MEDICAID ENROLLMENT & THE ACA:
Changes Coming to the HCH Community

POLICY BRIEF **May 2013**

Overview

Just over 46 million Americans were without health insurance in 2011 and of these, nearly one-third (29%, or 13.3 million people) were living below the federal poverty level (FPL).[1] Health Care for the Homeless (HCH) grantees are familiar with the intersection of poverty and the uninsured--of the 825,295 patients receiving care at HCH sites that same year, 90% were below the poverty level yet 62% were uninsured.[2] The Affordable Care Act seeks to reduce the number of uninsured through state health insurance Marketplaces (also known as 'Exchanges'), expansion of Medicaid coverage to non-elderly adults (ages 19-64) earning at or below 133% FPL, and by simplifying the current process for enrolling all individuals into insurance programs. **Starting on October 1, 2013 individuals will be able to begin applying for health coverage using a new single, streamlined application.** This policy brief provides an overview of the required changes to enrollment in all states, the additional options states can implement, resources that are available to states for enrollment assistance, examples of enrollment practices in an HCH setting, and recommendations for the HCH community to consider as enrollment activities are planned.

Requirements for All States

All states are required to make changes to their systems to ensure a simplified, streamlined enrollment process, regardless their decision whether to extend eligibility to non-elderly adults earning ≤133% FPL. These changes include the following:

- **Simplified categories:** Many states have numerous existing Medicaid eligibility categories, but many of these will be simplified into fewer groups, to include the following: adults, children, parents and pregnant women. Having fewer eligibility categories should create administrative efficiencies and make eligibility determinations easier.

- **No Wrong Door:** States must have a system where individuals and families can apply for health insurance coverage through a single entity, regardless the type of insurance they may ultimately enroll in (e.g., Medicaid, CHIP, Marketplace). States must also allow individuals to apply online, via telephone, mail, and in person.

- **Single, streamlined application:** States must use a single application for all insurance affordability programs, including Medicaid, CHIP, plans offered through Marketplace, and financial assistance for Marketplace plans. HHS has issued a model simple, streamlined application.[3] States can develop their own application (subject to HHS Secretary approval), but the state's application cannot introduce additional burdens on applicants.

- **Modified adjusted gross income (MAGI) with no asset tests or income disregards:** For individuals who fall in Medicaid categories for adults, children, parents, and pregnant women, financial eligibility will be based on the sum of the Modified Adjusted Gross Income (MAGI) of every individual in the household, plus a standard income disregard of 5% points (essentially increasing the 133% eligibility threshold to

138% FPL). Asset tests or additional income disregards are generally not allowed.[4] Although MAGI is determined on an annual basis, eligibility for Medicaid will remain based on income at the time of application (or current monthly income). Note that MAGI income determination will not be used for those qualifying for Medicaid under the mandatory disability category or for the elderly.

- **Income and Citizenship Verification:** To the extent possible, states are required to verify income and citizenship through electronic data-matching with trusted third-party data sources such as the Social Security Administration, the Internal Revenue Service, and the Department of Homeland Security. CMS will facilitate this verification through a "data hub" that will connect to federal data sources, and ultimately, to the online single point of entry. States may request additional information, including documentation, from individuals only when information cannot be obtained through an electronic data source or the electronically-available data is not reasonably compatible with information provided by the individual.

- **No in-person interviews nor paper documentation:** States are prohibited from requiring in-person interviews as part of the application or renewal process, and are not permitted to request paper documentation related to identity, citizenship or income as part of the initial application. Only if there is difficulty establishing eligibility using electronic verification are states able to request back-up documentation from applicants. States are not permitted to require additional information beyond that needed to establish eligibility, and while they may request social security numbers from non-applicants, they cannot require them (e.g., a non-citizen mother applying for coverage of a citizen child).

- **Must be accessible:** States must make the application process accessible to those with limited English proficiency and those with disabilities at no cost to the individual.

- **Must offer assistance:** States must provide all individuals with assistance with the application process, whether this occurs online, over the phone or in person.

