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Early Impacts of Medicaid Expansion for the Homeless Population
Kaiser Family Foundation
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FEMALE SPEAKER 1: I would now like to turn the conference over to Ms. Samantha Artiga with the Kaiser Family Foundation. Please go ahead.

SAMANTHA ARTIGA: Thank you, hello and welcome to our Kaiser Commission on Medicaid and the Uninsured web briefing to exam early impacts of the Medicaid expansion for the homeless population. Thank you all so much for joining us today. My name is Samantha Artiga with the Kaiser Commission on Medicaid and the Uninsured. Today we look forward to sharing the findings from a recently released report that provides an early look at the impact of the Medicaid expansion for homeless providers and the patients they serve.

This brief builds on an earlier project we conducted to exam how homeless health care providers were preparing for the Medicaid expansion and their anticipated impacts of the expansion. These findings are important for understanding how changes and coverage are affecting individuals with some of the most significant and complex healthcare needs; however, I think they also provide some important insights that may help inform our understanding of how coverage gains may be impacting the broader growing population.

The report we are sharing findings from today is based on focus groups conducted with administrators, providers, and front-line outreach and enrollment workers at four sites

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serving homeless individuals in states that have expanded Medicaid, including Albuquerque, New Mexico; Baltimore, Maryland; Chicago, Illinois and Portland, Oregon and one site in a state that has not expanded, in Jacksonville, Florida; as well as administrative data we've collected from the sites.

We're going to begin today, this web briefing with one of the coauthors of the report, Barbara DiPietro, Director of Policy for the National Healthcare for the Homeless Council in Baltimore, Maryland, who will highlight the key findings from the report. Following that, we'll hear perspectives from representatives from several of the sites included in the report who we are thrilled to have join us today. They include Kascadare Causeya, Program Manager for the Benefits and Entitlement Specialist Team at Central City Concern in Portland, Oregon. Nilesh Kalyanaraman, Chief Medical Officer at Healthcare for the Homeless in Baltimore and Karen Batia, Executive Director at Heartland Health Outreach and CEO of Together for Health in Chicago.

Following their perspectives, we'll open the discussion up for a question and answer period. I will admit that the presentation today will touch on the findings from the report at a high level, so I would encourage you to take a look at the full report from today's briefing for additional details and information beyond what we will be able to share today and that report is available on our website at www.KFF.org.

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Just briefly before turn to the key findings, a few housekeeping items. As mentioned in the opening slides, a recording the webinar will be made available after the event on our website at KFF.org. The Q and A session will be held after all panelists have provided their remarks, but you should feel free to submit questions as we proceed. We have a lot of folks listening in today, so we will be unlikely to get through all the questions, but we'll do our best to get through as many as we can. Now to get started, I'm going to turn it over to Barbara DiPietro from the National Healthcare for the Homeless Council to tell us more about the key findings from the report.

BARBARA DIPIETRO, PHD: Thanks Samantha. I just want to turn your attention to the first slide that shows the disparities in insurance status, that we start that as the baseline and when we look at the healthcare for the homeless patients that are served in the 250 healthcare for homeless grantees, which are special populations' health centers, largely funded by HRSA. You can see that in 2013 over half of the, about a million or so, patients that were served who were documented as homeless were uninsured with a about a third that were already in Medicaid and this is primarily a disabled population, very few are privately insured and a few are through Medicare.

This contrast even with regular health centers which do serve an underserved population, which sees about a third

uninsured, but many more Medicaid. Then when you even compare that then to the general public in the United States, where you see that over half of the population is privately insured and then equally split between uninsured and Medicare, you see almost 20-percent or one in five are on Medicaid.

Really some significant disparities that we were starting with, prior to the January 1, 2014, eligibility for those states that did decide to expand their Medicaid population to the Affordable Care Act expansion for those who are at or below 138-percent of poverty. Then when you think about the types of people who are in this homeless population, remember you're dealing with a vulnerable population that's got very high rates of chronic and acute disease. This is not just behavioral health condition, but this is also high rates of chronic disease such as diabetes, asthma, hypertension, and heart disease. The same kinds of conditions that are priorities for the general healthcare system and the general public, but really you see it at much higher rates. The disparities in health insurance is really going to have an impact and we'll talk a bit about that today with our speakers.

Then looking at the next slide where we show what the continuity of the enrollment with clients who have insurance and really you can see some incredible increases, particularly as we go back a few years you can see fairly consistent rates. Depending on where you are in the country, depending on what

the Medicaid benefits were in that state and depending on a different health centers targeted population, you will see some fluctuations. However, if you'll note that in January of 2014, really remarkable increases, particularly at three sites, in Baltimore, Portland, and in Albuquerque, you see really went way up.

Now, in Baltimore and Portland, you had expedited enrollment, either through a SNAP benefit through the food stamp benefit or you had a state only health program in Maryland where theirs automatically rolled over and so you saw really sharp increases.

