HEALTH REFORM & HEALTH CARE FOR THE HOMELESS

POLICY BRIEF **AUGUST 2010**

MEDICAID EXPANSION & HEALTH CENTER INVESTMENTS: KEY FACTORS, CHALLENGES & RECOMMENDATIONS FOR HCH GRANTEES

On March 23rd, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA).[1] A week later, on March 30th, 2010, a second law was signed, known as the Health Care and Education Reconciliation Act.[2] Together, these two laws are known more generally as Health Reform. Two major components of health reform will impact Health Care for the Homeless projects most directly: Medicaid expansion and Health Center investments. With each, there are both challenges and opportunities as states and grantees approach implementation.

Medicaid Expansion

Starting January 1, 2014, Medicaid will expand to include all single individuals who earn at or below 138% of the federal poverty level (FPL).[3] For single adults, this equals approximately $15,000 per year (using 2010 FPL guidelines). This income level approximates the earnings from a full-time job at minimum wage. For a family of three, the limit will be about $25,200 per year. This is the single greatest benefit the health reform law offers to individuals experiencing homelessness; nearly 70% of Health Care for the Homeless clients are currently uninsured.

Of the 32 million people anticipated to become insured under the provisions of the health reform law, the Congressional Budget Office (CBO) anticipates there will be 16 million new Medicaid enrollees.[4] While this expansion makes tremendous strides to reduce the uninsured population, the CBO anticipates 23 million non-elderly residents will still remain uninsured in 2019, despite the laws' various provisions. Of these, two-thirds (about 15 million) are estimated to be eligible—but not enrolled in—Medicaid.[5]

At the same time, the results of a recent Kaiser analysis demonstrate that a strong state-level outreach effort could enroll up to 23 million individuals (instead of CBO's 16 million), which would insure 7 million more people.[6] Unfortunately, even this enhanced scenario still leaves about 8 million eligible individuals unenrolled. It is important to note that these estimates include individuals who are currently eligible for Medicaid as well as those who will be newly eligible under the provisions of health reform, underscoring the need for even stronger outreach and enrollment campaigns.

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Reimbursement: The cost to cover newly enrolled Medicaid recipients will initially be fully funded by the Federal government, but the Federal contribution will gradually be reduced so that by 2020 and thereafter, the federal share will be 90% while the states will pay 10%. The federal share of Medicaid reimbursement to each state [otherwise known as Federal Medical Assistance Percentage (or FMAP)], will phase down as follows:

- 100%: 2014 through 2016
- 95%: 2017
- 94%: 2018
- 93%: 2019
- 90%: 2020 and thereafter

This Federal-State cost-sharing is quite different from the current level of FMAP, where the federal reimbursement ranged from 50% to 76% for FFY2008, and then was increased by 6.2 percentage points under the American Recovery and Reinvestment Act (ARRA, also known as the stimulus bill) to range from 61.2% to 84.9% in FFY2010.[7] This is often referred to as an "enhanced match" or an "enhanced FMAP." ARRA funding for the enhanced match is scheduled to end in FFY2011 and will return to the regular FMAP rate.

Exceptions: Several states have already expanded their Medicaid programs through 1115 Waivers to include single adults up to at least 100% FPL prior to enactment of health reform (i.e., Arizona, Hawaii, Delaware, Maine, Massachusetts, Vermont, New York); the health reform law refers to these entities as "expansion states" and provides a separate federal matching rate. For these states, the federal share of Medicaid reimbursement will be phased in starting at 50% in 2014 and going up to 90% in 2020 and thereafter.

Maintenance of Effort: States cannot reduce Medicaid or Child Health Insurance Program (CHIP) eligibility, increase premiums or enrollment fees, or otherwise restrict enrollment. Should states choose to do so, they risk losing all federal matching funding for their entire Medicaid program until the change is corrected. Note that states are not prohibited from reducing reimbursement rates or introducing other mechanisms in order to reduce costs, which in turn reduces access to care because fewer providers may be willing to see Medicaid patients.

Challenges: There will be a number of challenges implementing the Medicaid expansion, particularly at the state and local level, which will require planning and adequate time to implement system change. It will likely mean Governors and state administrative agencies, state legislatures, local health departments, and other public bodies will need to determine what adjustments in state and local laws need to be made to come into compliance with federal law, as well as determine how best to educate the general public about changes to come. Some of these challenges will include the following issues:

- **Enrollment:** How will states and localities handle a large influx of enrollment in Medicaid? The law requires the application process to be simplified and online. States will likely need to improve/change their current systems' capability for enrollment and plan for additional staffing to process the surge of new applications to ensure timely turnaround on approvals. Backlogs due to IT system failures or staffing shortages will inhibit enrollment and traditional barriers to enrollment faced by individuals experiencing homelessness, such as limited awareness and ability to provide documentation, will likely persist.[8]

- **Categorical Reimbursement:** How will states and local jurisdictions distinguish between those individuals who are newly eligible under health reform law and those previously eligible under traditional Medicaid? The reimbursement rates for each group are very different, with federal reimbursement being much higher for the former, and the regular FMAP still in place for those under the "old" categories. In addition, SSI eligibility will continue to be based on disability status, while Medicaid will become based solely on income. Medicaid eligibility systems and social service workers will need to have an efficient way of seamlessly differentiating between the two groups.

