A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health, and Support Services

January 2007

Centers for Medicare & Medicaid Services

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January 2007

Prepared for:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

January 8, 2007

Dear Reader,

Medicaid is a major federal program that can play a critical role in assisting people who experience or are at risk of homelessness to access vital medical, behavioral health and support services. Medicaid services can make important contributions to meeting the immediate needs of homeless people and help them to achieve self-sufficiency.

Since 2001, the Department of Health and Human Services has been vigorously engaged in numerous activities to improve access for homeless people to major DHHS programs such as Medicaid. For example, DHHS has co-sponsored *Policy Academies on Chronic Homelessness* that have resulted in the creation of cross-cutting State Teams and Action Plans to address homelessness in the states and territories. DHHS also has provided significant follow-up technical assistance resources to assist in the implementation of these Action Plans.

A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health, and Support Services pulls together information about Medicaid that is especially relevant in assisting homeless individuals, including people who experience chronic homelessness. The *Primer* is intended to serve as a resource for state officials and homeless program managers to support your efforts to access and coordinate services and supports for homeless people.

Medicaid is a complex federal-state program. Chapter 1 will provide you with a basic grounding in Medicaid's principal features. This information will help you understand how the program operates.

Chapter 2 describes Medicaid eligibility "pathways" for low-income children, their parents, and people with disabilities. Eligibility is a complicated topic, but it is important because people need to secure Medicaid eligibility in order to access the Medicaid benefits that a state offers. Understanding the basic parameters of eligibility will help you to identify opportunities to connect the homeless people you support to Medicaid benefits. Chapter 5 contains additional information about how third-parties can assist people to secure and maintain eligibility.

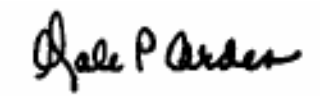
Chapter 3 describes the wide range of health and other benefits that a state may offer through its Medicaid program, including essential health and long-term services. Chapter 4 focuses in greater depth on critical Medicaid benefits such as personal assistance and mental health services that can make a real difference in the lives of chronically homeless individuals.

Each state has designed its Medicaid program differently. The *Primer* illustrates how some states have used Medicaid to support people who are homeless or at risk of homelessness. Since there are differences among state Medicaid programs, you will need to learn about the specific features of your state's program in order to connect homeless people to the Medicaid services

that are available in your state. The *Primer* will help you identify the type of information you should obtain about your state's program. For example, Medicaid can be used to purchase a wide range of behavioral health services, including services that can be linked to supportive housing programs. If you support chronically homeless people, you should find out what mental health services that your state's Medicaid program offers and how they are delivered. The *Primer* also identifies a wide-range of Web-based resources that can help you learn more about Medicaid services, including the services that your state offers.

The Centers for Medicare and Medicaid Services (CMS) is committed to working with and supporting states in their efforts to eliminate homelessness. We hope the *Primer* will aid in identifying strategies to employ Medicaid to help meet the needs of homeless people and assist them to achieve self-sufficiency.

Sincerely,



Gale P. Arden
Director

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Introduction

Each year, one percent or more of the nation's population experiences homelessness. An estimated 842,000 people are homeless in any given week. Of these, 66% are single adults and 34% are members of a homeless family (23% of homeless people are children).[1] Homelessness has many underlying causes, ranging from economic crises that dislocate individuals and families to the debilitating effects of chronic (and, frequently, co-occurring) disorders such as serious mental illness, substance abuse, and severe chronic health conditions that, when untreated, prevent people from leading stable, productive lives in the community.

Medicaid is a major federal-state program that can play an important role in assisting people who experience homelessness or are at risk of homelessness. But, the program is very complex and, therefore, often difficult to understand. One source of the program's complexity is that federal Medicaid policy never stands still. Over the years, there have been many changes that have altered both who may receive Medicaid benefits and the types of benefits that states may offer. A second major source of Medicaid's complexity is that states have considerable latitude in shaping their Medicaid programs, both with respect to who is eligible for Medicaid and the benefits that a state furnishes. As a result, there are major differences among Medicaid programs state-to-state.

> *A homeless person is "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelter) that provides temporary living accommodations, and an individual who is a resident in transitional housing."*

Effective strategies to combat and prevent homelessness entail applying a wide range of federal, state, and local public and private resources to assist people to become and remain self-sufficient. Medicaid alone cannot address all the assistance needs of people who experience homelessness. For example, not all homeless people can qualify for Medicaid benefits. Furthermore, Medicaid funds cannot be used to pay for housing or provide income support. Medicaid can and should be used in tandem with other resources as part of comprehensive strategies to address the problem of homelessness.

Due to Medicaid's complexity, state and local officials and homeless project managers frequently find it difficult to craft effective strategies that tie their efforts to support homeless individuals to Medicaid. This *Primer* is designed to provide basic, up-to-date information about how the Medicaid program works and how it can be used to assist persons who are homeless to secure vital medical, behavioral health, and support services. Throughout the *Primer*, the term "behavioral health services" means services that address mental illnesses and substance abuse disorders.

Medicaid and Assisting People Who Experience Homelessness

The Medicaid program provides federal funding to states to pay for a share of their expenditures in furnishing health and long-term services to low income individuals and families. Many people who experience homelessness or are at risk of homelessness are or could be eligible for Medicaid benefits and, thus, Medicaid can assist them to secure vital services and supports.

The substantial majority of individuals who experience homelessness usually require only short-term assistance. These individuals and families often have personal, social, and economic resources that they can draw on to help them exit homelessness. For them, Medicaid can provide access to essential health care benefits, both during and after their spell of homelessness. Access to Medicaid benefits also can reduce the risk of homelessness. Medicaid is an especially important source of health care coverage for low income families and children.

Episodically or chronically homeless persons experience frequent or protracted homelessness. A chronically homeless person is: "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or has had at least four (4) episodes of homelessness in the past three (3) years."[2] Chronically homeless persons account for about 10% (200,000 to 300,000 people) of all individuals who experience homelessness. They are especially heavy users of homeless assistance services such as shelters and account for about one-half of all individuals who are homeless on any given night. Several risk factors are associated with vulnerability to chronic homelessness, including:[3]

The majority of people who experience chronic homelessness have one or more disabling conditions.

- Disability – upwards of 85 percent of people who are chronically homeless have one or more disabling conditions.
- Untreated mental illnesses that make it difficult or impossible for individuals to maintain employment, meet their basic needs for food, shelter and safety, or maintain supportive social relationships. About 20-25% of people who experience chronic homelessness have a serious mental illness. Some 39% of all homeless people report that they had had a mental health problem in the past month.
- Substance abuse that can drain financial resources, destroy supportive social relationships, and make exiting from homelessness difficult. Some 38% of people who experience homelessness report alcohol use problems and 26% drug use problems.
- Co-occurring mental illnesses and addictive disorders that are especially challenging to treat. It is estimated that about 50% of chronically homeless individuals have these co-occurring disorders.
- Aging out of youth service systems such as foster care. These youth are very vulnerable to homelessness.[4]
- Serious acute and chronic medical conditions such as HIV/AIDS that are very debilitating and costly to treat.
- Severe physical and other neurological disabilities that impede a person's ability to function day-by-day, secure and maintain employment, and can trap them in poverty.

Absent stable housing and effective support, many chronically homeless individuals are caught in a recurrent cycle of costly institutionalization in psychiatric hospitals and facilities, jails and prisons, and living on the streets and in homeless shelters.

Assisting people who experience chronic homelessness to lead stable lives in the community can be challenging due to the complexity of their underlying conditions and disorders. These individuals frequently need several types of supports over an extended period in order to exit homelessness and become more self-sufficient. There is a large body of evidence that effective strategies can help these individuals become productive members of their communities. For example, supportive housing

combines housing assistance with mental health services and other supports (e.g., employment services) to promote the recovery of people with serious mental illnesses. People served through supportive housing experience less incarceration, rely less on emergency rooms and have less frequent high cost psychiatric hospitalization stays, and enjoy positive employment outcomes.[5] Supportive housing is the cornerstone for permanently reducing the number of chronically homeless people.

The Medicaid program can be used to purchase services that address the serious physical health conditions, debilitating illnesses, addictive disorders, and/or mental disorders such as serious mental illnesses that are the root causes of chronic homelessness. Such services include not only behavioral health treatment but also supports such as personal assistance and case management services to facilitate access to health and other supportive services. Medicaid, for example, can be used to pay for some components of supportive housing services for Medicaid beneficiaries with disabilities.

The Federal Response to Homelessness

In 2003, the President announced the goal of eliminating chronic homelessness in the United States by 2012. An outgrowth of the President's initiative has been substantially increased federal financial support for programs that target individuals who experience chronic homelessness. The President's initiative has spurred the creation of State Interagency Councils on Homelessness in 53 states and territories. Over 200 cities and counties and several states have crafted innovative and wide-ranging 10-Year Plans to End Chronic Homelessness. These plans are concentrating on securing permanent reductions in homelessness rather than relying on stop-gap temporary shelter and housing arrangements.

The President has set the goal of eliminating chronic homelessness by 2012.

The Department of Health and Human Services (DHHS) is one of twenty federal agencies that are collaborating to prevent, reduce and eliminate homelessness. DHHS is a member of the U.S. Interagency Council on Homelessness that coordinates the federal response to homelessness and provides leadership in creating a national partnership at every level of government and every element of the private sector to reduce and end homelessness. Major HHS organizations and programs that are charged with responding to homelessness include the Centers for Medicare & Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Administration for Children and Families (ACF), and the Assistance Secretary for Planning and Evaluation (ASPE).

DHHS administers several programs that specifically target people who experience homelessness (e.g., the Health Care for the Homeless program administered by HRSA) along with several other broader programs (such as Medicaid, which is administered by CMS) that serve low-income individuals and families and, thereby, can provide essential assistance to persons who are at risk of or experience homelessness. A central DHHS focus is increasing access to broad-based programs such as Medicaid by persons who experience or are at risk of homelessness.[6] This *Primer* is an example of DHHS efforts along these lines.

Since 2001, DHHS has teamed with other federal agencies to sponsor a series of Homeless Policy Academies designed to improve access to broad-based federal

programs that can provide critical assistance to chronically homeless individuals and families experiencing homelessness. The Policy Academies have brought together state-level program administrators and homeless service providers to develop state-specific action plans designed to increase access to key resources. Many of the action plans have identified steps to link Medicaid services and other critical funding streams (e.g., federal and state housing assistance programs) with state strategies to permanently reduce homelessness. The Academies have helped states partner in multiple ways to create, expand or improve necessary homeless services and systems of care. Follow-up technical assistance has been furnished to assist in the implementation of these action plans.

Organization of the Primer

The *Primer* has the following major chapters:

Medicaid's Basic Features. This chapter provides an overview of the structure and essential features of the Medicaid program. Medicaid is a complex federal-state program. This chapter provides basic information about how the program operates and, thereby, provides a foundation for readers who are not familiar with Medicaid.

Medicaid Eligibility. This chapter focuses on Medicaid eligibility. The essential features of Medicaid eligibility dictate who may access Medicaid benefits. There are multiple eligibility pathways to secure Medicaid benefits for children, their parents, and people with disabilities.

Medicaid Benefits and Service Delivery. This chapter describes the mandatory benefits that each state must provide through its Medicaid program along with the optional benefits that a state may offer. It also discusses federal requirements and certain dimensions of coverage. The chapter also outlines the structure of Medicaid service delivery and the use of alternative service delivery arrangements such as managed care.

Critical Medicaid Benefits for Chronically Homeless People. There are certain Medicaid benefits that are especially critical in assisting individuals who experience chronic, recurrent homelessness. These benefits (e.g., behavioral health services) are discussed in greater depth in this chapter.

Connecting Persons Who are Homeless to Medicaid Benefits. This chapter discusses strategies to assist persons who are homeless to access Medicaid benefits.

The Primer is not intended to answer every question about Medicaid but instead to provide a solid grounding in the program and how it links to supporting individuals who experience or are at risk of homelessness. Each chapter has a resources section about how to obtain additional information concerning the topics that are addressed in the chapter, either in the form of publications and/or web-based resources.

Resources

Web Accessible Resources[7]

United States Department of Health and Human Services
Web-address: http://aspe.hhs.gov/homeless/index.shtml

This website has information about DHHS programs and services that target people who experience homelessness as well as information about supporting people through DHHS programs.

United States Department of Housing & Urban Development
Web-address: http://aspe.hhs.gov/homeless/index.shtml

This website has information about HUD Homeless Assistance programs, including the McKinney-Vento Homeless Assistance Act. There are also links to other federal and non-federal websites that provide wide-ranging information on strategies to combat homelessness.

Homeless Policy Academies
Web-address: http://www.hrsa.gov/homeless/index.htm

This website contains extensive information about the Homeless Policy Academies, including materials that have been presented at each Academy since 2001 and state/territory action plans.

United States Interagency Council on Homelessness
Web-address: http://www.ich.gov/

The Council's website contains extensive information about its activities as well as state and local initiatives to end chronic homelessness. The Council publishes a weekly e-mail newsletter that contains up-to-date information about federal, state and local efforts to reduce homelessness. Subscribe to this newsletter at: http://www.ich.gov/subscribe_newsletter.html. In addition, the website serves as a portal to member federal agency web pages that contain information about their programs and services that target homelessness.

Notes

[1] National Research and Training Center on Homelessness and Mental Illness. Fact Sheets available at: http://www.nrchmi.samhsa.gov/default.asp. A homeless family is defined as one or two adults accompanied by at least one minor child who are either not housed or who have had recent periods during which they lacked housing. For more information about the characteristics of people who experience homelessness, see: Martha R. Burt et al. (1999) ***Homelessness: Programs and People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients – Technical Report. Interagency Council on Homelessness.*** Available at: http://www.huduser.org/publications/homeless/homeless_tech.html.

[2] United States Department of Health and Human Services (2003). ***Ending Chronic Homelessness: Strategies for Action.*** *Available at: http://aspe.hhs.gov/hsp/homelessness/strategies03/index.htm.*

[3] NRTC, op. cit.

[4] See *National Alliance to End Homelessness: Fundamental Issues to Prevent and End Youth Homelessness*, available at: http://endhomelessness.org/content/article/detail/1058.

[5] For example, in San Francisco, supportive housing resulted in a 44% reduction in number of days persons were incarcerated and a 37% reduction in the number of days of inpatient hospitalization. See The Corporation for Supportive Housing (2004). ***The Benefits of Supportive Housing: Changes in Residents' Use of Public Services***, available at: http://documents.csh.org/documents/ke/HHISN02-04.doc. See also: Culhane, Dennis P., Stephen Metraux, and Trevor Hadley. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate* Vol. 13, No. 1 pp. 107-163. Available at: http://www.fanniemaefoundation.org/programs/hpd/pdf/hpd_1301_culhane.pdf..

[6] DHHS, *op. cit.*

[7] Non-federal web-accessible resources include:

Corporation for Supportive Housing
Web-address: http://www.csh.org/. CSH is widely-recognized for its longstanding and effective efforts to promote supportive housing. The web-site contains extensive information concerning supportive housing and other strategies to reduce homelessness.

National Alliance to End Homelessness
Web-address: http://endhomelessness.org/. The National Alliance to End Homelessness is a nonprofit organization whose mission is to mobilize the nonprofit, public and private sectors of society in an alliance to end homelessness. Its web site contains extensive information about best practices in ending homelessness.

National Coalition for the Homeless
Web-address: http://www.nationalhomeless.org/. The Coalition is a national advocacy network of homeless persons, activists, service providers and others committed to ending homelessness through public education, policy advocacy, grassroots organizing and technical assistance.

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Chapter 1:

Medicaid's Basic Features[1]

The Medicaid program provides over 40 million low-income children and adults with access to essential health care and purchases more than one-half of all long-term services and supports for older persons and people with disabilities. Medicaid is complex, both from the standpoint of the federal policies that frame the program and how each state has designed its Medicaid program within this framework.

This chapter provides *basic* background information about the "nuts and bolts" of Medicaid, including its history, the nature of the program's federal-state relationship, eligibility, benefits, and other topics. This chapter is intended to serve only as an overview of Medicaid for persons who are not familiar with its basic structure. It also identifies additional resources that contain more in-depth information concerning Medicaid.

A Brief History of Medicaid

The Medicaid program (Title XIX of the Social Security Act) was created in 1965 in tandem with the Medicare program (Title XVIII).[2] The Medicare program is an entirely federally-funded and administered health insurance program for retirees, disabled workers, their spouses, and dependents. In contrast, Medicaid is a *joint* federal-state program through which the states, the District of Columbia, and the territories receive federal funds (called financial participation (FFP)) for their costs of furnishing health and long-term services to federally recognized groups of low-income families and individuals.

Medicaid and Medicare were launched in response to the problem of "medical indigence," especially among older persons (which led to the enactment of Medicare) and other low-income individuals who lacked health insurance. In the early 1960s, there were wide disparities among the states in the extent to which they provided health care services to low-income individuals and families.

Medicaid was designed to expand access of low-income individuals and families to "mainstream" health care benefits. States that elected to operate Medicaid programs were required to furnish a core set of basic mandatory health services to public assistance recipients. They also could elect to offer additional optional services and serve "medically needy" individuals who did not receive public assistance cash payments. Provision was made for shared financing of state Medicaid costs, with the federal government making open-ended payments to states to pay for one-half or more of their expenditures in furnishing services to beneficiaries. States were given considerable latitude in fashioning their medical assistance programs.

Changes in federal law over the past 40 years have significantly expanded the scope of the Medicaid program.

The past four decades have seen many changes in federal Medicaid law, including significant modifications to Medicaid eligibility, benefits, payment arrangements, and other program elements. Some of the major changes are summarized on the following page. The cumulative effect of these incremental changes – combined with state decisions regarding their Medicaid programs – has been to expand Medicaid well beyond its original focus on providing basic health services to public assistance recipients. Medicaid has served as an important tool for states to increase access to health care services for uninsured and underinsured individuals. Medicaid also has become the dominant payer of long-term services and supports for people with disabilities.

Major Changes in Federal Medicaid Law

1965-1980

- In 1967, states were required to establish Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs to ensure that children received essential health care services. [3]
- In 1972, the Supplemental Security Income (SSI) program was created. This federally-funded income assistance program for people with disabilities and older persons replaced preceding federal-state "aged, blind and disabled" cash assistance programs. Medicaid eligibility was linked to SSI eligibility, ensuring that SSI beneficiaries would have access to essential health care services.[4]

1980s

- Throughout the 1980s, Congress expanded both mandatory and optional Medicaid eligibility groups, especially in order to extend Medicaid benefits to low-income pregnant women and children who do not receive public assistance payments.[5]
- In 1981, two important waiver authorities were added.[6] §1915(b) of the Social Security Act gave states more latitude to implement managed care service delivery arrangements and other care management models. The addition of §1915(c) allowed states to launch home and community-based services (HCBS) waiver programs to provide a wide range of community services to assist individuals with disabilities and older persons to avoid institutionalization.
- In 1987, "nursing home reform" provisions were enacted to bolster protections for nursing facility residents, including requirements for improved pre-admission screening and treatment of individuals with mental illnesses and developmental disabilities. [7]
- In 1989, Congress revised and strengthened the EPSDT program by mandating that states furnish all medically necessary services to eligible children.[8]

1990s

- The Personal Responsibility and Work Opportunities Act (PRWOA) of 1996[9] (otherwise known as "welfare reform") severed the historical link between Medicaid eligibility and the Aid to Families with Dependent Children (AFDC) cash assistance program. The AFDC program was replaced by the Temporary Assistance to Needy Families (TANF) block grant program. A new mandatory Medicaid eligibility group was established for low-income households for whom enrollment in Medicaid was no longer automatically tied to receipt of public assistance cash payments.[10]
- In 1997, the State Children's Health Insurance Program (SCHIP) was created to give states additional funding to extend Medicaid services to children in low-income households or provide such children with an alternative benefit package.[11]
- Also in 1997 and 1999, Congress permitted states to provide Medicaid benefits to workers with disabilities who are no longer eligible for SSI (these provisions are discussed in more detail in Chapter 2).[12]
- In 1997, Congress gave states new options to implement managed care arrangements without securing special waivers. [13]

Post-2000

- Through the President's New Freedom Initiative, federal policies are being clarified to encourage states to promote community living for people with disabilities of all ages, including the expanded use of "consumer-directed" approaches in long-term services and supports. Since 2001, Congress has earmarked more than $250 million in grant dollars to assist states to improve long-term services delivery.
- In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act.[14] This measure initiated Medicare coverage of prescribed drugs (in 2006) and also switched the coverage of prescription drugs for Medicare-Medicaid dual eligibles to Medicare.
- Most recently, the Deficit Reduction Act of 2005[15] made numerous changes in Medicaid law. These changes included new options for states to offer home and community services, enable beneficiaries to direct personal assistance and other services, impose higher co-payments, expand Medicaid eligibility for children with disabilities, and implement "benchmark benefit plans" as alternatives to traditional Medicaid service coverages as well as other changes. This measure also established new requirements for verifying the citizenship of Medicaid applicants and beneficiaries.

Medicaid has evolved to become a linchpin in the nation's health care system. About one out of every seven of our nation's citizens obtains health care through Medicaid.[16] In 2005, state-federal Medicaid expenditures totaled $300.3 billion, an increase of about 87 percent since 1997.[17] Medicaid ranks second only to Medicare in federal health care outlays; it also is the single largest source of federal financial aid to states. At the state level, only spending for elementary and secondary education exceeds state tax dollar expenditures for Medicaid.

There are 51 highly distinct Medicaid programs that operate under common national guidelines but have been uniquely shaped by state decisions about who is eligible and the services that each state's residents may receive.

Over the years, federal Medicaid law has been modified many times. Federal mandates have increased, especially in the arena of services for low-income children. However, most changes have had the effect of making more options available to states in designing and administering their programs. States continue to have considerable flexibility in shaping their Medicaid programs, a principle inherent in Medicaid from its beginning. Despite the myriad changes, the fundamental nature of the program's federal-state relationship has not changed appreciably. As a consequence, 51 highly distinct Medicaid programs have emerged that operate under broad, common national guidelines but have been uniquely shaped by state decisions about who is eligible and the services that a state's residents may receive. State-by-state variations in the scope of Medicaid programs is one reason why Medicaid is especially complex.

Basic Features

Medicaid has several fundamental features. These features are briefly described here in the context of the "basic" Medicaid program. Some of these features may be altered by waivers of federal Medicaid law that states may obtain. The final section briefly describes the three waiver authorities that are contained in federal law and their effect on the features described here.

Program Structure

Federal-State Relationship

Medicaid was originally formulated as and remains a *cooperative* federal-state venture through which the federal government financially assists states to provide medical assistance, rehabilitative and other services to eligible low-income individuals and families. Within the broad national guidelines contained in federal law, regulations and other policies, states obtain federal financial participation in their costs of furnishing services to Medicaid beneficiaries. This federal-state relationship is a cornerstone of Medicaid. Federal policy dictates that states operate their programs in compliance with fundamental federal policies (including providing core mandatory services to mandatory eligibility groups) but leaves it to the states to determine the overall scope and extent of their programs.

Each state's Medicaid program is unique and operates differently. Each state bases the design of its Medicaid program on the state's demographics, health policy goals, objectives, needs, and financial capabilities. States are responsible for: (1) establishing eligibility standards within federal parameters; (2) selecting the services that they will offer and specifying the amount, duration, and scope of services; (3) designing the delivery of services; (4) determining payments for Medicaid services; and, (5) administering the program.

Medicaid State Plan

Each state must detail its program in its Medicaid State plan.[18] The State plan specifies the eligibility groups that the state serves, the benefits provided, and other dimensions of how the state operates its program. It also provides the basis for a state's claim for FFP in the costs of the services that a state provides and the expenses that a state incurs in operating its program. Each state's plan (and subsequent amendments to the plan) must be reviewed and approved by the federal government.

Single State Medicaid Agency

Federal law requires that each state designates a *Single State Medicaid Agency* (SSMA) that is responsible and accountable for the implementation of the State plan and the administration of the Medicaid program. The SSMA may not delegate its responsibilities to another state agency, although it may enter into cooperative agreements with other agencies to administer certain aspects of the program under the supervision of the SSMA.