- **Annual re-determination:** States are required to renew eligibility every 12 months (not more or less frequently) and must use an administrative renewal process that uses available information, including databases accessed by the Medicaid agency. States are not permitted to require additional information from the beneficiary if eligibility can be determined electronically. Once a renewal has been completed, the state must notify the individual they have been found eligible. The beneficiary is not required to take any action in order to be re-determined. If the state is not able to determine renewal using an administrative process, a pre-populated renewal form is mailed to the beneficiary, who has 30 days to provide the needed information. This step is likely to be problematic for those without stable mailing addresses.

These changes should help facilitate a faster, more efficient enrollment process, thus enabling a greater number of people to access health insurance. The changes related to automated verification and redetermination and the removal of paperwork burdens will be particularly helpful when assisting individuals experiencing homelessness.[5]

Options for States

States have the option to implement additional changes that could further enhance enrollment efforts.

- **Expand Medicaid eligibility to adults at or below 133% FPL:** States can choose to extend Medicaid eligibility to nonelderly adults who earn at or below 133% FPL. In 2013, single individuals earning less than $15,282 annually would be eligible; families of three earning less than $29,295 would be eligible.

Most of those experiencing homelessness will meet this income threshold.[6] Starting January 1, 2014, the costs of this option will be 100% federally financed for the first three years, gradually lowered to 90% federal funding starting in 2020 and thereafter. States can choose to expand earlier at their existing federal funding rate.

- **Expand Medicaid eligibility to individuals with income above 133% FPL:** States can elect to extend eligibility to those earning over 133% FPL and receive their existing federal funding rate, provided that the state has already covered those at a lower income threshold.

- **Use projected annual income:** States can base continuing eligibility on either current monthly income or projected annual income for the remainder of the calendar year. This could enable states to better align Medicaid income rules with those used to assess premium tax credits in the Marketplace. This option could prevent coverage gaps and minimize "churn" between programs, and prevent individuals from being denied for both Medicaid and tax credits. Looking at current income or a projection forward is helpful when assisting those who have had a sudden change in income (e.g., losing a job, having hours reduced, or inconsistent income related to temporary/seasonal/day labor work).

- **Multi-benefit applications:** While states are required to have a health-only application for all insurance programs, states may create an application that combines multiple benefit programs as an alternative. Service providers like HCH grantees who work with very low income populations may find it more efficient to use an application that also includes screening for food stamps, housing or energy assistance, or other programs.

- **Longer grace periods for renewals:** States have the option to extend beyond 30 days the grace period needed for renewals needing additional information provided.

- **Presumptive eligibility:** Currently, states have the option to identify and train qualified entities (such as hospitals and health centers) to screen for eligibility and temporarily enroll children and pregnant women into Medicaid or CHIP while a formal application is being completed. The ACA expands this provision, giving states the option to allow those qualified entities to extend presumptive eligibility to parents and other adults eligible for Medicaid.[7] (The law also now allows hospitals to temporarily enroll children and adults in Medicaid regardless of whether the state has adopted the option.[8]) As of January 1, 2013, 17 states allowed presumptive eligibility.[9] Examples of states that allow health centers to be qualified entities include Wisconsin, New Mexico, New Hampshire, New York and Connecticut.[10]

These options, particularly to expand eligibility to those at or below 133% FPL, offer significant benefits for the HCH community. Additionally, HCH grantees are well-poised to determine presumptive eligibility (should states participate) given the trusted relationships they have with extremely low income populations. Hopefully, use of the new, streamlined and simplified enrollment process that establishes real-time eligibility will mitigate the need for presumptive eligibility, but situations will still arise when the electronic system is unable to accurately verify identity, income and/or citizenship.

