Covered Clips

A Weekly Summary of News and Activities for the Cover Arizona Coalition

Weeks of November 16th – 30th

**Special Enrollment Period for Meritus Consumers Offered**

Below is a notice sent to Meritus consumers. The notice includes information on a special enrollment period. Meritus's current 2015 consumers can enroll as late as December 31 for a January 1 effective date and they'll have until March 1 to enroll (which effective date would be April 1).

[Insert consumer name]

[Insert address]

Important: Your enrollment through the Marketplace is ending and you should enroll in a new plan by December 31, 2015.

You are getting this notice because you or someone in your family has health coverage through [Insert Plan Marketing Name]. [Insert Plan Marketing Name] no longer meets the requirements to have its plans be Qualified Health Plans and will no longer have its plans be offered on the Marketplace effective January 1, 2016.

Effective January 1, 2016, you will stop receiving any advance payments of the premium tax credit and cost-sharing reductions (which lower your copayments, coinsurance, and deductibles) that you may receive in your [Insert Plan Marketing Name] plan. Enroll in a new Marketplace plan as soon as possible to keep receiving financial assistance, if applicable.

You qualify for a Special Enrollment Period to select a new health plan.

The Open Enrollment period for coverage beginning in 2016 is from November 1, 2015, to January 31, 2016. But since your enrollment through the Marketplace is ending, you qualify for a Special Enrollment Period from January 1, 2016 through March 1, 2016 to select a new plan. You may contact the Marketplace immediately to access this Special Enrollment Period. The first day that coverage under your new plan can begin is January 1, 2016.

How do I select a new health plan offered through the Marketplace?

* You can compare plans side-by-side by logging into your Marketplace Account at HealthCare.gov. You can see plans and prices at [www.HealthCare.gov/see-plans](http://www.HealthCare.gov/see-plans).
* You can call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

To make sure there isn’t a gap in your coverage, enroll in a new plan for 2016 coverage by December 31, 2015. If you call the Marketplace or apply online at [www.HealthCare.gov](http://www.HealthCare.gov), be sure to identify that you will be losing your current coverage as of December 31, 2015.

If you select a new plan between January 1, 2016, and March 1, 2016, coverage under your new plan will begin on the first day of the month after you select the plan.

You generally must pay the first month’s premium by the deadline established by the issuer of your new plan. Keep in mind that, depending on the plan you choose, your out-of-pocket costs could change. Also, any deductible or maximum out-of-pocket spending caps start over when you enroll in a new plan.

Can I enroll in a health plan not offered through the Marketplace?

You can enroll in a health plan that is not offered through the Marketplace, but you will not qualify for any advance payments of the premium tax credit, or cost-sharing reductions that lower copayments, coinsurance, or deductibles for that coverage.

For more help

* Visit HealthCare.gov, or call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. You can also make an appointment with an assister who can help you. Information is available at LocalHelp.HealthCare.gov.
* Get language assistance services. If you need language assistance in a language other than English, you have the right to get help and information in your language at no cost. Information about how to access these language assistance services is included with this notice, as a separate page. You can also call the Marketplace Call Center to get information on these services.
* Call the Marketplace Call Center to request a reasonable accommodation if you have a disability. These accommodations are available and provided at no cost to you.

**Comment Period for Proposed Medicaid Co-Pays, Other Changes, Extended**

Arizona Daily Star

Although the state’s public comment period on a controversial proposal to change how Arizona runs its Medicaid program has closed, a federal comment period has been extended through Dec. 6.

The proposal, which critics say is harmful to the poor, could make Arizona the first state in the country to impose lifetime limits of five years on Medicaid enrollment. The federal comment period was supposed to close Monday, but the U.S. Centers for Medicare and Medicaid Services (CMS) has extended it. Individuals and organizations are invited to comment.

The proposal is important because whatever the federal government approves determines how Arizona’s Medicaid program will operate in the future.

The state’s Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS), is for low-income residents. The threshold is a yearly income of 133 percent of the federal poverty level or less — that’s $31,721 or less for a family of four and $15,521 or less for an individual.

Arizona’s application for changes to its Medicaid program includes imposing copayments and premiums on certain enrollees, eliminating non-emergency transportation coverage for people earning more than 100 percent of the federal poverty level, and imposing a five-year lifetime enrollment limit on “able-bodied” Arizonans over the age of 18. The lifetime limits would not apply to Arizonans who have jobs.

