Living and Working in the Coverage Gap: Homeless Health Care in States Yet to Expand Medicaid

INTRODUCTION
The Affordable Care Act (ACA) originally intended that most U.S. citizens would have access to affordable health coverage through one of two main provisions: subsidized private health insurance for low and middle-income households (100-400% of the Federal Poverty Level (FPL)) and expanded Medicaid eligibility for those with lower incomes (at or below 138% FPL). While the June 2012 Supreme Court decision did not affect the provisions to provide subsidized private insurance, it made the Medicaid expansion provision of the ACA optional. Currently 23 states have yet to participate in Medicaid expansion, leading to a coverage gap where a household earns too little to qualify for subsidized private health coverage but does not qualify for Medicaid either. The 23 non-expansion states’ choice not to participate has left approximately 4.5 million impoverished citizens without access to affordable health coverage.

The large majority of consumers at Health Care for the Homeless (HCH) projects in non-expansion states fall into this coverage gap as very few earn more than 100% FPL ($11,670 for a single adult), and they do not otherwise qualify for Medicaid due to age, disability or family status. HCH projects and their communities have developed some ways to provide needed health care for those without insurance and with significant needs, but these are very limited. Access to Medicaid coverage would help address some, although not all, of these challenges. This policy brief draws on the experiences and perspectives of HCH staff and consumers to better describe the impact of the ACA for HCH projects and consumers in non-expansion states, the challenges that remain or have been exacerbated by the lack of Medicaid expansion, and the ways these challenges are being addressed.

BACKGROUND
It is well established that homelessness is a significant social determinant of health and causes tremendous barriers to accessing appropriate care. Individuals experiencing homelessness die 30 years earlier on average than their housed counterparts and suffer significantly higher rates of chronic disease. They face heightened risk of injury, threats of violence, exposure to the elements, and histories of trauma as well. In other words, homelessness is bad for your health.

Beyond poor health status, those without homes often face significant barriers to care. These barriers are numerous, including issues with transportation, storage of medications, and other basic needs that compete with obtaining health care, but financial barriers are among the most significant barriers to care. Homelessness is an extreme form of poverty and paying for health care is simply not possible for most people who are homeless. Safety net programs such as HCH clinics, other Federally Qualified Health Centers, and public hospitals provide care for those who earn little or no income, but comprehensive health insurance increases access to needed services beyond the safety net and reduces barriers to a much greater extent.
Most individuals experiencing homelessness are uninsured, with access to employer-sponsored insurance very rare and access to public insurance dependent primarily on state Medicaid policies. Prior to the ACA, most adults without dependent children or a disability were ineligible for Medicaid and allowable incomes for parents were quite restrictive, although this varied by state. An analysis of 2012 HCH data showed that 61% of HCH patients were uninsured nationally but with significant variation. In states expanding Medicaid, 55% of patients were uninsured but 74% were uninsured in states not expanding. The analysis estimated that 87-99% of those uninsured in non-expansion states would likely stay uninsured and fall in the coverage gap.\(^a\)

A difficult reality for HCH programs in non-expansion states is that many HCH consumers are not eligible for affordable coverage while others at higher income levels are eligible. The situation requires the HCH community to manage the expectations and frustrations of consumers, effectively enroll eligible clients, and adjust to other changes in the health care system without the financial gains Medicaid expansion would provide. The HCH community must face these challenges while continuing to provide primary health care and other supports to a very vulnerable population.

**METHODOLOGY**

To gain insight into these challenges and possible solutions, group interviews were conducted by telephone with staff and consumers at HCH projects in five cities in non-expansion states: Mercy Care in Atlanta, GA; City of Manchester HCH Program in Manchester, NH\(^b\); Downtown Clinic of United Neighborhood Health Services in Nashville, TN; Harris Health System and HCH Houston in Houston, TX\(^b\); and Fourth Street Clinic in Salt Lake City, UT. Two sets of interviews, one with frontline and enrollment staff and another with administrative and clinical leadership were conducted in all five cities. Interviews with HCH consumers were conducted in Atlanta, Nashville, and Houston. Those in the frontline/enrollment groups were generally enrollment assisters, front desk staff, outreach workers, or case managers. Those in the administrative/clinical leadership groups were HCH Directors, finance staff, or directors of certain clinical departments. Consumers were members of a consumer advisory board, a group that provides consumer feedback and guidance to the HCH project. The interviews were conducted from May 2014 to August 2014 and used a set of structured questions. The notes from these interviews were assessed by National HCH Council staff for common themes. Two follow-up interviews were conducted in September 2014 with administrators and enrollment staff from Manchester to assess how the decision to expand Medicaid in New Hampshire has since impacted their work. HCH projects also provided data related to enrollment figures, budgets, patients and other project areas.

