HEALTH REFORM & MEDICAID:

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

March 8, 2017
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
Where Are We Now?:

ACA Repeal and Replace Debate Update

Peggy Bailey
Director – Health Integration Project

March 2017
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

- ACA expansion group*
- Other Medicaid enrollees

*Enrollees under the Affordable Care Act's Medicaid expansion

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

March 8 and 9
House Committees
Mark Up Bills

March 13 – 24
House Floor Action

Week of March 27?
Senate Floor Action
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
Indiana HIP 2.0 Program

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

Miranda Bueno, Indiana Navigator

Clarence Walker, Indiana Navigator
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
## Monthly POWER Account Contribution Amounts

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<th>Monthly Income</th>
<th>POWER Account Contribution</th>
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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)

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<tr>
<td>Medical</td>
<td>20.5%</td>
<td>14%</td>
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<td>Dental</td>
<td>44%</td>
<td>31.4%</td>
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<tr>
<td>Behavioral Health</td>
<td>27%</td>
<td>16.3%</td>
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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
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
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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