Alameda County Health Care for the Homeless Program
Consumer/Community Advisory Board (CCAB)
384-14th Street
Oakland, CA 94612

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achchp@acgov.org
www.achch.org

Alameda County Health Care for the Homeless Program
Consumer/Community Advisory Board (CCAB)

Meeting FRIDAY 4/14/2017 12:00 Noon – 2:00PM
1404 Franklin Street #209 Highlander Meeting Room

Minutes

Meeting Location	HCH PROGRAM/TRUST Clinic offices 1404 Franklin Street 2nd Floor Highlander Meeting Room
Attendees	CCAB Board Members: (*Executive Committee) Bennie Whitfield — Brenda Whitfield Kimberlee Burks — Mark Smith* Ami Moe — Guitar Whitfield April Anthony* **Absent**: Sam Weeks* Participants: Sabrina Fuentes — David Modersbach, HCH Program (Ex Officio) Christopher Papazoglow Denise Norman Jeannette Johnigan
Agenda	1. **Welcome and introductions** (5 min) 2. **Meeting Roles** (facilitator, timekeeper, vibes-watcher, note-taker) We are working to spread out the process roles in the CCAB meetings. • Timekeeper: Christopher • Vibes-Watcher: Bennie • Facilitator: Mark • Notes: David M. It was decided that the group would select a Facilitator for the next meeting, and that person would be included with David in setting the agenda. Unfortunately a next-meeting facilitator was not selected. 3. **Review/Approval of Last Meeting Minutes**. (5min) Kimberlee moved to approve minutes; consensus agreement. 4. **Discussion/Announcements/Updates** (20 min) a. Health Care Legislation/Policy Updates: Discussion of health care changes from DC, the successes in preventing destruction of the Affordable Care Act, and threats to the ACA now moving towards the State level across the country. David will send out Frequently Asked Questions document about health care and homelessness. Brenda and April both co-authored letters from the

HCH CCAB which were sent to Jerry Brown, our Senators and the National HCH Consumer Advisory Board (NCAB) – attached.

b. Encampments
Encampment and street homelessness attention is growing along with numbers of people on the streets. HCH CCAB Statement on Unsheltered Homeless is being read by a lot of folks, and is informing people's thinking. Fire at the 23rd Ave encampment.

c. 2551 San Pablo Fire
A remarkable number of HCH CCAB members were involved with after-fire support services to victims. Discussion of unlicensed/unsupervised programs like Urojas, and sharing of negative experiences with programs like that. Key elements of discussion were
1. Community Response to the fire and victims
2. Need for preparation and response to disasters which affect people experiencing homelessness
3. Oversight of unlicensed living facilities
4. Who is to blame? Owner? Operator? Or City? Consensus was "Yes" all of them.

5. **TRUST Clinic Steering Committee Report** (Mark Smith) 5 min
TRUST Clinic leadership is moving to a every-two-months steering committee meeting. HCH CCAB liaison Mark Smith is concerned that this will weaken the ability of the Steering Committee to respond to changes and to directly communicate around program management. . Mark would like to link up better to the TRUST CAB, which April is a member of to be able to bring patients point of view to the Steering Committee. Next meeting is May 9th
6. **HCH Commission Report out** (Sam Weeks) 5 min
Sam was absent and not able to report on the HCH Commission.
7. **HCH Program Patient Experience/Patient Satisfaction** (20 min)
This discussion was postponed until next meeting.
8. **Future CCAB advocacy efforts** (20 min)
   a. Evaluation of CCAB meetings and mission, meeting process, advocacy efforts, new member recruitment, future skills building for CCAB members

   The HCH CCAB Executive Committee has met twice to discuss the state of the CCAB, and asked David to present about HCH CCAB accomplishments, and lead a discussion about goals and objectives for the CCAB. This presentation is attached.
   Non-Board members asked what is the process for incorporating new members to the CCAB, Sabrina, Denise, Christopher and Jeanette are interested. According to HCH CCAB bylaws, the Executive Committee appoints new members, and right now is prioritizing skills building and HCH CCAB development, so the new member process is going slowly. David distributed Applications for the HCH CCAB. The HCH CCAB Executive Committee will meet again and discuss the potential new members, and a

closed session of the 5/12/17 meeting is scheduled to discuss with current CCAB members.

