

March 2016

Managed Care and Homeless Populations:

Linking the HCH Community and MCO Partners



The state option to expand Medicaid to most non-elderly adults earning at or below 138% of the federal poverty level has meant that many people experiencing homelessness are now eligible for health insurance (in states that have opted to expand). This development means there are new opportunities for health insurers and health care providers to work together to improve health outcomes in a patient population that tends to have intensive needs and high service utilization.

Each year, millions of people experience homelessness in the U.S. Though it is difficult to determine a precise figure, the U.S. Department of Housing and Urban Development (HUD)'s most recent annual reports on homelessness found 564,708 people were homeless on a given night in January 2015,¹ while nearly 1.5 million people used a shelter program at some point during calendar year 2014.² Many others experience homelessness but remain outside these estimates because they avoided the shelter system, used privately funded shelters not part of HUD's network, or who stayed doubled up with friends and families to avoid the streets.

**1.5 MILLION
HOMELESS IN 2014**
Many are newly eligible for Medicaid
in the states that expand.

As states and insurers are increasingly enrolling people who are homeless into managed care plans, new issues are emerging related to identifying individuals who have special needs, linking them to service providers, ensuring access to care, tracking quality of care and health care outcomes, and lowering total costs. At the same time, there is a broad community of health care providers who specialize in caring for homeless populations who are now navigating an insurance system for a larger proportion of their patients. These providers are seeing an expanded focus on enrollment and continuity of coverage, connections to specialty care, more time spent on meeting and reporting on quality goals, and navigating provider networks, prescription formularies, and other parameters of a managed care insurance system.³

This policy brief is intended to serve as a resource for all managed care entities (regardless of affiliation) looking to better understand homelessness, for health care providers seeking to be more aware of managed care and its interests, and for both

groups to better understand the common goals each brings to a partnership. The brief includes the health care needs of this group, describes Health Care for the Homeless projects and the patients receiving care in these venues, a description of managed care, common goals between both entities, and issues that both providers and plans should consider when creating or strengthening partnerships. Because health care providers and insurance plans use different language, the terms "patient" and "member" are used throughout this brief to refer to the individuals being served.

Health Conditions of Those Experiencing Homelessness

Thirty years ago, the Institute of Medicine released a report with three major findings: homelessness causes poor health, poor health causes homelessness, and the experience of homelessness makes it more difficult to engage in health care.⁴ Since that time, numerous studies have shown that people without housing have greater rates of chronic, acute, communicable, and/or behavioral health care conditions compared to their housed counterparts.

For example:

- 30% of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition.⁵
- 73% have at least one unmet health care need, to include 46% having two or more medical comorbidities, 48% with a history of mental illness, and 41% needing dental care.⁶
- About one-third of homeless shelter users have chronic substance use disorders.⁷
- 27% of those who were homeless in Los Angeles screened positive for hepatitis C virus,⁸ while other studies have found a wide range of HCV prevalence (4% to 36%), depending on the location and specific patient population surveyed.⁹
- A HUD report found 20% of those who are homeless had a serious mental illness and 20% had a chronic substance use disorder.¹⁰
- While HIV infections impact <1% of the general population, people who are homeless are disproportionately infected with HIV/AIDS at a rate 3-9 times higher than the stably housed population.¹¹
- Higher exposure to violence, malnutrition, and extreme weather are additional risk factors for poor health and premature death.^{12,13}

- More frequent emergency room and hospitals visits than the general public, with high rates of readmissions.¹⁴
- Twice as likely to have fair/poor health and to have had an ED visit in the past year.¹⁵
- Inpatient hospital stay twice as long (eight days v. four days)¹⁶

PEOPLE WHO ARE HOMELESS HAVE HIGH RATES OF chronic, acute, communicable, and behavioral health conditions

The depth and breadth of health care conditions in this population coupled with a lack of stable housing introduces numerous challenges for health care providers tasked with managing complex patients and achieving health improvements.

