MEDICAID EXPANSION & THE ACA:
Issues for the HCH Community

POLICY BRIEF **September 2012**

Starting on January 1, 2014, two components of the Patient Protection and Affordable Care Act (ACA) will increase health insurance coverage: the option for states to expand Medicaid to non-disabled adults ages 19-64 earning at or below 138% of FPL,[a] and the establishment of state-based exchanges that will allow most individuals to purchase private insurance plans, with premium subsidies available for persons in families between 100% and 400% FPL. Nearly two-thirds of those served by federally funded Health Care for the Homeless projects were uninsured in 2011 (62.4%), with only 27.7% enrolled in Medicaid, despite 90.4% having income below 100% FPL.[1] Hence, many people experiencing homelessness are expected to gain eligibility for Medicaid in 2014. This policy brief provides a description of those who are newly eligible and poses questions that HCH administrators (and others providing health care for homeless populations) might consider as they prepare for ACA implementation.

Number of Those Newly Eligible for Medicaid

If all states expand Medicaid to all those earning below 138% FPL, an Urban Institute analysis found just over 15 million adults will be eligible to enroll (76% of them—11.5 million—are at or below 100% FPL).[2] Those eligible for Medicaid include citizens and legal immigrants who have exceeded the five-year-or-more waiting period; undocumented immigrants and those who have not met the five-year-or-more residency requirement are not eligible for Medicaid, but do remain eligible for *emergency care* under Medicaid (if they meet the State's other eligibility requirements).[3]

While the Supreme Court upheld the ACA, it determined the expansion of Medicaid would be a state option, rather than mandatory.[4] Since the decision was announced in late June 2012, a number of Governors have said they do not intend to expand Medicaid (even though some of these states have the most to gain from the ACA given their high rates of uninsurance). Additional states are delaying their decisions. Because significant advance planning is needed for successful program expansion, delays can disadvantage states that ultimately choose to provide Medicaid for their poorest citizens.

Medicaid Expansion is Optional:
Some states are declining participation, which will continue to leave many adults without insurance coverage.

Characteristics of Those Newly Eligible for Medicaid

Of those who would become newly eligible for Medicaid if all States chose to expand the program, 52% are male, 62% are aged 26 to 54, 31% have less than a high school education, and nearly half (49%) are below 50% FPL.[5] Approximately one in six of the expansion population is in fair or poor health, and one-third (32%) have at least one chronic condition (though the actual rate may be much higher because 61% have no usual source of care where conditions would be diagnosed).[6] SAMHSA has estimated that of those newly eligible for Medicaid, 7% have a serious mental illness (1.3 million), 15% have serious

[a] The ACA established eligibility at 133% FPL, but allows a 5% income disregard, essentially bringing eligibility to 138% FPL. In 2012, 138% FPL equals $15,599 annually for an individual and $26,660 for a family of three.

