NATIONAL HEALTH CARE for the HOMELESS COUNCIL

HEALTH REFORM & MEDICAID:

HCH Coverage Changes, Current Status in DC & the Expansion Experience in Indiana

March 8, 2017

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

TODAY'S DISCUSSION

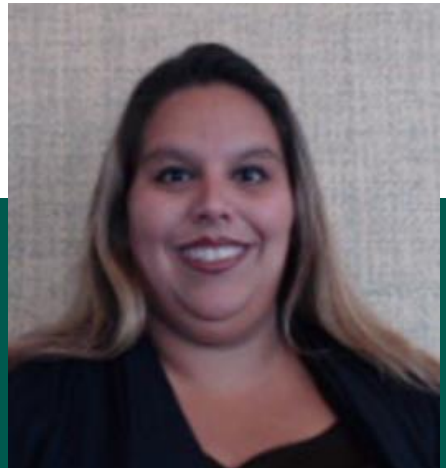
- Why health coverage is critical for people who are homeless & the providers that serve them
- Recent proposals to change how health care is financed and delivered
- Overview of HIP 2.0 in Indiana and the operational aspects of note
- How provisions of HIP 2.0 are impacting people who are homeless
- Briefly discuss proposals in Congress
- Q&A

IMPORTANCE OF COVERAGE

- Provides payment to treat significant health care needs:
  - Chronic illness (diabetes, asthma, hypertension, etc.)
  - Acute conditions and injuries (respiratory illness, wounds, etc.)
  - Behavioral health (mental health, addiction -- to include opioid tx)
  - Communicable disease (Hep C, TB, etc.)
- Provides payment for comprehensive care beyond outpatient primary care (e.g., specialty care, surgery, rehab, etc.)
- Stabilizes financing for providers & increases jobs
- Improves clinical options for providers & improves health outcomes

SPEAKERS TODAY

- **Peggy Bailey,** Director, Health Integration Project, Center on Budget and Policy Priorities
- **René Kougel,** MBA, RN, Chief Operations Officer, Indiana Health Centers, Indianapolis, IN
- **Miranda Bueno & Clarence Walker,** Outreach & Enrollment Assistants/Navigators, Indiana Health Centers, Indianapolis, IN
- Moderator: **Barbara DiPietro,** PhD, Senior Director of Policy, National HCH Council



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Where Are We Now?:

ACA Repeal and Replace Debate Update

Peggy Bailey
Director – Health Integration Project

March 2017

Center on Budget and Policy Priorities

What's At Stake: Medicaid

- Repeal of Medicaid Expansion
- Altering benefits required in plans (Essential Health Benefits)
- Changing from current program to per capita cap
- Multi-step process
  - Congress
    - Budget reconciliation (immediate concern)
    - Regular order legislation
  - HHS
    - Waiver policy
    - Regulations

American Health Care Act
Medicaid Policy Changes

End Medicaid Expansion

Results in $253 billion cut

Gradually ends starting in 2020

Convert Medicaid to Per Capita Cap

Results in $116 billion cut

Based on Medical CPI + 1% point (less than current cost growth)