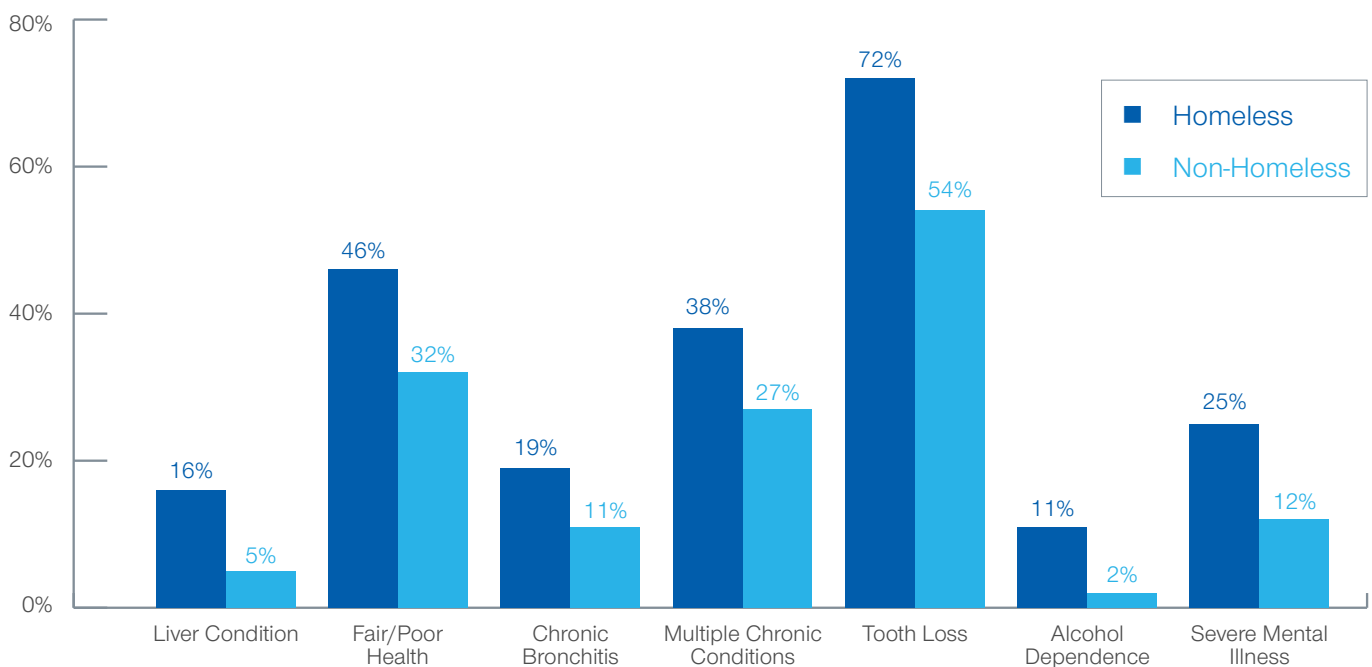
Health Care for the Homeless Projects

Health Care for the Homeless (HCH) projects are part of the consolidated health center program funded through the Health Services and Resources Administration (HRSA) within the U.S. Department of Health and Human Services (health centers are often known as federally qualified health centers, or FQHCs). All health centers are public or private, not-for-profit entities

required to conduct community needs assessments; provide primary, preventive, enabling health services and additional health services as appropriate and necessary on a sliding fee scale (but without regard to ability to pay or insurance status) within a geographically defined area; work collaboratively with community partners; and meet other specified program requirements as outlined in the Public Health Services Act, Section 330.¹⁷ As a “special populations” health center, HCH grantees are tasked with focusing on the complex needs of people who are homeless and providing a coordinated, comprehensive approach to health care that includes substance abuse and mental health services.¹⁸ In 2014, 268 HCH projects provided care to just over 850,000 individuals.¹⁹ These service sites can be provided in free-standing clinics serving only homeless patients, within a traditional health center; at a homeless shelter or other type of social services site or public health department; on a mobile van; or literally on the streets.

While most managed care entities are familiar with health centers/FQHCs that serve a general low-income population, there are important health disparities between patients seen at “traditional” health centers and those served at an HCH project that illustrate far greater service needs, as reflected in Figure 1 below.

Figure 1. Health Status of Health Center Users



Source: Lebrun-Harris, L., et al. (June 2013.) Health Status and Health Care Experiences among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey. Health Services Research 48 (3): 992-1017.

