Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples

Prepared for:

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Disabled and Elderly Health Programs Division

Prepared by:

Steve Eiken
and
Sara Galantowicz

The MEDSTAT Group, Inc.
Research and Policy Division
4301 Connecticut Avenue NW
Washington, D.C.

March 29, 2004

Table of Contents

This publication was produced under Contract Number 500-00-0021, Task Number 2, entitled "New Freedom Initiatives Research: Promising Practices II" sponsored by the Centers for Medicare and Medicaid Services, Department of Health and Human Services. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the Centers for Medicare and Medicaid Services or The MEDSTAT Group, Inc.. We gratefully acknowledge the many people, including people from States not highlighted in this report, who provided valuable information for the report.

Introduction

An estimated two to three million Americans experience a night of homelessness in any given year. Most of these people are homeless for only a short period of time and are not seen again in shelters or similar settings. About ten percent of these people, however, experience on-going, chronic homelessness. On any given night, these 200,000 to 300,000 people are close to half the homeless population. The President's proposed 2003 budget articulated a goal to end chronic homelessness by the year 2012 by encouraging local collaboration and awarding grants to support innovative strategies.

An important component of ending chronic homelessness is increasing access to mainstream health and social service programs for people who are homeless. Many people experiencing chronic homelessness heavily use health and social services, particularly from service agencies that target people who are homeless. However, their lack of stable housing and other barriers hinder their access to programs serving impoverished people in general, such as Supplemental Security Income, Food Stamps, housing subsidies, and Medicaid. These mainstream programs can increase ongoing support for people who are chronically homeless, which may reduce the demand for costly and inappropriate services such as emergency department visits and preventable hospitalizations.

This report presents several State initiatives that increase Medicaid access for people who are chronically homeless. This report is not a comprehensive description of Medicaid eligibility practices that benefit people who are homeless. For example, we excluded the many State efforts that increased access to the State Children's Health Insurance Program (SCHIP) because most people who are chronically homeless are single adults without children. Before the examples, we provide additional information about people who are chronically homeless and the Medicaid enrollment barriers they face. Medstat identified these barriers and State practices by reviewing reports on improving homelessness services, especially for individuals with disabilities that are common among people experiencing chronic homelessness: mental illness and addiction disorders. To obtain further information about these practices, we interviewed people from interest groups advocating services for people who are homeless, homelessness service providers, and State agencies.

Background

TERMINOLOGY

We used the definition of a "person experiencing chronic homelessness" that at least three federal departments use in planning how to reduce chronic homelessness. The Departments of Health and Human Services (DHHS), Housing and Urban Development (HUD), and Veterans Affairs use the following definition:

> 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.[1]

The Stewart B. McKinney Homeless Assistance Act defines a homeless person as:

> 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.[2]

CHARACTERISTICS OF PEOPLE EXPERIENCING CHRONIC HOMELESSNESS

Many factors contribute to chronic homelessness. According to a DHHS workgroup on the topic, up to 85 percent of people who are chronically homeless have disabling conditions, including mental illness, substance abuse, and severe health problems such as HIV/AIDS and tuberculosis. These people often have extensive and expensive histories with public programs such as shelters, hospital emergency departments, and the criminal justice system as a result of their conditions. Most people who are chronically homeless are single adults living by themselves. Often as a result of their disabilities, many of these individuals are disconnected from family members and other community supports that can provide a safety net against homelessness. Many people who are chronically homeless are racial or ethnic minorities and may be skeptical of service systems that do not demonstrate cultural competence. Other factors such as childhood trauma, lack of education, and poor life and job skills create additional barriers to self-sufficiency.

Evidence suggests that individuals experiencing chronic homelessness can transition to stable, productive community living when they receive stable housing and a wide array of services. Although the services necessary for this transition are often beyond the scope of a single provider, several initiatives have coordinated resources to assist people who are homeless.[3]

THE ROLE OF MAINSTREAM SERVICES

Mainstream health and social service programs are important funding sources for providing many services that can help people transition from chronic homelessness. Recognizing this, DHHS and HUD – with guidance and insight from federal agencies, state offices, local program representatives, and other parties – developed an interactive tool for outreach workers and case managers to assist people who are homeless in accessing mainstream programs.