**KEY FINDINGS**

*Access to care continues to be challenging for those without insurance*

While acute and primary care provided by the HCH clinic was reasonably accessible in most cases, accessing care not provided by the HCH remained difficult. This poor access led to unnecessary suffering, insufficient treatment, disability, and in some instances preventable death. This has always been a challenge for HCH staff and consumers, and it is particularly difficult now given the ACA’s option to expand Medicaid.

\[^a\] New Hampshire has since passed legislation to expand Medicaid but had not at the time of the interviews

\[^b\] Enrollment staff and administrative staff from Harris Health System were interviewed; the consumer advisory board of HCH Houston was interviewed

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“Even if we got a biopsy and found cancer, it’s like, ‘now what?’”

- Clinician, Fourth Street Clinic, Salt Lake City, UT
Preventive screenings and tests
Preventive screenings are essential to diagnosing and treating potential health problems early. Such early detection usually results in an improved prognosis and reduced cost of treatment. Despite these benefits, staff and consumers reported significant difficulty accessing screenings provided in an ambulatory setting. Colonoscopies were particularly challenging, as well as mammograms. Staff from Mercy Care reported a two-year wait for colonoscopies provided by the local public hospital for those without insurance and other respondents reported wait lists of many months. Staff and consumers also reported difficulties obtaining other diagnostic tests such as biopsies, neurological tests, and x-rays. Without these tests, appropriate treatments for cancer, orthopedic issues such as broken bones, and traumatic brain injuries were difficult to obtain.

Specialty care and ‘elective surgery’
Obtaining needed specialty care was reported as a tremendous challenge for those without insurance. The number of specialists that provide charity care through a hospital or other means is inadequate in almost every community surveyed and long wait times were the norm. Timely appointments were generally only available if a condition had become life threatening or the loss of a limb was imminent. In addition, access to treatment was limited for certain chronic conditions that require ongoing specialty care, such as diabetes. Cancer treatment was also commonly reported as difficult to obtain. One individual with an abdominal tumor was unable to obtain surgery to get it removed until it became much bigger and media attention forced the hand of the hospital. Another individual applied for compassionate care Medicaid in Utah and died of the cancer while waiting for coverage and treatment. Many needed treatments are also classified as ‘elective surgeries’ and thus not accessible to those without insurance, despite actually being very important for the health of a consumer. For example, orthopedic surgeries that are quite painful and debilitating are often categorized as elective and not eligible for charity care services. Consumers and staff reported difficulty obtaining other treatments and therapies for very painful yet sub-acute conditions such as fibroids or skin cancer. One particularly troubling case was of an individual suffering from a painful rash all over his body caused by Hepatitis C. He was unable to get treatment, repeatedly went to the emergency room for temporary relief, and his mental health has deteriorated, leading to suicidal ideation. Those without insurance also struggled to obtain dental treatment if it was not provided by the HCH project, encountering wait lists several months long.

Detox and other intensive behavioral health services
Staff commonly reported challenges identifying detox placements. Several communities reported several month long delays because of very limited placements for those without insurance or the ability to pay out of pocket. This left many struggling with substance use disorders unable to enter recovery. In New Hampshire, a physical exam was required in order to qualify for residential substance abuse treatment, but obtaining such an exam was very difficult for those without insurance. The HCH project would provide such exams, but other community providers would not for those without insurance. Copays for detox services also served as a barrier. In several other communities, detox services were provided, but only on an outpatient basis. Staff reported that outpatient detox has a much higher mortality rate, as high as 5%, and that closer supervision is clinically recommended. Needed follow-up care often did not occur for those receiving outpatient detox services, with the consumer often being discharged after six hours with some paperwork and a referral. Such treatment was rarely effective. Other inpatient treatment such as physical rehabilitation or psychiatric care was also difficult to access without insurance.
Available resources vary, but are frequently scarce and restrictive
While there is typically some process for obtaining needed care for those without insurance or the ability to pay, these processes require significant non-reimbursable staff time and result in delayed care. Considerable variability exists between communities in how one accesses charity or indigent care, but these processes are very much still needed in states that have not yet expanded Medicaid.

