Alternative Medicaid Expansion Plans: Key Elements for the HCH Community

The Affordable Care Act (ACA) originally envisioned all states expanding Medicaid to those earning up to 138% of the federal poverty level (FPL), but in June 2012 the Supreme Court ruled that Medicaid expansion effectively was optional for states. Since the ruling, states have debated whether and how to expand Medicaid, and 26 states and Washington D.C. have chosen to expand the program.[1] States are also considering alternative methods to expand the program, with Arkansas being the first to propose to use premium assistance, an existing Medicaid option where Medicaid beneficiaries enroll in private health plans and states use Medicaid funding to pay for the premiums. This approach has emerged as a market-oriented alternative to traditional Medicaid and has been appealing to states hesitant to expand government programs. The Center for Medicare and Medicaid Services (CMS) affirmed that premium assistance is a viable way to expand Medicaid as long as the proposals furthered the objectives of the program and maintained statutory cost-sharing and benefit protections.[2] In addition to premium assistance, states have proposed many other changes, such as Michigan's proposal to impose premiums and incentivize healthy behaviors, and Pennsylvania's effort to require job training for able-bodied, unemployed adults.

Changes in Medicaid policy that promote private-market solutions and place more responsibility on beneficiaries may appeal to some lawmakers, but the impact of these proposals on Health Care for the Homeless (HCH) projects and consumers could impose challenges. Expanding access to health coverage should be beneficial to those experiencing homelessness, but some policy changes may create barriers. This brief aims to evaluate the impact of various Medicaid expansion proposals on those experiencing homelessness, both for states implementing an alternative Medicaid expansion and for those who may wish to emulate similar policy changes in their state.

Medicaid Expansion under the Affordable Care Act

Medicaid is an important source of health coverage for low-income households and has become even more important thanks to the ACA. Prior to the ACA, Medicaid eligibility was limited to specific categories of people, with nondisabled adults without dependent children ineligible in most states. The ACA's Medicaid expansion extends eligibility to most of those earning up to 138% FPL, making the vast majority of those experiencing homelessness eligible for the first time. In states not expanding Medicaid, the very poor may be without affordable coverage options. Subsidies and tax credits to purchase private insurance are only available for those earning 100%-400% FPL, but those who earn less than 100% FPL are not eligible for these subsidies. About five million individuals are estimated to fall into this 'coverage gap'; too poor to receive subsidies but ineligible for Medicaid because their state opted out of the expansion.[3]

Medicaid expansion under the ACA maintained most statutory rules for the newly eligible population. Medicaid is an entitlement, meaning that all those who meet the program requirements are eligible to

enroll. Caps on enrollment and the use of waitlists are prohibited. Additionally, Medicaid does not allow premiums for most groups and limits copays and other cost-sharing to nominal amounts for most income levels.[4] For the newly eligible population, a benchmark or benchmark equivalent benefit package must be provided, meaning the benefit package must provide the ten Essential Health Benefits outlined in the ACA, as well as other mandated Medicaid benefits such as family planning, Early Periodic Screening, Diagnosis, and Treatment (EPSDT), nonemergency transportation, and FQHC/rural health clinic services.[5]

Section 1115 Waivers & Premium Assistance

Section 1115 of the Medicaid statue allows states to request waivers of certain requirements in order to test innovative Medicaid policies. Program requirements can only be waived if the proposed design furthers the objectives of the Medicaid program and is cost neutral. It is the state's responsibility to demonstrate cost neutrality by showing the innovation would cost the Medicaid program no more than traditional Medicaid. The state must also justify its request by outlining the objectives that would be furthered by the waiver. A public comment period is required for these waivers, allowing stakeholders the opportunity to weigh in. CMS then considers the waiver and may require changes to certain aspects of the proposal.[6]

Premium assistance has been allowable under Medicaid statute since its establishment in 1965, but was not widely used prior to the ACA. Premium assistance normally allows Medicaid beneficiaries to use Medicaid dollars to purchase private insurance plans at their option. Waivers by Arkansas, Iowa and Pennsylvania have required that some portion of newly eligible beneficiaries use premium assistance to purchase Qualified Health Plans (QHPs, or private insurance plans) on their health insurance marketplaces rather than enroll in traditional Medicaid. Mandating premium assistance for certain populations requires a Section 1115 waiver and these waivers have been the primary method of designing alternative Medicaid expansion policies. States and CMS have negotiated extensively over these proposals, leading CMS to issue guidelines, which are outlined below.[7]