The requested overhaul of the program, which requires federal approval, is a combination of changes by both Gov. **Doug Ducey** and the Legislature. A federal decision is expected by Oct.   1, 2016. Any changes in the overhaul would occur after that.

Ducey and other supporters of the plan describe the reforms as a much-needed way for Arizonans to take more responsibility for their own health, get more involved in their own healthcare, and to ensure Medicaid is a temporary option for Arizonans — more like a bridge to independence than a permanent solution.

Medicaid was originally designed to serve children, pregnant women, the elderly and people with disabilities, Ducey wrote in the application letter to U.S. Department of Health and Human Services Secretary Sylvia Burwell.

Subtitles

* subtitles off

Captions

* captions off

Chapters

* Chapters

But the program now serves nearly as many adults as it does people in those traditional categories, he wrote. More than one-quarter of all Arizona residents are now enrolled in AHCCCS, with 1.8 million enrollees, including 280,284 in Pima County.

U.S. Rep. **Raul Grijalva**, a Democrat from Tucson who has been critical of the public’s ability to be part of the overhaul, praised CMS for extending the federal comment period.

“This is critically needed given the fact the state formed this proposal behind closed doors, did not allow the public to see the full application before it was submitted and did not conduct proper consultation with our tribal communities,” Grijalva said in a news release.

The state held five public forums, including one in Tucson that was held at Casino del Sol southwest of Tucson during the Sun Tran bus strike. The state also accepted public comments via email and regular mail through Oct. 12.

To comment on the waiver, people can go to <https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1880675> and click on “Answer the Questionnaire”

The deadline for submission is December 6, 2015 at 9pm.

To comment on SNCP, people can go to <https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1880963>

Deadline is Nov 23, 2015 at 9pm.

**UnitedHealth Group May Leave Obamacare Exchanges by 2017**

Forbes

[UnitedHealth Group](http://www.forbes.com/companies/unitedhealth-group), [in a surprising announcement](http://www.unitedhealthgroup.com/Newsroom/Articles/Feed/UnitedHealth%20Group/2015/1119EarningsUpdate.aspx?r=1), said this morning it has revised its profit expectations for the rest of the year due to what it called a “deterioration” of its individual commercial insurance offerings on government-run exchanges under the Affordable Care Act and offered no commitment it would stay in the business beyond next year.

The nation’s largest health insurer said it was “evaluating the viability of the insurance exchange product segment,” pulling back on its marketing efforts for individual exchange products for next year and “will determine during the first half of 2016 to what extent it can continue to serve the public exchange markets in 2017.” The insurer sells individual plans on public exchanges in 24 states and covers more than a half million Americans in these plans.

UnitedHealth had been among the more cautious in offering coverage to individuals on the exchanges, entering only a handful of markets in 2014, the first year such coverage became available. The company expanded for this year and only recently said it would expand its offerings in nearly a dozen more states for 2016. But this morning, it said the business has deteriorated and it expects a reduction in earnings for the fourth quarter of this year of $425 million, or 26 cents per share “driven by 2015 and 2016 exchange product pressure.”

Just last month, UnitedHealth president and chief financial officer David Wichmann touted growth for the individual commercial business, saying “we continue to expect exchanges to develop and mature over time into a strong viable growth market for us.”

But UnitedHealth and other insurers need more Americans to come into the public exchanges because the patients that are signing up for coverage are sicker, making a “higher overall risk pool,” insurance executives say. It’s a key reason many Americans are seeing rate increases of 10% or more across the country on public exchanges.

<http://www.forbes.com/sites/brucejapsen/2015/11/19/unitedhealth-group-dogged-by-obamacare-may-leave-exchanges-by-2017/>

**Obamacare Boosting Breast Cancer Screening Among Poor: Study**

US News and World Report

More poor women are being screened for breast cancer due to expanded Medicaid coverage under the Affordable Care Act, also known as Obamacare, a new study finds.

States now have the option to expand Medicaid coverage of breast cancer screening to people younger than 65 whose income is up to 133 percent of the federal poverty level. So far, 23 states have opted for that expanded coverage and six others are implementing alternatives, according to the new report.

California, Connecticut, Minnesota, New Jersey, Washington state, and Washington, D.C., were among the first to adopt and implement the expanded coverage, and did so by 2011, the study authors said.