- **System Integration with State Exchanges:** The law establishes state-level Exchanges for individuals and small businesses to purchase private insurance. Individuals are eligible to participate in the Exchanges if they earn 100% of FPL or higher, with a combination of federal subsidies and tax credits available up to 400% FPL, depending on income. Those earning between 100% and 138% of FPL may participate in either Medicaid or the Exchange (with a subsidy). How will State private insurance Exchanges integrate with the Medicaid system in a seamless way, especially for those individuals who have fluctuating income? Ensuring continuity will require both systems to be integrated in a way that allows consumers to have full information and choice, and does not eliminate people from coverage.

- **Provider Availability and Reimbursement Rates:** How will states ensure that an adequate health care workforce is in place to support up to 23 million new Medicaid enrollees? There is currently a shortage of providers willing to serve Medicaid patients so there is a great need to plan for and recruit primary care physicians, nurse practitioners, dentists, and specialists of all kinds in order to meet the needs of a population that has high rates of chronic disease but has not been able to afford or access ongoing medical care. Part of the shortage of willing providers has been the low reimbursement rates associated with Medicaid services. There are provisions in the Health Reform law to increase Medicaid reimbursement rates to Medicare rates for FY12 and FY13, but whether and how this enhanced rate will continue thereafter is an open question. In order to attract providers, states will have to raise reimbursement rates and budget accordingly.

- **Block Grants and Other Revenue:** What changes will be made to the availability of block grants and other federal revenue sources once many previously uninsured individuals are covered under Medicaid? To date, these sources have been flexible sources of funding to fill gaps and implement innovative programs tailored to local needs. At this time, HHS has yet to issue guidance or make determinations on this issue, but states and individual grantees might begin to assess what gaps are likely to remain in coverage and services (especially supportive/enabling services, and remaining uninsured populations) and anticipate some changes that will impact funding across many aspects of health services. Additionally, the expansion of access to federally supported health care programs may mean that individual states move away from some of their prior (or planned) investments in health care services and programs. How this might play out at the local level is yet to be determined.

State Option to Choose Early Medicaid Expansion: States do not have to wait until January 1, 2014 to expand their Medicaid program. The law gives states the option to expand earlier, but only allows for the existing FMAP reimbursement for those newly eligible. For states that currently have state-only programs targeting single adults, expanding even incrementally at the lowest FPL levels would bring in additional federal funding. For example, Connecticut is the first state to request to expand their program early and has calculated it can add 45,000 people to Medicaid while saving $53 million over 15 months.[9] Likewise, the District of Columbia has determined it can add 35,000 people to Medicaid, saving DC taxpayers $56 million over 4 years. Other states that have robust state-only programs that might benefit most from an early expansion include Minnesota, Pennsylvania, Wisconsin, and Washington.

Factors for States to Consider: Each state should make its own determination based on current eligibility, the level of current participation (e.g., the rate of eligible-but-not-enrolled), and the policy goals it wishes to achieve regarding the rates of residents remaining uninsured. While states will have to balance the cost of those newly eligible with those previously eligible, and calculate the rate of federal reimbursement it receives, there are also benefits to consider.

- First, states that incrementally expand starting at the lower income levels may experience a smoother transition to full Medicaid expansion (rather than expand all at once in 2014).

- Second, costs related to uncompensated emergency services and inpatient hospital stays will decrease if individuals have access to meaningful preventive and outpatient acute care that helps maintain health rather than causes them to wait for a crisis or complications to occur before seeking care.

- This in turn helps people stay healthier and able to work, rather than turn to public safety net programs due to poor health, unemployment and disability (and, of course, also reduces the likelihood of individuals becoming homeless because of the inability to maintain their incomes and housing). These savings should at least partially offset the costs of expanding Medicaid.

Those Remaining Uninsured

As mentioned previously, the CBO estimates that 23 million individuals will remain uninsured in 2019 (based on current enrollment practices). Even as health centers and other community providers find and enroll as many eligible individuals as possible, there will continue to be populations that remain uninsured, even if for brief periods of time. These populations will include undocumented residents (who will not be eligible for insurance) and individuals who are either not engaged in services, lack the required documentation to enroll, or fall off the rolls during eligibility re-determination. Health centers will be vitally important for delivering health services to these groups.