Federal Administrative Structure

At the federal level, Medicaid (along with Medicare) is administered by the Centers for Medicare & Medicaid Services (CMS; formerly, HCFA – the Health Care Financing Administration) at the U.S. Department of Health and Human Services. Within CMS, the Center for Medicaid and State Operations (CMSO) has lead responsibility for Medicaid. CMSO has several divisions and offices that are responsible for various aspects of the program. In addition, there are ten CMS Regional Offices located around the country that are responsible for reviewing and approving most proposed changes in each state's Medicaid program and assuring that each state's program operates in compliance with the approved state plan, applicable federal regulations, and other CMS program guidance. [19]

Federal Laws, Regulations, and Guidance

Federal law governing the Medicaid program is found in Title XIX of the Social Security Act.[20] Federal regulations concerning the program are located in Parts 430 *et seq*. of Title 42 of the Code of Federal Regulations (CFR).[21] Additional federal guidance is contained in the State Medicaid Manual as well as letters, memoranda and technical assistance guides that are issued by CMS from time-to-time.[22]

Federal Payments to States

The federal government financially participates in the costs that states incur in furnishing Medicaid services to eligible individuals. Medicaid is more aptly described as a reimbursement program rather than a grant program. Federal payments are made for a fixed percentage share of the total costs that a state incurs in operating its Medicaid program. The amount of federal payments depends on how much a state expends for the covered services that it furnishes to eligible Medicaid beneficiaries and the costs that the state incurs in administering its Medicaid program. States manage their expenditures for Medicaid services through the selection of covered benefits, eligibility parameters, the determination of payment rates, and other methods.

The amount of FFP that a state receives from the federal government for Medicaid services is determined by the state's Federal Medical Assistance Percentage (FMAP) rate. This percentage is applied to state expenditures for services that are furnished to eligible individuals. A state's FMAP rate is calculated each year by comparing the state's average per capita income level in relationship to the national average. The higher a state's per capita income relative to the national average, the lower its FMAP

rate. However, the minimum FMAP rate is 50 percent and the maximum is 83 percent.[23] The average FMAP rate across all states is about 57 percent, meaning that for every dollar spent on Medicaid services, the state spends 43 cents from its own funds and the federal government provides 57 cents in FFP. There are a few services for which the federal payment rate is higher than the FMAP rate. For example, the uniform rate for services furnished by Tribal Governments to native Americans is 100%.

States must provide matching dollars (called the non-federal share) from their own public funds or a combination of their own funds and local tax dollars in order to draw down FFP. In some states (e.g., New York and Minnesota), counties are required to provide a portion of the state's matching fund obligation for some services.

Under federal law, Medicaid is characterized as a "payor of last resort." In general, states are required whenever possible to avoid paying for services for which another party is legally liable. If, for example, a beneficiary also has employer health insurance that source must pay for the service instead of Medicaid. States are required to recover "third-party" payments from other payers whenever it is cost effective to do so.

States can also claim matching federal dollars for their costs in administrating the Medicaid program. Functions that are eligible for such funding include day-to-day program administration (e.g., eligibility determination) and the costs of processing and paying claims submitted by providers for services furnished to beneficiaries. The base uniform rate of FFP in state Medicaid administrative costs is 50 percent. However, higher administrative claiming rates apply to certain activities, including the development and operation of automated Medicaid claims processing systems. In 2004, Medicaid administrative costs were 4.9% of total program outlays

Eligibility, Beneficiary Protections and Cost Sharing

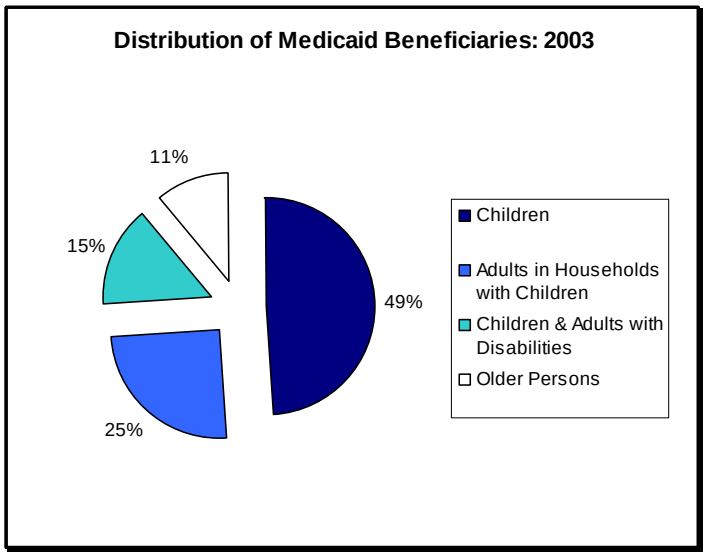
Eligibility Groups

Since eligibility is a complex topic in its own right and has major implications for the role that Medicaid can play in assisting people who experience or are at risk of homelessness, it is addressed in more detail in Chapters 2 and 5. For present purposes, there are certain features of federal policy that are especially important.

First, under federal law, any state that operates a Medicaid program must provide services to certain mandatory groups of individuals. Some of these mandatory groups include children who are members of especially low-income households and people with disabilities who receive federal SSI benefits. States may extend eligibility to other optional groups and the "medically needy."

Another important feature to keep in mind is that an individual only qualifies for Medicaid when determined to be a member of a federally-recognized *eligibility group* that a state includes in its State plan and by meeting the income and resource tests associated with the group, as specified by the state. Thus, simply being a low-income person does not automatically translate into eligibility for Medicaid. For example, low-income childless adults without disabilities cannot qualify for Medicaid unless the state operates a waiver program that covers this population. In June 2005, there were 45.4 million Medicaid beneficiaries, up from 33.7 million enrollees in June 2000.[24]

Finally, it also is important to point out that, once a state decides to include an eligibility group in its State plan, the state must enroll all persons in the group who apply for Medicaid. A state may not limit the total number of enrollees. This Medicaid feature means that qualified individuals have an entitlement to Medicaid.



Federal Medicaid law identifies 50 or more distinct eligibility groups to which states may offer Medicaid services. These groups are defined by income and resource tests and, in some cases, by disability or other tests. Broadly speaking, the Medicaid beneficiary population encompasses four main groups of enrollees: children, adults in households with eligible children, people with disabilities (children and adults (up to age 64) who meet Social Security disability tests), and older persons (adults age 65 and older). As the chart shows,[25] children comprised about one-half of all Medicaid beneficiaries in 2003, with older adults and people with disabilities together making up about 26 percent of beneficiaries.[26]

Each of these groups accounts for a different proportion of Medicaid expenditures. For example, people with disabilities accounted for 42% of Medicaid expenditures in 2003 even though they represented only 15% of total enrollees. The reason for this is that people with disabilities have relatively high health care and long-term services costs. In contrast, children accounted for about 18% of Medicaid spending.[27]

Beneficiary Protections

Federal Medicaid law provides certain basic protections for all beneficiaries. Specifically, each state must make the Medicaid Fair Hearing appeal process available to any individual who has been denied eligibility, who has been denied a service, whose services would be reduced or terminated, or who faces loss of eligibility. The state must notify beneficiaries in advance before an "adverse action" affecting their Medicaid coverage takes effect and include an explanation of their rights regarding the Fair Hearing process, including the right to an evidentiary hearing conducted by an impartial, uninvolved official (e.g., an administrative law judge). As long as an individual requests a hearing on a timely basis, services must be continued through the duration of the hearing process. In pursuing an appeal, a beneficiary has the right to enlist other individuals (e.g., peers, friends, families, advocates, attorneys) of the person's own choosing to assist in pursuing the appeal.

Beneficiary Cost Sharing

Depending on how they are eligible for Medicaid and the particular state in which they live, categorically eligible Medicaid beneficiaries may be required to pay deductibles, coinsurance, or co-payments for Medicaid services or be required to pay a premium. States have some discretion to decide who will pay for services and how much they must pay within federal limits. However, some groups are exempt from cost sharing requirements. These include pregnant women and children under 18 at or below 100 percent of the Federal Poverty Level (FPL).

The Deficit Reduction Act of 2005 substantially modified federal policies concerning beneficiary cost sharing and premiums. States are permitted to impose higher co-payments than in the past, disenroll beneficiaries who do not pay mandatory

premiums, and allow providers to refuse to provide a service when the beneficiary does not make a co-payment. The maximum amount of a co-payment is limited and the cumulative amount of individual or family liability also is capped. It is left up to states to decide whether to charge co-payments or premiums within the limitations of federal law.[28] States may not impose cost sharing for emergency services.

Nursing facility residents must contribute to the cost of their institutional care when their income exceeds the amount of a personal needs allowance. Medically needy beneficiaries must incur health expenses in order to qualify for Medicaid. Workers with disabilities who qualify under a "buy-in" option also may be required to pay premiums in exchange for Medicaid benefits when their income exceeds certain levels. Individuals and families who receive Medicaid services through a waiver but would not otherwise qualify for Medicaid may be required to make premium payments.

Medicaid Benefits (Coverage) and Payments

Coverage

Clearly, the role that Medicaid may play in assisting individuals who experience homelessness revolves around the types of services and supports that can be furnished to Medicaid beneficiaries. Chapters 3 and 4 of the *Primer* delve into this topic in greater detail.

States may cover a wide range of health and long-term services in their Medicaid programs.

A state may offer the full range of health care services through its Medicaid program. As will be discussed in greater detail in Chapter 4, states also may offer behavioral health benefits that are especially important to assisting people who experience chronic homelessness. Medicaid is distinguished from other forms of health insurance (including Medicare) by its inclusion of both institutional and home and community long-term services and supports.

With respect to benefits, federal law provides for mandatory and state-selectable optional service coverages. Under federal law, every state must offer fourteen basic mandatory services (identified in Chapter 3) to all categorically needy eligibility groups. Over and above these mandatory services, a state may cover other *optional* services. States have considerable latitude in defining the specific services and benefits that they offer within an optional coverage category. For example, states that employ the rehabilitative services option to support individuals with serious mental illnesses in the community include different mixes of services under their coverages. The statutory distinction between mandatory and optional services is long-standing. However, it is worth noting that about two-thirds of Medicaid spending nationwide goes toward the purchase of optional services. Some optional services (e.g., prescribed drugs) are offered by every state because they are integral to meeting beneficiaries' basic health care needs.

Regardless of whether a service is mandatory or optional, it must be provided on a *comparable* basis to all categorical eligibility groups unless an exception is provided in federal law. This means that a state may not offer a service to one eligibility group but not to others. Exceptions to the comparability requirement are permitted under the waiver authorities and in certain other limited circumstances.

In the case of medically needy individuals, federal requirements regarding benefits are less prescriptive than for the categorically needy. Just as states are required to cover certain populations to get federal matching payments for services provided under the medically needy eligibility option, they also must cover certain benefits such as prenatal and delivery care for pregnant women and ambulatory care for children.

However, they are not required to provide all mandatory and optional benefits to medically needy individuals at the same level as for categorically eligible individuals.

While Medicaid and Medicare are distinct programs, they intersect in their coverage of certain benefits for individuals who qualify for both programs (termed dual eligibles). Chapter 3 discusses the interplay between Medicaid and Medicare coverages.

Payments for Services

Except in the case of capitated managed care arrangements, Medicaid generally operates in a "fee-for-service" framework. Providers are paid for each distinct service they furnish to a specific Medicaid beneficiary. Payments usually are "unit" based – e.g., a provider is paid for a "visit," an hour or partial hour of service or, in the case of institutional services, a "day." Medicaid payments are made after the provider submits a "claim" that specifies the service rendered, the date of service and the beneficiary to whom the service was provided. In the fee-for-service framework, advance payments for services may not be made. Provider claims for payment for the services are processed through claims processing systems (termed the Medicaid Management Information System – MMIS). These systems verify the beneficiary's eligibility and check other elements of the claim. With some exceptions, federal Medicaid law requires that payments must be made directly by the state to the provider. In short, Medicaid does not operate as a "grant" program but instead is structured to pay for discrete covered services furnished to eligible beneficiaries.

States have latitude in how they establish payment amounts for services and units of reimbursement. Federal law (§1902(a)(30) of the Social Security Act) directs states to assure that "payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available under the plan." In general, providers cannot charge Medicaid more than they charge other payers for the same service. Providers may not charge beneficiaries an additional amount over and above the amount that they receive from Medicaid (except for the cost-sharing amounts that states may impose under the provisions of §1916 of the Act) because Medicaid payment is considered "payment in full" for any service rendered.

Under a managed care arrangement, a state may make capitated pre-payments to managed care organizations to furnish the full range of contracted services to enrolled beneficiaries. The amount of such payments must be based on data concerning the costs of serving beneficiaries under a fee-for-service arrangement.

Waiver Authorities

Federal Medicaid law permits the Secretary of Health and Human Services (HHS) to grant waivers of various statutory provisions that govern the operation of a state's Medicaid program. The use of these waiver authorities has increased since the early 1990s. Waivers allow states to receive FFP for covering individuals and/or services in ways that would not ordinarily be permitted. Depending on the type of waiver, a state can "waive" requirements such as comparability and statewideness to provide a targeted benefit package to individuals with a specific medical condition or who live in a certain geographic area. Here, the three main types of waivers – Section 1115, Section 1915(b) and Section 1915(c) – are outlined.[29] Some dimensions of how these authorities are employed are discussed in more detail in subsequent chapters.[30]

Section 1115 Research and Demonstration Waivers

Under Section 1115 of the Social Security Act, states may gain approval to use federal Medicaid dollars to cover groups of individuals and/or services that are not otherwise

matchable and/or demonstrate alternative approaches to furnishing services to beneficiaries. The 1115 demonstration authority is relatively broad; it allows for the waiver of a wide range of statutory requirements. In order to obtain federal approval of an 1115 demonstration, a state must demonstrate "budget neutrality," meaning that federal spending will not be more than it would have been in the absence of the demonstration.

The 1115 demonstration authority requires a research and demonstration component. States must arrange for an independent evaluation of the waiver to determine how successful they were at achieving their goal(s). States have employed 1115 demonstrations to expand Medicaid services to uninsured individuals (including single adults without disabilities) and families in their Medicaid programs who could not otherwise be covered. The authority also has been used on a more targeted basis to test different ways of serving Medicaid beneficiaries. Once an 1115 demonstration is approved, it usually expires after five years.

1915(b) Waivers

A 1915(b) waiver is commonly referred to as a "freedom of choice" waiver because it permits a state to waive the free choice of provider requirement. It also provides for waivers of comparability of services and statewideness requirements. Originally, 1915(b) waivers were most commonly used by states to implement managed care programs by restricting beneficiaries' choice of providers. However, the 1997 Balanced Budget Act allowed states to employ managed care for certain Medicaid beneficiaries through a state plan amendment rather than a waiver. The 1915(b) waiver authority can be used to create a "carve out" system of managed care delivery for specialized services such as mental health services as well as target certain services to a particular region or segment of the population.

States have used waiver authorities to cover uninsured individuals, implement managed care, and expand home and community services.

Unlike the 1115 demonstration, a state cannot employ the 1915(b) waiver authority to expand eligibility. By law, 1915(b) waivers are approved for an initial two-year period and may be renewed for additional two-year periods. A 1915(b) waiver program must be "cost effective" – i.e., the per-beneficiary costs must be no greater than the costs of serving individuals in the absence of a waiver program. The 1915(b) waiver authority permits a state to offer services that are not included in the State plan to the extent that such services can be financed out of savings. Several states deliver behavioral health services through a 1915(b) waiver.

1915(c) Home and Community-Based Services (HCBS) Waivers

The 1915(c) waiver authority permits a state to provide services (e.g., personal care, respite, habilitation, case management) to individuals who would otherwise require and be eligible for institutional services in a nursing home facility or ICF/MR. States must demonstrate that the average per person costs of furnishing home and community services does not exceed the average per person cost of institutional services. The 1915(c) authority permits a state to obtain a waiver of Medicaid comparability and statewideness requirements as well as extend institutional financial eligibility rules to people in the community. The waiver of comparability permits a state to target services to specific groups of beneficiaries (e.g., individuals with developmental disabilities). In addition, a state may limit the number of individuals who participate in a HCBS waiver. HCBS waivers have emerged as a critical element in state strategies to rebalance their Medicaid long-term service systems by creating more opportunities for people to remain in their homes and communities and avoid

institutionalization. In 2005, states operated approximately 300 HCBS waivers that served more than one million beneficiaries

In the past, many of the benefits that a state may offer through an HCBS waiver could not be covered under the Medicaid state plan. However, the Deficit Reduction Act of 2005 included a new provision that permits states to offer these types of services under their State plan. Chapter 4 discusses this provision in more detail.

Conclusion

Medicaid is a linchpin in meeting the health needs of low-income individuals and families in the United States. It has grown enormously in its scope and depth over the past four decades. During that time, federal policy has constantly evolved. Within federal parameters, states have considerable flexibility in crafting their Medicaid programs with regard to who will be served and which services will be offered. People who experience homelessness are poor. For many of them, Medicaid can provide a way to secure essential health and support services.

Resources

Publications

U.S. House of Representatives: Committee on Ways and Means

2004 Green Book
Available at: http://waysandmeans.house.gov/media/pdf/greenbook2003/MEDICAID.pdf

In this regularly updated document, the Ways & Means Committee provides an overview of the Medicaid program including legislative history, eligibility, services, and recent enrollment statistics. The Green Book also contains useful information on state Medicaid expenditures broken down by services, population, year, and other categories.

Kaiser Commission on Medicaid and the Uninsured

Schneider, A., Elisa, R., Garfield, R., et al. (2002). ***The Medicaid Resource Book.*** Menlo Park CA: The Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/2236-index.cfm

This publication provides comprehensive information concerning Medicaid policy, focusing on four topics: eligibility, benefits, financing, and administration. It provides extensive information on the demographics of Medicaid beneficiaries, expenditure and financing data and trends, federal and state obligations and options, different types of waivers, and examples of specific state policies. It also contains a useful reference guide with the entire Medicaid legislative history, statutory index, and regulatory index.

Congressional Research Service, The Library of Congress[31]

Elicia Herz et al. (Updated January 2006). **How the Medicaid Program Works**. Available at: http://lieberman.senate.gov/documents/crs/howmedicaidworks.pdf

This excellent report summarizes the basic elements of Medicaid. It describes federal Medicaid rules governing: (1) who is eligible, (2) what services are covered and how they are delivered, (3) how the program is financed and administered, (4) key provider reimbursement issues, and (5) the significant role of waivers in expanding eligibility and modifying services and health care delivery systems.

Centers for Medicare & Medicaid Services

Medicaid at-a-Glance 2005
http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf
This brief, 12-page publication provides an overview of Medicaid and state-by-state information concerning the services that each state offers in its Medicaid program.

Web Accessible Resources

Because the Medicaid program is complex and multi-faceted, it can be difficult to keep abreast of new developments and their implications for beneficiaries and states. This listing of websites identifies some web-sites where wide-ranging information can be found.

Centers for Medicare & Medicaid Services
Web-address: http://www.cms.hhs.gov/home/medicaid.asp

The CMS web site has extensive information and resources concerning the Medicaid program, including program descriptions, state specific information, and descriptions of major CMS initiatives, including those related to the President's New Freedom Initiative.

State Medicaid Agencies
Web-address: http://www.geocities.com/capitolhill/5974/

Since Medicaid programs vary widely from state-to-state, it is important to keep abreast of developments at the state level. This web-page has links to all state Medicaid agency websites.

Kaiser Commission on Medicaid and the Uninsured

Web-address: http://www.kff.org/medicaid/index.cfm

The Kaiser Commission is regarded as an authoritative source for information about Medicaid and health care services. The Commission regularly publishes wide-ranging information about the Medicaid program. The Commission operates an e-mail notification system that provides notices of new reports and publications covering many topics, including Medicaid. Subscribe (at no charge) at http://www.kff.org/profile/subscriptions.cfm.

Notes

[1] This chapter updates a parallel chapter in: Smith et al. (2005) *Using Medicaid In Support Of Working Age Adults With Serious Mental Illnesses In The Community: A Handbook*. Washington DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Available at: http://aspe.hhs.gov/daltcp/reports/handbook.htm.

[2] Medicare and Medicaid were enacted in P.L. 89-97 (Social Security Amendments of 1965). The Social Security Act Amendments of 1950 provided for federal financial participation in state "vendor payments" for health care services furnished to Aid to Families with Dependent Children (AFDC) and "aged, blind and disabled" cash assistance recipients. However, the amount of such payments was limited by formula. This state-managed "vendor payment" approach shaped the structure of the Medicaid program. The Social Security Bill of 1960 created the Kerr-Mills Program, which provided open-ended federal matching payments for state expenditures for health and other services provided to indigent older persons and, subsequently, people with disabilities. Under this program, states had wide latitude in deciding what services that they would furnish to individuals. Prior to Medicaid, there were wide variations in state medical assistance programs and ten states did not purchase any health care services for cash assistance recipients. The history of the enactment of Medicaid and its early implementation period is found in: Robert Stevens and Rosemary Stevens (1974). *Welfare Medicine in America: A Case Study of Medicaid*. New York: The Free Press.

[3] P.L. 90-248 (Social Security Act Amendments of 1967)

[4] P.L. 92-603 (Social Security Amendments of 1972)

[5] The expansion of Medicaid eligibility mandates and options began in 1988 when Congress mandated that states provide Medicaid coverage for pregnant women and infants with incomes up to 100 percent of the Federal Poverty Level (FPL). In 1989, mandatory Medicaid coverage of children under age 6 in households with incomes up to 133 percent of FPL was mandated. In 1990, Congress mandated the coverage of children ages 6 through 18 in households with incomes of up to 100 percent of FPL; this mandate was phased in and fully took effect in 2002. These mandates also were accompanied by options for states to expand coverage to children and pregnant women in households with incomes in excess of the FPL minimums.

[6] P.L. 97-35 (The Omnibus Budget Reconciliation Act of 1981)

[7] P.L. 100-203 (Omnibus Budget Reconciliation Act of 1987)

[8] P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989)

[9] P.L. 104-193

[10] When the §1931 family coverage was established, states were required to continue to cover families who met July 1996 AFDC-related eligibility criteria but also could provide for higher eligibility thresholds.

[11] P.L. 105-33 (Balanced Budget Act of 1997)

[12] P.L. 105-33 (Balanced Budget Act of 1997) and P.L. 106-170 (Ticket to Work and Work Incentives Improvement Act of 1999)

[13] P.L. 105-33 (Balanced Budget Act of 1997)

[14] P.L. 108-173.

[15] P.L. 109-171.

[16] Kaiser Commission on Medicaid and the Uninsured (1999). *Medicaid 101: A Primer*. Washington DC.

[17] Brian Burwell et al. (2006). Medicaid Long Term Care Expenditures in FY 2005. Cambridge, MA: Medstat.

[18] Federal statutory provisions concerning the Medicaid State plan are generally contained in §1902 of the Social Security Act.

[19] A list of CMS Regional Offices is at: http://www.cms.hhs.gov/regionaloffices/01_overview.asp

[20] Located on the web at http://www.ssa.gov/OP_Home/ssact/title19/1900.htm.

[21] Located on the web at access.gpo.gov/nara/cfr/waisidx_02/42cfrv3_02.html

[22] Some of this guidance takes the form of "state Medicaid director" letters. These letters are located on the web at http://www.cms.hhs.gov/smdl/01_overview.asp?

[23] There are a few services (e.g., family planning) for which there is a uniform rate of federal financial participation set in statute. State-by-state FMAP rates are at: http://aspe.os.dhhs.gov/health/fmap.htm.

[24] CMS Managed Care Enrollment Report, *op. cit.*

[25] The Kaiser Commission on Medicaid and the Uninsured (May 2006). *The Medicaid Program at a Glance*. Available at: http://www.kff.org/medicaid/7235.cfm.

[26] Based on the number of Medicaid enrollees at any given time during the year. The categories of children and adults do not include beneficiaries with disabilities; people with disabilities do not include adults 65 and over (they are in the Older Adults category).

[27] The Kaiser Commission on Medicaid and the Uninsured (May 2006). *Op. cit.*

[28] The DRA 2005 cost-sharing provisions are set out in: Center for Medicaid and State Operations: *State Medicaid Director Letter #06-015, June 16, 2006*. (Available at: http://www.cms.hhs.gov/SMDL/SMD/list.asp)

[29] These waivers are "named" after the respective sections of the Social Security Act that authorize their use. From here on, they are referred to simply as 1115, 1915(b), and 1915(c) waivers.

[30] More information about each waiver authority is at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/.

[31] The CRS makes its reports available directly only to members of Congress. However, the reports are posted on various Internet sites and usually can be located by using a web search engine.

Chapter 2:

Medicaid Eligibility

In order to access Medicaid services, people first must be found eligible. Medicaid eligibility is complicated. It hinges not only on a person's or family's income but also meeting additional tests (e.g., whether a person has a disability). While Medicaid targets low income individuals and families, not all low income individuals can qualify for Medicaid.

Each state must cover certain mandatory groups of individuals in its State plan; however, a state can elect to cover additional optional eligibility groups and has latitude in specifying many of the parameters that apply to each eligibility group included in the State plan. Federal law provides for many *pathways* to Medicaid eligibility but who may access Medicaid services depends on the decisions that each state makes about whom its Medicaid program will serve. In some cases, the Medicaid benefits that a person can receive differ by eligibility group.