"A recent patient diagnosed with cancer was initially denied Medicaid. He was later approved but had already passed away. Just one of many stories I hear all the time."
-Case manager, Fourth St. Clinic, Salt Lake City, UT

Qualifying for certain programs is difficult for consumers
A consistent theme among respondents was how challenging it was to qualify to receive health services outside of the HCH project. In Nashville, you needed to prove six months residency in Davidson County (where Nashville is located) in order to access specialty care services at the local safety net hospital. Newcomers were routinely told to stay at the main emergency shelter for six months and save their mail to prove their residency. Other documentation around income, residency, and proof of homelessness was required in many other cases. These eligibility requirements were not only burdensome for clients but often led to a delay of care and in several instances people died while waiting. Services through the emergency room were accessible, but only for acute issues.

Identifying resources is challenging for providers, but partnerships are helpful
The process of identifying resources for the uninsured was also very difficult for staff. HCH projects typically had partnerships and relationships with specialists, ambulatory care centers, and hospitals in order to obtain specialty care or other services not provided by the HCH project, but obtaining these services was still difficult. In Salt Lake City, three case managers devote most of their time to reaching out to specialists to see if they will treat a specific patient. In New Hampshire, specialty care is available through local hospitals, but some services are only available in Lebanon, NH, 90 miles away. This has led the HCH clinic to pay for bus fare and overnight accommodations just so an individual can access needed care. These arrangements cost the HCH approximately $750 for travel, accommodations, meals and lost staff time for each trip, a significant cost for a small project.

Nonetheless, partnerships are essential so that HCH consumers can obtain needed care. In Nashville, providers have partnered with specialists from Vanderbilt Medical Center and the National Academy of Medicine Bridges to Care Plus program to obtain charity care, although the number of participating specialists is much lower than the need. In Houston, Harris Health System is a large health care network including community health centers, school-based clinics, a dental center and dialysis center, mobile health units, a rehabilitation and specialty hospital, two full-service hospitals, and is also an HCH grantee. This formal relationship with a large health system is very helpful in obtaining needed services. In Salt Lake City, a number of volunteer specialists are very helpful in providing specialty care. There are numerous specialists who volunteer a half day per month and add up to 1.3 full-time equivalent employees. This improved access, but the relationship with these volunteers is tenuous. They often need to take time off of their primary place of employment to volunteer and the HCH clinic ends up being dependent on a single individual on one day out of the month for access to an entire type of specialty care. This reliance on volunteers makes meeting demand and continuity of care particularly difficult.
Some areas have programs that offer limited assistance
Certain state and local policies were helpful in obtaining care for those who lacked insurance. In New Hampshire, all nonprofit hospitals were required to provide a certain amount of charity care to the uninsured. This allowed HCH consumers to access specialty care at several hospitals located in Manchester, although these local hospitals did not provide all needed specialty treatment. In Utah, a limited benefit program called Primary Care Network was available through the state Medicaid program, although this benefit was not full health insurance. It provided coverage for a limited number of primary care visits, medications, and dental services, but enrollment was capped at a certain level. Fourth Street stakeholders did not report much difficulty with this cap and stated they were able to enroll most consumers into the program. Reimbursement rates for this limited benefit were one-third what the typical reimbursement would be under full Medicaid, failing to cover the actual cost of care for the service provided.

“I am very grateful for the Gold Card, although my options for care are limited.”
- Consumer, HCH Houston, Houston, TX

Harris County, TX had the most comprehensive program for those experiencing homelessness of those interviewed. Those without insurance who were certified as homeless by a service provider were eligible for the Harris Health System Financial Assistance Program (known as the ‘Gold Card’) which would allow them to access services without a copay at Harris Health System sites. This allowed consumers to access specialty care, surgery and other services not provided by the HCH sites themselves. The Financial Assistance Program is funded through local tax dollars, primarily property taxes. Staff and consumers in Atlanta and Nashville reported even more significant barriers as neither of these locales had additional programs to address care for the uninsured.

HCH services are accessible but heavily dependent on grant funding
Access to primary care through the HCH project was one bright spot reported by all stakeholders. Respondents did not report waitlists for HCH services and care was free of charge for those earning less than the federal poverty level. Many projects also offer a broad range of services such as mental health services, substance abuse services, chronic disease management, and dental services. HCH staff attempted to secure specialty care when it was needed and guided consumers through the required processes. Project sites were often located in convenient areas such as shelters, drop-in centers, hospitals, or on mobile vans.