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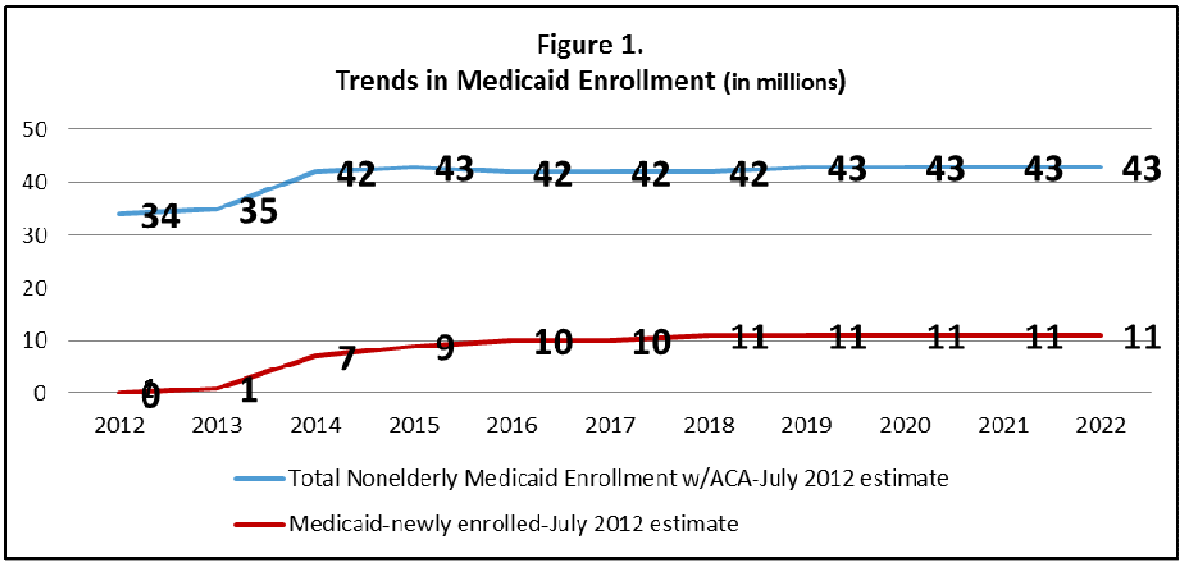
psychological distress (2.7 million), and 14.2% have a substance use disorder (2.6 million).[7] While the HCH community is already providing care to many of those who will become eligible, having health insurance provides new access to specialty care, behavioral health care, hospital care, residential treatment, and other needed services. A recent *New England Journal of Medicine* study found that expanding Medicaid is associated with a significant reduction in mortality (particularly among older adults, nonwhites, and residents of poorer counties), decreased rates of delayed care because of costs, and increased rates of self-reported health status (to excellent or very good).[8] Hence, while the population newly eligible for Medicaid has high health care needs, access to health care can help bring those conditions under control.

Eligibility Does Not Always Mean Enrollment

While 15 million individuals are expected to become *eligible* for Medicaid in 2014, the Congressional Budget Office (CBO) projects that *only seven million will enroll in the first year* (2014), and only 10 million two years after implementation (2016) (see figure 1 below).[9] Of those remaining uninsured after 2014, just over one-third are projected to be those eligible for Medicaid but un-enrolled (36.5%).[10] Hence, assertive outreach and enrollment campaigns are vital in order to enroll as many as possible.



Source: These estimates represent the *nonelderly* uninsured. CBO, July 2012: *Estimates for the Insurance Coverage Provisions of the ACA Updated for the Recent Supreme Court Decision*. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

The ACA requires states to establish procedures for "conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance…including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS."[11] These characteristics are heavily represented within the adult homeless population, which is responsive to concerted outreach efforts.[12] Though conducted prior to the revised July 2012 CBO estimates, a 2010 Kaiser study found a broad range of enrollment numbers based on the strength of outreach conducted, with 16 million new enrollees possible under a "standard participation scenario" and nearly 23 million new enrollees possible under an "enhanced outreach scenario."[13] These findings underscore the need for strong efforts to find those eligible and enroll vulnerable individuals into Medicaid.

Previous state-level Medicaid expansions have succeeded in removing enrollment barriers by clarifying eligibility requirements, assisting clients with the enrollment process, making use of out-stationed eligibility workers at locations frequented by those who are hard-to-reach, and collaborating with other community-based providers. Continued simplification of the application process, reduced documentation requirements, and assignment of staff to facilitate the enrollment process will continue to be beneficial.[14]

State Participation in Medicaid & Outreach Are Key to Enrollment:
15 million adults will be eligible for Medicaid in 2014, but only 7 million are anticipated to enroll in the first year.

Impact on the HCH Community & 10 Questions to Consider

Clearly the ACA brings new opportunities for Medicaid coverage to a significant number of very low-income people, to include those experiencing homelessness. At the same time, many adults are expected to remain uninsured. The following 10 questions are intended for HCH grantees (and others who deliver health services to homeless populations) to generate discussion with a broad range of stakeholders at your project/organization and in your community:

- **Increasing demand for services:** With the expansion of Medicaid, more people in the community will likely be seeking care for health conditions that may have gone untreated. What is your project's/organization's capacity to see new clients (especially those with multiple chronic conditions), and how will an increase in demand be accommodated?