David led a brainstorming of Goals for the CCAB and the following items made it on the board:

HCH CCAB: What do we Want to Accomplish?

- Constant miracles (!)
- Hygiene/Sanitation/Safety/health for unsheltered/encampments
- Actual roles and services of Encampments
- Partnership with businesses and community $ and efforts
- Access to bathrooms
- Children/Youth
- Transportation
- Coalition of Community Organizations
- Follow Through with our tasks and goals
- Service Providers Coordination / Best HCH Practices
- Continuing Training and Education for CCAB

The group also discussed organizing and scheduling a HCH CCAB retreat for summer of 2017. This retreat could be focused on:

- Developing mission, goals, objectives, strategies
- Training ourselves on skills, organizing, communicating, planning, etc.,
- Training on process, meetings, and productivity
- Teamwork, sharing our strengths and working as a group.

9. **NHCHC Conference in Washington DC 6/21-24/2017**
   Kimberlee and April will be attending. Sam is also planning on attending as a HCH Commissioner. Jerry Smith from the TRUST CAB is also attending.
10. **CCAB Board Member Meeting Stipends** (5 min)
    As always, some issues, David has to now ensure that checks are not issued twice in the same month as happened March. SSI counts that as $100 income for one month instead of two months. Please contact david if you are having this issue for March (overpayment).
11. **Letter from Ron Anderson from St. Mary's re: encampments.**
    The CCAB read Ron's letter and were impacted by it (attached). They agreed to invite Ron to the next meeting to hear more of his observations in more detail.

Following Meeting: Friday, May 12 , 12:00Noon

We have changed our regular meeting time!

SECOND FRIDAY OF EACH MONTH at NOON.

Friday May 12th

Friday June 9th.

Alameda County Health Care for the Homeless Program Consumer/Community Advisory Board

ACCOMPLISHMENTS

- 2015: Focus Groups in Berk, Hayward,E. Oakland, Oakland
- September 2015: Re-launch of the CCAB
- November 2015: Attend EveryOne Home Community Mtg
- Jan 2016: Input into AHS Homeless Screening processes
- Jan 2016: Supporting Right To Rest Act legislation (CA)
- Feb 2016: Response to TRUST clinic social worker shortage
- May 2016: Development of Encampment Statement re: Sanctioned Encampments
- June 2016: Meeting with HCSA Medical Director & Staff re: consumers
- June 2016: Present Poster and Attend 2016 NHCHC Conference PDX

