Medicaid and Health Care for the Homeless:

The Dangers of Block Grants or Per Capita Caps and Guiding Principles for Reform

Medicaid expansion directly helped improve access to health coverage for homeless populations in states that expanded. In the 30 states that expanded Medicaid in 2015, we have seen the uninsured rate fall significantly in just two years—from 59% in 2013 to 37% in 2015. HCH projects in some expansion states, like Arizona, Kentucky, Maryland and Michigan, have been able to reduce the level of uninsured among their patients by well over half. Unfortunately, in non-expansion states, very little has changed. By the end of 2015, 69% of patients at HCH projects in these 21 states lacked health insurance (down from 74% in 2013). The disparity in access to care based on Medicaid eligibility has direct implications for patient health status, overall public costs, the stability of safety net providers, and state-level health reform efforts.

People who are homeless have significant health care needs—to include addiction and mental health conditions—and have benefited from the Medicaid expansion. Poor health and limited access to care is a primary cause of homelessness. Those without homes often suffer from high rates of behavioral health conditions such as opioid addiction, depression, and anxiety; chronic disease such as diabetes, asthma, and hypertension; acute injuries such as frostbite and wounds; and communicable illness, such as Hepatitis C and tuberculosis. As outpatient primary care and behavioral health providers, there's a limit to what we can do in a health center—having access to the full system of care allows us to connect patients to the broader specialty services they need to get better and focus on regaining housing and employment. As many states continue to battle a growing opioid and mental health epidemic, Medicaid is the primary funder of these critical services—without it, there is little to no access to treatment or recovery. As a result, people with behavioral health conditions are overwhelmingly incarcerated in jails and prisons—often at 100% state and local expense. A stable health insurance benefit such as Medicaid helps prevent this downward spiral that has extensive human and economic consequences.

Medicaid helps lower costs and end homelessness. Because of high health needs and lack of housing, people who are homeless tend to use hospitals and emergency departments at high rates, with longer lengths of stays, higher risks for readmission, and poorer outcomes. Medicaid expansion has allowed states and local jurisdictions to better connect people to outpatient, community-based care and provide better coordination for needed services. A number of states have also used optional flexibilities in Medicaid to fund more support services to allow better transitions to housing for long-

term homeless individuals. This has been shown to reduce use of hospitals, emergency departments, jails, prisons, court systems, and first responders with direct savings to local, state and federal expenditures. As our patients get better, they become more stable, use fewer high-cost services, and can return to employment, housing, family stability, and greater overall productivity. Achieving these types of outcomes is much harder under block grants and caps since the funding would be limited to short-term patches rather than longer-term solutions.

Community-based providers need Medicaid's stability and comprehensive care in order to provide high quality, cost-effective care and expand the workforce. Prior to Medicaid expansion, we were only able to secure preventive health screens (like mammograms and colorectal cancer screenings) or specialty care (like cardiology or orthopedics) through ad hoc pro bono arrangements, which were time-consuming to secure and inadequate to meet the vast need we encounter. Now, our providers in expansion states have access to a wide range of prescription drugs, networks of specialists, and a more stable system of care in order to better manage the complex needs of our patients. The financial stability that Medicaid offers allows us to make better use of limited grant dollars to fund additional services like case management, adult dental care, and outreach as well as hire more staff to fulfill our mission. Since 2014, many of our clinics in expansion states have hired more physicians, nurses, care coordinators, outreach workers, case managers, addiction specialists, and mental health providers. These workforce expansions not only provide good local jobs but also help meet community health care needs and have allowed many clinics to expand needed services. Putting Medicaid under artificial limits like a block grant or cap will undercut these workforce expansions and public health goals.

Medicaid is a crucial part of state-based health reform and other public health efforts. States have invested heavily in transforming their health care systems, investing millions in new delivery of care models, information sharing systems, and moving to innovative payment mechanisms that recognize social determinants of health. Treatment and recovery services for those with mental health and opioid addiction (as well as a host of other chronic diseases) have featured prominently among these plans, and are connected to state-level goals for improving overall health. Changing Medicaid from a traditional insurance structure to a block grant or capped amount fundamentally compromises the significant amount of work that has already been invested to integrate newly insured individuals into a better health care system, particularly in states that have expanded Medicaid.

Block grants and caps stymie flexibility and innovation, and will harm the poorest and most vulnerable. These payment models do not allow for a *system of care,* but rather a rationed approach that isn't able to respond to individual or community needs, particularly in a crisis situation. For high-cost populations needing a broader and deeper range of care, grants-based annual budgets will again drive the majority of decisions, taking us back to the "penny-wise, pound-foolish" inadequate approaches that have plagued the American health care system for years. This only results in high costs, poor outcomes, and wasted opportunities for better health and more productive lives. The current Medicaid program is exceedingly flexible, and all states are currently using those flexibilities to demonstrate various new approaches to meet needs, such as supportive housing services, medical respite care, care coordination, integrated health, etc.

From our 30 years' experience providing health care to people who are homeless, we have found the following three principles are vital components of any high-quality health care system:

- **Establish universal eligibility to comprehensive coverage:** We advocate for a system that provides health coverage to every American with no restrictions based on income level, employment status, citizenship status, criminal justice involvement, or health status. While a single payer system would be the most efficient and cost-effective model, the expansion of Medicaid under the ACA to people earning at or below 138% of poverty filled extensive coverage gaps (in states that expanded) and should be maintained. Health coverage through any insurer, whether the federal government, employer, or other private insurer, should include the comprehensive set of essential health benefits already established in law but expanded to include adult dental services (this includes community-based and hospital services, behavioral health care, women's reproductive services, prescription drugs, preventive health screens, and any other service beneficial to the health of the individual).

- **Eliminate barriers to coverage and care:** Entry into coverage should be streamlined, simple to navigate, and continuous—with no premiums, copays or other out-of-pocket costs for those at the lowest income levels, and no lockout periods or discontinued coverage for failure to complete health assessments or similar requirements. Coverage should be affordable for all income levels. Health savings accounts, subsidies, and tax credits, although easier to use for those at higher income levels, serve as a significant barrier to accessing services for very low-income individuals and should never be required for coverage. Likewise, there should be no work, education, or training requirements for participation in health coverage, nor should coverage be limited or capped (via block grants or individual spending caps). Networks of care providers should be adequately available and reimbursed for services.

- **Recognize social determinants of health:** Lack of housing creates and exacerbates health problems and makes engagement in health care more difficult. Effective health care systems align health and housing services—such as supportive housing, medical respite care, case management, and residential treatment—to ensure positive health outcomes and housing stability for high-need populations.

We have seen first-hand how the Medicaid program as it currently configured brings states the flexibility they need to tailor programs, and how providers rely on Medicaid to facilitate high-quality care and stabilize the health of very vulnerable people. **Block grant and caps only undermine the progress made to connect people to the care they need, and will certainly limit our ability to prevent and end homelessness among the patients we serve.**