

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

MEDICAID AND HOMELESS INDIVIDUALS



**Richard P. Kusserow
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Department of Health and Human Services

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EXECUTIVE SUMMARY

PURPOSE

This inspection examined how Medicaid is used to serve homeless individuals with mental health, alcohol, or other drug problems.

BACKGROUND

Recent research suggests that approximately one-third of an estimated 600,000 homeless population are severely mentally ill, at least 40 percent have problems with alcohol, and an additional 10 percent abuse other drugs. In addition, it is estimated that at least one-half of the homeless mentally ill population also have alcohol or other drug problems.

The Department's response to homelessness is through both targeted and mainstream programs. The 1987 Stewart B. McKinney Act is the Federal Government's major targeted response to the homeless. Medicaid is one of the Department's largest mainstream programs that could serve the homeless. It provides reimbursement for health services, which can include mental health and substance abuse services, for the poor, including the homeless.

There is a lack of consistent, reliable data on Federal or State share Medicaid expenditures for either mental health or substance abuse services for the homeless. However, the Medicaid Director estimates that overall, Medicaid spends \$200 million (Federal/State) annually in assistance for the homeless.

SCOPE AND METHODOLOGY

Along with Medicaid, we looked at the Supplemental Security Income program (SSI) and the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant in this study. The issues examined were the availability, accessibility and appropriateness of these programs for this population. We spoke with 298 respondents in 10 States: California, Hawaii, Illinois, Ohio, Oregon, Maryland, Missouri, New Jersey, New York and Texas. They included: 224 ADMS grantees (95 mental health, 129 substance abuse), 33 McKinney-funded providers, persons from 25 Social Security district offices, and 16 State Medicaid staff.

FINDINGS

Medicaid is important because it provides access to primary care, and services in general. It also widens access to mental health or substance abuse services.

Nearly two-thirds of the ADMS grantees are Medicaid-reimbursed. Medicaid is a greater resource for the mental health grantees than the substance abuse grantees.

Providers perceive a disparity between the number of homeless individuals who are eligible for Medicaid and the number who actually receive it.

The close tie between Medicaid and SSI eligibility in most States may limit access to Medicaid for homeless individuals, particularly drug addicts and alcoholics.

Providers say that homeless individuals face numerous problems accessing Medicaid that they cannot overcome by themselves.

A majority of ADMS grantees help the homeless apply for Medicaid; mental health grantees are more likely to help than substance abuse grantees.

McKinney grantees suggested many ways in which problems in accessing Medicaid for homeless individuals can be overcome.

There is limited evidence of government initiatives which have made Medicaid more available, accessible, or appropriate for homeless individuals.

RECOMMENDATIONS

We are asking Health Care Financing Administration (HCFA) to take several actions to support the following efforts to expand access to Medicaid for homeless individuals: (1) Departmental and inter-Departmental initiatives to increase services for homeless individuals; (2) the development of similar initiatives by States; and (3) the development of special strategies by local providers. Specifically, we recommend that HCFA take these actions:

Work with the Social Security Administration (SSA) to develop a joint strategy to increase access to Medicaid for eligible homeless individuals.

Consult with the Public Health Service (PHS) and SSA to develop models to help homeless individuals apply for Medicaid. Disseminate these models widely to providers.

Provide technical assistance to States, to promote the development of State strategies and linkages designed to use Medicaid more effectively to serve this population.

Use the Interagency Council on the Homeless to provide technical assistance to other Federal agencies and McKinney providers to encourage special strategies and promote formal linkage to make Medicaid more accessible to homeless individuals.

COMMENTS

HCFA, SSA and the Assistant Secretary for Planning and Evaluation commented on this report; the full text of their comments is in Appendix C. They generally agreed with our findings and recommendations. We also received comments from PHS staff. We made several changes in response to the suggestions we received. We thank all those who commented on this report.

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INTRODUCTION

PURPOSE

This inspection examined how Medicaid is used to serve homeless individuals with mental health, alcohol, or other drug problems.

SCOPE

The number of homeless in the United States is not known. The Urban Institute estimated in 1988 that between 567,000 and 600,000 are homeless in the U.S. on any given night. In March, the U.S. Census Bureau counted 178,828 persons in emergency shelters and 49,793 persons at pre-identified street locations; however, they acknowledge that this is an undercount.

Recent research suggests that approximately one-third of an estimated 600,000 homeless population are severely mentally ill, at least 40 percent have problems with alcohol, and an additional 10 percent abuse other drugs. In addition, it is estimated that at least one-half of the homeless mentally ill population also have alcohol or other drug problems; we refer to such persons as the "dually diagnosed" in this report. This study focused on homeless individuals (as opposed to families) with these problems; the terms "the homeless" or "homeless individuals" in the report refer strictly to this population.

Federal efforts to assist the homeless are two-pronged: (1) specially targeted programs directed at the homeless population, and (2) mainstream programs that serve the homeless as a portion of their service population. The major Federal targeted response is the 1987 Stewart B. McKinney Act, funded for fiscal year (FY) 1991 at \$682.3 million. A 1990 study by the Office of Inspector General found that while McKinney programs have helped meet emergency needs, respondents did not view McKinney as the long-term solution to homelessness; rather, they advocated greater Federal and State efforts through on-going, mainstream programs.

This inspection looked at three major mainstream programs in the Department which could serve homeless individuals: Medicaid, the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant, and Supplemental Security Income (SSI). This report presents findings concerning Medicaid. Two separate reports present findings related to the ADMS block grant and SSI.

We examined the availability, accessibility and appropriateness of each of these mainstream programs for homeless individuals. "Availability" means whether a program or service exists in an agency or community and homeless individuals are eligible for it. "Accessibility" refers to the ease or difficulty homeless individuals have

in finding and utilizing available services. "Appropriateness" refers to whether available, accessible services match the homeless client's needs in a broad sense.

BACKGROUND

Medicaid is one of the Department's largest mainstream programs which could assist homeless individuals. The Health Care Financing Administration (HCFA) is responsible for Federal oversight of the program. A Federal-State jointly financed program which is administered by the States, Medicaid provides reimbursement for health services, which can include mental health and substance abuse services, for the poor, including the homeless. In 1989, 24 million people were served at a combined Federal/State outlay of \$54.5 billion; the Federal portion of Medicaid expenses nationally was 56 percent. The Medicaid Director estimates that Medicaid spends \$200 million annually (Federal/State) in assistance for the homeless.

Homeless individuals may apply for Medicaid directly with the appropriate State agency. For many, however, eligibility is primarily through SSI, where they must qualify as aged, blind, or disabled. Section 1634 of the Social Security Act allows States to contract to have the Social Security Administration (SSA) make Medicaid eligibility determinations; in such States, the SSI application also serves as the Medicaid application. Thirty-two States have adopted this process. In seven States, those eligible for SSI are also eligible for Medicaid but they must apply separately. In 12 States, both eligibility criteria and the application process are separate for each program.

States may also cover homeless individuals as "medically needy." In addition, States may have State-only programs to provide medical assistance to specified poor people, including the homeless, who do not qualify for Medicaid; matching Federal funds are not provided for such programs.

States may not impose residency requirements on individuals without permanent addresses as a condition of eligibility, and they must have a method for making Medicaid cards available for those without a permanent address.

Any person who receives Medicaid is entitled to certain federally mandated core services such as inpatient and outpatient hospital services, and physician services. States may also offer optional services to enhance their response to the homeless: prescription drugs, out-patient clinic services, targeted case management, rehabilitation services, and a home and community-based services waiver, which may be targeted specifically to the chronically mentally ill as an alternative to hospital care. They could also use a model application form now being developed by HCFA to specifically target the homeless, or develop a special "freedom of choice" waiver to target the homeless with alcohol or drug problems.