---

[1] Department of Health and Human Services, Secretary's Work Group on Ending Chronic Homelessness. *Ending Chronic Homelessness: Strategies for Action* March 2003, p. 13.

[2] Section 330(h)(4)(A) of the Stewart B. McKinney Homeless Assistance Act, as quoted in Post, Patricia A. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid* National Health Care for the Homeless Council. May 2001. p. 4

[3] Examples of effective initiatives, and some the services these initiatives provided, are available at Department of Health and Human Services, Secretary's Work Group on Ending Chronic Homelessness *Ending Chronic Homelessness: Strategies for Action* March 2003 and 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.

This tool comprises information about mainstream programs that provide the following services:

- Income support,
- Food,
- Health coverage,
- Housing assistance,
- Employment services,
- Alcohol and drug abuse services, and
- Other critical care services, including mental health and counseling services.

The tool, called "First Step" is available at http://www.cms.hhs.gov/medicaid/homeless/firststep/index.html and on CD-ROM.

Within this array of programs, Medicaid is an especially important funding source. Medicaid can cover many services that treat the underlying causes of a person's homelessness. These services include mental health services, prescription drugs, medical services, addiction disorder treatment, and case management. There are important differences, however, between Medicaid and other mainstream federally funded programs like the Community Mental Health Block Grant, the Social Services Block Grant, and the Substance Abuse Prevention and Treatment Block Grant.

Medicaid is an individual entitlement program jointly administered by the federal and State governments. As an entitlement program, Medicaid is only available to individuals who meet financial and non-financial eligibility criteria. States have flexibility in defining eligibility criteria, but only within federal parameters. For example, Medicaid law defines federal minimum requirements for whom States must cover. States can expand Medicaid coverage, but generally only within six broad categories of individuals:

- People age 65 or older,
- Pregnant women,
- Parents and caretaker relatives with children under age 21,
- Children under age 21,
- People who are blind, and
- People with disabilities.

The same principle applies to services. Medicaid law defines required services and optional services States can add. Within federal guidelines, States have flexibility within Medicaid to define who is eligible, what services they can receive, and how much is paid for those services. For both eligibility and services, States can apply for waivers, subject to federal approval, to serve additional individuals or to provide additional services. Some promising practices in this report require a waiver under section 1115 of the Social Security Act to serve individuals not otherwise eligible for Medicaid.

BARRIERS TO MEDICAID COVERAGE

Individuals experiencing chronic homelessness face many challenges in both obtaining and maintaining Medicaid eligibility. In a 1996 point-in-time study, 55 percent of people using homelessness services had no health insurance. In contrast, thirty percent of the study respondents had Medicaid.[4] Health insurance coverage data on people who are chronically homeless is not available, but it is likely that fewer of these individuals have health insurance. The challenges this population faces in obtaining Medicaid are discussed below.

MANY PEOPLE WHO ARE CHRONICALLY HOMELESS ARE NOT MEDICAID ELIGIBLE. Often people who are chronically homeless do not fit into the six categories identified above. The majority of people experiencing chronic homelessness are childless, single adult males or non-custodial parents under age 65. As a result, they need to demonstrate blindness or another disability to qualify for Medicaid.

Thirty-nine states, and the District of Columbia, use the disability criteria for Supplemental Security Income (SSI) for Medicaid eligibility. Eleven states have the option to use more strict criteria, but no state can use more lenient disability criteria. SSI criteria exclude people whose disability is caused by alcoholism or substance abuse. For people with addiction disorders, reviewers must determine whether the person has other conditions, like mental illness, that would cause disability even if he or she were not using drugs or alcohol. Also, while people experiencing chronic homelessness often suffer from disabling conditions, their disabilities are not always sufficient to meet the SSI criteria. These criteria require participants to have a medical condition that prevents them from performing "any substantial gainful activity" and is expected to last at least one year or to result in death.[5]

In addition, some immigrants are chronically homeless. Most immigrants who have been in the country for less than five years are not eligible for Medicaid, except for emergency services.[6]

ELIGIBLE PEOPLE EXPERIENCING CHRONIC HOMELESSNESS FACE SEVERAL ENROLLMENT BARRIERS. Despite the high prevalence of disability among people who are chronically homeless, many of these individuals do not receive Medicaid benefits based on disability even if they may be eligible. As noted above, eligibility for SSI payments confers Medicaid eligibility in the majority of States. In a 1996 study, 39 percent of people who were homeless reported a mental health problem in the past month. Almost half of the study participants (46 percent) met the definition of chronic homelessness because they had been homeless for greater than one year. However, only 11 percent of study participants received SSI.[7]

