133% FPL who have not been determined to be eligible for Medicaid and who are currently enrolled, or become newly enrolled, in the following state programs: Basic Health; Disability Lifeline; or Alcohol and Drug Addiction Treatment & Support
Wisconsin	BadgerCare Plus Health Insurance for Childless Adults	12/31/2013	X		Adults without dependent children, between the ages of 19 and 64 and with incomes that do not exceed 200% FPL

Conclusion

Many states are struggling with budgetary shortfalls, which have led to a heightened concern about the Medicaid expansion and potential state cost increases. The Congressional Budget Office, however, predicts that states will incur only modest cost increases – around 1.25 percent over five years – due to the significant increase in federal contributions for those newly eligible.²² Low-income childless adults who have no insurance often use costly inpatient and hospital services, thus increasing public cost for this uncompensated care. With Medicaid expansion, however, these public costs will be greatly reduced, thereby offsetting the modest cost increase incurred by states.

Waivers and state plan amendments can assist states in implementing innovative models of care to expand access to health insurance. Medical respite care programs and permanent supportive housing (PSH) projects are two potential avenues specific to individuals experiencing homelessness that can provide the medical and support services needed in order to improve health status, reduce high-end systems use, and stabilize individuals in the community. States can make a very strong argument for using the Section 1115 waiver to pay for cost-efficient medical respite and PSH services in lieu of more costly hospital inpatient stays.

Early expansion options like the Section 1902(k)(2) state plan amendment and the Section 1115 waiver offer states opportunities for innovative coverage during health care reform. Not only do these options provide states with revenue support, but they may also facilitate life-saving health care coverage to some of the nation's most vulnerable individuals.

Recommendations

- States should consider the 1902(k)(2) early expansion option in order to receive federal matching funds. With additional federal funding, those states that have already expanded but are using only state funds will free up state dollars that can then be used for expanded eligibility criteria or coverage. Savings will also be realized for states that have not yet expanded. By expanding coverage now, these states can implement preventive care programs offered through Medicaid, avoiding more costly hospitalizations in the future. Further, states that elect to expand early will experience fewer instances of uncompensated care and will avoid expenses related to unemployment and disability experienced by those who become too ill to continue working.
- States should adopt outreach and enrollment strategies known to work among homeless populations. These strategies include peer-to-peer, community-wide multi-agency collaboration, and site-specific (e.g., hospitals, homeless shelters) outreach efforts. States should consider stationing outreach and enrollment workers at Health Care for the Homeless projects or at other service sites. Employing Community Health Workers may also be beneficial in providing aggressive outreach to educate eligible individuals on benefits acquisition.
- To reduce health care costs for people who are experiencing homelessness, states should use Section 1115 waivers to implement innovative programs known to improve outcomes and reduce hospital utilization. Such programs could include permanent supportive housing and medical respite care.

ACCESS MORE RESOURCES ONLINE

- National Health Care for the Homeless Council | Health Care Reform | <http://www.nhchc.org/healthcarereform.html>
- National Health Care for the Homeless Council | Medicaid Tool Kit | <http://www.nhchc.org/medicaidadvocacytools.html>
- Respite Care Providers' Network | www.nhchc.org/Respite
- Permanent Supportive Housing | www.nhchc.org/supportivehousing.html

Notes

¹ PPACA, Section 1902(k)(2).

² Iowa Department of Human Services. (2010). "Iowa 1115 Demonstration Waiver: IowaCare." Available online at: <http://www.ime.state.ia.us/docs/IowaCareRenewalFinal100809.pdf>

³ Artiga, S. (June 2011). "Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers." Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

⁴ Office of the Governor, State of Minnesota. January 20, 2011. Governor Dayton Expedites Medicaid Expansion: Aggressive New Timeline Moves Implementation Date from October to March, Expands Access for Thousands of Minnesotans [Press release]. Accessed March 16, 2011 at <http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=9319>

⁵ Minnesota Department of Human Services. (March 2011). Minnesota Health Care Programs, Summary of Coverage, Copays and Limits. Accessed March 16, 2011 at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3860-ENG>

⁶ Urban Institute tabulations on the 2009 DC HIS. (Apr 2010). Reported Reasons for Not Enrolling in Public Insurance Programs Among Uninsured Non-elderly Adults.

