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Health Care for Homeless Individuals: Implications of the Patient Protection and Affordable Care Act

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Report

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Abstract

Health Care for Homeless Individuals: Implications of the Patient Protection and Affordable Care Act

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This Professional Report explores the unique health needs of homeless individuals, how homeless individuals access medical and mental health services, and the impact that the Patient Protection and Affordable Care Act (ACA) may have on medical services for homeless individuals. Homeless individuals are more likely to experience physical and mental health problems and earlier mortality rates than the general population. Common access points for homeless medical services include clinics, such as Community Health Centers, and emergency care centers, such as hospital emergency rooms. Homeless individuals often face barriers of access to medical services, including competing priorities to sustain life, strained relationships with medical providers, and an inability to pay for high health care costs. Through the expansion of Medicaid and the Community Health Center network, the ACA has the potential to increase access to medical services for homeless individuals. This report concludes by offering recommendations to ensure that homeless individuals benefit from health care reform through the ACA.

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CHAPTER I: Introduction

This Professional Report explores homeless individuals' medical needs and pathways to accessing medical services. This report assesses how the Patient Protection and Affordable Care Act (ACA) may impact access to medical services for homeless individuals. It concludes with recommendations for how stakeholders can help homeless individuals benefit from Medicaid expansion and the anticipated increase in Community Health Center funding.

Homeless individuals have unique health needs, including higher rates of physical health problems, mental health disorders, and early mortality. Homeless individuals are also more likely to report having unmet medical needs. Common health services access points include medical clinics, such as Community Health Centers, and emergency care centers, such as hospital emergency rooms.

In 2010, President Barack Obama enacted health care reform through the Patient Protection and Affordable Care Act (ACA). The ACA has the potential to increase access to medical services for homeless individuals through the expansion of Medicaid and increased funding for Community Health Centers and its Health Care for the Homeless program. Medicaid enrollment will be extended to all households whose income falls below 133% of the poverty line. Additional funding for Community Health Centers is estimated to double the number of clients served by opening new clinics and increasing medical and community services (National Association of Community Health Centers, no date). Recommendations to maximize the potential benefits of the ACA include targeted outreach, removing barriers, and supported integration of physical and mental health services.

REPORT PARAMETERS

This report focuses on adult homeless individuals. It does not address the unique medical needs of homeless families, children, unaccompanied youth, and domestic violence survivors. This report addresses adult homeless individuals' access to medical services and impact of the ACA on service delivery, but does not address the quality of medical services provided. This is a significant limitation given that quality of care can affect health outcomes, regardless of improved access to care.

This report assesses the ACA as President Obama signed it into law on March 23, 2010. Due to controversy surrounding the ACA, many provisions are currently being challenged at various judicial levels. Additionally, future federal, state, or local legislation may be passed modifying or defunding portions of the ACA. However, this report will review the ACA as it currently stands and was signed into law by President Obama on March 23, 2010.

REPORT ORGANIZATION

Chapter 2 reviews literature regarding homeless epidemiology. It defines homelessness and provides a demographic overview of the U.S. homeless population. The chapter provides a review of research evidence of the high medical needs of homeless individuals, including overrepresentation of chronic illness, mental health disorders, and premature mortality rates.

Chapter 3 assesses the state of homeless medical service delivery across the country. Common access points where homeless individuals seek services include medical clinics, specifically federally funded Community Health Centers, and emergency medical delivery access points such as hospital emergency rooms.

Chapter 4 begins with an overview of the ACA and the involvement of homeless advocates during the health care reform debate. The chapter explores how the expansion

of Medicaid and increased funding of Community Health Centers may affect access to medical services by homeless individuals if the ACA is implemented as currently written.

Chapter 5 summarizes the report and presents general and specific recommendations for how federal, state, and local governments can ensure that potential benefits of the ACA reach homeless individuals. Simplified enrollment strategies may help homeless individuals access needed Medicaid services. Enhanced Community Health Center services may also help homeless individuals find a medical home and access mental health services.

CHAPTER II: Epidemiology of Homeless Individuals

According to the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, homelessness is defined as an individual or family that meets any one or combination of the following criteria: "lacks a fixed, regular, and adequate nighttime residence," "primary nighttime residence…is a public or private place not designated for or ordinarily used as a regular sleeping accommodation for human beings," "living in a supervised publicly or privately operated shelter," and "will imminently lose their housing."

The term "sheltered" homeless refers to people that are sleeping in homeless shelters, motels, "doubled-up" with family or friends in their homes, or other forms of temporary housing. "Unsheltered" homeless refers to people who are living on the streets or in places not meant for habitation, including homeless camps, under highway overpasses, and abandoned buildings.

Chronic homelessness is defined by the HEARTH Act as an individual who has been homeless "for at least 1 year or on at least 4 separate occasions in the last 3 years." A person is also considered to be chronically homeless if they meet the definition for homeless and also have "a diagnosable substance use disorder, serious mental illness, developmental disability, post traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability" (2009).

The HEART Act amended the McKinney-Vento Homeless Assistance Act's definition of homelessness. The HEARTH Act modified the definition of homelessness to include "doubled-up" families and individuals, people living in temporary housing such as motels, and survivors of domestic violence. Expanding the definition of homelessness

means that many more people have been classified as homeless since its inception in 2009 and may be eligible to receive homeless services.

