

SUMMARY OF RECOMMENDATIONS

1. **Establish federal Medicaid guidelines requiring states to adopt outreach and enrollment procedures that reduce the number of individuals who are eligible-but-unenrolled, and to retain identification documents**
2. **Ensure comprehensive benefits are retained under Medicaid benchmark services for newly eligible recipients**
3. **CMS should encourage states to use existing state options under Medicaid to support services in medical respite and permanent supportive housing programs.**
4. **Ensure adequate resources to provide care for remaining uninsured or underinsured in 2014 and thereafter**
5. **Ensure health center funding opportunities are able to meet the unique needs of individuals experiencing homelessness**
6. **Implement integrated care delivery models throughout the health care system that are responsive to needs of low-income, chronically ill patients**

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA).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 PPACA (or more simply as “health reform”).³ The changes brought about by the PPACA 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, Federal agencies are preparing regulations and other guidance that will dictate 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 PPACA. 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 2010 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 \$25,200 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.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 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, thus reducing the eligible-but-unenrolled population to approximately 3 million to 4 million.⁸ Hence, there are two challenges: ensuring robust outreach and enrollment activities are conducted, and ensuring that adequate services remain available for those remaining uninsured.

The health reform law also creates a Health Center Fund and permanently authorizes health centers in the law. In addition to annual funding (\$2.2 billion in FY2010), there is \$11 billion in dedicated funding for Health Centers provided under the PPACA to be allocated across the next five years. Of this amount, \$9.5 billion will be dedicated to operating costs (\$1 billion in FFY11, \$1.2 billion in FFY12, \$1.5 billion in FFY13, \$2.2 billion in FFY14, and \$3.6 billion in FFY15). After 2015, a funding formula based on cost and patient growth will be implemented. 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 third priority area concerns the improved health care models outlined in the law, which include creating and implementing 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. Establish federal Medicaid guidelines requiring states to adopt outreach and enrollment procedures that reduce the number of individuals who are eligible-but-unenrolled, and to retain identification documents

The recent federal health legislation requires all states to simplify their enrollment procedures and coordinate the Medicaid system with the state exchange and the State Children's Health Insurance Program CHIP.⁹ The use of secure online systems with document scanning and electronic signature verification for enrollment and renewal is one option for simplifying and coordinating each system. 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

There will be a number of challenges in implementing the Medicaid expansion, particularly at the state and local level. States will need to design applications that are clearly written and simple to use, improve their current systems' capability for enrollment, determine eligibility quickly and efficiently, reduce common barriers to accessing service venues, plan for additional staffing to process the surge of new applications to ensure timely turnaround on approvals, and recertify eligibility in a seamless manner. These system improvements are vital to successfully engaging and enrolling vulnerable populations such as individuals experiencing homelessness.¹¹

Forthcoming Federal guidance should take into consideration the resources needed at the state level to engage in outreach and enrollment activities (especially as they apply to harder-to-engage populations) and should consider mandating these services as part of state plans. Recent investments in Medicare 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.¹² 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.¹³ The National HCH Council strongly recommends similar resources be dedicated to states for these same purposes with regard to the Medicaid expansion.

The PPACA requires that enrollment must be simplified and technology-enabled, mandating each state to “participate in a data matching arrangement for determining eligibility for participation” as well as to electronically match against existing federal and state data.¹⁴ The data-matching arrangement includes determining eligibility on the basis of reliable, third party data, such as vital records, employment history, enrollment systems, tax records, and other data determined by the Secretary to serve as evidence. The federal guidance to be issued regarding Medicaid enrollment procedures should take full advantage of the systematic efficiencies possible through these requirements. While many individuals experiencing homelessness fall under the income tax filing threshold, there are other existing programs that have already documented income (or lack thereof) that can be used (e.g., corrections data, enrollment data for safety net programs such as food stamps, temporary disability assistance, housing or energy assistance, unemployment benefits, etc.). States should use this as an opportunity to screen for many programs that can assist low-income individuals, not simply limit the screening to Medicaid eligibility.

