NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Insurance Coverage at Health Care for the Homeless Projects, 2013-2015

Introduction

The Affordable Care Act's state option to expand Medicaid to those earning at or below 138% of poverty fills a long-standing gap in coverage for many low-income adults who were not previously eligible for the program. Prior to 2014, most single adults living in poverty were generally ineligible for Medicaid under federal rules and could not afford (or did not have access to) employer-sponsored insurance or individual plans on the private market. **Due to expanded Medicaid eligibility and increased outreach and enrollment efforts, nearly 16 million people gained Medicaid coverage since 2014.**[1] This change helped bring the national rate of uninsured to 9% in 2015, an all-time low for the United States.[2] Unfortunately, not all states chose to expand Medicaid eligibility to the new "single adult" group. This left 2.6 million low-income people living in these states uninsured and ineligible for other coverage.[3]

Health Care for the Homeless (HCH) projects also saw increases in the rate of insurance coverage. Nationally, the rate of uninsured at HCHs dropped from 57% in 2013 to 38% in 2015, but wide variation exists between projects in states that expanded Medicaid and HCH projects in those that did not, as well as between states in these two categories. Using annual health center reporting data, this issue brief documents the changes in type of insurance coverage at HCH projects in each state during calendar years 2013, 2014 and 2015.[4] It also outlines why insurance coverage is critical for this population, the existing state-level health reform initiatives that are relevant, how current federal health reform proposals weaken Medicaid, and the actions HCH projects (as well as the broader health care community) can be taking at this time.

Federal proposals that repeal the Medicaid expansion and turn the entire program into a limited-funded program (using per capita caps or block grants) will harm people who are homeless and the HCH projects that serve them. Proposals that limit Medicaid spending will force states to absorb any funding shortfalls in order to maintain current coverage levels. To accommodate the lower funding, states will need to increase state dollars to Medicaid, reduce coverage, lower payments to providers, and/or limit benefits.[5] In addition, other policy provisions introduced in initial ACA repeal measures will make it even harder for individuals to enroll—and stay enrolled—in the program, as well as limit providers' ability to be reimbursed for services.[6]

HCH Projects Nationally

Since 2013, insurance coverage among HCH patients changed significantly, largely due to more streamlined insurance enrollment, high-profile outreach efforts, and changes in Medicaid eligibility in states that chose to adopt the expansion option. In 2015, 290 HCH projects across the U.S. served 886,879 patients where the majority (71%) had income below 100% of poverty ($11,770 for an individual). About half of all patients (49%, or 434,599 individuals) relied on Medicaid for their health coverage, while just above one-third (38%) remained uninsured. Only a small portion of HCH patients were Medicare beneficiaries (8%, or 71,708 individuals), and of these, half were dually enrolled in Medicaid. Very few had private insurance (5%, or 47,070 individuals).

While states differed widely in their progress to decrease the rate of uninsured among HCH patients, **HCH patients are nearly five times more likely to have gained insurance since 2013 if they live in a state that expanded Medicaid.** Beyond that, each health center differs widely with regard to outreach and enrollment practices, demographics of patients, and the broader resources in the community to see newly insured (or remaining uninsured) patients. The data reflected in this issue brief reflect the only consistent, national source for

insurance status among people who are homeless, however, it is limited because not everyone experiencing homelessness receives care at an HCH project.

