NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Leadership for Changing Times: Beyond Health Care Reform

March 13, 2013

Clinical Operations

Finances & Billing

HR/Personnel

State & Local Policy Change

Media Relations

Federal Policy Change

Board Relations

State & Local Relationships

Grants & Funding Sources

Fundraising

Administrative Operations & Requirements

Clinical Operations

Finances & Billing

HR/Personnel

State & Local Policy Change

Media Relations

HEALTH REFORM

Federal Policy Change

Board Relations

State & Local Relationships

Grants & Funding Sources

Fundraising

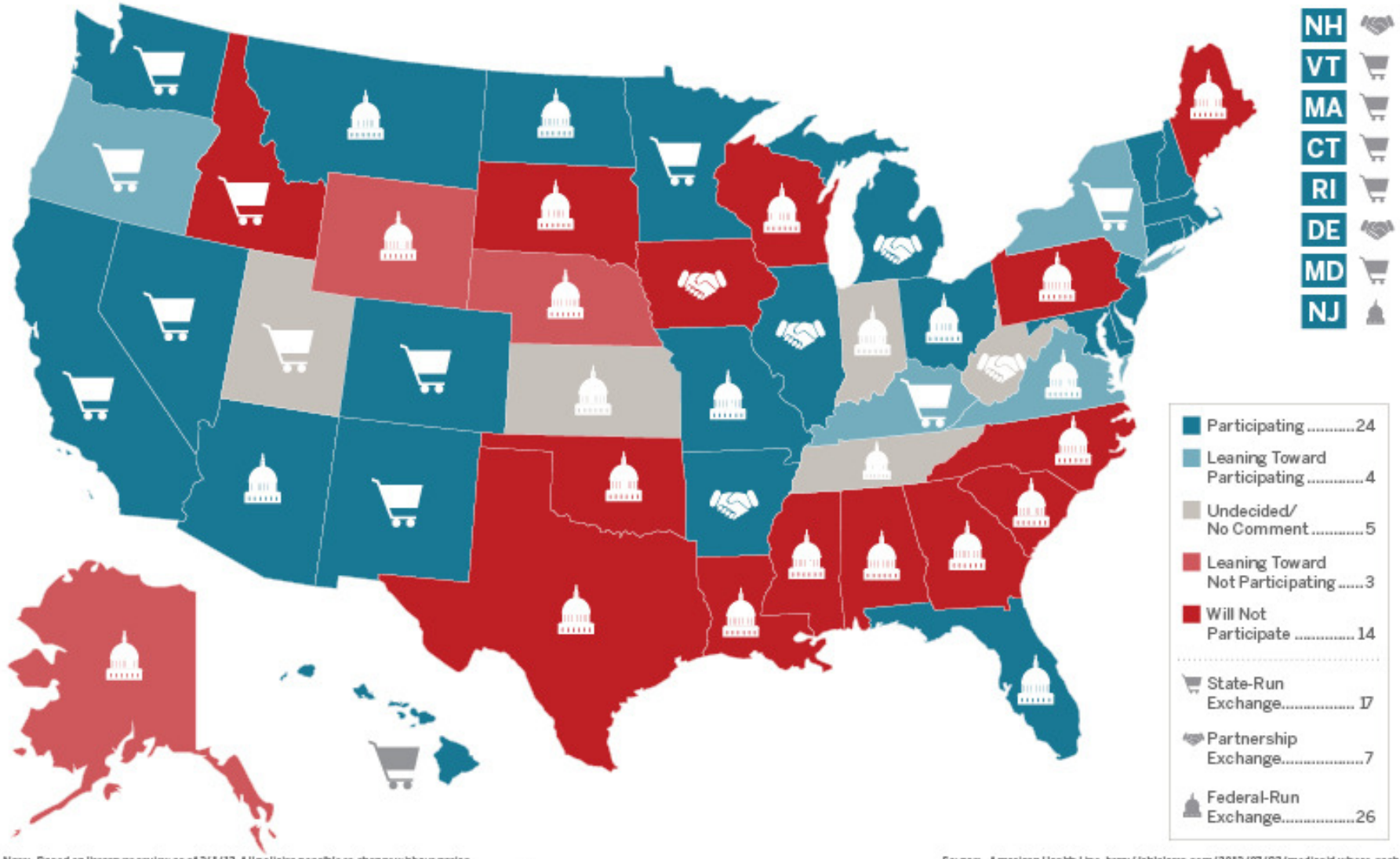
Administrative Operations & Requirements

