OVERVIEW

The Affordable Care Act (ACA) will extend Medicaid eligibility to most childless adults earning at or below 138%[a] of the federal poverty level (FPL), which will include most individuals experiencing homelessness. Safety net providers such as Health Care for the Homeless (HCH) grantees and other types of Health Center Program grantees will need to grow to meet the anticipated increased demand for services and take advantage of current and future funding opportunities. National health center data on patient demographics, visit patterns, and trends over time can be used to guide this effort as well as help HCH grantees plan for the anticipated gaps in services that will continue after ACA implementation. This Policy Brief uses publicly available health center data to highlight national trends for HCH grantees and makes recommendations for maximizing expansion efforts.

Introduction

The ACA is estimated to insure 32 million new individuals by 2019, either through the Medicaid expansion or through state health insurance exchanges. To prepare for an increase in demand for services, the ACA also dedicates $11 billion to facilitate health center expansion. While health centers can anticipate additional billable revenue through Medicaid, continued health center funding will still be necessary given that an estimated 23 million people will remain uninsured, Medicaid will not reimburse for all services needed, and ongoing support for a wide array of safety net programs (at both federal and state levels) is at risk of reductions. HCH grantees must plan for these changes, navigating both opportunities and uncertainties – all without losing sight of their mission to provide services to those who are most vulnerable.

To adapt and thrive in a changing environment, HCH grantees will have to maximize Medicaid enrollment, add staff, expand services, compete for new health center funding, and plan for the gaps in coverage and reimbursable services. The specific approach will be different for each community, but there are common themes across most states, especially around outreach and enrollment strategies. One study suggested robust outreach and enrollment efforts could lead to seven million additional Medicaid enrollees when compared to traditional approaches.[1] An additional study showed health centers in states with expanded Medicaid eligibility collected 24% more revenue per patient and employed significantly more medical professionals across disciplines than health centers in states with more limited eligibility.[2] The opportunity of increased Medicaid enrollment, additional revenue, and service expansion is clear, but realizing these opportunities will require a dedicated planning and implementation effort.

The Health Resources and Services Administration (HRSA) Uniform Data System (UDS) is one source that can provide concrete data for these efforts. Because all health centers report common measures, grantees can use and tailor the data for grant writing, research and strategic planning. Certain national trends in HCH UDS data may have implications for HCH grantees and can complement local and project level data.
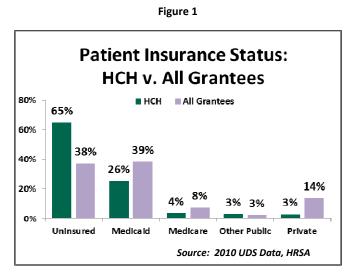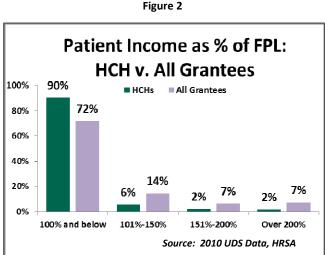
Distinctions between HCHs and other FQHCs

Started in 1985 as a pilot program funded through a public-private collaboration, Health Care for the Homeless projects were incorporated into the existing health center program under the Consolidated Health Centers Act

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[a] Medicaid eligibility is defined in statute as at or below 133% FPL with a standard income deduction of 5% FPL allowed, resulting in eligibility actually being 138% of FPL.
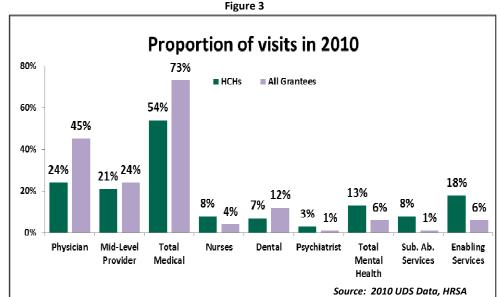
of 1996 and subsequently became special populations health centers (along with health centers targeted to migrant populations and those living in public housing). HCH grantees follow the same requirements as other health centers, with an additional requirement to provide substance abuse services. They are also eligible to apply for a waiver of some governance requirements. Because the HCH target patient population is homeless (and largely ineligible for Medicaid under current rules), patients served in these venues are more likely to be uninsured and have even lower incomes compared to the population served in other FQHCs (see figures 1 & 2).