July 2016: CCAB involvement in TRUST Clinic CAB

August 2016: CCAB training on consensus and conflict resolution

September 2016: CCAB supports Whole Person Care Initiative

September 2016: CCAB members supporting Alameda County Housing Bond A1

October 2016: CCAB Election Forum

September 2016: CCAB Chair Sam Weeks member of HCH Commission governing Board

October 2016: CCAB involvement in TRUST Steering Committee

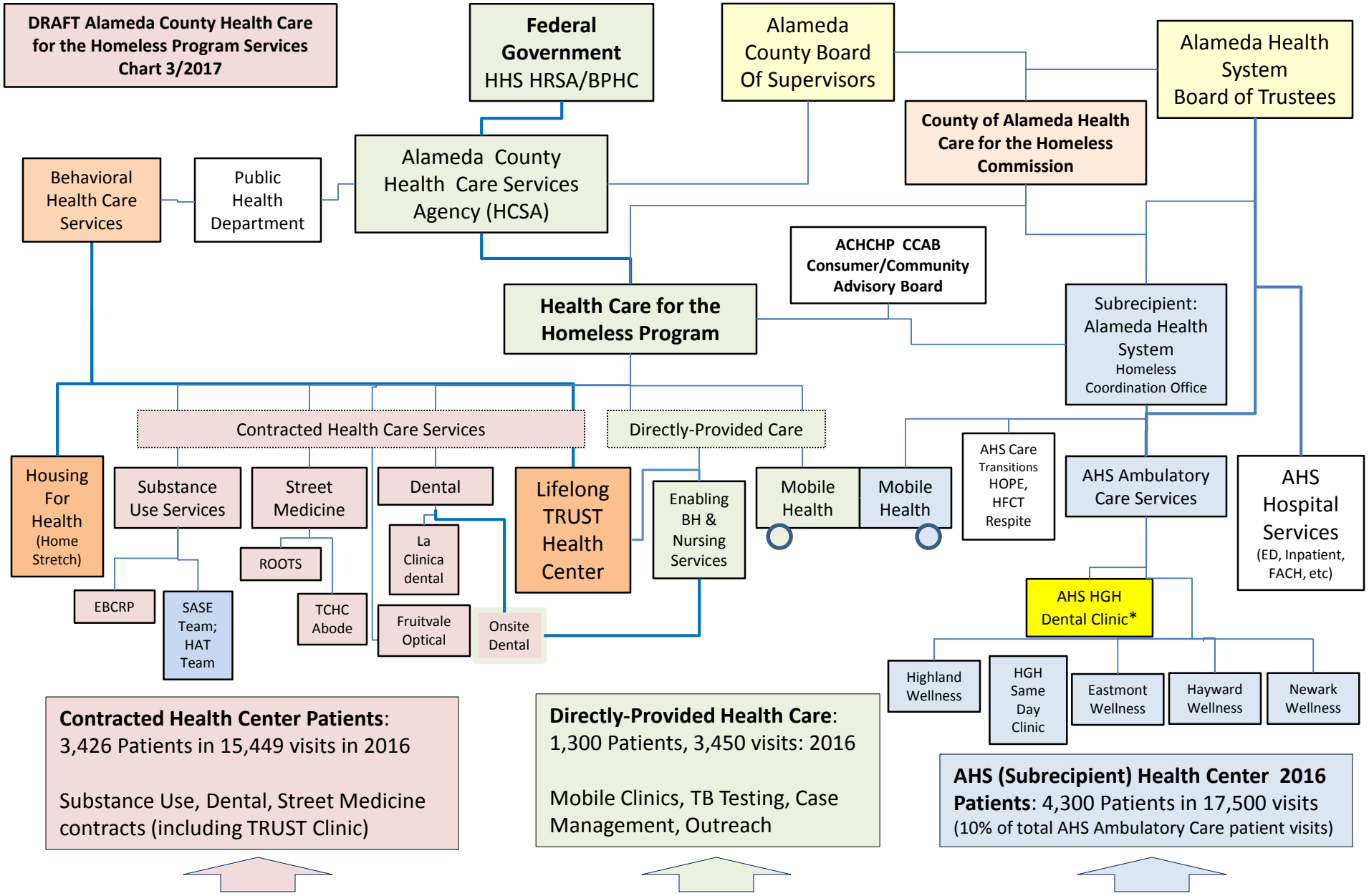
November 2016: HCH Optometry advocacy

December 2016: HCH CCAB sponsors 3 All-In Listening Sessions

January 2017: CCAB members participate in Point in Time Count

February 2017:: HCH CCAB taking on Patient Satisfaction, Support AB74, Letters to support ACA

March 2017: CCAB members attend Housing CA conference, involvement in Mervyn's debacle


DRAFT Alameda County Health Care for the Homeless Program Services Chart 3/2017
Federal Government HHS HRSA/BPHC
Alameda County Board Of Supervisors
Alameda Health System Board of Trustees
County of Alameda Health Care for the Homeless Commission
Behavioral Health Care Services
Public Health Department
Alameda County Health Care Services Agency (HCSA)
ACHCHP CCAB Consumer/Community Advisory Board
Health Care for the Homeless Program
Subrecipient: Alameda Health System Homeless Coordination Office
Contracted Health Care Services
Directly-Provided Care
Housing For Health (Home Stretch)
Substance Use Services
Street Medicine
Dental
Lifelong TRUST Health Center
Enabling BH & Nursing Services
Mobile Health
Mobile Health
AHS Care Transitions HOPE, HFCT Respite
AHS Ambulatory Care Services
AHS Hospital Services (ED, Inpatient, FACH, etc)
EBCRP
SASE Team; HAT Team
ROOTS
TCHC Abode
La Clinica dental
Fruitvale Optical
Onsite Dental
AHS HGH Dental Clinic*
Highland Wellness
HGH Same Day Clinic
Eastmont Wellness
Hayward Wellness
Newark Wellness
Contracted Health Center Patients: 3,426 Patients in 15,449 visits in 2016
Substance Use, Dental, Street Medicine contracts (including TRUST Clinic)
Directly-Provided Health Care: 1,300 Patients, 3,450 visits: 2016
Mobile Clinics, TB Testing, Case Management, Outreach
AHS (Subrecipient) Health Center 2016 Patients: 4,300 Patients in 17,500 visits
(10% of total AHS Ambulatory Care patient visits)
In 2016, a total of 8,265 homeless patients were treated in 35,025 visits at sites throughout the homeless health center.
We plan on roughly the same target numbers in 2017-2019.