Echoing legal definitions of homelessness, researchers have developed three typologies of homelessness, 1) transitional homelessness 2) episodic homelessness, and 3) chronic homelessness. Transitionally homeless individuals enter and exit homelessness briefly and general only experience homelessness once or rarely. Episodically homeless individuals enter and exit homelessness for varying lengths of time and frequently. And Chronically homeless individuals remain in homelessness for long periods of time and rely heavily on homeless basic needs and medical services (McAllister, Lennon & Kuang, 2011).

DEMOGRAPHIC OVERVIEW OF THE HOMELESS POPULATION

Across the country, communities conduct an annual point-in-time count of sheltered and unsheltered homeless individuals and families. The data collected from the point-in-time counts is reported to the U.S. Department of Housing and Urban Development (HUD). Because communities and surveyors employ different methodologies, national point-in-time count data is prone to both sampling and non-sampling error. However, this national point-in-time count is the most comprehensive and commonly used dataset for demographic information about homeless individuals on a national scale (HUD, 2010).

In an analysis by the National Alliance to End Homelessness and the Homelessness Research Institute, the 2009 point-in-time count reported 656,129 sheltered and unsheltered homeless people living in urban and rural areas across the United States (Sermons & Witte, 2011). This means that roughly 21 in every 10,000 people in the United States were homeless in 2009 (Sermons & Witte, 2011). In 2009 the

total homeless population, including both families and individuals, grew by approximately 20,000 people from 2008 (Sermons & Witte, 2011).

In 2009, 17% of homeless individuals and family members experienced chronic homelessness (Sermons & Witte, 2011). Approximately 61% of homeless individuals and family members were sheltered, while 39% were unsheltered (Sermons & Witte, 2011).

Table 1: People Experiencing Homelessness by Subpopulation, 2008 and 2009

Subpopulation	2008 Population	2008 Percent	2009 Population	2009 Percent
Unsheltered	249,493	39%	252,821	39%
Sheltered	386,831	61%	403,308	61%
Homeless Individuals	399,420	63%	412,973	63%
Persons in Families	236,904	37%	243,156	37%
Chronically Homeless	111,323	17%	112,076	17%
Total	*636,324*	*100%*	*656,129*	*100%*

Source: Sermons & Witte (2011).

Homeless Families

In 2009, there were 243,156 homeless adults and children in 79,652 family households (Sermons & Witte, 2011). Of the total homeless population, 37% of people were part of a family household. The three most commonly cited causes of family homelessness were a lack of affordable housing, poverty, and unemployment (The United States Conference of Mayors, 2008).

The number of families experiencing homelessness is quickly growing (HUD, 2010). This may be due to recent economic problems, including rising home foreclosure and unemployment rates. Poverty rates are also rising as minimum wage rates fail to keep up with inflation.

From 2008 to 2009, homeless adults and children in family households accounted for the majority of the increase in the total homeless population (Sermons & Witte,

2011). However, this point-in-time count may have underestimated the number of homeless families as families often double-up and live with friends or family (National Coalition for the Homeless, 2009). Point-in-time counts may fail to count doubled-up families because it can be difficult to reach this seemingly invisible population.

Homeless Non-Family Individuals

In 2009, homeless individuals that were not part of family households made up 63% of the total homeless population (HUD, 2010). Homeless individuals face a very different set of struggles than homeless families. These individuals suggest that lack of affordable housing, mental health disorders, and substance abuse are their top three causes for homelessness (The United States Conference of Mayors, 2008). Homeless individuals, both sheltered and unsheltered, were more likely than homeless families to stay in urban areas (HUD, 2010).

Homeless individuals are more likely to be unsheltered than homeless families, living on the streets, under highway overpasses, and in camps, cars and abandoned buildings. The 2009 point-in-time count found that 47% of homeless individuals were unsheltered, compared to only 21% of family household members (HUD, 2010). Of sheltered homeless individuals, over 70% were staying in a large urban area (HUD, 2010). For homeless individuals who slept at a shelter, a large percentage passed quickly through homelessness and used homeless services only one or two times without accessing services again (National Alliance to End Homelessness, 2010).

ISSUES OF HEALTH

Studies of homeless medical and mental health generally have small sample sizes and target participants who have received services at a particular service delivery site or group of sites, such as a shelter or clinic system. Convenience sampling of people who

have sought and/or received homeless services may not reflect general homeless trends. Additional widespread study limitations include challenges of locating and following up with transitory research participants.

Physical Health Concerns

Studies show that homeless individuals are more likely to experience physical health problems than the general population (Hwang, 2001; D'amore, Hung, Chiang, & Goldfrank, 2001). A Canadian study of homeless shelter users found that 41% reported having a physical health problem. The most common problems reported were caused by chronic health problems, such as back problems, old injuries, arthritis, and heart conditions (Acorn, 1993). In a study of the newly homeless individuals in New York City shelters, homeless individuals were more likely than the general population to have been diagnosed with hypertension, diabetes, and asthma (Schanzer, Dominguez, Shrout, & Caton, 2007).