- **Ensuring adequate workforce:** Associated with an increase in a demand for services is the need for a growing workforce to deliver and coordinate care. How is your project/organization prepared to recruit, retain and train both clinical and non-clinical staff to ensure high quality care?

- **Implementing new delivery care models:** With many individuals becoming eligible for Medicaid, a broader range of services may become available, such as specialty care, surgical procedures, and other services not usually delivered in health centers. Sharing data and coordinating plans of care will become even more important. Does your electronic health record facilitate this data-sharing across multiple service providers, or are new data-sharing agreements needed? Is your project/organization planning to become a patient-centered medical home[15] or participate in larger delivery of care changes in your community (e.g., Accountable Care Organizations, Coordinated Care Entities, etc.)?

- **Participating in outreach and enrollment:** While many will be able to enroll in Medicaid, others will remain un-enrolled (but still eligible). What resources will be available to conduct outreach to those needing further assistance, and how will your project/organization assist clients with enrollment?

- **Maximizing revenue:** The increases in health insurance for those who are low income will translate into higher revenue from Medicaid reimbursements. Is your project/organization prepared to maximize its billing for services provided? Are new IT systems and/or staff training needed to ensure a smooth financial transition to increased third-party billing?

- **Identifying gaps in services:** Medicaid plans are unlikely to reimburse for all the services needed to care for those who are homeless. What gaps in coverage (e.g., case management, adult dental, etc.) will remain, how will your health center grant funds be used to fill these gaps, and what additional

funding sources might be needed? How are you engaged with your state Medicaid office to encourage use of flexible state options to cover these services for targeted populations?[16]

- **Conveying needed information:** Are you actively discussing how—or whether—your state will be fully implementing the provisions of the Medicaid expansion? In order to be successful, it is important for key stakeholders to fully participate. Decisions will be made based on information received from these stakeholders, which include HCH grantees and consumers.

- **Involving your Staff and Board:** Significant financial and programmatic changes are likely to occur as a result of the Medicaid expansion. Are your staff and Board of Directors aware of these opportunities and challenges, and the impact these changes will have on operations and on those clients who are homeless? How will your health center be communicating with clients about the changes in eligibility and ensuring enrollment of all those eligible?

- **Updating your strategic plan:** As a result of health reform, each community will have different needs and solutions, each with immediate, short-term and long-term consequences that require adequate planning. Does your project/organization have an updated strategic plan that takes into consideration the changes from the ACA?

- **Collaborating within your community:** Every aspect of the health care system will feel changes from the ACA in general, if not the Medicaid expansion specifically. What other organizations are you collaborating with to express concerns, share strategies for overcoming challenges, expand your service network, and strategize how to best share appropriate information about the benefits and challenges involved in a Medicaid expansion.

Conclusion

HCH grantees should be looking ahead to 2014, actively planning outreach and enrollment efforts, and engaging with key stakeholders about the importance of Medicaid expansion in all states. Medicaid expansion should translate into greater access to a broader range of health services for those experiencing homelessness, improve overall health status, and increase revenue so health center program grantees can continue to fulfill their core mission. Achieving these goals will markedly advance the larger mission to prevent and end homelessness.

SELECTED RESOURCES

- **Urban Institute:** State-by-state table showing number of those newly eligible for Medicaid
- **Department of Health and Human Services**: Central website with federal information related to health reform materials covering a wide selection of issues: http://www.healthcare.gov/.
- **Health Resources and Services Administration (HRSA):** Health Center data, popular tools, news, and announcements: http://bphc.hrsa.gov/index.html
- **Substance Abuse and Mental Health Services Administration (SAMHSA):** State-by-state estimates on prevalence of behavioral health conditions for those uninsured: http://www.samhsa.gov/enrollment/states.aspx#estimates
- **Centers for Medicare and Medicaid Services (CMS)**: All federal guidance and other materials related to Medicaid: http://www.medicaid.gov/.
- **The National HCH Council:** Access more health reform resources at: www.nhchc.org/healthcarereform.html. A library of materials dedicated to improving access to Medicaid services for individuals experiencing homelessness located at http://www.nhchc.org/medicaid_improvingaccess.html.