Figure 1

Patient Insurance Status: HCH v. All Grantees

Source: 2010 UDS Data, HRSA

Figure 2

Patient Income as % of FPL: HCH v. All Grantees
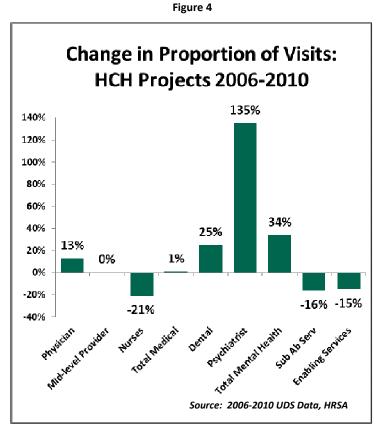
Source: 2010 UDS Data, HRSA

These differences in income and insurance status have implications for HCH projects. Social determinants of health—such as poverty and lack of housing--correlate with poor health outcomes, limited health literacy and unhealthy living environments.[3,4] Lack of health insurance also has consequences for health and health behavior. Difficulty obtaining specialty care, reliance on acute health services, poor management of chronic conditions, and delaying needed care are all associated with being uninsured.[5] In addition to implications for health status and service needs, the high proportion of patients who are currently uninsured but have incomes below 138% of FPL has direct implications for increased eligibility for the Medicaid expansion. While the impact on HCH patients will vary state to state, preparing for a Medicaid-based service and finance system will be a significant change for most grantees.

Figure 3

Homeless populations have significantly higher health care needs than other low income populations; hence, patients in HCH settings will likely have different visit patterns when compared to other FQHCs (see figure 3).   Nationally, HCH patients are more likely than patients of other types of health centers to have visits for mental health, substance abuse, and enabling services.[b] Given the patient population

Proportion of visits in 2010

Source: 2010 UDS Data, HRSA

[b] Enabling services described in statute and tracked in UDS data include case management, patient and community education, outreach, transportation, eligibility assistance, and interpretation services.

and the mandate for addictions services, one would expect to see a wider range of visit patterns across these disciplines. The Health Center Program overall has a higher proportion of medical services and physician visits.

Figure 4

Change in Proportion of Visits: HCH Projects 2006-2010
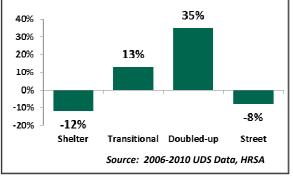
Source: 2006-2010 UDS Data, HRSA

HCH Grantee Changes over Time

The HCH program will change as the overall health care system changes. HCH grantees must adapt to these changes while still maintaining the integrity of their programs and their mission. Over the past five years, UDS data shows a very large increase in HCH visits for psychiatrists, and more modest increases in HCH patient visits for total mental health, dental, and physician visits. Over the same period, the proportion of visits for nursing, substance abuse services, and enabling services has declined (see figure 4).

The housing status of HCH patients nationally has also changed over the past five years (see figure 5). The proportion of HCH patients staying on the street or in emergency shelter are dropping while those in transitional housing or doubled-up with other households are on the rise. These patterns particularly have implications for the outreach and enrollment efforts needed to ensure maximum Medicaid enrollment.

Figure 5

Implications for HCH Grantees

The trends identified in this policy brief are based on national data. They reflect changing emphases within a range of programs, in part driven by funding availability and community circumstances, and do not necessarily reflect increases or decreases in the absolute numbers of any service delivered. However, considering the implications for the program as a whole can aid local projects in interpreting trends observed locally and in strategic planning to maximize growth opportunities expected in the coming years.