Rates of Currently Eligible but Not Enrolled

The state option to expand Medicaid eligibility to non-elderly adults ≤133% FPL has received the bulk of the policy and program attention for obvious reasons; however, the other required or optional improvements in enrollment processes should help expand Medicaid enrollment among those already eligible for Medicaid, but not enrolled. There remain 4.5 million adults who are eligible but not enrolled in Medicaid (comprising 11.5% of uninsured adults), which includes nearly 2.5 million parents and 2 million adults without dependent children.[11] Nationally, only 67% of eligible adults participate in Medicaid, but rates vary widely among states, with Massachusetts enrolling 93% of its eligible adults, and Nevada enrolling only

about half (51%). Further analysis shows very low-income families, especially those without dependent children, those in households earning less than 50% FPL, and those currently unemployed are less likely to participate in Medicaid, although eligible.[12] Individuals experiencing homelessness are likely to fall into one or all of these three categories. The required improvements to the enrollment process—even in states that do not expand their Medicaid programs to the new population—can help improve access to health insurance benefits for vulnerable people.

Resources for States and/or Grantees to Consider

Because many people will need help enrolling, either due to limited access to technology, low literacy skills, language/cultural barriers, confusion over eligibility, or simply personal preference, states and community organizations should be maximizing the resources available to offer in-person assistance.[13] There are a number of new roles being established related to enrollment, each connected to resources that states and/or grantees can use to maximize enrollment.

- **Navigator (required):** Navigator entities will conduct public education to raise awareness of insurance options, provide individuals and families with information related to insurance options available to them and what, if any, assistance they are eligible to receive, help determine which health insurance option best fits their needs, and facilitate enrollment in coverage.[14] These entities will be available in all states and funded via Federal grants or through the operating funds of a state-based health insurance exchange. A wide range of organizations can become Navigator entities, to include community- and consumer-focused nonprofit groups; trade, industry and professional associations; chambers of commerce; unions; licensed insurance agents and brokers; Indian tribes; or local human service agencies.[15] Navigators will be required to complete Federal and/or State training and certification, and will be required to receive requests and applications from all consumers seeking coverage as well as provide information on all insurance coverage options. Each state's process for handling Medicaid-eligible applications will vary, which may mean the Navigator must transfer Medicaid applications to the Medicaid agency for completion.

- **In-person assister (IPA, optional):** Distinct and apart from a Navigator agencies, IPAs supplement navigators by offering a wide range of consumer assistance (to include outreach work), and states will have broader authority over their roles and responsibilities, subject to forthcoming HHS guidance.[16] These funds can be used at the state level for personnel, or offered to community organizations through grants and/or contracts. Unlike for Navigators, funding to develop and operate Assister programs is available through state Marketplace planning grants (Levels 1 and 2) but states must specifically request funds for these purposes. IPA programs will be available in all states who have opted for a state partnership Marketplace (also known as consumer assistance partnerships); they will be optional for states with state-based Marketplaces; but they will not be available in federally-facilitated Marketplaces.[17, 18] Assisters can be focused on both Medicaid and Marketplace populations, and funding for these positions is available through states to help bolster staff support for enrollment activities. In states that support IPAs, these positions are likely to be very helpful to the HCH community. All IPA staff will be required to complete Federal or State training and certification.

- **Certified Application Counselor (CAC):** A term used to formalize existing roles, CACs are especially common in community-based organizations like health centers and hospitals. As of January, 2013, 23 states provided funding for such application counselors (though all states have these roles, dedicated funding is not always available).[19] Draft rules from HHS propose that states may certify staff and volunteers of designated organizations as long as they are registered and trained in eligibility rules, benefits, and confidentiality. Assistance from a CAC has been defined as "providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, gathering required documentation, submitting applications and renewals to the agency,

interacting with the agency on the status of such applications and renewals, assisting individuals with responding to any requests from the agency, and managing their case between the eligibility determination and regularly scheduled renewals."[20] This function already exists in most health centers (at least informally) and CACs may develop as important formal roles in HCH settings.

