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Serving the Homeless Community: New Findings on the Impact of the ACA Medicaid Expansion April 26, 2016

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SAMANTHA ARTIGA: Hello and welcome to today's Kaiser Commission on Medicaid and the uninsured web briefing, *Serving the Homeless Community: New Findings on the Impact of the ACA Medicaid Expansion*. Thank you all so much for joining us today. My name is Samantha Artiga with the Kaiser Family Foundations and today we look forward to sharing the findings from a recently released report that provides analysis of how providers serving the homeless population have fared since the ACA Medicaid Expansion took effect in 2014.

In addition to the slides shown on today's web briefing, you can download the full report on our Web site at www.kff.org. The report we are showing findings from today is based on an analysis of data reported annually by health centers that we conducted with the National Healthcare for the Homeless Council.

I want to start by acknowledging my co-authors on that report, Matt Warfield and Barbara DiPietro. The findings presented today provide increased understanding of how changes in coverage are affecting individuals with some of the most significant and complex healthcare needs and the providers who care for them. They also illustrate how experiences have varied between individuals and providers in the 32 states that are implementing the Medicaid Expansion to low-income adults and those in the 19 states that are not moving forward with the expansion at this time.

Barbara DiPietro, who's Senior Director of Policy at the National Healthcare for the Homeless Council, will begin today's

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briefing by presenting the key findings from the analysis. We will then hear perspectives from leaders at Healthcare for the Homeless centers in two states, one that has implemented the Medicaid Expansion and one that has not.

Jackie Engle, Outreach and Enrollment Director and Andy Patterson, Director of Homeless Services at Family Health Centers in Louisville, Kentucky, will provide insight into how the findings translate into on-the-ground experiences in an expansion state.

Cindy Funkhouser, President and CEO at Sulzbacher Center in Jacksonville, Florida will provide perspective on experiences from a non-expansion state. We will then open up the discussion for a Question and Answer period. I will note that today's presentation will touch on the findings at a high level, so I would encourage you to take a look at the full report for additional details and information beyond what we will be able to share today. Again, that report is available on our Web site at kff.org. Before we turn to the key findings, just a few housekeeping items. A recording of this webinar will be made available after the event on our Web site.

We will hold a Question and Answer session after all speakers have provided their remarks. 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 possible.

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Now to get started, let us turn to Barbara DiPietro from the National Healthcare for the Homeless Council to tell us more about the key findings from the report.

BARBARA DIPIETRO: Thanks Samantha. I really appreciate being able to do this analysis, which gives us greater data to put it to prior projects that we had done that were based largely on focus groups, but examined how Medicaid was impacting the Healthcare for the Homeless community, the patients and the providers that serve them, and looking at how people were planning for the expansion and then how its implementation was going.

So this gives us more data to be able to look at the disparities and learn a little bit more about this patient population and the folks that serve them. What we were really trying to do also was to look specifically at coverage differences, how services are used, and particularly the financing that goes behind these nonprofit community-based health centers.

So when we look at Healthcare for the Homeless, these are health centers that focus specifically on homeless populations and this population, generally, as Samantha had said earlier, they have got greater healthcare needs, they tend to have poor health outcomes, and so looking at this patient group and the providers that serve them can really help illustrate where we might target more attentions to get greater improvement.

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The data also allow us to make comparisons between Healthcare for the Homeless projects in expansion states and in non-Medicaid expansion states as well as then combining or rather comparing HCH experiences with other types of health centers that serve also low-income populations, but tends not to be as homeless. Again we are just building on prior work with a dataset that allows us to do a greater analysis. Next Slide.

When we look at the disparities, health coverage here has such a tremendous impact on patient care, the comprehensive services that are available, and then operations at a health center and so the differences across types of health centers and between expansion and non-expansion state projects are really important.

This slide here shows a lot of the disparities, in particular note that the Healthcare for the Homeless in expansion states, they started at a higher level of coverage than their counterparts in non-expansion states. So what we're seeing is as states adopt Medicaid coverage, which we hope more will, they will be starting from a lower threshold overall as a baseline, so that makes the outreach and enrollment efforts in those areas all the more critical and again just thinking about the realities and operations and patient needs based on where someone lives and then what type of health center they are. Next slide.

When we look at the type of coverage, this will mark a little bit more detail than the previous, which looked at any type of coverage, this looks at specifically what kinds of insurance

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generally cover either populations at other types of health centers or at HCH projects. As you can see, there are also clearly some disparities that are predicated on whether a state has expanded Medicaid or not.

You will see that in non-expansion states, patients are still largely uninsured and you can see that there has been a tremendous difference in the coverage in expansion states, although, when we look at other types of health centers, you see a broader range of the types of care or the types of coverage that people receive. In a HCH environment, you'll see that Medicaid is still the primary insurer with private insurance being very [inaudible 00:06:23]. And then Medicare or other public programs are really only being 6 or 8-percent of that and so we have got predominantly uninsured patient groups in non-expansion states still.