This chapter discusses the following dimensions of Medicaid eligibility:

- Basic elements of Medicaid eligibility;
- Eligibility pathways for pregnant women, children and non-disabled adults. These pathways are important for families who experience homelessness;
- Eligibility pathways for individuals with disabilities and older persons. These pathways are important for adults who experience chronic homelessness;
- Additional eligibility pathways; and,
- Medicaid application, eligibility determination processes, and related considerations.

This chapter provides basic information about Medicaid eligibility. In Chapter 5, some of the problems associated with securing and maintaining Medicaid eligibility for people who experience homelessness are discussed along with the ways these problems can be addressed.

Basic Elements of Medicaid Eligibility

Medicaid eligibility has two fundamental dimensions: (a) whether a person meets specific *categorical* criteria (e.g., age) and (b) whether a person's income and resources are within the state's threshold standards that apply to the eligibility group under which the person qualifies. Medicaid eligibility rules fall into two basic groups: categorical and financial. In the past, Medicaid eligibility was closely wedded to the receipt of public assistance (e.g., receipt of cash assistance through the now-defunct Aid to Families with Dependent Children (AFDC) program). Since the 1980s, there have been several changes in federal policy that allow states to offer Medicaid benefits to low income individuals who do not receive public assistance.

Medicaid eligibility has five generic features:

Categorical eligibility

In order to secure Medicaid eligibility, a person must fall into a statutorily recognized "category" or "eligibility group." There are six *broad* coverage groups: children, pregnant women, adults in families with dependent children, people with disabilities (adults and children), persons who are blind, and older persons. Altogether, there are more than 50 specific eligibility groups. Each group is defined categorically – that is, in order to qualify for one of these groups, a person must match the "profile" associated with the group. Some groups are defined narrowly (e.g., women with

breast and cervical cancer who are uninsured and otherwise not eligible for Medicaid); others are quite broad (e.g., children in low-income households).

The categorical eligibility groups are further divided into "mandatory categorical eligibility groups" (groups that every state must cover in its State plan) and "optional categorical eligibility groups" (groups that a state may elect to include in its State plan). For example, all states must extend Medicaid eligibility to children under the age of six who are in households with incomes below 133% of the Federal Poverty Level. States may exercise other eligibility options and take additional steps to extend eligibility to children in higher income households. In 2004, about one-half the states covered children under the age of six in households with incomes above 133% of poverty.[1] In the sections that follow, the principal mandatory and optional categorical eligibility groups are identified.

As a general matter, Medicaid eligibility does not extend to non-disabled, non-aged childless adults regardless of their income level. There are some limited exceptions (e.g., low-income pregnant women). A state may employ the 1115 waiver authority to extend Medicaid eligibility to childless adults (see below).

This facet of Medicaid policy means that some adults who experience homelessness cannot qualify for Medicaid in most states. This has major consequences in using Medicaid to assist young adults who transition out of foster care or other adults whose chronic homelessness arises principally from an addictive disorder. Medicaid is most relevant in supporting people who experience homelessness and are:

- Children in low-income households;
- Adults who have dependent children;
- People (up to the age of 64) with disabilities who meet Social Security disability tests and certain older (age 65 and over) persons.

On its own, homelessness does not automatically qualify a person for Medicaid. Homeless people must meet a state's eligibility criteria in order to qualify for Medicaid.

Income eligibility

Medicaid is a means-tested program. An individual not only must fit one of the program's specific categories/eligibility groups included in the State plan but also cannot have income that exceeds the *income standard* for the category. Medicaid income standards vary by beneficiary group (and by state) and are expressed in different ways. Some standards are expressed as percentages of the officially-established Federal Poverty Level while others are keyed to cash assistance programs (e.g., SSI). Some standards are set in federal law and others by the states within federal guidelines. Some vary based on household size.

Since the Federal Poverty Level (FPL) figures into Medicaid eligibility for many groups, for reference, the FPL guidelines that are in effect in 2006 are displayed on the following page. These guidelines are updated each year by the federal Department of Health and Human Services and published in the *Federal Register*. When a Medicaid income eligibility standard is tied to the FPL, it is automatically updated when the new guidelines are released.

It is important to point out that the income standard against which Medicaid eligibility is tested applies only to the income that remains after the application of *disregards*. Disregards reduce a person's or household's gross income (from all sources, including public assistance, work and others) to arrive at the amount of income that is *countable* and compared to the standard. This practice has a close counterpart in

2006 HHS Poverty Guidelines			
Persons in Family or Household	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$9,800	$12,250	$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
For each additional person, add	3,400	4,250	3,910

income tax rules, which exempt certain types or amounts of income from taxation and allow certain other types or amounts to be deducted from otherwise taxable income. For example, in the case of people with disabilities, the first $20 of monthly income (regardless of source) is disregarded. Under federal law (principally §1902(r)(2) of the Social Security Act), states have substantial flexibility in deciding how much income to disregard in the case of many eligibility groups. Many states have used this flexibility to extend Medicaid eligibility to higher income families and individuals.

In some cases, individuals who qualify under one eligibility standard can continue to receive Medicaid benefits when their income rises by qualifying for a related eligibility group or under other provisions. For example, if a family looses eligibility under Section 1931 (discussed below), eligibility for the family's children may continue under poverty-related eligibility provisions. Under certain circumstances, people with disabilities can retain Medicaid eligibility when they no longer are eligible for SSI cash assistance; a state also may extend eligibility to people with disabilities who secure significant income from work. Often, when examining a state's eligibility policies, it is important to understand how such policies interlock with one another across the income spectrum. The transition out of homelessness is aided when individuals can maintain eligibility for Medicaid as their income improves.

Resource Eligibility

In most cases, Medicaid eligibility also is tied to threshold amounts of resources (e.g., cash and savings). A *resource standard* is the maximum dollar amount of resources that a person may have and still qualify for Medicaid. A typical resource standard for people with disabilities is $2,000. As with an income standard, the resource standard is applied to the total dollar value of a person's resources after the application of rules about the specific types of resources that are countable and how resources are valued. For example, in the case of individuals with disabilities, the person's own home is not counted as a resource and, thus, is disregarded when determining eligibility. States have latitude (under the provisions of §1902(r)(2)) in deciding the assets they will disregard in determining Medicaid eligibility for many eligibility groups. Under other authorities, many states waive asset tests altogether in the case of children who qualify for Medicaid on the basis of poverty. Waiving asset tests is one way to simplify Medicaid eligibility determination.

Immigration Status

Immigrants who have entered the United States illegally cannot qualify for basic Medicaid benefits (although they may qualify for emergency services). Legal

immigrants may be eligible depending on when they entered the United States. For Medicaid eligibility purposes, the 1996 Personal Responsibility and Work Opportunity Act divided legal immigrants into two categories. Most legal immigrants who entered the United States before August 1996 and who meet all other financial and non-financial Medicaid requirements are eligible for Medicaid at a state's option. The majority of legal immigrants who entered after August 1996 are ineligible for basic Medicaid benefits (with the exception of emergency services) until they have been in the country for five years. Once an immigrant has met the five-year test, a state may grant the person eligibility before s/he becomes a citizen. The Balanced Budget Act of 1997 provided that legal immigrants who receive SSI benefits are eligible for Medicaid even though they may not have been in the United States for five years.[2]

The Deficit Reduction Act of 2005 added more stringent requirements for verifying the citizenship status of new applicants and current Medicaid beneficiaries. These requirements took effect on July 1, 2006, and replaced the previous requirement that applicants declare in writing that they are citizens. People who experience homelessness may experience problems in producing the necessary documentation to demonstrate their citizenship. Chapter 5 discusses this topic in more detail.

Residency

A person must be a resident of the state where he or she is applying for Medicaid. A state may not deny Medicaid eligibility because a person has not resided in a state for minimum period of time or because a person is temporarily away from the state. Furthermore, eligibility is not contingent on a person's residing in a permanent dwelling or having a mailing address. In the State plan, each state must establish a method for furnishing Medicaid eligibility cards to persons who do not have a permanent home or mailing address. Such methods may include mailing the card to a representative selected by the beneficiary or directing the card to an organization with which the person has an ongoing relationship.

Conclusion

The foregoing five parameters cut across Medicaid eligibility. The following sections provide more information about the principal eligibility groups.

Eligibility Pathways: Pregnant Women, Children & Non-Disabled Adults

About 11% of all people who experience homelessness are parents with children; single women account for the majority (84%) of these parents. Children under 18 with a parent comprise 23% of people who experience homelessness and 42% of these children are under 5 years of age. Altogether, parents and their children account for about one-third of all homeless individuals. By virtue of their low income, most of these children and many of their parents likely qualify for Medicaid through one of the eligibility pathways for pregnant women, children, and non-disabled adults. However, experience suggests only about 50% have Medicaid. In Chapter 5, ways to improve access to Medicaid benefits are discussed. Here, pathways to eligibility for pregnant women, children and non-disabled adults are described.

Mandatory and Optional Eligibility Groups

Mandatory Categorical Eligibility Groups

A state must cover certain mandatory eligibility groups of children and their parents in its State plan. The principal mandatory eligibility groups for pregnant women, children, and their parents are:

Family Coverage Under Section 1931. Family coverage under Section 1931 is mandatory in all states. Through this coverage, Medicaid is provided to children and parent(s) in very low income households. In 1996, the Aid to Families with Dependent Children (AFDC) cash assistance program was replaced by the Temporary Assistance for Needy Families (TANF) block grant program. When welfare reform was enacted, Section 1931 was added to the Social Security Act to ensure that low-income families would continue to be eligible for Medicaid. Section 1931 essentially required states to continue forward their pre-welfare reform Medicaid eligibility rules. Families who receive TANF benefits do not automatically qualify for Medicaid benefits, as was the case under the AFDC program. Instead they must qualify under the Section 1931 rules or through another eligibility category. In most states, Section 1931 and TANF eligibility rules are closely aligned.

Under Section 1931, the parent (or, in some cases, parents) of dependent children qualifies for Medicaid when incapacitated, unemployed, or employed fewer than 100 hours per month. A state may terminate the Medicaid eligibility of adult TANF recipients who refuse to work, although coverage of their children must continue.

The income and resource standards that apply to Section 1931 eligibility vary considerably state-to-state. States have the latitude to increase both income and resource standards and specify the amount of income and resources that are disregarded. Section 1931 eligibility thresholds range from as low as 20% of FPL for a family of three to as high as 200% of the FPL.[3] State policies regarding income disregards and the treatment of resources also vary state-to-state. State rules concerning Section 1931 eligibility often are complicated because they carry forward many of the equally complicated rules that applied to the AFDC program.

Coverage under the Section 1931 is a primary eligibility pathway for families who experience homelessness. While this eligibility pathway can be complex and varies considerably state-to-state, it affords adults with dependent children a way to secure health services for themselves and their children.

Transitional Medical Assistance. States are required to provide Transitional Medical Assistance (TMA) to both the parents and children in families that would otherwise become ineligible for Medicaid due to an increase in earnings. Under TMA, working families are entitled to Medicaid for at least six months and as many as 12 months so long as their income does not exceed 185 percent of FPL, net of child care expenses. Medicaid eligibility must be continued for a period of twelve months for adults and children in TANF welfare-to-work status. Some states have chosen to extend TMA to working families beyond the required 12-month period. In order to qualify, families must have been on Medicaid for three of the six preceding months.

Poverty-Related Pregnant Women and Children. The second principal eligibility pathway involves low-income pregnant women, infants and children. Starting in the 1980s, Congress added optional eligibility groups to encourage states to extend Medicaid coverage to uninsured children in low income households that did not qualify for AFDC cash assistance. In 1989, states were mandated to cover certain low-income pregnant women and children under the age of six and required to progressively extend Medicaid coverage to older children up to age 18 in low income households, starting in 1991. At present, states must cover:

- Pregnant women in households with a family income that is equal to or less than 133% of FPL. This coverage is limited to services related to pregnancy and complications of the pregnancy and must continue for 60-days after pregnancy;

- Infants less than one year old in households with a family income equal to or less than 133% of FPL;
- Children under the age of 6 in households with a family income equal to or less than 133% of FPL; and,
- Children under the age of 18 in households with a family income equal to or less than 100% of FPL.

These coverages do not extend to members of the entire household, only to the pregnant woman or child. States have the option to extend eligibility to pregnant women and infants up to 185% of FPL and several have. States also enjoy considerable flexibility in disregarding income in the case of these eligibility groups. Disregarding income effectively increases the amount of household income that a family can have in order for the child to still qualify for Medicaid. In some states, children in households with incomes of 200% or more of FPL can qualify for Medicaid via this eligibility pathway. In addition, states may waive asset tests for both low-income pregnant women and children and most have. States also may provide for *continuous eligibility* for extended periods of up to 12 months so that children do not lose eligibility due to month-to-month fluctuations in family income. Finally, states may provide for *presumptive eligibility* in order to start Medicaid coverage of hospital and ambulatory services right away for pregnant women and children while the Medicaid application is being processed. Presumptive eligibility is discussed in more detail in Chapter 5.

This eligibility pathway helps low-income families secure essential health care services for their children. Such services can be essential to avoiding homelessness due to high health care costs and are vital to ensuring children's health when the family experiences homelessness. Since household income thresholds typically are much more generous than the Section 1931 pathway, this pathway is a way to secure child Medicaid coverage for families who do not qualify under Section 1931. Since obtaining health care coverage is increasingly challenging, this pathway can be valuable for families who are exiting homelessness.

Other Mandatory Groups. States must also extend Medicaid coverage to certain other mandatory groups of children. These include children in foster care under Title IV-E of the Social Security Act and recipients of adoption assistance. In general, the other mandatory eligibility groups are limited to children.

Optional Categorical Eligibility Groups

There are only a few optional eligibility groups for children and adults, most of which are narrowly defined. Alternatively, children who live in households with incomes which are too high to qualify for Medicaid may qualify for health care coverage through the State Children's Health Insurance Program (SCHIP) program. The SCHIP program was created in 1997 and permits states to extend health insurance coverage to uninsured children when family income is below 200 percent of poverty. SCHIP is not part of Medicaid and states receive fixed sums to operate their programs. However, a state may use its SCHIP allotment to provide standard Medicaid benefits to low income children in households with incomes above the state's poverty-related income standard.[4] Otherwise, a state may offer a distinct health care services package to SCHIP children.

Eligibility Pathways: Non-Elderly People with Disabilities & Older Persons

Children and adults with disabilities and older persons account for about 26% of all Medicaid beneficiaries but 70% of Medicaid outlays. These individuals frequently require on-going chronic care services as well as long-term services and supports.

Access to Medicaid benefits is vital for these individuals and can play an important role in preventing their homelessness for lack of necessary services and supports. Many people who experience chronic homelessness have disabling disorders and conditions and can qualify for Medicaid benefits on the basis of disability.

Medicaid eligibility for people with disabilities and older persons is deeply rooted in the federal Supplemental Security Income (SSI) program for older persons, blind persons, and non-elderly persons with disabilities. The SSI program is federally administered and provides a floor level of income assistance to older persons and people with disabilities. Most states provide Medicaid coverage to individuals who receive SSI cash assistance payments. Like Medicaid, SSI eligibility has both categorical (a person must have a severe disability, be blind, or aged (i.e., over the age of 65)) and financial dimensions (SSI is means-tested both with respect to income and resources). As is the case with non-disabled adults and children, a state may include additional optional eligibility groups in its State plan in order to extend eligibility for people with disabilities and older persons to individuals who do not receive SSI cash assistance.

The determination that a person has a disability is based on criteria in Titles II and XVI of the Social Security Act. Disability determination is discussed in the next section since it plays a decisive role in whether a person may qualify for Medicaid on the basis of disability. This section also provides information on the operation of federal cash assistance programs for people with disabilities and older persons, since the receipt of cash assistance also is an important factor in Medicaid eligibility determination. Next, the mandatory and optional eligibility groups are described.

Federal Cash Assistance Programs for People with Disabilities & Older Persons

There are two major federal cash assistance programs that provide income assistance to people with disabilities and older persons: the Supplemental Security Income (SSI) program in Title XVI of the Social Security Act and the Social Security Disability Insurance (SSDI) program in Title II of the Social Security Act. Both the SSI and SSDI programs provide income assistance to individuals with severe impairments under the age of 65 who are unable to work. The SSDI program makes payments to medically disabled individuals who have worked and paid Social Security taxes for a minimum number of years. An individual's SSDI entitlement is based on his/her work history. SSDI payments also are made to the "disabled adult children" (DAC) of deceased or retired workers who worked and paid Social Security taxes. DAC beneficiaries are persons who became disabled during childhood. After a person receives SSDI for two years, the person is eligible for Medicare health care coverage.

Eligibility for SSI benefits does not hinge on a person's having paid Social Security taxes for a minimum period; children also can qualify for SSI. SSI eligibility is based on financial hardship. SSI benefits are further broken down into two subcategories: benefits for people who are blind and benefits for people with other severe disabilities. Benefits for people who are blind are more generous than for people who have other disabilities. SSI benefits also are available for older persons (the "aged") who did not accumulate a sufficient work history to qualify for regular Social Security benefits and who have low incomes. Some individuals receive both SSI and SSDI payments when the amount of their SSDI entitlement is less than the standard SSI payment.

Adults with disabilities who apply for Social Security benefits are evaluated to determine whether they qualify for either program; individuals who are determined eligible are assigned to the SSDI program if they qualify and SSI if not. Because SSI and SSDI disability criteria are the same, SSDI-only beneficiaries may qualify for Medicaid based on disability but usually only in the optional eligibility groups. SSDI-

only beneficiaries often have income or resources that are higher than the standards associated with SSI eligibility.

In order to qualify for SSI or SSDI, a non-elderly individual (a person up to the age of 65) must have a severe, medically determinable physical or mental impairment. Recognized impairments are specified in the "Listings of Impairment" that are issued by and periodically revised by the Social Security Administration.[5] The Listings of impairments are similar to diagnoses. For example, the Listings of Mental Impairments parallel the Diagnostic and Statistical Manual III that was used in the mid-1980's to diagnose mental disorders, including mental illnesses such as schizophrenic, affective, and anxiety disorders. The listings include immune system disorders such as HIV/AIDS. Not all severe impairments qualify a person for SSI/SSDI. For example, since 1996,[6] people for whom "drug addiction or alcoholism is the contributing factor material to their disability" are not eligible and, therefore, ineligible for Medicaid on the basis of their disability. ***As a consequence, people who experience homelessness due to addictive disorders may not be able to access Medicaid benefits unless they also have a primary impairment (e.g., serious mental illness) other than an addictive disorder***.

Having a severe impairment (including a serious mental illness) is not sufficient unto itself to make a person eligible for SSI/SSDI. The impairment must be assessed as likely to continue for at least twelve months or result in death. Children are evaluated on the basis of whether their impairment(s) result in "marked and severe functional limitations." In the case of adults, the impairment must be judged as so severe that a person not only is unable to perform his or her previous work, but "cannot, considering his [her] age, education and work experience, engage in any other kind of substantial gainful work." In 2006, a person's inability to work is defined in part as the person's earning less than $860 per month net of income-related work expenses.[7] Earnings above this level are considered by regulation as evidence of a person's ability to engage in *substantial gainful activity* (SGA).[8] SSI/SSDI eligibility is based on an individual's having a listed severe impairment that causes the person to be unable to engage in regular work where the individual earns more than the SGA standard.

The amount of income assistance that a person may receive varies by program. In the case of the SSI program, the maximum benefit amount is termed the Federal Benefit Rate (FBR). In 2006, the SSI FBR a person with a disability other than blindness is $603/month or about 74% of the FPL for a single person.[9] Individuals who are institutionalized may receive a reduced SSI benefit ($30/month). In May 2006, there were 7.2 million SSI beneficiaries.[10] About 6.0 million were individuals with disabilities; the remainder was older persons. The average federal benefit for working age adult SSI beneficiaries was $425/month.

In the case of SSDI, the benefit amount hinges on the person's prior earnings/work history. In May 2006, the average SSDI benefit for a disabled worker was about $943/month.[11] When the disabled worker has a spouse and/or children, an additional benefit is paid. There were about 6.2 million SSDI beneficiaries in May 2006.

Whether a person who has a qualifying severe impairment is eligible for a cash assistance payment depends on several factors. In particular:

- In the case of otherwise eligible children, eligibility for SSI cash assistance hinges on the determination of the income that is available to the child. If this other income is greater than the FBR, the child is not eligible for cash assistance. SSI rules provide for *deeming* a share of the household's total income to the disabled child.[12] If the amount deemed available to the child exceeds the FBR, then the child is ineligible for cash assistance. Deeming does

not apply when the child lives apart from her/his family. As discussed below, there are Medicaid options available to states to extend eligibility to children with severe disabilities but do not qualify for SSI cash assistance.

- In the case of otherwise eligible adults, eligibility for SSI cash assistance also hinges on the amount of other income (if any) available to the individual. Other income is classified into two categories: *unearned* and *earned* income. SSI rules provide for a disregard of $20/month of income regardless of type. After the disregard, unearned income is deducted dollar-for-dollar from the FBR in order to determine whether the person qualifies for an SSI cash assistance payment and the amount of the payment. SSDI income is treated as unearned income. Earned income is treated differently. Earned income is reduced by work expenses, the first $65 dollars in earned income, and then by one-half the remaining earned income.[13] The amount that remains is deducted from the FBR in determining whether the person qualifies for an SSI cash assistance payment and the amount of the payment. Federal law provides for the extension of SSI cash assistance and Medicaid eligibility for SSI beneficiaries whose earnings exceed the SGA amount.[14] However, sustained employment at a level in excess of the SGA amount can ultimately result in a person's being found ineligible for SSI altogether.
- In the case of SSDI beneficiaries, the SSDI payment is subject to reduction based on the receipt of other types of public assistance. SSDI payments are not reduced due to earned income but sustained employment at a level in excess of the SGA amount can lead to the termination of SSDI benefits.

In addition, eligibility for SSI benefits also is subject to resource tests. The resource limit for SSI beneficiaries is $2,000. However, many resources are excluded, including a person's home.

The interplay between Medicaid eligibility and SSI/SSDI eligibility may be summarized as follows:

- In order for a person to qualify for Medicaid on the basis of disability, the person must have been determined to have a severe impairment as defined under Social Security rules. Qualification as an "aged" person is based solely on age;
- In most states, receipt of an SSI benefit automatically translates into Medicaid eligibility for older persons and people with disabilities. In a few states (discussed below), SSI-qualified beneficiaries must meet somewhat more stringent eligibility criteria in order to qualify for Medicaid; and,
- Persons who meet SSI/SSDI eligibility criteria but who do not receive an SSI cash payment may qualify for Medicaid under optional aged and disabled eligibility groups. These individuals must apply separately for Medicaid.

Mandatory and Optional Eligibility Groups

Mandatory Eligibility Groups

Each state must provide Medicaid coverage to individuals with disabilities (the "disabled") and people who are blind (the "blind") and older persons (the "aged") who are SSI cash assistance beneficiaries. For these mandatory eligibility groups, most states follow SSI rules with respect to income and assets. A few states (discussed below) apply one or more rules that are more restrictive than SSI when determining Medicaid eligibility; however, these states still must provide a pathway to Medicaid eligibility for SSI cash recipients who do not meet the state's more restrictive rules.

SSI States. Thirty-nine states and the District of Columbia grant Medicaid eligibility to all individuals in any month in which they receive an SSI payment. These states gear mandatory Medicaid eligibility for people with disabilities and older persons exclusively to SSI rules. In thirty-two states and the District of Columbia (known as "1634" states), Medicaid eligibility is automatically granted, based on a list of SSI beneficiaries compiled by the Social Security Administration and transmitted monthly to the states.[15] The other seven states[16] (known as "SSI-criteria" states) require that SSI beneficiaries make a separate application for Medicaid benefits. These states follow SSI rules but do not automatically extend Medicaid eligibility to SSI cash assistance recipients.

State 209(b) Option.[17] Medicaid for the "Aged, Blind, and Disabled" historically was linked to receipt of cash assistance benefits. When the federally-administered SSI program replaced state-only programs of financial aid for older persons and people with disabilities in 1972, it was expected to lead to large increases in the number of beneficiaries. The 209(b) option was enacted along with SSI in 1972 to allow states to avoid similarly large increases in Medicaid enrollment and costs. At present, there are eleven 209(b) states.[18] In these states, older persons and people with disabilities face one or more eligibility rules that are more stringent than SSI rules.

Many Medicaid eligibility rules under the 209(b) option follow SSI rules. But states may choose, instead, to use some or all of the more restrictive Medicaid rules that were in effect in their state in January 1972, shortly before SSI was enacted. Typically these states have retained at least some of their pre-SSI rules concerning countable income or resources. Only a few have elected to use more stringent criteria for determining blindness or disability.[19] In general, 209(b) states have lower income and/or resource standards than states where eligibility is keyed solely to the receipt of SSI cash assistance.