Change in Proportion of Patients' Housing Status: HCH Projects 2006-2010

Source: 2006-2010 UDS Data, HRSA

One area that might be examined more closely is the increase in the visits for mental health services and the concurrent decrease in visits for substance abuse services. Because the ACA requires that all health insurance plans (to include Medicaid) include mental health and substance abuse services, demand for these services will rise. As grantees increasingly look to further integrate a wide range of behavioral health services (both mental health and substance abuse), it may be that an increasing emphasis on mental health in recent years has masked traditionally strong substance abuse programs—changing only the *proportion* of visits compared to other categories. Also, HCH projects may be using more mental health professionals to provide integrated substance abuse and mental health treatment, particularly for those patients who are dually diagnosed. An additional possibility is that HCH projects may be

implementing more mental health screening tools into primary care, case management, and other visits – leading to additional mental health visits and services. Finally, there may be local financial, workforce or administrative reasons that contributed to this trend. The planning process at the grantee level should consider how to maximize behavioral health services, and how UDS and other data can substantiate the need for additional resources to provide comprehensive patient care.

The proportional decrease in enabling services also raises questions regarding how HCH grantees are able to maximize opportunities and improve health outcomes. Enabling services are the support services that aid patients in accessing health services, such as outreach, health education, transportation, and translation. HCH projects have traditionally placed an emphasis on enabling services due to the nature of the patient population, so a reduction in this area may warrant additional attention at the national and local level. Insufficient grant funding, low rates of reimbursement, and strained capacity may all contribute to this trend. Research has shown that enabling services can improve health status, especially for the most vulnerable, so these services can help improve the quality outcome measures that HRSA is prioritizing.[6,7] Additionally, outreach and patient navigation will be crucial to ensure all patients eligible for Medicaid under the ACA are able to enroll and engage in services. HCH projects should be developing plans to provide increased enabling services during the implementation of the ACA.

A final observation stems from the change in housing status of HCH patients. It is difficult to draw definite conclusions because the story behind this data will vary by location, but a number of possibilities exist. An encouraging explanation is the proliferation of permanent supportive housing (PSH) programs that may have reduced the number of people living on the street or in shelters. This is likely the case where there has been community commitment to PSH and can serve as examples of success to others. An alternative explanation is a lack of affordable housing in general, which could cause HCH patients to stay in shelters or on the street longer, leading to fewer unique patients from these categories.   Other possibilities could include HCH grantees not seeking more clients due to reaching maximum capacity, an emphasis on deeper services for current clients that makes it more difficult to reach out to new patients, or a dearth of funding opportunities for outreach staffing. Emphasis on increasing the number of patients served, in response to national and state policy priorities, may also have strained the capacity to engage the hardest to reach, which can be resource-intensive compared to serving patients who seek care in established clinic facilities. Whatever the cause, HCH projects should be working in their communities to determine the greatest needs and craft effective service approaches as they have historically been among the few (or only) providers able and/or willing to serve the most vulnerable and difficult to reach. Seeking additional resources from public or private funders as well as using innovative program models could aid in this effort.

Limitations of UDS Data

UDS data can be limited, especially for HCH projects. One of the limitations specific to HCH grantees is the lack of publicly available national HCH data on all reporting elements, to include quality of care indicators, health outcomes and disparities, financial costs, patient-related revenue and other revenue measures. Additionally, while the total number of visits at HCH projects is available at the national level, the number of full-time equivalent staff is not. While this data element would be more difficult to splice given the number of health centers that receive multiple types of funding (over half of HCH grantees are funded together with heath centers serving the general public), this is especially problematic for enabling services staff because they do not report data on numbers of visits for most categories of services. Hence, HCH projects, which are anticipated to require extensive enabling services, only have data about total enabling service visits rather than specific types. The limited national data specific to HCH grantees makes drawing conclusions about the HCH program difficult.

A limitation of UDS data for all Health Center Program grantees involves the way diagnoses are reported. Currently only the primary diagnosis of a patient is reported, failing to capture multiple chronic conditions and even distorting the services needed and rendered. Low-income and homeless persons are particularly likely to

have multiple co-occurring disorders and the staffing and service needs of such patients are distinct from patients with less complex sets of conditions. The changes to 2012 UDS data (see figure 6) will address this particular limitation, and that data will become available in 2013.

Reporting on housing status by non-HCH grantees is an additional limitation. They are not required to report on this data, even though non-HCH grantees served nearly 250,000 homeless patients in 2010 (23% of total homeless patients seen in health centers). Likely this is a conservative estimate given the impact of foreclosures, unemployment, and other economic factors that have impacted traditionally stably housed (but still low-income) populations. More comprehensive housing status data would aid further understanding of how Health Center Program grantees in general can best serve this population.