One thing to note, too, is that within each of these categories even within expansion states, we still have wide range of experience based on the state. In the issued brief, you'll see the state-by-state breakdown in terms of the percentage change year over year from 13 to 14. You will see a wide range of experience, everyone is in a different place, so even with an expansion state, you saw some states that had a double-digit reduction in the number of uninsured patients. In other states, you'll see an increase in uninsured patients and the same is true in non-expansion states, so every state is going to be a unique state. Next slide.

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Another piece we wanted to look at was the kinds of services that patients access at the different types of providers. As you might imagine, the range of services that patients need in the Healthcare for the Homeless setting is going to be very different than other types of health centers. This I think reflects the broader range of behavioral health needs that our patients need.

It's also important to note, too, that Healthcare for the Homeless projects are required to provide substance abuse services, so that also will make a difference in what is infallible, what the patients need here is obviously reflected in how their services are spread.

One thing I would like to point out is the enabling services in the light-blue box or in that box, for those not from a health center environment, enabling services are those nonmedical services that make the medical care work better. That is case management, it's outreach and transportation, language translation services, health education, these are really critical services for a homeless population in particular because that helps them engage in care and keep organized and keep working on their benefits and other things. That might be also explaining why there is a threefold difference in enabling services in HCH projects compared to other types of health centers. Next slide.

One of the things we also want to take a look at is the volume of patients and so there is a national goal to increase health center patients and that is part of the reason the Affordable Care

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Act had included such an investment in health centers in general. It's also important to note that Healthcare for the Homeless projects as well as other health centers in both expansion and non-expansion states all saw increases in the number of projects. We know that outreach and enrollment is incredibly important to achieving all of that, but what's not quite clear is that Healthcare for the Homeless project in expansion states saw marginal decreases in the number of patients and the number of patient visits.

It's not quite clear from the data what might cause that, as maybe some of our discussion can highlight that, but some of the reasons that we believe might be that people have greater patient choice and they can go a lot of different places now that they have insurance. They might be seeking care in a non-homeless-specific setting, they might have been auto-signed by managing care to another provider, so there might be a number of things going on here and we hope to learn more about this in the future. Next slide.

We know that it is also key just as a health center operates, that you have got to keep the lights on, you have got to keep the staff paid, and so how is it that revenues and cost might be changing with the introduction of Medicaid, particularly in expansion states. One of the things we wanted to do here is look at how the revenue in particular change given that you'll have an increase in third party billing with the increase in health coverage.

Now please note that because of the way the UDS data is recorded, we can only look at data from the 60 Healthcare for the

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Homeless projects that only have a homeless grant, so those HCHs that are embedded within other health centers are in the other health center data, but the HCH project here really are standalone clinics that only do homeless.

One of the things that are interesting here is that even though you had a greater threshold of coverage gain, you only had half the increase of revenue experienced by other health centers. That was interesting to us and we are interested to learn more about that and it might stand to reason, too, that in non-expansion states and the HCHs, you had marginal increases in coverage, so you are going to see marginal changes in revenue.

I think that's the takeaway there, but again we would like to see more of this mirror of what other health centers are looking like where they had greater increases in revenue and cost, but had smaller changes in the nature of the coverage. Next slide.

We wanted to do a deeper-dive into the distribution of revenue and so one of the things that we find here is that we've got a greater distribution of types of funding compared to other health centers in the HCHs. Now again, these are only 60 health centers and 24 teams compared to obviously a far greater number, almost 1200 other types of health centers, but take a look at how the role of grant remains important for Healthcare for the Homeless projects, particularly compared to other health centers, but even among other health centers, grant still constitute a sizable portion of the budget. Thinking about how this complements Medicaid and the

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sensitivities any of these types of providers could change in either federal or nonfederal grant. Next slide.

When we look at the revenue, specifically at HCHs, we really are looking at some pretty stark differences and so that match from the previous slide, here is where you keep some of the strange disparities in the kinds of revenue that Healthcare for the Homeless projects experienced based on whether in an expansion or non-expansion state as we saw on the prior slide with regard to the disparities in healthcare coverage and so what we are seeing in non-expansion states, grants represent nearly the entire revenue projects to those health centers.

Now again, we are not talking about many health centers, you will see here at the bottom in 2014, which was 16 projects in non-expansion states, but you have to remember that these projects are serving some of the most vulnerable patients in their community and so it's really important that they have got the resources to be able to meet that level of need.

In an expansion state, I think the key takeaway here, it is so important to remember that Medicaid does not cover all the needed services to be able to meet those patients' population needs. Grants are intended to fill gaps in services and they're intended to complement Medicaid, they do not replace Medicaid.