This level of access was possible because of the HRSA health center grant and other resources such as the 340B pharmacy program. The HRSA health center grant was consistently the largest source of revenue for these projects and accounted for over 90% of revenue in some cases. Even in cases where a client was insured, many services provided by the HCH were not reimbursable or the process of obtaining payment was very time consuming (see Appendix). The 340B program allowed HCH projects to purchase medications at a reduced cost and provide these medications to HCH consumers without copayments. It was noted that the formulary for the 340B pharmacy program was more restrictive than that of Medicaid and that consumers sometimes had to change their medications as a result. Third-party billing typically made up a very small portion of the HCH projects’ operating revenue and some departments did not bill Medicaid or third-party funders at all. Front desk staff rarely handled payment. Staff noted their projects’ lack of familiarity with billing and mechanisms to support it, as well consumers’ difficulty affording copays should states decide to impose them. Significant infrastructure development and education will be necessary. Overall, HCH administrators reported very few recent changes in revenue or revenue sources.
Despite outreach and enrollment resources, those experiencing homelessness were not eligible for affordable coverage in most cases.

All health centers, including HCH projects, received additional financial resources through HRSA to conduct ACA outreach and enrollment activities. Some also received outreach and enrollment grants from other organizations such as Navigator entities. These resources were helpful, but few consumers experiencing homelessness were found eligible for new coverage options in most of the states surveyed (see figure 1). Some exceptions include Manchester and Salt Lake City, which began to see enrollment increases this summer. The increases in enrollment in Manchester are likely caused by the ramp up to Medicaid expansion in August, as more individuals became Medicaid eligible based on income alone. Salt Lake City is somewhat more difficult to account for, but staff reported their increase was likely based on improved enrollment screening and additional emphasis on enrollment thanks to outreach and enrollment resources. Nashville was unable to provide comprehensive enrollment information, but staff reported very little increase in enrollment and the vast majority of consumers remaining uninsured.

**Figure 1**

Percent of Visits with Clients Who Have Comprehensive Health Insurance: January 2013 to July 2014

- **Atlanta, GA**
- **Houston, TX**
- **Manchester, NH**
- **Salt Lake City, UT**

Note: Downtown Clinic was unable to provide this data.

**HCH projects used varying outreach and enrollment strategies**

Each community is different and HCH projects tailored their outreach and enrollment strategies to fit their unique needs. The degree to which they screened for likely eligible consumers, whether they focused on their current patient population or the broader community, and the number and type of partnerships all varied from project to project. In Manchester and Atlanta, the HCH enrollment staff provided services to the community at large and spent time assisting individuals at partner sites. They also worked closely with...
the financial departments of their clinics and local hospitals to identify those who might be eligible. In Atlanta, doctors would also refer consumers whom they thought might be eligible using a flag on the patient chart. Houston and Salt Lake City took a different approach, encouraging all consumers to meet with enrollment staff. Front desk staff in Salt Lake City encouraged everyone who came to the clinic to apply, and enrollment staff from Houston would assist all who were interested at shelters and encampments. Salt Lake City reported a noticeable increase in enrollment thanks to integrating enrollment screening into their patient flow. Houston did not, likely because of their stringent eligibility criteria in their current Medicaid program. In Nashville, outreach and enrollment services were very limited at Downtown Clinic and these resources were focused on other clinic sites that served a broader population.

"Let me put it this way, follow-up will be a challenge."
-Enrollment assister, Harris Health System, Houston, TX

Most sites also maintained a list of those who were found ineligible and their contact information in case their state decided to expand Medicaid. This list has proved valuable in New Hampshire as their state did decide to expand mid-way through 2014. Enrollment staff were concerned about connecting with individuals experiencing homelessness whose contact information frequently changed, but kept the list nonetheless.

**Outreach and enrollment staff often assisted with enrollment into other benefits**

With so few consumers eligible for affordable coverage under the ACA, staff often took the opportunity to apply for other benefits. In Salt Lake City, all consumers were encouraged to apply for the Primary Care Network benefit described above and most were eligible. In Houston, consumers were assisted with obtaining identification, enrolling in the Gold Card program and filling out an exemption form for the individual mandate. It should be mentioned that those earning too little to file taxes do not need to fill out an exemption form, but filling out the form may have provided some comfort or certainty to consumers. No HCH staff reported assisting consumers with non-partisan voter registration despite federal law encouraging such services for those providing public benefit enrollment assistance.

