Reducing Medicaid Enrollment Barriers for Individuals Who Are Homeless

APPLICATION:

- **Provide written information that is comprehensible to applicants,** explaining Medicaid eligibility, application, enrollment, and beneficiary rights. Provide language-appropriate forms and assistance for applicants.
- **Simplify the Medicaid application form and procedures.**
- **Encourage homeless applicants to list third-party contacts** (i.e., persons with a stable address authorized to receive communications on their behalf) on Medicaid applications.

ELIGIBILITY DETERMINATION:

- **Consolidate Medicaid eligibility determination within one agency** that is responsible for oversight of application, followup, and recertification.
- **Assure that all eligibility workers understand current Medicaid policy and procedures** and do not have excessive caseloads. Educate them about how to respond sensitively to individuals with behavioral health problems.
- **Promote outreach efforts to enroll eligible applicants and keep them enrolled**. Outstation eligibility workers in more federally qualified health centers serving homeless people.

ELIGIBILITY REQUIREMENTS:

- **Implement State options to expand Medicaid eligibility to nondisabled, nonelderly adults without dependent children** and to parents of Medicaid-eligible children.
- **Establish less rigid documentation requirements**; require only documentation specified in the Federal Medicaid statute for certification and recertification.
- **Implement the State option to eliminate assets requirements** for Medicaid eligibility.
- **Discontinue personal interview requirements** for eligibility determination and verification; permit mail-in Medicaid applications, and require documentation to verify eligibility.

ENROLLMENT BARRIERS:

- **Form community-based working groups to identify and address enrollment barriers for individuals who are homeless.** Include homeless beneficiaries, their advocates, and representatives of all agencies involved in the Medicaid application and enrollment process.
- **Establish Homeless Eligibility Units** to reduce enrollment barriers for homeless applicants.

RECERTIFICATION:

- **Require recertification no more than once annually or when circumstances affecting eligibility change. Require only new information during recertification.** Retrieve existing information from State databases rather than asking recipients to provide the same documentation again.
- **Target homeless beneficiaries for special outreach during recertification periods.** Add a data field for housing status to the Medicaid application and information management system to make this possible.
- **Provide timely information on the disposition of cases to authorized service providers** (e.g., applications approved or denied, cases recertified or terminated).
- **Protect Medicaid beneficiaries' due process rights** when there is reason to suspect that they are no longer eligible— i.e., the rights to *ex parte* determination of eligibility under any other category in the State Medicaid plan, to timely notification of termination or changes in eligibility requirements, to the appeal of decisions affecting eligibility, and to continued coverage of benefits while *ex parte* determinations and appeals are pending.

Source: *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid.* National Health Care for the Homeless Council: May 2001: http://www.nhchc.org/CasualtiesofComplexity.pdf.

Protecting Homeless Medicaid Beneficiaries Under Managed Care

Even when eligible homeless people succeed in enrolling in Medicaid, they often have difficulty obtaining services provided through managed care plans. States are enrolling homeless Medicaid beneficiaries into managed care plans without the benefits of cost and utilization data, practice guidelines, or access and quality standards specifically for this population. The National Health Care for the Homeless Council recommends that State Medicaid programs take the following actions to protect unstably housed people who are enrolled in managed care plans:

1. **Identify homeless enrollees; adapt eligibility determination processes to accommodate them:**
   - **Determine housing status** at initial enrollment and on a regular basis thereafter, record housing status in State and managed care information systems, and use residential instability as a marker for increased health risk to trigger the provision of specialized health and social services.
   - **Assure receipt of enrollment and recertification information** by homeless beneficiaries that addresses their distinct needs and is conveyed in language which they can understand.
   - **Enroll homeless beneficiaries by default only in plans that include experienced homeless providers** with a working knowledge of the health problems and life circumstances of individuals who are homeless.
   - **Ensure expedited disenrollment from managed care plans** if people experiencing homelessness choose to switch to a plan offering more appropriate service or elect the option of obtaining Medicaid services from federally qualified health centers.

2. **Tailor services to the distinct needs of people experiencing homelessness:**
   - **Involve homeless beneficiaries and their advocates** in the design, implementation, and evaluation of Medicaid managed care programs.
   - **Conduct face-to-face health and social assessments** of homeless managed care enrollees shortly after enrollment.
   - **Establish linkages to integrated health and social services** through HCH projects and other providers offering comprehensive, coordinated, and culturally appropriate care.
   - **Provide an appropriate range of "wraparound" services** including outreach, transportation, case management, 24-hour acute and subacute recuperative care in a residential facility, and social and housing services.
   - **Deliver services at accessible locations** such as soup kitchens, drop-in centers, and shelters where people experiencing homelessness feel comfortable and are willing to receive care.
   - **Cover and facilitate use of out-of-network services**, if appropriate health and social services are not available to homeless beneficiaries within the managed care plan's provider network.