HCH Projects in Medicaid Expansion States

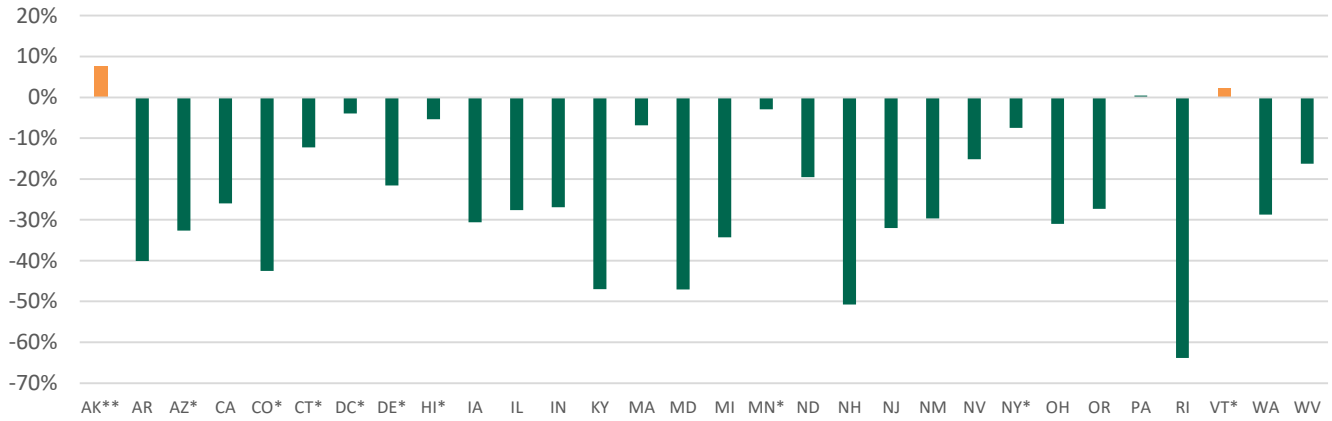
By the end of 2015, 30 states (to include DC) had opted to expand Medicaid to single, non-disabled adults earning at or below 138% of poverty. These states included 194 HCH projects, which saw 654,318 patients (74% of all HCH patients nationally). Since 2013, these states collectively saw significant changes in health coverage:

- Medicaid coverage increased from 37% in 2013 to 59% in 2015.
- Medicare (and other public insurance) coverage fell slightly, from 9% to 8%.
- Private plan coverage increased marginally, from 3% to 5%.
- Primarily due to increases in Medicaid, the rate of uninsured patients fell significantly, from 51% in 2013 to 27% in 2015.

Across these states, however, there was a wide range of success reducing the rate of uninsured (see figure 1 and Appendix A). *These data demonstrate that eligibility for Medicaid does not ensure enrollment in Medicaid.*

- 12 states decreased their uninsured rate by 30% or more (AR, AZ*, CO*, IA, KY, MD, MI, NH, NJ, NM, OH, RI).
- 10 states decreased this rate between 10% and 29% (CA*, CT*, DE*, IL, IN**, ND, NV, OR, WA, WV).
- 5 states saw decreases smaller than 10% (DC*, HI*, MA, MN*, NY*).
- The remaining three states had either no decrease or saw increases in the number of uninsured (PA, AK**, VT*).

Figure 1. Changes in Percentage of Uninsured Patients at HCH Projects in Medicaid Expansion States, 2013-2015



Notes: States with an * had already expanded Medicaid to non-disabled single adults (in full or in part) as of January 2013, which would impact the total changes reflected here. ** Indiana expanded Medicaid in February 2015 and Alaska expanded in September 2015 so did not have a full calendar year to conduct enrollment.

HCH Projects in Non-Medicaid Expansion States

There were 21 states at the end of the 2015 who had not opted to expand Medicaid to single low-income adults. These states included 96 HCH projects, which saw 232,561 patients (26% of all HCH patients nationally). Since 2013, these states saw only marginal changes in health coverage:

- Medicaid coverage increased marginally from 19% in 2013 to 20% in 2015.
- Medicare (and other public insurance) coverage did not change, remaining at 5%.
- Private coverage increased slightly, from 3% to 5%.
- The rate of uninsured patients fell from 74% to 69%.

This group of states also saw some variance in how much the uninsured rate had been reduced (see Figure 2 and Appendix A):

- 1 state decreased its uninsured rate by more than 20% (WI***).
- 4 states decreased this rate between 10% and 15% (FL, NC, OK, TN).
- 9 states decreased the uninsured rate by less than 10% (AL, GA, KS, ME, MO, NE, SD, TX, VA).
- 2 states saw no change in the uninsured rate (ID, WY).
- 5 states saw their rate of uninsured increase (LA, MS, MT, SC, UT).