So again I talked about case management, outreach and transportation as the kinds of services that are particularly important for this population. Those are services that Medicaid

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tends not to cover so, again, we want to really be careful that these remain important revenue streams for all HCHs, particularly non-expansion states, but just because you are an expansion state, does not mean that Medicaid alone can meet all of the needs. Next slide.

Finally, we really just wanted to look ahead, so some of the things, the larger findings that we have taken away is expansion states have seen a lot greater gains in coverage and related third party payments, which has brought a stabilizing revenue source to a lot of these community providers.

When we compare that to non-expansion states, really very little has changed in that regard and so we have to be mindful that we have got this growing disparity where we may see health outcomes in this patient population really start to also become dispirit.

In expansion states, those health outcomes really generate into decreased disparities with the general public, we are also seeing greater data systems in terms of more data being available both from not just a health center setting, but in the emergency room and in the hospital and other areas of care in the community, were able to do greater data analysis about meeting these and how can we be doing more efficient and innovative service delivery systems.

The third party payments again bring the financial stability that allows these community providers to do more like quality improvement, population health analysis, and some of these greater pieces that allow us again to learn more and do better with our outcome.

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In non-expansion states, we're still seeing a majority of the patient population is uninsured. There is a limit to what we can do in a health center environment. The access to that greater range of care in the communities is just not present and almost an exclusive reliance on grant funding. Thinking about how your primary healthcare and the health center grants that remains so critical to all health centers, particularly critical for this group of providers, and would make them very sensitive to any changes in either that grant or any other federal or nonfederal grants that are important to the revenue stream. With that, I will hand it back, but these are just the highlights of the findings of the issues we have. As Samantha said, if you read the brief, you will learn so much more. Thank you very much.

SAMANTHA ARTIGA: Great, thanks so much Barbara. Before we shift over to our next speakers, I just want to mention that if you are on Twitter, we invite you to use the hash tag ACA Homeless to join the conversation we are having related to this topic. Next, I would like to shift it over to Jackie Engel, Outreach and Enrollment Director and Andy Patterson, Director of Homeless Services at Family Health Centers, who can talk to us about what these findings have meant for them on the ground in Louisville, Kentucky.

ANDY PATTERSON: Thanks Samantha. This is Andy, I direct the Healthcare for the Homeless program for Family Health Centers,

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which is an FUHC Serving global Kentucky. Each year, we start at around 38,000 patients as a whole and around 5000 of those are identified as homeless and served through our Healthcare for the Homeless program.

Like most Healthcare for the Homeless program, we offer a comprehensive array of services including primary care, both in a clinic and through street and shelter outreach, dental services, psychiatric and mental health services, enabling services including outreach, case management, and peer support. We have a resident program and we also operate a permanent supportive housing program that houses around 200 individuals each year. Jackie will now talk about some of the data that is Medicaid expansion and with our program

JACKIE ENGEL: Thank you Andy. What I would like to talk about is how some of the data has really shifted since the ACA and the Medicaid expansion in 2013. We saw those are uninsured rates, basically, plummet as it went from 80-percent to 39-percent to a 31-percent and then we saw Medicaid coverage basically increased significantly from 2013 at 13-percent, to 49-percent the next year, and then 56-percent the following year.

Interestingly, our data here at Healthcare for the Homeless here at our Family Health Centers here locally, they're outcomes were actually at a higher rate than at the state level, so we were pretty proud of that and then when you go to the next slide please, then you

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will see that when you look at the findings, some of our findings that we had found from looking at the actual data is that when you look at federally qualified health centers, they tend to serve a more at-risk patient base. They are in the general public. When you take it apart and you look at just the Healthcare for the Homeless, they are at even greater risk.

What we've found is that even though our federally qualified health center experienced at the end of 2015, an uninsured rate of 19-percent, it remains 31-percent for our Healthcare for the Homeless. While most of the folks who were enrolled and covered in insurance were receiving Medicaid, it was higher amongst our Healthcare for the Homeless clients versus our general federally qualified health center clients.

Less folks through our Healthcare for the Homeless had qualified health plans. I and I know that probably, it does not seem to be a big shock to most folks, but that is what the findings state. What is interesting beyond that though is that when you look at what remains in the uninsured. There is still a greater proportion of uninsured within our homeless population than in our general, also considered higher risk population.

What is really interesting between those two as well is that when you look at some of the risk factors. One risk factor here is where folks can be dis-enrolled from their policies for various reasons or those who experience gaps in coverage. One of the specifics that I wanted to bring attention to is where you look at

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incarceration release, reactivations of coverage where gaps have occurred. While you look at the data, it only lasted for about three months before the very end of 2015. I am sure if they looked at now it would be much greater numbers. When you look at that, you see out of 1-percent or less than 1-percent, you know, no big deal.

