Health Care Reform & Medicaid Expansion: HCH Lessons Learned from Three States
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
Health Care & Housing Are Human Rights

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
Health Care & Housing Are Human Rights

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: 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

Robert Taube, Ph.D., MPH
Executive Director
Boston Health Care for the Homeless Program
Boston, Massachusetts
Homeless People Have Had Remarkable Success in Getting and Keeping Medicaid Benefits: CY 2011

- Medicaid, 72%
- Medicare only, 5%
- Commonwealth Care, 4%
- Commercial, 2%
- Uninsured, 16%
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 from 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*

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<th>Estimate of Uninsured ≤ 100% FPL</th>
<th>Estimate of Uninsured ≤ 10% FPL</th>
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<tr>
<td>2009</td>
<td>143,191 people</td>
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<td>2008</td>
<td>117,475 people</td>
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* 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
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
Health Care & Housing Are Human Rights

Advocacy

- 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.

Collaboration

- 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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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](http://www.nhchc.org)
- *Forthcoming*: Policy Brief related to Medicaid expansion
- Free individual memberships at: [http://www.nhchc.org/council.html#membership](http://www.nhchc.org/council.html#membership)
- Technical assistance available
- Other resource: [www.healthcare.gov](http://www.healthcare.gov)