Albuquerque you could see really put a lot of effort into bringing its enrollments way up and then Chicago had had the benefits of having an earlier expansion, which you can see from the rise in people with insurance. Please note, of course, that in the state that did not expand Medicaid in Florida, you see very little increases in the Medicaid rates, although, they did try to make some improvements in some outreach efforts, which does account for a couple of percentage points.

Through the focus groups that we had conducted in these five areas, if we look at the next slide, some of the outreach and enrollment experiences that were described to us, through many people who were doing front line enrollment work, really found that their experiences and the themes were very

consistent across the five sites. Outreach is done in a broad range of venues and for this population, really you want to make sure that you're not waiting for someone to walk through the front door. This is a population that's outreach in nontraditional settings is really important. This means in soup kitchens, in homeless shelters, under bridges, in encampments, on the street, places where people generally are not receiving traditional services, but going out and finding people who may be eligible and not only engaging them in a new benefit, but the idea is that we want that benefit to yield greater services. Thinking about the broad range of venues that people are going to find and enroll folks.

Once they did consistently, front line workers described that people were generally eager to enroll and access services. I think this is a little bit of contrast to a general population where there was some hesitancy. We really saw that clients for the most part in this population were excited to be getting enrolled in Medicaid. This is something traditionally people have not been eligible for and so really excited to see people wanting to get in.

What we also found fairly consistently, depending on the population you were working with, is that nearly all people experiencing homelessness are eligible for Medicaid in states, of course, that expanded. What you found was a lot of eligibility, a lot of people who were coming into the system.

Now areas that worked with more undocumented populations or some other populations may see that fluctuate a little bit, but for the most part we were seeing really vast majority were eligible. With that being said, they needed a lot of assistance to enroll. They really needed someone to help them through. A lot of what was happening was web-based. A lot of it was questions that maybe they needed help with, identifying the social security or a birth date. Some of those details we wanted to make sure we got right. A lot of that hands-on assistance was really important.

What we discovered was that once people got enrolled they were really unsure of how to use the benefit or what the new card meant. How do you access services? Really this is an ongoing issue that we'll talk about later, but some of the themes that we found from outreach and enrollment.

In the next slide, we really were thinking about, what is it that clients themselves were experiencing as a benefit? How were they being impacted by being eligible for Medicaid? What we found is that, as you would expect, there's an improved access to care that with the benefit came an increase in seeking services, which is what we wanted to see happen. We were able to connect people to a broader range of comprehensive care. Now what we do in federally qualified health centers like healthcare for the homeless is provide outpatient primary care in behavioral health for people regardless of ability to

pay and regardless of insurance status. Really there's a limit to what we can do in an outpatient primary care setting. We really need access to specialty care and a broader range of care to be able to meet a significantly ill population. Getting access was really important and I know we'll talk more about that later.

The broader benefits, not just health services are really coming as a result of this. What we were delighted to see is that as people are accessing services, they're better able to manage their care, to get stable. If we can get people less sick, then they're better able to work on the kinds of things that are getting in the way of retaining housing, and so working on housing, working on looking for work. All of those things are really important to ending homelessness.

What we saw also is that people weren't worried about medical bills. This is a population that uses the emergency room and when you are uninsured frequently many people know getting all those bills and those pile up, creates an amazing amount of stress, even in a population that generally does not pay those bills. The impact on stress and mental health really needs to be appreciated.

Then ultimately what we were seeing, too, is as people are engaging in care and were able to document their functional abilities or disabilities, we're able to provide a stronger documentation for applying for social security. What we might

be able to see over time is being able to access not just the health benefits through Medicaid, but then making the case for the disability that might get someone an income benefit as well. I think that is really the broader benefits that we're looking at.

Feeling empowered to manage their health and participate in care decisions, really being able to have a choice about where you go and who you see, this is all new for this population and something that we can't emphasize enough. Then again in non-expansion states we're continuing to see gaps in care and in poor health outcomes that we're not seeing the gains in access that we'd like to see there.

Moving on, though, to talking about what this means for providers, I think a lot of times we think about benefits in terms of the people that are enrolling, but there's an entire workforce of people who are made up of clinicians and service providers that really are seeing changes as well. I know Dr. Kalyanaraman later will touch on this, but wider treatment options available to physicians and other care providers, looking at increases in third-party payments are helping financial stability in a way that does manage the care that they're providing better, rather than incidental grants which are here today and may be gone tomorrow.

In thinking about long-term strategic and operational improvements, so how do we make quality improvements? How do

we put more people in place knowing that we have the stability of a revenue stream through Medicaid that we didn't necessarily have before. This opens up new opportunities to really be thinking about long-term growth from a provider perspective. Increasing staff, again, we're able to hire more people, more people to care for the folks with the increase in demands of services or shift staff responsibilities around so that we can be doing more coordinated care or better access to care.