The variation across States in terms of the types of mental health and substance abuse services covered, and the extent of coverage, is considerable. However, there is one important provision that applies across the board: Medicaid does not cover in-patient services for people between the ages of 22-64 at institutions for mental disease (IMDs): facilities of 16 or more beds with over 50 percent of the residents classified as mentally ill. Since both mental illness and substance abuse are categorized as mental diseases, this IMD exclusion pertains to drug addicts and alcoholics who get Medicaid, as well as to the mentally ill.

There is a lack of consistent, reliable data on expenditures (State or Federal share) for either mental health or substance abuse services for the homeless. However, it appears that Medicaid is a meaningful source of funding in the mental health arena. In FY 1987, according to the National Association of State Mental Health Program Directors, \$749 million in Federal Medicaid dollars accounted for 8 percent of all revenues directly controlled by State mental health agencies. They also estimate that of all funds received by mental health organizations in the U.S., 25 percent are from Federal sources, including Medicaid.

Little is known about the extent of Medicaid coverage of substance abuse services in general. Neither law nor regulations specify substance abuse treatment as a reimbursable Medicaid service, although reimbursement is allowed if treatment is provided under an approved service category.

The Omnibus Budget Reconciliation Act of 1990 included a provision that "no (Medicaid) service (including counseling) shall be excluded from the definition of 'medical assistance' solely because it is provided as a treatment service for alcoholism or drug dependency." In August 1990, HCFA wrote all State Medicaid directors to generally clarify its position on substance abuse treatment.

METHODOLOGY

During pre-inspection we conducted an extensive review of literature, including program descriptions, Federal legislation and regulations, and articles, reports and research papers of all kinds. We also talked with persons at the Public Health Service (PHS), SSA, HCFA, the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors and other related associations; foundations; and experts. We spent two days with a special mobile assessment unit in Chicago.

To collect data for the study, we reviewed portions of (1) the 1989 reports and 1990 plans for the ADMS block grant, and (2) the Medicaid plans, and summaries of the plans, for the 10 States in our sample: California, Hawaii, Illinois, Ohio, Oregon, Maryland, Missouri, New Jersey, New York, Texas.

We also spoke by telephone or in person to 298 respondents in these States. There were four types of respondents:

- . The executive directors or program directors of 224 ADMS mental health and substance abuse grantees. We discussed the inspection issues related to ADMS, Medicaid and SSI with them.
- . Staff of 33 McKinney-funded Health Care for the Homeless (HCH) grantees and research demonstration grantees (mental health and substance abuse). We spoke to them about Medicaid and SSI. With their experience in serving this population, they should be particularly knowledgeable about these issues. For example, HCH grantees have a mandate to refer clients to mainstream programs for benefits such as SSI and Medicaid, or for services, such as those provided by ADMS grantees.
- . Sixteen State Medicaid staff in the 10 States in the sample. We discussed questions raised through our review of State plans regarding State eligibility criteria, services, and activities related specifically to homeless individuals.
- . Social Security staff in 25 district offices located in the same areas as the McKinney respondents. We spoke with them for their perceptions about SSI and homeless individuals, to complement the perspectives of ADMS and McKinney respondents.

A detailed description of the methodology for this study is in Appendix A.

FINDINGS

Finding #1: Providers say that Medicaid is important because it provides access to primary care, and to services in general. It also widens access to mental health or substance abuse services.

According to a quarter of the ADMS grantees and 6 of the 33 McKinney grantees, Medicaid is important because it contributes to stabilizing a person by helping meet primary health care needs. Many respondents stressed that homeless individuals greatly need such care, including dental care. A fifth of the ADMS mental health grantees, and 36 percent of the substance abuse grantees, said that their homeless clients differ from other clients in having "multiple," "chronic," or "serious" physical problems. They called Medicaid a "cornerstone" or "step towards" rehabilitation in this sense.

Slightly over two-thirds of ADMS and McKinney respondents said that Medicaid is important in a solution to homelessness because it increases access to services, or to the service system in general. A typical comment was: "It gives them access to services they would not get otherwise. The more services you access, the more people you come into contact with who know about your problem and can help you get back into the mainstream."

A majority also said that Medicaid helps increase access to mental health or substance abuse services for homeless individuals, although there was no consensus about which type of service is made more accessible. There was notable agreement that Medicaid (1) makes more services, more diverse services, or more private providers available to the homeless, and (2) enables providers to accept more patients. Every McKinney respondent mentioned one or both of these points.

Despite this view, it is interesting that respondents were much more likely to think Medicaid is important for providing access to the service system, or for financing primary health care, than for widening access to treatment. One reason could be that they consider health care the most urgent need. Another could be that they see problems in accessing treatment, even for those on Medicaid. Some of the problems they mentioned are: (1) waiting lists or lack of beds, (2) too few treatment services (mental health and substance abuse, whether Medicaid-reimbursed or not), (3) too few providers who accept Medicaid reimbursement, and (4) inadequate coverage of services they see as particularly important for this population: community-based or residential treatment, outreach, or case management. In this vein, almost half of the

ADMS mental health grantees and a quarter of the substance abuse grantees recommended expanded coverage of some sort to better serve this population.

Only a quarter or less of respondents said that Medicaid is not as important as other resources in reaching a long-term solution. McKinney grantees were the most likely to see it as a "band-aid," or much less important than housing, employment, or SSI. A typical comment was: "You need so much else."

Finding #2: Nearly two-thirds of the ADMS grantees are Medicaid-reimbursed. Medicaid is a greater resource for the mental health grantees than the substance abuse grantees.

Sixty-three percent of the 168 ADMS grantees we spoke with were receiving Medicaid reimbursement last year. More of the mental health grantees (80 percent) than the substance grantees (49 percent) were Medicaid-reimbursed. From information they provided on their annual budgets and Medicaid reimbursement, we estimate that nationally, for ADMS-funded grantees that serve the homeless, Medicaid constitutes 9.1 percent of the total budget for mental health grantees and 5.6 percent for substance abuse grantees. (Appendix A explains how this projection was derived.)

Finding #3: Providers perceive a disparity between the number of homeless individuals who are eligible for Medicaid and the number who actually receive it.

Many providers, both ADMS and McKinney grantees, could not say how many of the homeless individuals they serve are either eligible for or receive Medicaid (actually have a "green card"). They do not collect this information. We found this particularly surprising of Health Care for the Homeless grantees; one of their mandates is to help the homeless in obtaining entitlements such as Medicaid.

Only 16 percent of the ADMS respondents actually knew how many, or what proportion, of the homeless individuals they serve are on Medicaid. Almost all ADMS and McKinney respondents gave us an estimate, guess, or narrative response such as "a lot" or "a few". Furthermore, their estimates were widely divergent, with no apparent patterns by type of grantee or any other criterion.

Hence, we do not know from respondents how many homeless individuals are eligible for or actually receive Medicaid. However, we can say that a majority perceive a disparity. Of those who answered the question "How many of your homeless individual clients are eligible for but do not receive Medicaid?", three-quarters estimated that half or more fell in this category.

Finding #4: The close tie between Medicaid and SSI eligibility in most States may limit access to Medicaid for homeless individuals, particularly drug addicts and alcoholics.

In our review of State Medicaid plans, we found that homeless individuals are not subject to eligibility requirements or criteria different from those for other Medicaid applicants in these States. However, our discussions with State officials highlighted the strong relationship between eligibility for SSI and Medicaid. These officials confirmed that homeless individuals are eligible for Medicaid in their States if they are determined to be disabled based on the SSI definition of disability.