Health reform includes a mandate for each individual to have approved health insurance. The penalty for non-participation starts at $95 in 2014 but by 2016, the penalty is increased to $695 or 2.5% of household income, whichever is greater. It is important to note that the penalty is assessed through tax filings; those who have income below the filing threshold will not be fined.

Hence, while the vast majority of HCH clients will be eligible for Medicaid, they are unlikely to be penalized if they are not enrolled.

The goal of HCH projects should be to enroll as many eligible individuals in Medicaid as possible.[10] Previous state-level Medicaid expansions have demonstrated important lessons on removing enrollment barriers**: clarifying eligibility requirements, making use of out-stationed eligibility workers at locations frequented by those who are hard-to-reach, and collaborating with other community-based providers**. Finally, continued simplification of the application process, reduced documentation requirements, and staff to facilitate the enrollment process will continue to be effective.[11] Staff at HCH projects should consider engaging in the state-level implementation planning efforts to ensure these strategies are included in your state's plan.

Investments in Health Centers

The health reform law creates a Health Center Fund and permanently authorizes health centers in the law. In addition to annual funding authorizations, there are $11 billion new dollars authorized for Health Centers to be allocated across the next five years. Of this amount, $9.5 billion will be dedicated to operating costs, as indicated below:

- FFY2011: $1 billion
- FFY2012: $1.2 billion
- FFY2013: $1.5 billion
- FFY2014: $2.2 billion
- FFY2015: $3.6 billion

These investments build on each other from year-to-year; thus, the $1.2 billion for FFY2012 includes the $1 billion from the previous year plus $200 million more. After 2015, a funding formula based on cost and patient growth will be implemented. These amounts are in addition to existing discretionary funding ($2.2 billion in FY2010). The remaining $1.5 billion will be reserved for capital investments.

The goal is to double the health center capacity within five years from 20 million patients in 2010 to 40 million patients by 2015. **The overriding theme expressed by Congress and the Administration: expand, expand, expand.**

On August 10, 2010, HHS released the first portion of the FFY2011 funds ($250 million for new access points). HRSA anticipates this amount will support up to 350 new access point grant awards for federal fiscal years 2011 and 2012 (with an annual cap of $650,000). The 100 point baseline scoring system for New Access Point applications includes up to 30 points for "Need for Assistance." [This is divided into 20 points for the Need for Assistance worksheet and 10 points for the Need Criterion narrative.] Health status and access problems that are common among homeless populations are measured in the Need criterion. In addition, HRSA will give special consideration to areas without an existing health center and will grant point adjustments based upon the following stated Priorities:

- Special Populations: Up to ten extra points will be granted to applicants proposing to serve Special Populations (migrant and seasonal farmworkers, people experiencing homelessness, and residents of public housing).

- High Poverty Areas: Proposals for service areas where at least 30% of the population is at or below 100% of the Federal Poverty Level will receive an upward adjustment of up to five points.

Applicants for funding can also include in their request up to $150,000 in the first year for one-time minor capital costs for equipment and/or alternations/renovations (to include Electronic Health Record systems). Projects should be planning how they want to expand their sites and services so they are prepared to submit strong applications, especially as subsequent funding announcements are released. Options for consideration might include adding mobile vans or new sites, extending hours, hiring additional staff, and offering new services such as oral health, enabling services, medical respite care, and additional behavioral health care. Each grantee should be evaluating its own project and community needs. Technical assistance in developing applications is available from HRSA, the National Association of Community Health Centers (NACHC), and from the National HCH Council.[12]

Recommendations for HCH Grantees

Health reform brings key opportunities to HCH projects and the clients they serve. In order to maximize both Medicaid and Health Center expansion, grantees need to plan accordingly. Below are a number of recommendations to consider for policy & planning, funding, and client services.

→ Policy & Planning

- *Participate in the planning process:* If your state has an official Health Reform Implementation Council/Task Force/Committee (or similar group), attend the meetings and track their progress; ask to make a presentation if possible. Ensure that they are considering in their decision-making the needs of HCH grantees and homeless and at-risk persons in the state.

- *Relationship with State Medicaid programs:* If you are not already familiar with your State's Medicaid director and/or senior staff, introduce yourself and invite them to tour your project. Discuss (in person or in writing) the concerns you have and suggest solutions for them to consider. It may be they do not fully understand the unique needs of individuals experiencing homelessness, but it is critical they do! Encourage them to consider early option Medicaid expansion, even incrementally at the lowest income levels.