What the big deal is when you drill that data down, what you find is that amongst our homeless population, they made up 55-percent of all those reactivation. They again are at a higher risk of experiencing those gaps and needing to have that coverage reinstated. To talk a little bit more about how that coverage though has made a difference, I am going to turn back over to Andy.

ANDY PATTERSON: Thanks Jackie. So, I just want to talk about some of the impacts on our Healthcare for the Homeless program that came about with Medicaid expansion, so now that our patients have Medicaid, they can get specialty services that our clinic does not provide and also get quicker referrals.

Prior to Medicaid expansion, some of our folks would have to wait—be put on a waiting list that could take years to get specialty services. Now they have much easier access to that and a payer source. They have access to substance abuse and mental health services that they otherwise could not get through the community mental health centers. They also have an increased choice of providers. This has actually resulted in some folks no longer coming to our clinic. What we have found is that folks that would typically

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come to our clinic for acute problems, minor problems tend to no longer come because they can now have a much wider array of providers. What happened is it kind of left us with a more complex level of clients because pretty much every clients that our providers now see have multiple chronic problems, both primary care as well as substance abuse and mental health issues.

It has increased the complexity of our system in addition to our patients. Insurance typically requires pre-authorizations and forms and you know a certain way to bill and we went from having a small minority of patients for whom we had to do that for to now the majority of our folks, so it has added the level of complexity.

We have mentioned that it has certainly increased our revenue, it has also decreased our medication cost. Prior to Medicaid expansion, we were paying over 300,000 dollars a year for medications for our clients. Now, we are paying less than 50,000, so a significant decrease in the amount of expenses that we were having to pay for medications and then finally it has just increased the self-esteem and access to stabilization for our clients. Most of our patients who now have insurance never had insurance in their life prior to Medicaid expansion, so just in talking to our patients, they get excited about the fact that they now have health insurance. It is normalizing to their lives to have that benefit, so turning back to you Samantha.

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SAMANTHA ARTIGA: Great, thanks so much. We really appreciate hearing about how our data findings have translated in the experiences out there in Kentucky. Before we shift it over to Cindy, I wanted to remind folks that you can submit questions any time through the chat function. We will be beginning the question and answer period after we hear Cindy's remarks next, so go ahead and get those queued up if you have ones that you would like answered and now we will turn it over to Cindy Funkhouser, President and CEO at Sulzbacher Center in Jacksonville, Florida.

CINDY FUNKHOUSER: Good afternoon everyone from the sunny non-expansion state of Florida. First of all, I want to say how jealous I am after listening to Jackie and Andy. Here in Florida, you know unfortunately without Medicaid expansion, the poorest adults in our state still have no access to affordable health coverage. Not only did they not get Medicaid, but also they do not qualify for subsidies under the Affordable Care Act. Basically nothing has changed for them.

Many of these adults are still relying on hospital emergency rooms, but are unable to pay, so this continues to cause an extreme burden on the system, but particularly our indigent hospital here in Jacksonville, who has had extreme difficulties staying afloat over the last few years.

At the Sulzbacher Center, we are the largest comprehensive homeless provider in Northeast Florida. We work around three areas;

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income, housing, and healthcare. All of that happens on one large campus here in Downtown, that is in our FUHC are 330H, we do provide access to primary care, dental, behavioral health, optical, substance abuse, HIV, primary care and limited pediatric services, all of that on site. A large problem for us remains specialty services, that is extremely challenging for people without coverage.

We do have a great nonprofit here in Jacksonville called We Care and I think other cities have We Care networks and they do partner with hospitals and doctors who will donate time for specialty care and actually just came from Mayo and Mayo here in Jacksonville is one of the largest donors of that specialty care, about a million dollars a year.

Ways that you know we are leveraging our very limited resources, we do communicate and collaborate as much as possible with our community partners such as other charity clinics, volunteers and medicine, We Care that I mentioned. We do a lot of partnering with our local health department.

We also serve as a teaching facility for medical and dental residents, interns, and students for all the regional medical schools, this increases capacity to serve our patients as well, so University of Florida, University of North Florida, all of the major colleges in the area do send patients to our dental clinics and to our primary care clinics, so that is one way that we are leveraging, which is very beneficial.

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As far as dental care, we are doing something really interesting. We are partnering with the local hospitals. We are diverting patients with dental needs from the ER and we have been tracking this ER diversion for about a year now. In the first eight months of that year, we were able to save local hospitals three-quarters of a million dollars, so that is something that is interesting in a great partnership that we have with the hospitals. Next slide.

What are some of the financing issues that we are seeing without Medicaid expansion. So without Medicaid expansion, we rely as Barbara was already saying, they are very dependent on our HRSA grant funding along with other federal and foundation grants, so just as a comparison, in 2014, 72-percent of our funding for our 330H came through our Healthcare for the Homeless grant compared to I noticed 54-percent of other HCHs.

