HEALTH REFORM AND HOMELESSNESS

2012 Policy Statement

SUMMARY OF RECOMMENDATIONS

1. **Allocate federal resources to states for assertive outreach and enrollment activities targeted to all populations needing assistance with Medicaid enrollment and engagement in services**
2. **Develop a common national standard for essential health services that meets the needs of vulnerable populations with complex health conditions**
3. **Maximize workforce expansion opportunities to ensure adequate supply of clinical and non-clinical staffing to meet increased demand for services**
4. **CMS should encourage states to use existing state options under Medicaid to support services in medical respite and permanent supportive housing programs.**
5. **Ensure adequate resources to provide care for remaining uninsured or underinsured in 2014 and thereafter**
6. **Ensure health center funding opportunities are able to meet the unique needs of individuals experiencing homelessness**
7. **Implement integrated care delivery models throughout the health care system that are responsive to the needs of low-income, chronically ill patients**

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA).[1] One week later, he signed a second law, known as the Health Care and Education Reconciliation Act.[2] Together, these two laws are generally still referred to as the ACA (or more simply as "health reform").[3] The changes brought about by the ACA have a significant impact on the level of consumer protections, access to public health insurance, how private insurance is marketed and subsidized, and how health care services are provided and coordinated at the community level. Although the largest changes do not take effect until 2014 and the Supreme Court is currently deliberating the future of the law itself (and its major components), Federal agencies are preparing regulations and other guidance that will determine how these new provisions are implemented at the state and local level and ultimately, how services are able to reach individuals needing health care. States have also begun making decisions about how they will proceed with implementation and utilize or limit the opportunities afforded under the ACA. *The recommendations contained in this policy statement are focused on the provisions of the current law and how implementation might best take into consideration the needs of individuals experiencing homelessness, Health Care for the Homeless grantees, and other service providers and organizations who care for low-income and homeless clients.*

Starting January 1, 2014, Medicaid will expand to include all single individuals who earn at or below 138% of the federal poverty level (FPL).[4] For single adults, this equals approximately $15,000 per year (using 2012 FPL guidelines). This income level approximates the earnings from a full-time job at minimum wage. For a family of three, the limit is about $25,500 per year. This is the single greatest benefit the health reform law offers to individuals experiencing homelessness given that 65% of Health Care for the Homeless clients are currently uninsured.[5]

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.[6] While this expansion makes tremendous strides to reduce the uninsured population, the CBO anticipates 21 million non-elderly residents will still remain uninsured in 2016, despite the laws' various provisions. Of these, approximately 10 million to 11 million are estimated to be eligible—but not enrolled in—Medicaid.[7] The results of a 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, thus reducing the eligible-but-unenrolled population to approximately 3 million to 4 million.[8] Hence, there are three challenges: ensuring resources are available to implement outreach and enrollment activities for those needing assistance with enrollment, ensuring adequate services remain available for those remaining uninsured, and preparing a workforce able to meet the increased demand for services.

The ACA also creates a Health Center Fund and permanently authorizes health centers in the law. In addition to annual funding ($1.6 billion in FY2012), there is $11 billion in dedicated funding for Health Centers provided under the ACA to be allocated over five years. The bulk of the funding--$9.5 million—is to be used for expanding health center services and locations, while the remaining $1.5 billion is dedicated to 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. After 2015, a funding formula based on cost and patient growth will be implemented.

The third priority area concerns the improved health care models outlined in the law, which include patient-centered medical homes/integrated health homes, accountable care organizations, and requirements to hospitals for improved discharge planning. These new models have tremendous potential for offering higher quality care, especially for individuals with chronic health care conditions.

Health Reform Recommendations in Detail

1. Allocate federal resources to states for assertive outreach and enrollment activities targeted to all populations needing assistance with Medicaid enrollment and engagement in services

The ACA and the subsequent guidance issued from HHS make many improvements to the way states determine eligibility and enroll people into Medicaid. These improvements include the following:

- A common eligibility standard that relies on electronic verification of income, identity and citizenship;
- Income determined by a modified adjusted gross income (MAGI), which eliminates asset testing and administrative barriers;
- Streamlined applications that will be processed more quickly and link multiple insurance programs (e.g., Medicaid, state health insurance exchanges and CHIP);
- Automatic annual redeterminations (unless something changes that impacts one's eligibility);
- An option to check "no fixed address" on the application; and no requirement to prove residency in a particular state (it is enough to live there without having to provide paperwork such as utility bills or rental agreements).[9]