Requirements for Section 1115 Waivers Seeking Mandated Premium Assistance Outlined in CMS FAQ March 29, 2013

- Must expand to 138% FPL in order to access full federal funding under the ACA.
- Cannot place caps on enrollment.
- Targeting premium assistance to those earning 100% FPL and above is preferred.
- Must offer a choice of at least two QHPs (private health plans).
- Must include all mandated benefits. The state must provide wraparound benefits for those services not covered by the private plan, such as EPSDT and nonemergency transportation.
- For populations earning up to 100% FPL, cost sharing must be nominal and premiums are prohibited. Total out of pocket costs are limited to 5% of income.
- For populations earning between 100-138% FPL, more cost-sharing is allowed but premiums are still prohibited. Total out of pocket costs are limited to 5% of income.
- Must provide traditional Medicaid to those who are determined medically frail and other specific groups.
- Must end by December 31, 2016. Starting in 2017, State Innovation Waivers authorized in the ACA become available. This should not disrupt coverage.

To date, CMS has approved Section 1115 waivers to expand Medicaid in an alternative way in Arkansas, Iowa, and Michigan. Both Arkansas and Iowa require premium assistance for portions of the newly eligible population, and all three make other significant Medicaid policy changes. CMS has rejected some policy

changes, but has also allowed some changes that conflict with the guidelines CMS released in the FAQ outlined above (see table 1).

Table 1: Policies approved and rejected by CMS to date[8,9]

Approved Policy Changes	Rejected Policy Changes
Mandated use of premium assistance	Enforceable premiums for those earning below 100% FPL. (Nominal premiums of $5/month allowed in Iowa for those earning 50-100% FPL).
Premiums of up to 2% of income for those earning 100-138% FPL.	
Waiving some required benefits, specifically nonemergency transportation.	Waiving other required benefits, such as EPSDT, family planning, and FQHC services.
Incentivizing healthy behaviors through cost-sharing and premium reductions.	Cost-sharing beyond what is allowable under current law.

The policy changes CMS allows or rejects are critically important, both for the Medicaid program in the state in question and for setting precedent. Pennsylvania submitted a Section 1115 waiver in February that requested to waive basically all the requirements that had previously been waived in other states, as well as several others. It seems likely that subsequent waiver submissions by other states will also request authority to waive the requirements CMS has already approved in other states. Thus, this process is changing Medicaid policy and these policies will directly impact HCH projects and consumers.

Specific Medicaid Expansion Waivers

Each state's Medicaid expansion debate has been unique, resulting in significant policy differences and prospects for the future. Understanding both the components of each plan and the policy goals that shaped them should aid stakeholders in other states in determining their best path forward.

Arkansas: As the first state to propose mandatory premium assistance for the newly eligible population, Arkansas set the stage for much of what followed. The main element of the Arkansas proposal, known officially as the Arkansas Health Care Independence Program (Private Option), was to mandate premium assistance; the state adhered fully to the CMS FAQ stating that wraparound benefits and cost-sharing protections must be provided to supplement the QHP. Initially, there was considerable skepticism that mandatory premium assistance would be able to meet the CMS cost-neutrality requirement, based in part on a GAO study that found private insurance cost $9,000 per year on average compared with $6,000 per year for Medicaid.[10] The GAO's findings were unsurprising considering public insurance generally pays lower rates and has significantly lower administrative costs. In Arkansas, however, the state was able to show that the difference in cost was substantially less. Arkansas also identified potential programmatic benefits of premium assistance not normally considered in cost analyses, such as reductions in overhead and reduced QHP premiums from a larger risk pool. CMS approved the waiver in September 2013 with few required revisions.[11]

Arkansas reauthorized the program again during their 2014 legislative session but faced significant resistance from some lawmakers. In the end, concessions were made requiring the state to submit a request to CMS by September 15, 2014 that would increase cost sharing and premiums, expand the use of Health Savings Accounts and eliminate nonemergency transportation benefits. The state also prohibited any funding for outreach and enrollment in the program after June 30, 2014.[12] The continued debate and desire to enact further policy changes should be a cautionary tale to stakeholders in other states, showing that state Medicaid expansion plans are subject to change even after their initial authorization.