3. **Assure responsible oversight and financing:**
   - **Conduct targeted quality assurance and improvement activities** that focus on homeless beneficiaries.
   - **Develop fiscally responsible payment methodologies** for service provided to homeless beneficiaries, using cost and service utilization data specific to people experiencing homelessness as the basis for computing reimbursement rates.

For more information, see:

Center for Health Services Research and Policy, The George Washington University Medical Center. *Sample Purchasing Specification:s Medicaid Managed Care for Individuals Who Are Homeless*. June 2000: http://www.gwhealthpolicy.org/newsps/Home/.

Wunsch, David. *Can Managed Care Work for Homeless People: Guidance for State Medicaid Programs*. Care for the Homeless, New York, NY. September 1998: http://www.nhchc.org/guidance.html.

Reducing SSI Enrollment Barriers for Homeless Claimants

Recommendations of the National Health Care for the Homeless Council

1. **Streamline SSI-related Medicaid eligibility determination systems** and shorten the eligibility determination process.

2. **Create Homeless Claims Units or Homeless Claims Specialists in each State's Disability Determination Service**, as has been done in Massachusetts, and ensure that the DDS conducts its own outreach to homeless service providers.

3. **Ensure that homeless disability claims are routed to claims representatives who are sensitive to homeless individuals** and knowledgeable about procedures involved in processing their disability claims.

4. **Work with homeless advocates to resolve disproportionately high denial rates for homeless disability claims**. Explore barriers to obtaining consultative examinations.

5. **Educate SSA intake workers about the difficulties faced by homeless people,** including behavioral health problems.

6. **Educate safety net providers about appropriate documentation of impairments** in support of their patients' applications for disability assistance.

7. **Encourage homeless claimants to identify a third-party contact** who could be helpful in processing their claim and to provide contact information for their medical providers.

8. **Engage in outreach and SSI application assistance at emergency shelters** and other sites where homeless individuals are found.

Homeless health care providers in several States report that most SSI-Medicaid applications are initially denied. Allowance rates for initial SSI applications vary widely from State to State. Although Massachusetts allows more disability claims for homeless individuals than most other States, there are over twice as many denials as allowances (2.3 times as great for homeless claimants versus 1.5 times as great for all claimants).

Reasons for 407 Denials of Homeless SSI Claims, 9/1/98 - 5/31/99
Department of Disability Services, Boston, Massachusetts

Percentage	Reason for Denial
28%	Can do other work; condition severe but does not meet requirements
20%	Failure to keep consultative examination appointment
14%	Failure to follow prescribed substance abuse treatment
13%	Insufficient medical evidence
10%	Lacking severity
10%	Condition will not last 12 months

Source: National Health Care for the Homeless Council: *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid.* May 2001: http://www.nhchc.org/CasualtiesofComplexity.pdf

Simplified Procedures in Medicaid for CHILDREN Programs, July 2004

	Enrollment Procedures:								Renewal Procedures:	
PA8 participant	**No waiting period before enrollment**	**Joint Application Mcd-SCHIP**	**No face-to-face interview**	**No asset test**	**Self-declaration income**	**No verification residency**	**No verification age**	**Presumptive Eligibility**	**Continuous eligibility 12 mos**	**No face-to-face interview**
Alabama*	3 mos	X	SCHIP only	X	SCHIP only	X	X		X	X
Alaska	12 mos SCHIP only	no SCHIP	X	X		X	X		6 mos	X
Arkansas	6 mos Expans. pop. only	no SCHIP	X	X	X	X	X		X	X
Georgia	6 mos	X	X	X	X	X	X		6 mos	X
Hawaii	X	no SCHIP	X	X	X	X	X		X	X
Kansas	X	X	X	X		X	X		X	X
Minnesota	4 mos Expans. pop. only	no SCHIP	X	X	(X) not yet implemented	X	X		6 mos	X
Pennsylvania	X	X	X	X		X	X		X	X
U.S.	19 states	35 states	45 states	46 states	10 states	44 states	47 states	7 states	15 states	49 states

* Interview required by Medicaid program but may be conducted by telephone; piloting e-mail process.

CA,IL,MA,MO,NH,NJ,NM

Simplified Procedures in Medicaid for PARENTS Programs, July 2004

	Enrollment Procedures:					Renewal Procedures:
PA8 participant	**Family Application**	**No face-to-face Interview**	**No asset test**	**Presumptive eligibility for pregnant women**	**Continuous eligibility 12 mos**	**No face-to-face interview**
Alabama	X		X		X	X
Alaska					6 mos	X
Arkansas				X	X	X
Georgia		X		X	6 mos	X
Hawaii	X	X			X	X
Kansas	X	X	X		X	X
Minnesota	X	X			X	X
Pennsylvania	X	X	X	X (phasing out; replacing with expedited eligibility)	X	X
U.S.	25 states	36 states	21 states	29 states	38 states	42 states

Sources:
Kaiser Commission on Medicaid and the Uninsured. *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families: A 50 State Update on Eligibility, Enrollment, Renewal and Cost-Sharing Practices in Medicaid and SCHIP*. Center on Budget and Policy Priorities, October 2004: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=47039.
Kaiser Commission on Medicaid and the Uninsured. *State Health Facts on Medicaid & SCHIP*: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Medicaid+%26+SCHIP.