Chronically homeless individuals may have an even greater risk of experiencing physical health problems. For example, in a study of public shelter users in New York City and Philadelphia, chronically homeless individuals were more likely to experience medical problems than other homeless individuals (Kuhn & Culhane, 1998).

Homeless individuals are also more likely to have a disability and/or chronic illness. Approximately 38% of homeless families and individuals had a disability, compared to 15% percent of the total U.S. population (HUD, 2010). An Atlanta-based study found that 46% of homeless survey respondents had one or more chronic health problem (Wiersma et al., 2010). Homeless older adults were more likely to be disabled and/or have a chronic illness than younger homeless individuals (Gelberg & Linn, 1992).

Homeless individuals also have a higher probably of contracting an infectious disease (D'amore, Hung, Chiang, & Goldrank, 2001). Overcrowded day and night shelters and poor sanitation facilitate the spread of infectious diseases, such as Hepatitis C and Tuberculosis (Substance Abuse and Mental Health Services Administration; Cheung, et al., 2002; Health Care for the Homeless Clinicians' Network, 2006). A New York City study found that homeless individuals were 11 times more likely to contract Tuberculosis than the general population (Santora, 2006). Research conducted in Houston, Texas found that homelessness is a risk factor for contracting West Nile Virus. This is due to the large number of hours that homeless individuals spent outside which increased their risk of being bitten by mosquitoes carrying the virus (Meyer, et al., 2007).

Mental Health Concerns

Homelessness is closely associated with mental health disorders (D'amore, Hung, Chiang, & Goldfrank, 2001). The National Alliance to End Homelessness reports that 57% of the homeless population has had a mental illness problem in the past year, and 25% have a serious mental illness (National Alliance to End Homelessness, 2009). The United States Conference of Mayors' survey of homeless individuals in 25 cities found that 26% considered themselves severely mentally ill, compared to less than 5% of the general population (National Institute of Mental Health, 2008; National Institute of Mental Health, 2008). Chronically homeless individuals are even more likely to experience mental health disorders than the general homeless population (Kuhn & Culhane, 1998).

Mental health disorders are also a risk factor for homelessness. Mental health was ranked as the number one cause of homelessness by 60% of those surveyed by the United States Conference of Mayors (2008). A study of mental health patients found that those

diagnosed with schizophrenia were most likely to be homeless, followed by patients with bipolar disorder and major depression (Folsom, et al., 2005).

Schizophrenia has been closely associated with homelessness for over a hundred years (Timms, 2005). Symptoms of schizophrenia include delusions, hallucinations, and disordered speech, which may interfere with an individual's ability to live their daily life. A study of Philadelphia homeless shelter users found that schizophrenia was the most commonly diagnosed mental illness. Research has also found that that schizophrenia is at least seven times more common in homeless persons than in the general population (Folsom & Jeste, 2002).

Schizophrenia may also perpetuate homelessness: Research has shown that lack of community health resources contributes to homelessness (Folsom & Jeste, 2002). Homeless individuals diagnosed with schizophrenia remain homeless for longer periods of time and are more likely to be chronically homeless (Folsom & Jeste, 2002). Schizophrenia's interference with an individual's ability to live independently, coupled with limited availability of mental health and other services, may be at fault for elevated rates of chronic homelessness.

There are comparatively fewer studies of homeless individuals suffering from bipolar disorder. Bipolar disorder symptoms include dramatic shifts in mood and energy level, which may interfere with an individual's ability to thrive. A study of veterans diagnosed with bipolar disorder found that over half had been homeless or incarcerated, indicating that bipolar disorder can be a contributing factor of homelessness (Copland, et al., 2009).

Symptoms of major depression include feelings of sadness or irritability, and sleep, appetite, and energy changes. Estimates of the prevalence of major depression among the homeless vary widely. One study of homeless mental health patients found

that approximately 9% reported signs of major depression (Folsom, et al., 2005). Another study found that approximately 75% of the homeless individuals they sampled showed mild signs of depression, while 59% showed strong signs of depression (La Gory, Ritchey, & Mullis, 1990). Other research studies have found the rate of depression among homeless individuals to be at various points within these two extremes (Irwin, La Gory, Ritchey, & Fitzpatrick, 2008).

While the causes of depression are not completely understood, biochemical, genetic, and environmental factors all play a role in causing depression (Mayo Clinic, 2009). In a study of homeless individuals, researchers found that stressful events and daily trials were triggers of depression, and that trusting bonds and religious affiliation decreased an individual's disposition for depression (Irwin, La Gory, Ritchey, & Fitzpatrick, 2008).

Early Mortality

Studies show that homeless individuals are more likely to die prematurely than the general population. A Philadelphia study found that homeless adults died at an age-adjusted rate that was 3.5 times that of the general population (Hibbs, et al., 1994). In New York City, homeless men died at an age-adjusted rate that was two times that of the general New York City population; women died at an age-adjusted rate that was 3.7 times that of the general New York City population (Barrow, Herman, Córdova, & Struening, 1999).