Mission and Goals

From HCH CCAB Bylaws 4/2016

Purpose:

- To bring together a group of people with shared concerns and interest in improving the health of persons experiencing homelessness and in ending homelessness in Alameda County. To help direct Alameda County Health Care for the Homeless Program (ACHCHP) with identifying unmet needs, evaluate homeless services, assessment of programmatic changes and other desired issues.

HCH Program Mission and Goals Statement

Alameda County Health Care for the Homeless Program

Our Vision:

In a socially just society, all persons have access to quality health care and housing. We believe the problems of homelessness and health disparities can be solved.

Our Mission:

The mission of Alameda County Health Care for the Homeless Program is to improve the health of persons in Alameda County who are homeless or at risk of homelessness.

CORE WORK AND VALUES

We place the needs and strengths of homeless patients and clients at the center of our work. Our core work is to:

1. Provide patient-centered care: Provide accessible, harm reduction-based services to our clients.
2. Provide quality health care: Ensure the highest standard of care for our clients, utilizing best practices, quality assurance and quality improvement.
3. Provide clients with access to the resources they need: Develop and link clients to the resources they need to improve their health and lift them out of homelessness.
4. Build healthy communities: Reduce health disparities and promote social justice through advocacy, community organizing, and public health work.

The work we do with homeless persons is guided by the following core values:

- We treat the client in an empathetic, non-judgmental manner, respecting dignity and providing a safe environment for clients
- We provide care and services in a culturally and linguistically appropriate manner.
- We strive to deliver the highest quality services and resources possible. There should be no closed doors and only appropriate referrals.
- We work as a team: with clients, with one another and with the community in an inclusive, participatory, respectful manner to provide the best care for our patient population.

What Would You like to Accomplish as a Board?

Exercise: Mapping the strengths of HCH CCAB members

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California Governor Jerry Brown
Sacramento, CA

March 21st, 2017

Dear Honorable Governor Brown,

We are the Consumer/Community Advisory Board (HCH CCAB) of the Alameda County Health Care for the Homeless Program.

We are sure that you have received many letters, emails, and phone calls giving you testimonials about Medi-Cal, and how it has helped them become whole again and save lives. We want to emphasize how necessary the medi-cal program is, to enable people to live with the quality of life each and every one of us deserves.

Medi-Cal is a life-changing program that goes so much farther than just doctors' visits and prescriptions. It is an all-encompassing system that helps people reach their life goals and stabilize their lives. The support of medi-cal services would not be available to many us without the Affordable Care Act.

What would become of the 14M + California residents, should medi-cal no longer be available to them?

- Would people be forced to choose between paying rent and paying for life-saving medication?
- Would they even be able to afford said medications?
- Would we see an increase in the population of people experiencing homelessness?
- With people desperate to afford lifesaving medication, would we see a substantial increase in crime, causing individual devastation as well?
- What would this do to our judicial system? Our jails and prisons are maxed out currently. How much would this increase the operational costs for these departments?

The fastest growing population of people becoming homeless are aging people 50+ years old. People don't become homeless because of drug use or personal choice, they become homeless due to the housing crisis and the lack of a safety net. One devastating event in one's life is all it takes to become homeless: loss of employment, illness, medical bills, or death of spouse or family. With Medi-cal, there is a network of resources for people to end their homelessness.

The elimination of medi-cal will result in increased homelessness, increased crime and overloaded jails.

Here is something to think about: What will the elimination of medi-cal do to our state? How will it effect our budget? How will it affect homelessness? How will it affect crime and the criminal justice system? What would it take for you, or any other Californian to become homeless? How many Californians are one step away from homelessness already?

In order to prevent these disasters from occurring, we need to keep the medi-cal system as it is.