We are heavily, heavily dependent on that grant funding here and obviously we are having to supplement that with fundraising and private donations, which is about 28-percent of the funding and absent Medicaid funding, this is limiting the availability of services obviously and it also makes it difficult and this is a huge problem for us to recruit and retain providers.

We actually have had a psychiatric position open for two years. We have had the funding for it, we have not been able to hire a psychiatrist for two years. Then you can see the chart, which basically shows you from 2013 to 2015. The uninsured rate in our

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clinics is—it's very. We're still at 92-percent uninsured. Compared to in the State of Florida, at HCHs very high. We are still at 92-percent uninsured and that is compared to in the State of Florida at HCHs—72-percent. We are 20-percent higher than even HCHs and again I think one of the reasons for that might be that we are co-located on the same campus with our shelter. The vast, vast majority of everyone coming into our clinics are coming from the shelters in our Downtown area. Next slide.

What are we seeing as far as the service gaps and future priorities in our environment? Mental health is without a doubt the number one largest gap in service in our particular state. Florida is 49th out of 50 states in mental health funding, so we are at the bottom of the barrel. We have a very fractured system with a dearth of resources. I have already mentioned this, and this is I know a nationwide problem, but particularly here in our area there is a severe shortage of and we have an inability to hire psychiatrists.

We actually lost the one psychiatrist that we had—was killed in Zambia. It was a very freak accident that happened on Thanksgiving Day, so right now we are without a psychiatrist at all. We are using locum tenens at this point in time. On the plus side new legislation was just passed in this session that just ended to expand the role of ARNPs here in Florida. We were one of the few states where nurse practitioners could not prescribe medication without being under the direct supervision of a doctor. Now that has

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changed and ARNPs are going to be able to prescribe, so that will be beneficial for us moving forward because we do have ARNPs in place.

Dental is our number two service gap. For us, there is little to no access for uninsured adults. There is limited financial support from private donors around the area of dental, that is not something at least we find in our area that donors are very interested in supporting.

We did find one this past year that did support dental specifically, but that is a rarity. The lack of volunteer dentists, and when I say that, I mean on an ongoing basis. We do have specific events throughout the year where we can get a lot of dentists there, you know in one day or in one weekend. As an ongoing issue, we have a hard time getting dentists to volunteer regularly.

We already talked about the ER diversion, which is on the plus side—is something we are tracking with the hospitals. They recognize that we are saving them a lot of money. We probably have four of the major hospitals on our board, so we do receive a lot of support here from the hospitals.

Lastly in the State of Florida, HIV is a huge problem. Florida leads the nation in new HIV infections. HIV rates per 100,000 people—there are three cities in the State of Florida in the Top 10. Miami, Number one; Jacksonville, Number three; and Orlando, Number eight in the nation. Unfortunately at our state level, this is not treated as a crisis and as a matter of fact, Department Of Health, their funding at the state level has been cut over the last

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several years, particularly around HIV. Although we are having a crisis, it is not being recognized. We recently received a CBC and Department Of Health grant and we have expanded our HIV care, our primary care. We have an interdisciplinary team now at both of our clinics. We have expanded our primary care for HIV in the last year.

That is what it looks like from the 10,000-foot level in the non-expansion state of Florida. It is pretty dire consequences here for people who are poor and uninsured.

SAMANTHA ARTIGA: Thanks so much for sharing that perspective, Cindy. I would invite folks now to go ahead and ask any questions you would like through the chat function. Just to sum up what we have heard so far today, I think Barbara presented the data analysis, which really showed through numbers how Healthcare for the Homeless projects in states that have expanded Medicaid have experienced large gains in coverage since the expansion took effect. That has translated into gains in third party revenue.

We have heard from Jackie and Andy that that has meant increases in access to care for their patients as well changes administratively for their operations as a Center. In contrast, in the non-expansion states, things have remained pretty much the same. They continue to serve a very high-uninsured population and remain heavily reliant on grant funding as the primary source of their funding. Cindy I think has really touched on a lot of the challenges that means for patient care and for Center operations.

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Again, the information from today's briefing including a recording of the briefing will be available on our Web site at kff.org, but let's go ahead and jump into some questions. Barbara, can you maybe talk a little bit about how grant funding is distributed across different projects and across the states and would there ever be a case in which the funding would be diverted from expansion and non-expansion states?

BARBARA DIPIETRO: Sure, the one revenue stream for the grants is through HRSA and the Bureau of Primary Healthcare and its health center grants. Those are either competitive grants where they will release an opportunity to apply for a new access point or expanded services. There have also been times when they have done base adjustments or other across the board increases that have benefitted everyone.