Model of Care: Since the 1980s, the HCH approach to care has been characterized by compassionate and persistent engagement; an emphasis on harm reduction and low-barrier access to services; an understanding of the complex needs of vulnerable people and the intersection between homelessness and poor health; a “whole person” approach to care that includes medical, behavioral and social services; a trusting and respectful relationship; and delivering comprehensive services through multi-disciplinary teams.²⁰ Given the needs of this population, HCH projects typically have integrated behavioral health and primary care services, and a commitment to enabling services such as frequent and intensive street outreach and case management, care coordination across multiple venues of care, and peer mentors/community health workers.^a These projects often partner with local hospitals to engage frequent users who could be better served in an outpatient setting, helping to reduce ED and hospital utilization when appropriate. To illustrate the differences in service provision, Table 1 shows the types of services delivered in HCH settings compared to other health centers, where there are nearly twice as many visits per patient for mental health, seven times the visits for substance abuse, and two and a half times the visits for enabling services.

Patient demographics: When compared with patients at other types of health centers, the majority of people seeking care at HCH projects are non-elderly adults earning at or below the federal poverty level, more men and people of color (though fewer people of Hispanic ethnicity), more people who are uninsured, and far fewer people with private health insurance (see table 2). HCH projects report that 32% of their patients stay in a homeless shelter, 28% are doubled up with family or friends, 13% are in a transitional housing program, and 9% live on the street.²¹

Although 43% of all HCH patients remained uninsured in 2014 after ACA implementation (see Figure 2), this is a substantial decrease from prior years when more than 60% of HCH patients lacked insurance. Now that this group is largely eligible for Medicaid (in states that have opted to expand), gaining access to a broader range of needed health care services is much easier to obtain.

^a The Public Health Services Act, Section 330(b)(1)(A)(iv), defines enabling services as non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.

Table 1. Services Received: HCH Visits v. Other Health Center Visits

Visits by Major Service Category	HCH Patient Visits	All Other Health Center Patient Visits
Physicians	24%	40%
NP/PA/CNM	22%	227%
Nurse	8%	3%
Dental	8%	13%
Mental Health	15%	7%
Substance Abuse	7%	1%
Vision	1%	1%
Enabling Services	15%	6%
Total	~ 100%	~ 100%

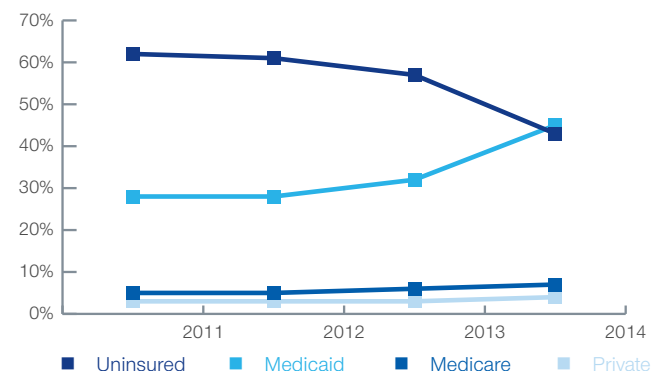
Source: HRSA 2014 UDS data, Table 5 – Staffing and Utilization

Table 2. Characteristics of HCH Patients v. Other Health Center Patients

Demographic Element	HCH Patients	All Other Health Center Patient Visits
Age		
0-17	12%	31%
18-64	83%	61%
65+	4%	8%
Male	55%	42%
White	56%	67%
Hispanic/Latino	25%	35%
<100 FPL	89%	71%
Insurance Status		
Uninsured	43%	28%
Medicaid	45%	47%
Medicare	7%	9%
Private	4%	16%

Source: HRSA Uniform Data System, 2014.

Figure 2. Insurance Status of HCH Patients, 2011-2014



Source: HRSA Uniform Data System, 2014.

Medicaid Managed Care

For those who qualify, Medicaid offers low income individuals access to health insurance, with states and the federal government sharing the costs and program oversight. The federal government establishes basic rules and guidelines for states to follow, to include outlining required services and making provisions for adding other benefits at state option. States work with the Centers for Medicare and Medicaid Services (CMS) to develop their programs, agree on modifications to the benefits, design or delivery of the program and fund health care spending and health reform initiatives. The ability to customize the program to the goals and political realities of each state leads to significant differences in programs.