The law also permits outreach and enrollment activities targeting vulnerable and underserved populations (such as children, *unaccompanied homeless youth,* children and youth with special

health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.)[10] *Unfortunately, the law does not require outreach and enrollment activities, and federal resources have not been dedicated for this purpose.* HHS should take into consideration the funding and workforce needed at the state level to engage in outreach and enrollment (especially as they apply to harder-to-reach populations) and should consider mandating these services as part of state plans. For example, there is a significant difference between outreach plans that aim to erect billboards and post advertisements for Medicaid eligibility on public transportation lines and those plans that dedicate funding for trained outreach teams to find people living in encampments, under bridges and in other isolated places to enroll in Medicaid and then engage in health services. Given that many states have current budget shortfalls that make such investments difficult to advance amid many competing priorities, HHS should assist states by providing resources that would reduce the number of individuals remaining uninsured once the expansion is implemented.

Recent investments in Medicare and CHIP outreach might serve as a model for these activities. In December 2010, CMS provided $45 million to State Health Insurance Assistance Programs to expand and develop new strategies to strengthen their community-based and grassroots networks by providing personalized, one-on-one counseling, information, education and outreach to help people understand their new Medicare benefits, and provide targeted outreach to individuals with disabilities, those with low income and/or limited English proficiency, and those in diverse racial and ethnic groups to ensure these populations take full advantage of their Medicare benefits.[11] The *Insure Kids Now* campaign launched by CMS to enroll eligible children in CHIP through community partnerships, media campaigns, and outstationed eligibility workers also serves as a model for robust outreach and enrollment.[12] The National HCH Council strongly recommends similar resources be dedicated to states for these same purposes with regard to the Medicaid expansion.[13]

2. Develop a common national standard for essential health services that meets the needs of vulnerable populations with complex health conditions

The ACA requires that all insurance plans sold through Exchanges (to include Medicaid and CHIP plans) contain "essential health benefits," which will consist of the following ten classes of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[14] Subsequent HHS guidance gives states the ability to define the details of these service classes, based on one of ten types of plans using enrollment data from the first quarter of 2012:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state's commercial market.[15]

States have flexibility to adjust benefits, including the specific services covered and the quantitative limits, provided all categories are covered. If states choose not to select a benchmark, the default will be the small group plan with the largest enrollment. States must select a benchmark in the third quarter two years prior to the coverage year (i.e., by September 30, 2012). Given the range of differences in benefit levels, particularly for behavioral health, preventive health, rehabilitative

and habilitative care, as well as pediatric dental and vision care, it is likely that states will design 50 different standards of benefits. It is also possible that the benchmark service package for those newly eligible for Medicaid (those single adults at or below 138% FPL) will differ from those services included for currently eligible populations (e.g., children, pregnant women, those with disabilities, etc.). Failure to cover a consistent, comprehensive set of services within states and across all states will create the same gaps in services that currently exist. For example, populations will continue to shift across Medicaid eligibility categories (children become adults, those yet to prove disability then receive benefits, etc.). For these populations, categorical eligibility is not a static situation, but fluctuates as life circumstances change; a different benefit structure compromises continuity of care, and risks continuing the same existing gaps in service coverage as people change categories. Similarly, services in one state will be very different from services in another state. As people seek employment, reconnect with family, and otherwise change locations, service coverage then becomes based on geography, not patient needs. This would seem to introduce a service variation that lacks consistency, equity, and administrative efficiency. The Medicare program, by contrast, offers a consistent level of services nationwide regardless of geography. The National HCH Council recommends using this model to determine scope, level, duration and amount of services across all categories named in the ACA.

The law also requires the HHS Secretary to periodically evaluate and report to Congress on the essential health benefits to determine whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost, or whether there remain any gaps in coverage.[16] While a specific timeline for this review has yet to be established, the National HCH Council recommends this be done as soon as possible, with an assertive aim to highlight remaining gaps in services, unmet need, and categories of essential health benefits that have not been implemented in a comprehensive manner.

Lastly, the categories named in the ACA are unlikely to meet the complex needs often present in homeless populations. The most obvious of gaps is the limitation of oral and vision care to pediatric populations. Dental and vision care are two of the most critical unmet medical needs, and there exists a dearth of funding to provide such services. And while Medicaid is primarily required to fund core medical care, high-needs populations need support services built in to make the health care services more effective. Hence, Medicaid plans should also be covering case management and outreach services as part of its requirements, as well as extend to cover the medical and support services provided in permanent supportive housing and medical respite care programs. CMS should also consider implementing financial incentives to encourage states to go beyond the minimum standard by rewarding improvements in health status. This could include encouraging managed care organizations to include housing as a cost-effective intervention for the most vulnerable, frequent users of health services.