Federal rules require that all 209(b) states counterbalance the potential negative effects of the 209(b) option on SSI beneficiaries. Any residents who are elderly, blind, or have disabilities — including those with too much income for SSI — must be allowed to "spend down" to the state's Medicaid income standard if their expenses for medical services so erode their income that their "net" remaining income would be less than a standard set by the state. This requirement creates a medically needy-like program for this population, even in states that have not chosen specifically to cover the medically needy as an option. Spend-down rules for 209(b) are virtually identical to spend-down rules for the medically needy (discussed below).

Medicaid Protection for Certain Former SSI Beneficiaries. Federal law also requires that all states, including 209(b) states, provide Medicaid to certain former SSI beneficiaries who would, but for increases in their Social Security benefits, continue to be eligible for SSI.[20] Congress passed these provisions in 1986[21] to ensure that annual Social Security increases – intended to improve people's lives – did not harm this group by causing them to lose Medicaid as well as SSI. For Medicaid purposes, these individuals are treated as if they are still receiving SSI. Most of the individuals affected by this provision have incomes just marginally above the income levels at which they might qualify for SSI and Medicaid.

Low-Income Medicare Beneficiaries. States also must underwrite the out-of-pocket expenses of certain low-income Medicare beneficiaries under what are sometimes termed Medicare Savings Plans. Qualified Medicare Beneficiaries (QMBs) are people with disabilities and older persons who have incomes at or below 100% of FPL. For this group, states must cover the costs of Medicare Part A and Part B premiums as well as deductibles and co-insurance that apply to Medicare covered

benefits. Specified, Low-Income Medicare Beneficiaries (SLMBs) are persons who have incomes over 100% of FPL but no higher than 120% of FPL. In the case of this group, states must pay the Medicare Part B premium. There are also provisions for states to pay Part B premiums for other Medicare beneficiaries with higher incomes.

QMBs and SLMBs who also qualify for Medicaid via another Medicaid eligibility pathway are termed as "full-benefit" *dual eligibles*. There are about 6.2 million full benefit dual eligibles.[22] Most are older persons; 2.9 million are people with disabilities. As a group, dual eligibles have significant functional limitations and frequently significant health care challenges.

Optional Eligibility Groups

States may extend Medicaid eligibility to several other groups of people with disabilities and older persons. These optional eligibility groups include:

Recipients of State Supplemental Payments. Many states supplement the SSI FBR cash assistance payment and pair these state supplementary payments (SSP) with Medicaid eligibility. These states have elected to spend state-only, unmatched money to supplement the basic SSI FBR in circumstances where they have determined that the SSI FBR is insufficient to cover the expenses necessary for minimally adequate living standards. These state supplements are state-determined and vary widely by state. Some states provide across-the-board supplements to all SSI-eligible persons. Several states also provide supplements to individuals who live in certain types of community residences or for other reasons. In states that provide supplements, the effect of the supplement is to increase the *income standard* from the SSI FBR to the SSI FBR plus the amount of the SSP for which a person qualifies. Some individuals have too much income to qualify for SSI cash assistance but still may qualify for an SSP benefit. States can elect to make such persons eligible for Medicaid. There are 35 states that extend Medicaid eligibility to SSP recipients. With respect to these optional eligibility groups, states have flexibility in establishing income and resource disregards.

100 Percent of Poverty Option. States also have the option to raise the income level at which an older person or a person with disability can qualify for Medicaid to as high as 100 percent of FPL ($9,800 for one person in calendar year 2006 or about one-third higher than the SSI FBR). When this option is selected, SSDI-only beneficiaries are more likely to qualify for Medicaid because many receive SSDI payments that are too high to qualify for SSI cash assistance but less than 100 percent of FPL. States that use this option may not set limits on countable resources lower than SSI levels but may set them higher.

It bears repeating here that what is compared to these eligibility levels is countable (not total) income and resources. Under the 100 percent of FPL option, at the very least, states must disregard the same kinds and amounts of income and resources that SSI disregards, but they may also use more liberal income disregards than SSI. Because there is no spend down requirement associated with this option, beneficiaries do not have to spend their own funds on medical services in order to qualify (unlike the medically needy option described below). Twenty-one states have selected this option.[23] Most have tied their income standard to 100 percent of FPL, although some have pegged their standard to a lower amount (between 80 to 95 percent of FPL.)

Medicaid "Buy-In" Options for Workers with Disabilities.[24] Any benefit program that uses an income cutoff to determine eligibility contains a powerful disincentive for beneficiaries to return to work, if the earnings from work put them above the financial eligibility threshold level. To the extent that Medicaid coverage is needed in order to

live, the problem becomes an absolute barrier to employment rather than simply a "disincentive."

Basic SSI rules contain a work incentive by disregarding a significant portion of earned income; the SSI §1619(a) and §1619(b) provisions of the Social Security Act enable SSI beneficiaries who work and earn more than the SGA standard to retain Medicaid for a period of time. States also may employ §1902(r)(2) to create additional work incentives by disregarding earned (or unearned) income in the case of people with disabilities who work but are not SSI beneficiaries.

In 1997 and 1999, new options were enacted to make it possible for a state to extend Medicaid eligibility to workers with disabilities who have significant earnings but may not qualify for Medicaid for various reasons, including some of the limitations inherent in the SSI work incentives (e.g., the low SSI limits on resources or the requirement that a person must have previously received an SSI cash assistance payment). These options are termed "buy-in" options because beneficiaries may be required to pay an income-related premium to secure Medicaid coverage. Over 30 states have elected to employ one of these options.

Section 4733 of the **Balanced Budget Act of 1997 (BBA-97)** permitted states to extend Medicaid eligibility to working individuals with disabilities who, because of their earnings, cannot qualify for Medicaid under other statutory provisions. States that have employed these provisions have implemented more liberal income and resource methodologies than used in SSI. Under the BBA-97 buy-in option:

- A state extends Medicaid eligibility to individuals with disabilities in *households* with a net family income of less than 250 percent of FPL, based on family size;
- Except for earned income (which is completely disregarded), the individual must meet all SSI eligibility criteria, including: (a) unearned income that does not exceed the SSI FBR ($603 per month); (b) resources that do not exceed the SSI resource standard; and, (c) SSI disability criteria.
- A state also may employ §1902(r)(2) provisions to disregard both income and resources that would be counted under SSI methodologies.

In addition, a state may charge a premium and require beneficiary cost-sharing.

The **Ticket to Work and Work Incentives Improvement Act of 1999**[25] created two more optional eligibility groups for people with disabilities who work: (a) the Basic Coverage Group and (b) the Medical Improvement Group. The key differences between the TWWIA eligibility groups and the BBA-97 eligibility group are as follows:

- **Basic Eligibility Group**. There is no 250 percent of FPL limit as under BBA-97. Instead, a state may set its own income limit. This group is limited to persons between the ages of 16 and 64. In addition, there are no required income and resource standards. Like the BBA-97 eligibility group, individuals must meet SSI disability criteria.
- **Medically Improved Group**. The difference between this group and the Basic Eligibility Group (and the BBA-97 group) is that it may include individuals whose condition has improved to the extent that they no longer meet SSI disability criteria. The Social Security Administration makes this determination during the regularly scheduled continuing disability review.[26] These individuals must have met SSI disability criteria before the review was conducted.

Like the BBA-97 group, states may require beneficiaries to pay premiums and share in the cost of services. In addition, with respect to the TWWIA groups, states may employ §1902(r)(2) provisions in order to use more liberal income and resource methodologies for these groups.

In many respects, the TWWIA option provides states more flexibility in crafting work incentives than the predecessor BBA-97 option. While there are differences between the BBA-97 and TWWIA eligibility options, both give states greater latitude to extend Medicaid eligibility to people with disabilities who succeed in the work place. These expansions potentially can benefit both SSI and SSDI beneficiaries who return to work. It is important to point out that the SSDI program has weaker basic work incentive provisions than the SSI program[27]. These options (or the use of income disregards in other optional coverage groups) can provide important assistance to SSDI beneficiaries who work but also need access to Medicaid benefits.

One important result of the BBA-97 and TWIAA work provisions is that individuals who formerly could only qualify for Medicaid via the medically needy option can now instead receive benefits under these options. By avoiding the steep spend down requirements associated with the medically needy option, these individuals can retain more of their work income and, thus, be more independent. In March 2005, about 110,000 people nationwide were benefiting from Medicaid buy-in options, including significant numbers of persons with serious mental illnesses.

TEFRA 134. Many children with severe disabilities do not qualify for Medicaid because they do not receive SSI cash assistance payments as a result of the deeming of parental income. Such deeming can stand in the way of securing Medicaid eligibility for children in households with relatively modest income levels. Federal law gives states the option to cover children with physical and mental disabilities in the community if the child would be eligible for Medicaid institutional services but can be cared for more cost effectively at home. This option was authorized by Section 134 of the Tax Equity and Financial Responsibility Act of 1982 (TEFRA); it is sometimes called the Katie Beckett option after the child whose situation inspired it. About 20 states have adopted this eligibility option.

Family Opportunity Act. Section 6062 of the Deficit Reduction Act of 2005 enacted the Family Opportunity Act (FOA). The FOA gives states the option of extending Medicaid eligibility to children with severe disabilities who live in households with incomes up to 300% of FPL ($60,000 for a family of three). This provision goes into effect on January 1, 2007 and can be phased-in. In the first year, states can limit Medicaid under this group to families with a child under the age of 6. In 2008, a state may extend eligibility to children up to age 12 and, in 2009, to children under the age of 18. The child must meet SSI disability tests but, unlike the TEFRA 134 option, does not need to be found to require institutional services. States may charge families income-related premiums and parents must participate in employer-sponsored insurance if the employer covers at least 50% of the premium.

300% of SSI Eligibility Option. This option – also called the *special income standard* – is available for older persons and people with disabilities who meet a states' criteria for Medicaid institutional services (nursing facilities and ICFs/MR) and HCBS waiver programs. Under this option, a state can establish a special income threshold up to 300 percent of the maximum SSI benefit ($1,809 in 2006). This income standard is tied to a person's gross income (not just countable income). Individuals with income up to the threshold qualify for Medicaid without spending down, but, when institutionalized, such individuals have a "share of cost" obligation that requires them to turn over all their income except for a personal needs allowance to offset the cost of institutional services. More than 30 states employ this option.

This option was originally created so that states that did not wish to cover the entire category of medically needy could at least cover higher income persons residing in a medical institution. Some states employ this option in tandem with the medically needy option for persons served in institutional settings. States may employ this

financial eligibility option for individuals in 1915(c) HCBS waiver programs in order to "level the playing field" between institutional and non-institutional services. Persons receiving waiver services may also have a "share of cost" obligation that requires their contributing to the cost of waiver services. [28]

Conclusion

Medicaid eligibility pathways for people with disabilities are especially important for people (especially single adults) who are at risk of homelessness or experience homelessness as a result of a chronic condition or disorder.

Other Eligibility Pathways

There are two additional eligibility pathways that states may employ to expand access to Medicaid services: (a) the "medically needy" option and (b) eligibility expansions permitted under the Section 1115 waiver authority.

Medically Needy Option

States can cover people who have too much income to qualify in any categorical eligibility group under the "medically needy option." Under this option, a person must still fit into one of the Medicaid-coverable categories — for example, meet SSI/SSDI disability criteria. If not, they cannot qualify as medically needy no matter how low their income or how extensive their medical need. There is no specified ceiling on how much income a person can have and still potentially qualify as medically needy if their medical bills are high enough. Under the medically needy option, a state establishes income standards (also called the "medically needy income limit") and resource standards that apply to individuals who cannot otherwise qualify for Medicaid. Once individuals incur sufficient medical expenses to reduce their income to the state's standard (that is, they "spend down" to the medically needy income limit), they become eligible for Medicaid payment of covered services.

The medically needy option can be beneficial for persons who have high prescribed drug or other medical expenses. It also is a Medicaid eligibility "pathway" for persons who require Medicaid-reimbursable institutional care (e.g., nursing facility services) in states that cover nursing facility care in their medically needy program. In 2000, there were about 3.6 million Medicaid beneficiaries in the medically needy category, including approximately 1.3 million older persons and people with disabilities. The medically needy option can serve as a pathway to Medicaid eligibility for SSDI beneficiaries who cannot otherwise qualify for Medicaid.

Thirty-three states and the District of Columbia have medically needy programs that include individuals with disabilities. The income and resource standards that apply to these programs vary considerably among states. Some income standards are less than $200 per month while others are over $500. However, states may disregard income and resources when they employ the medically needy option (as they can with other optional eligibility categories). When income is disregarded, the effect is that individuals can qualify for Medicaid as medically needy at lower levels of incurred medical expenses.

The role that the medically needy option plays in enabling people with disabilities to qualify for Medicaid hinges on the other optional coverages that a state has in place. For example, in states that have adopted the 100 percent of FPL option, medically needy eligibility would come into play only for higher income individuals who do not qualify under that option. Where a state has not adopted the 100 percent of FPL option, the medically needy option may be the only pathway to Medicaid eligibility for non-SSI beneficiaries.

Under the medically needy option, a state is not required to offer its full package of Medicaid benefits. A state may limit its coverage for the medically needy to certain mandatory Medicaid benefits (e.g., physician services). In general, most states that operate medically needy programs offer their full Medicaid package. However, some exclude significant benefits.[29]

There are additional features of the medically needy option that warrant mention:

- A state that opts to operate a medically needy program must extend coverage to children under age 18 and pregnant women. States are not required to cover people with disabilities and older persons but most have.
- A state may not restrict eligibility based on medical condition, type of services needed, or place of residence.
- A state must use a single eligibility level for income and resources for all the medically needy groups that it covers. In the case of income levels, this single level may not exceed 133 1/3 percent of the state's pre-welfare reform AFDC payment levels. As noted above, in some states, these medically needy income levels are quite low.
- Medically needy persons with incomes above the state's threshold must spend down before becoming eligible for Medicaid benefits. This spend-down requirement can be problematic. The reason is that medically needy persons with countable incomes above the state's Medicaid income threshold must spend down to that threshold *on a periodic basis* in order to remain eligible for Medicaid funding of the services they need.[30] Until their spend-down limit is reached, they are responsible for their own medical expenses. There is no federal or state requirement that individuals spending down actually pay their bills. But as a practical matter, providers are unlikely to continue serving them if they fail to pay. Alternatively, states can offer people the opportunity to meet their spend-down obligation by paying it directly to the state in exchange for immediate coverage of all their medical expenses. In either case, however, persons with incomes above the state threshold may have a spend-down liability that leaves them little income available to meet living expenses.

The medically needy option permits a state to extend Medicaid eligibility to individuals whose income is higher than the amount that would permit them to qualify for other optional eligibility categories that a state has in effect. This option provides access to health care for people who experience high medical expenses.

Section 1115 Waiver Eligibility Expansions

The Section 1115 authority permits the Secretary of HHS to grant waivers of Social Security Act provisions in order to permit states to conduct demonstrations that promote the objectives of the Act. Under this authority, several states have extended comprehensive health insurance coverage to individuals who would not otherwise be eligible for Medicaid. Waivers granted under the Section 1115 authority must be "budget neutral." That is, federal outlays cannot be greater than they would have been in the absence of the waiver. Often eligibility expansions under the Section 1115 authority have been accompanied by the use of managed care arrangements to contain Medicaid expenditures.

Several states have used the Section 1115 authority to further expand eligibility for uninsured and underinsured children. Some states have used the authority to extend eligibility to the parents of Medicaid-eligible children in low income households. A few states (e.g., Massachusetts and Hawaii) have used the authority to provide Medicaid eligibility to uninsured adults (including childless adults) up to 100% or higher of

FPL.[31] In these states, many homeless childless adults are able to access critical Medicaid benefits.

Medicaid Application & Eligibility Determination Processes

Applying for Medicaid

In almost all instances,[32] an individual must make a written application in order to be considered for Medicaid benefits. Federal law and regulations do not specify the form or content of the application. Furthermore, neither federal law nor regulation specifies the manner in which the application must be made. While many states require that the application be made in person, a state may provide for taking applications any where in the community, by mail or electronically. For example, some states outstation eligibility workers in community hospitals to take applications in order to start Medicaid services right away. The State Medicaid agency must make the determination that a person qualifies for Medicaid; however, the determination may be made by other public agencies that are responsible for the determination of eligibility for financial assistance, as specified in the State plan.

Federal law and regulations[33] require that an individual's eligibility be determined with "reasonable promptness." The standard for processing applications is no more than 45-days except in the case of persons who apply on the basis of disability for whom the standard is 90-days (due to the extra time needed to verify the person's disability). Allowable exceptions to these standards include the failure of the applicant to supply information that is necessary to make a decision concerning the application. A state may not delay the processing of applications for administrative convenience or as a device to wait list individuals for services. States may grant presumptive eligibility in certain cases (discussed in Chapter 5) in order to speed up the delivery of services to applicants. When a person qualifies under more than one Medicaid eligibility category, the person has the right to select the category s/he prefers.

Persons with disabilities frequently experience delays in securing Medicaid eligibility due to problems in verifying disability. Disability is determined by state disability determination units that operate under contract with the Social Security Administration. Social Security rules permit the granting of presumptive disability in the case of certain disabilities and conditions. In the case of other disabilities and conditions, the disability determination process can be elongated.

Federal law also provides for retroactive eligibility. In particular, Medicaid must be provided for any services covered under the State plan that were furnished during the three-months preceding the application if the person would have been eligible for Medicaid during that period. States must determine if applicants have unpaid medical bills and pay such bills if the person is determined eligible.

A state must make a formal finding as to a person's application for eligibility. In the event that the state disapproves the application, the state must inform the applicant in writing of the reason(s) for the disapproval and offer the person the opportunity to request a Fair Hearing to protest the decision.

Eligibility Redetermination

Federal law dictates that a person's Medicaid eligibility must be redetermined no less frequently than annually. However, some states follow a more frequent redetermination schedule, especially in the case of families and children, due to fluctuations in family income.

If it is determined that an individual no longer qualifies for Medicaid in a category, the state must determine whether the person qualifies under any other category before

terminating the person from Medicaid. The state must provide a written notice of termination to the person and the reason(s) for the termination; in addition, the state must afford the person the opportunity to request a Fair Hearing.

Conclusion

Medicaid eligibility is complicated due to the combination of categorical and financial factors, the mixture of mandates and options, and the discretion afforded each state to select coverage categories, establish income and resource standards, and decide how income and resources are treated. As a consequence, eligibility varies considerably state-to-state.

That said, federal law provides that every state must provide coverage to:

- Very low income families through the Section 1931 Family coverage. In some states, this coverage is more generous and permits additional families to qualify;
- Pregnant women, infants and children in low-income households; and,
- People with disabilities and older persons who receive SSI cash assistance, except in §209(b) states where individuals must meet somewhat more stringent criteria.

Generally, every state has adopted several eligibility options to extend Medicaid to additional groups of low income individuals. Federal policy, however, generally prevents the extension of Medicaid eligibility to childless, non-disabled, non-elderly adults (except by demonstration waiver) and individuals who have primary addictive disorders.

Many people who experience homelessness or who are at risk of homelessness can and do qualify for Medicaid under various eligibility pathways. This is important because access to health care is important for avoiding homelessness or assisting people who are homeless to secure health care. Moreover, features of Medicaid eligibility permit the continuation of Medicaid services once individuals secure jobs. This is why such eligibility options as the Medicaid Buy-In are important.

Chapter 5 explores ways to improve access to Medicaid for people who experience homelessness. It identifies some barriers that such individuals face and how they may be addressed.

Resources

Publications

Congressional Research Service, The Library of Congress, Washington, D.C.

Julie Lynn Stone (2002). ***Medicaid: Eligibility for the Aged and Disabled*** (RL 31413)
Available at: http://www.opencrs.com/document/RL31413/

Karen Tritz (2005). ***A CRS Series on Medicaid: Dual Eligibles*** (RL 32977)
Available at: http://www.opencrs.com/rpts/RL32977_20050706.pdf

Jean Hearne (2005). ***Medicaid Eligibility for Adults and Children*** (RL 33019)
Available at: http://opencrs.cdt.org/document/RL33019

The Congressional Research Service at the Library of Congress is the non-partisan public policy research arm of the United States Congress. The foregoing reports (which are periodically updated) provide comprehensive information about Medicaid eligibility options. These reports also contain state-by-state information concerning the use of many the options.

Web Accessible Resources

Social Security Administration

Web-address: http://www.ssa.gov/notices/supplemental-security-income/text-understanding-ssi.htm

This SSA web page contains the publication: ***Understanding Supplemental Security Income***. This publication is a valuable tool for understanding the many facets of the SSI program.

Web-address: http://www.ssa.gov/pubs/englist.html#Disability

This web-page lists many SSA publications related to disability and disability determination.

Centers for Medicare & Medicaid Services

Web-address: http://www.cms.hhs.gov/MedicaidEligibility/01_Overview.asp

This part of the CMS web site contains information about Medicaid eligibility groups.

Kaiser Commission on Medicaid and the Uninsured: State Health Facts

Web-address: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi

This Kaiser Commission website contains state-by-state information regarding health care. It includes information (as of 2005) concerning Medicaid eligibility groups and some eligibility parameters.

Notes

[1] Jean Hearne (2005). *Medicaid Eligibility for Adults and Children*. Washington D.C.: The Library of Congress, Congressional Research Service

[2] Legal immigrants who entered the U.S. before August 22, 1996 must also meet the definition of a "qualified immigrant" in order to be eligible for Medicaid. A qualified immigrant is one whose category of immigration status is (a) Legal Permanent Resident (LPR), (b) Refugee, (c) Asylee, or one of several other categories. Immigrants deemed "nonqualified" are not eligible for basic Medicaid services regardless of legal status. Non-qualified immigrants are either (a) a Person Residing Under Color of Law (PRUCOL), (b) undocumented or (c) a non-immigrant such as a student or foreign visitor. For more detailed information, please see the National Health Law Program paper *Immigrant Access to Health Benefits: A Resource Manual*, available at http://www.accessproject.org/downloads/Immigrant_Access.pdf.

[3] Hearne (2005), *Op. Cit.*

[4] See Sarah Knipper (2004). *EPSDT: Supporting Children with Disabilities*. Cambridge MA: Human Services Research Institute (available at: http://www.hsri.org/docs/792FinalEPSDTBooklet.PDF) for a discussion of the interplay of Medicaid and SCHIP in securing services for low income children.

[5] Information about the disability determination process and the adult and child listings is contained in the Social Security Administration publication *Disability Evaluation Under Social Security* (also known as the Blue Book). The publication is available at: http://www.ssa.gov/disability/professionals/bluebook/

[6] The Social Security Act was amended in 1996 by P.L. 104-121 to prohibit the payment of SSDI benefits and SSI payments when drug addiction or alcoholism is material to the finding of disability

[7] Effective January 1, 2007, this amount will increase to $900 per month.

[8] From 1982 through June 1999, the SGA standard remained unchanged at $500 per month. In July 1999, the standard was increased to $700 per month and indexed to the year-over-year change in the national average worker wage index.

[9] Effective January 1, 2007, the SSI FBR for persons with disabilities will increase to $623 per month.

[10] U.S. Social Security Administration, Office of Policy, SSI Monthly Statistics – May 2006

[11] U.S. Social Security Administration, Office of Policy, OASDI Monthly Statistics – May 2006.

[12] Knipper (2004). *Op. Cit.*

[13] If a person only has earned income, then the amount of income that results in the loss of SSI cash assistance altogether is $1,291 in a month. This is referred to as the "breakeven point."

[14] In particular, §1619(a) of the Social Security Act provides that cash assistance will continue for persons with earned income above the SGA amount but below the breakeven point until the person is found ineligible for SSI and §1619(b) provides for the time-limited continuation of Medicaid eligibility for people whose earned income exceeds the breakeven point.

[15] §1634 of Social Security Act authorizes SSA to enter into agreements with states for this purpose.

[16] Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon and Utah

[17] Section 209(b) refers to the section of the Social Security Act Amendments of 1972 that gave states this option. This provision is contained in §1902(f) of the Social Security Act.

[18] Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

[19] For example, SSI is based on whether a person's disability will cause substantial impairment for at least 12 months. In Indiana and New Hampshire, the expected duration of the impairment must be at least 48 months.

[20] See also: CMS/Center for Medicaid and State Operations/Disabled and Elderly Health Programs Group (June 2002). "Groups Deemed to be Receiving SSI for Medicaid Purposes."

There are three eligibility groups for whom Medicaid must continue after SSI is lost: (a) People who lost SSI when they received automatic cost-of-living adjustments (COLAs) in Social Security (sometimes nicknamed "Pickle people" after Congressman Pickle, one of the sponsors of the original COLA legislation); (b) "Adult children with disabilities" who lose SSI when they become entitled to Social Security benefits based on a parent's Social Security entitlement. "Adult children with disabilities" are individuals who have a disability existing before age 22. When such a person's parent becomes disabled, retires or dies, the individual becomes eligible for SSDI. If an individual had an SSI benefit, then the SSDI benefit – if sufficiently large – completely replaces SSI. Federal law requires that these individuals continue to be considered SSI beneficiaries and receive Medicaid coverage; and, (c) Individuals ages 60-64 who lose SSI due to receipt of Social Security benefits for widows and widowers with disabilities.