That has been a mix and it is my understanding from discussions we have had with personnel at HRSA that they have not used a state's decision on Medicaid to sway their decisions on grants. That might be a question that we could ask our federal counterparts for their perspectives in another setting. Also we look at other types of grants—SAMHSA Block grants for mental health and addiction, other PATH grants for outreach. There are a number of other grant sources that come from the Feds that are targeted to homeless populations from various services or there might be more general where a state then can really take that to targeted areas.

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Of course, states and localities also will develop their own grants based on community needs and where data assessments have targeted opportunity. I think that we see a wide range of things and I would be curious if Andy or Cindy or someone could talk a little bit about like where they see those opportunities being the greatest for them. I'm going to put you on the stop. Sorry, Andy.

SAMANTHA ARTIGA: While you think about that, Andy, you had mentioned in your remarks that one of the main impacts of the coverage gains for you all has been the increased access to specialty care among your patients. One of our participants has noticed that in Boston, they have seen some increased diagnoses of cancer, as more patients are getting connected into specialty services. Do any of you all have similar observations or experiences related to how increased access to specialty care is maybe changing patterns of diagnoses of different conditions?

ANDY PATTERSON: Yes, this is Andy. Unfortunately, I can't speak to that with any data, sorry.

SAMANTHA ARTIGA: It's okay. Can you maybe speak to the types of specialty care that the coverage gains have really facilitated for you all that used to be a real barrier for folks?

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JACKIE ENGEL: Well, a lot of the specialty care are going to be around, particularly things like cancer treatments. It's going to be a lot of mental health and substance abuse treatment, those types of things. Wherever you are going to need any type of referral from a PCP, all of those things, they were all impacted, this is Jackie by the way.

SAMANTHA ARTIGA: Cindy, similarly, you mentioned to the fact that access to specialty care remains challenging without the Medicaid expansion. Can you provide some examples of the types of specialty care that folks maybe have difficulty accessing and what does that really mean. Are there sometimes case in which folks are not just getting care?

CINDY FUNKHOUSER: Well, I mean I think you know when you are looking at cancer treatment, in particular, you know we may find something in our—as they're here doing their primary visit—we may find a lump, we may find that sort of thing. Then because we are utilizing We Care, which is great, but sometimes people have to wait many many months before they can get in to seek that specialty treatment.

I would say oncology definitely would be one that is a big problem. We do have—I will say—I do want to point this out, Mayo Clinic actually comes to our clinic one night a month. They do

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Special Procedure's clinic, they do a GI Specialty Clinic, they do a Psychiatric Clinic.

We do have another doctor that comes from Baptist Hospital, he comes one night a month and he does a Cardiology Specialty Clinic. We are pulling in specialists as much as we can, but there is still a lengthy wait for people to get in and seek the treatment that they need.

When we identify something in their primary care visit that needs a specialist we try to get people in as soon as possible but it is very limited. It can take a long time to get someone seen. That remains a huge, huge dilemma and a huge problem. We used to say-it's almost terrible to find that lump and to get the biopsy and then find out, in fact, that person does have cancer and then it takes a long time in order for that person to get the treatment that they need, so it's a very dire situation.

SAMANTHA ARTIGA: Thanks for that Cindy. I think another challenge you mentioned in your remark was the access to psychiatrists and behavioral health services. Cindy you had mentioned that specifically in a non-expansion state, but I think that continues to be a challenge across states. Do any of you want to speak to any ideas or initiatives that may be underway to increase access to these types of providers for Healthcare for the Homeless patients?

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CINDY FUNKHOUSER: I mean I will just say—and this is Cindy—that we have talked to the local hospitals about this. The hospitals can't even recruit. Psychiatry for some reason is a specialty that new doctors are not going into at the numbers that they used to. It's one of the, from what I understand, one of the lower-paid specialties.

I think with the old supply and demand, eventually psychiatrists—the demand for them is at a very high level right now. As we're recruiting—we're recruiting two psychiatrists right now because we lost one and we had funding for another. We're really having to up the salary in order to have anybody even looking at our positions. When you have big hospitals like Baptist not being able to find a psychiatrist—how difficult it is for a Healthcare for the Homeless project? It's at a crisis level.

SAMANTHA ARTIGA: Jackie and Andy, what is the situation like for you all?

ANDY PATTERSON: With psychiatry services, we have a full time psychiatric nurse practitioner. We actually contract with our community mental health centers, so it is actually a CMHC employee, but she works on site for us full-time. We have had that collaborative agreement for 10 years or so now. We have not had an issue filling that position, knock on wood, so we have not had that problem, thankfully.

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SAMANTHA ARTIGA: Andy, while we are with you, can you talk a little bit about—you saw increased revenue coming from your coverage gains among your patient base—can you talk about how those revenues have helped operations at the Center and what you have been able to do with them?