3. Maximize workforce expansion opportunities to ensure adequate supply of clinical and non-clinical staffing to meet increased demand for services

To help expand the clinical workforce to meet the anticipated increase in demand for services, the ACA dedicates resources to the National Health Service Corps (NHSC), a program operated by the Health Resources and Services Administration (HRSA). NHSC provides student loan repayments and scholarships to those pursuing careers in primary care and willing to work in underserved areas (such as health centers). Both scholarships and loan repayments are available to the following specific professions:

- Primary Care Physician (MD or DO)
- Dentist (DDS or DMD)

- Primary Care Certified Nurse Practitioner (NP)
- Certified Nurse-Midwife (CNM)
- Primary Care Physician Assistant (PA)

Loan repayments are available to the following specific professions:

- Registered Dental Hygienist (RDH)
- Health Service Psychologist (HSP)
- Licensed Clinical Social Worker (LCSW)
- Psychiatric Nurse Specialist (PNS)
- Marriage and Family Therapist (MFT)
- Licensed Professional Counselor (LPC)

The ACA specifies the following specific annual levels, estimated to place approximately 15,000 primary care providers in provider shortage areas, intended to be supplemental to existing annual funding: $290 million for FY2011; $295 million for FY2012; $300 million for FY2013; $305 million for FY2014; and $310 million for FY2015.[17] Unfortunately, Congress reduced annual discretionary funding for the NHSC in both 2011 and 2012 (eliminating it altogether in 2012). Even more disheartening, the President's budgetary request for FY2013 does not restore these losses, requesting only the ACA funding of $300 million. Congress and the Administration should ensure full funding levels for the NHSC, which not only emphasize employment among those graduating professional schools, but also contribute to health care access in underserved areas. In addition, a wider range of clinical professions should be included in these opportunities, especially licensed addictions and mental health counselors. Overlooking these roles risks not having an adequate workforce to meet the increase in demand for mental health and addictions services (part of essential health benefits) that will be needed after health insurance expansions are implemented in 2014 (or earlier at state option).

In addition to focusing on health-related professions, HHS should consider how to bolster the availability of non-clinical support professions, to include case managers, peer mentors, community health workers, and other positions that can aid the effectiveness of core health services. Particularly for populations who often have multiple service providers as well as social services needs, these positions can help coordinate care and services, navigate complex and fragmented systems, and ensure follow up on appointments. Together, clinical and non-clinical positions work to ensure high quality care is accessible and effective for a high-needs population.

4. CMS should encourage states to use existing state options under Medicaid to support services in medical respite and permanent supportive housing programs.

In all states, Medicaid is used to pay for in-home medical and support services provided to seniors and individuals with disabilities. While traditionally these services have been covered as a method to prevent higher-cost institutional level of care (usually a nursing home or other non-community residential setting), individuals experiencing homelessness are in need of these same services but are usually not included in these community service packages. Still, this population has high levels of emergency department (ED) utilization, longer inpatient hospital stays, and increased contact with police, courts, and correctional systems that put them at very high risk of institutionalization in acute medical and psychiatric hospitals, and jails/prisons. This high-end system use is often driven by lack of housing, acute and chronic disease, and untreated behavioral health conditions that require ongoing care. Absent appropriate venues to promote healing and both short- and long-term stability (e.g., stable housing), these individuals are at great risk of recidivism to the

hospital/ED, corrections system or the streets. Medical respite care programs and permanent supportive housing (PSH) projects provide the medical and support services needed in order to improve health status, reduce high-end systems use, and stabilize individuals in the community.[18] States should expand eligibility for Medicaid supported home- and community-based services beyond those who are elderly and disabled or would otherwise need institutional care, and should include people who are experiencing homelessness who require medical and supportive services in order to achieve or maintain housing stability.