Research shows that the leading causes of homeless deaths include injuries, heart and liver disease, cancer, and poisoning (Hibbs, et al., 1994; O'Connell & Swain, 2005). Violence, suicide, and drug overdose also contribute to the high mortality rate of homeless adults and youth (Hwang & Orav, 1997; Boivin, Roy, Haley, & du Fort, 2005).

Heart disease was also found to be a major cause of death in a Boston study of 17,292 adults aged 45-65 that were patients at a homeless health clinic (Hwang, Orav, O'Connell, Lebow, & Brennan, 1997). For Boston homeless clinic patients, homicide was one of the leading causes of death, particularly among homeless youth (Hwang & Orav, 1997). Studies of homeless youth show that suicide and drug overdose are large problems among the homeless. In a Canadian study of homeless youth, high mortality rates were primarily caused by suicide and drug overdose (Boivin, Roy, Haley, & du Fort, 2005).

Studies on homeless mortality often do not include people who are unsheltered and do not access homeless services, such as medical services, soup kitchens, and case management. Unsheltered individuals who do not access services are particularly susceptible to extreme weather and violence (O'Connell, 2005). Due to harsh living conditions and lack of services, this population may have higher mortality rates than those who access services and participate in research studies (O'Connell, 2005). Preliminary results from a Boston study have indicated that unsheltered individuals have a significantly higher mortality rate than homeless sheltered individuals (O'Connell & Swain, 2005, as cited in O'Connell, 2005).

CHAPTER III: Access to Homeless Medical Services

Common places where homeless individuals receive medical services include medical clinics, including hospital outpatient clinics and Community Health Clinics, and emergency rooms. Homeless individuals often face systemic and financial barriers when attempting to access physical and mental health services.

MEDICAL CLINICS

Medical clinics serving homeless individuals are located in most urban areas, often in hospitals, community centers, and shelters. Medical clinics serving homeless individuals include hospital clinics, Community Health Centers, and Health Care for the Homeless clinics. Additionally, many churches, nonprofits, and other civil society groups operate community-based clinics that also serve homeless individuals.

Medical clinics play an important role in providing medical services to homeless individuals. In a national study of homeless adults, 38% of respondents had received outpatient care at a hospital clinic in the past year, 22% had received care at a Community Health Center, and 8% had received care at a Health Care for the Homeless clinic (Kushel, Vittinghoff, & Haas, 2001).

Clinics often serve as a medical home for homeless individuals. A medical home is a comprehensive approach to providing high quality primary care by linking patients with a personal primary care provider. A medical home is more than just having access to a primary care provider; it is also a place where wrap-around medical services can be coordinated (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007).

Studies have shown that when individuals have a medical home they have better access to needed medical services, receive more preventive care, are better able to manage chronic health problems, and have a more positive view of health care (Beal, Doty, Hernandez, Shea, & Davis, 2007; Schoen, et al., 2007). Homeless individuals may experience the benefits associated with having a medical home through their use of medical clinics, which often employ the medical home model. Reflecting overall improved health that has been associated with having a medical home, research shows that clinic use by homeless individuals correlates with fewer non-emergency emergency room visits (Han & Wells, 2003).

COMMUNITY HEALTH CENTERS

Community Health Centers are community-based, nonprofit health clinics that primarily serve low-income adults and children. Community Health Centers are a federally funded network of clinics that serve everyone, regardless of ability to pay. Community Health Centers are targeted to the medically underserved; patients are disproportionately lower income, lack health insurance, and/or have Medicaid (National Association of Community Health Centers, no date). Clinics offer a wide variety of primary care services including counseling, dental care, hearing and vision screening, and health education. Clinics also provide transportation, case management, and other services to help people access medical services.

The Community Health Center network includes clinics that cater specifically to homeless individuals; these clinics are part of the Health Care for the Homeless program. In 2009, 214 HCH centers provided medical and supportive services to almost one million homeless individuals across the United States (National Health Care for the Homeless Council, 2010). In a large-scale study of Health Care for the Homeless

patients, 25% had been homeless for over a year, and over 75% had at least one chronic health problem, including arthritis, high blood pressure, liver problems, diabetes, heart disease, and cancer (Zlotnick & Zerger, 2008).

Because the homeless population is extremely transitory and may not know about available medical services, outreach is a key part of Health Care for the Homeless programming. Health Care for the Homeless programs often use street teams and mobile clinic vans to conduct outreach and provide services. Case management, benefits eligibility assistance, and other supportive services are integral parts of Health Care for the Homeless programming (Health Care for the Homeless, no date).

Recognizing that many homeless individuals struggle with both physical and mental health problems, co-located health services are common in Health Care for the Homeless programs. Co-located physical and mental health services maximize the effectiveness of mental health treatment and improve treatment outcomes (Lee, et al., 2010; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005). If a Health Care for the Homeless program is not able to provide mental health services, they are required to refer the patient to another mental health service agency.

EMERGENCY MEDICAL SERVICES

Despite the availability of medical clinics, many homeless individuals are more likely to go to a hospital emergency room to access medical care (D'amore, Hung, Chiang, & Goldfrank, 2001). Homeless individuals may also choose to forego primary care entirely, until they are faced with a medical emergency and need to go to the emergency room by necessity. In one study of homeless adults, 32% of respondents had received care in a hospital emergency room in the past year (Kushel, Vittinghoff, & Haas,

2001). Another survey showed similar results; 40% of homeless adults had visited the emergency room in the past year (Kushel, Perry, Bangsberg, Clark, & Moss, 2002).