Several providers serving people who are homeless said the SSI eligibility process creates a "Catch-22" situation. People with mental illness who are sufficiently impaired to meet disability criteria usually cannot navigate the process themselves. They may understate the severity of

[4] Results from this survey were published in December 1999. See Burt, Martha R., Laudan Y. Aron, Toby Douglas, Jesse Valente, Edgar Lee, Britta Iwen. *Homelessness: Programs and the People They Serve.* Urban Institute.
[5] Section 1614(a) of the Social Security Act.
[6] Refugees, persons granted asylum, and certain other immigrants are not subject to the five-year ban on Medicaid eligibility. See http://www.cms.hhs.gov/immigrants/ for details.
[7] Burt, Martha R., Laudan Y. Aron, Toby Douglas, Jesse Valente, Edgar Lee, Britta Iwen. *Homelessness: Programs and the People They Serve.* Urban Institute.

their condition during an assessment, and they may not be able to collect medical and financial records. Documentation is particularly difficult for people who are homeless because they may lose records by misplacing an item or as a result of theft. Also, initial denials of SSI are common, particularly for people alleging mental illness. Homelessness and mental illness both make it harder to appeal an initial denial of SSI. Many providers and advocates provide legal assistance once a person has filed an appeal because the assisting organization receives a percentage of any retroactive benefits. However, there is little available funding to assist people with initial applications.

People who are homeless face other challenges in addition to verifying their disability status. The Medicaid enrollment process can be especially difficult for people with limited education, transportation access, and English language skills. Also, the lack of a permanent address makes it difficult for Medicaid eligibility workers to communicate with the person, unless the person names an authorized representative to receive Medicaid communication. Even when a person receives Medicaid, the determination may not be made until 90 days after application, if a disability determination is necessary, or 45 days if the person is in another eligibility group. This long process often means that individuals may not receive Medicaid benefits for nearly three months. Many providers are reluctant to provide services without proof that a person is insured.

INDIVIDUALS WHO ARE CHRONICALLY HOMELESS FACE ADDITIONAL BARRIERS TO MAINTAINING MEDICAID ENROLLMENT. Even after qualifying for Medicaid, individuals can lose Medicaid benefits after any of three scenarios:

- Redetermination of financial eligibility,
- Incarceration under the criminal justice system, or
- Admission to an Institution for Mental Disease (IMD) such as a State psychiatric hospital.

States cannot always contact individuals who are homeless to perform financial eligibility redeterminations, which must occur at least once every 12 months. States often conduct redeterminations by sending participants a form requesting updated information. Some States terminate a person's enrollment if 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 can still 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.

The availability of Medicaid benefits after incarceration is particularly important to people who experience chronic homelessness. More than half of people who used homelessness services in the 1996 survey had been incarcerated in a jail, prison, or juvenile detention center.[8] The Medicaid law prohibits using federal funds to pay for services provided while a person is incarcerated, but allows payment for services upon the person's release.[9] Theoretically, the person is eligible for Medicaid immediately upon release and can receive services, unless the

[8] Ibid.
[9] Section 1905(a) of the Social Security Act.

time for the person's eligibility redetermination has passed. However, many States implement this requirement by terminating a Medicaid participant's enrollment upon incarceration. The person must then reapply for Medicaid to receive services upon his or her release.

People ages 22 to 64 admitted to Institutions for Mental Disease (IMD), including State psychiatric hospitals, face similar challenges. The same federal statute prohibits Medicaid payments for people in IMDs unless they are under age 22 or age 65 and older.[10] Some states enforce this law by terminating a person's Medicaid enrollment. A person must then submit a new application to receive Medicaid services upon discharge.

Promising Practices to Increase Medicaid Access

States can address many of the barriers noted above with the flexibility available in Medicaid. For example, States can use waivers to expand Medicaid access to almost all impoverished adults, including people under age 65, without a disability, and without dependent children. Changes in eligibility policy, such as eliminating financial documentation requirements, can facilitate enrollment and make it easier for people to remain Medicaid-eligible. In addition, States can combine changes in their eligibility determination process with outreach efforts to address other barriers, such as incomplete documentation of disability and incomplete applications.