ANDY PATTERSON: Well, actually the larger community with mental health—the larger agency—as I have said earlier, we have seven sites. Six of those serve the general population—we are Healthcare for the Homeless. The general community health center was subsidizing our Healthcare for the Homeless because our budget was much larger than our revenue. Medicaid expansion has basically allowed us to get even basically. We're not making a whole lot of money necessarily, we are just not losing it like we were before.

SAMANTHA ARTIGA: Okay, great. Barbara and others, can you speak to any examples of how Healthcare for the Homeless centers may be working with permanent supportive housing providers and how Medicaid fits in there?

CINDY FUNKHOUSER: I can start. Certainly this is an area that is emerging as housing is increasingly showing health benefits. It's certainly a social determinant of health. It's, obviously, an

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issue that our clients specifically lack and then you can see that reverberate across the other systems.

CNS has been really proactive in issuing guidance to states, but specifically gives permission for states to ask to add housing support services into their Medicaid plan. We are really excited to see more and more states submit 1115 Waivers or 1915 Waivers or different types of state plan amendments or health home models that incorporate housing-related services.

Now, I'm sure everyone on CNS that's on this call will want me to say this does not cover—use Medicaid dollars to pay for housing. The kinds of services that are considered important to stabilize people and make that transition and keep them stable are really, I think, going to revolutionize the integration of housing and healthcare. Andy and Cindy, I know both of you were doing work in this area, so maybe you can talk a little bit more.

CINDY FUNKHOUSER: I can talk about it from a non-expansion perspective. We have a really interesting housing first model, I know Barbara knows about this and it is called the Chronically Homeless Offender Program.

Jacksonville sheriff's office came to us a couple of years ago and they basically said we have 74 homeless people who are rotating through the jail five, 10 times a year for misdemeanor arrests. These are really you know lifestyle crimes—trespassing,

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open container, that sort of thing. It makes no sense that they are rotating through the jail.

This was actually our first foray into a true housing first program. We are partnering with the jail, the public defender, the state attorney, the probation office, our housing authority, Lutheran Services of Florida who has SAMSHA funding. What we are doing is when we've identified 25 of those frequent fliers and we identified the people that were the most medically vulnerable—the top 25 of the 74 who would have died on the street the soonest.

When that person is arrested in the system, they're flagged and they are then given an opportunity—they have a choice of either going to jail and doing their time whatever that would be, which would at this point be extensive because they have been arrested so many times or behind door number two, we will give them a permanent supportive housing, fully-furnished apartment, low barrier. The only thing that you have to do is stay housed and not get arrested.

We are connecting those folks directly to our clinics so they have complete healthcare, they have housing. We're sending in peer support specialists, supportive living coaches into their home, and we are tracking recidivism and it has been a huge success.

That's an example of complete wraparound services for those folks that we're putting into that permanent supportive housing project. They have you know complete access to all of our services. We do have a store processor here, so someone that is signing people directly up for disability if they are not already signed up.

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It's a very compressive model of wrapping all the healthcare, the housing, everything into one program. We're really proud of the fact that at this point, we have been doing that for about 18 months. We have 21 people in that program, some of them have been in there the full 18 months. We have only lost two people out of the program the whole time and they have complete access to all services. Some of these folks are people that have been on the street for 20 years and longer.

That is truly a partnership where we are partnering the housing and the healthcare directly. We're able to do that because within our organization we have the services, but we are partnering also with all of the other community agencies that I mentioned, so that is kind of an interesting model that we are doing.

SAMANTHA ARTIGA: Great. Andy or Jackie, do you have anything you wanted to add?

ANDY PATTERSON: Yes, this is Andy. We have a program that almost is identical to what Cindy was just saying, so I would not repeat that. We have about 200 individuals that are in permanent supportive housing with us, all about to base housing first program funded by HUD and with services funded by SAMHSA. One thing we do is our nurse practitioner one day a week will do home visits to folks in our permanent supportive housing program for those folks that are

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especially vulnerable and isolating and not getting out to try to reach out to them and provide medical services there at home.

Kentucky is in the very, very early stages of doing some of those innovating housing payments—not for housing, but for services that Barbara was mentioning. Many agencies here in Louisville are working towards doing more of that, but I think having the permanent supportive housing program within a Healthcare for the Homeless program is really great because that housing piece and that the healthcare piece is very easily integrated and connected.

JACKIE ENGEL: I think another area where Healthcare for the Homeless projects have a lot of experience is the integration of behavioral and medical services. We saw in the data that Barbara presented that this behavioral health and enabling services account for a much larger share of services compared to other house centers.

Do any of you have some best practices or lessons learned that you can share about integrating those services because I know that is an area that a lot of other providers outside of the homeless community are now really interested in trying to make progress in.