Iowa: Iowa was the second state to submit a Section 1115 waiver to mandate premium assistance and obtained approval in December 2013. Iowa's plan will target premium assistance to those earning 100-138% FPL, known as the Iowa Marketplace Choice Plan. Individuals earning less than 100% FPL will be

enrolled in Medicaid Managed Care Organization (MCO), in this case known as the Iowa Wellness Plan. Iowa was the first state to propose changes to cost-sharing and benefits for the newly eligible population. Originally, Iowa proposed to charge premiums to those earning 50-138% FPL, although a failure to pay these premiums would not result in a loss of coverage. They also proposed to eliminate nonemergency transportation and EPSDT benefits. CMS rejected some of these proposals but did allow premiums of up to 2% of income for those earning 100% FPL and a nominal $5/month premium for those earning 50-100% FPL. They also allowed a one year waiver for nonemergency transportation benefits. [13] Iowa's negotiations with CMS began to show the limits of what CMS will accept but also the potential reductions in benefits and cost-sharing protections that CMS would approve.

Michigan: Michigan is the only other state to have a Section 1115 waiver for Medicaid expansion approved to date. Michigan chose to use Medicaid MCOs rather than premium assistance, but did include other changes including the use of Health Savings Accounts (HSA) and incentives for health behaviors. Failure to contribute to the HSA would not result in a loss of coverage. This state was also the first to propose expanding Medicaid after January 1, postponing their expansion to April 1, 2014.[14] Michigan plans to submit a second waiver that will increase premiums on beneficiaries who remain enrolled in Medicaid for longer than 48 months. It is unclear if CMS will approve such a waiver.

Pennsylvania: The Pennsylvania proposal has gone through several iterations, showing the impact that public comments and concerns can have on the decision process. The initial proposal sought numerous changes, including mandatory premium assistance, enforceable premiums for those earning 50% FPL and above, waiving the FQHC Prospective Payment System rate and required FQHC benefit, and a required job search/job training component. [15] Following a state public comment period and numerous public hearings, Pennsylvania revised its proposal, reinstating FQHC benefits and reducing premiums.[16] Most recently, the Pennsylvania Governor wrote a letter to CMS revising the work requirement, proposing instead a voluntary job search and training program.[17] These changes will help reduce barriers individuals experiencing homelessness may face, as meeting the previous requirements regarding employment and job training may have been difficult. Nonetheless, the proposal still imposes premiums and limits benefits in other ways.

Table 2 provides details of each of the four states' proposals.

Table 2: Medicaid Expansion Waivers Compared
(Adapted from the Kaiser Commission on Medicaid and the Uninsured)[18,19]

	AR (approved)	IA (approved)	MI (approved)	PA (submitted)
Mandated premium assistance groups	All newly eligible beneficiaries (parents age 19-64, 17-138% FPL; childless adults age 19-64, 0-138% FPL).	Only those newly eligible beneficiaries age 19-64 earning 101-138% FPL.	Not planning premium assistance. Intend to use Managed Care Organizations for newly eligible.	All newly eligible beneficiaries (parents age 21-64, 33-138% FPL; childless adults age 21-64, 0-138% FPL).
Coverage starts	January 1, 2014	January 1, 2014	April 1, 2014	January 1, 2015
Premiums	None	Premium assistance population charged premiums not to exceed 2% of annual income. $10/month is the maximum premium. Those earning 50-100% FPL charged a 'nominal' $5/month. Premiums waived in first year.	Those earning 100-138% FPL are required to make additional contributions to a MI Health Account of 2% of income per month. Contributions waived for first six months. Cannot be denied coverage for failure to pay premiums.	Premiums for those earning 100% FPL or higher will be $25/mo. for an individual and $35/mo. per household. Eligibility will be terminated for non-payment of premiums for 3 consecutive months. No premiums the first year.