To further enhance health center ability to conduct enrollment, HRSA is distributing $150 million through formula-based supplemental awards to health centers for outreach and enrollment assistance (with each health center receiving a base amount of $50,000), an additional $5,000 for initial one-time expenditures (e.g., supplies), and an additional amount allocated by the grantees' proportion of uninsured patients, as reported in calendar year 2012 Health Center Program Uniform Data System (UDS). Funds will support at least one additional FTE outreach worker and/or eligibility assistance worker to enable new and expanded outreach and enrollment assistance efforts. To receive this funding, health centers must submit an application indicating planned use of funds by May 31, 2013.[21]

- **Outreach and Enrollment workers funded through Medicaid:** Section 1902(a)(55) of the Social Security Act requires States to place an Outstationed Eligibility Worker (OEW) in Federally Qualified Health Centers and disproportionate share hospitals, or else to implement an alternative plan which has been shown to be equally or more effective. At present, states are eligible to receive Federal funds to cover 50% of the costs of these workers, but starting this fall, this rate will increase to 75%.[22]

- **Projects for Assistance in Transition from Homelessness (PATH):** A program through the U.S. Department of Substance Abuse and Mental Health Services Administration (SAMHSA), PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illnesses—including those with co-occurring substance use disorders—who are experiencing homelessness or are at risk of becoming homeless. In 2011, nearly 82,000 individuals received PATH-funded outreach services, and while most PATH funding goes directly to states,[23] 16 HCH grantees received PATH funding directly.[24] These resources may aid outreach efforts, especially to vulnerable populations with a high rate of mental health conditions.

- **Cooperative Agreements to Benefit Homeless Individuals (CABHI):** CABHI grants can be targeted directly to community-based non-profit entities (like health centers) or they can be targeted directly to states (called CABHI-States grants). Funded through SAMHSA, CABHI grants help increase treatment services, access to housing, and other critical services to persons who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders. Explicitly included in the intended outcomes, CABHI grants emphasize increasing the number of individuals enrolled in Medicaid and other mainstream benefits (e.g., SSI/SSDI, TANF, SNAP). There is currently a CABHI-States grant opportunity open until May 28, 2013 to distribute 12 awards of $800,000 each to state substance abuse services agencies.[25] Using CABHI funding can help HCHs and other non-profits with enrollment initiatives as well as other needed services (like connection to housing).

These six resources are avenues that the HCH community can investigate to help add new staff or formalize the roles of existing staff when planning enrollment activities. While PATH and CABHI grants are not new, and health center staff who provide benefits assistance are clearly fulfilling core health center requirements, the ACA creates new roles for navigators and assisters and the ACA-related rules and regulations are formalizing an array of new terms. States have a strong interest in maximizing the federal resources available to help with these activities and will be partnering with trusted community providers to help fulfill enrollment goals.

Role of HCHs and Other Health Centers

Enrollment and outreach are naturally co-occurring activities, and both are core health center requirements. The program requirements outlined in the Public Health Services Act Section 330 specifically highlight the importance of outreach: "required primary health services means…services that enable individuals to use the services of the health center (including outreach and transportation services…); and education of patients and the general population served by the health center regarding the availability and proper use of health services."[26] Enrollment activities are also a key enabling service, which are considered required primary health services in health centers. These services include "assistance in establishing eligibility for and receiving benefits from public entitlement programs including income support, Medicare, Medicaid, Supplemental Security Income, Veteran's Benefits, and food stamps."[27] All health centers must also provide services which help ensure access to these basic health services as well as facilitate access to comprehensive health and social services. The HCH community has been a national leader in developing effective strategies to reach vulnerable populations, and is well-positioned to share its practices with other service providers to help further improve core competencies in local communities.[28] In particular, the outreach activities of HCH projects have successfully identified and engaged very isolated and disaffiliated persons who stand to benefit greatly from the new eligibility rules and procedures; few other providers are as well-suited to reach this population.

Many low-income people are likely to turn to their health care providers for help with enrollment.[29] Health centers (to include Health Care for the Homeless grantees and other homeless service providers) are trusted venues where clients have established relationships with a wide range of both clinical and non-clinical staff who can provide information and assistance. As outlined earlier, health centers can also be determined as "qualified entities" that are allowed to make presumptive eligibility determinations for Medicaid and CHIP.