Now with all that said Medicaid does not pay for everything so what we really want to emphasize is that Medicaid, while critical and is certainly bringing a lot of opportunities, other funding streams like HRSA and SAMHSA, block grants and other grant funding remain vital to be able to fill the gaps that Medicaid may not necessarily provide like case management or outreach or other services that are needed.

When we think about access and the delivery and changes in the care that we're providing, we're all thinking about the larger health structure in the country and thinking about how is health reform impacting how we are organizing and delivering the care that we provide. For this population, really thinking about support services in addition to the direct care services.

Trusting relationships and making sure people are engaged and that we have the time to form relationships so that we can deliver longer-term services to a more fragile population and coordinate that care across many venues.

Thinking about social determinants of health, now this is something that we are talking a lot more about in the broader health care community now, which is a really great thing, but thinking about how housing impacts health care fundamentally. Thinking about poverty and hunger and thinking about some of these other things that really will impact longer-term health outcomes and their health status and ability to be stable is really important, particularly for this population and something that we might focus on as we move forward.

What we also found is that we thought initially that if you have a lot of care options and a lot of providers that are available to use, that this population would, like anyone else, want to go other places for their care. What we found was that clients are staying with the people that they have relationships with. For the most part healthcare for the homeless has not seen its patients leaving to go to other providers. In the examples where people said that people did leave and go somewhere else, they were quick to come back, again for that trusting relationship and for a place where really the model of care addresses the need specifically of the homeless population.

In thinking also about broader systems, how do we address poor health and the significant needs of a population that specifically does not have stable housing? Thinking about

how we provide care in this manner and how are we folding housing into a conversation that butts up a new against the kinds of healthcare improvements we're trying to make. This is a whole new conversation, but one I think we really need to be sensitive to and think about how do we use Medicaid to the extent that it can.

What we found also is that while many homeless provider sites that we talked with had great internal data sharing, teams with a lot of communication back and forth, both electronically and with case conferencing and all of those mechanisms, were coordinating care. What we see is that improvements are needed for accessing hospital data and emergency room data or where other care venues for those patients might go, so that we really can achieve that vision of coordinated care across all providers, is where we're trying to move. These are some of the issues that we're looking at in terms of access and delivery and how we organize care.

Lastly, some of the things that we wanted to bring up, how fundamentally to deal with managed care. Thinking about how most states are putting the expansion population into a managed care environment and that brings with it some realities that we have to be honest about with this population in particular. One being auto-enrollment into plans and providers. Many states and localities if you don't select someone, then some provider will be selected for you. For this

population it may be someone that they can't reach because transportation is an issue, or it may be it's someone they don't have a relationship with and it may also be a provider that just does not have the core competencies or the interest in serving a very high needs fragile population that needs a lot of accommodation. That's what we were seeing in terms of people trying to make their way back to the HCH provider, if indeed they had gotten separated.

What we found also is narrow or changing provider networks. Again, the homeless population tended to have care venues that they did use. Now those care venues may not always have been labeled appropriate, but those were the relationships they had and so if your hospital is part of your managed care plan, was not the hospital you typically used, what we found was people are continuing to go where they're used to going and going somewhere else may introduce new barriers. Thinking about how networks really will impact how people access care.

Prior authorizations and changing drug formularies, these are the kinds of things that do interrupt the ability to get services quickly. Particularly in the areas of behavioral health, where you want to make sure you're getting prescriptions and you're getting treatment in a very timely manner and sometimes it’s a three-day or 24 hour wait, to wait for authorization to provide service and sometimes that does trip off for being able to get timely interventions.

Credentialing of providers, these are not new barriers or challenges for the provider community in general, but I think for this population of providers, it's really coming into a mainstream program means playing by mainstream rules and so we'll have to determine what that means for our business models and how from an administrative perspective are we going to accommodate that.

Then again, we're thinking about managed care plans. These are typically arranged for moms and kids and in some cases for people who are disabled or even seniors, increasingly so, but they are not really designed for understanding the needs a chronically ill adult population. I think we're seeing that managed care does not understand the needs of the people they're newly insuring and so they're looking to providers to really help them understand, how do we deliver care the best way that meets this populations needs, because there's now more entities that are responsible for coordinating care. Just thinking about what does this look like moving forward and building the education and awareness we need about a special population and I think this is really again, as Samantha had indicated in the beginning, this is a broad implication beyond just the homeless population, but now really thinking about how the Medicaid system, in particular, is able to address a broad range of needs that a really broad population who is newly eligible for Medicaid is bringing.

We are hoping to bring some perspective on a particularly vulnerable population today. I will turn it over with that back to Samantha and appreciate the opportunity to really share with you the findings of this report.