Income Threshold for Children & Parents Applying for Medicaid, July 2004
Percent of Federal Poverty Level

	CHILDREN			PARENTS	
PA8 participant	**age 0 – 1 year**	**age 1-5 years**	**age 6-19 years**	**Nonworking**	**Working**
Alabama	133%	133%	100%	13%	19%
Alaska	175%	175%	175%	75%	81%
Arkansas	200%	200%	200%	16%	20%
Georgia	200%	133%	100%	32%	58%
Hawaii	200%	200%	200%	100%	100%
Kansas	150%	133%	100%	31%	38%
Minnesota	280%	275%	275%	275%	275%
Pennsylvania	185%	133%	100%	200%	200%

HI has expanded coverage for parents under waivers using Medicaid and/or SCHIP funds. Enrolled families whose income exceeds 200% FPL can purchase coverage through a State program by paying a monthly premium. This program, QUEST-NET, has an income eligibility guideline of 300% FPL.

MN has expanded coverage for parents under waivers using Medicaid and/or SCHIP funds.

PA has expanded coverage for parents under waivers using State funds. Before the expansion, nonworking parents were eligible at 33% FPL; working parents were eligible at 66% FPL.

Sources:

Kaiser Commission on Medicaid and the Uninsured. *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families: A 50 State Update on Eligibility, Enrollment, Renewal and Cost-Sharing Practices in Medicaid and SCHIP*. Center on Budget and Policy Priorities, October 2004: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=47039

Kaiser Commission on Medicaid and the Uninsured. *State Health Facts on Medicaid & SCHIP*: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Medicaid+%26+SCHIP

PA8 participant	Compliant with State Medicaid outstationing requirements August 2004
Alabama	mostly
Alaska	non-compliant
Arkansas	mostly
Georgia	mostly
Hawaii	partially
Kansas	partially
Minnesota	non-compliant
Pennsylvania	non-compliant
U.S.	3 states – fully 8 states – mostly 21 states – partially 17 states – non-compliant

Fully compliant: outstationed workers in every health center and every high-volume site, paid for by the State.
Mostly compliant: outstationed workers in some health centers and some sites, paid for by the State.
Partially compliant: outstationed workers in some health centers and some sites, paid some by the State and some by the health
Noncompliant: no outstationed workers in any health centers or sites that are paid for by the State; if there are workers at centers, they are paid for entirely with health center dollars.

Source: National Association of Community Health Centers. *State Medicaid Outstationing Compliance*, August 2004: ***http://www.nachc.com/advocacy/files/outstationing.pdf.***

How States Enroll Disabled People in Medicaid

	Mandatory Programs – SSI or State-specified criteria			Optional State Programs			Medicare
PA8 participants	**"§1634 states** automatic Medicaid for SSI eligibles federal SSI criteria*	**"criteria states"** separate Medicaid application federal SSI criteria*	**"§209(b) states"** State-determined disability/Medicaid criteria (at least 1 more restrictive standard than SSI)	**SSP-only recipients**** income/resources above SSI/209(b) limits (individual)	**"medically needy"** program, spend-down Medicaid (individual)	**OBRA86** aged and disabled up to 100% FPL	**"dual eligibles"** supplemental coverage for low-income, disabled, noninstitutionalized Medicare recipients
Alabama	X 74% FPL; SSA determines Medicaid eligibility						X
Alaska		X		X 137% FPL			X
Arkansas	X 74% FPL; SSA determines Medicaid eligibility				X 15% FPL		X
Georgia	X 74% FPL; SSA determines Medicaid eligibility				X 44% FPL		X
Hawaii			X	X 75% FPL	X 51% FPL		X
Kansas		X			X 66% FPL		X
Minnesota			X	X 85% FPL	X 67% FPL		X
Pennsylvania	X 74% FPL; SSA determines Medicaid eligibility			X 78% FPL	X 59% FPL	X 100% FPL	X
U.S.	32 states + DC	7 states	11 states	23 states (2001)	35 states +DC	12 states + DC (1998)	51 states + DC

* SSI (Social Security Income) – means-tested Federal entitlement program for aged, blind, or disabled people
**SSP (State Supplementary Payments) – linked to optional Medicaid coverage for disabled persons with income/resources above SSI/209(b) standards

Sources:
SSA Policy Site: POMS Section SI 01715.010: http://policy.ssa.gov/poms.nsf/lnx/0501715010.
2004 Annual Report of the SSI Program: http://www.ssa.gov/OACT/SSIR/SSI04/ProgramDescription.html#wp2308.
Kaiser Family Foundation State Health Facts: http://www.statehealthfacts.kff.org/.
Brian K. Bruen, et al. *State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People*, 1999: www.urban.org/UploadedPDF/discussion99-09.PDF.