	AR (approved)	IA (approved)	MI (approved)	PA (submitted)
Healthy Behavior Incentives	None.	Can waive premiums by completing a health assessment or wellness exam. Future incentives still under development.	Required contributions to MI Health Account can be reduced by completing certain health behaviors. Protocols still under development.	Premiums can be reduced by 25% by completing a wellness visit in year 1 and a Health Risk Assessment in year 2. Further incentives still under development.
Benefit Package	Same as Medicaid state plan benefits.	Plan to provide benefit package at least equivalent to state employee benefit package, as well as adult dental coverage.	Medicaid state plan with additional benefits: adult dental, vision, home health, hearing services.	Proposes a two tiered benefit package for low and high risk beneficiaries. All Essential Health Benefits and adult dental are covered but limits on scope, amount and duration will vary between the low and high risk plans.
Wraparound Benefits	Will provide all required wraparound benefits.	One year waiver of obligation to provide non-emergency transportation. Will provide all others.	N/A because all required services provided through MCOs.	Seeks to waive the requirement to provide wraparound benefits.
FQHC Services and Rates	At least one of the two QHPs available will contract with at least one FQHC. State seeks to develop alternative payment model.	At least one of the two QHPs available will contract with at least one FQHC.	Based on MCO contracting.	Revised proposal to include mandated FQHC services and PPS rate for all premium assistance beneficiaries.

Other Provisions:

Arkansas: Recently reauthorized the program. Instructions were included for the state to seek to make several changes to the existing premium assistance program by September 15, 2014. These include waiving nonemergency transportation benefits, imposing premiums, and establishing a Health Savings Account provision. The state also prohibited state funding for outreach and enrollment assistance.

Michigan: Plans to seek a second waiver requiring beneficiaries earning over 100% FPL who stay on Medicaid longer than 48 months to either pay higher premiums or leave the Medicaid program.

Pennsylvania: Initially included a requirement for all able-bodied beneficiaries to work, engage in job search activities, or in job training. Failure to meet these requirements would result in a loss of coverage. A recent letter proposed to make this voluntary program with premiums and copay reductions as incentivizes for beneficiaries to participate.

Assessing the Impact on HCH Projects and Consumers

Beyond these four states, many of the 24 states who have yet to expand Medicaid are considering similar policy changes. In addition to Pennsylvania who is still awaiting a decision from CMS, several other states are currently debating this such as Missouri, Virginia, Indiana, and Utah. New Hampshire also voted to expand its Medicaid program during its 2014 legislative session. Understanding how these policy changes will impact HCH projects and consumers is essential to realizing the benefits of expanded Medicaid coverage.

➢ Mandated Premium Assistance:

Widespread use of premium assistance in the Medicaid program has not been attempted in the past. It will require significant coordination between the state Medicaid agency, the private insurers, providers and beneficiaries. The processes involved may be similar to Medicaid MCO arrangements that are common in

many states, but the private insurers may not have the same familiarity in working with a low-income and vulnerable population.

The manner in which QHP insurers handle prior authorizations, denials, appeals, auto-assignment of primary care providers and correspondence with beneficiaries will impact how individuals experiencing homelessness can access needed care. HCH administrators should work with both the state and the insurers participating in the premium assistance waiver to build processes that are sensitive to the barriers faced by individuals experiencing homelessness and those that serve them.

> ***"Systems often don't take the patient perspective into account. Things that do not seem too difficult can be a pretty big burden for the people we serve. The system should be designed for their reality, not ours."***
>
> -Andrea Pearce, Benefits Coordinator, Primary Health Care, Des Moines, IA

The impact of premium assistance will also vary based on which populations are included. In Iowa, those earning less than 100% FPL will be enrolled in a Medicaid MCO. Most newly eligible individuals experiencing homelessness will therefore not be enrolled in a premium assistance plan as their income is typically less than 100% FPL. In Arkansas, potentially Pennsylvania, or elsewhere, all nonexempt newly eligible populations will be enrolled in QHPs. Many individuals experiencing homelessness who may not have been insured before will need assistance in understanding the terminology used in private health insurance.[20]

States pursuing mandated premium assistance have been required to exempt certain populations from mandated enrollment, such as those who are medically frail and those who are dually eligible (enrolled in both Medicare and Medicaid). Each state has developed its own process, ranging from questions regarding health status on the enrollment application to required medical history documentation. The traditional Medicaid program requires additional benefits and protections over private plans, so it is important that those who are eligible based on medical frailty or other criteria are easily screened. Minimizing documentation and lengthy evaluation will streamline access to needed services and be particularly helpful for people who are homeless.

