



**Connecting Homeless
Individuals To
Medicaid & Health
Care Services:
*Key Lessons from
Administrators and
Frontline Workers***

March 14, 2013



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+ Opportunities & Challenges



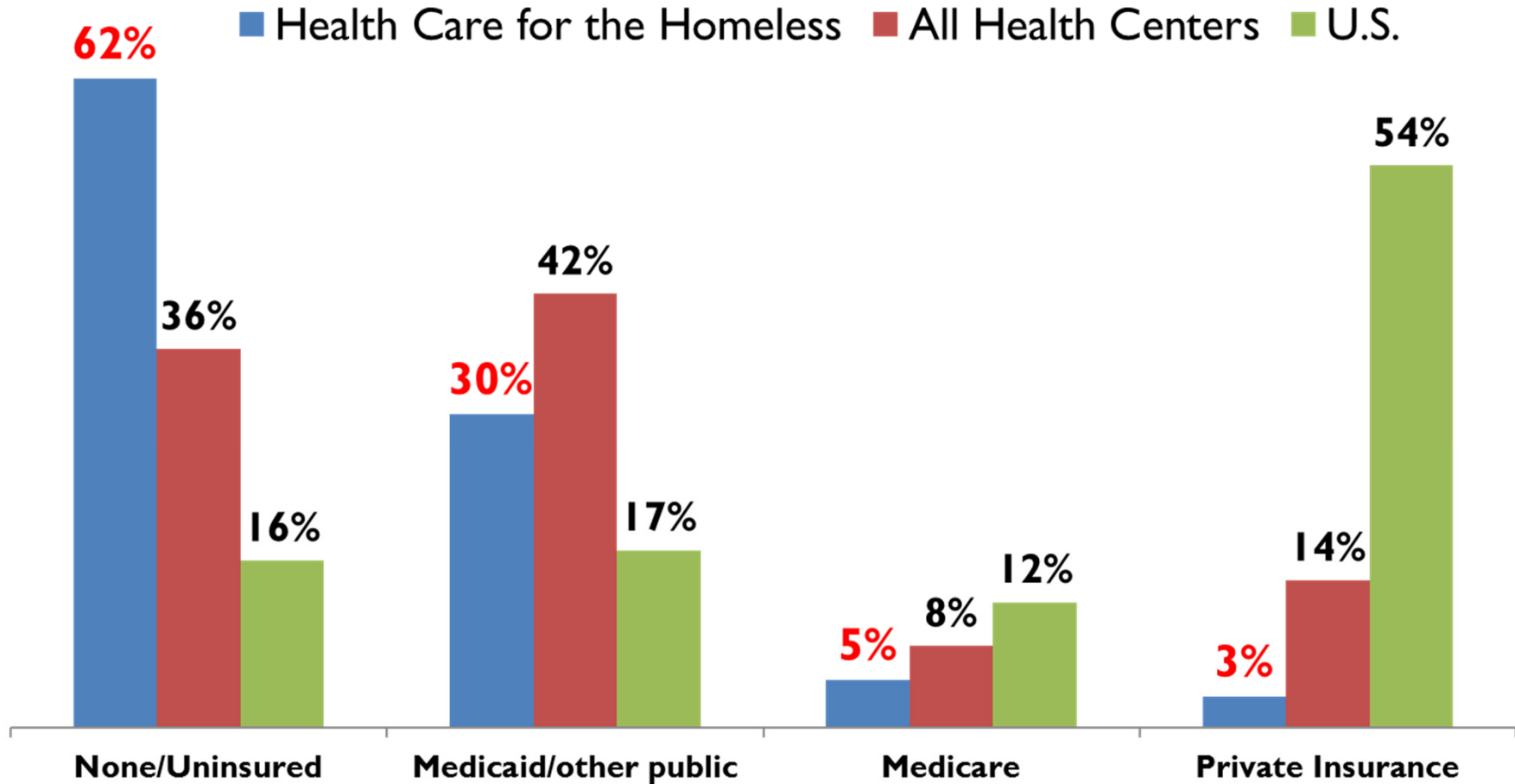
- Time of significant change
- **Requirements** to improve enrollment in all states
 - Some address traditional barriers for homeless populations
 - Still a need to implement mindful strategies to ensure connections to benefits & care
- **Option** to expand Medicaid to childless adults $\leq 138\%$ FPL
- 50 different Medicaid programs
 - Each with unique opportunities & challenges
 - Meeting states “where they are” to make improvements