April Anthony
On behalf of the HCH Consumer/Community Advisory Board Membership

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California Governor Jerry Brown
Sacramento, CA

March 21st, 2017

Dear Honorable Governor Brown,

My husband and I are writing as members of the Alameda County Health Care for the Homeless Consumer/Community Advisory Board. In recent years, we have been recipients of Medi-Cal (Medicaid) health insurance. Any of the proposed cuts to this life saving program will severally impact the health of the poor, elderly and disabled.

With Medi-cal, I was able to get a regular doctor and get on medications for chronic back pain. For over a year, I had a painful heal spur that forced me to walk on crutches, with MediCal I was sent to specialists that helped me get the surgery I needed. After losing most of my teeth, I received dentures through MediCal that gave me back my smile. I cannot describe how having dentures helped my self-esteem. Without MediCal, I am not sure how I would have survived.

My husband Bennie has had Hepatitis C since 1971. Not until 2016 was there a viable treatment for him. Gratefully in the fall, he was able to receive a three month treatment worth $38,700 that resulted in the virus being undetectable by December. He is a diabetic and suffers from neuropathy which requires monthly treatments. Before Medi-Cal he used to worry about where he was going to get the care he needed and now he knows that if he follows his doctor's instruction he is able to live a full and healthy life.

We are examples of how important the Medi-Cal program is for extremely low income seniors. We are active community members who work to increase quality of life for other seniors and the disabled. Reducing Medi-cal protections for people who need it will affect the community at large, creating a greater hardship on county emergency services and increasing anxiety for the chronically ill, making them ever sicker.

We ask you earnestly not to cut our Medi-Cal/MediCaid insurance.

Sincerely,

Brenda L. Whitfield Bennie Whitfield
On behalf of the HCH Consumer/Community Advisory Board Membership

Ron Anderson
2017 Foothill Blvd, Apt. 503
Oakland CA 94606

Healthcare for the Homeless
Community Consumer Advisory Board (CCAB)
1404 Franklin Street, Suite 200
Oakland CA 94612

Dear CCAB Members,

This correspondence's intention is to give you an inside perspective from the people in the midst of that living nightmare of homelessness. My name is Ron Anderson and I qualify myself to speak on this crisis by being homeless for four hard years on the streets of Oakland.

I overcame homelessness from what St. Mary's Center had to offer through their winter shelter, their transitional house and other programs within the center. I now have a one bedroom apartment in Oakland and I am active in their Hope and Justice program as a Senior Advocate.

On March 5th, I spent the night at the encampment near West Grand, not to tell them what they needed to do to change or what they needed to correct but to offer encouragement and let them know that anyone can overcome homelessness. We sat on milk crates on a cold March night, we ate sandwiches while I listened as they talked about their fears, despairs and why help takes so long to reach them.

The following is what was told to me in their voices. I have used "I" statements instead of their names.

This is what we deal with while living on the streets under the underpass by the Greyhound station in West Oakland.

A. Police come down here for warrant checks because they know they have given out citations for "indecent exposure" because we have no restrooms. The citations have turned into warrants because they know I am not going to court dirty and smelly, it is their way to get rid of us, slowly but surely.
B. The city is reluctant to bring in portable toilets down here. Public restrooms are a thing of the past and once the drop in center closes there is nowhere to go to use the restroom.
C. Shelters are few in Oakland and I don't have $5 a night to stay in one, to sleep on a mat then get put out at 5:00 am to panhandle for another night. I rather sleep on the streets and spend that money on food.
D. I tried to get into that drug program near Chinatown, the next day they woke me up to take my weary body to their dock to load and unload trucks for eight hours, I just could not do it.
E. I was in the Social Services office no more than a few minutes before the Deputy escorted me out saying they got a complaint about my foul smell. I know people break wind in there and they don't get put out.
F. I can't get a free cell phone because I don't have ID, so I go to the shelter to use their phone but the bulletin board information is out dated and the phone numbers are out of service.

G. I go to the drop-in center to shower just to put back on the same clothes I been wearing for weeks, which is better than putting on second hand clothes, cause I saw bed bugs on them.
H. We call the old people, "auntie" and "uncle". I try to look out for them but they still get jacked for the food they leave in their tents either by the rats or someone else.
I. I feel we are looked at like we are a contagious disease, the way they look at me, makes me ashamed to enter a public office.