This report will focus on three types of practices that have increased Medicaid access for people experiencing chronic homelessness:

- Expanding eligibility using waivers authorized by Section 1115 of the Social Security Act (1115 waivers)
- Assisting people leaving psychiatric facilities and correctional facilities (who are at risk of homelessness) to obtain Medicaid quickly
- Simplifying the eligibility determination process

WAIVERS TO EXPAND ELIGIBILITY

Eleven States and the District of Columbia have implemented 1115 waivers that expand Medicaid eligibility to impoverished adults under age 65 without children, regardless of disability.[11] Federal law requires 1115 waivers to be budget neutral for the federal government. States have used several different means to expand eligibility while meeting this requirement, including:

- Diverting funds previously paid to Disproportionate Share Hospitals

[10] Ibid. See Title 42 of the Code of Federal Regulations, section 435.1009 (42 CFR 435.1009) for a definition of an Institution for Mental Disease.

[11] The 11 States are Arizona, Delaware, Hawaii, Maine, Massachusetts, Michigan, New York, Oregon, Tennessee, Utah, and Vermont, according to descriptions of States' waivers at www.cms.gov/medicaid/. Arizona added a HIFA amendment to the 1115 waiver that authorizes the State's entire Medicaid program. This information does not include waivers that pay for only particular services, such as Family Planning waivers and Pharmacy Plus waivers.

- Diverting unspent dollars from its State Children's Health Insurance Program (SCHIP) allocation
- Requiring participants to use managed care
- Limiting benefits for some Medicaid participants that previously received full Medicaid coverage

States have implemented their 1115 waivers with the goal of increasing overall access to health insurance. While most States do not specifically target people who are homeless, these waivers make Medicaid available to many childless individuals who are homeless and who do not meet federal disability criteria. A few States have tracked their success in enrolling people who are homeless. Some of these States also increased outreach to this population. These States' waivers and outreach initiatives are described below.

MASSACHUSETTS: MassHealth, the Commonwealth's 1115 waiver, has been operational since 1997. This waiver extends Medicaid eligibility to a number of populations, including certain uninsured workers, low-income workers and their families, long-term unemployed adults, working and non-working people with disabilities, persons with HIV, and women with breast or cervical cancer. Of particular relevance to people who are homeless is the inclusion of long-term unemployed adults with income up to 100 percent of the Federal Poverty Level (FPL). As a result of this expansion, advocates and providers estimate that about half the Massachusetts residents who are homeless are currently eligible for Medicaid. In addition, the Commonwealth has waived the resource limit for people under age 65 when evaluating eligibility. Therefore, if an applicant has no income, eligibility can be established quickly, usually within 7 to 14 days.

There are seven levels of benefits available under MassHealth, tied to different eligibility categories. Both Essential and Basic coverage, the benefit levels generally available to long-term unemployed populations, include a range of services, such as hospitalization and community-based services, as well as mental health and substance abuse services. They do not include long-term care services and non-emergency transportation. For certain long-term unemployed persons, the Essential benefit replaced the similar Basic benefit, which the State dropped for selected groups in April 2003 as a result of budget cuts. The Essential benefit has a one-year appropriation, due to expire in October 2004, and is subject to an overall enrollment cap of 36,000. Indications are that the program will receive a second year of funding. Recipients of Essential MassHealth are required to enroll in the State's primary care clinician plan.

In order to reach out to the expansion populations, Massachusetts undertook a series of outreach activities to facilitate Medicaid enrollment. These included an incentive system providing cash bonuses to workers for enrolling people who are homeless, mini-grants to providers to augment their outreach and enrollment activities, and direct shelter outreach to provide on-site enrollment. While these initiatives have ended, the Commonwealth's "train the trainer" program has added the capacity to assist with completing and submitting MassHealth applications to many locations.

To better identify and serve people who are homeless, Massachusetts has placed a check-off box indicating homeless status on the MassHealth application form. This allows the Medicaid

agency to track applicants and beneficiaries who are homeless. Historically, the greatest challenge to Medicaid enrollment for people who are homeless has been receiving member notices and the initial benefit card. Previously, Massachusetts suspended enrollment if a beneficiary's mail was returned, including the initial Medicaid card. However, this practice was ended for people who are homeless. The Commonwealth also no longer terminates MassHealth if a person who is homeless fails to choose a primary care clinician (PCC). If a member does not choose a PCC, MassHealth will assign the member to a PCC. Eligibility for Essential is activated as soon the member is enrolled with a PCC. This policy also applies to continuing eligibility; people who are homeless are not automatically dropped if they fail to respond to redetermination notices.