In 2013, there were 62.2 million Medicaid beneficiaries nationally and 71.7% of those beneficiaries were in some form of managed care.²² While the term “managed care” can be used to describe a variety of arrangements, the most prevalent model is risk-based managed care. Under risk-based managed care, the state sets a per-member-per-month rate (based on historic utilization trends) for broad categories of individuals, using gender, age and eligibility categories to dictate the rate and payment. The health plan is then responsible for managing the benefits and ensuring the individual receives his/her needed services while meeting access and quality requirements. If service utilization for an individual is above the rate, the health plan must cover the cost of care. If utilization is below the rate, the health plan will retain the balance of the funds not spent for that member. Under-utilization over time can lead to poor quality ratings, unmanaged conditions and high-cost service use. There are numerous regulatory and contract requirements that are built into the managed care arrangements with the state and CMS that drive the health plans to ensure that utilization is not unnecessarily high or inappropriately low.

Populations Enrolled in Medicaid Managed Care

States have traditionally used MCOs to serve relatively healthy populations in Medicaid, predominately mothers and children. However, in recent years, states have increasingly looked to MCOs to cover a broader range of populations. States have adopted managed care models for long term supports and services programs at historic rates, added individuals with intellectual and developmental disabilities into managed care contracts and developed specialized managed care programs for children with special healthcare needs, individuals with serious mental illness, and children and youth in foster care.

In addition to the increasing use of managed care for individuals with more complex medical, behavioral, social and functional support needs, states are also leveraging managed care heavily with the newly enrolled Medicaid expansion population. The vast majority of states that have chosen to expand Medicaid have done so by enrolling the population into Medicaid managed care. Of the 32 jurisdictions that have expanded Medicaid to date (to include DC), at least 23 have enrollment in Medicaid managed care above 80% for the expansion population.²³ The heavy reliance on Medicaid managed care for the expansion population has meant that MCOs serving Medicaid beneficiaries are motivated to understand, engage and address issues that are unique or more pressing with the expansion population.

Nationally, almost half of the expansion population is between the ages of 18 and 34. About 44% are parents and almost 60% are female.²⁴ Almost 60% of the newly enrolled were previously uninsured.²⁵ In comparison to the previously eligible Medicaid population, expansion adults report fewer average days in poor physical health, but report similar rates of poor mental health.²⁶ While these statistics underscore that the general expansion population is similar to the previously eligible Medicaid population, subpopulations with complex physical, behavioral health and social support needs (such as those experiencing homelessness) can cause concern for states, health plans and service providers as they seek to improve quality and utilization while effectively leveraging available resources.

Services and Benefits in Medicaid Managed Care

MCOs are required to cover a specific set of benefits as outlined by federal law and the contract with the state. The benefits are typically a portion of or the full set of benefits and services outlined in the state’s Medicaid State Plan. In addition to State Plan Benefits, there may be additional benefits that are offered to a sub-set of qualifying Medicaid beneficiaries. The MCO contract details which benefits are to be covered by the MCO and if there are limits to those benefits. Occasionally, health plans offer additional benefits or programs to attract membership, improve health outcomes and/or improve member satisfaction.

State contracts with MCOs also stipulate key quality metrics, improvement projects, care coordination requirements and additional program responsibilities the MCO must meet in order to remain in good standing with the state. In most states and most MCO contracts, there are specific requirements for care

coordination that include particular targeted requirements for individuals who are at high risk or meet particular criteria.

Many states are working with managed care entities on a variety of strategies and efforts to address the needs of those who are at high-risk and have historically high need and utilization patterns. One example of such a program can be found in Health Homes which are leveraged within both Medicaid managed care and fee for service Medicaid. According to CMS, as of December 2015, 19 states and the District of Columbia have a total of 27 approved Medicaid health home models.²⁷ To be eligible for health home services, an individual must be a Medicaid beneficiary diagnosed with the following according to state-defined criteria: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness. The statute creating health homes listed chronic conditions that include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and overweight (body mass index over 25). Those enrolled in the health home program receive access to six core services (in addition to the standard Medicaid benefits): comprehensive care management; care coordination; health promotion; comprehensive transitional care and follow-up; individual and family support; and referral to community and social support services. These types of services can be particularly helpful to provide to people experiencing homelessness.