**Outreach and enrollment staff often provided education and counseling**

Poor health literacy is common among the uninsured and low-income populations, to include those experiencing homelessness. HCH staff consistently reported the need to provide HCH consumers information on how health insurance worked, as well as how eligibility was determined. Manchester HCH employed a health educator for this purpose. Explaining how some with higher incomes were eligible for financial assistance while those with lower incomes were not was particularly challenging. Most HCH staff did point out that it was a state decision not to expand Medicaid, but also tried to avoid politically fraught conversations regarding the basis for these decisions.

Enrollment staff also provided counseling to many consumers who were disappointed or upset by their ineligibility. Staff frequently stated how difficult it was to explain eligibility levels for Medicaid compared to financial assistance for private plans. Staff emphasized the need to show compassion towards those found ineligible and some noted that a background in counseling or mental health services was helpful. Informing
consumers of the health care and other services that were available regardless of insurance status also aided in providing support to those found ineligible.

**Previously eligible still needed significant assistance**
HCH staff reported little improvement in the enrollment process for those who were previously eligible for Medicaid. Enrollment staff typically still referred consumers who were previously eligible to another set of disability determination staff or even other agencies. Consumers frequently still needed to go in person to a determination office and the process of obtaining Medicaid benefits still took many months. One exception was in Atlanta, where the state used electronic verification of vital records to determine Medicaid eligibility. Enrollment staff reported this cut down on the time and documentation needed to enroll, although the system still frequently malfunctioned.

**Consumer perspectives varied but their relationship with HCH remains strong**
Consumers living in non-expansion states had a variety of responses to being found ineligible for affordable health coverage. This is not surprising considering the numerous sources of information and misinformation in the media and elsewhere. Being aware of these common reactions and perspectives will hopefully aid HCH projects in navigating these challenging situations.

"People responded with bewilderment and mild anger to find out they were too poor to qualify."
-Case manager, Downtown Clinic, Nashville, TN

"It plays into feelings of despair and hopelessness."
-Consumer, Mercy Care, Atlanta, GA

"The marketing was awful. Murky at best, wrong at worst."
-Case Manager, Downtown Clinic, Nashville, TN

Consumers were generally uninformed about the ACA
Consumer respondents were not particularly confident in their knowledge of the ACA. Most had received some education from HCH staff or other community groups, but most had heard much more on the news than from community providers. Consumers reported that most people in the community know whether they have access to a doctor or prescriptions but the intricacies of health insurance were less known. The marketing in most states was also either nonexistent or misleading. Consumers consistently reported that education from HCH staff or other trusted community groups was most helpful.

Some had significant concerns about the individual mandate
Some consumers reported that many in the community were very concerned about the individual mandate, fearing large fines that would send them deeper into poverty. HCH staff worked to assure consumers that they were not subject to the requirement to have health insurance because of their low incomes, but some still had concerns. In Nashville in particular, some consumers were opposed to the concept of the ACA,
having heard much more about the fines associated with the individual mandate than the financial assistance available to purchase coverage.

The relationship with the HCH has remained strong
Thankfully, few consumers or staff reported that the strong reactions of some consumers led to a loss of trust or rapport with the HCH project or staff. Consumers consistently reported appreciation for HCH services and staff. While denials of eligibility are disappointing, most consumers have not blamed this circumstance on the HCH project and instead are aware that it is a state government decision. Consumers reported they felt HCH staff were genuinely concerned about their well-being and knowledgeable about what resources were available. Consumers also appreciated the financial assistance and lack of copays at HCH projects, noting that there would be nowhere they could afford to access care without the HCH project.

LOOKING AHEAD

While little change has occurred at HCH projects in non-expansion states so far, staff and consumers both reported numerous hopes and concerns for the future. HCH stakeholders generally hoped that their states would eventually expand Medicaid but were concerned about changes in health care funding and policy that were on the horizon.