Reductions in hospital readmissions through quality health care and robust hospital discharge planning programs as well as ensuring lowering costs and promoting better health outcomes are important goals of the Affordable Care Act, particularly as preparations are made to expand Medicaid more broadly to low-income individuals. Unfortunately, state Medicaid directors may be unaware of the options they have to cover services in medical respite programs and PSH, while at the same time maximizing federal revenue to do so. CMS should send an Informational Bulletin to state Medicaid directors describing medical respite and PSH programs, their impact on health outcomes and costs, as well as existing state options under Medicaid that can be used to finance these models.[19] Such a bulletin from CMS would also support the U.S. Interagency Council on Homelessness' Federal Strategic Plan to Prevent and End Homelessness which describes medical respite care and PSH models as strategies to end homelessness.[20]

Two options that could be used by states to support medical respite and PSH programs include a state plan amendment to provide targeted home and community-based services under Section 1915(i) of the Social Security Act, and a demonstration waiver under Section 1115 of the Social Security Act.

Under Section 1915(i) of the Social Security Act, states are permitted to provide home and community-based services to individuals that earn less than 150% of the Federal Poverty Level and require less than institutional levels of care. The Affordable Care Act made some changes to the HCBS program that could be used to finance services in either of these models and states should strongly consider including medical respite care or PSH services for people who are experiencing homelessness in any 1915(i) state plan amendments. Options CMS might encourage through the 1915(i) include the following:

- States may now propose additional services beyond those traditionally covered under the HCBS program (case management, homemaker/home health aide, personal care, adult day health, habilitation).

- States can establish specific packages of services for targeted populations. For example, a state could propose a package of home and community-based services to be available to people who are experiencing homelessness and in need of recuperative care and/or in-home services.

- States can also create a new Medicaid eligibility category for individuals receiving home and community-based services. This is a good opportunity to implement early Medicaid expansion at an incremental level to a targeted population that tends to be frequent, high-cost hospital users and further minimize costs for states by maximizing federal matching funds.

Under Section 1115 of the Social Security Act, states can receive waivers to conduct demonstrations that promote the objectives of the Act. States may use the 1115 waiver to provide services to Medicaid beneficiaries as long as the services covered under the waiver are budget neutral (meaning federal spending is not more than it would have been in the absence of the

demonstration). States can make a very strong argument for using the 1115 waiver to pay for cost-efficient medical respite and PSH services in lieu of more costly hospital inpatient stays. CMS should seriously consider any 1115 waiver application submitted by states that include medical respite care and PSH services for homeless beneficiaries.

5. Ensure adequate resources to provide care for remaining uninsured or underinsured in 2014 and thereafter

As the health care system is preparing to expand services for those groups who are newly eligible for health insurance (either through Medicaid or expanded private insurance options), there will still be individuals not able to access regular, affordable health care services. These include those who are undocumented (approximately 7 million people), and those who are eligible but not enrolled in Medicaid (between 8 and 15 million, depending on the level of local outreach and enrollment).[21] For those enrolled in Medicaid, there will likely still remain gaps in services (e.g., states are either not required to offer these services or have reimbursements at levels so low that there is no provider base). These are populations who are likely to continue using emergency departments and other high-cost services that do not adequately address ongoing health issues. While health centers will continue to serve those in need of services regardless of their ability to pay, planning efforts for health reform implementation in 2014 and beyond should include resources that enable these populations to receive adequate care. To this end, SAMHSA block grants and other targeted funding (i.e., PATH), HRSA health center grants, Ryan White program funds, and other funding sources should be retained to ensure safety net services are adequate to fill these ongoing needs. Unfortunately, the ACA does not extend health insurance to all individuals, leaving an ongoing need to provide for those remaining uninsured. Only a universal health care plan (i.e., Medicare for All, or single-payer) will address this problem.

6. Ensure health center funding opportunities are able to meet the unique needs of individuals experiencing homelessness

The ACA allocates $11 billion over five years to HRSA to expand health centers and create the capacity to see many more patients seeking care as a result of Medicaid and other insurance expansions. Specifically, the ACA seeks to allocate $9.5 billion to operating expansions (such as new access points and expanded services) through the following phased funding: $1 billion for FY2011; $1.2 billion for FY2012; $1.5 billion for FY2013; $2.2 billion for FY2014; and $3.6 billion for FY2015. The remaining $1.5 billion is to be dedicated to capital funding projects.[22] This additional funding was to be supplementary to annual discretionary allocations, but unfortunately, Congress failed to continue those allocations as projected. Hence, expansion goals originally projected will be more difficult to meet. The National HCH Council strongly recommends that Congress restore those funding losses, which contribute to employment growth in local communities as well as increase access to care for those in need of services.