[21] The Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99-643).

[22] Kaiser Commission on Medicaid and the Uninsured (2006). Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. Washington DC.

[23] According to the Congressional Research Service: California, District of Columbia, Florida, Georgia, Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont and Virginia.

[24] There is more information concerning these options on the CMS web site (cms.hhs.gov/TWWIA/01_Overview.asp#).

[25] P.L. 106-170

[26] Periodic continuing disability reviews assess whether individuals still meet SSI/SSDI eligibility criteria.

[27] SSDI beneficiaries whose earnings exceed the SGA standard enter what is termed a Trial Work Period. Once that Trial Work Period is completed and the person's earnings continue to exceed the SGA standard, the person faces the potential termination of SSDI. SSDI does not have a provision similar to 1619(a) that benefits SSI beneficiaries.

[28] States at their option may disregard a certain amount of income for waiver beneficiaries to support themselves and any dependents in the community. This amount is typically called a personal maintenance allowance. The amount of income remaining after subtracting the personal maintenance allowance is the cost-sharing obligation. States vary in the amount of the maintenance allowance they allow, from $800 to $1,809 (the full 300 percent of SSI standard).

[29] For example, Louisiana excludes mental health services as well as others; some states do not include prescribed drugs.

[30] Typically this is every month. In some states, it is every six months. But in the latter case, the person must be able to spend-down an amount that equals six times their monthly "excess" income before becoming eligible.

[31] Information about waivers is located at: cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp

[32] An exception arises in the case of SSI recipients in §1634 states, as previously noted.

[33] §1902(a)(8) of the Social Security Act and 42 CFR 935.911.

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Chapter 3:

Medicaid Benefits and Service Delivery

The services that a state covers in its Medicaid program have important ramifications for assisting people who are at risk of or experience homelessness and qualify for Medicaid. A state may offer a wide range of health, chronic care, and long-term services through its Medicaid program. Indeed, the scope of the benefits that a state *potentially* may cover is robust, far exceeding the benefits that are available through the Medicare program or covered by most private health plans.

Federal law requires that each state must provide a core package of fourteen mandatory benefits in its Medicaid program. These required services may be supplemented by many optional benefits. Also, by operating one or more waiver programs, a state may provide still additional benefits. However, as is the case with eligibility, there are major differences among the states in the benefits that they offer.

This chapter contains information about the benefits that states must and may offer through their Medicaid programs. It also discusses the basic parameters that apply to the "coverage" of a service. The chapter then spotlights certain dimensions of coverage that affect certain groups of Medicaid beneficiaries (e.g., children). Finally, the chapter delves into topics related to the *delivery* of covered Medicaid benefits, including the use of managed care and other service delivery arrangements. Chapter 4 provides additional information about certain Medicaid benefits that can be especially important in assisting people who experience chronic homelessness.

Mandatory and Optional Benefits

The table on the following page displays the mandatory benefits that each state must include in its Medicaid program along with the optional benefits that a state may cover. As can be seen from the table, mandatory benefits include core health services such as inpatient and outpatient hospital, physician, and laboratory and x-ray services. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children are especially important and are discussed in more detail below.

As also can be seen, there are many optional services that a state may offer. Optional services include essential health services such as prescribed drugs (covered by all states) and therapeutic services such as physical and occupational therapy. Optional services also include long-term services and supports that can play a critical role in supporting people who have major functional limitations. Federal Medicaid law does not explicitly provide for the coverage of non-institutional behavior health services such as substance abuse and mental health treatment. However, behavioral health services may be and are furnished by states through the mandatory (e.g., physician services) and optional coverage categories (e.g., rehabilitative services), as will be discussed in Chapter 4.

In 2005, about 68.5% of Medicaid expenditures paid for acute and chronic care health services.[1] Historically, hospital, prescribed drugs, outpatient, and physician services have accounted for the bulk of Medicaid expenditures.[2] Spending for institutional and community long-term services and supports accounted for the remaining 31.5% of all Medicaid expenditures.[3] Between 2000 and 2005, spending for health services grew at a faster rate than long-term services due to the increased enrollment of children and non-disabled adults during the period. Outlays for mandatory services historically have accounted for about 69.5% of total Medicaid spending.[4]

Mandatory & Optional Medicaid Benefits

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- Pregnancy-related services
- Physician services
- Nursing facility services for persons age 21 or older
- Home health services for persons entitled to nursing facility services
- Federally qualified health-center (FQHC) services and ambulatory services of an FQHC that would be available in other settings
- Rural health clinic services.
- Laboratory and x-ray services
- Nurse-midwife services
- Vaccines for children
- Family planning services and supplies
- 60-days of postpartum-related services
- Certified pediatric and family nurse practitioner services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

Optional Benefits

- Diagnostic services
- Physician-directed clinic services
- Private duty nursing services
- Dental services and dentures
- Transportation services
- Durable medical equipment
- Rehabilitative services
- Occupational therapy
- Therapies for speech, hearing and language disorders
- Psychologist services
- Podiatrist services
- Primary care case management
- Skilled nursing facility services for children under age 21
- Inpatient hospital and nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Psychiatric residential treatment facility services for people under age 21
- Home and community-based services as an alternative to institutionalization (§1915(c) waiver authority)
- Self-directed home and community services*
- Screening and preventive services
- Optometrist services and eyeglasses
- Prescribed drugs
- Prosthetic devices
- Chiropractic services
- Tuberculosis-related services
- Physical therapy
- Hospice care
- Respiratory care for ventilator-dependent individuals
- Services for persons with sickle cell disease[5]
- Personal care/assistance
- Targeted case management
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Inpatient psychiatric facility for people under age 22
- Home and community-based services (§1915(i) State plan coverage authority)*
- Program of All-inclusive Care for the Elderly (PACE)
- Other medical or remedial care furnished by licensed practitioners under state law[6]

* Effective January 1, 2007

As previously noted, states vary considerably in their coverage of these optional services. Many of the optional services (e.g., prescribed drugs) are covered by nearly every state. However, variation arises from the discretion that states have in defining the parameters of their coverage of services. For example, there is variation among the states with respect to whether services are available only to categorically eligible persons, medically needy individuals or both. There also are major variations in the scope and amount of services that states furnish under optional coverages. For example, a state may furnish targeted case management services to one or several "targeted" groups of beneficiaries. As a consequence, it is always necessary to delve into the details of each state's coverages to understand their scope. One state's coverage of a service may be more or less generous than another's.

Chapter 4 discusses in detail certain services that are especially pertinent to supporting people who are at risk of or experience homelessness. These services include behavioral health services, personal assistance, case management, and home and community services.

Coverage Parameters

Certain parameters apply to the coverage of services under Medicaid. These include:

Amount, Duration, and Scope of Services

Within broad federal guidelines and certain limitations, a state may establish limits on the amount, duration, and scope of the services that it offers. For example, a state may limit the number of outpatient mental health visits that it covers during a year or limit the number of hours of community support that may be furnished each month. However, such limitations must be crafted so that each covered benefit is "sufficient in amount, duration, and scope to reasonably achieve its purpose."[7]

Also, a state may not arbitrarily deny or reduce the amount, duration, or scope of a service based on a beneficiary's diagnosis, type of illness, or condition.[8] This restriction applies to all categorically needy individuals, even those whose eligibility depends upon a specific diagnosis, such as women in need of treatment for breast or cervical cancer. For example, a state may not impose different limits on the amount of personal care that can be provided to people with disabilities than to older persons.

Any limitation on the amount, duration, and scope of a service must uniformly apply to all categorically needy beneficiaries in a state's program, regardless of whether they are mandatory or optional beneficiaries. However, this requirement does not apply to medically needy beneficiaries. States have more flexibility in limiting benefits to this group of beneficiaries. There is one benefit upon which states may not place limitations of amount, duration, and scope except based on medical necessity: EPSDT services for children under 21 (discussed below).

Medical Necessity

In the Medicaid program, states are responsible for developing their own *medical necessity* criteria. Often these criteria are embedded in state limitations on the amount, duration, and scope of services. Medicaid beneficiaries are entitled to covered services that are medically necessary to meet the person's needs. A state may deny payment for a service that is not considered medically necessary even if it arguably falls under a state benefit. Depending on a state's definition, this could occur if an individual's diagnosis does not warrant an intense level of treatment (even if the treatment is generally covered by the state). For example, states often limit the provision of Medicaid mental health rehabilitative services to individuals who have substantial functional limitations. States may also require prior authorization before a service is furnished to a beneficiary in order to determine its necessity and appropriateness. States also engage in utilization review and management to ensure that the services furnished to beneficiaries are medically necessary.

Comparability

Any Medicaid benefit offered to one group of categorically eligible individuals must be offered to all groups of categorically eligible individuals,[9] except when federal law itself creates an exception (e.g., as in the case of ICF/MR services, which may only be furnished to persons with mental retardation and other related conditions). This comparability requirement is a fundamental feature of Medicaid. A state cannot design its benefit package so that, for example, dental services are only available to pregnant women but not SSI recipients. Contingent on any limitations on the

amount, duration, and scope, dental services must also be available in the same quantity to all categorically needy beneficiaries. An exception to the comparability requirement is "targeted case management." Under the provisions of Section 1915(g) of the Social Security Act, states may "target" case management services to specific sub-populations of Medicaid beneficiaries, such as persons with serious mental illness or pregnant women under age 21. States also may request waivers of this requirement under the three principal waiver authorities.

Statewideness

States are required to offer the services in their Medicaid benefit package to all eligible recipients without regard to geographic location.[10] For example, a state cannot offer services under the clinic option (such as outpatient mental health services) to persons in urban areas but exclude access to people living in rural areas. Again, the exception to this rule is targeted case management. Not only can a state target case management services to a specific population, but also limit the services to specific areas of the state. The waiver authorities also permit waiving this requirement.

Free Choice of Provider

Medicaid law (§1902(a)(23) of the Social Security Act) provides that beneficiaries must be free to choose any provider of a service from among all qualified participating providers, except as specifically provided by law.[11] The primary exception to this fundamental and longstanding requirement is when a state has secured federal approval to employ a managed care service delivery arrangement or otherwise has secured a waiver under the provisions of §1915(b)(4) of the Act in order to limit the providers of a service to preferred providers. Free choice of provider extends only to qualified providers who have a provider agreement with the state.

Except under managed care arrangements, Medicaid beneficiaries have free choice of provider.

Prohibition Against Coverage of Room and Board

Federal Medicaid law does not permit states to claim federal financial participation in the costs of "room and board" (shelter, food and other routine living expenses) associated with the delivery of a service except in Medicaid-reimbursable institutional settings such as nursing facilities. This prohibition is long-standing and also applies to services that are furnished under the waiver authorities. The costs of room and board must be met from a beneficiary's own resources and/or other federal, state and local programs. As a general matter, states disregard the value of federal, state and local housing subsidies, and other income-related benefits such as food stamps when determining whether a person is eligible for Medicaid.

Provider Requirements

States have latitude in establishing the requirements that providers must meet in order to qualify to furnish Medicaid services. Providers, of course, must possess any licenses or meet other requirements which are specified in state law that pertain to the provision of a service. The qualifications that a state establishes must be reasonably related to the provision of the underlying service. In the case of a few services (e.g., nursing facility or ICF/MR), providers are required to meet detailed standards that are spelled out in federal law and/or regulations. In some cases (e.g., home health services), providers must also be certified under the Medicare program.

Once a state has established its requirements, then the state must offer a provider agreement to any willing provider that meets the state's requirements, agrees to

accept Medicaid payment, and abides by other fundamental requirements. In other words, a state may not pick and choose among qualified providers. In many states, it is possible for an individual or organization to quickly enroll as a Medicaid provider over the Internet. The main exception to the open enrollment of qualified providers again arises in managed care service delivery arrangements.

Provider Agreement

In order to receive payment for rendering Medicaid services, a provider must have entered into a formal "provider agreement" with the State Medicaid agency. There are some exceptions to this requirement (e.g., when a managed care arrangement is used, providers enter into agreements with the managed care entity).

Payments

In order to receive payment for services rendered, a provider must prepare and submit a "claim" for payment, usually to a state-contracted financial intermediary (fiscal agent). The financial intermediary receives and "adjudicates" claims and processes payment to the provider when the claim passes the checks in the claims processing system.[12] The claim must identify the beneficiary to whom the service was rendered and include information about the service that was provided as well as the date and location of the service. Providers are expected to maintain sufficient underlying documentation (e.g., signed service logs) so that the claim can be verified if need be. Medicaid does not operate as a grant program; it is a claim-based reimbursement program. Except when services are delivered through a managed care arrangement, Medicaid payments are not made in advance of the provision of services, only after the service has been provided.

States generally provide for the electronic submission of claims. Medicaid electronic transactions are subject to the provisions of the Health Insurance Portability and Accountability Act of 1996[13] (HIPAA). Under federal law, the Medicaid payment must be paid to the provider that rendered the service.[14] In managed care arrangements, payments are made by the managed care entity to the service providers in the managed care entity's provider network.

Additional Coverage Dimensions

There are certain dimensions of service coverage that warrant additional discussion.

EPSDT[15]

The federal EPSDT mandate requires states to provide a full range of preventive and comprehensive care to children.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is a mandatory component of every state's Medicaid program.[16] Under federal EPSDT requirements, a state must operate a comprehensive, preventive child health program (including periodic screening, vision, dental, and hearing services) for Medicaid-eligible individuals under the age of 21. Under the provisions of Section §1905(r)(5) of the Social Security Act, any medically necessary health care service that is listed in §1905(a) of the Act must be provided to an EPSDT-eligible beneficiary, even when the service is not provided under the State plan to other Medicaid beneficiaries. The EPSDT mandate extends to all Medicaid beneficiaries under age 21 regardless of their eligibility pathway (e.g., whether as a poverty-level children or as a child with a disability).

The EPSDT program consist of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. These components enable states to operate a comprehensive child health program of prevention and treatment, to reach out to eligible children and their families to inform them of the benefits of prevention and the health services and assistance that are available, and assist them to use health resources. EPSDT provides for the assessment of the child's health needs through scheduled initial and periodic examinations and evaluations so that health problems are diagnosed and treated early before they become more complex and their treatment more costly.

It is important to emphasize that federal EPSDT requirements override any other limitations on services under the State plan. EPSDT requirements dictate that a state must furnish any medically-necessary service that could be covered under the State plan to eligible children and youth even when the State plan itself does not specifically include the coverage. For example, a state must make payment for necessary behavioral health services for children who have a serious emotional disturbance even though such services may not specifically be included in the State plan.

Cross-Over of Medicare and Medicaid Benefits

As previously noted, there are approximately 6.4 million individuals who are "full benefit" Medicare and Medicaid dual eligibles. These persons have full Medicare coverage and also are entitled to the services offered through their state's Medicaid program.[17] Medicare Part A (Hospital Insurance) covers inpatient hospital services, post-hospitalization nursing facility services, and home health services. Medicare Part B (Medical Insurance) covers physician services, outpatient medical and surgical services and supplies, diagnostic tests and laboratory services, and certain durable medical equipment. It also covers limited outpatient mental health services and some types of therapeutic services. Medicare Part D covers prescription drugs and is discussed below.

There is overlap between the services provided under Medicare Parts A and Parts B and the services that states must or may offer under their Medicaid programs, especially with respect to acute and chronic care services. In the case of most acute health care services, full-benefit dual eligibles obtain such services through Medicare. Medicaid plays the role of covering "wrap around" benefits when the state's Medicaid program offers additional services that are not covered by Medicare. In the case of full-benefit dual eligibles, Medicaid pays all Medicare deductibles and co-pays as well as the monthly Part B premium. For example, Medicare coverage of mental health services is limited to outpatient/clinic treatment services and limited hospitalization. Under Medicaid, states may and usually do offer a fuller range of rehabilitative mental health services that are not offered through Medicare. Another major difference between Medicare and Medicaid is that Medicare only covers limited long-term services while states may offer a full range of such services through their Medicaid programs.[18] For example, Medicare does not provide for the coverage of personal assistance services.

Prescription Drugs & Dual Eligibles

Until January 2006, the coverage of prescription drugs was one of the major differences between the Medicare and Medicaid programs. Medicare did not cover prescription drugs while Medicaid did. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"; P.L. 108-173) added the Part D coverage of prescription drugs to the Medicare program, effective January 2006. Part D enables Medicare beneficiaries to sign up for a prescription drug plan (PDP) that is operated by

a CMS-approved vendor. As a general matter, Medicare beneficiaries who want this coverage must pay an additional monthly premium and are subject to co-payments and deductibles. Also, Medicare beneficiaries are responsible for prescription drug costs that they incur between $2,250 and $5,100 each year (sometimes referred to as the "doughnut hole"), after which Part D coverage resumes with substantially reduced beneficiary cost-sharing requirements. Premiums, co-pays, and deductibles vary by plan. Each PDP may offer multiple plans and specify the range of medications that its plan covers. However, some classes of medications are subject to special requirements.[19] Some low income Medicare beneficiaries are eligible for premium assistance through a program called "Extra Help" (see below).

MMA also mandated that full-benefit dual eligible Medicare-Medicaid beneficiaries obtain their prescription drugs through a Part D PDP or a prescription drug plan offered by the Medicare Advantage plan (operated under Medicare Part C[20]) in which they are enrolled. In particular, after January 2006, states were no longer permitted to claim federal financial participation in the costs of prescription drugs furnished to dual eligibles except for certain classes of medications that are not covered by Part D.[21] In late 2005, full coverage dual eligibles enrolled in a Part D plan; individuals who did not select a plan were "auto-enrolled" in a PDP. New dual eligibles are auto-enrolled in a plan but may select another PDP if they wish. Full benefit dual eligibles do not pay a Part D premium nor are they subject to deductibles. However, they are subject to co-payments.[22]

This change affected approximately 6.4 million full benefit dual eligibles. These individuals previously obtained their prescription drugs through Medicaid. Depending on the state, these persons often did not face co-payment requirements. In addition, state drug formularies (the types of prescribed drugs available under the State plan) generally are relatively open, especially with respect to medications that are important for treating mental illnesses. As could be expected, the switch-over to Part D coverage proved to be especially challenging for CMS, states, and beneficiaries. During the changeover period, many states took steps to ensure that beneficiaries continued to receive necessary medications without interruption.

Full benefit dual eligibles who obtain prescription drugs via Part D may change their PDP at any time. They can select a plan that furnishes the types of medications that they require or change to a plan that provides them with more satisfactory service and coverage. This ability to switch plans is important for dual eligibles who typically have complex drug regimens. Many dual eligibles are people who have serious mental illnesses who rely heavily on mediations to treat their illness.

Low-income Medicare beneficiaries who are not full benefit dual eligible beneficiaries potentially can obtain financial assistance with paying the Part D premium through the Extra Help program. The Extra Help program provides full or partial premium assistance for persons with incomes up to 150% of FPL. Extra Help enrollees also have reduced exposure to the doughnut hole coverage gap. Extra Help assistance can provide important benefits for low-income individuals who are enrolled in Medicare Savings Plans.

Benchmark Benefit Plans[23]

The Deficit Reduction Act of 2005 permits states to provide alternative benefit packages (a.k.a., "benchmark plans") to Medicaid beneficiaries in lieu of their obtaining Medicaid services through customary fee-for-service arrangements.[24] A state may mandate that certain beneficiaries (generally, healthy adults and children) enroll in a benchmark plan. A state also may provide for the *voluntary* enrollment of other beneficiaries (e.g., people with disabilities and children with

special health needs) in a benchmark plan. When coverage is furnished through a benchmark plan, the state pays a premium to the plan.

This option permits states to provide Medicaid beneficiaries with access to mainstream health networks where they may enjoy fuller and more reliable access to benefits. In some instances, states may be able to craft benefit packages for some populations that are more robust than are offered under the State plan.

A benchmark plan is defined as one that provides equivalent coverage to one of three recognized coverage standards: (a) the Federal Employees Health Benefit Plan; (b) the health benefits plan that a state makes available to its own employees; or, (c) the health plan offered by the largest commercial Health Maintenance Organization (HMO) insurer in a state. A state may craft its own benefit plan but must demonstrate to CMS that the plan will provide appropriate coverage. In the case of beneficiaries who work and have access to an employer-sponsored health plan, a state may pay the health plan premium on behalf of the beneficiary, provided that the coverage under the employer plan is at least equivalent to a benchmark plan. In addition, a state may augment the benchmark benefit plan with additional wrap-around services.

The state must ensure that children and youth under the age of 19 who are enrolled in a benchmark plan receive the full range of EPSDT services. In order to meet this requirement, a state must furnish wrap-around benefits to augment the coverage that is provided by the benchmark plan. The state also must ensure that beneficiaries continue to have access to rural health clinic services and Federally Qualified Health Center services (see below).

Service Delivery Arrangements

Over the years, alternative service delivery arrangements have emerged under Medicaid. The emergence of such arrangements has more or less paralleled similar changes in the rest of the nation's health care service delivery system. This section focuses on three specific types of Medicaid service delivery arrangements: (a) managed care; (b) "care management" models; and, (c) rural health clinics and Federally-Qualified Health Centers (FQHCs).

Managed Care

Starting in the early 1990s, there was a major shift in private-sector health care service delivery to the expanded use of "managed care" arrangements. Such arrangements feature a payer (e.g., an employer) making a fixed monthly "capitation" payment to a managed care organization (MCO) that agrees to provide a specified set of services to enrollees. The MCO either furnishes the services directly to enrollees and/or obtains the services through a network of contracted providers. Usually, the MCO is financially at risk: that is, if costs exceed premium payments, the MCO bears the loss; if costs are less than premiums, the MCO makes a profit.

Over the past decade, states have stepped up their use of managed care arrangements to deliver Medicaid services.

States were slower to shift the delivery of Medicaid services to managed care arrangements than the private sector. However, there has been a steady growth in the use of such arrangements over the past decade. In 1996, about 40 percent of Medicaid beneficiaries nationwide were enrolled in managed care arrangements; by 2005, the figure had climbed to about 63 percent.[25] Federal law provides several options for employing managed care arrangements to deliver Medicaid benefits. In the main, two types of arrangements are employed:

- **Primary Care Case Management (PCCM)**. Under this type of arrangement, Medicaid beneficiaries are assigned to or select a physician who agrees to coordinate the delivery of their health care services. Physicians usually receive a fixed "per member per month" payment for performing this care coordination function. Under a PCCM arrangement, beneficiaries obtain services through fee-for-service arrangements. PCCM arrangements are intended to give beneficiaries a "medical home" and also promote the effective and efficient delivery of services.
- **Managed Care Entities**. A state may contract with one or many managed care entities to deliver specified services to Medicaid beneficiaries. Federal law defines three basic types of managed care entities: (a) managed care organizations (MCO); (b) prepaid inpatient health plans (PIHP); and, (c) prepaid ambulatory health plans (PAHP). An MCO provides comprehensive services under a risk-based contract. PIHPs and PAHPs arrangements typically encompass a narrower range of benefits and may operate under various types of risk-bearing arrangements. A PIHP arrangement includes the provision of in-patient hospital and other services. For example, some states contract with behavioral health PIHPs for mental health services where the PIHP is at risk for psychiatric hospitalization episodes. A PAHP arrangement does not include the delivery of in-patient services. PAHP arrangements sometimes are limited to the delivery of single services such as dental or transportation services.

In 2005, most Medicaid beneficiaries enrolled in a managed care arrangement received services from managed care entities rather than through PCCM arrangements. Also, while initially states targeted the use of managed care to children and adults, there has been a steady increase in the number of individuals with disabilities who are served through such arrangements.

The delivery of services through a managed care arrangement does not affect the underlying overage of a service as set forth in the State plan. A managed care arrangement is best understood as an alternative means of delivering the services that are covered in the State plan. The essential parameters of the State plan coverage remain the same. Managed care arrangements are designed to integrate the delivery of services, better manage service utilization, and reduce costs by negotiating favorable payment rates with providers and provider-networks. To the extent that managed care results in lower costs, a state may reinvest the savings it realizes by providing additional services to enrolled beneficiaries over and above those covered in the State plan.[26]

A state may provide for the mandatory enrollment of beneficiaries in a managed care arrangement or, alternatively, provide that beneficiaries may voluntarily select a managed care arrangement in lieu of obtaining services on a fee-for-service basis. A state may provide for mandatory enrollment in a managed care arrangement under its State plan under the provisions of §1932 of the Social Security Act[27], so long as beneficiaries are afforded the choice of two or more service delivery arrangements (e.g., the choice between a managed care entity and a PCCM arrangement). Alternatively, a state may request waivers of Medicaid statutory provisions for the purpose of mandating the enrollment of beneficiaries in a plan. Waivers may be requested under the §1915(b) waiver authority or the broader Section 1115 authority for this purpose. Alternatively, a state may contract with a managed care entity to provide a package of services but not mandate that beneficiaries enroll with the entity to receive services.[28] In other words, beneficiaries can elect to continue to receive services on a fee-for-service basis. This type of arrangement is sometimes employed to integrate the delivery of health and long-term services or to provide coordinated

services to certain high risk populations (e.g., people living with AIDS), as discussed in the next section.