The Biggest Changes

1. State Exchanges
2. Medicaid expansion (optional)
3. Enrollment improvements (required)
4. Additional health center revenue
5. New demonstrations
6. Payment/delivery system changes
7. Focus on data, quality & outcomes
8. New insurance protections
9. New partnerships
10. Revitalized health care discussions

Where the States Stand: March 1, 2013

24 Governors Support Medicaid Expansion



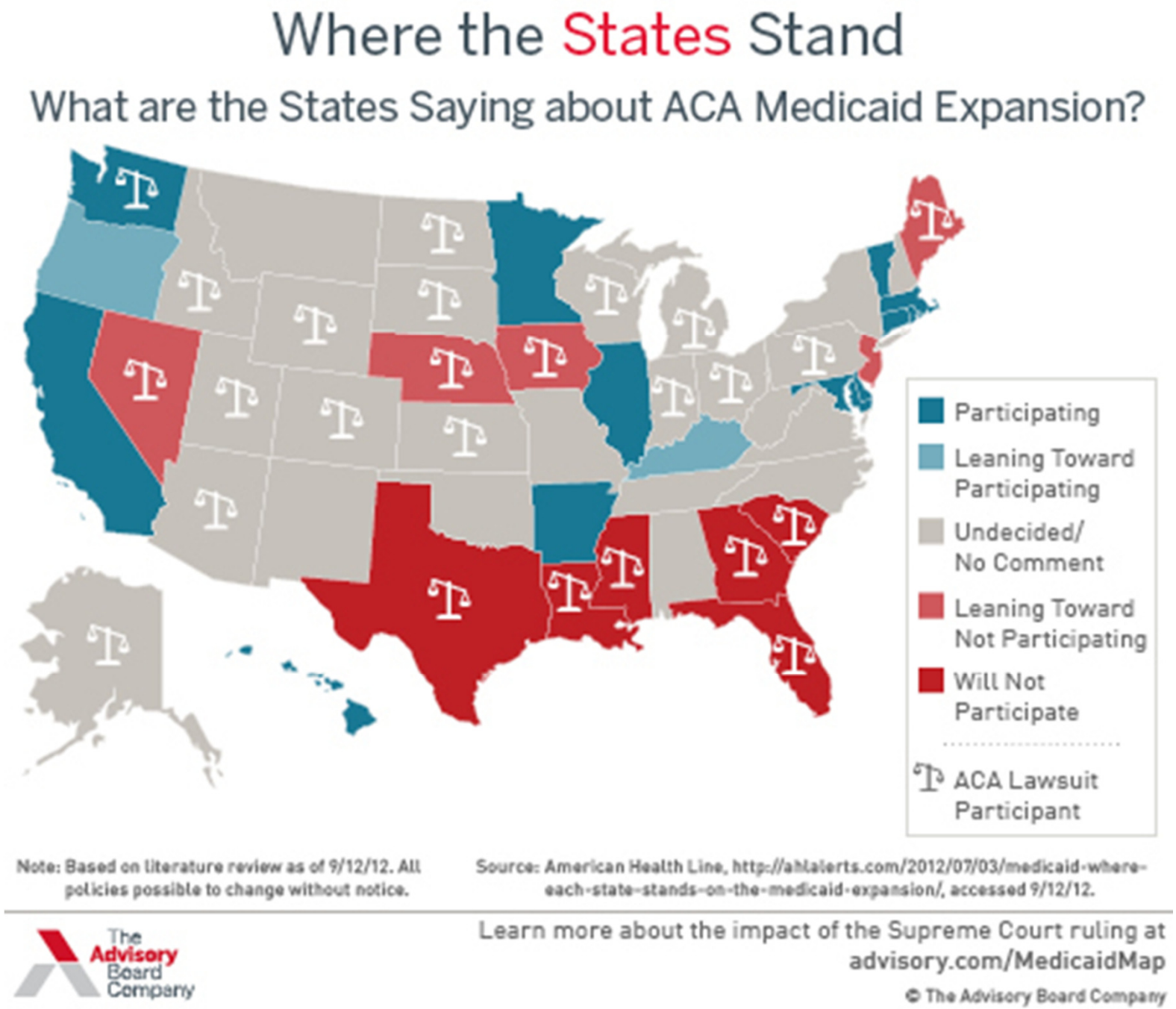
Note: Based on literature review as of 3/1/13. All policies possible to change without notice.
The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

Source: American Health Line, http://ahlalerts.com/2012/07/03/medicaid-where-each-state-stands-on-the-medicaid-expansion/, accessed 3/1/13.

