NATIONAL HEALTH CARE for the HOMELESS COUNCIL

HEALTH REFORM & HOMELESSNESS

16 KEY ADVOCACY AREAS FOR THE HCH COMMUNITY

Spring 2016

Health reform through the Affordable Care Act (ACA) presents new coverage opportunities for people experiencing homelessness, many of whom have significant health care needs. Improvements include required changes to the Medicaid enrollment process in all states and a state option to expand Medicaid to most low-income adults. Increased Medicaid enrollment will provide access to a wider range of health services, increase employment, bring needed revenue for service agencies, and save money that states can redirect to ongoing needs—such the remaining uninsured and services not covered by Medicaid.

Federal and states policy makers continue to refine health care systems and policies to improve quality of care, decrease costs, and improve outcomes. These decisions will determine how individuals needing care are able to access services. Unless the homeless health care community is part of these discussions to influence the choices made, these plans may not be sufficient to reach vulnerable people.

When the health care system works well, it can help prevent and end homelessness.

The HCH Community Should Communicate with Policy Makers On These Concerns & Opportunities:

1. **Medicaid Expansion:** All states should fully expand Medicaid to those earning at or below 138% of the federal poverty level.

2. **Outreach:** States should ensure that assertive outreach and Medicaid enrollment efforts are targeted to people experiencing or at risk of homelessness, and that resources for these activities are available to homeless service providers.

3. **Medicaid Application:** The single, streamlined health insurance application process should combine enrollment in a Medicaid plan in the same step as eligibility determination. States should maximize options for greater efficiency (such as a consolidated application for numerous assistance programs and multi-year automatic Medicaid redeterminations), prevent ongoing enrollment barriers (such as mailing address requirements), and include service providers as authorized representatives to the fullest extent possible.

4. **Provider selection:** States should ensure that all health plans include an adequate network of providers who are willing and able to meet the complex health care needs of those experiencing homelessness, and carefully tailor "auto-enrolled" provider selection to patient needs and geographic location. Changing providers should be administratively quick and easy when access or continuity of care becomes problematic.

5. **Barriers to care:** In order to eliminate major barriers to care, improve outcomes and save administrative costs, states should eliminate Medicaid cost-sharing (fees for prescription drugs, outpatient services, ED visits, hospital stays, etc.), especially for those earning ≤100% FPL; suspend—not terminate—Medicaid coverage for people who are incarcerated; and ensure seamless transitions between Medicaid and private insurance plans.

6. **Workforce capacity:** States should establish adequate provider reimbursement levels to promote Medicaid provider participation; and should ensure a sufficient supply of trained primary care and behavioral health care providers who are willing and able to serve populations that have intensive medical and social needs.

7. **Benefits:** Because the essential health benefits required by the ACA do not include key services (such as adult dental, adult vision, and case management), states should exercise Medicaid options to provide more comprehensive benefit packages in order to meet the intensive needs of vulnerable populations.

8. **Insurance protocols:** Health insurance carriers must not be allowed to engage in practices that effectively discriminate among populations based on socio-economic status, health status, or the presence of certain diagnoses. In addition, they must be prohibited from introducing administrative barriers to plan participation or access to services, and must be held accountable for the same high standards of care for all enrollees.

9. **Safety net:** Health center grants, SAMHSA block grants, Ryan White, PATH, and other HHS programs must remain available as the safety net for the millions of people who will remain uninsured under the ACA, and to help fill gaps in Medicaid service packages. The policies and guidelines of these programs should be reassessed within the context of a changing health care environment.

10. **Medicaid options:** States should consider adopting Medicaid options that allow for additional services and payment structures to be added to the state plan (e.g., 1115 demonstrations, 1915i amendments, Health Homes, etc.).

11. **Risk-adjusted payments:** As states make changes to health care delivery systems and/or implement risk-sharing models, provider payments should be adjusted based on patient acuity and intensity of needs to accurately reflect the depth and breadth of services required to achieve improvements in health outcomes.

12. **HCH Model of Care:** As HCH projects and clients are increasingly participating in insurance programs, there is a growing need for state policy makers and Managed Care Organizations to better understand the connections between housing and health care, and how to best serve homeless populations. Stronger relationships with these partners will result in necessary system changes.

13. **Homeless individual and provider perspectives:** To ensure stakeholder input, advisory boards and other structures should include individuals who are currently/previously homeless and providers of homeless services to ensure these points of view are considered, as they have unique experiences of the health care system.

14. **Data:** Providers and health care systems should screen for and document homelessness, add the ICD-10 code for homelessness to electronic health record software, and use these codes to identify intervention opportunities *(ICD-10 = **Z59.0**).*

15. **Housing:** States and local jurisdictions should increase affordable housing in general, but also maximize supportive housing, medical respite care, and other arrangements that ensure residential stability.

16. **Universal health care:** Though the ACA may significantly improve access to care for many low income people, additional reforms are necessary to ensure lower cost, higher quality universal coverage for everyone in the U.S.

Additional health reform resources for the HCH Community are available at https://www.nhchc.org/policy-advocacy/reform/