Figure 6

APPROVED UDS CHANGES FOR 2012

HRSA Program Assistance Letter 12-03 adds the following to required UDS reporting:

➢ **Diagnosis reporting:** All diagnoses are reported, not just the primary diagnosis
➢ **Tenure of staff:** total number of months employed
➢ **New clinical measures:** Lipid therapy, aspirin therapy, colorectal screening
➢ **Electronic Health Records:** Adoption of meaningful use standards and other quality standards

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Recommendations

HCH grantees are essential safety net health care providers for the most vulnerable in our communities. It is critical that HCH projects use all available resources and opportunities to prepare for changes to come and maximize funding and programmatic opportunities. The following recommendations are based on the national trends discussed in this brief:

Participate in state and local ACA implementation and planning. Most of the changes created by the ACA depend on state level implementation and decision making. Participating in health reform task forces, advisory groups, and/or public hearings is a significant opportunity for HCH grantees and the patients they serve to educate others about the needs of homeless populations. Decisions regarding outreach resources, enrollment processes, and benefit design will have vast implications for our patients. Partner with your state and other stakeholders in the decision making process. State Medicaid officials, public health officials and other direct decision makers need the input of HCH projects to ensure the systems designed are responsive to the needs of individuals experiencing homelessness. Consumers, clinicians, Board members, and administrators should all participate to the fullest extent possible.

Use all available data in planning for growth. UDS and other national data, state and local data, and data from electronic health records can all aid in strategic planning, public policy education/advocacy, and grant writing.[8]

Collaborate with HRSA to improve HCH data and services. Make sure to communicate your needs and the trends you are seeing in your community to your Project Officer. Feedback and communication are essential to ensuring HRSA provides the support, resources, and data most appropriate for your patients and community.

Seek alternative sources of funding for outreach and other enabling services. Public programs outside the health center program, such as the Ryan White program and the Projects in Assistance in Transition from Homelessness (PATH) program, offer funding for outreach but are tied to very specific diagnoses. Pursue these as appropriate, but also seek out funding for more flexible outreach services based on housing status rather than diagnoses. Private foundations, HRSA, and your state Medicaid Agencies are all possible sources of funding for outreach and community health work more generally.[9] There are also opportunities for community health workers to fill the role of patient navigators in the state health insurance exchanges and potentially state Medicaid eligibility systems. Maximize these opportunities and make sure targeted efforts to reach homeless persons are put in place.

Notes

[1] 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. Available at: http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf.

[2] Shin, P and Rosenbaum, S. (March 2012). *Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities*. Kaiser Commission on Medicaid and the Uninsured, Washington, DC. Available at: http://www.kff.org/medicaid/upload/8293.pdf.

[3] Center for Disease Control and Prevention (2011). Health Disparities and Inequalities Report. Available at: http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.

[4] World Health Organization (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Geneva, Switzerland. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

[5] Kaiser Family Foundation (Oct. 2011). The Uninsured: A Primer. Available at: http://www.kff.org/uninsured/upload/7451-07.pdf

[6] Babamoto K, Sey KA, Camilleri AJ, Karlan VJ, Catalasan J, Morisky DE. (2009). Improving Diabetes Care and Health Measures among Hispanics using Community Health Workers: Results from a Randomized, Controlled Trial. *Health Education Behavior* 36: 113–126.

[7] Brownstein JN, Chowdhury FM, Norris SL, et al. (2007). Effectiveness of Community Health Workers in the Care of People with Hypertension. *American Journal of Preventive Medicine* 32: 435–447.

[8] National Health Care for the Homeless Council. (2011). *Learning about Health and Homelessness in Your Community: A Data Resource Guide.* Available at: http://www.nhchc.org/wp-content/uploads/2011/09/DataResourceGuide_final.pdf.

[9] National Health Care for the Homeless Council. (2011). *Community Health Workers: Financing and Administration*. Available at http://www.nhchc.org/wp-content/uploads/2011/10/CHW-Policy-Brief.pdf.