Figure 2. Change in Percentage of Uninsured Patients at HCH Projects in Medicaid Non-Expansion States, 2013-2015

*** Note: Wisconsin expanded its Medicaid program to those earning up to 100% FPL, which accounts for its decrease in uninsured; however, because it was not a full expansion to 138% FPL, they are not considered a Medicaid expansion state.

Comprehensive Health Coverage Can Prevent & End Homelessness

Homelessness can be caused by poor health, and the experience of homelessness can create additional health care problems or exacerbate existing ones, while making engagement in health care services more difficult.[7] Health insurance coverage is particularly important for this population given that individuals have disproportionately poor health and intensive health care and social service needs.[8, 9, 10] Gains in coverage among this population provide an important opportunity to increase access to health care services that contribute to improved health outcomes and increased stability as well as decrease health disparities. Recent data show that federally funded health centers in Medicaid expansion states have improved treatment and outcomes of chronic disease and higher rates of using recommended preventive services compared to those in non-Medicaid

expansion states.[11] Likewise, Medicaid pays for mental health and substance use services, which are particularly important for this population, as is accessing specialty care and ensuring screening and treatment for a broader range of chronic conditions.[12] [13]

Health reform proposals that reduce the comprehensiveness of required benefits in Medicaid (or other health plans), reduce or limit funding for care, and/or introduce barriers to enrolling and/or retaining benefits will undermine access to care. Improvements in health status and stability in housing and employment requires consistent access to comprehensive health insurance that will cover needed services.

Existing State Health Reform Initiatives Impact Homeless Providers & Patients

Many states are using managed care to promote value-based payments and better integrate social determinants of health into larger health care systems. Other delivery system reforms include patient-centered medical homes (PCMHs), Accountable Care Organizations (ACOs), Delivery System Reform Incentive Payment (DSRIP) programs, and other efforts to better manage the care of high-need populations.[14] [15] The investments made in changing larger systems of care and the goals being established for better health outcomes as a result will depend on comprehensive health insurance coverage, especially for those with significant health care needs like homeless populations. Many of these initiatives focus on social services needs and/or social determinants of health broadly, or housing-related needs specifically.[16] [17] Medicaid is central to these initiatives and plays a major role in helping states transform their systems of care.

Current Federal Health Reform Changes Weaken Medicaid

Federal attempts to replace the Affordable Care Act with new legislation are currently focused on changing how Medicaid is structured and funded. Rather than reimbursing states a percentage of the cost for providing a comprehensive set of benefits to everyone who qualifies for Medicaid, current proposals aim to pay states a fixed amount of money per enrollee. If additional health care services are needed, states would be responsible for paying for that care. Other provisions of proposed legislation aim to:

- Repeal the requirement that Medicaid plans have essential health benefits
- Limit retroactive coverage in the program
- Require stronger documentation of citizenship before obtaining coverage
- Require re-redetermination for Medicaid every 6 months
- Repeal the ability for providers to make presumptive eligibility for the expansion population

Any of these changes alone or in combination will create barriers to enrollment and continuity of benefits, as well as limit the types of health care services available to enrollees. For people who are homeless and need a broad range of services, these changes would be particularly onerous. States that have exercised the flexibility in Medicaid to create partnerships with medical respite and/or supportive housing programs may see funding for those services curtailed because funding will be more limited. Finally, states that have invested in new delivery systems and set public health goals may find these more difficult to realize should fewer people have access to comprehensive insurance.

Actions for HCH Projects & the Health Care Community to Consider

Leaders at HCH projects and in the broader health care community can use the coverage data in this fact sheet to advocate to protect Medicaid. Combine this with additional local data to “tell the Medicaid story” about how improved coverage helps patients achieve better health, greater stability, and lower total costs of community care. New or strengthened efforts to engage in any of the following actions will also help illustrate how Medicaid is a critical health insurance program for the HCH community:

1. **Meet with state and local policymakers:** Talk with the health care leaders in your community about the serious health conditions that exist in the homeless population, and the importance of having a strong health insurance benefit that covers the full range of needed services. This not only includes core health care services, but also a wide range of supportive services (case management, housing supports, outreach, care coordination, etc.). Governors, mayors, state and city/county legislators, public health and behavioral health officials, the justice community, and others are key stakeholders concerned about making health improvements and realizing cost savings. Also, states are responsible for paying for the shortfall in federal funding under a capped Medicaid program, which will force them to either raise taxes, cut services or eligibility, or reduce payments to providers (which are already low).