There are extensive federal statutory and regulatory requirements that govern the operation of managed care arrangements. These are contained in §1932 of the Act and federal regulations located in 42 CFR 438.[29] There are important safeguards that are designed to guard against managed care entities under serving enrollees. For example, states are expected to specify how managed care plans will maintain provider networks that provide sufficient geographic access to services and develop and monitor quality indicators such as enrollee satisfaction surveys or grievances. In addition, states are required to identify individuals with special health needs (e.g., individuals with chronic conditions or disabilities and/or persons who are homeless) and require that managed care entities assess "each special needs enrollee to identify conditions that require regular treatment and monitoring and provide these enrollees with direct access to health care providers who specialize in that condition."[30] Medicaid regulations also require that states take steps to accommodate the language or cultural differences of managed care enrollees.

Care Management/Integrated Services Models

Several states have designed "care management" models to address the needs of Medicaid beneficiaries who have complex conditions. Some are "disease management" models that focus on beneficiaries with conditions such as congestive heart failure, diabetes, coronary artery disease, chronic pulmonary disease and asthma. People with these conditions have high health risks and, if the condition is not treated properly, individuals experience high rates of costly hospitalization and emergency room use. Disease management models feature the use of skilled practitioners and interdisciplinary clinical teams to improve the health outcomes of individuals with specific diseases by employing optimal practices. Examples of disease management activities include medical assessments, patient disease and dietary education, and instruction in health self-management, and medical monitoring. States contract with disease management organizations and individual practitioners for these services. Disease management offers states a way to improve beneficiary health and reduce the high costs associated with certain diseases.[31] For example, North Carolina recently embarked on a major initiative to expand these types of services to beneficiaries who have specific diseases. Some people who experience homelessness can benefit from disease management strategies.

States also are stepping up their use of care management/integrated care models. These models usually are broader in scope than disease management models. Integrated care models often wrap around both health and long-term services and usually target children and/or adults with disabilities. The premise of integrated care models is that coordinated care can lead to better outcomes and reduced costs in serving people who have complex, multi-dimensional needs. For example, people with disabilities frequently also have accompanying complex health care conditions or their disability makes them vulnerable to health care problems. By integrating the delivery of health and long-term services, it can be possible to improve not only a beneficiary's health but also reduce their vulnerability to hospitalization and/or institutionalization.

For example, Minnesota Disability Health Options (MnDHO) is a program for working age people with physical disabilities who are eligible for Medicaid, including dual eligibles. MnDHO operates in a multi-county area around Minneapolis. Enrollees receive the full range of Medicaid and Medicare benefits (if they are dual eligibles), including acute care, home and community-based services, and others. All enrollees

are matched with a health coordinator, a nurse who helps them navigate the health care system and get the services that they need. MnDHO takes a holistic approach by focusing on enrollee strengths and on preventive care, housing, employment, and other needs. Enrollees and health coordinators work together to plan the best way to maintain their health and independence. MnDHO operates under federal waivers that permit the integration of acute and long-term services and contracting with a managed care entity for the provision of health services. Enrollment in MnDHO is entirely voluntarily; people who are dissatisfied may return to the regular fee-for-service system at any time.

Other states (e.g., Georgia, Texas, and Wisconsin) also have developed and implemented integrated service delivery models that are promising approaches to addressing the health and other support needs of Medicaid beneficiaries.

Federally Qualified Health Centers

Federally-funded or designated community health centers furnish primary and preventive care to low-income individuals and families. About 69% of the individuals served by community health centers have incomes below 100% of FPL and 90% have incomes lower than 200% of FPL. Nationwide, an estimated one out of every four persons who experience homelessness and one out of every eight Medicaid beneficiaries obtain their health care through community health centers.

Community health centers focus on serving medically underserved areas (e.g., inner cities) and medically underserved low-income populations (e.g., migrant workers). Nationwide, there are more than 1,000 community health centers that operate more than 5,000 sites in urban and rural areas. Through the Health Center Initiative, the President has set the goal of substantially expanding the network of community health centers to expand access to health care on behalf of uninsured and underinsured individuals and families.[32] An important element of the initiative has been to expand the capacity of centers to provide mental health and substance abuse services. Community health centers furnish comprehensive preventive and primary care, including dental, mental health/substance abuse, and pharmacy services. They also provide support services such as transportation, social services and patient education. Community health centers must treat individuals regardless of their ability to pay.

FQHCs link the delivery of Medicaid services to the nation's community health center network.

In recognition of the important role that community health centers play in serving low-income individuals and families, states must cover the services that are furnished by "Federally Qualified Health Centers" (FQHCs) under their Medicaid programs.[33] This requirement links state Medicaid programs to the community health care center network. An FQHC is:

- A community health center that has received a grant under §330 of the Public Health Service Act (see below) and meets the standards related to quality, cost, and oversight associated with such grants;
- A community health center that does not receive a grant under §330 but meets all the eligibility requirements associated with the receipt of such a grant. These entities are termed FQHC "look-alikes;" and,
- Outpatient health programs or tribal facilities operated by a tribe or tribal facility under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

FQHCs also enjoy special status as providers under the Medicare program. A related entity that also enjoys special status under the Medicare and Medicaid programs is a rural health clinic (RHC). A RHC is a clinic that is staffed principally by nurse practitioners and physician assistants and is located in a federally designated rural area where there is limited access to primary health.

The §330 health center grant program is administered by the federal Bureau of Primary Health Care (BPHC) at the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services. There are four types of §330 grantees: (a) community health centers; (b) migrant health centers; (c) public housing health centers; and, (d) Health Care for the Homeless (HCH) grantees. HCH grantees provide primary health care and substance abuse services at locations that are accessible to people who are homeless (e.g., at or near shelters); emergency care with referrals to hospitals for in-patient care services and/or other needed services; outreach services to assist difficult-to-reach homeless persons in accessing care; and, assistance in establishing eligibility for entitlement programs and housing.[34] In 2004, there were 182 HCH grantees who served about 600,000 individuals. HCH grantees as well as other community health centers are an important source of health care for people who experience homelessness, including individuals who do not qualify for Medicaid.

Medicaid beneficiaries account for about 36% of the individuals served by FQHCs. Under Medicaid, FQHCs provide a package of primary and preventive care services, including services furnished by a physician, nurse practitioner, physician assistant, clinical psychologist and clinical social worker and other ambulatory services covered in the State plan. Centers are paid for the services that they furnish to Medicaid beneficiaries on a per visit basis rather than billing separately for each discrete service that is provided during a patient visit. In 2004, federal-state Medicaid spending for FQHC-provided services totaled about $1.3 billion. Medicaid is the single largest source of FQHC revenue.

In 2000, a prospective payment system (PPS) for FQHC-provided Medicaid services was established.[35] This system replaced the previous cost-based reimbursement system. Payments under this system are indexed to the Medicare Economic Index. States have the option of using the PPS payment rates, maintaining the predecessor cost-based reimbursement system, or developing an alternative payment mechanism so long as the resulting rates are no lower than the rates that would be paid under PPS. As a general matter, rates paid to FQHCs are more generous than rates paid to other providers of comparable Medicaid services. In addition, states are required to make supplemental payments to FQHCs that provide services to individuals who are enrolled in a managed care when the payment from the managed care entity is less than the amount that Medicaid would pay.

Conclusion

Federal law permits states to supplement mandatory Medicaid benefits with a wide range of optional services. When offering a service under Medicaid, states must fashion their coverages to comply with certain federal requirements.

The federal EPSDT mandate dictates that states furnish a full range of preventive and comprehensive health care to child Medicaid beneficiaries. Recent changes in federal law permit states to fashion benchmark benefit packages to link Medicaid beneficiaries to mainstream health care service delivery systems.

States may employ alternative arrangements, including managed care, to deliver services to beneficiaries. Some of the alternative arrangements that states employ

are aimed at improving the care of beneficiaries with specific health care conditions or integrating the delivery of health and long-term services. States are required to pay for services furnished by Federally-Qualified Health Centers. Such centers are an important source of health care for people who experience homelessness.

Resources

Publications

Kaiser Commission on Medicaid and the Uninsured

The Medicaid Resource Book (2002)
Available at: http://www.kff.org/medicaid/2236-index.cfm

Chapter 2 of this publication contains additional information about Medicaid benefits and the parameters of Medicaid coverage.

National Health Policy Forum at George Washington University

Jessamy Taylor (2004). The Fundamentals of Community Health Centers. Washington DC.
Available at: http://www.gwumc.edu/sphhs/healthpolicy/ggprogram/BP_CHC_08-31-04.pdf

This report provides an overview of the roles that community health centers play along with information about Federally-Qualified Health Centers.

Web Accessible Resources

Centers for Medicare & Medicaid Services

Web-address: http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/

This CMS web-page provides information about EPSDT benefits and requirements for states in operating EPSDT.

Web-address: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/

This CMS web-page contains information about the waivers that states may employ to implement managed care service delivery arrangements.

Kaiser Commission on Medicaid and the Uninsured

Web-address: http://www.kff.org/medicaid/benefits/index.jsp

This site contains Medicaid Benefits survey data about Medicaid benefits covered, limits, co-payments and reimbursement methodologies for the 50 states, the District of Columbia and the Territories.

Bureau of Primary Health Care, Health Resources and Services Administration
Web-address: http://www.bphc.hrsa.gov/

This web-site contains information about the funding and operation of community health centers under the Public Health Services Act and the President's Health Center Initiative (at: http://www.bphc.hrsa.gov/chc/pi.htm).

National Conference of State Legislators

Web-address: http://www.ncsl.org/programs/health/hcweb.htm

This web-page contains a wide range of information concerning community health centers and the President's Health Center Initiative.

Notes

[1] Brian Burwell et al. (2006). *Medicaid Long Term Care Expenditures for FY 2005*. Cambridge MA: Medstat.
[2] Elicia Herz et al. (2005). *How Medicaid Works – Program Basics*. Washington DC: The Library of Congress, Congressional Research Service.

[3] Burwell et al., op. cit. Medicaid long-term care services include institutional services (nursing facility and ICF/MR services) and community services such as personal care, home health, and home and community-based services furnished under the 1915(c) waiver authority.

[4] Anna Somers, Ph.D., Arunabh Ghost and David Rousseau, M.P.H. (2005). *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories*. Washington DC: The Kaiser Commission on Medicaid and the Uninsured.

[5] This coverage was added by the American Jobs Creation Act of 2004 (AJCA) (P.L. 108-357). See also CMS State Medicaid Director Letter #05-003, available at: http://www.cms.hhs.gov/smdl/downloads/smd092905.pdf.

[6] For example, California covers acupuncturist services

[7] See federal regulation at 42 CFR 440.230(b)

[8] See federal regulations at 42 CFR 440.230(c)

[9] See federal regulations at 42 CFR 440.240

[10] As provided in §1902(a)(1) of the Social Security Act and federal regulations at 42 CFR 431.50.

[11] See also federal regulations at 42 CFR 431.51

[12] Most Medicaid claims are processed through a federally-approved Medicaid Management Information System operated by contractors. Claims adjudication includes determining that the beneficiary was Medicaid eligible on the date that the service was rendered and performing other checks to verify that the claim is allowable.

[13] P.L. 104-191

[14] As provided in §1902(a)(27) of the Social Security Act. There are limited exceptions to this requirement. Claims may be submitted and payment routed through billing agents and organized health care delivery systems.

[15] In addition to the information posted on the CMS website (see Resources above), see also Sarah Knipper (2004). *EPSDT: Supporting Children with Disabilities*. Portland Oregon: Human Services Research Institute (available at: http://www.hsri.org/.

[16] This mandate was added in the Omnibus Budget Reconciliation Act of 1989.

[17] See Centers for Medicare & Medicaid Services: *Medicare and You* – 2006 for more complete information about Medicare coverages. Available at: http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

[18] Medicare covers skilled nursing facility services for a period of up to 180-days following a hospitalization. Medicare also covers home health services.

[19] Plans are required to cover "all or substantially all" of the drugs in the following classes: anticonvulsants; antidepressants; anticancer drugs; antipsychotics; immunosuppressants; and HIV/AIDS drugs.

[20] Part C contains provisions for obtaining Medicare services through health plans operated by HMOs and other types of provider networks.

[21] The main classes of drugs that are not covered by Part D are barbiturates and benzodiazepines. Benzodiazepines and barbiturates are prescribed in the treatment of disorders such as generalized anxiety, insomnia, and seizures—disorders commonly diagnosed in the elderly population. If a state elects to offer excluded drugs to other Medicaid beneficiaries, it must offer them to dual eligibles.

[22] However, dual eligibles are limited to selecting a plan with a premium that is no more costly than the regional average.

[23] CMS issued guidance concerning benchmark benefit plans in State Medicaid Director Letter #06-008 (March 31, 2006), located at: http://www.cms.hhs.gov/smdl/.

[24] This option was added in Section 6044 of the Deficit Reduction Act of 2005.

[25] CMS: Finance, Systems, and Budget Group: *Medicaid Managed Care Enrollment Report (as of June 30, 2005)*. Available at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/mmcer04.pdf.

[26] For example, under the 1915(b) waiver authority, a state may cover and make available to individuals enrolled in a managed care plan additional services up to the amount of the savings that the state realizes. These are termed "(b)(3)" services. Such services are available to plan enrollees but a state is not required to provide them to other Medicaid beneficiaries who are not enrolled in the plan. For example, Michigan, under its 1915(b)/1915(c) combination waiver for developmental disabilities and mental health services, applies savings to purchase supported employment services for enrollees.

[27] §1932 was added to the Social Security Act by the Balanced Budget Act of 1997 in recognition that managed care service delivery arrangements had become more widespread. Previously, states were required to apply for waivers in order to mandate the enrollment of beneficiaries in managed care arrangements.

[28] Voluntary managed care arrangements may be approved under the provisions of §1915(a) of the Act.

[29] CMS issued comprehensive managed care regulations in 2002.

[30] United States Government Accountability Office (2004). *Medicaid Managed Care: Access and Quality Requirements Specific to Low Income and Other Special Needs Populations.* Washington DC.

[31] See CMS State Medicaid Director Letter #04-002, located at http://www.cms.hhs.gov/smdl/downloads/smd022504.pdf. Additional information about the provision of disease management services under Medicaid is available at http://www.dmnow.org/dmdefined/definition.asp.. See also

Mathematica Policy Research (2004). *Disease Management Options: Issues for State Medicaid Programs to Consider*, available at: http://www.mathematica-mpr.com/publications/pdfs/diseaseman.pdf. See also: Claudia Williams (2004). *Medicaid Disease Management: Issues and promises. Washington DC: Kaiser Commission on Medicaid and the Uninsured*. Available at: http://www.kff.org/medicaid/upload/Medicaid-Disease-Management-Issues-and-Promises-Issue-Paper.pdf.

[32] For more information about this initiative, go to: bphc.hrsa.gov/chc/pi.htm Additional information also is available at: ncsl.org/programs/health/hcweb.htm

[33] This requirement was added in the Omnibus Budget Reconciliation Act of 1989.

[34] Additional information is available at: http://bphc.hrsa.gov/hchirc/about/face_homelessness.htm. Federal funding for Healthcare for the Homeless was originally authorized in 1987 through the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77). In 1996, this funding was consolidated with other funding for community health centers.

[35] The PPS payment system was established under the provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

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Chapter 4:

Critical Medicaid Benefits for Chronically Homeless People

Medicaid is an important avenue for individuals and families who experience homelessness to secure basic health care services. In addition, there are certain Medicaid benefits that can play an especially important role in assisting people who are at risk of or experience *chronic homelessness* to achieve greater self-sufficiency and independence. This chapter provides in-depth information about the following critical Medicaid benefits:

- Behavioral health services, including mental health and substance abuse services;
- Case management;
- Personal care/personal assistance services; and,
- Home and community-based services

Federal policies concerning each of these benefits are summarized and additional information is provided concerning how the benefits can be used to assist people who are at risk of or experience homelessness.

Behavioral Health Services

About 39% of all people who experience homelessness evidence mental health problems. Children and their parents experience adverse mental health outcomes as a result of homelessness. A high percentage of people who experience chronic homelessness have serious mental illnesses or addictive disorders and people with such disorders are at high risk of homelessness. About one-half of chronically homeless individuals have co-occurring mental and addictive disorders. Serious mental illness and addictive disorders are root causes of chronic homelessness. In addition, people who have behavioral health disorders experience high rates of incarceration and placement in costly public psychiatric hospital stays. When effective behavioral health services are provided, individuals who experience these disorders can be put on the road to recovery and increased self-sufficiency. It is important to integrate the delivery of behavioral health services with the provision of other services and supports such as case management, housing and income support in order to effectively meet the needs of chronically homeless individuals.

Effective behavioral health services can help put chronically homeless people on the road to recovery.

States may offer a wide variety of behavioral health services through their Medicaid programs. These services can range from short-term outpatient treatment and interventions to longer-term, more intensive rehabilitative and other services that are critical in addressing the needs of people with serious mental illnesses and/or addictive disorders.

Mental Health Services[1]

Medicaid is the largest single purchaser of mental health services in the United States. The Medicaid program affords states several avenues to obtain federal financial participation in the costs of mental health services.

Medicaid Coverage of Mental Health Services

Medicaid coverage of mental health services may include:

- **Short-Stay Inpatient Hospitalization** (furnished as an inpatient hospital service). Short-stay inpatient hospitalization is furnished to people who experience a psychiatric crisis and require stabilization.
- **Inpatient Psychiatric Hospital Services for Individuals up to age 21**. States have the option of covering long-stay inpatient psychiatric services for children and young adults up to the age of 21.[2] These services are furnished in mental health hospitals to children and young adults who need intensive treatment on an extended basis.
- **Psychiatric Residential Treatment Facility Services (PRTF)**. States also have the option of covering long-stay residential mental health treatment for children and youth under age 21 in non-hospital residential treatment facilities.
- **Services in "Institutions for Mental Disease" for Persons Age 65 and Older**. States also may cover long-stay mental health residential treatment services for older persons. These services also are usually furnished in state-operated mental health hospitals but may be furnished in nursing facilities as well.
- **Outpatient Mental Health Treatment**. Mental health outpatient treatment services may be furnished either as an outpatient services benefit or under the optional Medicaid "clinic services" coverage. In general, these services must be provided at a clinic site and are limited to professional treatment of mental illnesses. Outpatient services are the most commonly provided type of mental health services that states furnish under Medicaid. All states cover outpatient mental health services in one form or another. These services may include individual and group therapy along with family counseling and medication management. In some states, more intensive outpatient services (e.g., day treatment) are furnished to persons who require services on an extended basis. Outpatient service delivery often is linked to a state's network of community mental health centers. Many Federally-Qualified Health Centers also provide outpatient mental health services. Outpatient services must be directly furnished or supervised by a physician. Usually, states impose limits on the amount of outpatient treatment services that may be furnished.
- **Practitioner Services**. Services that are furnished by a psychiatrist are covered under Medicaid as physician services and services provided by psychologists and/or clinical social workers may be covered as an optional state plan service under the "other practitioner services" category. Again, it is not uncommon for states to limit the amount of these services that may be provided to a Medicaid beneficiary.
- **Rehabilitative Services**. States have the option of offering mental health services under what frequently is termed the "rehab option." Under this coverage, a state may offer a wide range of recovery-oriented mental health services to people in the community. Nearly all states offer rehabilitative mental health services, although there are marked differences in the scope of the rehabilitative services that each state offers. This optional coverage is discussed in more detail below because it can play an especially important role in supporting chronically homeless people with serious mental illnesses.

In addition to the foregoing, Medicaid prescription drug coverage enables people to obtain medications that are important in the treatment of their mental illnesses.

Federal EPSDT requirements mandate that states provide a full range of mental health services to Medicaid-eligible children and youth.

Federal law does not permit states to obtain federal financial participation in the costs of long-stay residential services that are furnished to people between the ages of 22 to 64 in an "*Institution for Mental Disease*" (IMD). The IMD exclusion dates to the beginning of the Medicaid program and is based on the view that such services are a state rather than federal responsibility. An IMD is a facility that is principally engaged in the provision of long-stay mental health treatment to its residents *and* serves 17 or more persons. A facility that has fewer than 17 beds is not considered to be an IMD. In addition, a state may not claim federal Medicaid funds for the costs of other non-mental health services that are furnished to IMD residents. The next chapter discusses the effects of placement in an IMD on Medicaid eligibility. Below the relationship between Medicaid and community housing for people with mental illnesses is discussed.

In some states, mental health services are delivered under managed care arrangements. Mental health services are sometimes delivered through "comprehensive" health plans that provide the full range of Medicaid services to enrollees. Under these arrangements, the comprehensive health plan furnishes basic outpatient and practitioner mental health services to enrollees, often through contractual arrangements with mental health provider organizations. Usually, however, more intensive mental health services are provided outside the comprehensive health plan on a fee-for-service basis.

Elsewhere, mental health services have been "carved out" into specialty mental health managed care arrangements and are delivered through PIHPs, either through a single state-wide managed care organization (e.g., Iowa, Arizona, and Massachusetts), by regional organizations (e.g., Pennsylvania, Colorado, and Washington), or by Administrative Service Organizations (ASO) (e.g., Maryland). Medicaid mental health managed care models typically are designed to tightly control the use of costly inpatient hospital services in favor of stressing the provision of treatment and other services in the community, especially in the case of people with serious mental illnesses. As discussed in Chapter 3, the delivery of mental health services through a managed care arrangement does not affect the underlying coverage of such services but rather their method of delivery.

Rehabilitative Services

Medicaid coverage of mental health rehabilitative services can play an especially important role in assisting individuals with serious mental illnesses to become self-sufficient and recover from their mental illnesses. Effective rehabilitative services can contribute to preventing homelessness among people with serious mental illnesses as well as contribute to chronically homeless individuals to lead stable lives in the community. Medicaid coverage of rehabilitative services is congruent with contemporary best mental health practices that aim at helping people overcome the functional limitations that stem from their illnesses and take charge of their own lives under the recovery paradigm that stresses people assuming increasing personal control and responsibility for achieving self-sufficiency.

The authority for states to cover mental health rehabilitative services through their Medicaid programs is contained in §1905(a)(13) of the Social Security Act which defines rehabilitative services as:

> "Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting)

recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

The Medicaid statute does not limit the coverage of rehabilitative services solely to mental health services. States offer other types of rehabilitative services in their Medicaid programs, including substance abuse treatment and physical rehabilitation services (e.g., occupational therapy and physical therapy.) However, the coverage of mental health services is one of the most common uses of the rehabilitative services coverage. Today, nearly every state employs the rehabilitative services option to underwrite services and supports for individuals with mental illnesses. However, states vary considerably in the scope of services that they offer under the rehab option.

Rehab services can be provided in a wide variety of locations in the community by non-clinicians.

A rehabilitative service must involve the treatment or remediation of a condition that results in an individual's loss of functioning and, therefore, the service must be restorative or remedial. Rehabilitative services are distinguished from outpatient services by the fact that their provision is not limited to fixed clinic sites. This is important because it permits these services to be delivered in a variety of locations, including the person's living arrangement. Rehabilitative services also are distinguished from outpatient services because they can be delivered by non-clinicians under the provisions of a person's service plan. It is important to point out that services furnished under this option must have a rehabilitative objective. For example, this coverage option may be employed to teach daily living skills such as meal preparation to individuals but cannot be used to pay for the costs of performing daily living activities on behalf of the person (e.g., preparing a meal for the individual). Skill restoration is coverable to the extent that the skill was once present or the functional capacity necessary to perform the skill has been lost. Other Medicaid coverages (e.g., personal assistance) can be used to augment rehabilitative services to address other types of support needs.