2011 Insurance Status: HCH v. All Health Centers v. U.S.



■ Health Care for the Homeless ■ All Health Centers ■ U.S.



Sources: 2011 UDS Data, HRSA;
2011 Census Data

+ Health Centers as Key Partners



- Embedded in community, part of health care system
- Trusted medical provider
- Experienced with vulnerable, high-needs populations
- Combine service with advocacy
 - Success of health reform depends on state level decisions
 - Relationships with policymakers are key to educating & influencing choices
- **Goals: Enrollment, engagement in services, stabilizing health & housing**
- Lessons learned from others serve as models for moving forward

Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion

**Samantha Artiga
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**For
National Health Care for the Homeless Conference
March 14, 2013
Washington, DC**

FIGURE 5

The ACA expands Medicaid eligibility to fill current gaps in coverage.

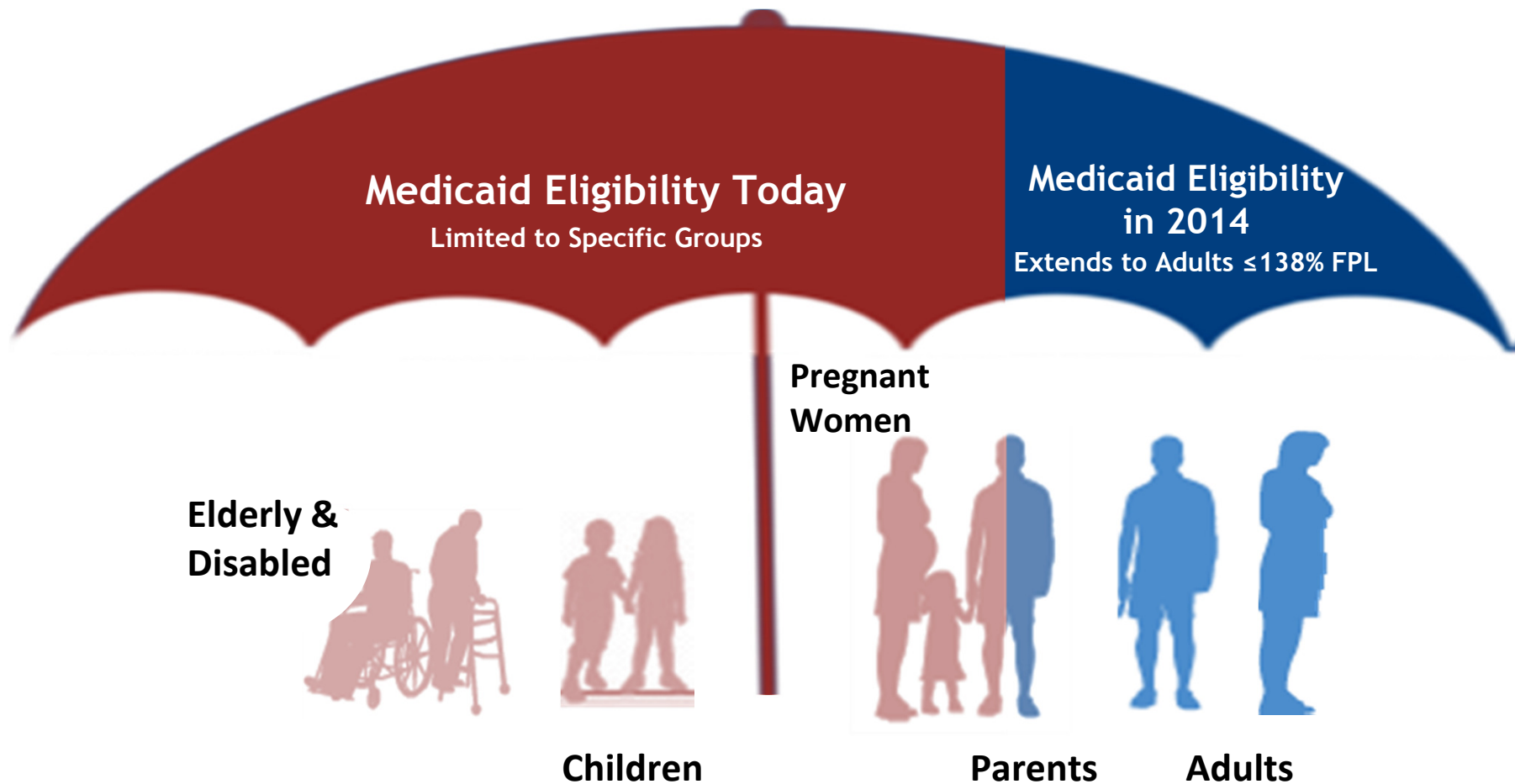
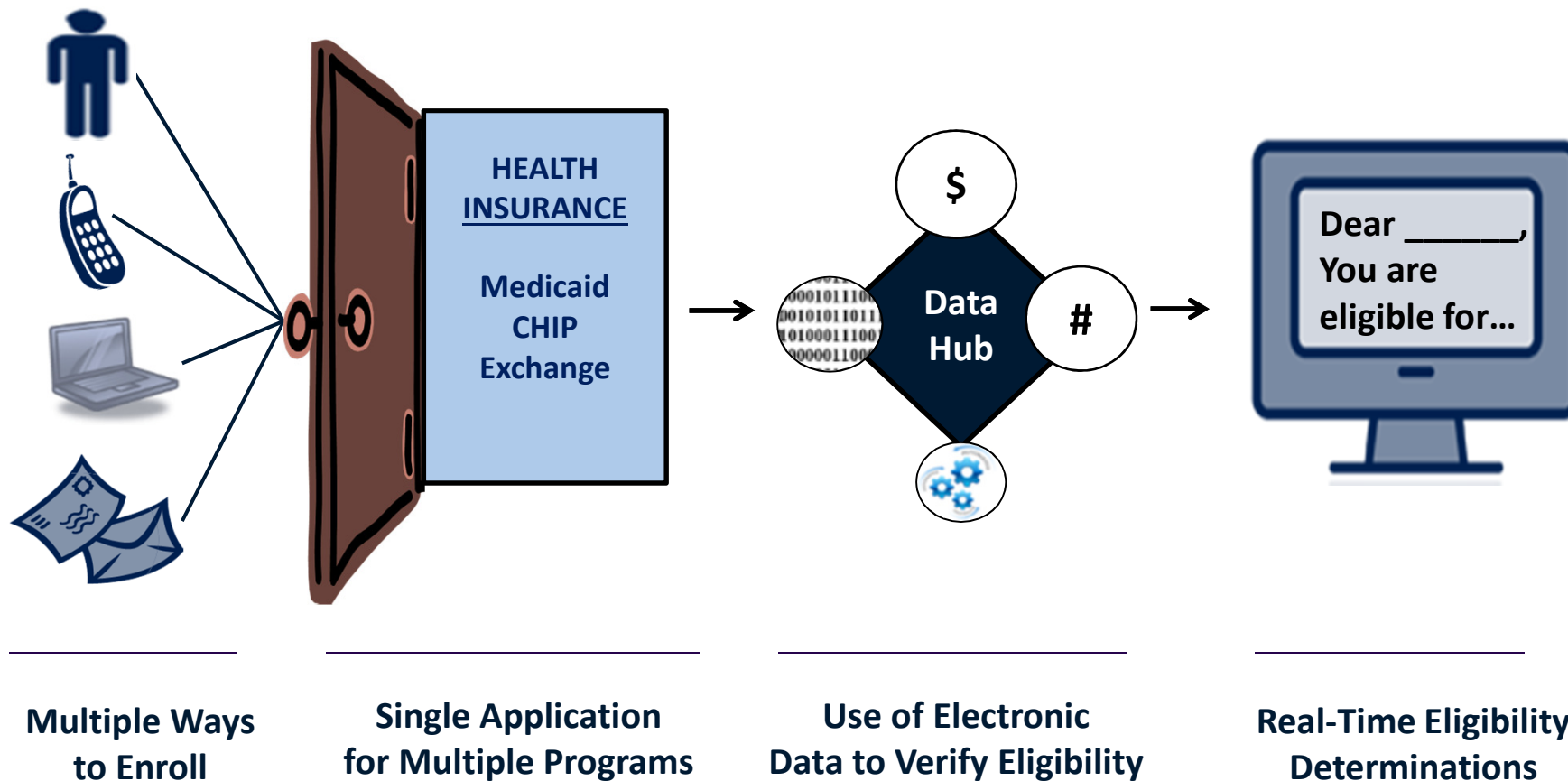