Homeless individuals are more likely to use the hospital emergency room than the general population. In an eight-week study at an inner-city emergency room, researchers found homeless individuals accounted for approximately 20-30% of all emergency room visits (D'amore, Hung, Chiang, & Goldfrank, 2001). Once hospitalized, homeless adults stay longer in the hospital, on average, than the general population (Salit, et al., 1998). High emergency services usage rates and inpatient hospital stays often leave hospitals burdened with bearing the costs associated with these services.

In addition to being more likely to use the emergency room, homeless individuals are also more likely to visit the emergency room more often. In a community-based survey of homeless adults, 8% had visited the emergency room more than three times in the past year (Kushel, Perry, Bangsberg, Clark, & Moss, 2002). An analysis of emergency room visits by homeless patients of an Atlanta hospital found that 16% of these patients accounted for 66% of these visits (Rask, et al., 1998).

For homeless adults, high usage of emergency medical services correlates with physical and mental health problems, unstable housing, and prior hospital admission (Kushel, Perry, Bangsberg, Clark, & Moss, 2002; Rask, et al., 1998). Research has found that homeless adults with two or more medical problems were more likely to use the emergency room if they also had mental health problems (Kushel, Perry, Bangsberg, Clark, & Moss, 2002).

BARRIERS TO ACCESSING MEDICAL SERVICES

Despite the studies showing that homeless individuals experience higher rates of physical and mental health problems, homeless individuals often face significant barriers

to accessing medical services (Hwang, 2001; D'amore, Hung, Chiang, & Goldfrank, 2001; National Alliance to End Homelessness, 2009). Barriers to accessing medical services include competing priorities, strained relationships with medical providers, and high medical costs (National Alliance to End Homelessness, 2010; Plumb, 2000; Hwang, et al., 2010).

It is important to address barriers of access as they can lead to untreated physical and mental health problems among the homeless. Many homeless individuals report a need for medical and mental health services. A national survey of homeless adults found that 73% had at least one unmet health need (Baggett et al., 2010). Thirty-two percent needed medical or surgical care, 36% needed prescription medications, and 36% needed mental health services (Baggett et al., 2010).

Systemic Barriers

When medical services are available, homeless individuals may encounter frustration, misconceptions or prejudices from health care professionals (Plumb, 2000). Barriers to receiving medical services can include long appointment wait times due to underfunding and high need. Perhaps because of this contentious relationship with medical providers, homeless individuals may be resistant to seek out medical services. A national survey of over 2500 homeless adults found that 27% of respondents had not contacted a nurse, doctor, clinic or hospital in the past year (Kushel, Vittinghoff, & Haas, 2001).

For a person who is homeless, it can be difficult to complete treatment plans, attend follow-up appointments, and adhere to medication regimens because of the high level of transience. Since many homeless individuals do not have a fixed home or phone number, scheduling and follow-up can be a challenge. Homeless individuals may fall out

of medical treatment when systems do not make an aggressive effort to maintain contact and follow up (Health Care for the Homeless, 2004).

Competing priorities also mean that many homeless individuals may not seek out the medical services that they need. Health care can become a lower priority as people struggle to find their next bed or meal. Barriers to receiving services include difficulty accessing basic needs such as housing, food, clothing and safety (Plumb, 2000). Research shows that when a homeless person struggles to locate housing and food they are more likely to go without necessary medical services and are less likely to have a medical home (Gelberg, Gallagher, Anderson, & Koegel, 1997).

For chronically homeless individuals, the relationship between providers and patients may be even more strained. The high number of unsheltered chronically homeless individuals may make coordinating treatment and follow-up especially difficult. Chronically homelessness individuals are often not able to efficiently receive services from medical providers, such as emergency rooms and hospitals (National Alliance to End Homelessness, 2010). This inefficiency of homeless services utilization may be due to lack of a fixed residence, high rates of poor health and mental health disorders, and competing priorities.

Financial Barriers

Financial barriers also affect homeless individuals' access medical services. Due to the high costs of obtaining medical care, many people may not seek medical care unless it is absolutely necessary. Homeless individuals are more likely to get medical care when the services are free or low-cost. A 2010 study in Canada found that homeless patients were more likely to use medical services consistently over a longer period of time when the services were free (Hwang, et al., 2010).

Homeless enrollment in health insurance programs varies from region to region. Some states extend Medicaid eligibility to all low-income adults. Nationally, homeless individuals who receive Social Security Disability Insurance (SSDI) are eligible for Medicare. Many regions have localized health insurance programs for low-income adults. Although there is no exact data on the number of homeless individuals who have health insurance, a study of Health Care for the Homeless patients found that over 50% did not have health insurance (Zlotnick & Zerger, 2008). Another study also found that almost 56% of homeless individuals were uninsured and were not covered under Medicaid or any other public health insurance program. (Kushel, Vittinghoff, & Haas, 2001).