To date, a series of new access points, expanded services and capital funding grants have been awarded (or are in the pipeline for announcement). When considering funding priorities, the National HCH Council requests that HRSA consider those services that are used disproportionately by individuals experiencing homelessness (when compared to other low-income housed patients) such as outreach, enabling services, behavioral health, and recuperative care (also known as medical respite care). Innovative partnerships with other federal agencies might help combine health services with housing opportunities. For example, HRSA could partner with HUD on a funding collaborative that combines health center funds for medical services and HUD funds for the housing/shelter costs associated with permanent supportive housing and medical respite services. While national goals aim to serve increased numbers of patients, HCH grantees

also need to provide deeper, more intensive services per patient given the additional needs often present with homelessness. We recommend HRSA consider this dynamic when setting programmatic goals and issuing funding initiatives.

7. Implement integrated care delivery models throughout the health care system that are responsive to the needs of low-income, chronically ill patients

The needs of individuals who are chronically ill, low-income and often without stable housing need to be considered as guidance is issued for new health care delivery models that facilitate better coordinated care using electronic health records and teams of providers, the integration and co-location of behavioral health and primary care, and better discharge planning. Hospitals should include medical respite programs in their discharge planning options to reduce re-admission and achieve better patient health outcomes. The "Health Home" model as well as Accountable Care Organizations (as currently envisioned) likely assume physicians are leading a patient care plans (not usually the case at HCH projects) and patients are stably housed with a safe, clean place to recuperate and store medications, have access to reliable and affordable transportation, do not change address often, and are able to use the same hospital and/or emergency department. The models also envision patients as full participants in the decision-making process, but this may assume a level of education, literacy, trust and/or general functionality that is not always possible in a patient population that is more focused on obtaining the most basic human needs of food and shelter each day. As HHS proceeds with guidance to clarify how these new models will operate, an appreciation of the wide range of patient needs and abilities, as well as provider challenges, is critical to achieve the health care outcomes envisioned through health reform.

Notes

[1] Public Law 111-148, "Patient Protection and Affordable Care Act (ACA)."
[2] Public Law 111-152, "Health Care and Education Reconciliation Act of 2010."
[3] A consolidated version of the two laws can be found at http://www.healthcare.gov/law/full/index.html.
[4] 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.
[5] Health Resources and Services Administration (HRSA). 2010 Uniform Data System (UDS). Available at: http://bphc.hrsa.gov/uds/socioeconomic.aspx?year=2010&state=&prog=HO.
[6] 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.
[7] Ibid. This estimate notes one-third (or about 7 million) of the 21 million remaining uninsured are undocumented residents, and the remainder will choose not to be covered by health insurance.
[8] 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.
[9] ACA, Subtitle C, Sections 1413 (c), 1561, and 2201; as well as numerous sections of the final HHS rule outlining eligibility regulatory changes to be found at 42 CFR Sections 431, 433, 435 and 457. Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.
[10] ACA, Section 2201 (b)(1)(F).
[11] Centers for Medicare & Medicaid Services (CMS). December 16, 2010. Press Release: Affordable Care Act Provides New Resources for Medicare Outreach Efforts.
[12] U.S. Department of Health & Human Services. December 27, 2010. Press Release: States Get Bonuses for Boosting Enrollment for Uninsured Children in Medicaid. Available at: http://www.hhs.gov/news/press/2010pres/12/20101227a.html.

[13] More information regarding recommendations to reduce Medicaid barriers to enrollment can be found at: http://www.nhchc.org/HealthReform/ReducingMedicaidBarriersAug2010.pdf.
[14] ACA, Section 1302.
[15] HHS, Center for Consumer Information and Insurance Oversight (CCIIO). Essential Health Benefits Bulletin. (December 16, 2011.) Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.
[16] ACA, Section 1203(b)(4)(G) and (H).
[17] ACA, Section 10503.
[18] Medical respite care is defined as acute and post acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. More information about medical respite is available at: http://www.nhchc.org/Respite/. Permanent supportive housing projects combine affordable housing with services in order to stabilize both health conditions and the ability to maintain housing. More information about PSH is available at: http://www.nhchc.org/supportivehousing.html.
[19] Such a letter might be modeled on a related letter sent by CMS to State Medicaid Directors in August, 2010. Centers for Medicare and Medicaid Services (CMS). (August 6, 2010.) "Improving Access to Home and Community-based Services." SMDL#10-015/ACA #6. Available at: http://www.cms.gov/smdl/downloads/SMD10015.pdf.
[20] U.S. Interagency Council on Homelessness (June 2010). *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.* Available at: http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf
[21] CBO, March 20, 2010; and Holahan, J and Headen, I., May 2010.
[22] ACA, Section 10503.