Staff and consumers believe Medicaid expansion would be beneficial
Overwhelmingly, staff and consumers reported disappointment that their state had not yet expanded Medicaid and the belief that choosing to expand would benefit their states. HCH staff thought that the increased revenue Medicaid expansion would provide would allow them to expand health care services, other supports, and outreach to the community. It would also eliminate many of the barriers referenced earlier in this brief and allow for timely treatment. Consumers reported that access to affordable health coverage would give them peace of mind and improve their quality of life by limiting the number of burdensome steps currently required to obtain certain services. Staff and consumers also mentioned the need to prepare for the possibility of Medicaid expansion now, through investments in infrastructure, health education, staff training and revisions of job descriptions. Some HCH projects have devoted resources to developing new billing structures and assessing what additional resources will be needed.

Staff and consumers were apprehensive about the future
Many respondents worried about the future of the health care system if their state did not expand Medicaid. Staff from Nashville and Atlanta reported hospital closings in certain parts of the state, changes in hospital financial assistance policies, and increased waitlists in recent months. These changes were not directly attributable to the ACA, but still represented trends in their areas. Rural hospitals in particular have faced closures and financial burdens. Staff also reported concern about the reductions in Disproportionate Share Hospital payments scheduled to take effect in 2017. These payments offset the cost of uncompensated care at hospitals and this reduction could have a dramatic impact on the financial solvency of public hospitals in states that have not expanded Medicaid.
HCH stakeholders also voiced concern about the financial stability of their own organizations going forward. In Salt Lake City, the HCH project’s reliance on donations and volunteers made it particularly susceptible to downturns in the economy, as experienced during the recent recession. Community members were less likely to donate and volunteer during tough economic times and this reduced available resources. Staff worried that another recession could once again harm their project. Staff expressed apprehension about their projects’ reliance on grant funding as well, noting the lack of diversified revenue streams made them vulnerable. The scheduled reduction in health center funding in particular caused grave concern. Several projects reported they would need to reduce staff if the scheduled 70% reduction occurs in 2015, with Salt Lake City predicting a reduction in staffing from over 50 to only 14 employees based on an internal projection.

Consumers reported anxiety about the continued operations of their HCH project. Several respondents mentioned rumors and worries about the closure of the HCH project. Some blamed the ACA for the possible closure of the HCH project and for other possible harms to the health care system. Consumers also reported concerns that health care access would be rationed thanks to the ACA and that those with few financial resources would be left out.

Some staff expressed concern regarding premium assistance plans, others did not
Several states have expanded Medicaid using Section 1115 waivers to make changes to the program for newly eligible beneficiaries. A prominent feature of these waivers has been premium assistance, a program where Medicaid dollars are used to purchase private insurance for Medicaid beneficiaries. Staff were split in their attitudes towards such policies. All staff thought that premium assistance was much better than no coverage, but staff from Salt Lake City and Manchester reported concerns about the cost of using private insurance instead of traditional Medicaid as well as the complexity for both staff and consumers.

NEW HAMPSHIRE MEDICAID EXPANSION
While conducting the interviews, New Hampshire enacted a law to expand Medicaid, effective August 15, 2014. Enrollment could begin on July 1, 2014. This made New Hampshire the 26th state to expand Medicaid and will have far reaching implications for HCH projects and consumers. Follow-up interviews with HCH enrollment staff and leadership at Manchester HCH illustrated how this change is impacting their project.

Outreach and enrollment has been more successful with Medicaid expansion
HCH enrollment staff were prepared to leverage their experience over the previous months to quickly and effectively enroll HCH consumers into coverage. While most of their efforts had previously focused on outreach to the broader community, they have focused primarily on those experiencing homelessness since the enactment of Medicaid expansion. Virtually every consumer who comes in for an appointment is referred to the enrollment team by nurses or providers. Staff have also been going to shelters and the local day center to conduct outreach and enrollment assistance.

Staff kept a list of individuals who were previously denied coverage prior to the expansion of Medicaid, but only about one-third of the several hundred on this list have been successfully contacted. Staff presumed this was due to the transient nature of those they worked with, with cell phone numbers and mailing
addresses changing frequently for those who are unstably housed. Those contacted were generally interested in coverage and voiced no concern or confusion over the change in state policy.

Enrollment appears to be going smoothly, although new processes have been needed to overcome barriers. Staff have been using paper applications, mostly because consumers have preferred them over using electronic applications. Applications typically take about ten minutes and have not needed additional documentation besides a photo identification card unless there was a problem verifying the information. The state requires identification for anti-fraud purposes according to staff. Staff have been working with the State Medicaid Office directly and have not been going through the federal exchange because it has not been updated to reflect the new expansion. Some processes that have been put in place to reduce barriers include having HCH staff identified as a representative for the consumer on the application, assisting consumers in officially changing their mailing address at the post office to ensure proper delivery of confidential mail, and receiving copies of determinations at the HCH project.