SAMANTHA ARTIGA: Thanks Barbara, I really appreciate you highlighting those findings and if you found those of interest I would encourage you to also go check out the full report online for more information beyond what we were able to share today. Now I'm really excited to be able to turn to several folks from the field on the front line providing care and services to individuals, to hear some of their perspective on current and future challenges and opportunities now in this new world of increased coverage options as a result of the Medicaid expansion. We are going to start with Kascadare Causeya, Program Manager for the Benefits and Entitlements Specialist Team at Central City Concern in Portland Oregon to hear his thoughts. Thank you so much Kas.

KASCADARE CAUSEYA: Thank you Samantha. I wanted to let you know what some the challenges and some of the opportunities are here in Oregon with this whole process. Some of the new enrollment systems and requirements created a little confusion for front line workers. The problems faced this year due to states changing from state run systems to a federally run system. With the federal system there are new and different websites for Medicaid and qualified health plans.

The conveniences we had in the past were pretty much nonexistent anymore. There was, in addition to the federal system troubleshooting for what a client has, had additional limitations like finding the status of an application and requiring client consent via the phone for assistance to help. Also a waiting time for Medicaid eligible applications to be sent to the state agency overseeing the Medicaid process has created some additional problems for us. The need for phone numbers and email addresses has created barriers.

For those who serve—

SAMANTHA: Sorry to interrupt. Can you speak up a little bit louder? I think some folks are having a little trouble hearing you.

KASCADARE CAUSEYA: Okay. Let me turn the phone up a little. For those who serve the homeless and those at risk of homelessness, so many of our clients don't have a phone or an email address. Some clients without a phone or an email address are reluctant or somewhat embarrassed to come in and apply. The challenge for us has been to get the information to the public that there are ways to get enrolled if you don't have an email address or a phone number. In cases where people without a phone number or email address come in to enroll, we can use the paper applications, fillable PDF applications, or we can call the federal phone line, so that they can get enrolled via the phone. Though these methods may not offer

immediate eligibility determination, except via the phone line, their applications will get processed.

Also the loss of year two funding added to some of the difficulties we experienced. They had lost of funding in year two has created hardships on clinics with smaller staffs. Many of these clinics, in an effort to keep staff, had to shift some of their responsibilities, while increased training time for assisters and lack of funding made it difficult or made it necessary to eliminate some positions. The reduction in training the assisters has increased the workload on programs that still have assisters. The challenge for an assister is to continue to do the much needed in-reach and outreach to community partners.

Community agencies are already working together to ensure that all who need enrollment will have the help they need. State agencies are also helping by contacting those who will need to renew or to have redeterminations made. The hardship for agencies is that as the federal and state agencies tweak procedures to make them more efficient, the continued hours of training creates hardship on agencies that don't have the manpower to spare someone. Thus far each month there are new and tweaked procedures and this has been continual over the last year.

Potential for coverage loss during renewals. In an attempt to stay ahead of the renewals in the large numbers of

the population; one of the challenges we've noticed is that due to various reasons, some people are suffering a temporary coverage loss and being switched from their preferred provider to a doctor or clinic that they are familiar with. The loss of coverage is because the renewal application wasn't process before the termination date. Once the application has been processed, participants are finding that the covered provider has been changed.

Being told by the provider or pharmacist with whom they've developed trust, that they are no longer covered can be a frightening experience. Unfortunately most Medicaid participants and their clinics and pharmacies aren't aware that this can be fixed fairly easily. In some cases this temporary loss can change with coverage, may results in medical and mental health appointments being missed and, in some instances, not available.

The opportunities that we're seeing is that clients are willing to enroll and they're happy to have benefits. People understand now that they can and will actually receive healthcare coverage. They believe now that healthcare coverage is available for them and they get treatment for conditions that many have had for years. They enjoy the chance to choose their own network and primary healthcare locations. So many are continuing to come in for new coverage and others are coming in with their renewal or redetermination letters, as

well as questions about when and where and how they can use that coverage.

Not only do they seek out assisters for help enrolling, but are only too happy to have friends and family come in. They also bring in many people whom they share or they spend time with in the shelters.

Consumers are spreading the word leading to additional people initiating enrollment. As a result of people getting coverage and being happy with it, by word of mouth others are coming in to enroll. Many times we've had people bringing friends and or family members in. We've noticed this trend among people who've never had health benefits before, as well as some of our long time clients. As a result, we have been fortunate enough to help many who we may not have been able to reach before. Also establishing a presence at a site where others can see how we engage and work with people. We've helped people with doubts about the whole process.

After once such occurrence, when the client received his healthcare card and went to the hospital to have nagging injury checked, he reports receiving more treatment then he had received in the emergency room without insurance and given the follow-up plans for treatment. He made the transition from doubtful to hopeful and encouraging others. Not only did he come back and tell us and everyone at the site where we were,

but he went out and told a friend and actually brought that friend in to get enrolled.