As noted above, states have the option of adding benefits specifically designed to address the needs of qualifying beneficiaries through the use of waivers and state plan amendments. Many states, including California, Texas, Washington and New York, have sought flexibility from CMS to pay for expanded benefits including housing supports and services. In June 2015, CMS released guidance that noted while CMS would “not provide Federal Financial Participation (FFP) for room and board in home and community based services,... [it] can assist states with coverage of certain housing-related activities and services.”²⁸

Components to Medicaid Managed Care Service Delivery

Each health plan is unique in its specific approach and service delivery model; however, there are five common elements to Medicaid managed care that are consistent pillars of how health plans operate.

Risk Stratification – Health plans leverage health risk assessments, data and claims information to identify and target beneficiaries for appropriate care coordination, and service delivery models and programs. Those who are high-risk or have a history of high utilization are more likely to be engaged in more intensive care coordination strategies than those with lower risk profiles.

Care Coordination – State contracts with MCOs outline base requirements for care coordination and key target populations for receiving care coordination services. Health plans may find it advantageous to go above and beyond these criteria for particular populations. Within care coordination, health plans assign individuals to care coordinators and/or interdisciplinary care teams that work to ensure individuals are accessing needed services and programs.

Outreach and Engagement – Some MCOs leverage community health workers to conduct outreach and engagement for individuals that are experiencing barriers to accessing health care. Peer Support Specialists are also used by health plans as part of care teams to support improvements in health and quality of life for the individual served.

Network and Provider Engagement – Each MCO must meet particular access standards set forth by the State within their contract. Contracts may also stipulate particular targets for providers under value-based contracting arrangements. Beyond the stipulations of the contract and the state and federal requirements, MCOs develop network and provider engagement strategies to ensure access, quality improvements and cost management.

Linkage to Community Resources – As part of care coordination, MCOs offer linkages to a variety of community-based resources and organizations.

Common Goals and Key Factors

The HCH community and MCOs have many goals in common that can serve as the foundation for successful partnerships. Table 3 outlines the key factors of mutual interest.

Table 3. Common Goals and Collaboration Opportunities Between HCH Projects and Medicaid MCOs

FACTOR	HCH PERSPECTIVE	MCO PERSPECTIVE	OPPORTUNITIES FOR COLLABORATION
<p>Health and stability: Central to the mission of both MCOs and HCH providers, improving health and achieving stability are overarching goals.</p>	<ul style="list-style-type: none"> Providers are deeply vested in patients achieving better health and greater stability Provide low-barrier access to health care in a trauma-informed, harm reduction setting Place high value on developing a trusting, ongoing relationship Consider population health and aim to serve those who do not access traditional primary health care 	<ul style="list-style-type: none"> Employ and/or contract with clinicians and other experts to ensure required health care services are provided and needs of beneficiaries are met, and quality is improved 	<ul style="list-style-type: none"> Address broader issues in communities through policy, community events, educational outreach, trainings and public service announcements Exchange data on service utilization and patient needs, especially for high-cost individuals Leverage claims data to identify those who should be placed in a high risk category Identify additional supports needed to fill unmet needs
<p>Integrated care: As a best practice, integrated care is particularly effective for individuals who need a full spectrum of care.</p>	<ul style="list-style-type: none"> Primary care and behavioral health services offered in one venue through same electronic health record Interdisciplinary care teams creating a common care plan Multiple services to be delivered in one day to best meet the needs of the individual 	<ul style="list-style-type: none"> Responsible for full scope of Medicaid benefits (unless state has carved out specific benefits or responsibilities, in which case likely responsible for coordination across payers) Integrated care team at plan level assists with authorizations, assessments and support access 	<ul style="list-style-type: none"> Work jointly to support policies that encourage same-day appointments Exchange data regarding gaps in care Work together on Medicaid program design that reduces fragmentation and eliminates carved-out services
<p>Case management/care coordination (CM/CC): A critical need for those who are homeless, CM/CC needs to be more intense than for many other low-income groups.</p>	<ul style="list-style-type: none"> Required to offer CM as part of its package of services A wide range of clinical and non-clinical staff assist patients to navigate services, apply for benefits, and connect to care Providers increasingly included in local/regional health information exchanges to enable better care coordination Nursing staff provide medication adherence 	<ul style="list-style-type: none"> Contracts between the state and MCO detail MCO CM/CC requirements Community health workers/peer supports or clinical staff could be added to meet needs Care coordinator at MCO is a point of contact for patient to help navigate services and connect to provider/medical home Case management is frequently telephonic, though sometimes CM staff are out-stationed/ embedded with provider or community-based for high risk individuals 	<ul style="list-style-type: none"> HCH providers could share data with MCO on CM/CC barriers and needs, or additional support needed Identify where additional services are needed based on unique needs of patient population and available community resources Explore telehealth arrangements where needed/possible Discuss how care coordinators or case managers could be added directly at provider level for better support or how coordination efforts at the plan and provider level can work collaboratively and enhance each other's services avoiding duplication Work with state to evaluate the addition of targeted case management benefits
<p>Outreach and engagement: Building a trusting relationship with vulnerable people can take weeks, months or even years before engagement in services can begin. Outreach is an essential component of quality care.</p>	<ul style="list-style-type: none"> Individual staff or entire teams are dedicated to identifying those who are homeless and engaging them in care Usually focused outside a traditional clinic setting, to include at shelter sites, encampments, soup kitchens, and other venues Wide range of services from relationship-building to case management to Medicaid applications to clinical care Increase access to specialty care services by providing escorts and transportation assistance 	<ul style="list-style-type: none"> Contractually obligated to locate and support beneficiaries as well as assess risk and health care needs Identifying/locating those who are homeless is a challenge using traditional communication methods such as phone or mail Responsible for health outcomes and health care utilization regardless of whether or not the beneficiary is located or engaged in care 	<ul style="list-style-type: none"> Mutually share data on individuals who cannot be located Consider placing MCO staff with provider outreach team, funding an additional position to ensure engagement, or using HCH provider as connection point Review MCO mailings to ensure they are clear and understandable