NEW YORK: The Partnership Plan, New York State's 1115 waiver, extended Medicaid eligibility to childless adults previously covered under the State and county-funded Home Relief program in 1997. The State mandates managed care enrollment for most participants, but exempts many people who are homeless. All New York City participants who are homeless are exempt from managed care, and counties outside New York City may exempt individuals residing in the homeless shelter system. SSI participants and individuals with a diagnosis of serious mental illness or HIV also are exempt from required managed care enrollment. In addition, several counties in upstate New York do not require Medicaid participants to enroll in managed care because county residents do not have a choice of managed care plans. Medicaid participants who are homeless and who choose to use a managed care plan may receive expedited disenrollment if they want to leave managed care. The expedited disenrollment is retroactive to the first day of the month the person requests disenrollment.

According to State officials and advocates, the transient nature of the homeless population makes managed care impractical because individuals often may find themselves far from their primary care provider when they need medical services. This is especially true in New York City since people often move throughout the city when using the shelter system, sometimes even to a different borough.

To cover additional uninsured people, New York subsequently amended this waiver to include additional childless adults with income up 100 percent of FPL, and caretaker parents with income up to 150 percent of FPL, who are not otherwise eligible for Medicaid. Beginning October 1, 2001, these two groups became eligible for a limited Medicaid benefit called Family Health Plus. This health care benefit, provided through managed care plans, is comparable to commercially offered health insurance. The State mandates managed care enrollment for all people receiving Family Health Plus.

To facilitate the application process overall, the State no longer requires Medicaid applicants to document their social security numbers, unless they cannot be validated through other sources. Furthermore, applicants who were previously on Medicaid do not have to produce documentation that has already been verified by the program once, such as a birth certificate, when the information is not subject to change. Also, beginning in the summer of 2004, Family Health Plus participants will only be required to attest to, rather than document, their financial resources.

ARIZONA: The entire Arizona Medicaid Program operates as an 1115 demonstration project, known as the Arizona Health Care Cost Containment System (AHCCCS), with mandatory managed care enrollment for most populations. A 2001 Health Insurance Flexibility and Accountability (HIFA) amendment to this waiver expanded eligibility to childless adults and other individuals with incomes up to 100 percent of FPL. This population is eligible for the full Medicaid benefit. Providers estimate that as a result of the expansion approximately 30 percent of people who are homeless are eligible for either Medicaid or Medicare.

Arizona has historically engaged in a number of outreach initiatives to educate and assist all AHCCS beneficiaries, including people who are homeless, about the AHCCCS program. State staff conduct on-site training for shelter staff, Health Care for the Homeless grantees, and other staff serving this population on how to assist low-income individuals with the application process. In addition, they try to link provider staff with AHCCCS district office staff so they can develop a productive working relationship. According to State staff, getting program information, including benefit cards, to people who are homeless is a real challenge. AHCCCS works with homeless shelters as potential mail recipients for homeless beneficiaries. However, a recent change in the redetermination schedule, mandated by the State legislature, that shifts the timetable from 12 months to six months, may further exacerbate this problem of locating AHCCCS participants who are homeless.

In March 2004, the Day Resource Center (DRC) opened in Phoenix to provide a walk-in, one-stop shop for services to people who are chronically homeless. The DRC will be an integral component of a new Human Services Campus – developed through collaboration with faith-based, governmental, non-profit, private and community organizations – that will be operational in 2005. The DRC focuses on three objectives: 1) providing a safe place during the day, 2) engaging people who are chronically homeless and who have been reluctant to participate in formal service provision, and 3) providing a "one stop" location for people who are homeless to access mainstream resources and integrated services.

The DRC is staffed and supported by a wide range of participating organizations, including the Department of Economic Security, which determines eligibility for AHCCCS. DRC staff and participating agencies assist people who are homeless in applying for housing, health, and other benefits. Applications for AHCCCS can be filed on-site. The organization Advocates For The Disabled provides legal counsel to assist people who are homeless in applying for SSI, which confers automatic Medicaid eligibility in Arizona. In addition, provider outreach teams identify people who are chronically homeless and accompany them to the DRC during specially designated hours.