> ***"If you went to the hospital and had Medicaid, you'd be put at the back of the line. That stigma followed from the reality that Medicaid paid less. Hopefully the private option will reduce that stigma."***
>
> -Patrick Goolsby, Enrollment Assister, Jefferson Comprehensive Care, Little Rock, AR

The nature of the relationship between the state Medicaid program and the QHP insurers receiving Medicaid dollars is also critical to these proposals. States thus far have proposed entering into a memorandum of understanding with the private insurers, rather than a formal contract, and it is unclear if oversight will be rigorous or how it will be handled. QHPs in premium assistance states will be receiving public dollars to provide care to a vulnerable population, so sufficient oversight and due process protections must be maintained.

Premium assistance could potentially offer some improvements compared with traditional Medicaid. Providers may be more likely to accept new patients with private health insurance due in part to higher reimbursement rates.[21] Another potential advantage may be reduced churning. Churning occurs as households' income or life circumstances change, leading to changes in program eligibility. Specifically, having to change insurance carriers from Medicaid or a Medicaid MCO to a private plan and back again could be disruptive to care and administratively burdensome. Premium assistance could reduce these changes by allowing households to stay enrolled in the same QHP even as their income fluctuates near

138% FPL. Ultimately, premium assistance may be the most politically viable option in some states, and this might be its most important advantage.

- **Premiums and Cost-Sharing:**

Premiums had never been allowed for Medicaid beneficiaries earning less than 150% FPL, but CMS has now approved premiums for those earning at or above 100% FPL in Iowa and Michigan. These premiums may discourage low-income beneficiaries from enrolling in coverage, although most individuals experiencing homelessness will be under this income limit. Some states have proposed charging premiums to those earning at or above 50% FPL and this certainly would impact more of those who are homeless and impose a burden to other very low-income beneficiaries. Providing an easy way to waive premiums in the case of financial hardship will help reduce barriers. It is important to ensure premiums are not mandatory and beneficiaries are aware that they will not lose coverage for non-payment.

Co-pays and other forms of cost-sharing can also be a barrier and ultimately costly for states. HHS has not yet approved higher cost-sharing, but state proposals to charge higher co-pays will likely continue. A substantial body of research shows that cost-sharing leads low-income beneficiaries to forego needed care, have poorer adherence to medical treatments, and can lead to higher costs to public systems through administrative complexity and increased hospitalization.[22,23] For individuals experiencing homelessness, even the smallest costs can pose significant barriers. States should consider eliminating or reducing cost-sharing if only to streamline program administration.

> ***"The rumors and misinformation about cost-sharing might be a bigger barrier than the costs themselves. A lot of education will be needed."***
>
> -Joe Ferguson, Executive Director, Advantage Health Centers, Detroit, MI

In order to maintain Medicaid cost-sharing protections, states may need to provide QHPs additional wraparound payments to cover the cost-sharing QHPs typically impose. It is important to ensure this process is implemented in way that is streamlined for beneficiaries. States have proposed to provide up-front payments on a quarterly basis, which should suffice as long as these payments cover the necessary wraparound co-payments.

Ensuring that FQHCs and HCH projects can continue to waive Medicaid cost-sharing requirements is also important. FQHCs are able to waive co-pays and other cost-sharing for individuals earning less than 100% FPL based on federal guidance, and this should continue to apply in the case of QHPs, MCOs or any other type of insurance.[24]

- **Healthy Behavior Incentives:**

Proposed incentives for health behaviors to date have revolved around reducing premiums and cost-sharing when beneficiaries obtain an annual wellness visit or other rather low-barrier requirements. Most states plan to introduce additional incentives and requirements, and some proposals have suggested developing ways to tie premiums to various health indicators such as improvements in blood pressure or cholesterol. Individuals experiencing homelessness or other vulnerable populations face added challenges in improving these health indicators. In evaluating these provisions, stakeholders must determine if the incentivized behavior can be achieved without an undue burden on the beneficiary and if the behavior will be truly beneficial, such as obtaining needed check-ups and preventive services.