People are able to access services at the point of enrollment. One of the opportunities we've had this year is that now with the immediate eligibility determination, clients receive from online enrollment, state agencies are encouraging hospitals and clinics to accept those and offer services based on that determination. Now immediate eligibilities determinations are resulting in immediate opportunities for people to receive services.

Seeing visible improvements in outward appearance, increased trust, and looking better and they have more help. This is another opportunity that we're seeing as assisters. Oftentimes when we first see a client they appear uninterested or doubtful of any positive outcome for their time and involvement in this process, but through genuinely engaging clients we often see a change in their face and glimmer of hope. After they received their benefits and have had treatment, in many we can see changes in their appearance, presentation and even the willingness to engage and work with others. Many times you'll see someone without coverage tending to isolate themselves in the clinic, but once they have coverage and engaging in treatment, their whole presentation in the clinic changes. Before coverage clinic staff tries to make

them feel welcome. Now with coverage they know and act like they know that they're welcome.

Thank you, I'm going to turn this back over to Samantha.

SAMANTHA ARTIGA: Thank you so much Kascadare. Now I'm going to turn it over Dr. Nilesh Kalyanaraman, Chief Medical Officer at Health Care for the Homeless in Baltimore, who I think can give us some great perspectives from a clinical provider's point of view. Take it over Nilesh.

NILESH KALYANARAMAN, MD: Thank you Samantha. We are hearing some of the challenges for enrollment and once you get somebody into the clinic there's a number of challenges that still exist for a staff. There's still lack of reimbursement for key services and Medicaid extension in Baltimore and in Maryland in general has been fantastic as you may remember from one of the earlier slides. There are still things that are not covered and I know this varies from state to state, but case management, outreach, dental services, depends [inaudible 00:31:36] in most states and as you know these are critical enabling servings for the population that we serve and so we continue to need to find other ways to fund these activities.

Just a brief point on dental, we have, as I'm sure many of you had, we have many people who state they have difficulty getting jobs because their teeth are so poor and we were able to get a small foundation grant to help fund some restorative

dental work and it's made a world of difference for the people who've gotten those dentures, who can smile proudly now, and it just highlights for the vast majority of patients for whom we can't do this, how critical a service this is.

On a provider level, Medicaid expansion has created some interesting challenges that didn't exist before. Formularies change—formularies are different between the different insurers, the Medicaid insurers. Formularies change and they change quarterly if not more frequently and there's prior authorizations. These are the sort of things that providers aren't as used to dealing with, but get complicated because of the population we serve. When we send somebody down with a prescription for a medication that we believe is covered, they go down and they can't get it, a lot of our patients get confused and they get discouraged and they leave. By the time we figure it out, either at the next visit or even in the interim and we try to get back in touch with them, we have difficulty doing so.

I've got a patient right now who I've tried to get on a particular blood pressure medicine that I'm convinced is covered and it took about four different calls to the pharmacist, to the insurer, and to the patient, and about an hour to figure out what's going to happen and how we're going to get that medication, but this happened over the course of three weeks because once the patient left the pharmacy, it was

a challenge to get in touch with him. There was no message capability on the phone, so I couldn’t leave a message. I have to try it few times. Then I'd in touch with the pharmacy, and then I have to get back in touch with the patient. These are just some of the challenges that we as providers are going to learn to get used to, but also have to figure out how to deal with them, particularly with our population.

Lack of housing. Lack of housing is still lack of housing. It's still the biggest problem our patients face in general and I know that there are interesting programs around housing for people who are homeless. It goes without saying that when we talk about social determinants of health, the Medicaid expansion is fantastic, it addresses what is essentially a financial resource issue. It doesn't touch the housing piece and many of the other social determinants that affects our patients.

Then learning how to navigate the insurance landscape, this is a hard thing. I haven't figured it out and nobody I know has figured it out. Every time I go somewhere people grumble about it because it's really difficult. What's truly difficult for our population is that patients have a tough time figuring it out too. If you think about the resources that our patients have available to them, it becomes that much harder to try to get through these insurance issues, trying to figure out where to get an x-ray can be an ordeal, particularly when

patients aren't really used to getting services. They don't really know how to navigate these systems and frankly the providers aren't necessarily really good at that either. This is just another wrinkle to keep in mind as we celebrate the success of Medicaid expansion, just what are some of the challenges that also come out of this expansion. Next slide please.