DELAWARE: Delaware's 1115 waiver, the Diamond State Health Plan, expanded Medicaid eligibility to uninsured adults, including those without children or a disability, with incomes up to 100 percent of FPL. The eight-year-old program also waives the asset requirement for Medicaid. The State estimates most people who are homeless now receive Medicaid. In January 2004, 1,169 people who were homeless received Medicaid, based on self-reported data maintained by the State's social service eligibility database. State estimates of Delaware's homeless population on a given night range from 1,125 to 1,500 people, suggesting that at least 78 percent of people who are homeless are Medicaid participants.

Delaware uses expanded eligibility and general outreach activities to reach people who are homeless, and has not conducted outreach specifically for this population. The State's Medicaid agency, the Department of Health and Social Services, contracts with a Health Benefits Manager to conduct outreach to the uninsured. The Health Benefits Manager is available at community centers, clinics, and other places where eligible people may be found.

Many Diamond State Health Plan participants receive their services from a managed care organization. To ensure access to community health clinics, all the managed care organizations contract with Federally Qualified Health Centers. For people with serious and persistent mental illness, fee-for-service behavioral health services are available through the State's Division of Substance Abuse and Mental Health.

ELIGIBILITY PRACTICES RELATED TO DISCHARGE PLANNING

Immediate access to Medicaid when people leave psychiatric facilities and correctional facilities is an important part of increasing Medicaid access for people at risk of chronic homelessness. This population has a high risk of entering these facilities, and possibly losing Medicaid enrollment, because mental illness and addiction disorders afflict many people who are chronically homeless. Also, people leaving these facilities are at a high risk of homelessness because they may no longer have housing in the community. Several initiatives that have increased Medicaid access for people leaving jails, prisons, and psychiatric facilities are described below.

MARYLAND: Maryland maintains incarcerated Medicaid participants on their enrollment list, even if the person has been incarcerated for more than 30 days. Maryland notes the incarceration in its information system to prevent claims payment. Keeping people on the enrollment list allows the person to immediately obtain Medicaid services once Medicaid is informed of the person's release.

Medicaid often learns about participants' release from incarceration from the Community Criminal Justice Treatment Program, a partnership between the mental health and criminal justice systems. This program funds mental health case managers, located at local jails in Baltimore City and the State's 23 counties, who assist in release planning for 5,300 people per year. 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. The case managers also help individuals complete initial SSI and Medicaid applications if necessary.

The Maryland Department of Health and Mental Hygiene started each local program with seed grants to the local Core Service Agency, with an expectation that counties contribute local funds to support the program on an ongoing basis. Each Core Service Agency, which administers community mental health services at the local level, contracts with a non-profit organization to provide case management.

MASSACHUSETTS: Concerned about the large number of people re-entering homelessness from institutional settings, Commonwealth officials, providers, and homeless advocates in Massachusetts developed a common set of discharge protocols for individuals leaving institutions in the Commonwealth who are at risk of homelessness. These protocols include assessment tools for determining risk of homelessness, as well departmental policies and resource materials. The Massachusetts Department of Mental Health developed zero tolerance policies for its own facilities in 1983, reviewed those policies in 2001, and promulgated regulations that applied more broadly to a range of mental health facilities, including privately owned inpatient psychiatric facilities. Working with these inpatient psychiatric facilities, the Department of Mental Health is aiming for a goal of near zero tolerance for discharge to homelessness. In addition, members of the working group are looking at discharge planning across county jails and other institutions, to identify people at high risk for homelessness and link them with appropriate agencies, including Medicaid. More information on these protocols can be found at http://www.ich.gov/innovations/1/.

The Commonwealth also has several pilot projects to assist individuals to receive Medicaid benefits upon release from the criminal justice system. Formal re-entry programs initiate application for MassHealth 30 days prior to discharge in rural Bristol County and in Suffolk County, which includes Boston. All application paperwork is completed in advance, so that the individual is poised for approval upon discharge.