→ Funding

- *Health Center funding opportunities:* Update your community needs assessments and gaps analyses and plan to respond to the funding opportunities coming to Health Centers. This may include establishing new partnerships or collaborations with other service providers (e.g., hospitals, HRSA-funded health centers and other community-based nonprofit

providers, local government, behavioral health providers, medical respite programs, etc.). Documenting your service needs will also help plan for additional staffing, and substantiate your application for new and/or expanded services.

- *Other potential funding:* Encourage your State to apply for the myriad of demonstration projects and other grant opportunities contained within health reform.[13] Other Health Centers and community homeless service providers can serve as partners to States on these applications.

→ Client Services

- *Outreach:* The goal is not simply Medicaid enrollment, but also delivering services and improving clients' health. HCH programs have the expertise and the infrastructure to facilitate the enrollment of low-income, childless adults (and in many cases also homeless children and adolescents and children and adults in families) and should partner with public agencies to ensure this expertise and infrastructure is utilized. Additionally, ensure your outreach team is as effective as possible and integrated into the community (ideally with other service providers as partners in that effort) so that as many people as possible are engaged in service. It is also important that hand-off procedures between outreach teams and clinical providers are seamless. If your front desk staff discourages the entry into care of a client that your outreach worker spent 6 months engaging, a key opportunity for Medicaid enrollment and medical services is lost.

- *Assist clients in obtaining documentation in order to demonstrate eligibility for Medicaid:* Medicaid still requires proof of identity and citizenship in order for an individual to qualify for coverage. Given that many of HCH clients lack documentation, projects should plan to respond to a large increase in the number of identification documents needed in order to enroll in Medicaid. This likely will require additional funding and/or negotiating a memorandum of understanding (MOU) or other agreement with your State to offset these costs.

Looking Ahead

Health Center programs should look ahead and envision their projects in three to four years. How do you want to expand and how are you positioning yourself to get there? Integrating your efforts with your State and local community will be of great assistance in the coming years as the key components of the health reform law are implemented. As additional guidance is available from HHS, these policy briefs will be updated and the information incorporated into the Council's health reform materials, upcoming regional trainings and technical assistance consultations.

ACCESS MORE HEALTH REFORM RESOURCES ONLINE

National Health Care for the Homeless Council | Health Care Reform Webpage | www.nhchc.org/healthcarereform.html

Notes:

[1] Public Law 111-148, "Patient Protection and Affordable Care Act."

[2] Public Law 111-152, "Health Care and Education Reconciliation Act of 2010."

[3] P.L. 111-148, Section 2001 (a) (1). Note the law adds an 8th categorical eligibility: those who are under 65 years of age, not pregnant, not entitled to or enrolled for Medicaid benefits under another category. Note also the law establishes eligibility at 133% of FPL, but allows for an additional 5% modified adjusted gross income.

[4] Congressional Budget Office (CBO). Letter to Speaker Pelosi from CBO Director Douglas W. Elmendorf. March 20, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

[5] Ibid. This estimate notes one-third (or about 8 million) of those remaining uninsured are undocumented residents.

[6] Holahan, J and Headen, I. (May 2010). *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL.* Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

[7] The ARRA holds harmless all states from any declines in their FMAP that would have otherwise occurred based on changes in their per capita income relative to the national average; increases the federal share every state receives by 6.2 percentage points; and further reduces the state share in most states by 5.5%, 8.5%, or 11.5% depending on changes in each state's unemployment rate. The estimated total amount of additional federal Medicaid funding that each state could potentially receive over all nine calendar quarters (October 1, 2008 through December 31, 2010) is available at www.statehealthfacts.org.

[8] More specific recommendations are available at: National Health Care for the Homeless Council. (August 2010). *Reducing Medicaid Enrollment Barriers for Individuals Who Are Homeless.* Available at: http://www.nhchc.org/reducingmedicaidbarriers.pdf.

[9] HHS press release. (June 21, 2010.) *Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act.* Available at: http://www.hhs.gov/news/press/2010pres/06/20100618h.html.

[10] The National HCH Council has a library of materials dedicated to improving access to Medicaid services for individuals experiencing homelessness, located at: http://www.nhchc.org/medicaid_improvingaccess.html.

[11] 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.

[12] HRSA will schedule three pre-application TA conference calls focused on general assistance, special populations, and clinical/financial performance measures (register at: http://www.hrsa.gov/grants/apply/assistance/nap/). NHCHC also offers TA as you develop your application (call 615-226-2292 or email TA@nhchc.org).

[13] For more information about demonstration project grants available to Health Centers, see NHCHC's policy brief entitled: *Creating Healthier Communities: Chronic Disease Prevention Initiatives of Interest to Health Centers,* June 2010. available at: http://www.nhchc.org/HealthReform/chronicdisease.pdf.