What are some of the opportunities that have come out of this? Well there's certainly better access to comprehensive care. Preventative services are easier to pay than the specialty care. We say access to specialty care. What does that look like? We had a woman in 2013 who started to lose feeling in her left arm and she wasn't able to feel temperature. She burned herself repeatedly. It was difficult for her to work. What we found out over the course of 2013 was that she had a mass pressing on her spine and affecting the nerves that traveled down her left arm, which is why she wasn't able to feel and was burning herself. For you and me, the next thing would be to go get surgery, but nobody was willing to do surgery on her. She had to go through some process for indigent patient account at the hospital and that wait is three months and that got rescheduled twice on her and this is a woman who is ready to show up the minute that they had her booked. This lead on for months and months and she continued to lose feeling in her left arm. All of a sudden she got an

appointment, but it did not get switched out because she wasn't an indigent patient account anymore. She was just another patient with Medicaid and that sort of statement, the thing that we've been looking to do for our patients all along, to treat them like other people, that got her an appointment in the middle of January where we've been planning for months and months and months and within a few weeks she was scheduled for surgery. She got that mass removed and she did not get all the feeling back in her arm, but the damage stopped and some of it has come back and she's able to work successful jobs. When we mean access to specialty care sometimes it really is life or death.

There is also increased availability to medications, particularly to some of conditions I listed, asthma, hepatitis C. Asthma medications are very expensive. We've usually dealt with that by handing out samples. Those are usually big boxes with a weeks worth of supply of the medication, of an inhaler of some sort. What was interesting about that was that there's only so much sample you can get and so you have to portion it out to your patients. You want to give them a couple of a months worth, but that's eight boxes and that means that the next person who comes in might not get any. You give them two boxes, that's two weeks and they know they're going to have to make it stretch because they might not be able to get back to you in two weeks. You can't give them an appointment as

quickly as you want to. You're literally playing with people's breath as you're trying to figure out how you can get them the medication they need to breathe properly for their asthma.

What we are able to do now with insurance is that you can prescribe them their inhaler and you can prescribe refills and you know what? They don't have to come in and see you and carry multiple boxes of medications and worry about losing it. They can use their inhaler and when they're done at the end of the month, they pick up their next one. It helps control a great many of people with asthma and with COPD, in helping to stabilize their breathing and make easier one of the logistical difficulties they have with coming back and forth to the clinic just to get a medication.

With this comes people having greater control over their health. I mentioned that people can get refills. People can get their medications more easily. They can go to any pharmacy that's closer to them. They tend not to have to use the pharmacy that you have a relationship with. If they're traveling, if they're moving about, which our patients have to do quite frequently, they can get their medication elsewhere. They can also make appointments for specialty services, for preventive services, on their own. What we found is that we have only so many slots for our patients in 2013 and before because they were charity cases. They were indigent cases as they were called. If you have only so many slots, we have to

say, okay you can go get your services on this date at this time and there's really no flexibility. If that person can't make it, they can't make it and that's not the way any of us operate. That's a really hard way to go about your day.

Now with Medicaid expansion, once again, you're just like everybody else. You call up the specialist, call to make an appointment. You find out what time works and then you make that appointment. What we found is people are much, much, much—have a much greater capacity to make their appointments and we see this for all of our specialties, particularly for physical therapy, which is a big concern for patients of ours or GI. We have a lot of hepatitis C and a lot of colonoscopies for colon cancer screening and now people are able to make these appointments and we've seen these patient compliance go up with these visits tremendously.

What all this brings us to is that really has true potential for improving health outcomes over the long-term. When you stop having to deal with all of these logistical issues and get closer to focusing on the actual health issues, it makes it easier to manage the health issues themselves. When we're not switching medications frequently, when we're able to consistently prescribe it and have refills, that helps with long-term care, whether it's for diabetes, whether it's for a cold, whether it's for HIV. These are the sort of things that help improve outcomes.

For preventive services we can more easily get colon cancer screening done. Breast cancer screening done. We can more easily get follow up for cervical cancer screening. These are the things that will help improve long-term outcomes and we're not going to see those results in the first year or even the first few years. You need time for this to develop and you need stability and Medicaid expansion provides the stability to allow us to see these gains. I am going to turn it over to Samantha now for our last piece.

SAMANTHA ARTIGA: Thanks so much Nilesh and to finish us up with our presentations today, we'll have Karen Batia, Executive Director of Heartland Health Outreach and CEO of Together for Health in Chicago, Illinois, who's going give us some perspectives from an administrators point of view and I know Karen's going to try and wrap up her remarks quickly so that we have some time for Q and A and we may run a few minutes after the hour, just to try to get in as many of your questions as possible, but take it over Karen. Thanks.

KAREN BATIA: Thank you Samantha and the beauty of going last is that there are some very common themes, so if we can go to the next slide please. I will try and focus on some of the things that have not been touched on yet and do so quickly.

From my perspective Medicaid expansion, like everyone else has talked about, brings numerous challenges and

opportunities. One of the biggest challenges in something that as a director, we spend a great deal of time focusing on is is there going to be enough money to ensure that we can provide the services and the quality care that we're seeking to provide.

Medicaid does bring in the opportunity for increased revenue. That revenue stream is not necessarily steady as people fall on and off of Medicaid and churn occurs amongst the managed care organizations. On top of that, as many of the speakers have commented, many of the services that people experiencing homelessness continue to need to achieve those improved health outcomes and the decrease in the cost of care, really are not paid for Medicaid. Medicaid is health insurance and we have to remember that, that means the service has to be medically necessary, which this is really a pretty narrow definition.