In closing, I, Ron Anderson would like to say we are a long way from that so-called light at the end of the tunnel. When you are out on the streets, hope is out of reach. I respectfully, recommend that city officials meet them half way and come down to the encampment and show that they want to help. People need a free shelter that is not tied to work requirements but tied to personal goals and where they could rest and stay longer than a day or a week. This will give us time to clear our heads, rest, talk to a case worker and help heal from the stuff we have buried inside, so we can release it and get a new outlook and hopefully a better life.

Sincerely,

Ron Anderson

Ron Anderson
and the voices your heard
510 776-5562
Ronaldanderson146@gmail.com

Federal Health & Housing Policy:
Frequently Asked Questions for the HCH Community

March 29, 2017

1. **What is happening now on housing and health care?**

   In March, two big things happened. First, Congress introduced the American Health Care Act (AHCA), which was designed to repeal much of the Affordable Care Act and replace key provisions with new approaches to financing health care for many Americans. In the past week, it became clear there was not enough support among both House Democrats and Republicans to advance the bill to the Senate (where it also did not have enough support to pass). The President now wants to move on to address tax reform and has announced that health care is no longer on the action agenda. Second, President Trump issued some of the details for his first budget, though more details will come later. This budget had substantial cuts to programs under Housing and Urban Development (HUD) in order to offset the Administration's intent to increase military spending.

2. **What will happen next?**

   It is unclear what Congress will do next on health care, if anything. The lack of consensus among Republicans prevented the AHCA from moving forward, but many members are likely to still want to pursue changes. The next major hurdle for Congress is passing a budget for the remainder of fiscal year 2017. The current fiscal year is funded through April 28th through a temporary funding measure. Failing to reach a budget agreement by this date may mean a government shutdown. Following the 2017 budget deal, Congress will begin on Fiscal Year 2018's budget, for which Donald Trump has recommended many funding cuts and will release further budget recommendations for over the next few months (see more under "What Do We Know About the Budget?"). Following the passage of a 2017 budget, Congress will work on their own budget plan called a "budget resolution" and then work on passing funding bills.

3. **What was American Health Care Act, and how did it propose to change Medicaid?**

   On March 9, health care committees in the House introduced the AHCA, which would have ended the Medicaid expansion for single adults and replaced the entire program with per capita caps (or a state option for a block grant). This represents a fundamental restructuring of the Medicaid program, and presents numerous problems (see more below). The AHCA also proposed replacing the current subsidies and tax credits for private insurance on the federal and state marketplaces with a fixed tax credit based on age. Combined, the Congressional Budget Office estimated the AHCA would have reduced the federal deficit by $337 billion, but resulted in 24 million people losing either Medicaid or

private coverage by 2026. For Medicaid itself, the AHCA would have cut federal Medicaid spending by $880 billion and reduced Medicaid enrollment by 14 million people in the next 10 years.

The AHCA also contained numerous policy provisions that would have likely created barriers to care for people who are homeless and the providers who serve them. Specifically, it would have:

- Repealed the requirement that Medicaid plans have essential health benefits
- Imposed significant penalties for losing coverage
- Established state high-risk pools for those with chronic illnesses
- Prohibited federal Medicaid funding for Planned Parenthood
- Limited retroactive coverage in the program
- Created a state option for a Medicaid work requirement
- Required stronger documentation of citizenship before obtaining coverage
- Required re-determination for Medicaid every 6 months
- Repealed the ability for providers to make presumptive eligibility for the expansion population

While the Affordable Care Act can certainly be improved, critics of the AHCA asserted it would not have made insurance more affordable, covered more people, or facilitated access to comprehensive health care, particularly for vulnerable people.

For more information about the AHCA and Medicaid, check out these resources:

- Kaiser Family Foundation: Summary of the American Health Care Act (March 2017)
- Urban Institute: Who Gains and Who Loses under the American Health Care Act (March 2017)
- Center on Budget Policy and Priorities (CBPP): House Republican Health Plan Shifts $370 Billion in Medicaid Costs to States: Funding Cuts Would Force State to End Expansion for Low-Income Adults, Cut Coverage and Services for Other Groups (March 8, 2017)
- CBPP: Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families (March 21, 2017)

4. **How are Medicaid Block Grants and Medicaid Per Capita Caps different from how Medicaid is funded now?**