Very little research has been conducted on the effects on homeless individuals of not having insurance. One national survey of homeless adults found that not having health insurance was a predictor of at least one untreated medical condition, such as hypertension, diabetes, liver disease, arthritis, cancer, or mental illness (Baggett, O'Connell, Singer, & Rigotti, 2010). Another study on health insurance in the general population shows that people without health insurance receive roughly half of the amount of medical care as those with health insurance (Buchmueller, Grumbach, Kronick, & Kahn, 2005). People who are uninsured are also not as likely to receive preventive and routine medical care and are at greater risk for illness and premature death (Buchmueller, Grumbach, Kronick, & Kahn, 2005; Bovbjerg & Hadley, 2007).

For homeless individuals, having health insurance does appear to reduce barriers to medical services. Homeless individuals with health insurance reported fewer barriers to accessing needed medical care and were more likely to comply with a prescription medication regimen (Kushel, Vittinghoff, & Haas, 2001). Health insurance has also been positively linked to use of non-acute hospital-based care in multiple studies of homeless

individuals (Kushel, Vittinghoff, & Haas, 2001; O'Toole, Gibbon, Hanusa, & Fine, 1999).

However, health insurance does not clearly equate with receiving needed medical services. A Canadian study found that even when health care was free, 17% of homeless respondents still reported having an unmet health need (Hwang et al., 2010). This research may signal that cost is only part of the reason why homeless individuals do not, or cannot, access the physical and mental health care that they need.

CHAPTER IV: Health Care Reform: The Patient Protection and Affordable Care Act (ACA) and Homelessness

The Patient Protection and Affordable Care Act (ACA) was passed by Congress and signed into law by President Barack Obama on March 23, 2010 (P.L. 111-148). In both houses of Congress there was heated disagreement about the ACA that fell along party lines. The votes in the House and the Senate were deeply partisan. In the Senate, all Democrats and Independents voted for the bill, while Republicans unanimously voted against (60-39). In the House of Representatives, 219 Democrats voted for the bill, while 34 Democrats and all 178 Republicans voted against (219-212).

The ACA has broad-reaching implications for physical and mental health care access and delivery. The Congressional Budget Office (CBO) estimates that the ACA will increase health insurance coverage to almost 95% of nonelderly citizens and residents by 2021 (2011). Recent CBO analysis estimates that the ACA will reduce the federal deficit by $210 billion between 2012-2021 (2010).

Perhaps the most controversial provision is the individual health insurance mandate. Enforced via tax penalties, all citizens and residents will be required to have health insurance. Those with incomes so low that they do not file taxes will be exempt from the penalty as it is assessed via taxation. Also, people experiencing financial hardship will be exempt from tax penalties.

To ensure that more citizens and residents have health insurance, the ACA attempts to improve access to quality, affordable health insurance. To make health insurance more affordable, the federal government will set up state Health Insurance Exchanges to encourage pricing competition. New consumer protections will restrict insurance companies from using pre-existing conditions to determine insurance costs.

Companies with over 50 employees will face a fine for not providing health insurance. The ACA also mandates that states extend Medicaid coverage to all individuals with incomes below 133% of the poverty line.

The ACA names behavioral health care as an essential health benefit (2010). Behavioral health treatment encompasses both mental health and substance abuse disorders. As an essential health benefit, behavioral health services must be covered by health insurance plans. Together, these provisions and others have the potential to dramatically change the ways that health care is administered and funded in the coming years.

HEALTH CARE REFORM AND HOMELESSNESS

During the health care reform debate, there was little mainstream news coverage of how health care reform would affect homeless individuals (Roman, 2009). However, homeless advocacy and service organizations rallied around health care reform, viewing the ACA as a way to expand needed medical homeless services.

Many stakeholders saw increasing access to medical services as a step on the path towards ending homelessness. Some of the groups that lobbied for the ACA included the National Alliance to End Homelessness, the National Coalition for the Homeless, and the National Health Care for the Homeless Council. In October 2009, the president of the National Alliance to End Homelessness wrote that "poor health can lead to homelessness, and homelessness can aggravate poor health…. In our efforts to reform health care…we have a chance to provide for homeless people and lighten the load on our beleaguered health care system (Roman, 2009)."

Both before and after the passage of the ACA, the Obama administration made the case that the passage of the ACA was a significant step in ending homelessness

(Donovan, 2009; Mostrous, 2009). In July 2009, HUD Secretary Shaun Donovan stated that "publicly-funded programs like Medicaid and Medicare are essential to preventing and ending homelessness (Donovan, 2009)." Advocacy groups echoed this sentiment and the Interagency Council on Homelessness called the ACA, "the secret weapon in the fight against homelessness (Ho, 2010)."

IMPACT OF THE ACA ON HOMELESS MEDICAL SERVICES

The ACA has the potential to increase access to needed medical and mental health services for homeless individuals. The ACA provisions that may most directly impact homeless medical services are 1) expansion of Medicaid, and 2) increased funding of Community Health Centers, which may expand the Health Care for the Homeless programs and further integrate physical and mental health services.