We found that five of these 10 States provide Medicaid automatically to individuals who receive SSI. The other five apply the SSI disability criteria but use more stringent income and resource eligibility criteria. In our related study on SSI and homeless individuals, a fifth of the ADMS respondents said that none of the homeless individuals they serve received SSI. Two-thirds said that less than 20 percent receive it. We therefore conclude that the tie between SSI and Medicaid may serve to reduce access to Medicaid for homeless individuals.

Furthermore, Medicaid officials acknowledged that there are added difficulties for people with an alcohol or other drug problems who try to get Medicaid. In six of the 10 States, officials told us that individuals with strictly a substance abuse problem might have more difficulty obtaining the disability determination necessary to receive Medicaid. They also noted that this group finds it especially difficult to provide the documentation needed to prove eligibility.

We did not discuss Medicaid eligibility specifically with other respondents. However, in discussing the issue of accessing Medicaid, McKinney grantees named several factors which, they believe, limit eligibility for homeless individuals in their States. These factors include: (1) criteria excluding individuals, or alcoholics or drug addicts; (2) State cuts which have tightened or restricted Medicaid eligibility for individuals, as compared with women and children; (3) the close tie between Medicaid and SSI, which they say is very difficult to get; (4) Medicaid workers who deny benefits on the mistaken assumption that such individuals can work; and (5) "easier" eligibility standards for the mentally ill than alcoholics or drug addicts who, some believe, must have a physical disability to qualify.

Finding #5: Providers say that homeless individuals face numerous problems accessing Medicaid that they cannot overcome by themselves.

A strong majority of both ADMS (72 percent) and McKinney (30 of 33) providers described problems that homeless individuals face when trying to get on Medicaid. Most of the McKinney respondents named multiple problems. The problems they mentioned are portrayed in Figure 1.

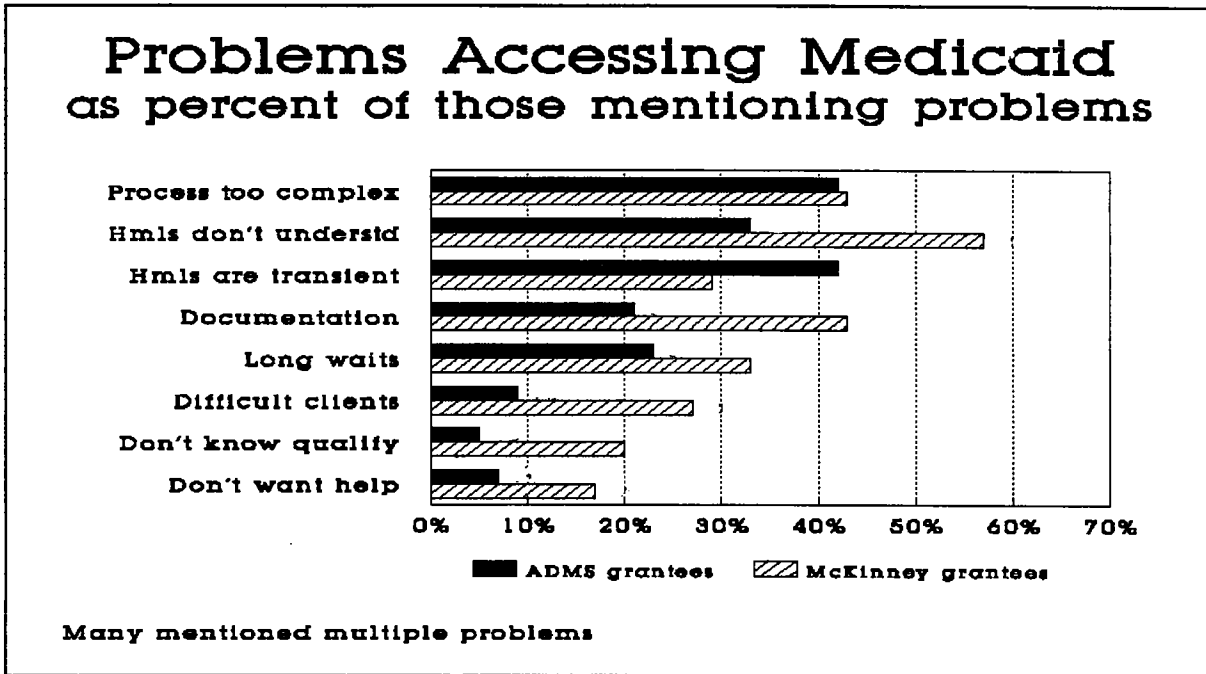


Figure 1

As the reader will note, these problems are not only numerous, but diverse and interrelated. Despite this variety, however, we find it interesting that the highest proportion of respondents in each group named two closely related problems: the complexity of the application process, and the inability of the homeless to understand the process.

A high proportion of ADMS grantees say that the transient lifestyle of many of these individuals makes it difficult to notify them of upcoming appointments, needed documentation, or decisions. Long waits for appointments or approval are also a problem, according to both ADMS and McKinney providers. They said many homeless individuals, given their instability and transient lifestyle, "disappear" during the long wait and fail to follow through.

According to a quarter of the McKinney respondents, welfare offices do not welcome homeless individuals because they are particularly difficult to deal with: look or act strange, are dirty or unkempt, don't follow through, or cannot conform to procedures or rules.

Some McKinney respondents also commented that Medicaid budget problems in their States have made welfare offices alternately tighten and loosen eligibility standards or cut staff, limiting the number of workers available to take applications. Others complained that policies and procedures vary between office, making it difficult to understand how decisions are made or appropriately advise applicants.

Few providers, ADMS or McKinney, mentioned that the homeless do not want or seek help. Those who did often qualified their remark by saying this is not because the homeless are unwilling to get help, but because they are not "tuned in enough" to recognize the value of Medicaid. Or, providers said, "health care is not the first thing on their minds" compared to food or shelter. Some said that the mentally ill, especially if not taking medication regularly, may not seek help due to paranoia or fear that providers will hospitalize them.

Finding #6: A majority of ADMS grantees help the homeless apply for Medicaid; mental health grantees are more likely to help than substance abuse grantees.

Seventy percent of the ADMS respondents said that they routinely try to help the homeless get Medicaid; another 10 percent said they sometimes help. However, as Figure 2 shows, a homeless individual is more likely to get help from a mental health grantee than a substance abuse grantee. Of the 34 ADMS respondents who said they did not help, or did not respond to the question, all but three were substance abuse grantees.