2. **Advocate with your federal Congressional delegation:** Meet with your Congressional representative and your Senators to talk about the importance of Medicaid expansion for people who are homeless. Connect priority issues like addressing the mental health crisis and/or the opioid epidemic to the vital role that Medicaid plays to access treatment services. Invite them to visit your HCH project and see directly how Medicaid helps expand services and workforce, as well as improves health and connections to employment and housing. Call and/or write their offices expressing your concerns about the impact the current proposals will have on your health center operations, your patients, and your community.

3. **Advocate to expand Medicaid in all states:** HCH projects working in non-expansion states have been unable to extend health coverage to many of their patients, putting them at a significant disadvantage regarding health outcomes and financial stability. All patients at all HCH projects in all states deserve comprehensive health insurance.

4. **Promote health and homelessness as a targeted issue:** Talk about the intersection between health and homelessness and identify which services covered by Medicaid are most relevant to preventing and ending homelessness. Use local media sources as well as social media outlets to publish op-Eds or letters to the editor to promote Medicaid as an important component to meeting the needs of very vulnerable populations.

5. **Participate in local/state efforts:** All states are in the process of making changes to the health care system, even those that have not yet expanded Medicaid. Attending these meetings or getting nominated to be a formal member to these efforts helps keep the needs of vulnerable populations (and those that serve them) at the forefront of the discussion.

6. **Demonstrate value using data:** Combine health center with other community system data to demonstrate reduced emergency department visits, hospital utilization, and/or recidivism to jails and/or prisons, as well as improvements in health care access and health outcomes as a result of Medicaid. This will not only show the value of health centers, but also the role that Medicaid plays in helping fulfill the larger goals to achieve better health. Sharing data across hospital and managed care/insurer systems also helps identify where targeted achievements have been made or could be strengthened.

7. **Share patient and provider stories:** Illustrate the personal impacts of Medicaid by talking about how it facilitated needed care, provided stability, and improved health status for someone who needed care. Examples that illustrate how Medicaid allowed a patient to attain and/or regain employment, family reunification and/or housing can be even more compelling.[18]

Conclusion

Since 2013, HCH projects in nearly all states have seen at least some reductions in uninsured patients, but the largest changes occurred in states that expanded Medicaid to single adults. Because this population has intensive

health care needs, health coverage is particularly important to accessing comprehensive services, improving health, and reducing health disparities. As states continue to reform health care delivery systems, providing coverage for vulnerable populations will be vital to ensuring larger goals for health improvement are reached. HCH projects, together with the larger health care community, can help illustrate how Medicaid coverage benefits people who are homeless by actively sharing data and personal stories as well as directly participating in local and state health care policy decisions.

Federal proposals to change Medicaid into a capped program as well as the additional barriers to enrollment and continuity of benefits will likely reduce insurance coverage for vulnerable populations like those experiencing homelessness. As well, more limited funding for Medicaid will likely mean states cover fewer health care services and may be unable to maintain new investments in medical respite care and supportive services for those in housing programs.

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[18] Please share your story with us at the National HCH Council as well. Our stories page is available at: https://www.nhchc.org/gotmedicaid/.