Expansion of Medicaid

Medicaid expansion will mean that many homeless individuals will be newly eligible for Medicaid-funded physical and mental health services. The ACA mandates that states extend Medicaid coverage to all citizens and legal residents under 65 with incomes below 133% of the poverty line by January 1, 2014. In 2009, 133% of the poverty line was $14,404 for one person and $28,327 for a family of four (Dunkelberg, 2010). Before the ACA, states that extended Medicaid coverage generally shared the cost burden with the federal government. Through the ACA, states will have a guaranteed federal funding match and will not have to regularly reapply for federal funding to assist with their state-run public health insurance programs. The expansion of Medicaid means that many homeless individuals who are low-income will be able to be newly covered under Medicaid.

The majority of the expenses associated with expanding Medicaid will be bourn by the federal government. States will assume more financial responsibility over time and will begin to make phased-in payments to cover Medicaid expansion in 2016. From 2014 to 2016, the federal government will pay 100% of the costs associated with expanding Medicaid, in 2018 it will be 94%, in 2019 it will be 93%, and for 2020 onwards the federal government will fund 90% of new Medicaid enrollee costs. The financial burden that both the federal government and states will bear for expanding Medicaid is substantial. However, states and local governments may see some cost savings as people transfer from state and local public health insurance programs to Medicaid.

Estimates of the number of additional people who will participate in the expanded Medicaid program vary. In 2010, the Kaiser Commission on Medicaid and the Uninsured modeled two scenarios assuming standard participation and enhanced outreach (Holahan & Headen, 2010). Assuming standard participation, an estimated 57% of newly eligible uninsured will enroll, meaning that a total of 15.9 million people will be newly enrolled in Medicaid by 2019 (Holahan & Headen, 2010). Enhanced outreach assumes a 75% enrollment rate for a total of 22.8 uninsured enrolled in Medicaid by 2019 (Holahan & Headen, 2010).

As most homeless individuals have low or no income, the large majority of homeless individuals will be eligible for health insurance through state Medicaid programs. It is unknown how many homeless individuals will be newly enrolled, as estimates of homeless participation rates have not been developed. Using the standard participation scenario assuming 57% participation rate and the national 2009 point-in-time homeless count, 373,994 homeless individuals may be newly enrolled in Medicaid. However, a standard participation scenario may be overly aggressive given the significant barriers that homeless individuals face when accessing medical services. Without more

accurate data on the homeless population and estimates that take into account barriers to enrollment in federal programs and service accessibility, it is impossible to know how many homeless individuals will newly enroll in and receive Medicaid-funded medical services.

While it is unknown how many homeless individuals will enroll in Medicaid, the expansion of Medicaid has the potential to strengthen and grow homeless medical services. Newly enrolled homeless individuals will be able to receive medical services paid for through Medicaid. Medicaid-funded services are available through Community Health Centers, hospitals, and private providers.

Newly enrolled homeless individuals will also be eligible to receive Medicaid-funded Home and Community Based Services (HCBS). HCBS programs help individuals who are homeless and are at risk of homelessness by providing home-based medical care, transportation to and from medical appointments, and case management services. These services are state managed which allows states to tailor HCBS approaches and develop targeted community-based medical services. The ACA gives considerable discretion to states to develop and manage new HCBS allocations, meaning that states have the ability to direct increased HCBS funding specifically towards addressing homelessness.

The National Alliance to End Homelessness recommends aggressively expanding HCBS funding for homeless case management services, mental health services, and home health aids to help people who are placed in transitional and permanent housing maintain their housing and their independence (2011). The National Alliance to End Homelessness sees expanded medical supportive services as having an essential role in ending homelessness.

Expansion of Medical Clinics

The ACA allocates $11 billion in additional funding from 2010 to 2015 for Community Health Centers. The majority of this new funding ($9.5 million) will be used to expand primary care services as well as bring Community Health Centers to medically underserved areas. The remainder of the funds ($1.5 million) will be used to renovate existing Community Health Centers. Federal funding will increase from year to year, reaching a high of $3.6 billion in 2015. Community Health Centers serving special populations, of which homeless are included, and in high poverty areas will be given priority during funding allocations (National Health Care for the Homeless Council, 2010). After 2015, the federal government will study patient enrollment and costs to determine future funding needs and allocations.

The ACA aims to double Community Health Center capacity, allowing clinics to serve an additional 20 million people. Data from the National Association of Community Health Centers shows that additional ACA funding will expand services to over 40 million people by 2015 (no date).

Community Health Centers can also play a pivotal role in providing care to homeless individuals who are not newly enrolled in Medicaid. In an example from a state that has already expanded Medicaid coverage, health centers have served an increasing number of those who do not have health insurance (Ku, Jones, Finnegan, Shin, & Rosenbaum, 2009).

Community Health Centers also serve as the primary medical homes for many homeless individuals (Healthcare.gov, 2010). The ACA encourages states to expand the medical home model by making $25 million available for planning grants (National Alliance to End Homelessness, 2011). All states can apply for theses funds to develop plans to expand medical homes for new Medicaid enrollees. States have the opportunity

to use these planning funds to extend the medical home model through Community Health Centers and Health Care for the Homeless programs that are specifically targeted at homeless individuals.

Mental health programs will also be expanded as Community Health Centers grow. Research shows that co-located physical and mental health services maximize access to care and improve treatment outcomes (Lee, et al., 2010; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005). As homeless individuals often present with both physical and mental health problems, co-locating services will ensure that people are able to conveniently access the services they need without having to be referred to other service providers.