- **Benefit Packages and Wraparound Benefits:**

Newly eligible Medicaid beneficiaries are supposed to have access to all ten Essential Health Benefits as well as all other mandated Medicaid benefits. For benefits not provided by the QHPs, state Medicaid

agencies will need to provide supplemental wraparound benefits. States need to make sure beneficiaries can easily access these wraparound benefits.

CMS has allowed Iowa to waive nonemergency transportation for one year despite their guidance stating all required benefits must be provided. Other states are also seeking to waive this benefit. This raises concerns as newly eligible beneficiaries and especially individuals experiencing homelessness need access to transportation in order to access health care services. Research has demonstrated that 3.6 million patients miss appointments due to lack of transportation; failure to attend nonemergency medical appointments such as dialysis or cancer treatments can also result severe health complications and higher overall costs.[25] In addition, nonemergency transportation has been upheld as a critical component of the Medicaid program in several court cases.[26]

The scope, amount and duration of benefits provided under QHPs may also be different than typical Medicaid services. Pennsylvania in particular seeks to limit numerous types of health services to a certain number of visits per year. If a beneficiary exceeds the annual limit, they may need to go without needed care or face financial burdens. Individuals experiencing homelessness may have difficulty both keeping track of these limits and may exceed them as they have poorer health than the population as a whole. These limits will be at odds with goals related to increasing service access, especially for those with multiple chronic conditions.

- **FQHC Services and Rates:**

Medicaid is required to cover FQHC services, but QHPs have no such requirement. Recent regulations stated that Medicaid benchmark benefits must ensure access to FQHCs, but 'access' has not been explicitly defined.[27] All approved waivers to date have required that beneficiaries have access to at least one QHP who contracts with FQHCs, but not all QHPs are required to contract with every FQHC. It is possible that beneficiaries experiencing homelessness may be enrolled in a QHP that has not contracted with the FQHC that would serve them best. These services are important since other private practices may not have the cultural competence or knowledge of the clinical adaptations needed to provide medical care to those without homes.[28]

> ***"Health Centers were supposed to be part of the long-term goal of the ACA to improve access to primary care. If health centers are left out of the QHP networks, it would undermine the goals of the ACA. This is particularly concerning, especially for a portion of the population which may have limited options for primary care.***
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> -Melissa Fox, HCH Director, Public Health Management Corporation, Philadelphia, PA

Maintaining the Medicaid prospective payment system (PPS) reimbursement rate for health centers is an important concern. QHPs are only required to pay health centers whatever rate is agreed upon in their negotiated contract, with states providing a supplemental payment to make up the difference. Hence, a health center may be getting two payments for each visit. It is important that state processes ensure these supplemental payments are timely. Both Arkansas and Pennsylvania proposed developing an alternative health center payment system that may not maintain the same level of reimbursement. The PPS reimbursement rate is typically higher than other providers' rates, but this allows FQHCs to provide additional services not provided in other settings and spend the time needed to serve a population with complex health needs. Maintaining this rate is critical to maintain this level of services.

- **Other Provisions:**

One policy of particular concern was the Pennsylvania proposal to require unemployed able-bodied beneficiaries to register with the state and engage in specified job search and job training activities. Failure

to meet these requirements could lead to a loss of health coverage for up to nine months. The state justified this unprecedented requirement by claiming employment led to better health, although this argument fails to consider other factors related to health status and the ability to work. A more likely cause for the correlation between employment and good health may be that people in good health are able to work more. Either way, individuals experiencing homelessness would likely struggle to meet this requirement and may therefore lose access to health coverage. The Pennsylvania Governor has since amended this policy by making the work search and training program voluntary for beneficiaries. Participation in the program would be incentivized by reducing participant premiums and cost sharing based on the number of hours worked or the completion of certain job search or training activities. This change should reduce the barriers to enrollment faced by those experiencing homelessness who may have difficulty meeting the job-related requirements.

Another proposal is Michigan's intention to submit an additional waiver that would raise premiums on beneficiaries after 48 months of enrollment. As an entitlement, Medicaid beneficiaries should remain eligible for the program without any penalty as long as they meet program criteria, and certainly imposing any premium on low-income groups is a barrier to care.

The changes Arkansas is seeking after their most recent legislative session also cause concerns. In particular, the restrictions on outreach and enrollment will reduce participation in the private option and ultimately harm access. Beneficiaries with lower health literacy or computer experience will have difficulty enrolling on their own. Stakeholders in other states, even those who have already expanded Medicaid, should be wary of future changes that may limit access to coverage.