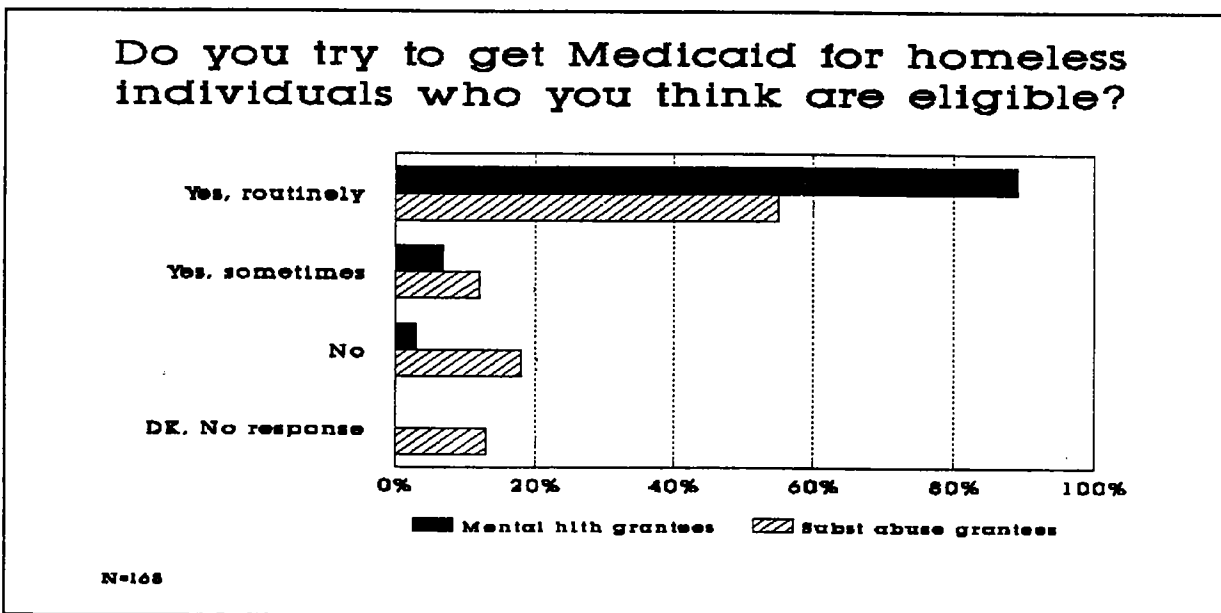


Figure 2

Mental health respondents were more likely to name several ways in which they help clients and to say that they tailor their assistance to the client, providing the greatest help to the most dysfunctional. They were also much more likely to say that helping get Medicaid for all clients is routine, especially as part of case management. In contrast, substance abuse grantees were more likely to say that they simply refer homeless clients to a welfare office to apply; of the 17 who said that they only refer, 14 were substance abuse grantees.

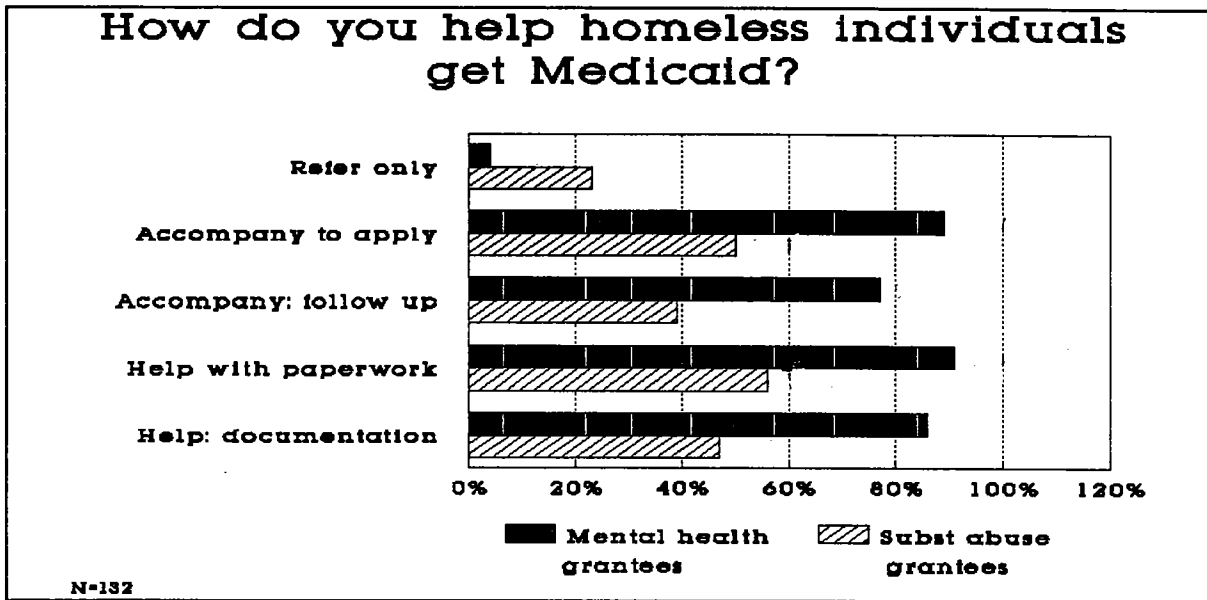


Figure 3

This same trend is apparent in Figure 3, which portrays responses to a question about how grantees help clients get Medicaid.

Although ADMS grantees said they help homeless individuals get Medicaid, McKinney grantees say that only "some" or "a few" mental health and substance abuse providers in their areas help. Their opinions reinforce our conclusion that mental health providers are the most likely to help; 15 of the 33 made comments to this effect. These comments include: (1) more mental health than substance abuse providers are reimbursed by Medicaid, thus have a financial incentive to help clients get it; (2) mental health providers often have case managers to help clients get benefits but substance abuse providers do not; (3) some substance abuse providers do not encourage clients to apply because they believe that getting public assistance (including Medicaid) runs counter to their treatment philosophy of self-help or self-sufficiency; or (4) it is easier to qualify for Medicaid on the basis of mental illness than substance abuse.

Finding #7: McKinney grantees suggested many ways in which problems accessing Medicaid for homeless individuals can be overcome.

McKinney respondents strongly advocate a number of measures to help this population get on Medicaid. These include:

- ▶ Case management to shepherd homeless individuals through what they call an "intimidating," "degrading," or "confusing" Medicaid application process. They call case management critical: "We need to advocate to push the client through because so much is riding on whether or not (the client) is eligible." They also strongly recommend stationing case managers at shelters as well as day programs that function as "one-stop shops," where they can help the homeless get Medicaid and all the other services they need.
- ▶ Outreach by Medicaid workers to the homeless in shelters and on the streets.
- ▶ Cross-training between Medicaid workers and homeless providers. This should increase the sensitivity of Medicaid workers to the special characteristics of the homeless and help homeless providers understand Medicaid eligibility and the application process.
- ▶ Simplification of the application process could be done by shortening forms or processing times, and working with homeless providers locally to develop special procedures to expedite the process.
- ▶ Out-stationing Medicaid workers at shelters or "one-stop shops," where the homeless can receive a variety of services in one place.

Finding #8: There is limited evidence of government initiatives which have made Medicaid more available, accessible, or appropriate for homeless individuals.

Few States appear to be deliberately targeting homeless individuals under Medicaid.

Discussions with State Medicaid officials revealed few formal State Medicaid efforts to specifically target homeless individuals, whether through special eligibility criteria, optional services or an expedited application process.

These respondents told us that mental health and substance abuse services are available to everyone who receives Medicaid, but they also said that there are probably fewer substance abuse than mental health services reimbursed by Medicaid. However, some emphasized that their States are now focusing more attention on expanding coverage for substance abuse services, in general.

Seven Medicaid officials reported linkage of some kind between their agency and other State agencies. However, none of them mentioned any such collaborative effort relative to the homeless. In each of these States, the link was with the State

mental health agency; only one was with the substance abuse agency. Some of these respondents said that the State Medicaid agency is under the same umbrella as the mental health agency; this, they said, facilitates coordination between the two agencies in a general sense.

Few providers said that a government initiative has led them to help homeless individuals get Medicaid.

Only 18 percent of the ADMS grantees said that a State or Federal initiative has influenced them to help homeless individuals get Medicaid. Most of them mentioned a State initiative; the highest proportion were from Missouri, where 11 of 25 grantees mentioned an initiative to expand substance abuse coverage, an emphasis on serving the homeless, or Medicaid case management for the severely mentally ill.