Establishing identity is often a barrier to enrollment because birth certificates are either lost or stolen and can be cost-prohibitive to replace. While States are upgrading their Medicaid systems to prepare for additional enrollment, guidance should also require state systems to retain copies of vital documents (identification cards, birth certificates) to reduce the need for re-issuing these. Not only does a lack of documentation serve as a barrier to enrollment, but the costs to individuals and service providers are very high.

2. Ensure comprehensive benefits are retained under Medicaid benchmark services for newly eligible recipients

All Medicaid plans must include the “benchmark” benefit package, as defined by Section 1937(b) of the Social Security Act, which requires coverage as being equivalent to the Federal Employees Health Benefit Plan, state employee coverage, coverage offered by the largest non-Medicaid commercial health organization in the state, or HHS Secretary-approved coverage.¹⁵ Resources available under the benchmark include inpatient and outpatient hospital visits, physicians’ surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and any other appropriate preventive service designated by the DHHS Secretary. Beginning in 2014, the benchmark coverage must include at least “essential health benefits,” which includes prescription drugs, rehabilitative and habilitative services and devices, pediatric services (to include oral and vision care), mental health and substance abuse services, and mental health parity (for managed care plans).¹⁶ The DHHS Secretary will be providing additional information to states with specific guidance on the type and level of coverage that will be required, with notice and opportunity to comment. In defining the essential benefits, the DHHS Secretary is required to take into consideration the health care needs of diverse segments of the population. The law also requires the DHHS 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 to coverage.¹⁷

It is possible that the benchmark service package for those newly eligible for Medicaid can differ from those services included for currently eligible populations. Failure to cover a comprehensive set of services will create the same gaps in services that currently exist, thereby continuing to drive ED utilization and other high-cost, uncompensated care. Services that are crucial to serving individuals experiencing homelessness include adult dental, enabling services (e.g., outreach, translation services, health education, etc.), case management, brain injury rehabilitation services, optometry, and a range of specialty services to include ophthalmology, neurology, cardiology, etc.

3. 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 even though this population has high levels of emergency department (ED) utilization, longer inpatient hospital stays, and increased contact with police, courts, and correctional systems. This high-end system use is often driven by both acute and chronic disease as well as untreated behavioral health conditions that require ongoing care. Absent appropriate venues to promote healing and both short- and long-term stability, 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 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 an important parts of the Affordable Care Act, particularly as preparations are made to expand Medicaid more broadly to low-income individuals. Unfortunately, many state Medicaid directors are 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 a “Dear State Medicaid Director” letter 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 letter 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 a strategy 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 should strongly consider any 1915(i) state plan amendments that include medical respite care or PSH services for people who are experiencing homelessness. 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.

4. 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). 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, 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 PPACA 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.

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

The \$11 billion allocated to HRSA for health centers to expand capacity over the next five years will enable more patients to be seen at existing HCH program sites (expanded services and/or medical capacity) as well as provide an opportunity for new HCH projects to be created (new access points). There are some services that are used disproportionately by individuals experiencing homelessness (when compared to other low-income housed patients) such as enabling services, behavioral health, and recuperative care. Innovative partnerships with other federal agencies might help combine health services with housing/shelter 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. This combination would be more easily facilitated if HRSA provided a higher capitated rate included in its grant allocations for some of these targeted populations and initiatives.

6. Implement integrated care delivery models throughout the health care system that are responsive to 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 (PPACA).”

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.ncsl.org/documents/health/ppaca-consolidated.pdf>.

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). 2009 Uniform Data System (UDS). Available at: <http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nathosumdata.html>

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 PPACA, Subtitle C, Section 2201.

¹⁰ PPACA, Section 2201 (b)(1)(F).

¹¹ More information regarding recommendations to reduce Medicaid barriers to enrollment can be found at:

<http://www.nhchc.org/HealthReform/ReducingMedicaidBarriersAug2010.pdf>.

¹² Centers for Medicare & Medicaid Services (CMS). December 16, 2010. Press Release: Affordable Care Act Provides New Resources for Medicare Outreach Efforts.

¹³ 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>.

¹⁴ PPACA, Sections 1413 (c) and 1561, respectively.

¹⁵ PPACA, Section 2001(a)(2)(A).

¹⁶ PPACA, Section 1302.

¹⁷ PPACA, Section 1203(b)(4)(C, G, H).

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