In those states, breast cancer screening rates among low-income women rose 25 percent between 2008 and 2012, the study found. The findings are scheduled to be presented Monday at the annual meeting of the Radiological Society of North America, in Chicago.

"While increased use of screening mammography has significantly contributed to improved detection of breast cancer, substantial disparities in breast cancer screening exist among populations in the country," study author Dr. Soudabeh Fazeli Dehkordy, of St. John Providence Hospital in Southfield, Mich., said in a society news release.

"Understanding the impact of Medicaid expansion on breast cancer screening rates in early expander states can provide valuable insights that can be very useful to both state and federal policymakers when considering key health policy," she added.

"Adoption of Medicaid expansion by more states can result in considerable improvement of disparities in breast cancer screening, leading to better health outcomes for all women across the United States," Fazeli Dehkordy concluded.

Research presented at meetings is viewed as preliminary until published in a peer-reviewed journal.

<http://health.usnews.com/health-news/articles/2015/11/30/obamacare-boosting-breast-cancer-screening-among-poor-study?tr=y&auid=16270264>

**How High Is America’s Health Care Cost Burden? Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, July–August 2015**

One-quarter of privately insured working-age adults have high health care cost burdens relative to their incomes in 2015, according to the Commonwealth Fund Health Care Affordability Index, a comprehensive measure of consumer health care costs. This figure, which is based on a nationally representative sample of people with private insurance who are mainly covered by employer plans, is statistically unchanged from 2014. When looking specifically at adults with low incomes, more than half have high cost burdens. In addition, when privately insured adults were asked how they rated their affordability, greater shares reported their premiums and deductible costs were difficult or impossible to afford than the Index would suggest. Health plan deductibles and copayments had negative effects on many people’s willingness to get needed health care or fill prescriptions. In addition, many consumers are confused about which services are free to them and which count toward their deductible.

<http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/how-high-health-care-burden>

**Some Legal Immigrants May Not Be Getting Full AHCCCS Benefits**

AHCCCS

Please be aware that some customers who are qualified immigrants were being incorrectly changed from full AHCCCS Medical Assistance to Federal Emergency Services (FES) only by mistake. For some qualified immigrants, this change in benefits may have occurred as early as January 2014. Not all qualified immigrants may be aware that this has happened.

To help spread awareness about this issue, the following notice has been posted on the AHCCCS website in English, Spanish, Arabic, Nepali, Somali, Burmese, Kirundi and Swahili.

Important Notice about AHCCCS Benefits

Did you come to the United States as a refugee? Are you eligible for AHCCCS Medical Assistance? If you answered yes to both questions, you can get full AHCCCS benefits.

Some refugees had their AHCCCS benefits changed from full AHCCCS benefits to emergency services only by mistake. Please tell us right away if your AHCCCS benefits are for emergency services only. We will help make sure you are getting the correct AHCCCS benefits. If you are eligible for full AHCCCS benefits, you will be put on full AHCCCS benefits back to the date of the mistake.

You can reach us by:

• Phone: 1-855-HEA-PLUS (1-855-432-7587)

• Going to a local DES office. Tell DES you were changed from full AHCCCS coverage to emergency services by mistake. Be sure to bring your immigration papers and numbers with you. Click here to find an office near you.

If you know of any customers who may meet this criteria, please ask them to follow the above instructions.



From The Commonwealth Fund “ How High Is America’s Health Care Cost Burdent? Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, July – August 2015.

<http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/how-high-health-care-burden>

**AHCCCS Health Plan Enrollment Growth**

The Hertel Report

AHCCCS is reporting double-digit growth margins for some Arizona Medicaid plans from November 2014 to November 2015. Reporting significant membership gains are UHC (19 percent), Health Choice (17 percent), Mercy Care Plan (14 percent) and Maricopa Health Plan (13 percent). UHC gained nearly 63,000 members, Mercy Care Plan 43,000, Health Choice 34,000 and Maricopa Health Plan grew by almost 10,000. Health Net lost 15,000 members (20 percent) and Phoenix Health Plan lost almost 11,000 members (16 percent).