The expectation that health centers will be conducting health insurance enrollment was included in a recent draft HRSA policy information notice: "The health center must evaluate a patient's eligibility for insurance and/or related third party coverage and assist the patient with applying for such coverage, as appropriate, prior to determining a patient's eligibility for the sliding fee discount."[30] Hence, health centers are clearly at the center of enrollment activities and will play a critical role in connecting clients to health insurance.

Two Case Studies

Boston Health Care for the Homeless Program, Boston, Massachusetts

Public health insurance has been available to nearly all residents in Massachusetts for years now, so the Boston Health Care for the Homeless Program (BHCHP) has been well-positioned to incorporate enrollment activities into its daily practice. Front desk staff at BHCHP's 12 full-service clinics verifies MassHealth (Medicaid) eligibility for every patient visit and, if needed, an application is filled out on the spot, where income and citizenship are verified electronically. One-page 'cheat sheets' help ensure all information is captured, a letter from BHCHP can attest to state residency, and a flag is placed in the EMR to indicate the next redetermination date (or any further documentation that is needed). Management staff run regular reports on application trends so enrollment processes continue to be honed, and then attend monthly stakeholder meetings and quarterly best practice trainings convened by MassHealth.

Outside of the 12 full-service clinics, BHCHP also has small satellite sites at most area shelters and drop-in centers. Providers and allied health staff at these sites have access to the EMR flags and have benefits specialists out-stationed several days per week. Benefits specialists also aid front desk staff in resolving any particularly complicated issues. While not focused on enrollment, the BHCHP street outreach team builds relationships with consumers, helps connect them to benefits specialists, and encourages individuals to come to a BHCHP clinic for services. Additionally, the

BHCHP Consumer Advisory Board conducts educational outreach several times a year and regularly hosts health fairs where benefits specialists can conduct additional enrollment.

KEY ACTIONS

- Screen for eligibility and ensure enrollment at every visit.
- Ensure benefits workers are out-stationed at satellite sites and have access to EMR notes.
- Develop strong relationship with Medicaid agency through attending public meetings.
- Organize health fairs and community events to facilitate enrollment, and maximize CAB members and benefits specialists in these venues.

Heartland Health Outreach, Chicago, Illinois

Illinois received a waiver to allow early Medicaid Expansion in Cook County, effective December 2012. As a key health services provider in Chicago, Heartland Health Outreach (HHO) has had to "cast a big net, fast" to enroll as many of their patients as possible when the waiver went into effect. HHO initially hired two benefits specialists through foundation grants to focus on disability benefits, but then redirected those roles into broader benefits enrollment as Cook County policy changed, and is now working to integrate screening and enrollment into their intake and front desk operations. A total of three benefits specialists have focused on agency-wide education and training on benefits eligibility and enrollment, as well as education and outreach to community homeless service partners. Benefits specialists are out-stationed at these community partners' sites with laptops to facilitate fast enrollment. Street outreach is conducted primarily through the PATH Team, which focuses on engagement rather than enrollment. The Consumer Advisory Board (CAB) is planning an informational table in the lobby and has developed a simple flyer on Medicaid Expansion to help with consumer education efforts.

HHO is also working to ensure at least one front desk staff person can focus on screening and enrollment at all times. This is requiring some alteration of patient and work flow, as well as some change in work duties, but can be achieved without needing additional resources by spreading the new work duties across teams. The use of flags in the EMR and hardship exemptions for ID fees has also helped facilitate enrollment. HHO recommends obtaining wide stakeholder feedback, revising processes in an ongoing way, planning as far in advance as possible, and developing back billing systems.

KEY ACTIONS

- Pursue foundation grants to support the cost of enrollment activities and staff.
- Educate all staff and community partners on Medicaid Expansion.
- Provide information in the lobby, possibly through CAB volunteers.
- Plan ahead and have structures & data in place for process improvement.

Ten Recommendations for the HCH Community

Consider incorporating these actions into your operations to ensure you maximize available staff and resources, and are able to realize the benefits of increased Medicaid enrollment among clients.