The rehabilitative services coverage permits a state to offer a wide range of services in the community. In many states, this coverage is reserved for community support services for individuals with serious mental illnesses who require especially intensive supports to aid in their recovery. This coverage may span the following services:

- Diagnosis, assessment, treatment planning and coordinating the delivery of rehabilitative services to individuals.
- Individual and group clinic outpatient mental health services.
- Crisis services in order to prevent hospitalization or quickly stabilize a person so that the individual can return to the community.
- Family psychosocial education in order to enlist a person's family in addressing and managing the person's mental illness.[3]
- Peer support and counseling whereby individuals who have experienced mental illnesses furnish support to individuals in managing and coping with their mental illnesses. For example, peer specialists can assist individuals to adhere to their treatment plans.
- Basic life and social skills training and support across a variety of community living dimensions to promote self-sufficiency and independence by overcoming functional limitations associated with mental illnesses. For example, basic life skills training may include "restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and

mobility skills" and social skills training may include "redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques."[4]

- Intensive Assertive Community Treatment with the capability to step-down yet maintain intensive support as needed. Assertive Community Treatment is a team-based model of supporting people whose mental illnesses cause instability in their lives and experience frequent hospitalizations.
- Medication education and management, including teaching people to adhere to and manage their own medications.
- Community residential services that integrate the delivery of mental health services into licensed and supportive housing arrangements.
- Illness and disability management that is designed to increase a person's ability to recognize and respond to symptoms.
- Supported employment to assist individuals in overcoming barriers to employment that stem from their mental illness. The rehabilitative services option may not be employed to provide job training, vocational and educational services. Rehabilitative supported employment services can be provided to assist individuals to function in the work place, provided that the services are not directly associated with specific job performance. Successful employment strategies blend Medicaid rehabilitative services with funding from such sources as Vocational Rehabilitation to secure and maintain employment.

Fundamentally, the rehabilitative services coverage option gives states considerable flexibility in offering effective Medicaid-funded mental health services to promote recovery. Rehabilitative services can play an important role in supporting children and youth with serious emotional disturbances as well as adults with serious mental illnesses. The coverage of rehabilitative services is playing a central role in many states' efforts to transform their mental health systems to promote recovery and resilience.

Increasingly, states are incorporating evidence-based practices into the delivery of mental health services. An evidence-based practice is a practice that research has revealed is especially effective in the treatment of mental illness. Medicaid funding may be employed to fund most elements of recognized evidence-based practices.[5]

Medicaid and Housing

Medicaid funds cannot be used to underwrite the costs of community housing for individuals. Medicaid funding for shelter and routine living expenses is confined to institutional settings such as nursing facilities. The costs of community housing must be met out of a person's own resources (e.g., disability benefits and/or earnings) or through non-Medicaid federal, state and local housing assistance programs. Medicaid funding is confined principally to underwriting the costs of health and rehabilitative services that are delivered to beneficiaries.

Medicaid funding is commonly used to underwrite services and supports in a wide variety of community living arrangements. Medicaid funding can pay for personal assistance services (discussed below) that are furnished to supportive housing residences, under either the Medicaid State plan and through the coverage of home and community-based services. Medicaid funding also is available to pay for case management services that are furnished on behalf of people in supportive housing. Medicaid-funded services (especially rehabilitative services) certainly may be furnished to people who reside in non-IMD community living arrangements, including through and as part of supportive housing programs. In many states, staffed community residences are operated that serve people with mental illnesses who require intensive services and Medicaid dollars can be and are used to reimburse the

mental health treatments that are furnished in such residences. Similarly, Medicaid funding through the rehabilitative services options can pay for the mental health services that are furnished delivered in tandem with other supports in supportive housing arrangements.

Substance Abuse Services

States may cover a wide range of substance abuse treatment services under Medicaid for persons who have addictive disorders. The coverage options that states may employ for substance abuse services in many respects parallel those that apply to the coverage of mental health services.

Medicaid Coverage of Substance Abuse Services

Medicaid coverage of substance abuse services may include:

- **Short-Stay Inpatient Hospitalization** (furnished as an inpatient hospital service). Short-stay inpatient hospitalization is furnished to people who require detoxification and stabilization in an inpatient setting.
- **Outpatient Services**. Substance abuse outpatient treatment services may include diagnosis, assessment, treatment, and medication management services. Outpatient services may include opioid treatment services (e.g., methadone maintenance). Some states furnish more extensive outpatient substance abuse treatment services including day treatment and supervised day programs.
- **Psychiatric Residential Treatment Facility Services (PRTF)**. States also can use this coverage to serve children and youth under age 21 who need addiction treatment services in a non-hospital residential treatment facilities.
- **Practitioner Services** also may be employed to furnish substance abuse/ addictive disorders treatment.
- **Rehabilitative Services**. Rehabilitative services also may be provided to people who have addictive disorders along lines that parallel the provision of such services to people who have mental illnesses. Rehabilitative services may include therapy, counseling, training in communication skills, recovery training, employability skills, and relationship skills. Some states furnish rehabilitative services in specialized community residences. Some states also furnish crisis management services.

As a general matter, state Medicaid coverage of substance abuse services is not as extensive as mental health services. Some states cover only a limited range of substance abuse services. As is the case with mental health services, some states deliver substance abuse services through comprehensive managed care plans. In some states, substance abuse services are furnished through “carve out” managed care arrangements, usually in tandem with the provision of mental health services.

Services for Persons with Co-Occurring Disorders

A large percentage of individuals with serious mental illnesses also have a co-occurring addictive disorder. Meeting the needs of some of these individuals often is most effective when integrated, concurrent treatment approaches are used. Obstacles to effective treatment sometimes arise when mental health and substance abuse services are furnished through separate service delivery systems and provider networks. A growing number of states have merged the delivery of substance abuse and mental health services under a single state agency and taken steps to integrate service delivery at the local and provider levels. Several states (e.g., GA, NC) that have combined their coverages of Medicaid mental health and substance abuse

services, especially with respect to their coverages of rehabilitative services. This coverage approach encourages the integrated delivery of mental health and substance abuse services to people who have co-occurring disorders.

Case Management

People who experience or are at risk of homelessness can benefit from the provision of case management or service coordination to assist them in accessing Medicaid services and connecting to other services and supports financed by other funding streams. Medicaid affords states three avenues to obtain federal financial participation for case management services. First, Medicaid administrative funding can be employed to finance case management services. Case management services also may be covered in an HCBS waiver program (see below). Finally, under its State plan, a state may cover "targeted case management" (TCM) services in order to link Medicaid beneficiaries to community services and supports, regardless of how they are funded.

Federal TCM Coverage Policies

The coverage of TCM services was added to the Medicaid program in 1987 by the addition of §1915(g) to the Social Security Act. Under this provision, case management services are defined as "services which will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services." This coverage stands apart from other services provided under the State plan because a state can limit the provision of TCM services to a state-defined "target population" rather than furnishing such services to all categorically eligible Medicaid beneficiaries. Moreover, a state may furnish these services on a less than statewide basis. A state also may operate more than one TCM program in order to provide services to multiple distinct target populations. The scope of allowable Medicaid TCM services was further specified in the Deficit Reduction Act of 2005 (in Section 6052) to span four principal activities:

- Assessment in order to determine the service needs of an individual;
- Development of a service plan that "specifies the goals and actions to address the medical, social, educational and other services needed by the … individual;"
- "Referral and related activities to help an individual obtain needed services;" and
- Monitoring and other follow-up activities to ensure that the service plan is effectively implemented, including whether services are furnished in accordance with the plan and the services are adequately addressing the needs of the individual.

Further, additional provisions were added to prevent states from claiming FFP for certain activities for which other federal and state programs bear primary responsibility.[6]

It is important to point out that the chief purpose of TCM services is to connect Medicaid beneficiaries to services. Such services can include other Medicaid services as well as non-Medicaid services, including income support and housing. TCM cannot be employed to provide direct services to a beneficiary. When a case manager furnishes a direct service (e.g., transporting a person to a doctor's appointment), the costs must be claimed as a direct service rather than as case management.

State Coverage of TCM Services

States furnish TCM services to a wide range of target populations. Some of these include:

- People with developmental disabilities
- People living with AIDS
- Adults with serious mental illnesses
- High risk pregnant women
- People with substance abuse disorders
- Adults in need of protective services
- Children with serious emotional disturbances

One state (Utah) has a TCM coverage that specifically targets homeless individuals.[7] This coverage is intended to connect people in emergency shelters to other benefits. Many states cover TCM in tandem with the provision of rehabilitative and other services to persons with serious mental illnesses. The TCM coverage usually is employed to develop a service plan for individuals, monitor its implementation, and connect people to other services and resources.

Personal Care/Personal Assistance

A state has the option of covering personal care services under its State plan. Through this coverage, a state may furnish hands-on, direct assistance to individuals in the performance of everyday living activities. Personal care services often are referred to as personal assistance services (PAS), personal attendant services, or attendant care services. PAS is vital for helping many people with disabilities of all types to live and function in the community and avoid institutionalization. PAS can be furnished in the person's own home, in supportive housing or other types of community living arrangements. PAS also may be furnished outside the person's living arrangement in the community, including assisting people with disabilities to maintain employment. States also may cover PAS through an HCBS waiver (see below).

Personal assistance services are vital for helping people with disabilities of all types to live and function in the community.

Federal PAS Coverage Policies

The authority for states to cover PAS in their Medicaid programs is located in §1905(a)(24) of the Social Security Act. Until 1993, PAS coverage was limited to services that were furnished in a person's living arrangement and PAS had to be authorized by a physician and supervised by a nurse. In 1993, Congress expanded where PAS could be provided and how the service could be authorized.[8] In 1997, CMS issued updated PAS coverage guidance to states.[9] This guidance made it clear that states could use alternate assessment processes to authorize PAS. Also, CMS made it clear that PAS could be provided in settings outside the person's living arrangement. In its guidance, CMS describes the scope of PAS as follows:

> Personal care services … may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs [Activities of Daily Living] and IADLs [Instrumental Activities of Daily Living]. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

While PAS frequently is identified with supporting persons who have physical disabilities, it may also be furnished to persons who have mental disorders who have functional limitations that impede their performing essential daily living activities

without assistance. States have latitude in establishing the qualifications of PAS providers.

State Coverage of PAS

Roughly 35 states cover PAS through their Medicaid programs. In 2005, federal-state Medicaid PAS expenditures were $8.6 billion and accounted for roughly 25% of Medicaid home and community-based services spending.[10] In many states, State plan coverage of PAS is the centerpiece of state strategies to support people with disabilities in the community and avoid institutionalization. The availability of PAS results in reduced utilization of nursing facility services.

However, there is considerable variation among the states in their coverage of PAS under the State plan, both with respect to whom PAS is provided and the amount of PAS that is furnished. For example, Idaho limits PAS to 16 hours of assistance per week while Nebraska allows for up to 40 hours of PAS per week. Some states limit PAS to individuals who have limitations in one or more Activities of Daily Living while others authorize PAS based on broader measures of functional limitations. Some states permit only home health agencies to deliver PAS while many others permit PAS to be furnished either by a community provider agency or self-employed personal assistants. Recently, several states (e.g., California, New Jersey, Nebraska) have modified their coverage of PAS to permit individuals to use PAS to support them in the work place.[11]

PAS can be very beneficial in helping people enjoy stable lives in the community. PAS can help people with physical impairments and mental disorders in the performance of everyday living activities such as shopping, meal preparation, and money management. PAS can be furnished as a component of supportive housing strategies across a wide range of Medicaid beneficiaries. In Oregon, for example, PAS helps more than 600 people with psychiatric disorders live independently by providing assistance with chores such as doing laundry, light housekeeping, grocery shopping, planning meals, arranging medical appointments, and managing their medications.

Home and Community-Based Services

Home and community-based services (HCBS) can play a critical role in supporting people who have disabilities and major functional limitations in the community. Such persons frequently are at risk of homelessness and/or institutionalization when they do not have supports available to assist them in daily living activities. States may furnish home and community services by operating a HCBS waiver program and/or, effective January 2007, by covering such services under the State plan.

HCBS Waiver

§1915(c) was added to the Social Security Act in 1981. This provision permits states to obtain waivers of certain provisions of the Act in order to offer HCBS to individuals who require the level of care furnished in a Medicaid reimbursable institutional setting (i.e., a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR)). By operating a HCBS waiver, a state can provide a wide-array of services and supports to assist individuals to remain in the community and avoid institutionalization.

Federal HCBS Waiver Authority

The federal §1915(c) HCBS waiver authority permits a state to obtain waivers of the comparability and statewideness requirements for the purpose of providing HCBS. A state may also obtain a waiver so that people who would be eligible if institutionalized can qualify for Medicaid in the community. These waivers permit a state to:

- Target HCBS to a state-specified groups of Medicaid beneficiaries;
- Furnish a state-defined package of HCBS to waiver participants; and,
- Limit the number of persons who participate in a waiver.

A state specifies a waiver's target population by level of care (e.g., the waiver targets individuals who require a nursing facility level of care) and other state-specified parameters (e.g., by condition or disorder) (for example, persons who have experienced a brain injury), age and other factors). A state may include some or all of its State plan Medicaid eligibility groups in the target population. Operating a HCBS waiver does not permit a state to cover eligibility groups that are not already included in the State plan.

In order to secure CMS approval of a HCBS waiver, a state must demonstrate that the program will be *cost-neutral*. That is, the state must show that the estimated average annual cost of supporting individuals in a HCBS waiver is no greater than the average annual cost of serving persons in an institutional setting.

More than one million people participate in HCBS waivers nationwide.

The HCBS waiver statute identifies certain services (e.g., case management, personal care, supported employment, respite) that a state may include in a waiver. A state may also propose to cover additional services over and above those specified in the statute, subject to CMS review and approval. By operating a HCBS waiver, a state may provide: (a) services that it could not otherwise offer under the State plan; (b) services that it could offer under the State plan but does not; and, (c) services that it offers under the State plan but in an amount greater than allowed under the State plan. Waiver services wrap-around the services that are covered under the State plan. Waiver services may be provided in a person's home, a non-institutional community living arrangement, and at other locations in the community. Waiver participants also are entitled to receive the full range of Medicaid State plan services.

The waiver and other services that a waiver participant receives must be spelled out in a participant-centered service plan. A state must also demonstrate to CMS' satisfaction that it has satisfactory systems in place to the health and welfare of waiver participants. A new waiver may be approved for an initial period of three-years. Provided that the waiver has been operated in a satisfactorily fashion, it may be renewed for a period of five-years. There is no federal limit on the number of HCBS waivers that a state may operate. CMS oversees the operation of waivers by performing periodic reviews to ensure that the waiver is being operated in accordance with federal requirements.

Use of the HCBS Waiver Authority

Except for Arizona, every state operates multiple HCBS waivers. Arizona furnishes comparable HCBS under the provisions of a Section 1115 Research and Demonstration waiver. At present, there are more than 300 HCBS waivers in operation nationwide that provide services and supports to more than 1 million Medicaid beneficiaries. In 2005, state-federal HCBS waiver expenditures totaled $22.7 billion compared to $12.8 billion in 2000.[12] States principally target waiver services to the following target groups of Medicaid beneficiaries:

- Older persons
- People with physical disabilities
- People who have experienced a brain injury
- Children with serious emotional disturbances

- People with intellectual and developmental disabilities
- People living with AIDS
- Technology-dependent individuals

Because the federal HCBS waiver authority affords states great latitude in specifying a waiver's target population (including how many individuals that the waiver will serve) and the services that are offered through a waiver, there is significant variation among waivers. Since waivers wrap around State plan services, additional differences arise due to differences in the types of services that a state already covers under its State plan. Waivers typically provide services and supports such as personal assistance to people in their homes or non-institutional community living arrangements. Other waiver services usually are selected to meet the specific needs of the waiver's target population.

The past decade has seen states substantially step up their use of the HCBS waiver authority. Various factors explain the rapid-paced growth in waivers:

- It has proven to be significantly less costly for states to support individuals in the community than in institutional settings. Operating HCBS waivers provides states a cost-effective tool to respond to the rising demand for long-term services and supports;
- In part as an outgrowth of the U.S. Supreme Court *Olmstead* decision that directed states to serve people in the most integrated setting and in response to the expressed preferences of individuals to receive services and supports in the community, states have expanded HCBS waivers in order to increase access to community services and rebalance their long-term services in order to reduce reliance on institutional services; and,
- The flexibility afforded states in designing HCBS waivers has allowed them to customize services and supports to meet the needs of a wide variety of target populations. Since states may limit the number of waiver participants, expenditures for waiver services are more predictable than other types of Medicaid services.

A recent important development in the operation of HCBS waivers has been the introduction of consumer-direction of waiver services in many states.[13] Federal policy permits a state to offer consumer-direction opportunities in HCBS waivers, including positioning waiver participants to hire and supervise their direct support workers and manage waiver funding, including shifting funds among waiver services.

Use of the HCBS waiver authority to support adults with serious mental illnesses has been relatively limited.[14] One reason for this has been the "IMD Exclusion." Because an Institution for Mental Disease is not a Medicaid-reimbursable institutional setting for working age adults with serious mental illnesses, a state cannot craft a HCBS waiver to support individuals who require an IMD level of care. However, people with serious mental illnesses can receive waiver services, provided that they meet a waiver's target population criteria. For example, in Minnesota, about 2,500 people with mental illnesses receive services and supports through a waiver that serves people with disabilities who require a nursing facility level of care. Many waivers use functional limitation criteria in specifying the waiver target population. When people with serious mental illnesses meet these criteria, they may be eligible to receive HCBS.

In a similar vein, a waiver may not serve as an alternative to placement in a PRTF because PRTFs are not specified in the waiver statute as a type of setting for which HCBS may serve as an alternative. However, the Deficit Reduction Act of 2005 has

authorized up to ten states to demonstrate the delivery of HCBS services as an alternative to PRTFs.[15]

The HCBS waiver authority can play two key roles in supporting individuals who experience or are at risk of chronic homelessness. First, waiver services (along with State plan services) can play an important role in assisting individuals to lead stable lives in the community by furnishing them critical supports in their living arrangement, including supportive housing. Additionally, states may offer supported employment services under a waiver to help people with disabilities to secure and maintain employment. The second role that the HCBS waiver may play is enabling individuals to qualify for Medicaid benefits. The financial eligibility standards that states apply to institutional services usually are more generous than "community standards." States usually apply their institutional financial standards to HCBS waivers. These more generous standards permit more individuals to qualify for Medicaid services, including people who are successful in the workplace. For example, these higher income thresholds have proven useful for people living with AIDS to secure Medicaid eligibility and thereby access the medications upon which they rely.

State Plan Coverage of HCBS

The Deficit Reduction Act of 2005 added §1915(i) to the Social Security Act, effective January 2007. This provision permits a state to offer HCBS under its State plan without having to secure federal approval of a waiver. While this optional coverage is similar to the longer-standing HCBS waiver authority, there are important differences between the two authorities. The new option gives states the opportunity to offer HCBS to a wider-range of people with disabilities, especially adults with mental illnesses.

Federal HCBS State Plan Authority

The §1915(i) authority is a State plan coverage authority. Like other State plan services, a state must submit a State plan amendment in order to cover these services. Unlike the HCBS waiver authority, a state does not have to periodically request federal approval to continue the delivery of benefits that it covers under the State plan.

The new §1915(i) authority permits a state to cover the same services that are specifically identified in the HCBS waiver authority under §1915(c). However, a state may not cover services that are not specified in §1915(c). As a consequence, a state cannot propose to cover additional services that are not specified in the waiver statute.

Unlike the HCBS waiver authority, the §1915(i) authority does not limit the provision of services to people who require an institutional level of care. This is an important difference between the two authorities. As previously discussed, the "IMD exclusion" has proven to be a barrier in many states to furnishing HCBS to adults with serious mental illnesses. Potentially, under the new authority, such individuals might enjoy expanded access to HCBS, including services such as personal assistance and supported employment.

Another important difference between the two authorities is that, under the §1915(i) authority, a state may not secure a waiver of comparability. This means that a state may not limit HCBS to some groups of beneficiaries to the exclusion of others. Instead, the §1915(i) authority provides that a state must establish generic eligibility criteria that apply to all people seeking HCBS. States have latitude in specifying these eligibility and such criteria may be based on functional limitations. The statute also

specifies that the criteria established by a state must be less stringent than the criteria that apply to institutional services.

Like the HCBS waiver authority, a state may limit the number of beneficiaries who receive HCBS under the new authority. In addition, the §1915(i) authority permits a state to modify its eligibility criteria in the event that the state finds that more people qualify than the state estimated. The new authority does not require that a state demonstrate cost neutrality.

The new authority permits states to offer HCBS to individuals with incomes up to 150% of the FPL. Consequently, a state may offer HCBS to a wide range of current Medicaid beneficiaries. However, the income limitation associated with the new authority applies only to the Medicaid eligibility groups that the state already covers under its State plan. The new authority does not permit states to extend institutional eligibility rules to the new authority or create entirely new eligibility groups.

A state may offer services under the §1915(i) authority and continue to concurrently operate HCBS waivers. In other words, employing the §1915(i) authority does not require that a state cease operating targeted waivers. However, states will face the challenge of how to mesh the two authorities in furnishing long-term services and supports to beneficiaries.

Use of the New HCBS State Plan Authority

Since the new authority does not take effect until January 2007, it is uncertain how states will employ it to meet the support needs of Medicaid beneficiaries in the community. As previously noted, the new authority may afford broader access to HCBS for adults with serious mental illnesses, depending on the eligibility criteria that states adopt. In addition, the use of functional eligibility criteria may provide a pathway to HCBS for people who experience or are at risk of homelessness but who do not meet the sometimes relatively stringent institutional level of care criteria that apply to institutional services.

Conclusion

Through the Medicaid program, states may offer a wide-range of services and supports that can assist individuals who experience or are at risk of chronic homelessness to function successfully in the community and become more self-sufficient. The provision of effective behavioral health services can address the root causes of chronic homelessness for individuals who have serious mental illness and/or addictive disorders. Services such as personal assistance and home and community-based services can also assist individuals to obtain the assistance that they require to lead more stable lives in the community.

Resources

Publications

U.S. DHHS, Assistant Secretary for Planning and Evaluation

Gary Smith et al. (2005). *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses: A Handbook*. Washington D.C.
Available at: http://aspe.hhs.gov/daltcp/reports/handbook.htm

This publication provides comprehensive information on how Medicaid can be used to support adults with serious mental illnesses in the community. It focuses on the use of the rehabilitative services option to furnish recovery-oriented mental health services.

Gary Smith et al. (2000). *Understanding Medicaid Home and Community Services: A Primer*. Washington D.C.

Available at: http://aspe.hhs.gov/daltcp/reports/primer.htm

This publication discusses the how Medicaid funding may be employed to underwrite the costs of furnishing home and community-based services.

U.S. DHHS, Substance Abuse and Mental Health Services Administration

Robinson et al. *State Profiles of Mental Health and Substance Abuse Services in Medicaid*. Washington DC.
Available at: http://mentalhealth.samhsa.gov/publications/allpubs/State_Med/default.asp

This publication provides extensive information concerning the provision of behavioral health services under Medicaid. Accompanying state profiles provide information about the specific types of behavioral health services that are offered in each state.

… (2003) *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Abuse Disorders*.
Available at: http://mentalhealth.samhsa.gov/publications/allpubs/sma04-3870/default.asp

This publication contains state-of-the-art information about ending homelessness for people who have serious mental illnesses, including those with co-occurring substance use disorders. Chapter 8 contains information about using mainstream resources, including Medicaid, to serve people who are homeless.

ILRU Community Living Partnership – National State-to-State Technical Assistance Center

John O'Brien. *The Medicaid Rehabilitative Services ("Rehab") Option*. Houston Texas: Independent Living Research Utilization
Available at:
http://www.hcbs.org/moreInfo.php/nb/doc/1263/Community_Living_Brief:_The_Medicaid_Rehabilitativ

This Community Living Brief provides a succinct overview of how states may employ the "rehab option" to furnish effective mental health services to individuals in the community.

President's New Freedom Commission on Mental Health

… (2003) *Achieving the Promise: Transforming Mental Health Care in America*. Washington DC.
Available at: http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html

This publication discusses the rationale for shifting to a recovery orientation in the provision of mental health services and the role of evidence-based practices in the delivery of effective services.

The Center for Workers with Disabilities

Stone (et al.) (2006). *Providing Personal Assistance Services Through a Medicaid State Plan Option*. Washington DC: American Public Human Services Association.
Available at: http://www.aphsa.org/disabilities/home/index.htm

This publication provides a succinct overview of the coverage of personal assistance services under the Medicaid state plan and how states may employ the coverage to support people with disabilities in the work place.

Web Accessible Resources

Centers for Medicare & Medicaid Services

Web-address: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp

This website contains extensive information concerning HCBS waivers, including is extensive technical guidance concerning the design and operation of such programs

Web-address: http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp

This web-site contains information about promising practices that states are employ to improve the delivery of home and community-based services to Medicaid beneficiaries.

Clearinghouse for Community Living Exchange Collaborative

Web-address: http://hcbs.org/index.php

This website serves as a portal to extensive information and resources about the delivery of home and community-based services to a wide variety of Medicaid beneficiaries, including people with serious mental illnesses.