Does not adjust for epidemics or bad economic times

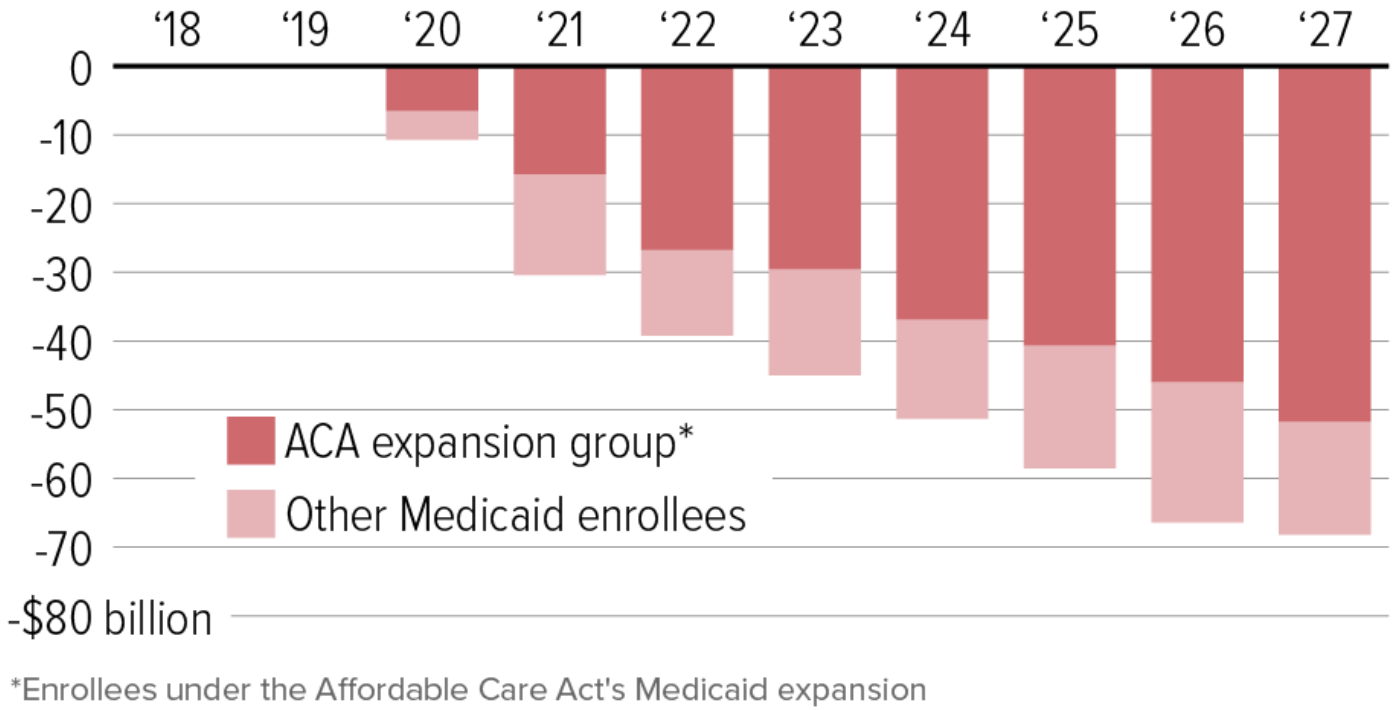
Reduce Covered Benefits

Medicaid Benchmark plans no longer must meet EHB requirements (2020)