FIGURE 6

The ACA streamlines enrollment processes to make it easier to enroll.



Study Approach

- **Conducted by Kaiser Commission on Medicaid and the Uninsured and National Health Care for the Homeless Council**
- **Focus groups with outreach and enrollment workers and administrators serving individuals experiencing homelessness**
 - During March and April 2012
 - Baltimore, MD; Chicago, IL; Houston, TX; Portland, OR
- **Focus group themes:**
 - Key barriers to Medicaid enrollment
 - Successful strategies to overcome enrollment barriers
 - Access to and coordination of care
 - Potential opportunities and challenges of the 2014 Medicaid expansion

FIGURE 8

Enrollment Barriers for Individuals Experiencing Homelessness

- Limited Medicaid eligibility
- Disengagement and distrust
- Difficulty understanding and completing the application
- Lack of transportation
- Unstable contact information
- Challenges obtaining documentation

“The challenge, I think, is to really engage someone experiencing homelessness, one who does not trust the system of care because they’ve not necessarily been treated well where they have gone.”

Karen, administrator, Chicago

“You’re asking people who are mentally compromised to be able to navigate a very complex and difficult system that people who are not trained case managers cannot navigate.”

Diana, administrator, Houston

“If a person has no ID whatsoever...you have to [have] ID to go into social security...but if you don’t have a social security card, it’s almost impossible to get the photo ID that you need to get into social security”

Betty, administrator, Baltimore

FIGURE 9

Strategies to Overcome Enrollment Barriers

- **Dedicated outreach staff**
 - Gradual relationship-building
 - Meeting individuals where they are
 - Addressing immediate needs
 - Educating individuals
- **Providing one-on-one assistance**
 - Helping to complete application
 - Obtaining and storing documentation
 - Providing transportation
 - Using the clinic as contact point
- **Building community partnerships and engaging clinical staff**

“Sometimes we’ll have cough drops available in the winter cold season or warm socks, as tools to kind of engage people and just do very minimal trust building at that moment...”

Julie, frontline worker, Chicago

“...Another positive is educating clients about the benefits...If there’s something that I could do to educate the client as to how the process works, what we need to do to activate this benefit, and what I can do on my part to assist the client with the process, I will.”

Pete, frontline worker, Baltimore

“When our guys...they’ll get their ID, they lose it, but we’ve asked them to let us make copies of those and give them the copy...and we keep the originals on file...”

Preston, administrator, Houston

FIGURE 10

Access to and Delivery of Care for Individuals Experiencing Homelessness

- Need a broad array of services
- Primarily rely on safety-net providers
- Lack of housing and uncoordinated hospital discharges exacerbate health conditions
- Medicaid coverage improves health care access and care coordination

“I keep finding a lot of people who need specialty care...they need to see a neurologist, they need to see an orthopedic, or they need physical therapy.”