Appendix A. Health Coverage Distribution of Patients at HCH Projects, 2013-2015

	# Grantees in 2015	Medicaid				Medicare/Other Public				Private				Uninsured			
		2013	2014	2015	% Point Change 2013-2015	2013	2014	2015	% Point Change 2013-2015	2013	2014	2015	% Point Change 2013-2015	2013	2014	2015	% Point Change 2013-2015
States that Had Expanded as of end-2015																	
	194	**37%**	**55%**	**59%**	**22%**	**9%**	**8%**	**8%**	**-1%**	**3%**	**4%**	**5%**	**2%**	**51%**	**33%**	**27%**	**-24%**
Alaska**	2	20%	18%	28%	8%	21%	13%	6%	-15%	7%	7%	8%	1%	51%	62%	59%	8%
Arkansas	1	3%	29%	21%	18%	4%	3%	3%	-1%	1%	15%	25%	24%	91%	53%	51%	-40%
Arizona*	3	28%	55%	56%	28%	8%	7%	9%	1%	6%	7%	9%	3%	59%	31%	26%	-33%
California	45	34%	53%	60%	26%	12%	9%	8%	-4%	2%	3%	6%	4%	51%	35%	25%	-26%
Colorado*	5	25%	58%	64%	39%	5%	8%	9%	4%	1%	1%	2%	1%	69%	34%	26%	-43%
Connecticut*	8	56%	63%	66%	10%	8%	9%	9%	1%	5%	6%	6%	1%	31%	22%	19%	-12%
DC*	1	64%	59%	62%	-2%	12%	14%	3%	-9%	1%	3%	2%	1%	23%	25%	19%	-4%
Delaware*	2	38%	54%	57%	19%	6%	6%	5%	-1%	5%	5%	8%	3%	52%	35%	30%	-22%
Hawaii*	1	62%	64%	65%	3%	8%	9%	9%	1%	4%	4%	5%	1%	26%	23%	21%	-5%
Iowa	4	32%	50%	57%	25%	6%	6%	7%	1%	8%	12%	11%	3%	55%	32%	24%	-31%
Illinois	8	32%	51%	58%	26%	5%	6%	7%	2%	4%	5%	4%	0%	59%	38%	31%	-28%
Indiana**	6	20%	30%	45%	25%	3%	4%	4%	1%	1%	3%	3%	2%	76%	62%	49%	-27%
Kentucky	6	12%	43%	52%	40%	6%	6%	9%	3%	2%	4%	5%	3%	81%	46%	34%	-47%
Massachusetts	7	57%	63%	62%	5%	19%	18%	20%	1%	3%	4%	3%	0%	22%	15%	15%	-7%
Maryland	2	22%	74%	66%	44%	7%	8%	10%	3%	0%	0%	0%	0%	71%	18%	24%	-47%
Michigan	13	41%	51%	63%	22%	6%	7%	9%	3%	6%	7%	15%	9%	47%	35%	13%	-34%
Minnesota*	2	67%	65%	67%	0%	7%	6%	8%	1%	1%	2%	3%	2%	25%	27%	22%	-3%
North Dakota	1	17%	15%	37%	20%	5%	5%	6%	1%	6%	23%	4%	-2%	73%	58%	53%	-20%
New Hampshire	3	15%	32%	49%	34%	9%	12%	15%	6%	2%	8%	12%	10%	75%	47%	24%	-51%
New Jersey	7	28%	51%	58%	30%	4%	5%	6%	2%	5%	6%	6%	1%	62%	37%	30%	-32%
New Mexico	6	12%	39%	41%	29%	2%	6%	6%	4%	6%	6%	3%	-3%	80%	50%	50%	-30%
Nevada	3	12%	33%	28%	16%	3%	6%	5%	2%	10%	6%	8%	-2%	74%	55%	59%	-15%
New York*	21	57%	61%	63%	6%	6%	6%	7%	1%	4%	4%	5%	1%	33%	29%	25%	-8%
Ohio	7	18%	45%	50%	32%	5%	6%	5%	0%	1%	2%	1%	0%	75%	48%	44%	-31%
Oregon	12	28%	53%	55%	27%	10%	8%	10%	0%	3%	3%	3%	0%	59%	36%	32%	-27%
Pennsylvania	6	44%	46%	44%	0%	8%	8%	9%	1%	3%	4%	3%	0%	45%	42%	45%	0%