Currently, the federal government gives states a fixed percentage of their Medicaid spending no matter how much the state spends (averaging around 57% for the non-expansion population). This "federal match rate" is different for every state, based roughly on average household income. States that are relatively poor have a higher match rate and those with more wealth have a lower match rate. For example, Mississippi has the highest match rate at about 75%; hence, for every dollar the State of Mississippi spends on Medicaid, the federal government pays the state three dollars. In this way, both states and the federal government share a predictable portion of the cost for providing Medicaid services. If there's a recession or other reason for increased enrollment, the funding goes up on both sides. If there's an expensive new technology or medical treatment like Hepatitis C medication, funding also goes up on both sides.

Under a block grant or a per capita cap, states get a fixed amount of federal money. A block grant gives states a fixed amount of money for the whole state, and a per capita cap gives the money based on a fixed amount for each person. The goal of either of these changes is to reduce the money the federal government spends on Medicaid, but this reduction means states have to make up the difference by making hard choices—and each state will react differently. They could respond in any of the following ways:

- Reduce the benefits offered
- Cut eligibility or put in work requirements or lock-out periods so fewer people qualify
- Take money from other areas in the state budget
- Raise state taxes to collect more money
- Require Medicaid recipients to pay for part of their own Medicaid coverage (known as cost sharing)

It will be very hard for states to cover the loss of federal funding so however states respond, but block grants and caps mean cuts to the program in some way.

For more information on block grants and per cap, check out these resources:

- Kaiser Family Foundation: Restructuring Medicaid in the American Health Care Act: Five Key Considerations (March 15, 2017)
- Urban Institute: The Impact of Per Capita Caps on Federal and State Medicaid Spending (March 2017)
- The Commonwealth Fund: What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid? (November 2016)

5. What would block grants or per capita caps mean for supportive housing or medical respite care programs?

Because states would be responsible for funding a greater share of traditional medical services, it would likely be more difficult to continue (or start) funding for "optional" services like recuperative care, housing supports, case management, outreach, and other services we know work well for people who have unstable housing.

6. What is HHS under the Trump Administration doing to change health care?

HHS can do a lot to change health care, and these actions are likely to draw less attention than the highly publicized Congressional push to repeal the Affordable Care Act. This month, newly confirmed Secretary Tom Price and CMS Verma sent a letter to Governors outlining the following changes they would like to see from states:

- Fast track approval of state Medicaid waivers (this could be a positive step, or it could block the ability for public comment when states propose controversial changes like those below)
- Conduct a full review of managed care regulations to "prioritize beneficiary outcomes and state priorities" (this could mean weakening coverage protections, limiting innovations that benefit the single adult population, or other actions)

- Use Medicaid waivers to implement work requirements ("The best way to improve the long-term health of low-income Americans is to empower them with skills and employment.")
- Require premiums, co-pays for emergency room or other services, or other cost-sharing payments *at all income levels*
- Implement health savings accounts *at all income levels*
- End non-emergency medical transport benefits (which help people get to their medical appointments)
- End presumptive eligibility and retroactive coverage (which helps qualified people get on Medicaid faster and allows providers to bill for services already provided)

This letter to Governors specifically says that expanding Medicaid "to non-disabled, working age adults without dependent children was a clear departure from the core, historical mission of the program." This letter—and the changes it seeks—should come as no surprise. HHS Secretary Price strongly supported the American Health Care Act and its drastic changes to Medicaid. As a conservative Republican U.S. Congressman from Georgia, he also was opposed to expanding Medicaid to very low income people in his district. CMS Administrator Verma has previously worked with numerous states on Medicaid waivers that include premiums, co-pays, health savings accounts, and work requirements.

While HHS cannot end the Medicaid expansion or change the federal law, it can stop enforcing provisions of Medicaid law as indicated in President Trump's first executive order related to the Affordable Care Act. This order gave broad permission to waive or exempt any provision of the ACA that caused a fiscal burden to states or others, though the vagueness of the wording makes it difficult to fully interpret and is surely to invite legal interventions. Look for more information and future action alerts related to HHS regulations, Medicaid waiver approvals, and other measures that may impact vulnerable populations.