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FACTOR	HCH PERSPECTIVE	MCO PERSPECTIVE	OPPORTUNITIES FOR COLLABORATION
<p>Continuity of benefits and providers: People who are homeless can be very mobile, may not receive mail, and/or may only present to an individual provider once or twice before moving on, creating challenges for care.</p>	<ul style="list-style-type: none"> • Missed deadlines for re-enrollment lead to churning on/off insurance coverage • Patient may present to different providers or venues for care (e.g., hospital, emergency department), creating challenges for continuity of care • Patient may change plans (opportunity to do so varies by state), which may impact covered services and reimbursement 	<ul style="list-style-type: none"> • Beneficiary may formally change providers, but keep his/her plan, creating challenge for care transition • Beneficiary may change plans, interrupting clinical care, but MCO plan still responsible for health outcomes over time and utilization from time of enrollment 	<ul style="list-style-type: none"> • Use MCO service utilization data to identify where individual is seeking services and use outreach staff to help link to assigned medical home • Collaborate to engage individuals in continuity of care at medical home • Work with state, MCOs and HCH providers to implement electronic verification and re-enrollment procedures to reduce insurance churn (e.g., tracking recertification dates)
<p>Quality outcomes: Health reform is increasingly linking payment to outcomes rather than services delivered, creating new opportunities to focus on underlying patient needs.</p>	<ul style="list-style-type: none"> • HCH projects subject to UDS and other quality measure outcomes reporting • Patients may not present to provider more than once or twice a year; or may present in other care venues despite attempts to engage at medical home location • Individuals often present in crisis making it difficult to focus on anything else • Challenges to addressing all acute and preventive/screening needs in one or two clinical visits • Patient priorities for care may differ from clinical goals and/or requirements of larger health care system 	<ul style="list-style-type: none"> • MCOs required to report quality of care measures to the state; many states require plans to obtain NCQA accreditation • Poor engagement and/or health outcomes will negatively impact the plan's measures and may be penalized or at risk for corrective action 	<ul style="list-style-type: none"> • Work jointly for state-level quality measures that address issues relevant to the health care of people who are homeless • Collaborate to support positive sustained engagement to promote better outcomes for everyone • Partner to create and/or expand medical respite care and supportive housing programs
<p>Appropriate venue of care: This group visits emergency rooms more often, which drives up costs but does little to improve health outcomes.</p>	<ul style="list-style-type: none"> • Projects serve as a medical home, offering as many services as possible in one location • Actively engage patients in care • Provide health education, to include when ED visits are appropriate • Collaborate with emergency departments to identify frequent users and connect with outpatient care • Partner with local hospitals to get referrals and do in-hospital visits to bridge to primary care • Transition patients to other community providers once stabilized in housing 	<ul style="list-style-type: none"> • MCOs are tasked with ensuring beneficiaries are receiving the right services, in the right settings at the right times • MCOs are responsible for reducing unnecessary over utilization • Emergency department visits and hospital stays are more expensive than those in a primary care setting and often cannot address the longer-term, complex set of medical, behavioral and social needs of this group 	<ul style="list-style-type: none"> • Implement ED diversion programs that provide alternatives for individuals in need of outpatient primary care • Use MCO data to identify those who may benefit from targeted interventions to ensure they are engaged at the appropriate venue of care • Promote an adequate supply of health care providers to meet needs (to include specialty care and residential treatment options)
<p>Social determinants of health: Lack of housing or housing supports creates health care problems, exacerbates existing ones, and complicates engagement in health care—all leading to poor health outcomes.</p>	<ul style="list-style-type: none"> • Providers attempt to stabilize health conditions in a primary care environment as well as connect to housing and other services needed (e.g., food and/or income assistance, job training, etc.) • Provide recuperative care services for patients who are released from hospitalization but need to recuperate to avoid re-hospitalization 	<ul style="list-style-type: none"> • To achieve health improvements, plans can offer additional supportive services beyond the traditional package targeted at beneficiaries who could benefit from greater stability 	<ul style="list-style-type: none"> • Collaborate to determine what cost-effective services could be offered from the plan • Work with the state about housing support services and the covered package of benefits • Work together for additional housing opportunities