Rhode Island	2	16%	71%	67%	51%	4%	7%	8%	4%	3%	6%	12%	9%	77%	17%	13%	-64%
Vermont*	1	70%	74%	69%	-1%	12%	13%	13%	1%	6%	5%	3%	-3%	13%	8%	15%	2%
Washington	8	45%	65%	72%	27%	8%	8%	8%	0%	3%	6%	5%	2%	45%	21%	16%	-29%
West Virginia	1	1%	62%	16%	15%	0%	1%	1%	1%	0%	0%	1%	1%	98%	37%	82%	-16%
States that Had Not Expanded as of end-2015																	
	96	**19%**	**20%**	**20%**	**1%**	**5%**	**6%**	**5%**	**0%**	**3%**	**4%**	**5%**	**2%**	**74%**	**70%**	**69%**	**-5%**
Alabama	3	14%	16%	17%	3%	4%	4%	5%	1%	2%	2%	3%	1%	80%	78%	75%	-5%
Florida	16	19%	18%	23%	4%	5%	7%	8%	3%	2%	3%	5%	3%	74%	72%	63%	-11%
Georgia	5	2%	5%	5%	3%	2%	2%	3%	1%	0%	1%	3%	3%	96%	92%	89%	-7%
Idaho	2	7%	8%	7%	0%	6%	4%	4%	-2%	1%	2%	2%	1%	86%	86%	86%	0%
Kansas	3	14%	40%	18%	4%	1%	2%	4%	3%	2%	3%	4%	2%	82%	56%	74%	-8%
Louisiana	6	52%	44%	47%	-5%	3%	4%	3%	0%	5%	6%	9%	4%	40%	46%	41%	1%
Maine	2	28%	28%	26%	-2%	8%	7%	14%	6%	2%	3%	3%	1%	62%	62%	57%	-5%
Missouri	3	19%	21%	21%	2%	4%	6%	7%	3%	4%	7%	7%	3%	73%	66%	65%	-8%
Mississippi	2	29%	22%	26%	-3%	6%	5%	3%	-3%	8%	17%	8%	0%	57%	56%	63%	6%
Montana	4	12%	14%	16%	4%	6%	9%	8%	2%	17%	4%	4%	-13%	65%	73%	71%	6%
North Carolina	10	16%	20%	24%	8%	9%	8%	8%	-1%	7%	9%	9%	2%	68%	62%	58%	-10%
Nebraska	1	6%	7%	10%	4%	3%	3%	3%	0%	1%	2%	4%	3%	90%	88%	83%	-7%
Oklahoma	2	7%	14%	14%	7%	3%	4%	4%	1%	0%	2%	3%	3%	90%	81%	79%	-11%
South Carolina	4	18%	20%	18%	0%	9%	10%	8%	-1%	9%	10%	8%	-1%	65%	60%	66%	1%
South Dakota	2	15%	12%	14%	-1%	3%	4%	6%	3%	4%	5%	6%	2%	78%	79%	74%	-4%
Tennessee	7	10%	15%	20%	10%	5%	6%	7%	2%	2%	3%	3%	1%	83%	76%	69%	-14%
Texas	12	10%	13%	13%	3%	3%	4%	4%	1%	1%	2%	4%	3%	86%	82%	78%	-8%
Utah	3	22%	29%	19%	-3%	4%	5%	5%	1%	0%	0%	0%	0%	74%	67%	76%	2%
Virginia	4	6%	7%	9%	3%	6%	6%	7%	1%	6%	10%	5%	-1%	82%	77%	79%	-3%
Wisconsin***	3	26%	32%	47%	21%	1%	5%	2%	1%	0%	3%	2%	2%	73%	59%	50%	-23%
Wyoming	2	4%	3%	4%	0%	7%	6%	4%	-3%	0%	2%	3%	3%	89%	89%	89%	0%

Source: 2013, 2014, and 2015 Uniform Data System data.

* Nine states expanded Medicaid (in full or in part) as of January 2013, which would impact the changes reflected here.

** Alaska and Indiana expanded Medicaid within calendar year 2015.

*** Wisconsin expanded Medicaid to those earning up to 100% FPL.

Note: Puerto Rico has five HCH projects, but as a U.S. territory, it receives a Medicaid block grant (hence is not included in the above calculations).