Conclusion

Individuals experiencing homelessness are disproportionately uninsured and in poor health. Any expansion of health insurance, either through Medicaid or through premium assistance, should be beneficial, but additional many factors can serve as barriers to care. The HCH community should be actively engaged to ensure any alternative expansion plans will work well for those experiencing homelessness and the providers who serve them.

State Stakeholder Interviews

To better understand the impact these proposals are having in local communities, HCH providers and other stakeholders from Arkansas, Iowa, Michigan, and Pennsylvania were interviewed for their perspectives. Summaries of these discussions follow.

ARKANSAS

Providers were generally positive about the potential for Arkansas' private option program to improve health status and health access for homeless populations in Arkansas. Arkansas had very restrictive Medicaid eligibility prior to the ACA and the private option, so the expansion represents a significant improvement in health coverage for this population. The benefits were seen as robust and the use of QHPs rather than traditional state Medicaid coverage was not seen as problematic. One potential benefit of the private option was reduced stigma in accessing health services. In Arkansas, the low reimbursement rates of Medicaid often reduced access and beneficiaries were not necessarily treated as well as other patients. The QHPs generally have higher reimbursement rates compared to Arkansas Medicaid, so beneficiaries may experience improved access and better treatment overall.

Outreach and enrollment has been challenging, but significant progress has still been made. Arkansas implemented an option to streamline enrollment using the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) to identify those likely eligible. The state sent letters to all SNAP recipients with a simple form that they needed to sign and return to be enrolled in the private option. This was effective for some low-income residents, but was likely less effective for individuals experiencing homelessness who have difficulty dependably receiving and responding to mail. AR enrollment assisters did report that many homeless households did not get this mailing and had to be enrolled in person. Nonetheless, over 100,000 people enrolled in the private option thanks to these mailings alone.

Arkansas also employed several hundred in-person assisters to aid in the enrollment effort. Their support was critical, as most newly eligible residents both with and without stable housing had significant difficulty understanding insurance terms and using the internet. Political and philosophical opposition also impeded outreach, with many businesses and faith organizations refusing to allow enrollment events or information at their locations. Homeless service providers were also rather unfamiliar with the enrollment process and left most outreach and enrollment work to the in-person assisters.

Arkansas narrowly reauthorized its private option plan during its 2014 legislative session. Many changes were made in order to garner the support needed to continue the program. In particular, a restriction on using state dollars for outreach and enrollment was included in the reauthorization. As of March 2014, less than half of all eligible residents had enrolled in the private option and interviewees did not think most low-income or homeless individuals could navigate the enrollment process without assistance. Thus, the restriction on outreach and enrollment may significantly reduce the program's reach.

Key Takeaways:

- Most newly eligible populations will need assistance in enrolling in coverage.
- States should use existing means-tested programs to help target enrollment efforts.
- Philosophical and political opposition are barriers to enrollment, even when using premium assistance.
- Efforts to change the Medicaid program may continue even after initial Medicaid expansion.

IOWA

Iowa received CMS approval and is engaged in active outreach and enrollment. Their waiver, the Iowa Health and Wellness Plan (IHWP), included two programs: the Iowa Wellness Plan and the Iowa Marketplace Choice Plan. The Iowa Wellness Plan covers those earning less than 100% FPL through Medicaid MCOs; the Iowa Marketplace Choice is a premium assistance program to purchase QHPs on the federal marketplace. Key upgrades over previous limited benefit programs include expanded provider networks and mental health, prescription drug, and dental coverage. Primary Health Care (PHC), one of the HCH grantees in Iowa, is observing improved access to care for patients; however the greatest challenge is helping the patient understand how their insurance works.

Patients have needed education regarding networks, covered benefits, and associated cost-sharing. For beneficiaries enrolled in QHPs (those earning 100% FPL and above), they will be held financially responsible for services they access out-of-network. This leaves beneficiaries financially exposed to a larger degree than traditional Medicaid. Premiums are also imposed for Marketplace Choice beneficiaries and Iowa Wellness Plan beneficiaries earning 50%FPL or more. The first year is waived and subsequent years can be waived by completing preventative services and/or wellness activities.