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NOTES:

[1] UDS 2011 data. Available at: http://bphc.hrsa.gov/uds/view.aspx?fd=ho&year=2011.

[2] Kenney, G.M., Dubay, L., Zuckerman, S., and Huntress, M. (July 5, 2012.) *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not be Eligible for Medicaid?* Urban Institute; Washington, DC. Available at: http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf.

[3] National Immigration Law Center (April 2010). How Are Immigrants Included in Health Care Reform? Available at: http://www.nilc.org/document.html?id=157.

[4] A very thorough analysis of the Supreme Court ruling is available from the Kaiser Family Foundation at: http://www.kff.org/healthreform/upload/8332.pdf.

[5] Kaiser Family Foundation (April 2010). Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty. Available at: http://www.kff.org/healthreform/upload/8052-02.pdf.

[6] Ibid.

[7] SAMHSA, National and State Estimates on Prevalence of Behavioral Health Conditions. Available at: http://www.samhsa.gov/enrollment/states.aspx#estimates. Note these estimates were based on 2008-2010 National Survey of Drug Use and Health and the 2010 American Community Survey, and were based on earlier (higher) estimates of the number of people newly eligible for Medicaid.

[8] Sommers, B., Baicker, K, and Epstein, A. (July 25, 2012). Mortality and Access to Care among Adults after State Medicaid Expansions. New England Journal of Medicine, Special Report. Available at: http://www.nejm.org/doi/full/10.1056/NEJMsa1202099.

[9] CBO, July 2012: *Estimates for the Insurance Coverage Provisions of the ACA Updated for the Recent Supreme Court Decision*. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[10] Buettgens, M, and Hall, M.A. (March 2011.) *Who Will Be Uninsured After Health Insurance Reform?* The Urban Institute and Robert Wood Johnson Foundation. Available at: http://www.urban.org/uploadedpdf/1001520-Uninsured-After-Health-Insurance-Reform.pdf. Notes: this analysis was conducted prior to the Supreme Court decision, which would make this estimate a conservative one. The remaining groups include those who are exempt from requirements to buy health insurance because they have an affordability exemption, 7.5% would qualify for subsidies in the Exchange, while 15.3% would be able to afford insurance without a subsidy.

[11] ACA, Section 2201.

[12] Information from the National HCH Council on outreach guidelines and training materials is available at http://www.nhchc.org/resources/clinical/tools-and-support/outreach/.

[13] Kaiser Commission on Medicaid and the Uninsured (May 2010*). Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL.* Available at: http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf.

[14] Artiga, S., Rudowitz, R. & McGinn-Shapiro, M. (July 2010.) *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences.* Kaiser Commission on Medicaid and the Uninsured, Washington, DC. Available at: http://www.kff.org/medicaid/upload/8087.pdf. Also see National HCH Council. (August 2010.) Reducing Medicaid Enrollment Barriers for Individuals Who are Homeless. Available at: http://www.nhchc.org/wp-content/uploads/2011/10/ReducingMedicaidBarriersAug2010.pdf. The Council has a wealth of information on outreach located at: http://www.nhchc.org/medicaid_improvingaccess.html.

[15] Information from the National HCH Council on Patient-Centered Medical Homes is available at http://www.nhchc.org/resources/general-information/health-care-reform/.

[16] More information about state options on Medicaid has been outlined in two recent Council policy briefs. National HCH Council (May 2012). *Medicaid's Home and Community-Based Services System: An Orientation for Health Care for the Homeless Providers.* Available at: http://www.nhchc.org/wp-content/uploads/2011/10/HCBS-Policy-Brief.pdf. National HCH Council (July 2011). *State Options for Medicaid Expansion.* Available at: http://www.nhchc.org/wp-content/uploads/2011/10/PolicyBriefMedicaidExpansionOptions.pdf.