New opportunities expected with Medicaid expansion
HCH leadership have not yet completed official projections on how Medicaid expansion will change patient insurance status or operating revenue for the HCH, but expected a significant impact. Virtually all of Manchester HCH consumers are expected to be eligible for Medicaid under the expansion with very few non-citizens seen at the clinic. It is hoped that half or more of all patients will be insured by the end of 2014. Operating revenue is also expected to increase and possibly even double. Staff expects pharmacy costs and transportation costs to decrease and hope to use new revenue for additional primary care, behavioral health, and dental care. It should be mentioned that many HCH services are not reimbursable by Medicaid, such as support services and those provided by certain mid-level providers (see Figure 2, Appendix). Maintaining these services will require continued grant funding. Consumers have also expressed appreciation for the new coverage. Access to a broader range of medications and pharmacies has been among the most commonly mentioned improvements. They also have not experienced any increase in out-of-pocket costs as a result of becoming insured.

Taking full advantage of Medicaid expansion will be challenging
Consumer education has been a challenge thus far, with many becoming insured for the first time. Many also thought that they were no longer able to receive services at Manchester HCH if they became insured. Concerns about the future of hospital uncompensated care programs was also mentioned, with some hospitals instituting policies requiring patients to apply for insurance prior to receiving any charity care services. This may prove to be a barrier for particularly vulnerable consumers who may be resistant to applying.

The most significant challenge reported was the increased staff time and resources needed to successfully file claims and receive payment from Medicaid managed care organizations. Learning the system of prior authorizations, denials, and requests for additional information required by managed care organizations has been time-consuming, with only two HCH staff at the small Manchester HCH program to handle these new tasks. New Hampshire recently transitioned many of their traditional Medicaid population to managed care, so this has been a new system across the board. The HCH Administrator intends to hire more billing staff once the organization better learns the processes, but also noted she would rather spend that revenue on service providers rather than administrative staff. Staff reported that managed care organizations have been helpful in some ways, offering additional care coordination for consumers and communicating frequently.
with providers. Nonetheless, the number one hope expressed by staff is that managed care billing processes can be streamlined and requests for further information and documentation reduced.

ISSUES TO CONSIDER
HCH projects in non-expansion states must continue to provide services to those experiencing homelessness and plan for the future regardless of state decisions regarding Medicaid expansion. The issues identified through these stakeholder interviews are intended to allow HCH projects to learn strategies from each other and educate federal and state officials on the issues faced by HCH projects in non-expansion states.

Strengthening existing partnerships and forming new partnerships
The access limitations experienced by HCH consumers lead to deterioration in health, unneeded suffering, and inefficient use of health care resources. One of the primary ways HCH projects can increase access for uninsured consumers is through partnerships with other providers. HCH projects in non-expansion states may want to further strengthen and formalize relationships with hospitals, specialists, and other community organizations to ensure consumers without insurance are able to access needed care in a timely manner, even without insurance.

Exploring state and local policy responses
State and local policies had a significant impact on uninsured consumers’ access to care. Harris Health System in particular reported little difficulty in accessing specialty care or surgery because of indigent care programs funded through county resources. While states continue to consider whether to expand Medicaid, other policies can be put in place to expand access for those with low-incomes. These policies will not be able to access the substantial federal funding provided through Medicaid expansion, but can still be effective at expanding access to care for low-income households.

Targeting outreach and enrollment resources
Enrollment assisters in non-expansion states successfully enrolled very few HCH consumers. HCH projects may want to consider the likely eligibility of different segments of their community when developing outreach and enrollment strategies. Focusing on higher income populations may be more effective. This may also limit feelings of anger or disappointment from HCH consumers who are found ineligible. Enrollment assisters should be prepared to provide support to HCH consumers they do screen for coverage eligibility and should emphasize the HCH project’s commitment to continuing to provide them care regardless of insurance status. Providing assistance with other benefits such as local health programs or voter registration can also be an effective way to use enrollment resources and limit consumer disappointment.

Providing needed education to HCH consumers
HCH consumers generally had very little understanding of the ACA or the basic ways health insurance works. HCH projects and other community groups can start educating consumers about health insurance and the different aspects of the ACA now, even if they do not currently qualify for affordable coverage. Providing information on the individual mandate, possible other changes to the health care system, and state decisions regarding Medicaid expansion can also help to provide clarity and reduce anxiety about current and future changes.