Few McKinney respondents spoke of any government initiative which had led them to try to help get their clients get Medicaid. Eight knew of Federal initiatives to increase SSI outreach and enrollment or widen Medicaid access for children and pregnant women. Only one mentioned a specific State homeless initiative.

RECOMMENDATIONS

This study points out that while Medicaid could be a valuable resource to homeless individuals, at the very least in terms of providing access to primary care, a number of factors limit its usefulness for this population.

One of the most significant barriers, we believe, is State eligibility criteria. In 39 States, individuals must qualify for SSI in order to get Medicaid; yet our study on SSI found many providers who believe that a small number of the homeless individuals they serve are getting SSI. Furthermore, 12 other States use even more stringent criteria. Thus we conclude that many homeless individuals may not even qualify for Medicaid, greatly limiting its availability to this population.

Another factor which limits the usefulness of Medicaid is that State coverage of mental health and substance abuse treatment, particularly the latter, is often lacking. Our respondents pointed to a number of problems which affect the availability of such services in their areas. In this light, a June 1991 report by the General Accounting Office found that Medicaid generally limits coverage for substance abuse treatment, and that multiple barriers prevent States from expanding such services under Medicaid.

We found little evidence that States are deliberately targeting this population under Medicaid, whether through special eligibility criteria or targeted services. On the local level, many providers see a need to assist homeless individuals in applying for Medicaid, given the complexity of the process and the instability of such clients. However, not all of them - especially substance providers - are providing this needed assistance.

In making recommendations to HCFA about how these problems can be addressed, we are mindful that Medicaid is in reality 50 different State programs, and that States are allowed considerable flexibility in setting forth the populations they wish to target and the methods for doing so. We know that the IMD exclusion is being examined both in Congress and by HCFA. We are also aware of concerns about expansion of the program in general. The Medicaid director recently testified against a bill proposing expanded coverage specifically for the homeless, on the basis that Medicaid is not designed to address problems of specific groups in a piecemeal manner.

For these reasons, we are not recommending that HCFA expand Medicaid eligibility or coverage for this population. Our focus, instead, is to suggest ways that HCFA can work with States and other Federal agencies to help make Medicaid more available and accessible to this population generally. We should also note that we have made recommendations to SSA about helping eligible homeless individuals get

SSI. Given the close association of these two programs, we believe that these recommendations can also increase access to Medicaid for such clients.

The thrust of our recommendations is threefold. Through them, we are asking HCFA to support: (1) Departmental and inter-Departmental initiatives to increase services for homeless individuals, (2) the development of similar initiatives by States, and (3) the development of special strategies by local providers, including welfare offices, to expand access to Medicaid for homeless individuals with mental health, alcohol, and other drug problems.

Recommendation 1: HCFA should work with the Social Security Administration (SSA) to develop a joint strategy to increase access to Medicaid for eligible homeless individuals.

Our reports on both Medicaid and SSI highlight that this homeless population needs help to overcome the many problems they face in accessing these programs. We have recommended to SSA that they work with other agencies in a variety of ways to help the homeless overcome problems related to accessing SSI. However, Medicaid and SSI are closely tied in most States. Thus we believe that a joint HCFA-SSA strategy to assist this population would have considerable impact in widening access to both programs for them.

The goal of this joint strategy should be to help local welfare offices and SSA district offices work more closely together. It could address: publicizing Medicaid to homeless individuals, joint outreach, cross-training, expediting the application process, and establishing formal linkages or coordination with local providers who serve the homeless.

Recommendation 2: HCFA should consult with the Public Health Service (PHS) and SSA to develop models for States and local providers to use to help homeless individuals apply for Medicaid, and then disseminate these models widely.

To help homeless individuals apply for Medicaid, HCFA, in cooperation with PHS and SSA, should develop models for formal linkages between local welfare offices, SSA district offices, and other providers who serve the homeless. These models should address, at the very least: (1) publicizing Medicaid, (2) outreach, (3) an expedited application process, and, (4) cross-training, whereby welfare workers and SSA district office staff learn effective ways of dealing with this population, and PHS-funded providers learn more about Medicaid eligibility guidelines, the application process, and services in their States.

The SSA should be included in developing such models given the close tie between Medicaid and SSI. As for PHS, at least four agencies should be involved: (1) the National Institute on Alcoholism and Alcohol Abuse, which administers McKinney-funded research demonstration grants; (2) the National Institute of Mental Health,

which also administers such grants as well as the Projects for Assistance in Transition from Homelessness program for the homeless mentally ill and dually diagnosed; (3) the Office for Treatment Improvement, which administers the ADMS block grant; and (4) the Health Resources and Services Administration, which administers Health Care for the Homeless.

All three agencies should disseminate these models widely through their own networks.

Recommendation 3: HCFA should provide technical assistance to States, to promote the development of State strategies and linkages designed to use Medicaid more effectively to serve this population.

We believe that States could use Medicaid more effectively to serve homeless individuals - for example, using optional services to expand community-based treatment, developing model application forms or other ways to expedite the application process, or developing a "freedom of choice waiver" targeted at them.

Also, many providers of mental health and, especially, substance abuse treatment lack a good understanding of Medicaid eligibility, coverage of treatment, and other policies that affect homeless individuals. Thus, they may not know about the model application form that HCFA is developing which could be adapted for homeless persons. Or, they may make incorrect assumptions about what Medicaid policies allow; they may erroneously assume that States are precluded from out-stationing Medicaid workers, having workers help in the initial processing of applications, or developing systems to track whether homeless people receive the Medicaid services for which they qualify.

We recommend that HCFA undertake a national effort to encourage State Medicaid agencies to provide technical assistance and training to State mental health and substance abuse agencies. The goal of this effort should be three-fold: (1) to increase their understanding of Medicaid and how it can be used to serve this population; (2) to encourage these agencies, including the Medicaid agencies, to develop strategies to use Medicaid more effectively to serve them; and (3) to encourage them to develop formal linkages for this purpose.

As part of this effort, HCFA regional offices should do everything possible to encourage the other State agencies to disseminate information about Medicaid through their networks of local treatment providers.

Recommendation 4: HCFA should use the Interagency Council on the Homeless as a vehicle to provide technical assistance to other Federal agencies and McKinney providers. Technical assistance should encourage special strategies and promote formal linkages which will make Medicaid more accessible to homeless individuals.

Many other Federal agencies receive McKinney funding to serve the homeless. The Interagency Council on the Homeless provides a forum, both on the Federal and regional level, for these agencies to discuss ways to better serve the homeless. Besides bringing Federal agencies together, the Council holds a biennial conference in each region for providers of all kinds, to promote better understanding and coordination on behalf of the homeless.

We recommend that HCFA use the various forums of the Interagency Council, to pursue the activities outlined in the recommendations above with regional staff of other Federal agencies and McKinney-funded providers. The goal should be to increase their knowledge of Medicaid and promote special strategies and formal linkages between Medicaid and other service providers, at the State and local level. The ultimate purpose of these activities is to increase access to Medicaid for eligible homeless individuals.

COMMENTS

The Assistant Secretary for Planning and Evaluation, HCFA and SSA commented on this report; the full text of their comments is in Appendix C. We also received comments from PHS staff. We made editorial changes to the text of the report in response to all of these comments and wish to thank all those who commented.

In the text of their comments, HCFA concurred with all but the second recommendation (notwithstanding their cover memorandum). They agreed with the intent of the second recommendation but raised concerns that they lacked sufficient staff to carry it out. Also, SSA suggested that we include them, along with PHS, in Recommendation 2, to more efficiently and effectively coordinate Departmental resources. In response, we revised the second recommendation to include both PHS and SSA. We also modified it to recommend consultation between the agencies as opposed to a formal Memorandum of Understanding. We believe that this will accomplish the intent of the recommendation, which remains unchanged.