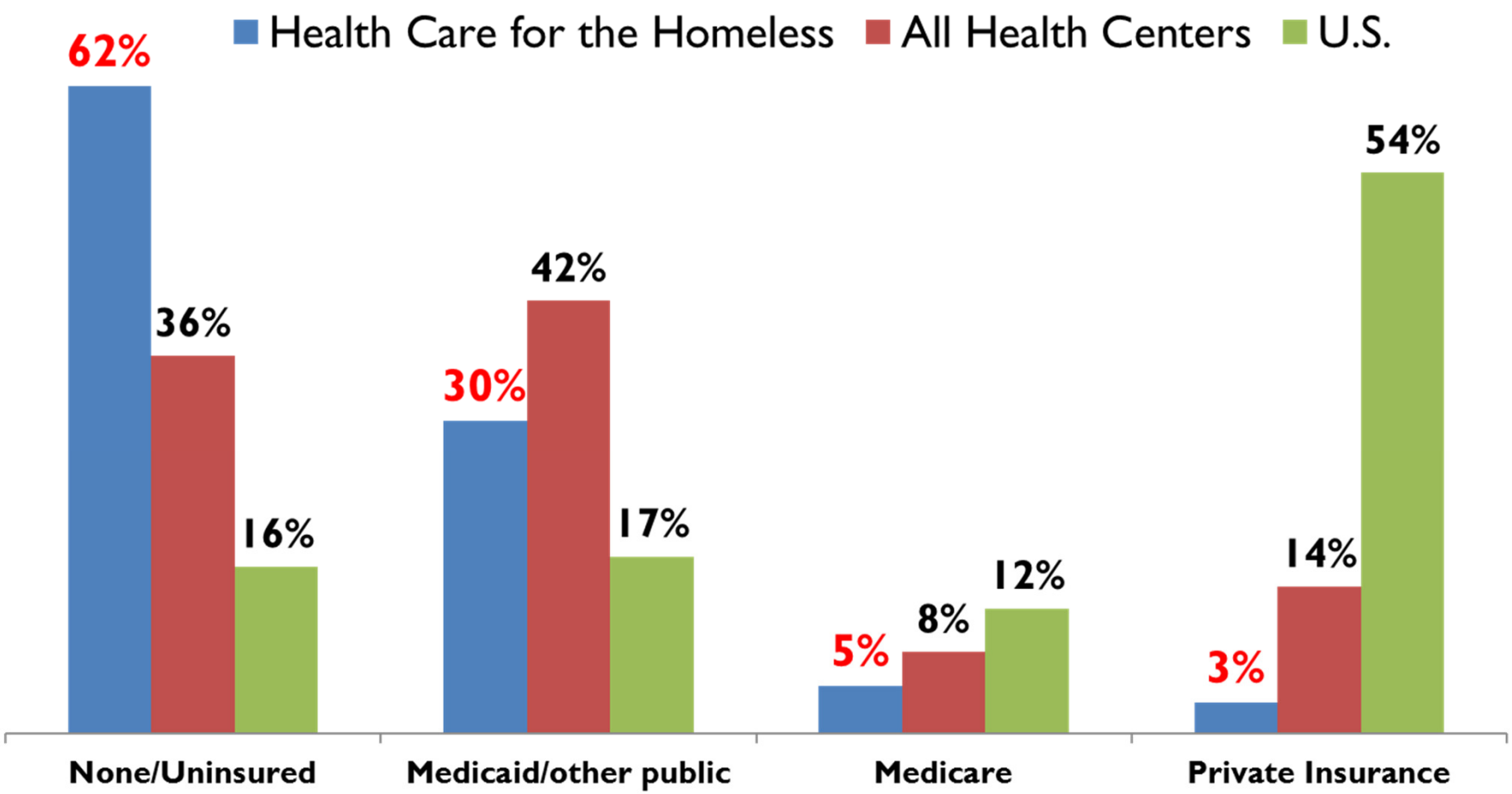
The Advisory Board Company

Learn more about the impact of the Supreme Court ruling at **advisory.com/MedicaidMap**