⁷ DC Department of Health Care Finance. October 29, 2010. DHCF Receives Federal Funding to Support Health Reform Initiatives [Press release]. Accessed March 15, 2011 at <http://newsroom.dc.gov/show.aspx/agency/dhcf/section/2/release/20684/year/2010>

⁸ Craig, T. (2010, Apr 14). D.C. expects health care legislation to save millions of dollars. *The Washington Post*.

⁹ DC Department of Health Care Finance. August 6, 2010. DHCF Expands Medicaid Program [Press release]. Accessed March 15, 2011 at <http://newsroom.dc.gov/show.aspx/agency/dhcf/section/2/release/20289/year/2010/month/8>

¹⁰ Kromm, C. and Sturgis, S. (2008). *Hurricane Katrina and the Guiding Principles on Internal Displacement: A Global Human Rights Perspective on a National Disaster*. Durham: The Institute for Southern Studies.

¹¹ *Ibid.*

¹² Sermons, M.W. & Witte, P. (January 2011). State of Homelessness in America: A Research Report on Homelessness. Available online at: <http://www.endhomelessness.org/content/article/detail/3668>

¹³ Louisiana Department of Health and Hospitals. (August 6, 2010). Greater New Orleans Community Health Connection: Section 1115 Research and Demonstration Waiver Proposal. Accessed April 20, 2011 at <http://www.dhh.louisiana.gov/offices/publications/pubs-92/1115%20proposal.pdf>

¹⁴ *Ibid.*, p. 5.

¹⁵ California Department of Health Care Services. (November 2010). California Bridge to Reform: A Section 1115 Waiver Fact Sheet. Available online at: <http://www.dhcs.ca.gov/Documents/1115%20Waiver%20Fact%20Sheet%2011.2.10.pdf>

¹⁶ Artiga, S. & Schneider, A. (June 2011). "California's "Bridge to Reform" Medicaid Demonstration Waiver." Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

¹⁷ California Department of Health Care Services. (November 2010). Section 1115 Comprehensive Demonstration Project Waiver, Webinar Summary: "California's Bridge to Reform: Our 1115 Demonstration Waiver". Available online at: <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/WebinarSummary11-4-10.pdf>

¹⁸ Gilmer, T. (April 2011). Costs of Chronic Disease Management for Newly Insured Adults. *Medical Care*. Published ahead of print.

¹⁹ Corporation for Supportive Housing. (2009). Frequent users of public health services: Ending the institutional circuit. Available online at: <http://documents.csh.org/documents/pubs/FUFReportFINAL1209.pdf>.

²⁰ Kertesz, S. G., Posner, M. A., O'Connell, J. J., Swain, S., Mullins, A. N., Shwartz, M., & Ash, A. S. (2009). Post-hospital medical respite care and hospital readmission of homeless persons. *Journal of Prevention & Intervention in the Community*, 37(2), 129–142. Also: Buchanan, D., Doblin, B., Sai, T., & Garcia, P. (2006). The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health*, 96(7), 1278–1281.

²¹ California's "Bridge to Reform" Section 1115 Waiver is set to expire on October 31, 2015. However, the Low-Income Health Program (LIHP) will run only through December 31, 2013, after which full health care reform will be implemented and expanded coverage for adults with incomes at or below 133% FPL will be mandated in all states.

²² Congressional Budget Office. March 20, 2010. "Letter to the Honorable Nancy Pelosi Providing an Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872, the Reconciliation Act of 2010 (Final Health Care Legislation)."