As administrators, we need to be very vigilant in continue to advocate for grant based funding so that we can fill in those gaps. One of the other biggest challenges has to do with managed care as we've been hearing about and not only are there the complications of having to insure that, you as a provider, are able to do what's necessary based on each individual that you're trying to serve, but as an organization we must contract with multiple managed care organizations. Depending on who in your community is providing that managed

care, if we want to maintain continuity of care because of the churn that I just mentioned, it means that we probably are going to need to contract with every managed care company that we potentially can.

Each contract requires significant investments in infrastructure and increased compliance requirements. As an administrator I want to invest the resources that I have really and truly into that care, but there's so much that has to happen behind the scenes that it becomes an increased burden. Data is a really important issue and, again, as we are contracting with new payers and new systems, data is sitting in new and different fragmented silos and that makes it really challenging to manage your population and individuals.

Some of the other things, just to touch on in terms of challenges, is that as more people have Medicaid and access to health insurance, there is more of demand for services, which is fabulous, however, that means that as an organization, we have to continually be expanding our capacity to provide those services and recruitment of qualified staff and retention remains a very significant challenge.

Lastly on this slide, I wanted to touch on the idea that we are working towards bringing the overall cost of care down, both for individuals as well as populations and what we are seeing with people who are newly insured, is that they are actually accessing more care and so the cost of care goes up.

We do anticipate that it will come down, but it's going to take some time and all the things that folks on this call have already talked about, in terms of teaching people how to access their services and making sure that people are receiving preventive care and not just crisis care. Next slide please.

In terms of opportunities, I think we've heard, and Barbara talked about this from the very beginning, there is an opportunity for increased revenue and that allows you to offset some of those challenges that I just mentioned. Also, if we can start to figure out how to knit together the data that is available, we are going to do a much better job of getting to those health outcomes that we're all trying to achieve and to managing the costs of care, which I just mentioned as well.

We also have the potential to really better understand what reimbursement ought to be to providers based on stratifying the types of risks that are populations are bringing in to us. Right now we are paid the same as a child might be paid for services or for an adult who doesn't have a disability or an adult who is experiencing homelessness and the cost to providing the care that we're talking about is significant different. There is the opportunity to start to really think about what is an impropriate reimbursement methodology that takes on that risk and also what is really appropriate in terms of the outcomes that we're trying to achieve.

Lastly, is the opportunity to really build a system of integrated services. As then several of the speakers have mentioned, the opportunity in the conversation is really shifting towards the social determinants of health and we know for our populations in particular, without being able to provide housing, without being able to provide some of those services that aren't covered by Medicaid, we certainly are not going to be able to impact those health outcomes that we're driving and so this is also an opportunity. With that, I'm going to turn it back over to Samantha.

SAMANTHA ARTIGA: Thanks so much Karen. Now we're going to turn the questions that you can submit via chat and we have a number in there that we're going to start working through, but feel free to continue to add ones in as we move through the question and answer period.

Since we've just finished focusing on some financing issues, why don't we start with a couple of questions that relate to financing and I think a couple folks from the audience have noted that Medicaid does allow for coverage of case management services. Maybe Karen and Barbara, if you could speak to the expense that, that coverage meets needs, but also why you may still be having needs that are beyond what can be financed through Medicaid for case management and other supportive services.

BARBARA DIPIETRO, PHD: I'll let Karen start.

KAREN BATIA: I think the most important piece to answer that question is that case management in and of itself is not a billable service and what we can do is we can bundle together a case management visit when somebody comes in to see their provider and they do have a billable service. The needs of the folks that we're caring for go well beyond what a provider is going to be able to do and so we end up providing many enabling services when we can't actually bill for that visit or that encounter and that's the bottom line crux of the issue.

BARBARA DIPIETRO, PHD: I would add that states do have options, health home options and other state planned amendments and waivers, that they can pursue to add benefits, but right now and while there are some examples of that, I think states are really just trying to get their arms around where they are right now, before they start adding benefits. I think we'll see more of that in the future, but right now I think the system is trying to adjust.

SAMANTHA ARTIGA: Keeping on with the financing theme, Karen you touched on the point related to having appropriate capitation rates to address the needs of this population. Can you speak maybe to any initiative or efforts under way or what efforts wouldn't need to be under way to help make sure that payment rates reflect the needs of the population?

KAREN BATIA: I am not aware of any efforts at this time specifically targeting people experiencing homelessness and having that be categorized as a population. There are multiple populations with appropriate rates and it's one of the reasons that it's continually a mantra that we need to be speaking about. One of the first things that needs to happen is that across our Medicaid claims data in this country, we need to have a data field that actually lists if somebody is homeless. That varies from state to state, our understanding of that demographic varies from state to state, and what that means and that's the bottom line. It's critical before we can even start to dive deeper into the data that's available in terms of costs.