Working Together: Five Actions to Consider

Clearly, there are numerous reasons why MCO and HCH project staff could collaborate more and work together to coordinate benefits and care approaches. Below are five steps to consider initiating or strengthening:

- 1. Meet and identify priorities:** MCO and HCH project staff could meet regularly, discuss the model of care and services being provided at the HCH project, and identify mutual priorities. Additionally, MCOs may have unique capabilities and tools that are designed to connect members to additional resources and supports. An MCO and HCH project could strive to make these services complimentary, each maximizing the others' investments to improve outcomes for those jointly served.
- 2. Share data:** Take the time to match MCO membership and broader service utilization patterns with individuals being served by the HCH project, to include where they are being served and the services delivered (to include identifying a subset of very vulnerable, high-cost, and/or frequent ED or hospital users). The MCO and HCH provider would benefit from a clear memorandum of agreement or other documentation in place to allow for the appropriate sharing of member data due to ensure adherence to all applicable personal health information and patient privacy rules and regulations.
- 3. Identify challenges:** Discuss the factors that make it challenging to improve health. For example: lack of housing, need for more intensive case management or transportation services, out of pocket costs, insufficient specialty care in certain disciplines, lack of healthy or affordable food, high crime or violence, inadequate behavioral health treatment capacity, etc.
- 4. Implement solutions:** Since MCOs and providers have greater flexibility and can respond more quickly than larger state systems, they could work together to implement policy or programmatic improvements that will address those challenges and improve outcomes for individuals experiencing homelessness. States may not be aware of problems that occur within subpopulations so use the data collected can be used for systemic improvement.
- 5. Improve the broader system:** Share successful solutions more broadly so that other MCOs and providers can realize improvements, and discuss how innovative strategies or additional services could benefit the state Medicaid plan to help standardize better approaches to care for vulnerable populations.

Conclusion

The changing landscape in health care coupled with expanded eligibility for Medicaid (in states that have opted to do so) has made the relationship between MCOs and homeless health care providers more vital than ever before. Insurers are now responsible for health care use and outcomes for people who lack housing and have significant health care needs, and providers are now seeing a broader proportion of their patients covered through managed care. Both entities have a number of common goals and objectives, but may not be familiar with the other's point of view. Partnerships between the two entities are vital and have the real potential to improve the lives of those they serve.

Disclaimers: This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09746, a National Training and Technical Assistance Cooperative Agreement for \$1,625,741, with 0% match from nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

The National Health Care for the Homeless Council is grateful for its partnership with UnitedHealthcare in producing this policy brief; however, we recognize that there may be significant philosophical and/or operational differences that exist between HCH projects and any health insurer or managed care entity. This policy brief does not necessarily endorse UnitedHealthcare over other health insurers, nor does it endorse any individual plan or its provisions.

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