We also made some revisions to the third recommendation. Although HCFA concurred with it, and described some of their current activities in this connection, we were not convinced that these activities alone constitute an adequate response to the intent of the recommendation. We revised it to reflect these activities but also describe what we believe would be a better targeted technical assistance effort. We believe that this recommendation as now written is better focused and will also not be overly burdensome to HCFA.

APPENDIX A

GENERAL COMMENTS REGARDING THE DATA

We collected both qualitative and quantitative data for this inspection. The qualitative data presented in the reports is not weighted. Quantitative ADMS data was used to make national projections (described later in this Appendix) based on weighted State averages for our sample States. For the most part, data collected from ADAMHA, States and respondents was for 12 month periods representing fiscal years 1989 or 1990.

In general, data from States and respondents regarding ADMS expenditures was very difficult to obtain as well as extremely variable. They rarely kept this data in a complete or uniform manner. Also, State fiscal years varied, as did those of respondents.

STATE SAMPLE SELECTION

We used a stratified, multi-stage methodology in choosing States, since we intended to make national projections with the quantitative data. We wanted to talk to ADMS grantees and certain McKinney-funded grantees (described later in the Appendix), who could discuss Medicaid and SSI. Thus we divided the 50 States into two categories: those with both ADMS grantees and more than one McKinney grantee, and those with ADMS grantees and one or no McKinney grantees. (As noted in the Methodology section, McKinney respondents were Health Care for the Homeless grantees or grantees of research and demonstration projects funded by ADAMHA.) We selected six States from the first category and four States from the latter. The sample States from each category were selected, with replacement, based on probability proportional to the estimated FY 1991 ADMS funding.

The table lists the sample States, estimated amount of ADMS 1991 funding, and the States' percent of total ADMS funding. The sample represents a significant portion of total ADMS funds.

<u>STATE</u>	<u>ESTIMATED ADMS FUNDS FOR FY 1991</u>	<u>PERCENT OF TOTAL ADMS FUNDS</u>
California	\$151,048,450	13%
Hawaii	6,077,746	1%
Illinois	62,484,994	5%
Maryland	23,274,979	2%
Missouri	22,789,494	2%
New Jersey	47,169,435	4%

New Jersey	47,169,435	4%
New York	103,642,170	9%
Ohio	56,646,814	5%
Oregon	12,583,566	1%
Texas	<u>73,452,804</u>	<u>6%</u>
Total	\$559,530,452	47%

Total FY 1991
Estimated
ADMS Funding \$1,187,357,962

SAMPLING METHODOLOGY FOR ADMS RESPONDENTS

We intended to sample 30 grantees from each State which would represent a proportional mix of mental health and substance abuse grantees. Respondents were program directors or managers. The number of grantees sampled in each of these two categories was determined by the proportion of FY 89 mental health ADMS funding to substance abuse funding in each State. This was the most recent year for which States had this information. We contacted the 10 States and asked for the amount of ADMS funds they received in FY 1989, and the total amount that went to mental health grantees and substance abuse grantees. In addition, we asked for a listing of the mental health grantees and substance abuse grantees and the amount of ADMS funding each received.

In most States, mental health and substance abuse grantees were then selected with probability proportional to the amount of the ADMS grant received. In instances where the grant money was given to counties, we selected six counties proportional to mental health and substance abuse funding. We then selected five grantees within each county with probability proportional to the amount of the ADMS grant received.

There were some exceptions to these two basic methodologies. In those States where the amount of ADMS grant money for 1989 was not readily available, we chose a simple random sample of grantees. In instances where a grantee subcontracted over 50 percent of its ADMS funds, we asked the grantee to identify the two subgrantees who received the largest proportion of grant funds, whom we then interviewed.

Several grantees were dropped because they were no longer receiving ADMS funds in FY 1991. Our final sample consisted of 224 grantees in 10 States. There were 95 mental health and 129 substance abuse grantees. The subsampling in each State was independent of that conducted in any other State.

This methodology enabled us to capture, in most cases, a significant portion of States' ADMS funds in our sample. The following table gives the percent of ADMS mental health and substance abuse FY 1989 funds sampled in each State.

<u>STATE</u>	<u>PERCENT OF SAMPLED ADMS MENTAL HEALTH FUNDS TO TOTAL STATE ADMS MENTAL HEALTH FUNDS</u>	<u>PERCENT OF SAMPLED ADMS SUBSTANCE ABUSE FUNDS TO TOTAL STATE ADMS SUBSTANCE ABUSE FUNDS</u>
California	24%	12%
Hawaii	82%	54%
Illinois	62%	46%
Maryland	41%	35%
Missouri	77%	39%
New Jersey	45%	22%
New York	12%	28%
Ohio	12%	44%
Oregon	68%	39%
Texas	78%	14%

We spoke with sampled respondents by telephone. Our first objective was to learn if the grantees served homeless individuals. We did not pursue further questions with the 56 grantees who said they do not serve the homeless. We discussed the availability, accessibility and appropriateness of their services and Medicaid and SSI for this homeless population, with 168 grantees who did serve them. We also asked respondents to provide basic data on their total agency budget and ADMS grant, clients served, including homeless clients, and Medicaid reimbursement.

ADMS PROJECTIONS

We made two national projections in this inspection: (1) the percent of ADMS going to grantees that told us that homeless individuals were among their served population, and (2) Medicaid funds as a percent of total budget of the grantees. The projections are based on what these ADMS respondents told us. In some cases, they could not give us numbers, or could only give estimates. The Data Verification Sheet we sent to respondents prior to calling them is in Appendix B.

The definition of "homeless" we asked respondents to use in providing this information was: "A person who is not a member of a homeless family, and who lacks stable housing (including a person whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, or a person who is a resident in transitional housing."

These projections are based upon unbiased estimates derived from the sample of grantees within each State. Estimates of the totals, and the variance associated with each total, accounting for the sub-sampling within each State, were calculated using methods described by Cochran¹. Given these totals, the percentages, as ratios, were easily derived.

The results of these estimates are presented, by State and overall, in the following tables.

Percent of ADMS Money Associated with
Grantees Serving Homeless

	<u>Mental Health Grantees</u>	<u>Substance Abuse Grantees</u>
NEW JERSEY	100.0%	64.7%
MISSOURI	92.9%	91.7%
CALIFORNIA	45.1%	77.9%
OHIO	75.7%	83.8%
ILLINOIS	66.7%	93.3%
NEW YORK	8.8%	64.0%
Strata Avg	71.5%	72.4%
TEXAS	82.4%	75.0%
MARYLAND	87.5%	100.0%
OREGON	98.9%	84.0%
HAWAII	38.5%	60.0%
Strata Avg	72.4%	74.9%
Overall Avg	71.8%	75.8%
Std. Err.	21.8%	21.8%
Precision ²	49.5%	47.8%
L 90% CI	35.9%	39.9%
U 90% CI	107.6%	111.6%

¹ Cochran, William G., (1977) Sampling Techniques. John Wiley & Sons, New York, Sec. 11.9, pg. 306.

² The precision is defined as the semi-width of the confidence interval as a percent of the estimated mean.

Because of the extreme variability in the data, the upper 90 percent confidence limit exceeds 100 percent. Logically, the upper limit should be truncated at 100 percent. The coefficient of variation for Mental Health programs is 30 percent and that for Substance Abuse programs is 29 percent.