**AHCCCS Application at Estrella Jail Begin**

Maricopa County

Today, after months of planning, pre-release AHCCCS applications were made available to female [@MaricopaSheriff](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUxMTE5LjUxNjY1NzExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MTExOS41MTY2NTcxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTQzODU0JmVtYWlsaWQ9a2ltLnZhbnBlbHRAc2xoaS5vcmcmdXNlcmlkPWtpbS52YW5wZWx0QHNsaGkub3JnJmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&100&&&https://twitter.com/MaricopaSheriff) ALPHA inmates at Estrella Jail. This morning, [@KeoghHealth](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUxMTE5LjUxNjY1NzExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MTExOS41MTY2NTcxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTQzODU0JmVtYWlsaWQ9a2ltLnZhbnBlbHRAc2xoaS5vcmcmdXNlcmlkPWtpbS52YW5wZWx0QHNsaGkub3JnJmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&101&&&https://twitter.com/KeoghHealth) and [@EnrollAmerica](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUxMTE5LjUxNjY1NzExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MTExOS41MTY2NTcxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTQzODU0JmVtYWlsaWQ9a2ltLnZhbnBlbHRAc2xoaS5vcmcmdXNlcmlkPWtpbS52YW5wZWx0QHNsaGkub3JnJmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&102&&&https://twitter.com/EnrollAmerica) presented critical health care education to the ALPHAs and helped eligible inmates apply for AHCCCS so that when they are released from jail in December, they can re-enter the community with health insurance and continue on a path to health and wellness!

The Department of Economic Security (DES), Arizona Health Care Cost Containment System (AHCCCS), Maricopa County Sheriff's Office, Maricopa County Adult Probation, Keogh Health Connection and Enroll America have been critical partners in this endeavor. This service would not be available to our inmates without them!

**Medicaid Drives Biggest State Spending Boost in Decades**

Governing

States increased their spending in fiscal year 2015 by the biggest margin in more than 20 years, but most of the increase was thanks to huge leaps in Medicaid spending under the first full year of the Affordable Care Act (ACA).

Spending increased last fiscal year, which ended on June 30 for most states, by 7.8 percent, according to [new estimates from the National Association of State Budget Officers](http://www.nasbo.org/publications-data/state-expenditure-report) (NASBO). It's the biggest boost since 1992 and was thanks to a 15.1 percent increase in Medicaid spending, much of that paid for via federal Medicaid funds. Illinois, Michigan, Kentucky, Nevada and Oregon saw more than 30 percent increases in federal funding because they expanded Medicaid under the ACA.

But 2015 was also a year where states were putting up more of their own money again. General Fund spending, money the state collects generally via its taxes and fees, increased by an estimated 4.9 percent -- the highest increase since the recession. It still falls below the historic average of 5.5. percent annual spending increases, but NASBO Director of State Fiscal Studies Brian Sigritz said it is unlikely states will be able to get back to that average spending level in the foreseeable future. He expects that recent spending hikes (last year [saw a 3.9 spending increase](http://www.governing.com/topics/finance/gov-nasbo-fiscal-states-survey.html)) will be standard going forward.

The low interest rate environment has also played a role in muting spending growth, he added.

“In some ways states are getting a little bit more bang for their buck because inflation has been so low,” Sigritz said.

Still, all is not great for state fiscal health. On average, state revenues aren’t keeping pace with spending; NASBO estimates General Fund revenues will increase by just 3.8 percent. That is likely because some states are still having trouble balancing their budgets, as a handful transferred money from special funds or dipped into savings to close 2015 in the black, said Sigritz.

NASBO released the new data Thursday in its annual State Expenditure Report, which details state-by-state data on the seven main program areas of state spending: elementary and secondary education, higher education, public assistance, Medicaid, corrections, transportation and “all other” types of spending. The report also has data on state general fund revenue. The report contains actual data from fiscal 2013, fiscal 2014 and estimated fiscal 2015 data.

This year states also increased their education funding -- by a lot.Funding for elementary and secondary education spending grew 5.1 percent compared with 3.3 percent a year earlier. Higher education funding saw a 6 percent boost, compared with 4.2 percent a year ago.

Spending increases in most major categories were larger than last year, with the exception of transportation. That is because federal transportation funding dollars declined by 2 percent. Recently, states have stated taking control of transportation funding on their own; many have raised gas taxes and other taxes to boost their own transportation funds. Over the past two years, state transportation funds have increased by more than 9 percent each year.

The only spending category to see an actual decline was public assistance, which is largely due to fewer people qualifying for food stamps.