Non-Medicaid plans no longer subject to EHB

American Health Care Act: Medicaid Cuts

Cuts Medicaid by $370 Billion Over 10 Years



*Enrollees under the Affordable Care Act's Medicaid expansion

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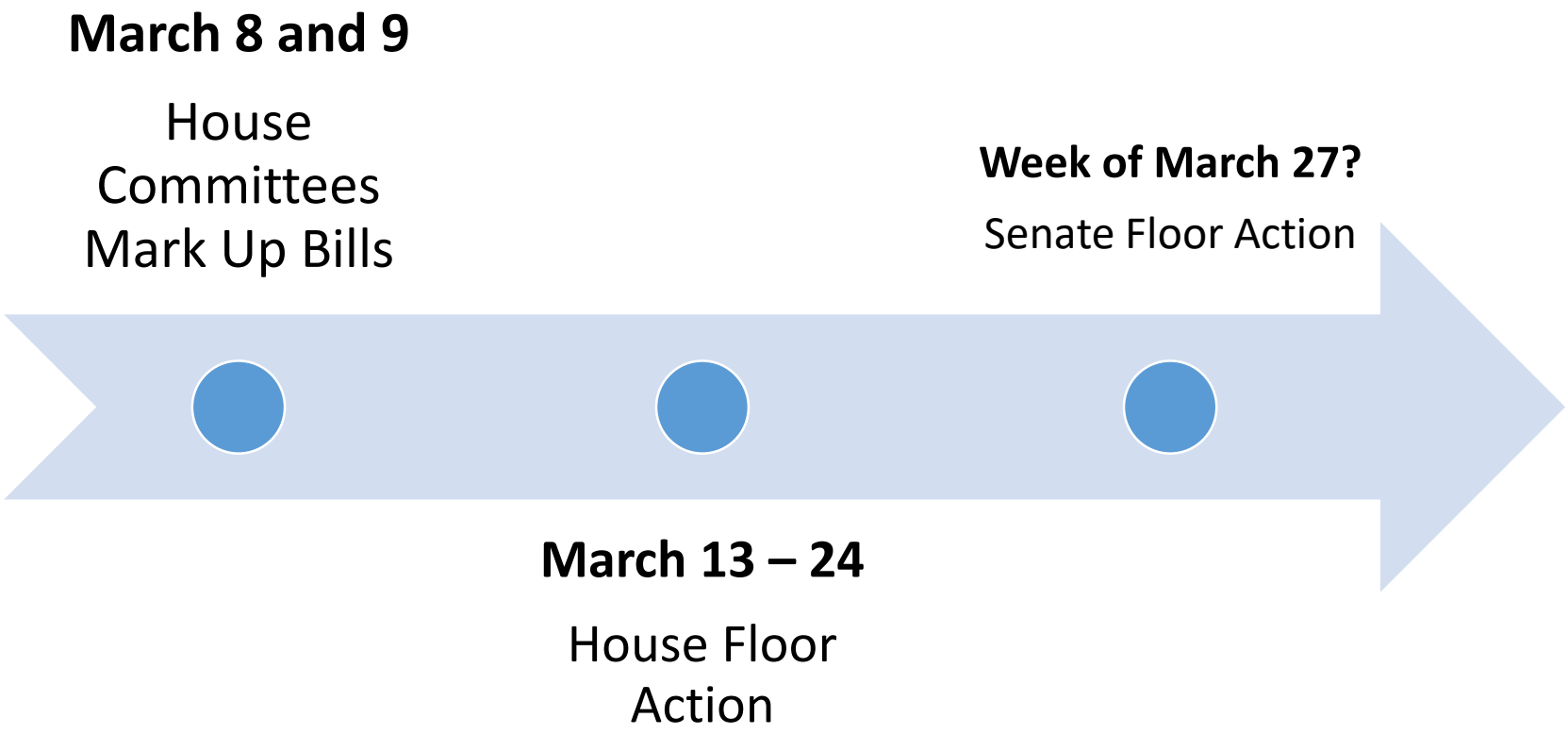
Source: *CBPP analysis of cost shifts relative to current law using Jan. 2017 CBO Medicaid baseline and inflation estimates from CBO and CMS*

Congressional Schedule for ACA Repeal

Budget Reconciliation Legislation
as of March 8th



HHS/CMS Policy Changes

- Much of ACA/Medicaid at discretion of HHS and CMS
- Regulatory Authority – can take time to change
- Waiver Authority – much more immediate multi-step process
  - This is where Indiana's ACA implementation fits in
  - New CMS and CMCS leadership led IN waivers
  - Carryout 'flexibility' goals of states

What Could More Flexibility Bring?

- More premium or co-pays for certain people
- Drug Testing
- Work Requirements
- Other enrollment caps (Medicaid expansion restrictions)

Healthy Indiana Plan (HIP) 2.0

- Indiana recently submitted an extension request
- Initial demonstration increased Medicaid population by 400,000 (60% were previously uninsured)
- Two Programs: HIP Plus and HIP Basic

Elements of HIP Basic and HIP Plus

All HIP 2.0 Enrollees

- Incomes b/t 0 – 138% FPL
- Have POWER Accounts (HSA)
- Waived NEMT
- Employer insurance premium assistance
- Tests work requirements

HIP Basic

- Incomes below 100% FPL who do not pay premiums
- Fewer benefits
- Required co-payments

HIP Plus

- Incomes 101% - 138% FPL or others who pay premiums
- Expanded benefits
- Premiums range from $1 - $27
- Co-pays for non-emergency use of ER
- Missed premium payments = disenrollment

Peggy Bailey

Director, Health Integration

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www.cbpp.org/connecting-the-dots

Center on Budget and Policy Priorities

Indiana HIP 2.0 Program

RENE' KOUGEL, MBA, RN-- CHIEF OPERATIONS OFFICER
INDIANA HEALTH CENTERS, INC.