Medicaid Funds as a Percent of Total Budget
by Type of ADMS Grantee

	<u>MH</u>	<u>SA</u>
NEW JERSEY	18.9%	0.3%
MISSOURI	8.1%	13.2%
CALIFORNIA	16.5%	6.8%
OHIO	25.8%	12.8%
ILLINOIS	7.1%	5.7%
NEW YORK	3.0%	35.3%
	13.0%	13.7%
TEXAS	1.6%	1.8%
MARYLAND	15.2%	0.3%
OREGON	28.3%	4.1%
HAWAII	0.0%	0.3%
	7.2%	1.7%
Weighted Avg	9.1%	5.6%
Std Err	1.82%	0.87%
Precision ³	33.0%	25.5%
C.V.	20.0%	15.5%
L 90% CI	6.1%	4.2%
U 90% CI	12.1%	7.0%

This data demonstrates less variability than that in the ADMS funds data. However, the coefficient of variation is below 10 percent for only one of the estimates, the percent homeless among Mental Health grantees.

³ The precision is defined as the semi-width of the confidence interval as a percent of the estimated mean.

SAMPLING METHODOLOGY FOR OTHER RESPONDENTS

McKinney Grantees

The 33 McKinney grantees in our sampled States included 25 Health Care for the Homeless grantees and 8 other providers who have received McKinney research demonstration grants from either the National Institute for Mental Health or the National Institute on Alcohol Abuse and Alcoholism. We spoke by telephone or in person with these respondents. The focus of our discussions was the availability, accessibility and appropriateness of Medicaid and SSI. We were especially interested in comparing their perspectives - as providers whose mandate is to serve the homeless - with those of ADMS grantees, who have a much broader mandate.

Social Security District Office Respondents

These 25 respondents included district managers, assistant district managers and claims and service representatives in district offices near the McKinney grantees in the sample. We discussed their experiences serving this population, their opinions about how to enhance access to SSI for them, and their views on the role of SSI in a long-term solution to homelessness.

State Medicaid Staff

For background, we reviewed portions of the Medicaid plan for each of the 10 sample States, looking at eligibility criteria and services relevant to homeless mentally ill or substance abusing individuals. We then talked by telephone with 16 Medicaid staff in the 10 States to clarify our understanding of eligibility and services, and to ask if there were any special State Medicaid policies, procedures or special initiatives which affect this population.

APPENDIX B

DATA VERIFICATION SHEET

Please have the following background information available for our telephone discussion; do not return it to us by mail. If possible, we want this data for Federal Fiscal year (FFY) 1990. However, if you maintain data on a State fiscal year (SFY) or calendar year instead, please tell us when we call.

Please provide only the information that you maintain in your existing management information system; otherwise, do not generate it specifically for us. We realize that you may not know or keep some of this information. In this case, we ask that you provide your best estimate, if you are comfortable with doing so. If not, just tell us you don't know.

For FFY, SFY or Calendar 1990 ACTUAL or ESTIMATED

1. Total agency budget:	\$ _____	_____
2. Total ADMS ¹ block grant funds received:	\$ _____	_____
3. Total McKinney funds received:	\$ _____	_____
4. Total clients served by your agency (unduplicated count; all programs or services):	_____	_____
5. Total clients served by your agency (unduplicated count) with <u>ADMS dollars</u> :	_____	_____

¹Alcohol, Drug Abuse and Mental Health Services Block Grant

**DATA VERIFICATION SHEET
PAGE TWO**

6. Total homeless individuals²
over 18 served by your agency
(unduplicated count) _____

 a. # mentally ill (no
 substance abuse problem): _____

 b. # substance abusers (not
 mentally ill): _____

 c. # dually diagnosed
 (both problems) _____

7. Total homeless individuals over
18 served by your agency
with ADMS dollars (unduplicated
count) _____

 a. # mentally ill (no
 substance abuse problem): _____

 b. # substance abusers (not
 mentally ill): _____

 c. # dually diagnosed
 (mentally ill and
 substance abusing) _____

8. Total Medicaid reimbursement
OR percent of total agency budget
that was Medicaid reimbursement _____

9. Number OR percent of total
clients served by your agency
who were on Medicaid _____

10. Number OR percent of total homeless
individuals over 18 served by
your agency who were:
 on Medicaid: _____

 on SSI: _____

²Person who is not a member of a homeless family, and who lacks stable housing (including a person whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, or a person who is a resident in transitional housing.)

APPENDIX C

AGENCY COMMENTS

**Memorandum**

Date DEC 19 1991
From Gail R. Wilensky, Ph.D. *grw*
Administrator
Subject OIG Draft Report - "Medicaid and Homeless Individuals" (OEI-05-91-00063)
To Inspector General
Office of the Secretary

We have reviewed the subject report which examined how Medicaid is used to serve homeless individuals with mental health, alcohol, or other drug problems. This report is one segment of a review of three major mainstream programs in the Department which could serve homeless individuals: Medicaid; the Alcohol, Drug Abuse, and Mental Health Services block grant (OEI 91-05-00062); and Supplemental Security Income (SSI)(OEI 05-91-00060).

This report found that access to Medicaid may be limited for many homeless individuals, especially given the close tie between eligibility for SSI and Medicaid in most States. The report contains four recommendations which ask the Health Care Financing Administration (HCFA) to support Departmental and inter-Departmental initiatives to increase services for homeless individuals, as well as the development of similar initiatives by States and local providers. HCFA agrees with two of the recommendations, but has some concerns with the other two. Our specific comments on each recommendation are attached, as well as technical comments on the report.

Thank you for the opportunity to review and comment on this draft report. We have no comments on the other two draft reports. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the OIG Draft Report -
"Medicaid and Homeless Individuals"
(OEI-05-91-00063)

Recommendation 1:

HCFA should work with the Social Security Administration (SSA) to develop a joint strategy to increase access to Medicaid for eligible homeless individuals.

Response:

We concur with this recommendation. Since the Supplemental Security Income program is closely linked to the Medicaid program, a joint strategy could be developed with SSA to increase access to Medicaid for eligible homeless individuals.

Recommendation 2:

HCFA should sign a Memorandum of Understanding with the Public Health Service (PHS) to develop models which States and local providers can use to help homeless individuals apply for Medicaid, and should disseminate these models widely.

Response:

We agree with the intent of this recommendation. Unfortunately, we do not have the staff resources that would be needed to implement the recommendation and develop the recommended models. We would, however, be able to consult with PHS regarding this activity.

Recommendation 3:

HCFA should provide technical assistance to States to support or encourage the development of strategies to use Medicaid more effectively to serve this population.

Response:

We concur with this recommendation. We already provide technical assistance to States to support the development of strategies to use Medicaid more effectively.

The following options are currently available to States and provide examples of our assistance:

- o A model Medicaid application form is being developed in response to section 6506(b) of the Omnibus Budget Reconciliation Act 1989 for use by individuals who are not receiving cash assistance under Part A of title IV of the Social Security Act (the Act) and who are not institutionalized. Use of this model application is optional. While the development of this model application does not specifically target the homeless population, a State may adopt it as part of its State Medicaid plan. The model application form should contain all the necessary criteria to make it less burdensome, and may make Medicaid more available and accessible.
- o States could develop a section 1915(b) of the Act "freedom of choice waiver." The waiver could specifically target the homeless population with chemical dependency problems and provide for a primary care case manager.
- o There is no Federal requirement which precludes States from outstationing workers at specific areas where the homeless population is high. Workers could assist in the initial processing of applications. Further, States could create a process that ensures clients are tracked after they complete the application to ensure that they receive the services for which they are eligible.
- o A significant portion of homeless are substance abusers. An ongoing function of the Medicaid Bureau, acting in accordance with the National Drug Control Strategy, is to develop materials to assist States in providing substance abuse services under the Medicaid program. In fiscal year 1992 the Medicaid Bureau plans (1) to sponsor a national conference providing training to regional office staff on Medicaid eligibility, coverage, reimbursement and Federal financial participation issues involved with substance abuse, chemical dependence, and mental health and (2) to publish a document articulating Medicaid policy on chemical dependency, target populations, and the Institutions for Mental Disease exclusion.