<http://www.governing.com/topics/finance/gov-nasbo-medicaid-state-spending.html?utm_medium=email&utm_source=Act-On+Software&utm_content=email&utm_campaign=Medicaid%20Drives%20Biggest%20State%20Spending%20Boost%20in%20Decades&utm_term=Medicaid%20Drives%20Biggest%20State%20Spending%20Boost%20in%20Decades>

**States Freed to Use Medicaid Money for Housing**

The Pew Charitable Trusts

Communities with big homeless populations are increasingly turning to a strategy known as housing first. The idea: helping chronically homeless people to find a permanent home—and stay in it—is the best way to help them lead stable, healthy lives.

The approach has been used in cities like Chicago and Cleveland, as well as in several states, such as Massachusetts, Minnesota and Washington, as local nonprofits have worked to provide both housing and health care to homeless people.

And it got an important endorsement in June, when the Centers for Medicare & Medicaid Services (CMS) told state Medicaid offices around the country that Medicaid dollars, usually reserved for clinical services and medications, could be used to help chronically homeless people and others with long-term disabilities to find and maintain permanent housing.

That means a fresh source of funds for everything from helping homeless people apply for housing and understand the terms of their lease to teaching them how to get along with neighbors and make healthy food choices.

The CMS policy statement comes as many states continue to struggle with large homeless populations. The U.S. Department of Housing and Urban Development (HUD) [reported](https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf) Thursday that while the overall number of homeless in the U.S. dropped by 2 percent, or by 11,742 people, this year over last, it increased in 17 states. New York had the largest increase, of 7,660 people, followed by California with 1,786 more homeless.

Advocates for the homeless have welcomed the CMS move, which will allow states and localities to spend more on other services for the homeless, including the construction of more housing. Thus far, no opposition has surfaced to using Medicaid money this way.

“The more we can offset supportive services through Medicaid, the more we can reallocate [federal housing] dollars and private dollars to rent more units,” said Ed Stellon, interim director of Heartland Health Outreach, a nonprofit focused on helping the poor access health care in the Midwest. “If I can pay for even one of the case managers through Medicaid, I might be able to pay rent for a dozen units and expand the number of people with housing with existing resources.”

Earlier approaches to homelessness focused on helping the homeless take transitional steps toward permanent housing as they acquired the skills needed to live independently. That philosophy has gradually given way to the idea that it is more effective to move the homeless to permanent housing as soon as possible, while still giving them the support services they need to survive on their own.

“Frankly, we used to underestimate the stabilizing impact that housing has,” said Joe Finn, president of the nonprofit Massachusetts Housing and Shelter Alliance. “If we can keep people housed, some of these other things tend to work out better.”

Homelessness advocates say the CMS announcement came in response to requests from California and New York, which had urged the agency to allow that Medicaid money be used to build housing or pay rent for the homeless. CMS refused to go that far. Even without federal support, New York has taken action, using state Medicaid funds on housing projects and other efforts.

Nonetheless, state Medicaid officials are pleased with CMS’ commitment to pay for supportive housing services. “I think it was a signal that the federal government gets it—that they see the relationship between housing and health,” said Elizabeth Misa, deputy director of New York Medicaid. “This is going to be a very helpful tool for New York and the rest of the country.”

California and Washington already have signaled an interest in using Medicaid funds for supportive housing.

Supportive Housing

The chronically homeless, many of whom suffer from mental illness or addiction, are a particular problem for states and localities. After significant drops the previous two years, the number of them who remain on the streets and not in shelters leveled off somewhat in the past year, according to HUD. And they often need a variety of services to get off the street and remain in a home.

Housing-first programs encompass many such services: help in identifying appropriate housing, assistance with the application process and understanding the terms of a lease, and aid in moving into and furnishing a home. Some programs provide intervention services if a person’s tenancy becomes jeopardized (which often occurs with the mentally ill), coaching in maintaining relationships with neighbors and landlords and in shopping for healthy food, and crisis intervention services.

The programs also generally provide coordinated health care to beneficiaries, including help with keeping medical appointments and taking prescribed medication.

The federal government has paid for such supportive housing services in the past, typically through grants from HUD, which in 2014 sent about $1.8 [billion](http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/budget/2014) in grant money to states for homeless services.

Medicaid, a health plan financed jointly by the federal government and the states to provide medical care for 72 million poor or disabled Americans, typically pays for clinical care and medication. But the CMS bulletin indicates that, at least when it comes to the chronically homeless, the Obama administration interprets health care more broadly.