As of Sept. 2012: 10 yes 6 no



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



Sources: 2011 UDS Data, HRSA; 2011 Census Data

ENROLLMENT REQUIREMENTS

- No wrong door (online, phone, mail, in person)
- Electronic verification of income & identity
  - *No paper documentation*
- Coordinated Exchange, Medicaid & CHIP
- Timely processing
- Single, streamlined application
- No in-person interviews
- Automatic renewals every 12 months
- Use of modified adjusted gross income (MAGI)
- Enrollment assistance available

OUTREACH & ENROLLMENT

Law **requires** states "establish procedures for outreach and enrollment activities to vulnerable & underserved populations" (ACA § 2201)

- Children
- Unaccompanied homeless youth
- Children and youth with special health care needs
- Pregnant women
- Racial and ethnic minorities
- Rural populations
- Victims of abuse or trauma
- Individuals with mental health or substance-related disorders
- Individuals with HIV/AIDS

ELIGIBILITY OPTION

- **63 million currently enrolled:** children, pregnant women, disabled, and some parents of children
- **15 million newly eligible (starting January 1, 2014):** Law gives states option to expand Medicaid to non-disabled adults earning ≤138% FPL
  - About $15,000/year for singles
  - About $25,500/year for family of 3
- **7.3 million currently eligible, un-enrolled:**
  - 4.4 million adults (67% take-up rate)
  - 2.9 million children (84% take up rate)
- **85 million possible Medicaid enrollees** (1 in 4)