Providing services to those who remain uninsured may also be challenging. An IHWP application can take up to 45 days to be approved. The ACA expanded presumptive eligibility but this is limited to hospitals in Iowa. Presumptive eligibility has shown to be a successful tool in encouraging people to access coverage, access care, and remain retained in care. FQHCs are often the access point for many uninsured people and expanding ACA presumptive eligibility to FQHCs could help improve enrollment, access and retention. Under current rules, a provider may need to wait to prescribe needed treatment while awaiting approval.

Another significant issue is the medically exempt (previously known as medically frail) determination process. Anyone enrolled into the IHWP can be evaluated and subsequently enrolled in the State Medicaid Benefits Plan if they meet the medically exempt definition. State Medicaid has more robust coverage for people living with chronic and mental health conditions. The IHWP application includes questions to identify those who may qualify for a medical exemption, but follow-up must be provided by mail or by phone at a later time. This may be difficult for those who are unstably housed. Additionally, many people who have recently received a disability determination through the Social Security Administration (SSA) are likely eligible for a medical exemption and full state Medicaid benefits. SSA does not share those records with the Iowa Medicaid Program at this time, but that practice could improve access to insurance through auto-enrollment.

Key Takeaways:

- Health insurance may be complicated to vulnerable populations; education is key.
- Administrative processes can pose barriers to care (such as prior authorizations and determining medical frailty).
- Safety net providers must be in QHP networks (including community mental health) in order to serve high need clients.

MICHIGAN

Expanded Medicaid coverage through MCOs started in Michigan on April 1, 2014. The use of MCOs will be familiar to HCH providers, but complex new cost-sharing and health savings account (HSA) policies may be confusing for providers and beneficiaries alike.

FQHCs are able to waive co-payments for those earning 100% FPL or less, reducing the direct impact of complex cost-sharing arrangements on their practices. Other providers may experience difficulties charging and collecting the rather small co-payments. The process the state will have to go through to collect the mandated beneficiary contributions to HSAs may be administratively burdensome for all involved. Ultimately, the biggest barrier imposed by the cost-sharing may be the rumor and misinformation about the requirements, leading some potential beneficiaries to not enroll for fear of high costs.

An additional concern was whether the state would put in place needed training, infrastructure, and support. Health centers and hospitals are planning to collaborate on outreach and enrollment, as well as monitoring implementation and advocating for new beneficiaries who experience enrollment difficulties and other bureaucratic issues.

Key Takeaways:

- FQHCs can waive co-pays for those at or below 100% FPL.
- New concepts such as health savings accounts and mis-information about costs may impact enrollment.
- Partnering with other safety net providers enhances outreach and enrollment.

PENNSYLVANIA

HCH and health center stakeholders were actively engaged in discussion with the state following the initial Health Pennsylvania Medicaid waiver proposal. Comments and testimony were provided at public hearings and the importance of including FQHCs in QHP networks and maintaining the PPS rate was made very clear. The subsequent official submission to CMS did not include changes to these FQHC policies.

The job search and training requirements originally proposed would have been difficult for vulnerable populations to meet (it was not clear that housing status would be considered in determining exemptions from this requirement). In response to many concerns about this provision, the Governor amended the final proposal sent to HHS, asking to make the job search/training program voluntary.

Other policy changes that have been retained in the waiver request include limits on amount, scope, and duration of benefits and cost-sharing for out-of-network providers. These barriers and restrictions may make it more difficult to engage vulnerable populations in care and could lead to higher costs for the QHPs and the state.

Key Takeaways:

- Ensure proposals provide access to safety net providers, especially FQHCs.
- Consider the long-term costs of restricting benefits.
- Engaging in discussions with the state on the benefits and drawbacks of different proposals can be effective in making improvements.

ADDITIONAL RESOURCES

- CMS *Medicaid and the Affordable Care Act: Premium Assistance* (March 2013): http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf
- Kaiser Family Foundation *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (March 2013): http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8422.pdf
- Center for Health Care Strategies *Alternative Medicaid Expansion Models: Exploring State Options* (February 2014): http://www.chcs.org/usr_doc/Alternative%20Medicaid%20Expansion%20Models%20-%20Exploring%20State%20Options.pdf
- National Health Care for the Homeless Council Health Reform Materials: http://www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials/

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