“CMS is making the clear statement that the way to improve the health of homeless people is to ensure that people have stable housing,” said Richard Cho, deputy director of the U.S. Interagency Council on Homelessness, an independent federal agency that coordinates the government’s approach to homelessness.

Technically, the CMS bulletin only clarified existing policy, but just a few states, including Louisiana, Massachusetts and Texas, had been using Medicaid money to pay for supportive housing services. More often, Cho said, state Medicaid programs were paying for supportive housing services for the severely mentally ill and the elderly. The bulletin made it clear that the chronically homeless qualify for the same services.

To begin using the funds that way, states will have to hop through several bureaucratic hoops. Most will have to apply for a CMS waiver, but the bulletin signals that they will get a friendly reception from the Obama administration. CMS is also offering to advise states on how to devise effective supportive housing programs, which it says should involve coordination among numerous state and local health, mental health, social service and housing agencies.

While homelessness advocates have applauded the Obama administration’s move, some states had hoped the administration would go farther. In recent years, New York and California urged CMS to allow Medicaid to pay for construction of housing for the homeless and for rent subsidies, in addition to the support services. While the administration was unwilling to go that far, those conversations prompted CMS to issue last summer’s bulletin, Cho said.

CMS’s resistance to using Medicaid money for housing construction didn’t stop Democratic Gov. Andrew Cuomo. This year, New York spent $34 million of state-only Medicaid dollars on capital housing projects for the homeless and other targeted groups. “We’re convinced this is going to prove to be a cost-effective use of our Medicaid dollars,” Misa said.

Homelessness and Health

In many ways, homelessness itself contributes to poor health. With little access to healthy food, frequent exposure to severe weather and vulnerability to violence, homeless people are generally in far [worse health](http://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf) than the rest of the population. They have much higher rates of mental illness, addiction, diabetes, high blood pressure, asthma, HIV and many other conditions; the homeless often ignore easily treatable symptoms until they become debilitating and far more expensive to treat. What health care they receive is usually by way of the emergency room.

Historically, few of the homeless have had health insurance. But the 2010 Affordable Care Act changed that, targeting nearly $1 billion over five years to specialized clinics for the homeless, out of $11 billion earmarked for community health. And, while Medicaid traditionally was available to the poor, to pregnant women, to children and to the disabled, the health law extended Medicaid benefits to all Americans earning an annual income under 133 percent of the poverty line, or $15,654 for an individual. So far, 30 states, plus the District of Columbia, have chosen to [expand](http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/) eligibility under the new law.

Homeless agencies say thousands of homeless have been enrolling in Medicaid, and early [studies](http://kff.org/report-section/early-impacts-of-the-medicaid-expansion-for-the-homeless-population-key-findings/) have demonstrated significant increases in the number of homeless with health insurance since states began to expand Medicaid in accordance with the health law, in 2014.

Still, advocates for the homeless say health insurance is not enough to ensure that homeless people access the health care they need. For that, advocates insist, they need permanent housing and help staying there.

As Finn, of the Massachusetts Housing and Shelter Alliance, put it, “What we found that helps the most is just having someone dropping by regularly to ask, ‘Is there anything you need?’ ”

Even without the Medicaid funding, cities and states have successfully moved many of their homeless into housing and surrounded them with support services, including medical care. Although HUD has provided funding for those services, much financial support has also come from private sources.

The programs typically select as participants frequent users of emergency rooms and those who’ve been hospitalized often, in hopes that providing supportive housing will help them stay out of the hospital and reduce overall health care costs. Misa said New York Medicaid is currently collecting data to determine if that is the case.

Several programs have been established around the country:

* **In Ohio:** Housing First, in Cuyahoga County, comprises several antipoverty nonprofits in the Cleveland area and has provided 584 homes for single adults and 76 for families since 2006. Residents are linked to health care at a specialized clinic for the homeless. A mobile medical clinic staffed by a nurse practitioner and psychiatric specialists also visits patients.
* **In Massachusetts:** Since 2005, various state agencies and local nonprofits have provided a panoply of services to help chronically homeless adults to live independently, including teaching them living skills, coordinating case management, crisis support and directing them to peer-support and self-help groups.
* **In Minnesota:** Hearth Connection, allied with other local poverty and health agencies, provides supportive housing services to 85 formerly homeless Medicaid beneficiaries.

http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/11/20/states-freed-to-use-medicaid-money-for-housing

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at kim.vanpelt@slhi.org.