Frontline worker, Baltimore

“How can you keep your medications up if you can’t keep them safe? How can you get over a cold if you are sleeping in a doorway? You can’t. Everything is all combined and directly affected.”

Diana, frontline worker, Portland

“When they have Medicaid, all of a sudden, you have a ton of options in front of you. So, if you want mental health treatment, not only do you have the decision to see a psychiatrist or a counselor, but you have the decision of doing that at different places or doing outpatient groups...”

James, frontline worker, Chicago

FIGURE 11

Potential Opportunities of Increasing Coverage under the ACA Medicaid Expansion

- **Increased health coverage leading to better access to care, better management of health conditions, and improved health**
- **Reductions in:**
 - Health care costs
 - ER use
 - Uncompensated care costs
 - Use of other state-funded services, such as mental health services
- **Increased Medicaid reimbursement for providers**
- **Broader social and economic benefits, including higher employment and lower criminal justice recidivism rates**

FIGURE 12

Key Priorities Facing Organizations Serving the Homeless Population

- **Operating under constrained financial situations**
- **Preparing for increases in managed care enrollment**
 - Need adequate capitation payments and appropriate quality measures
 - Impact of network restrictions, service limits, and authorization requirements
 - Limited prior provider experience with managed care
- **Ensuring adequate capacity to meet needs**
 - Maintaining other funding resources
 - Need for administrative, staffing, and system changes

Policy and Implementation Issues To Consider

- **To what extent the circumstances of homeless individuals are addressed in:**
 - Single streamlined application
 - New eligibility and enrollment processes/systems
- **Effectiveness of screening tools to identify individuals that may qualify for broader Medicaid coverage**
- **Availability of direct one-on-one assistance to support enrollment, connection to care, and renewal**
- **Assuring individuals can access providers with experience caring for the population**
- **Coverage for the broad range of services to address health needs**



**Healthcare
for the
Homeless
Houston**

health • hope • dignity

Frances E. Isbell, CEO
Healthcare for the Homeless -
Houston

March 14, 2013

TEXAS AND MEDICAID

- Considered the most restrictive state in regard to Medicaid
- Recent legislation expanded managed care
- Highest rate of uninsured, 29% in state and 32% in Harris County (~1.4 million)
- Mental health spending lowest in nation
- CHIP program has lost 2 federal court battles due to low rate of enrollment in past 10 years

MEDICAID EXPANSION

- 1.8M people would be eligible
- Gov. Rick Perry vehement in his rejection
- Medical community in favor of expansion, with some revisions, esp. in regard to provider compensation
- Urban business communities favor (in general)

MEDICAID EXPANSION/CONT

- Texas legislature: wants to find a “Texas way”
 - ❖ “Culture war” – urban vs. rural demographics
 - ❖ Block grant
 - ❖ Cost sharing; i.e., co-pays and deductibles
- Movement toward expansion, but outcome very uncertain

HARRIS COUNTY POSSIBILITIES

- Harris County is geographically larger than 4 states and has a population larger than 24 states
- Currently analyzing the possibility of requesting a regional expansion; unclear whether this would require state approval
- Regional expansions would occur at the current ~60% / 40% federal and state rates

MEDICAID 1115 WAIVER

- September 2011, granted a 5-year waiver
- Over a year spent in planning; expect approval of regional plans by state and CMS to be complete by mid-2013
- Over 1,100 projects were submitted for review
- 4 projects from Houston specifically targeting either homeless individuals or FQHC patients
- Includes people not traditionally covered by Medicaid in Texas
 - Eligibility determined by specific project

DEPT. OF STATE HEALTH SERVICES ACTIVITIES

- New commissioner – conservative, but possibly open to some form of expansion
- Most resources are focused on 1115 Waiver implementation
- State-wide planning sessions on enrollment implications if Texas decides to expand

ADVOCACY

- Coordinated advocacy efforts, local and state levels
- Homeless issues largely ignored at state level; especially important to address possibility of cost sharing & bundled payments
- Mental health and re-entering criminal justice population are of greater interest to both state and local officials, which can be useful
- ROI: cost/benefit analysis most helpful; legislators concerned about future funding