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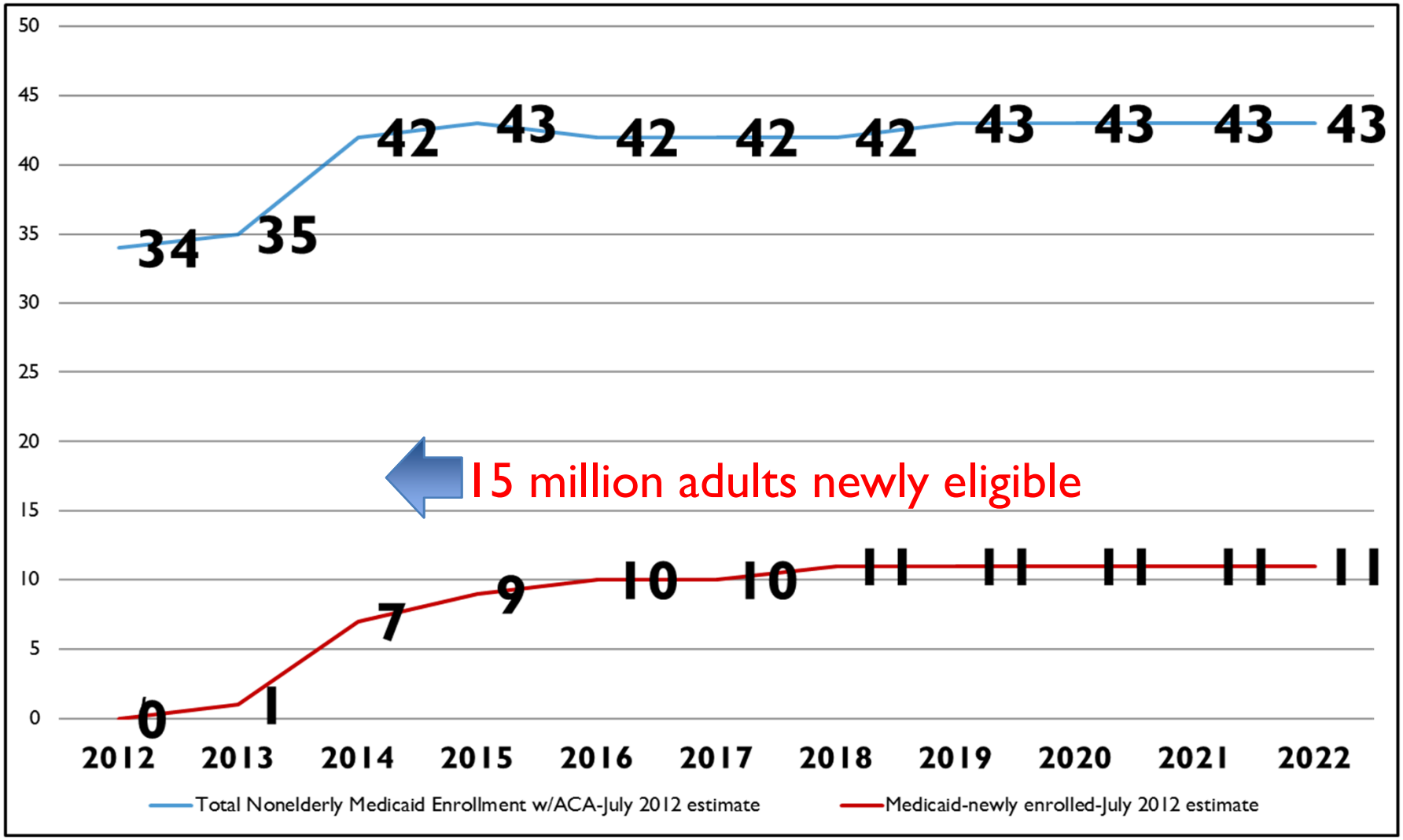
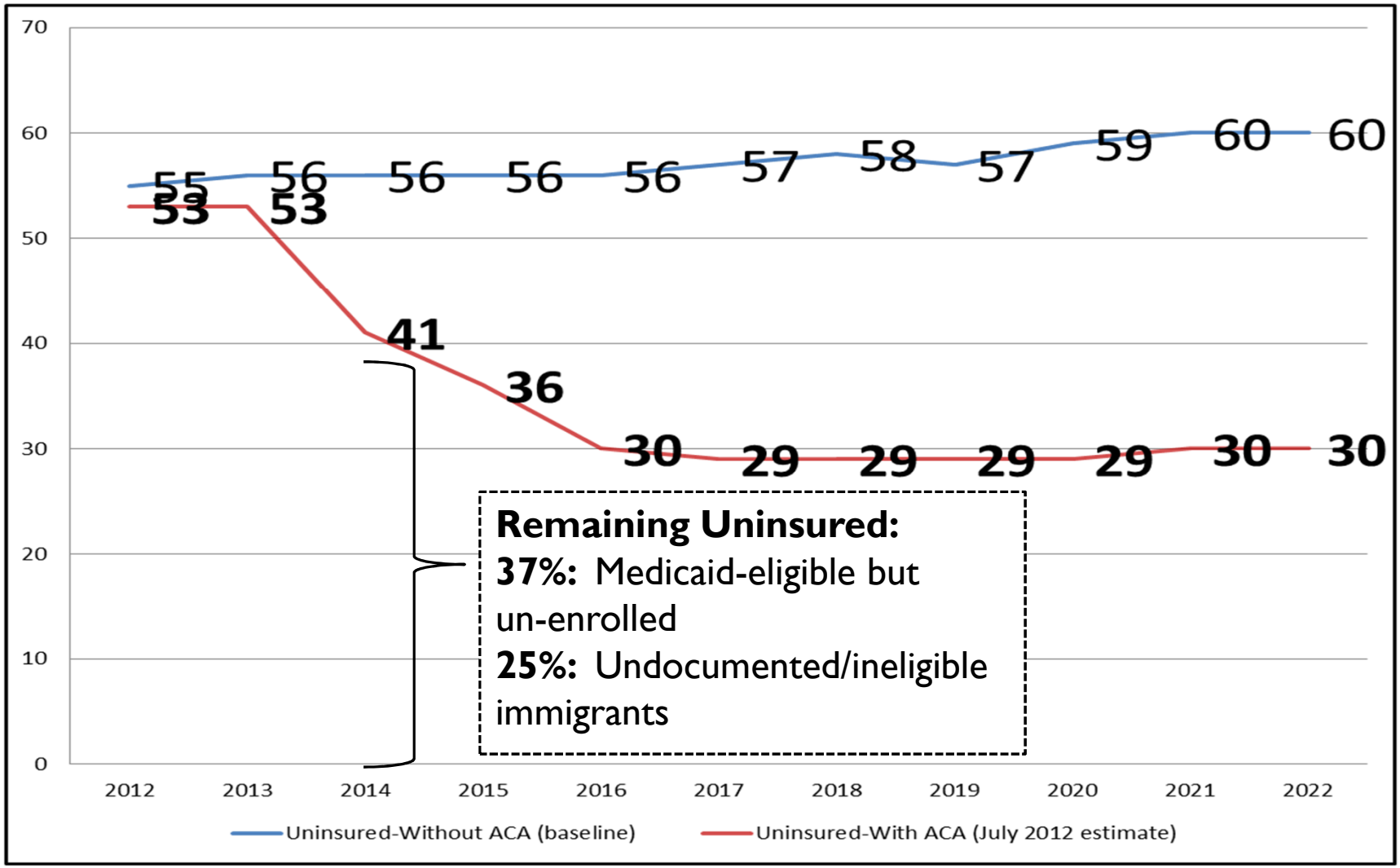
CBO PROJECTED MEDICAID ENROLLMENT (NON-ELDERLY)