Recommendation 4:

HCFA should use the Interagency Council on the Homeless as a vehicle to provide technical assistance to other Federal agencies and McKinney providers. Technical

assistance should encourage special strategies and promote formal linkages which will make Medicaid more accessible to homeless individuals.

Response:

We concur with this recommendation. We recognize that access to medical care for the homeless is very important. Use of the Interagency Council on the Homeless can provide the technical assistance to make Medicaid more accessible to this population.

Technical Comments:

- o If the outreach efforts suggested in this report are successful, Medicaid enrollment and expenditures will increase. It would be helpful if the final report could address the issue of what the additional costs might be. In addition, it is not clear whether the Office of Management and Budget would require offsetting savings to ensure that spending stays within the baseline under the Budget Enforcement Act.
- o The report cites an estimate of \$200 million for current Medicaid expenditures for the homeless. The final report should clarify whether this estimate includes both Federal and State expenditures.

Refer to:

Memorandum

Date:

. NOV 26 1991

From:

Gwendolyn S. King
Commissioner of Social Security

Subject:

Office of Inspector General Draft Report, "Medicaid and Homeless Individuals" (OEI-05-91-00063)--INFORMATION

To:

Mr. Richard P. Kusserow
Inspector General

Attached is our response to the subject report. If we may be of further assistance, please let us know.

Attachment:
SSA Response

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION ON THE OFFICE OF
INSPECTOR GENERAL DRAFT REPORT, "MEDICAID AND HOMELESS INDIVIDUALS"
(OEI-05-91-00063)

We have reviewed the Office of Inspector General (OIG) draft report, and although its recommendations were addressed to the Health Care Financing Administration (HCFA), we have the following comments and observations to make.

The draft report notes on pages 2 and 7 that homeless individuals must be eligible for Supplemental Security Income (SSI) based on a determination that they are disabled in order to be derivatively eligible for Medicaid. This statement is inaccurate. Homeless individuals may be eligible for SSI, and thus Medicaid, on the basis of age or blindness as well as on the basis of disability. Furthermore, individuals may apply for Medicaid directly with the appropriate State agency, although the definition of disability for Medicaid eligibility is the same as used in the SSI program, in all but three States which use more restrictive definitions. Moreover, in many States, the same State Agency will make the determination for both the SSI and the Medicaid programs.

OIG's second recommendation calls for HCFA to sign a Memorandum of Understanding (MOU) with the Public Health Service (PHS) to (1) develop models which States and local providers can use to help homeless individuals apply for Medicaid, and (2) disseminate these models widely. We support this recommendation and believe that the Social Security Administration (SSA) should also be a partner in this collaboration. (OIG Draft Report, "Supplemental Security Income for Homeless Individuals" recommends that SSA work with PHS to institute collaborative outreach and application processing projects.)

We suggest that OIG expand the recommendation to read that "HCFA should sign a MOU with the PHS and SSA ..." for Medicaid and SSI ...". A memorandum that includes SSA as one of the signers could more efficiently and effectively coordinate the resources of all three agencies to improve homeless individuals' access to available and appropriate benefits and services.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

NOV 22 1991

Washington, D.C. 20201

TO: Richard P. Kusserow, Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports: "Supplemental Income for Homeless Individuals", "Alcohol, Drug Abuse and Mental Health Services for Homeless Individuals", and "Medicaid and Homeless Individuals"

PDIG _____

DIG-AS _____

DIG-EI _____

DIG-OI _____

AIG-MP _____

OGC/IG _____

EX SEC _____

DATE SENT 11/25

05/91-00060 / 0E1-05-91-00062

0E1-05-91-00063

This memorandum provides comments on the three subject draft inspection reports which examined the availability, accessibility and appropriateness of the Supplemental Security Income Program (SSI), the Alcohol, Drug and Mental Health Services (ADMS) block grant, and Medicaid programs for homeless individuals who have mental health, alcohol or other drug problems.

In general, the assessments found that: 1) most ADMS grantees provide some, but usually not specialized, services to homeless people; 2) the type and adequacy of those services are unclear due to the lack of data on the quantity of services or their impact; 3) access to SSI and Medicaid programs is limited although special efforts are now being made by most SSA Field offices to increase access to SSI. Another finding is that most program providers and SSA field office staff recognize that it is especially difficult for the mentally ill or substance abusing population to access SSI and Medicaid programs.

Overall, the findings in these assessments are consistent with what we are learning from other studies and program monitoring, particularly with respect to the need for improved linkage and coordination among different levels of government, between government agencies, and within local service systems. Unfortunately, the data available for these assessments did not allow for more specific findings concerning numbers served, the quality of services provided, or for descriptions of successful, generalizable models.

Nevertheless, the findings and recommendations from these three assessments will help shape a current initiative to simplify programs and make them more accessible to severely mentally ill homeless individuals. Your staff has already briefed the Federal Task Force on Homelessness and Severe Mental Illness and its outside Advisory Committee regarding these assessments. The Task Force will recommend a plan of action to the Secretary by the end of January, 1992.

I have a few additional comments listed below and editorial comments written in the attached copies of these reports.

Alcohol Drug and Mental Health Services for Homeless Individuals

- o The background section on page i should include a sentence or two in the discussion of the McKinney Act programs, on the Projects for Assistance in Transition from Homelessness (PATH) program, its purpose, and a clarification that while states award most of their PATH funds to ADMS grantees, those funds are not included by grantees that report providing services to the homeless mentally ill.
- o A statement in the background section indicates that the ADMS dollars spent for substance abuse treatment as a portion of state expenditures for this purpose is unknown. We understand that as of 1990, there is an indicator in the National Drug and Alcohol Treatment Utilization Survey that provides this information.
- o In the findings section on page 4, the third paragraph under finding #1, this statement should be reworded to clarify that the dollars referred to go to grantees that use an unknown but probably small portion of their grants to serve this population. One could interpret the current statement to mean that over 70% of their block grant funds serve this population.
- o Appendix A, pages 4 and 5 contain very low percentages for New York state ADMS funds that go to grantees serving the homeless, and the extent to which ADMS grantees in New York state seek Medicaid reimbursement for services. These estimates are so at odds with those for other states in the sample and with New York's usual participation in such programs that you may wish to re-check them.

Supplemental Security Income and Medicaid for Homeless Individuals

- o The same data issue concerning New York state described above for Appendix A of the ADMS Report applies to Appendix A of the reports on SSI and Medicaid as well.
- o On page iii of the Executive Summary, we suggest adding a recommendation to ensure that a national survey of the homeless population being planned for 1992/1993 include the proportion receiving SSI benefits.

Page 3 - Richard P. Kusserow

- o The description of the targeted federal response to homelessness on page 1 of all three reports would be more complete with the addition of the following sentence after the second sentence of the fourth paragraph: "An additional \$200 million in non-McKinney federal funds is targeted at the homeless population." Total spending in these targeted programs will rise to over \$1 Billion in FY 1992.



Martin H. Gerry