The other thing that I think is critical is ensuring that we are starting to look at the true cost of care, which doesn't exist in any one dataset. While a state may have Medicaid claims data, first that data typically is very old and lags behind the real time of providing that service. On top of that it does not capture anything that's being paid for within the system that is not paid for by Medicaid.

If we continue to carve people up based on their problem or their challenge and pay for it out that system, we're never going to have a true sense of the total cost of care and be able to start to manage that and think about those capitated rates in a more realistic way, as well as in terms of

outcomes. Those are two recommendations that need to happen before we can even start to really dive into the data.

SAMANTHA ARTIGA: Thanks Karen. Now a little bit more of a clinical perspective. Nilesh, maybe you can comment on this. Have you seen any changes with respect to care for individuals with HIV or AIDS stemming from coverage gains?

NILESH KALYANARAMAN, MD: Yes, this is a great question. We have. It's complicated. There's been emergence. We've had Ryan White funding and there's emergency funding available and through the gains by Medicaid it's easier to take care of folks with HIV now. You don't have to go through all these hoops. What it's actually doing, though, is focusing our attention on how are we not just getting people access to care, but how are we improving their quality of care, because now they're kind of in this same pool as everybody else. We're looking at what are their outcome measures, how are we taking care of their other comorbidities?

Of particular interest, though, is that Ryan White funding now is going to have to change. It started to change a little bit because in the Medicaid expansion states at least, there is now a funder and that is the Medicaid program and so what is the role for Ryan White, how do we continue to do the enabling services that are important for people with HIV. I think what we also know is that they're important really for everybody and we know enabling servings are important for

people with homelessness. We know they're important for people with diabetes. How does the whole structure of HIV care funding change to bring HIV more into the main stream? I think that's the challenge that we're seeing in the Medicaid expansion state and those without still need Ryan White to help fund the care for people with HIV.

SAMANTHA ARTIGA: Great and I just want to do a little plug. I think we are anticipating having a report coming out that will be identifying some of the impacts on the expansion specifically for people with HIV in the near term, so be on the lookout for that as a Kaiser resource in the near future.

More on the outreach and enrollment front, Kascadare, maybe you can speak to the extent to which newly enrolled clients now have an opportunity to active peer recruiters. I think you spoke to this happening on an informal basis. Are there any efforts that are sort of formalizing having clients act peer recruiters or enrollment outreach workers?

KASCADARE CAUSEYA: Well not necessarily peer recruiters, but they are out in the public and they do come to the sites. We do a lot of enrollment fairs, enrollment events, and they're there and they talk up the whole process. A lot of them bring their friends or people that they know to these enrollment events and to help get enrolled. There are no jobs that we have at this time. Well I'm not saying no jobs, but

there are few jobs at this time that are posted for people to tell people get enrolled.

SAMANTHA ARTIGA: We had one data clarification question that relates to the coverage change graph. Amanda, I don't know if you want to pull that up, which was asking why Chicago did not show a major reduction after the Medicaid expansion. I will maybe add a couple comments on that and then maybe Karen if you want to add in as our Chicago representative. Chicago is actually one area that got an early start on the Medicaid expansion. When you're seeing the jump earlier, before 2014, from 33-percent to 41-percent in January 2013, they actually started expansion earlier and it occurred a little bit more on a gradual basis relative to the other sites. I don't know Karen, if you have other clarification, if you want to add to that.

KAREN BATIA: No, that's absolutely correct.

SAMANTHA ARTIGA: One more data clarification question related to the uninsured bar chart at the beginning. Barbara you referenced the 57-percent uninsured in 2013 pre-ACA. Do we have a sense of what share of those are likely eligible for Medicaid?

BARBARA DIPIETRO, PHD: We do believe that a significant share of those will be embarked as Medicaid in expansion states when the data gets released for 2014. We

anticipate seeing a wide change out there and are very much excited about it.

SAMANTHA ARTIGA: I think with that, that's a great point to end on. I think really caps off the major findings that we've been trying to highlight here, which is where states expand in Medicaid, the homeless providers. The sites really have seen a marked shift in the coverage of the patients they serve and that's really having important benefits for both the individuals they serve who are experiencing homelessness and have a wide range complex and significant healthcare needs, as well as the providers ability to serve them and meet their needs. We hope that you found these finds interesting and helpful for your work and your efforts and we look forward to continuing to track the experiences moving forward and highlighting some of the longer-term benefits and outcomes that will likely see in the future.

Again, the materials from today's webinar will be available on our website at KFF.org. The link is provided for you here and the full report from which these findings were drawn is also available on our website. We hope to hear from you soon and that you'll keep updated with our work. Thanks so much.

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[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.