CBO THOSE REMAINING UNINSURED



THE CHA(LLE)NGES

(Part I)

- Outreach is funded, assertive & targeted
- Enrollment process works for most vulnerable
  - Newly eligible + currently eligible (but unenrolled)
- Move to majority billable visits
- Balancing productivity with quality & HCH model of care
- Staff training, consumer education
- Expanding services & workforce to meet demand
- Documenting gaps in services
- Identifying resources to serve remaining uninsured
- State-level advocacy

WORKFORCE

- 7,200 new primary care providers needed (2.5% of the current supply)
  - Geographic disparities in level of disruption
  - 44 million (14%) live in areas where 5%+ increase in demand
  - 7 million (2%) live in areas where 10%+ increase in demand

Source: Huang and Finegold. (March 2013.) Seven Million Americans Live in Areas Where Demand For Primary Care May Exceed Supply by More than 10%. Health Affairs. http://content.healthaffairs.org/content/early/2013/02/19/hlthaff.2012.0913.full.pdf+html.

- 96% physician practices accepting new patients
  - 31% unwilling to accept Medicaid
  - Increases in reimbursements help

Source: Decker, S. (August 2012). In 2011, Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. *Health Affairs* 31 (8): 1673-1679.

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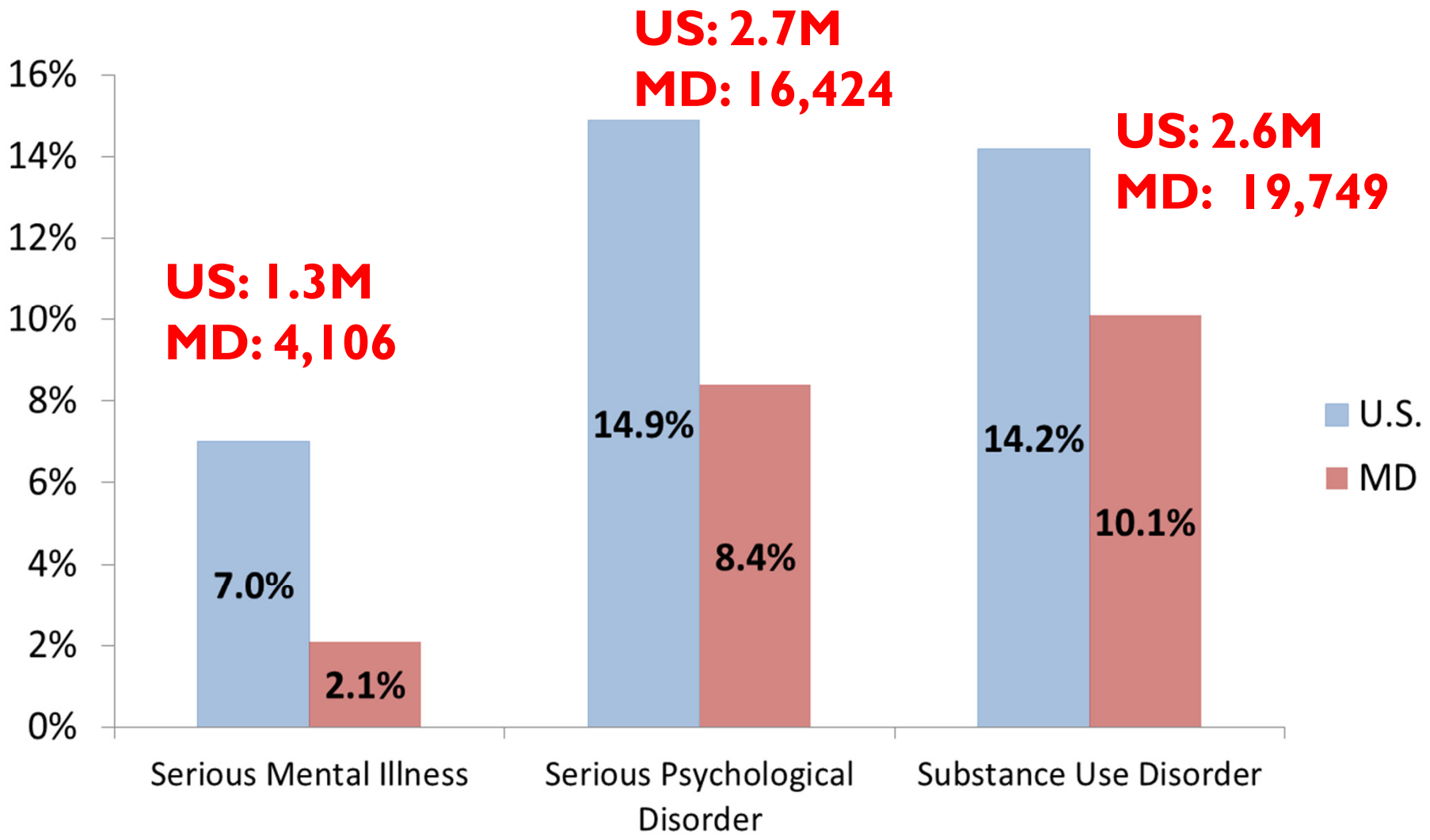
Characteristics of 18-64 Year-Olds Projected in Medicaid Expansion Population