CHAPTER V: Discussion and Conclusion

The ACA has the potential to dramatically change how homeless individuals access medical services. The unique medical needs of homeless individuals and the ways in which homeless individuals access medical services necessitate specialized approaches in the implementation of the ACA. Making medical services more accessible to homeless individuals through expanding Medicaid eligibility and Community Health Centers can be an important step in the path towards ending homelessness.

Collaboration between public agencies and service providers is important to ensure that homeless individuals can and do receive expanded medical services. Federal, state, and local public agencies must involve homeless individuals and advocates to develop implementation strategies tailored to homeless individuals. Input from homeless and medical service providers is essential as these providers may be responsible for implementing enrollment and outreach strategies.

Outreach can play a large role in increasing new Medicaid enrollment and making sure that all eligible homeless individuals are able to enroll. The National Health Care for the Homeless Council recommends that homeless clinics organize outreach teams to help homeless individuals and families enroll in Medicaid (2010). Enrollment strategies from state public health insurance programs have included personalized counseling and education on health benefits for hard-to-reach populations such as homeless individuals (National Health Care for the Homeless Council, 2011). Other public insurance enrollment strategies have conducted outreach through community partnerships and even media campaigns (National Health Care for the Homeless Council, 2011).

A significant barrier to enrolling homeless individuals in Medicaid is the difficult current enrollment process. The National Health Care for the Homeless Council

recommends simplifying the Medicaid enrollment process to make it more accessible for homeless individuals to enroll (2010). Understanding the potential difficulties of enrolling homeless individuals in Medicaid, homeless clinics have begun to advocate for additional funding and improved partnerships with state agencies (National Health Care for the Homeless Council, 2010). Potential threats to developing and implementing an enrollment plan directed at homeless individuals include reduced funding and staffing due to federal, state, and local social service funding cuts.

One suggested strategy to simplify the Medicaid enrollment process is to have online Medicaid enrollment and renewal where people can upload documents and digitally sign paperwork (National Health Care for the Homeless Council, 2011). Currently, homeless individuals must have access to an address, whether at a shelter or other physical place, to enroll in and receive notifications about their Medicaid coverage. By placing the enrollment process online, homeless individuals will be able to apply for Medicaid without a physical address. The National Health Care for the Homeless Council recommends coordinating federal and state databases so that Medicaid eligibility can be determined using existing income eligibility documents that may exist in other public agencies' databases, such as food stamps and unemployment benefits (2011). Serious potential drawbacks to this strategy include ensuring the security of online systems, difficulties in coordinating document sharing between agencies, and the need for client confidentiality throughout the process.

To help homeless individuals enroll in Medicaid, systemic change is needed to make sure that people are able to access identification documents in a timely manner. Beginning in 2006, Medicaid applicants were required to produce documentation of citizenship, such as a passport or birth certificate (Ku & Broaddus, 2006). The current process of procuring documentation can be tedious and costly. For homeless individuals,

producing such documentation can be difficult as identification documents are often misplaced, lost, or stolen. Federal, state, and local agencies must simplify the process of procuring identification documents to facilitate Medicaid enrollment.

Additional funding is needed for agencies to work with homeless individuals to request identification documents. In addition to documentation fees, additional staff and case managers must be trained and supported to work with homeless individuals and navigate them through the complex process of producing identification documents. It is important that all staff at homeless service agencies and clinics, particularly front desk staff, be trained to help homeless patients enroll in Medicaid (National Health Care for the Homeless Council, 2010).

To offer more targeted medical services to the homeless, the National Health Care for the Homeless Council recommends locating expanded medical services in locations frequented by homeless individuals, such as shelters or soup kitchens (2010). By placing medical services in an accessible location, homeless individuals may be more likely to access the medical services that they need. Locations frequented by homeless individuals should also have case managers available to enroll people in Medicaid and help them procure identification documents.

Expanded Community Health Center funding should be used to target homeless individuals through Health Care for the Homeless programming. Community Health Centers and Health Care for the Homeless programs already care for a large number of homeless individuals. Continued outreach to homeless individuals can help ensure that people access the medical services they need. In addition, Community Health Centers and Health Care for the Homeless programs can expand the medical home model, giving homeless individuals a place to access regular primary and secondary care.

States must also ensure that mental health services are accessible to homeless individuals through Medicaid. Because such a high number of homeless individuals struggle with mental health issues, access to quality and timely mental health services is essential. Reducing wait-list times and increasing co-located medical and mental health services are ways that states can use additional ACA and Medicaid funding to improve mental health services access.

Homeless individuals have unique medical needs including high rates of physical problems, mental health disorders, and early mortality. Homeless individuals primarily access health services through community-based clinics and emergency services. Barriers to accessing these services include inefficient interactions with health care systems, competing priorities, and high medical care costs. The ACA will extend Medicaid services to most homeless individuals, alleviating some of the cost barriers to accessing medical services. The expansion of Community Health Clinics will increase access to medical services, including the medical home model, to homeless individuals. Through strategic implementation and outreach, the ACA has the potential to improve access to needed health care services for homeless individuals.

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