1. Discuss with your state Medicaid director how your state is implementing the required enrollment changes and whether it is pursuing any of the state options; ask how your project can be a partner in enrollment activities.
2. Use existing health center staff to provide enrollment assistance, and ensure they are trained and certified as appropriate, and ensure that your State Medicaid program is aware of the increased Federal match for Outstationed Eligibility Workers placed in FQHCs and DSH hospitals.
3. Add additional staff by participating in a navigator or assister program.

4. Partner with other organizations to maximize enrollment among clients.
5. Educate clients about new health insurance options available to them.
6. Incorporate enrollment into outreach activities.
7. Pursue all available funding opportunities, whether federal, state, local or private.
8. Investigate (or expand) state options allowing health centers to conduct presumptive eligibility.
9. Maximize training, technical assistance or other resources from the National HCH Council, your Primary Care Association, or other recognized experts (and encourage or assist them in developing a focus on special populations, like homeless and other hard to reach groups).
10. Help craft the state's single, streamlined application to help ensure it facilitates enrollment for hard-to-reach populations, which may include using a multi-benefit application.

Conclusion

Changes that improve and simplify the Medicaid enrollment process in all states should help facilitate greater access to health insurance for people experiencing homelessness. Beyond these requirements, states have further options that expand eligibility and give further flexibility and improvements, which can greatly improve access to needed health care services (particularly the option to expand Medicaid eligibility to non-elderly adults earning at or below 133% FPL). Outreach and enrollment services have long been health center requirements, but now are increasingly a federal and state priority with an array of new roles and funding sources intended to complement existing resources. The HCH community should consider how the changes impact internal operations and incorporate the recommendations offered in this policy brief. Specifically, projects should be training and re-evaluating staff roles, maximizing funding opportunities, and engaging in state-level health reform activities.

The policy and practice landscape is changing significantly, but in ways that support long held desires and established practices of the HCH community. HCH clients and agencies alike will be well-served by these changes, and it is incumbent upon the HCH community to maximize the opportunities that now exist.

ADDITIONAL ENROLLMENT RESOURCES

- **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):** Resources on the Marketplaces, Medicaid coverage, Essential Health Benefits, etc: http://www.hrsa.gov/affordablecareact/
- **Centers for Medicare and Medicaid Services (CMS)**: Medicaid/CHIP Eligibility and Enrollment Webinars: http://medicaid.gov/State-Resource-Center/Eligibility-Enrollment-Final-Rule/Medicaid-CHIP-Eligibility-and-Enrollment-Webinars.html
- **Substance Abuse and Mental Health Services Administration (SAMHSA):** Resources for States, state-by-state enrollment processes, analysis and reports: http://www.samhsa.gov/enrollment/states.aspx and State-by-state data on number of those with behavioral health conditions newly eligible for enrollment in Medicaid and Exchanges http://www.samhsa.gov/healthreform/enrollment.aspx
- **Enroll America:** State-by-state profiles related to Exchanges, In-Person Assistance, and Outreach plans: http://www.enrollamerica.org/best-practices-institute/states, factsheet on types of assistance available: http://files.www.enrollamerica.org/best-practices-institute/enroll-america-publications/Enrollment_Assisters_Fact_Sheet.pdf, and policy briefs specific to health centers: http://www.enrollamerica.org/best-practices-institute/enroll-america-publications/healthcenters
- **The National HCH Council:** Outreach resources: http://www.nhchc.org/resources/clinical/tools-and-support/outreach/ and health reform information: http://www.nhchc.org/policy-advocacy/reform/

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[28] National HCH Council resources dedicated to outreach (to include guidelines, trainings and webinars) can be found at: http://www.nhchc.org/resources/clinical/tools-and-support/outreach/.

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[30] Health Resources and Services Administration (HRSA). (July 9, 2012.) *Policy information notice: clarification of sliding fee discount program requirements* (draft for comment, page 9). Available at: http://bphc.hrsa.gov/policiesregulations/policies/draftslidingfee.pdf.