For more information on Medicaid work requirements, check out these great resources:

- Health Affairs article "Myths about the Medicaid Expansion and the 'Able-Bodied'" (March 6, 2017)
- National Health Law Program: Medicaid Work Requirements—Legally Suspect and Medicaid Work Requirements—Not a Healthy Choice (both March 21, 2017)
- Kaiser Family Foundation: Medicaid and Work Requirements (March 23, 2017)

7. What do we know so far about the budget?

President Trump wants Congress to put $3 billion towards a border wall, raise defense spending, and slash funding for other nondefense programs (which includes health care and housing). Many Democrats and Republican's disagree with his ideas and will have to work out a compromise for the remainder of Fiscal Year 2017 and Fiscal Year 2018 (see "What Happens Next" for more on the timeline). It is important to remember that President Trump's budget is only a recommendation for Congress. Regardless, his budgetary recommendations so far include many large cuts to programs that benefit the HCH community. Items of particular concern are a $6.2 Billion (13.2%) cut to HUD's budget, which funds housing rental support and vouchers. The cuts would eliminate programs that support affordable housing such as HOME, Community Development Block Grant, and the Choice Neighborhood program. Trump's budget also cuts $15 Billion (18%) out of HHS budget, which would include funding reductions for the Low Income Home and Energy Assistance Program (LIHEAP), Community Services

Block Grant, HIV funding programs, mental health block grants, and public health programs. The budget eliminates funding entirely for the U.S. Interagency Council on Homelessness (USICH), a coordinating office for the federal response to homelessness. The budget adds $500 million for substance abuse programs and indicates further investments in health centers (although the Administration emphasizes they want to support health centers as an alternative to Planned Parenthood clinics).

8. **What are other issues of concern for the HCH Community?**

   There are numerous other policy changes the Trump Administration and Congress are pursuing that are of concern. Restrictions on immigration not only create a chilling effect on patient access to care, but also have implications for primary care workforce recruitment and retention. Threats to stop funding to "sanctuary cities" also attempt to create divisiveness at the local level while stemming needed funds for local development. Blocking funding for Planned Parenthood restricts access to a wide range of family planning and women's health care services. Expanding funding for a wall along the Mexican border and more military power comes at the expense of medical research, environmental programs, housing, health care, and many other vital domestic programs. All these policy issues are inter-related.

9. **How can the health care system get better in the current environment?**

   Let's focus on three ways. First, there are still 19 states who have not yet expanded Medicaid, leaving 2.5 million low-income adults uninsured (to include many of those experiencing homelessness). The Council's recent issue brief demonstrates the disparity in coverage between HCHs in states that have expanded Medicaid and those who have not. A new and chaotic environment could yield opportunities to make the case for expansion now when it was not possible before. Second, more people are talking about single payer or picking back up "the public option" as a possibility. Let's not give up hope that big things are possible. Third, continue including social determinants of health and engaging Medicaid managed care and state Medicaid agencies in supportive housing and medical respite programs (and other initiatives) that benefit people who are homeless.

10. **What can I be doing to help right now?**

- **Share your personal experience with Medicaid**: If you (or a client you serve) have benefited from Medicaid (or could be benefiting if eligible), take a few minutes to send us a few sentences on your experience. These stories are valuable to our advocacy and make a difference when we share with policymakers (we do so anonymously unless you give us permission). Send to rreed@nhchc.org or submit online at https://www.nhchc.org/gotmedicaid/
- **Connect with your Congressperson:** Find your House Representative here and Senators here. Make a phone call, send an email, or invite them to tour your facility. You may keep it simple and easy. Follow this formula: "*Hi my name is ____ I am calling from ___. Please tell my Senator/Representative I am against large budget cuts to HUD and for protecting and expanding Medicaid funding in order to end homelessness. Thank you"*. The Council has resources to help and can coordinate these efforts on your behalf. Contact: rreed@nhchc.org or 443-704-1337
- **Build support for single payer (this is a great action item if your Representative is already supportive and knowledgeable of HCH**!) Call your Representative and ask them if they signed on the Single Payer/Medicaid For All bill, H.R. 676! If so, thank them; if not, ask them to sign.
- Sign up for our Mobilizer to get monthly updates and action alerts on policy items of importance to the HCH Community.
- Finally, practice self-care! It's an intense and stressful time. Take care of yourselves.

For more information, contact Regina Reed, Health Policy Organizer, at rreed@nhchc.org.