INNOVATIONS WITHIN A RED STATE

- Private philanthropy essential; 58% of HHH budget comes from private donors
- Local Partnerships
 - County hospital district
 - County mental health authority
 - County sheriff's office
 - Area homeless-provider agencies
- Local center-controlled network



Connecting Homeless Individuals To Medicaid & Health Care Services:

Key Lessons from Administrators and Frontline Workers

March 14, 2013

Katie League, MSW, LCSW-C

Outreach Disability Specialist
Health Care for the Homeless
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Importance of Outreach

- Outreach identifies the most vulnerable clients who are not accessing care
- Allows clients to be met on “their turf” to begin relationship building process
- Identifies locations to target for enrollment: encampments, meal programs, day shelters



Benefits are Engagement Tools

- Health insurance is no longer a long-term goal
- Many of the **client's goals** will be easier to obtain with benefits
 - *Motivational interviewing skills are helpful*
 - *Outreach worker's agenda is not the priority*
- Health care opens access to housing
- Consider health care as part of a larger benefits picture



Start Outreach Now

- Multiple outreach attempts needed before engagement
 - *Think weeks & months, not hours and days*
- Trust-building happens over time
- Clients may already have benefits (or know about them)
 - *Don't assume service history*
- Open enrollment starts October 1
 - *Don't assume desire to enroll*



Clinical Challenges

- Engagement can take time that you may not have during enrollment rush
- Ability to gain informed consent from those who are most severely mentally ill and/or addicted
- Mailing address and/or phone numbers for on-going communication
- Initial hostility or reticence may be mistaken for disinterest



Clinical Strategies

- Identify **client's goals** and determine how they can be met with health care services
- Find out what barriers they have faced in accessing services
 - *Don't assume they have not tried engaging in the past*
- Respect space – this is the client's home
- Ask permission to speak with them and clearly identify yourself
 - *Leave a card & tangible assistance ("goodies")*
 - *Offer to come again and make good on that*



Systems Challenges

- Multiple agencies involved
 - *Funding drives agenda*
 - *Differing strengths & service philosophy*
 - *Not everyone seeks same outcomes*
- Coordinate team approach
 - *Identify lead point of contact*
- Limited service capacity to meet client goals
- Short-term political/public decisions supersede long-term goals



System Strategies: Partnering with Other Agencies

- Many hospitals, health clinics and mobile treatment teams already have outreach teams that are in the community
- Use them to identify encampments, hang-outs, etc.
- Connect with shelters, meal programs, day-resource centers, emergency rooms, re-entry services
- Partner with agencies for training, mailing address and enrollment education



Education & Follow-Up

- Need additional follow-up after enrollment – identify who would provide this early on in the relationship
- **Options for care:** Educate the client on what services they will have access to – this might have been used for engagement, but will need to be discussed again
- Discuss what barriers they might face once they get to a service provider and aim to minimize or eliminate them
 - *Work together with the service provider*





Illinois Medicaid ~ An Administrative Perspective from a Blue/Purple State

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March 2013

HEARTLAND
ALLIANCE
HEALTH

Current Medicaid System in IL

- Medicaid Categorical Eligibility (All Kids; Family Care; Moms and Babies; SPD)
- The Disability Determination: SSI and SSDI
- Medicaid Medically Needy (Spend down)
- Medicaid Buy-In for Workers with Disabilities
- Medicaid Home and Community Based Waivers
- Fee-for-service: pays for quantity, in a fragmented system that lacks continuity of care

Illinois Statistics

- 1,668,800 Uninsured (over 700,000 are under 133% FPL)
- 2.7M adults and children enrolled in Medicaid
- 16,000 in ICHIP (high risk pool) – very high premiums
- Approximately 2,525,000 – almost 1 out of 4 – Illinoisans under age 65 have a pre-existing condition
- 16% of Medicaid enrollees who are Seniors and Persons with Disabilities (SPD) cost 55% of Medicaid budget – they have most complex health/behavioral health needs