Building infrastructure needed to bill third-party payers
Most HCH projects in non-expansion states rely heavily on grant funding and do not have well-developed systems, staff capacity, or administrative infrastructure needed to bill effectively. HCH grantees should consider developing this expertise regardless of their state’s current stance on Medicaid expansion. New
Hampshire’s experience with their recent expansion and transition to Medicaid managed care shows the potential challenge of obtaining reimbursement for claims. HCH projects may want to consider investing in infrastructure, training staff, and developing relationships with potential insurers even if their state has not yet expanded Medicaid. History shows that states were initially reluctant to sign up for Medicaid when the program was first implemented in 1965, but virtually all states had signed up within a few years. Medicaid expansion may follow a similar trend and HCH projects would be well-served to be prepared.

CONCLUSION

HCH projects in expansion states and non-expansion states have had divergent experiences with the first year of the ACA’s coverage expansions. While the uninsured rate has dropped significantly for HCH projects in expansion states, those in non-expansion states still serve a predominantly uninsured population. Enhanced creativity in providing care, conducting outreach and enrollment, and educating consumers about the law will be needed to navigate changes in the health care landscape. HCH projects in these circumstances should learn from one another’s experiences to provide high quality care to those they serve. More states may expand Medicaid in the future, but in the meantime, HCH projects will continue to carry out their mission to provide high quality care to those without stable housing regardless of their ability to pay.

APPENDIX: Background data on study site demographics and enrollment

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<thead>
<tr>
<th>HCH Grantee</th>
<th>Mercy Care, Atlanta, GA</th>
<th>Downtown Clinic Nashville, TN</th>
<th>Harris Health System, Houston, TX</th>
<th>Manchester HCH Manchester, NH</th>
<th>Fourth Street Clinic, Salt Lake City, UT</th>
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<td>Number clients served</td>
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<td>Primary Care Dental</td>
<td>Primary Care Dental</td>
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</tr>
<tr>
<td></td>
<td>Dental</td>
<td>Mental Health Addictions</td>
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<tr>
<td></td>
<td>Vision</td>
<td>Case Management</td>
<td>Vision Addictions</td>
<td>Case Management Health</td>
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</tr>
<tr>
<td></td>
<td>Dental Health Addictions</td>
<td>Pharmacy</td>
<td>Education</td>
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<tr>
<td></td>
<td>Case Management Health</td>
<td>Prenatal Care</td>
<td>Pharmacy</td>
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<td>Pharmacy</td>
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<tr>
<td></td>
<td>Education Addictions</td>
<td>HIV Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent clients with insurance* (2013)</td>
<td>5%</td>
<td>12%</td>
<td>9%</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td>Number clients assisted with enrollment</td>
<td>6,041</td>
<td>N/A***</td>
<td>844</td>
<td>3,423</td>
<td>1,584</td>
</tr>
<tr>
<td>Number clients newly enrolled</td>
<td>1,142 (19%)</td>
<td>N/A</td>
<td>0 (0%)</td>
<td>117 (3%)*</td>
<td>106 (7%)</td>
</tr>
<tr>
<td>Total budget (2014)**</td>
<td>$14,502,623</td>
<td>$2,490,519</td>
<td>$4,188,762</td>
<td>$688,757</td>
<td>$8,709,366</td>
</tr>
<tr>
<td>% budget from third-party billing</td>
<td>2%</td>
<td>8%</td>
<td>1%</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>% budget from public grants</td>
<td>43%</td>
<td>91%</td>
<td>97%</td>
<td>80%</td>
<td>42%</td>
</tr>
<tr>
<td>% budget private grants, donations, other</td>
<td>55%</td>
<td>1%</td>
<td>2%</td>
<td>8%</td>
<td>54% (includes significant in-kind and financial donations)</td>
</tr>
</tbody>
</table>
ADDITIONAL RESOURCES


Acknowledgements: Many thanks to Marianne Savarese, Jean Jacques, Amy Pratte, Nelson Gonzalez, Bobby Hansford, Joseph Benson, Denny Anderson, Bill Friskics-Warren, Jeff Driver, Cathryn Marchman, Monique Winters, Tina Hayes, and Jenn Hyvonen for their partnership and for organizing the interviews and providing data.


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NOTES:


9 Bonin et al., 2010.