CINDY FUNKHOUSER: This is Cindy and I just want to say that I always, when I am taking people through on towards and especially people that are in the healthcare field, I always like to say that the FQHC model, the Healthcare for the Homeless model that we are running is the most comprehensive and holistic model of any

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model. We have in the same building and on the same floor, we have our primary care clinic and we have our dental clinic right side-by-side. Right upstairs is behavioral health and an optical embedded in there as well. All the services embedded together sharing the same electronic health record, which is you know really, really important.

Someone comes into our dental clinic and we take blood pressures when people come into the dental clinic. If someone comes in there and they notice the person's blood pressure is really high, they walk them right over to primary care. If someone comes into the dental clinic—and the same with behavioral health. If someone is in behavioral health and they become very agitated or they start having any sort of health issues—I mean you literally can walk the person right next door.

It is so integrated the providers are talking to each other on a regular basis, not just through electronic health records, but they are together, they are co-located in the same facility. Not just behavioral health and primary care, which I know a lot of people talk about, but we are very integrated all the way around.

When does your therapist ever talk to your primary care doctor, when does your dentist ever talk to your primary care doctor. I think FQHC generally speaking is so comprehensive. I mentioned I was at Mayo a little earlier doing a presentation and Mayo has as everyone knows has a really comprehensive model.

No one has a model where all of those size of providers are co-located together talking to each other and providing that

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comprehensive care, that holistic care for the patient. I think that whether you are expansion state or non-expansion, it doesn't matter, we should all be very proud of that model. I think that people that are not in FQHCs could learn a lot from the model that we use.

SAMANTHA ARTIGA: Jackie, Andy, any thoughts from your end?

ANDY PATTERSON: No, it sounds like our setup is exactly the same as Cindy. I stated the two main things are EHR where everything is integrated and co-locating, so it's easy to get folks from one department to another.

JACKIE ENGEL: The only thing I would add would be from an outreach and enrollment perspective is the fact that you have so many open doors through the various services and because those providers do talk to one another and we have shared departmental head meetings where those providers interact with one another, then the referrals to outreach and enrollment obviously benefit from that. Obviously the biggest referral sources we have besides one another is word of mouth through our patients.

Since we have been able to garner the respect of our patients for the most part, they are number one referral source for enrollment. 40-percent of those who have enrolled have been from the general population and not our patients, so we are very proud of that fact.

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SAMANTHA ARTIGA: Jackie and Andy, while we are with you, so I believe there are a number of potential changes afoot in Kentucky, can you talk a little bit about what those potential changes are and how you think they might affect you and the patients you serve?

JACKIE ENGEL: Well, a lot of that is unknown and we will find out as things go forward, so unfortunately I won't be able to speak a lot to that because frankly it is really unknown. We do know that it is the absolute goal for the State of Kentucky to go from a successful state exchange back to transitioning into the Federal healthcare.gov model. While no one should lose coverage as a result of that, the devil is in the details. It's going to really depend on how many barriers are there and how many are perceived, how many are real, how difficult is it for people to navigate web systems, how difficult is it for people to access people who can help, folks to enroll and understand very complicated questions and just how the people access them. When we are talking about the Healthcare for the Homeless population, the barriers are high.

They do not have phones where they can be on hold for hours. We've heard that there are certain issues like that with healthcare.gov. I don't know that firsthand, it's just what we've heard. We also know that when we're talking about relying on web-based systems, when folks do not have a roof over their heads, they

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certainly don't have internet. We are very aware of what could be and very hopeful that it will be a smooth transition, but we just simply don't know at this time.

SAMANTHA ARTIGA: We are coming to the close of the hour. I just want to squeeze in one question for Cindy. Is there details available on your Dental Diversion program and the Homeless Offender program that you mentioned? Are there results or details available in another place that folks can maybe access?

CINDY FUNKHOUSER: Not that they can access, but if anyone is interested in further information on those, they can reach me directly on my e-mail, cindyfunkhouser@tscjax.org. They can contact me and I'm happy to answer any questions or give them any additional information.

SAMANTHA ARTIGA: Great and along that note, if folks have additional questions or want additional information that we weren't not able to cover today, you can reach out to Chris Lee, our communications officer here at the Kaiser Family Foundations and he can direct your questions to the appropriate person from today's webinar and try to gather the draft.

With that, I really want to thank you so much for taking the time to participate in today's web briefing. We hope you found it informative and useful for your work. I want to again thank our

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speakers, Barbara DiPietro with National Healthcare for the Homeless Council, Jackie Engel and Andy Patterson with Family Health Centers in Louisville, Kentucky, and Cindy Funkhouser with Sulzbacher Center in Jacksonville, Florida.

As a reminder, you will find the forward port for the findings presented here today on our Web site at kff.org along with the two earlier focus group reports on this topic. In the coming days you will also be able to access the recording and transcript of today's briefing. Again if you have follow up questions, contact Chris Lee. Thanks again, we hope you will join us for future events.

[END RECORDING]

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