Notes

[1] The material in this section is based on Gary Smith et al. (2005). *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses: A Handbook*. Washington DC. See the Resources section for more information.
[2] States have the option of continuing to serve youth who turn 21 up to the age of 22.
[3] Family psychosocial education must revolve principally around training and educating family members to address the Medicaid beneficiary's mental illness and integrated into the beneficiary's mental health treatment plan. Its aim cannot be to address the support needs of family members who are not Medicaid beneficiaries.
[4] In 1992, the Director of the HCFA Medicaid Bureau (now CMS) issued an information memorandum to Regional Administrators concerning services for persons with mental illnesses that could be included under the "optional rehabilitation benefit."
[5] CMS policy guidance concerning the coverage of evidence-based practices is located at: http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf.
[6] Principally, child welfare services delivered under Title IV-E of the Social Security Act.
[7] More information concerning this coverage is available at http://www.rules.utah.gov/publicat/code/r414/r414-33c.htm.
[8] This change was made in the Omnibus Budget Reconciliation Act of 1993.
[9] This guidance is contained in the State Medicaid Manual: Part 4 – 4480**.**
[10] Brian Burwell, Kate Sredl, and Steve Eiken (2006). *Medicaid Long-term Care Expenditures in FY 2005*. Cambridge, MA: The Medstat Group.
[11] See Stone (et al.) (2006). Providing Personal Assistance Services Through a Medicaid State Plan Option. See the Resources section for more information about this publication.
[12] Burwell et al., *op. cit*.
[13] In 2002, CMS launched the Independence Plus HCBS waiver initiative to encourage states to offer consumer-directed services to waiver participants. In 2005, CMS revised the HCBS waiver application so that consumer-directed services could be accommodated in any HCBS waiver.
[14] Colorado operates an HCBS waiver that specifically targets people with serious mental illnesses. These individuals must meet Colorado's functional nursing facility level of care criteria. More than 2,000 people participate in this waiver. This waiver provides services and supports to people with serious mental illnesses in community residences. Mental health services are furnished to these individuals through Colorado's mental health services managed care program**.**
[15] For more information, see http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PRTF%20Solicitation.pdf.

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Chapter 5:
Connecting People Who are Homeless to Medicaid Benefits

Connecting people who experience or are at risk of homelessness to Medicaid and other benefits is challenging. The lack of a fixed address and instability in the lives of people who experience chronic homelessness may pose significant obstacles in obtaining and maintaining benefits.[1] The complexities of Medicaid eligibility determination and redetermination processes can be the source of additional challenges. Still other problems can arise in securing or maintaining Medicaid eligibility when homeless people are placed in psychiatric facilities or incarcerated.

This chapter focuses on two topics: (a) assisting people who experience chronic homelessness to secure and maintain Medicaid eligibility and (b) connecting or reconnecting people to Medicaid when they are discharged from a psychiatric facility or released from jail.

Assisting Homeless People to Secure and Maintain Medicaid Eligibility

Securing Medicaid eligibility can be complicated in the best of circumstances. Medicaid eligibility determination is an application-driven process that frequently requires the applicant to produce considerable documentation. Since Medicaid is a means-tested program, applicants also must provide information about their income and assets. In the case of people with disabilities, Medicaid eligibility processes are intertwined with the necessity of determining that a person meets applicable Social Security disability tests.

People who experience homelessness often benefit from third-party assistance in securing and maintaining Medicaid eligibility because they are displaced or have impairments that make it difficult for them to navigate the Medicaid application process. In this regard, agencies and organizations that assist people who experience homelessness can play a critical role in brokering benefits on their behalf. In addition, states can take additional steps to facilitate access to Medicaid benefits.

Third-Party Assistance in Securing and Maintaining Medicaid Eligibility

There are elements of federal policy that speak directly to the provision of third-party assistance in helping individuals and families to secure and maintain Medicaid eligibility. In particular:

- Federal regulations provide that each state must allow Medicaid applicants or beneficiaries to select an "individual or individuals to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility."[2] With the consent of the individual, agencies that support people who experience homelessness can help them navigate the Medicaid eligibility process. Many agencies provide this type of assistance.
- As discussed in Chapter 2, each state must provide for a process for sending Medicaid cards and other notices concerning a homeless person's Medicaid eligibility to a third-party addressee. This requirement helps overcome problems when a person does not have a fixed address or concerns about people missing notices and deadlines associated with Medicaid eligibility redetermination.

- In the case of people with disabilities, there are similar provisions that permit third-parties to help people navigate the Social Security application and disability determination processes. Since Medicaid eligibility for adults with disabilities hinges on their meeting Social Security disability tests as well as complying with ongoing SSI and SSDI program requirements, third-party assistance can prove critical in their securing and maintaining benefits. A person may appoint a third-party to represent them in their dealings with Social Security and to receive their Social Security benefits on their behalf.

The ***Resources*** section of this chapter identifies tools (such as the HHS/HUD ***FirstStep*** tool and ***GovBenefits***) that can assist third-parties in identifying potential benefits (including Medicaid) for which individuals and families might qualify. Some of these tools provide step-by-step guidance in navigating eligibility determination processes. For example, ***Stepping Stones to Recovery*** contains detailed information about securing Social Security disability benefits.

Securing Medicaid Benefits

In order to effectively assist people who experience homelessness to secure Medicaid benefits, it is important that third-parties become familiar with each state's unique eligibility requirements and eligibility determination processes. In general, state Medicaid agencies make such information available on their web-sites. Additionally, it is usually beneficial for third-parties to make connections with local offices where Medicaid applications are processed. States can contribute to the role that third-parties can play in assisting people to secure Medicaid benefits by providing training to third-party personnel concerning Medicaid eligibility determination processes. For example, some states regularly provide training and education about benefits to homeless agency personnel.

Some states and localities are taking proactive measures such as creating "One-Stop" centers where people who experience homelessness can access a full range of assistance, including connecting them to benefits such as Medicaid. For example, in downtown Phoenix Arizona, a coalition of faith-based private, non-profit, state and local government, and other community agencies have established the Human Services Campus to provide integrated services and supports to people experiencing homelessness. The Arizona Department of Economic Security, which administers the state's Medicaid program, participates in this coalition. The Lodestar Day Resource Center (LDRC) serves as a gateway to the campus and focuses on three objectives: (a) providing a safe place for homeless people during the day; (b) engaging people who are chronically homeless and who have been reluctant to participate in formal service provision; and, (c) providing a "one stop" location for people who are homeless to access mainstream resources and integrated services. LDRC staff and participating agencies assist people who are homeless in applying for housing, health, and other benefits, including Medicaid. Legal counsel also is available to assist people who are homeless in applying for SSI. Other agencies and organizations located on the campus include the county Healthcare for the Homeless Center, behavioral health service providers, and housing agencies. In addition, outreach teams identify people who are chronically homeless and accompany them to the LDRC during specially designated hours.[3]

Along similar lines, a coalition of nonprofit, public and private sector organizations have teamed up to establish the Fertitta Community Assistance Center (FCAC) in Las Vegas, Nevada.[4] FCAC is a portal to tailored services and supports for people who experience homelessness. Participating governmental agencies include Clark County Social Service, Nevada State Welfare Division (which is responsible for determining

Medicaid eligibility) and Southern Nevada Adult Mental Health Services, as well as nonprofit organizations including Courtney Children's Foundation and Women's Development Center. The Center expects to support 60,000 people annually.

Maintaining Medicaid Eligibility

Third-party assistance also can be especially important in maintaining Medicaid eligibility. Medicaid financial eligibility redeterminations must be performed at least every twelve months. States cannot always contact individuals who are homeless to perform financial eligibility redeterminations. States often conduct redeterminations by sending participants a form requesting updated information. Some States terminate a person's enrollment when the Post Office returns the mailed form because the person is no longer at that address. This practice is especially likely to affect people who are homeless. If the State cannot reach the person, he or she may lose Medicaid by not responding to the redetermination form. People who are chronically homeless may not follow through on redeterminations (or on initial applications) because their mental illness or substance abuse hinders their response or because they are addressing other challenges to survival. By putting themselves in the loop to receive notices on behalf of individuals, third-parties can assist their maintaining Medicaid eligibility.[5]

Outstationing Eligibility Workers

The One-Stop centers described strategies that states, organizations that support homeless people, and communities can employ to assist people who experience homelessness to quickly access Medicaid and other critical benefits. States have the latitude to assign eligibility workers to community locations where they can take and process Medicaid applications. As part of their outreach efforts, most states now outstation eligibility workers at provider sites such as community hospitals that serve large numbers of low-income individuals, especially pregnant women and children.[6] States also have the flexibility to dispatch workers periodically to other community locations to take and process applications.

States are required to outstation financial eligibility workers at all Federally Qualified Health Centers (including Health Care for the Homeless grantees) that serve Medicaid-eligible pregnant women and children under age 19, unless CMS approves an alternative outreach plan to reach these potential beneficiaries' children.[7] However, states are not required to outstation financial eligibility staff at all HCH grantees since many grantees do not serve pregnant women and children.

Outstationing financial eligibility workers at HCH grantees or periodically assigning them to these locations can contribute to improving Medicaid access for chronically homeless people. On-site eligibility staff can address common barriers for people who are chronically homeless, especially applicants' lack of follow-through. First, eligibility staff is in a convenient location for people who are homeless. Second, staff at the homeless service provider can easily approach the provider staff for medical records documenting the person's disability status, if the eligibility staff has written permission from the applicant. Third, outstationed staff can conduct "rolling" redeterminations – asking a Medicaid participant to update their financial eligibility information when they are at the provider's office for treatment instead of waiting for a redetermination deadline.[8]

Federal policy does not permit states to delegate final Medicaid eligibility determination to other entities and organizations.[9] The final Medicaid eligibility determination must be made by the Medicaid agency, the state agency responsible for administering certain financial assistance programs, or the Social Security

Administration (in the case of states where SSI eligibility is automatically linked to Medicaid eligibility). However, this requirement does not prevent other organizations such as HCHs from assisting applicants in completing the Medicaid application, providing information and referrals, obtaining required documentation and assuring that the information is complete.

Simplifying/Expediting Eligibility Determination

People who experience or at risk of homelessness (as well as other low income individuals and families) can benefit when a state simplifies its Medicaid eligibility determination process and/or takes additional steps to expedite the process. Medicaid regulations allow states great flexibility in conducting outreach and designing the Medicaid application and eligibility redetermination processes. As part of their efforts to reach more low-income families and children, many states have taken measures to simplify eligibility determination, including steps such as eliminating asset tests and reducing documentation requirements.

People who experience homelessness often do not have financial and medical records. They may even lose their identification, such as a driver's license. The only federally required documentation that a Medicaid applicant must provide is: (1) proof of disability, if a disability is required for Medicaid eligibility; (2) proof of citizenship; and, (3) for non-citizens, proof of legal immigrant registration from Citizenship and Immigration Services. States may require additional documentation or may collect self-reported information for other eligibility requirements such as income, assets, Social Security Number, and date of birth. States are required to verify an applicant's Social Security Number by contacting the Social Security Administration but applicants do not have a produce a Social Security card. With respect to citizenship, receipt of Social Security benefits is sufficient because SSA has already verified citizenship. In the wake of the new Deficit Reduction Act requirement regarding the verification of citizenship, some states (e.g., Oregon) now link directly into their vital records systems to obtain birth certificates. States can choose to verify other self-reported information to maintain program integrity. Some states, however, still require applicants to produce more documents than are federally required. To the extent that such requirements are reduced or eliminated, eligibility determination can be expedited.

Federal regulations require that applicants submit a written, signed Medicaid application. However, states may allow for remote applications to Medicaid, especially in the case of people who do not need to demonstrate a disability. Several States now allow people to submit applications via mail, phone, or the Internet and, in some states, a single application covers multiple benefit programs. Federal regulations do not require that applicants apply in person or submit to a face-to-face interview, although that remains the practice in many states. For phone applications, people must submit their required signature separately. For example, some states accept an application over the telephone and mail a printed version to the applicant, who signs and returns the document. For renewals, States can use passive renewals that only require a participant to respond if changes are necessary. If the person's contact information and financial information have not changed, eligibility is maintained without replying to the renewal notice.[10] Similarly, the Social Security Administration has created the capability for SSI and SSDI applicants to complete portions of the application process online.

In the case of low-income children, pregnant women, and women with breast or cervical cancer, states may establish a presumptive eligibility process in order to start Medicaid benefits as quickly as possible.[11] Presumptive eligibility is determined using

simplified procedures that may be conducted by non-Medicaid agency personnel (e.g., community hospital staff) under state parameters. A determination of presumptive eligibility must be followed quickly by the submission and review of a regular Medicaid application. Presumptive eligibility continues only so long as it takes to make a regular eligibility determination. There are no other similar federal presumptive eligibility provisions that apply to adults, including adults with disabilities. The Social Security Administration provides for expedited disability determination in the case of certain types of especially severe disabilities. A few states (e.g., Washington and Minnesota) expedite eligibility determinations for people with disabilities, employing back-up state-funded health care programs to pay for services in the event a person is found ineligible by SSA.

Connecting People to Medicaid Following Incarceration or Institutionalization[12]

Unfortunately, a high percentage of chronically homeless persons experience incarceration or episodes of institutionalization due to a mental health crisis. Federal law prohibits states from claiming Medicaid federal financial participation in the costs of health care services that are furnished to individuals during the period when they are incarcerated under the criminal justice system or while they are in an Institution for Mental Disease (IMD) (e.g., a state psychiatric facility). Many states unnecessarily terminate Medicaid eligibility altogether in these circumstances. When Medicaid eligibility is terminated and individuals are discharged, they face the prospect of having to secure Medicaid eligibility all over again. This can delay or impede the provision of critical Medicaid benefits such as behavioral health services that these individuals need when they return to the community. Moreover, when people in these circumstances do not have Medicaid but might be eligible, steps can be taken prior to release or discharge to secure Medicaid benefits.

Best practice in reducing chronic homelessness is to avoid discharging people who require behavioral health services without a plan to connect them to services and supports in the community. It is important to maintain or establish connections to people with mental illnesses who have been jailed or institutionalized and engage in effective discharge planning before their release or discharge so that they can transition back to stable community living arrangements with the services and supports that they need. Connecting people to benefits like Medicaid prior to discharge or release is important in preventing homelessness or exposing the person to recurring episodes of incarceration or institutionalization.[13]

Suspension of Medicaid Benefits

While states cannot claim Medicaid funding for services furnished to people who are incarcerated or served in an IMD, it is not a federal requirement that Medicaid eligibility be terminated while individuals are in jail or a mental health facility. Instead, a state may place the person in suspended status and return the individual to active Medicaid eligibility upon release from jail (including release to parole or probation) or discharge from the mental health facility.

In 2004, CMS issued a State Medicaid Director Letter to clarify federal policy in this arena (a link this letter is provided in the resources section at the end of this chapter). In this letter, CMS points out that incarceration or institutionalization:

> "… does not affect the *eligibility* of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD."

Instead of terminating Medicaid eligibility, CMS urged states to:

> "… establish a process under which an eligible inmate or [IMD] resident is placed in a suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility."

Several states (e.g., MD, MN, TX, and WA) have adopted policies to suspend Medicaid eligibility when a person is jailed, thus permitting the rapid restart of Medicaid services upon release.[14] In these states and others, partnerships have been developed between community agencies and the criminal justice system to coordinate pre-release activities to ensure the prompt reinstatement of Medicaid benefits when the person is released. Massachusetts has long had in effect policies designed to ensure that people who are hospitalized in psychiatric facilities are not discharged to the streets without necessary supports.[15] These policies include quickly reconnecting people to Medicaid.

Resuming eligibility for persons in the "disabled" Medicaid eligibility groups can be more complicated since it entails restarting SSI and/or SSDI benefits. When an SSI beneficiary is jailed, his/her benefits generally cease immediately. When incarceration is for fewer than twelve consecutive months, the person is placed in suspended status by the Social Security Administration. Individuals in this status may have their benefits reinstated upon release. If the Social Security Administration is notified in advance of release, the person's SSI benefit can be reinstated quickly. Action to restart benefits can begin prior to release. In states where Medicaid eligibility is automatically linked to SSI eligibility, restarting SSI restarts Medicaid. In states where there is not an automatic linkage between the two programs, suspending rather than terminating Medicaid eligibility facilitates connecting people to benefits post-release. If a person is incarcerated for more than 12 months, SSI is terminated and the person must apply for reinstatement. In the case of SSDI, benefits are suspended following conviction and confinement in jail for 30 or more days. SSDI benefits are immediately reinstated once release has been verified.

In the case of people who are placed in an IMD, SSI benefits are suspended after thirty days but can be reinstated quickly at discharge. SSDI benefits continue to be paid to individuals who been placed in an IMD. In either instance, suspension of rather than termination of Medicaid benefits enables people to be reconnected to services post-discharge.

Securing Medicaid Benefits in Advance of Release or Discharge

Securing immediate access to Medicaid when people leave psychiatric facilities and correctional facilities can play an important role in combating chronic homelessness, especially among individuals with mental illnesses and substance abuse disorders. To the extent that these persons can be connected to community behavioral health services as well as other services and supports immediately after discharge or release, the cycle of chronic homelessness can be broken. Many people with behavioral health disorders leaving facilities are at a high risk of homelessness because they may no longer have housing in the community.

In the case of people who did not have Medicaid eligibility prior to their confinement, steps may be taken to secure eligibility prior to release. Such steps include

completing Medicaid applications that can be submitted prior to discharge or release and acted upon when the Medicaid agency is notified of the person's actual release. Similar steps may be taken to start the Social Security disability determination process in advance of release.

Along these lines, several states have launched initiatives to connect people in facilities to services and supports, including Medicaid, following their discharge or release.[16] For example, in Maryland the Community Criminal Justice Treatment Program is a partnership between the mental health and criminal justice systems.[17] This program funds mental health case managers who participate in release planning at jails around the state. The case managers work with people before their release to connect them to community supports, including mental health services, addiction disorder treatment, and long-term housing supports funded by HUD's Shelter Plus Care program and matching local funds. For inmates who were on Medicaid before incarceration, the case manager helps them send a copy of their release papers to the Medicaid agency to resume benefits. These case managers also help individuals complete initial SSI and Medicaid applications, if necessary. Texas and Massachusetts also link prisoners with behavioral health disorders to community programs and services including Medicaid during the pre-release planning process.[18] Washington State has workers assigned to work directly with jails to facilitate effective pre-release planning.

Many people who experience chronic homelessness due to behavioral health disorders cycle and recycle through the criminal justice system and public institutions. States and localities can take steps to break these cycles by implementing effective pre-release and discharge planning processes so that people return to the community with necessary services and supports, including Medicaid benefits and housing.

Conclusion

People who experience or are at risk of homelessness frequently can benefit from third-party assistance in securing and maintaining Medicaid eligibility and, therefore, continuous access to Medicaid benefits. Federal policy permits third-parties to provide such assistance and affords opportunities for Medicaid agencies to partner with community agencies to increase access to Medicaid. States can take steps to avoid disruptions in Medicaid eligibility when people who have Medicaid eligibility are incarcerated or placed in psychiatric facilities. Other steps can be taken to address securing Medicaid benefits before people are released or discharged back to the community.

Resources

Publications

Centers for Medicare & Medicaid Services

Center for Medicaid and State Operations (May 25, 2004). State Medicaid Director Letter. *Ending Chronic Homelessness*
Available at: http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/SMDLetter.pdf

This letter clarifies federal policy with respect to the effects of incarceration or placement in an IMD on Medicaid eligibility.

Steve Eiken and Sara Galantowicz (2004). ***Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples***. Washington DC**:** The MEDSTAT Group, Inc. Available at:
http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/ImprovingMedicaidAccess.pdf

This publication describes how several states have improved access to Medicaid benefits for people who experience chronic homelessness.

National Health Care for the Homeless Council

Patricia A. Post (2001). ***Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid***. Nashville, TN.
Available at: http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf

This publication identifies problems and barriers that persons who experience homelessness face in securing and maintaining Medicaid eligibility based on a survey of Health Care for the Homeless centers.

James J. O'Connell, MD Paul D. Quick, MD and Barry D. Zevin, MD edited by Patricia A. Post, MPA (2004) ***Documenting Disability – Simple Strategies for Medical Providers***. Nashville TN.
Available at: http://www.nhchc.org/DocumentingDisability.pdf

This publication is intended to help primary care physicians and other health care professionals understand and effectively document disabilities for SSI and SSDI.

Center for Mental Health Services/Substance Abuse and Mental Health Administration

Rosen, J. and Perret, Y. (2005), *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults Who Are Homeless, with Social Security Disability and Supplemental Security Income Applications.* DHHS Pub. No. SMA 05-4051. Rockville, MD.
Available at: http://www.prainc.com/SOAR/tools/manual.asp

This manual is designed to help case managers and others assist adults who are homeless, especially adults who are homeless and have serious mental illnesses, apply for SSDI and SSI benefits. While this manual has been prepared for case managers working with individuals who are homeless, the information is useful for assisting anyone with the disability benefit application process and applicants themselves. It is likely to be helpful whether individuals are disabled by mental or physical illnesses and whether they are homeless or housed.

Bazelon Center for Mental Health Law

… (2006). ***Best Practices: Access to Benefits for Prisoners with Mental Illnesses***
Available at: http://www.bazelon.org/issues/criminalization/publications/BestPractices.pdf

This publication describes innovative approaches that state and county correctional systems are using to ensure that jail and prison inmates with mental illnesses have prompt access to income support, medical care and other services when they re-enter the community. A related, more technical Bazelon Center publication is: ***Finding the Key to successful transition from jail to the community: An Explanation of Federal Medicaid and Disability Program Rules.***
Available at: http://www.bazelon.org/issues/criminalization/findingthekey.html

Web Accessible Resources

CMS: FirstStep

Available at: http://www.cms.hhs.gov/apps/firststep/index.html

FirstStep is an interactive tool that can be used to assist individuals who are homeless to access federal benefit programs, including Medicaid, SSI, SSDI, TANF and others. FirstStep provides step-by-step guidance and advice about accessing these. See web-based resources below for additional resources of this type. The tool may be accessed on-line, downloaded to a personal computer, or obtained on CD-ROM.

Other on-line tools to assist in identifying potential benefits for individuals include:

GovBenefits.gov located at http://www.govbenefits.gov/govbenefits_en.portal and ***BenefitsCheckUp*** located at: http://www.benefitscheckup.org/.

Social Security Administration

The Social Security Administration provides various on-line tools and resources to assist individuals in learning about Social Security benefits for which they may qualify and to complete

some parts of the application process on-line. These tools are located at: http://www.ssa.gov/disability/ and include Disability Starter Kits (located at: http://www.ssa.gov/disability/disability_starter_kits.htm) and on-line application tools for adults (located at: http://www.socialsecurity.gov/applyfordisability/adult.htm)

Notes

[1] See especially Patricia A. Post (2001). *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid*. Nashville, TN: National Health Care for the Homeless Council.
[2] 42 CFR 435.908
[3] Based on Steve Eiken and Sara Galantowicz (2004). *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples*. Washington DC The MEDSTAT Group, Inc. The campus and LDRC became operational in 2005.
[4] For more information, go to http://www.uwsn.org/sup.php?id=133.
[5] Eiken and Galantowicz, *op. cit*.
[6] *Ibid*.
[7] 42 CFR 435.904
[8] Based on Eiken and Galantowicz, *op. cit*.
[9] Section 1905 of the Act. 42 CFR 431.10(c)
[10] Based on Eiken and Galantowicz, *op. cit*.
[11] Provisions regarding presumptive eligibility are located in §1920(a) of the Social Security Act and 42 CFR 435.1000 *et seq*. These provisions are confined to low-income children and permit a state to recover FFP during the period of presumptive eligibility.
[12] See Bazelon Center for Mental Health Law (2004). ***Finding the Key to successful transition from jail to the community: An Explanation of Federal Medicaid and Disability Program Rules*** for an in-depth technical discussion of the interplay between Medicaid and Social Security program rules and incarceration.
[13] Additional information about offender reentry programs is located at the U.S. Department of Justice, Office of Justice Programs (OJP) website: http://www.reentry.gov/publications/health.html
[14] There is more information about states that suspend Medicaid eligibility and/or connect people who are jailed to Medicaid benefits in Eiken and Galantowicz, op. cit.
[15] See policy at: http://www.ich.gov/innovations/1/IV%20F%20Massachusetts%20Dept%20of%20Mental%20Health%20Discharge%20Protocol.pdf and additional materials at: http://www.ich.gov/innovations/1/V%20C%20Behavioral%20Health%20Services%20and%20Discharge%20Planning.PDF.
[16] See Eiken and Galantowicz, *op. cit*. for a description of several of these programs.
[17] More information about this program see: Catherine Conly (1999) ***Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program.*** Washington DC: USDOJ, National Institute for Justice. Available at: http://www.ncjrs.gov/pdffiles1/175046.pdf#search=%22%22Community%20Criminal%20Justice%20Treatment%20Program%22%22.
[18] Eiken and Galantowicz, *op. cit*