Miranda Bueno, Indiana Navigator

Clarence Walker, Indiana Navigator

IHC
INDIANA HEALTH CENTERS
Your Pathway to Health

HIP 2.0 Qualification Standards

- 1. Covers adults age 19-64
- 2. Income levels up to 138.5% of the FPL
- 3. Cannot be eligible for Medicare or Medicaid (excludes disabled)
- 4. No enrollment cap

Two Different Levels of Coverage

- 1. HIP 2.0 Basic
  - A. Covers medical only
  - B. $4.00 Co-pay per visit
- 2. HIP 2.0 Plus with Power Account
  - A. Covers medical, dental and vision
  - B. No co-pay

Power Account

Monthly POWER Account Contribution Amounts

Monthly Income	POWER Account Contribution
$216.00	$4.32
$445.00	$8.90
$664.00	$13.28
$996.00	$19.92
$1,382.54	$27.65
$1,516.00	$30.32
$1,864.33	$37.29
$2,021.00	$40.42
$2,827.91	$56.55

Eligibility limit for an individual

Eligibility limit for a household of two

Eligibility limit for a household of four

Consequences of Not Making a Power Account Contribution

- 1. If client is at or below 100% of the FPL, they are moved back to HIP Basic
- 2. If client is above 100% of the FPL, they are removed from HIP 2.0 and ineligible for 6 months

Payer Mix Impact
(Self-Pay Improvements)

	2014	2015	2016
Medical	20.5%	14%	12%
Dental	44%	31.4%	32.2%
Behavioral Health	27%	16.3%	9.8%

Power Account Cards

- 1. Challenges
  - A. Medicaid Contracting Entities (MCEs) do not all have the same website
  - B. Clinics need to fund the credit card machines
  - C. Repetitive process between the EHR and the MCE websites

Power Account Cards

- 2. Benefits
  - Personal Responsibility: the state wants to emphasize to recipients what their visit/procedure costs compared to the premiums they are paying

How do individuals prove that they have paid their power accounts?

- 1. Outreach & Enrollment staff can verify with the Medicaid Web Interchange
  - If individual loses or card is stolen, must contact the MCO immediately—but enrollment can be easily verified-they can be seen without it.
- 2. Outreach & Enrollment staff can call on patients behalf, but the patient must be present at the time of the call
- 3. Patients may sign authorization form

Application Process

- 1. Challenges
  - A. Amount of documents for proof of income
  - B. Length of time for the application
    - Single Family vs. Family
  - C. Length of time for Approval vs. Denial
  - D. All fields must be completed otherwise they will be denied
  - E. Appeal Process

Homeless Population

- 1. Challenges
  - Proof of income (lots of paperwork)
  - Cost of the premiums
  - If they fail to pay premiums, they will be ineligible for the program for 6 months (thus they lack any type of coverage)
  - Can incur a $25 co-pay for an ER visit

Homeless Population Continued

- Many organizations available to assist with monthly/yearly premiums.
- If annual income is below 100% FPL, member will be moved to HIP Basic Plan.
- Exception--Members will not be removed from the plan if they are:

  Medically frail
  Living in a domestic violence shelter
  Living in a natural disaster area.

Overall Challenges

- 1. Medicaid Contracting Entities and Families & Social Services Administration (state Medicaid agency) do not "talk to" one another!
- 2. Completing of the paperwork from clients
- 3. Presumptive eligibility challenges
- 4. Disrupts care plans and referral process

Overall Benefits

- More people than ever are getting coverage for medical, pharmaceutical and dental care.

QUESTIONS?

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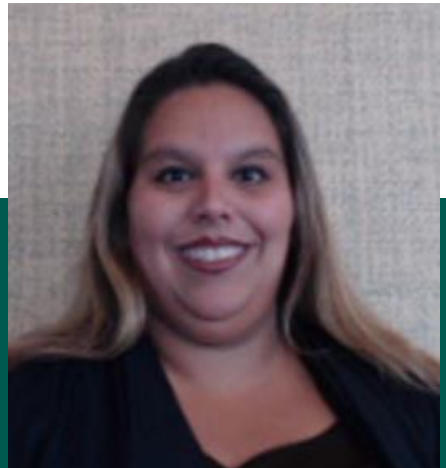

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