Cook County 1115 Waiver

- Social Security Act gives CMS authority to waive certain Medicaid requirements to allow state to use federal Medicaid funds in advance of 2014
- Approved November 2012 → February 2013 start
- Based on patient centered medical home
- Demonstration program
- Fully capitated
- Expand capacity beyond CCHHS
 - FQHC providers
 - Specialty care

CountyCare Eligibility

- Live in Cook County; 19-64 years old
- Have income at or below 133% of the Federal Poverty Level (\$14,856 individual, \$20,123 couple – annually)
- Not eligible for “state Plan” Medicaid (parent, pregnant, blind or receiving disability income)
- Not eligible for Medicare
- Be a legal immigrant for five years or more or a US citizen
- Have a Social Security number or have applied for one

CountyCare ~ Goal to Become an Managed Care Coordination Network (MCCN)

- Goal = enroll 147,000 people into a medical home
- Enrollment by CCHHS and FQHCs
- Assigned to medical home based on risk, complexity and need
- Primary care providers will coordinate all services needed by their own panel of patients, supported by care management and information technology
- CountyCare network includes access to behavioral health services coordinated by MCO

Medicaid Expansion in IL??

- Extends benefits beginning Jan 1, 2014
 - Age 19 to 65
 - Income at or below 138% poverty level
- Modified gross income test and no asset test, which is different from current Medicaid and SCHIP Programs
- Newly eligible = 342,000 adults (over 60% employed)
- If Illinois does not fully opt-in to the new Medicaid program, Cook County will lose its 1115 waiver
- Passed the Senate February 26 → on to the House
- Enrollment to begin October 2013

Financial Incentives to Expand Medicaid

- Paid 100% by federal government until 2016 and does not fall below 90% match until 2020
- Kaiser Family Foundation estimates uncompensated care would decline by \$953M from 2013 – 2022
- Through 2016 bring about \$4.6B in Medicaid provider payments
- Illinois will be bringing in \$12 Billion in federal funds; state would be responsible for \$573 Million in state GRF funds
- Federal dollars will support some currently state supported services

Challenges for Homeless Providers within Medicaid System

- Establishing disability
 - Length of time to establish case
 - Access to services
 - Record of clinical documentation
 - Stigma for those with serious mental illness
- Securing identifying documentation
- Numerous barriers due to mobility of population
- Application complexity and fragmentation of benefit systems

Opportunities & Strategies for Homeless Providers

- Improve payer mix and ability to access services → reduce disparities
- Elimination of disability determination
- Streamlined enrollment system
- Flag homeless status within electronic data systems
- Transition to participant-centered health home
- Become “go to” expert on integrated care

Lessons Learned & Challenges to Come

- Highly vulnerable people will continue to have trouble securing coverage
- Need to manage “churning” across systems, providers and across MCOs, CCEs and exchange
- Coordination across providers
- Evolution of workforce
- Transitioning to a participant-centered health home → need for education and assertive outreach
- Competition for paying patients and growth goals
- Evolution of MCOs, CCEs and outcome-based capitated systems

How Can Medicaid Help Bend the Cost Curve?

- Average family with private health insurance pays an annual “hidden tax” over \$1,000 to offset cost of uncompensated care (Families USA)
- Nationally per enrollee cost growth in Medicaid (6.1%) is lower than per enrollee cost growth in comparable coverage under Medicare (6.9%), private health insurance (10.6%), and monthly premiums for employer-sponsored coverage (12.6%)
- Coordination of care via MCOs, CCEs and outcome-based capitated systems

+ Questions?

- **Samantha Artiga**, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation
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- **ISSUE PAPER:** *Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion*
- Available at: <http://www.kff.org/medicaid/upload/8355.pdf>

- **OTHER RESOURCES:**
- National HCH Council health reform materials available at: <https://www.nhchc.org/policy-advocacy/reform/>
- Kaiser Family Foundation: <http://www.kff.org/>