Source: SAMHSA, 2013. Available at: http://www.samhsa.gov/healthReform/enrollment.aspx.

THE CHA(LLE)NGES

(Part II)

- Ensuring sufficient primary care & behavioral health providers
- Staffing case managers & benefits coordinators
- Training (and revitalizing) burned out workforce
  - EBPs, new approaches to care
  - Treating intense needs
- Absorbing local gaps in care
- Recruiting/retaining best skills
- Adapting clinical curricula to include social determinants of health, working with homeless population

MODELS OF CARE

- Integrated, team-based care (mental health, addictions, medical)
- Focus on quality and outcomes, not quantity of procedures
- Patient-centered medical homes
- Electronic health records
- Coordinated care across multiple venues
- Collect data, eliminate disparities
- Coordinated care entities/accountable care organizations, etc.
- Health care viewed in a wider perspective
  - Renewed attention to social determinants of health

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THE CHA(LLE)NGES

(Part III)

- Changing on top of more change
- Retaining HCH approach to care amidst 'working at top of license'
  - Amending 'assembly line' model of primary care
- Assuming risk, adjusting reimbursements to meet level of care/need
- Integrating with larger health care system
  - Pros and cons
- Matching partnerships to mission & practice

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INTERNAL FOCUS

- Needs assessments/ strategic plans
- Recruitment/retention
- Streamlining access/PCMH
- Integration of care
- Staff training
- Consumer education
- Maximizing revenue/ productivity
- Tracking data & outcome measures
- Board involvement

EXTERNAL FOCUS

Relationships with Policymakers

- Medicaid director
- Chief Executives
- Health reform lead
- Public health lead(s)
- Social services lead(s)
- Behavioral health lead(s)
- Legislative leaders
- Housing lead(s)
- Criminal justice lead(s)

Everyone Else

- Funders
- MCO executives
- Hospital executives/assoc.
- PCA
- CoC leaders
- Media
- Fellow service providers (health and housing/shelter)
- Community/public

ADVOCACY AREAS

1. Medicaid expansion
2. Outreach
3. Insurance application
4. Provider selection
5. Cost sharing
6. Continuity of care
7. Workforce capacity
8. Available benefits
9. Insurance protocols
10. Remaining safety net
11. Housing
12. Further reform *(universal health care)*

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

OPPORTUNITIES

- Improved individual & public health
- Improved health care system
- Reduced personal bankruptcy & poverty
- Increased individual & family stability
- Increased employment & productivity
- Reduced recidivism to criminal justice
- Preventing & ending homelessness

RISKS

- Fail to reach newly/currently eligible (lack of outreach)
- Continued barriers to enrollment
- Inability to find provider(s)
- Difficulty engaging in care
- Ongoing housing instability risks engagement in care
- Poor transition to exchange jeopardizes gains in health, income
- Ongoing homelessness & poor health

THE CHA(LLE)NGES

(Part IV)

- Making it all work well
- Retain (or re-assess) HCH identity and role in community
- The possibility of competition (really?)
- Continuing to meet client need
- Juggling internal and external priorities
- Unclear budget allocations over coming years
- Continuing to pursue comprehensive reform