In Hamden County (which includes Springfield), Behavioral Health Networks (BHN), a local community mental health center, has a contract to provide services to the Hamden County Correctional Center. When inmates are within three months of their projected release date, a discharge planner from the agency completes a MassHealth application and faxes it to the State Medicaid agency. As expected, the application is denied because the applicant is incarcerated. However, MassHealth maintains the application on file. When the discharge planner faxes the paperwork showing the applicant has been released, the application is activated and approved. Also, when an inmate is approaching release, the discharge planner tries to make appointments with a community provider during the first few weeks following discharge. Inmates are given a 30-day prescription for their medications upon discharge, along with a four-day supply. If the person has difficulty securing an appointment within 30 days of release, she or he can call BHN and a physician will call in an additional prescription to continue medications.

MINNESOTA: When a Medicaid participant enters an Institution for Mental Disease (IMD) and is no longer eligible for Medicaid coverage of services, Minnesota replaces Medicaid with a state-funded health insurance program. One agency administers both programs through the same information system. When people are discharged from an IMD, the facility notifies a local eligibility worker, who can start Medicaid coverage by simply changing a program code in the information system. Minnesota also uses state funds to subsidize housing payments for up to 90 days for people admitted to psychiatric hospitals. These funds allow short-term patients to keep their housing in the community.

TEXAS: For people in jail less than 30 days, Texas suspends Medicaid enrollment instead of terminating enrollment. This allows quick access to Medicaid upon notification of release. The Texas Health and Human Services Commission, the State's Medicaid agency, also is part of the

interagency Texas Council on Offenders with Mental Impairments (TCOMI). The State legislature established TCOMI to identify and treat people with special needs in contact with the criminal justice system.

TCOMI started a Continuity of Care system in 1994 that provided discharge planning for 3,305 people in State fiscal year 2002. Seven Eligibility Benefit Specialists and 27 case managers (called Continuity of Care workers) work with the correctional facilities to assist people leaving these facilities. TCOMI staff first contact inmates within 6 months of their expected release date. Continuity of Care workers develop pre-release plans in conjunction with the primary provider the inmate will use in the community. Continuity of Care workers also provide up to 90 days of follow-up after a person's release. With the inmate's permission, an Eligibility Benefit Specialist gathers necessary information from the facility and the community and submits applications to SSI, Medicaid, State-funded prescription drug programs, mental health services, substance abuse treatment, and other supports 90 days before release.

TCOMI focuses on 30 to 40 prisons, State-operated jails, and substance abuse incarceration facilities with high percentages of people with special needs. These correctional facilities house most inmates who are separated from the general population because of substance abuse and dangerous or inappropriate behaviors.

WASHINGTON: Like Texas, Washington State suspends Medicaid enrollment for people in jails up to 30 days. Washington also has established two partnerships between the State Medicaid agency and correctional facilities to allow quicker access to Medicaid. First, the Department of Social and Health Services (DSHS) outstations an eligibility worker at the Seattle Municipal Justice Center (MJC) in King County, so people leaving the jail there can arrange to receive their Medicaid coupons upon leaving the facility. The King County partnership is part of that county's effort to address jail overcrowding. Jail staff notify the DSHS eligibility technician when an inmate is 45 days from his or her projected release date. The eligibility worker then collects medical and financial information for the Medicaid eligibility process, and helps the person obtain substance abuse treatment, mental health services, and income support. DSHS also waives the face-to-face interview requirement for certain jail inmates with mental illness or addiction disorder treatment needs. The new Seattle MJC was designed with a space for social services, and newly released inmates can walk down the hall to access services.

The on-site person also assists people in community detention (i.e., probation or parole) and people identified by a nearby homelessness service provider's outreach program. State staff estimate the current half-time person helps 100 people obtain services during a year, and offers quick information and referral to many others.

The county is in the process of contracting for an additional full-time DSHS eligibility worker to handle the various specialty programs in the jail. The additional contracted full-time eligibility worker is expected to allow for expanded services to the jail and to courts targeting people with special needs, like the mental health court and the drug court.

Second, DSHS works with the State Department of Corrections regarding a small minority of prison inmates that the State's criminal justice system labels Dangerously Mentally Ill Offenders

(DMIOs). Only 66 DMIOs left prisons or civil commitment in a State psychiatric hospital between April 2000 and June 2002. DSHS designates a local office in each of six regions to process applications for income support and health and social services. The prison faxes or mails the inmate's relevant medical records and financial eligibility information to the designated local office, which makes an eligibility determination based on these records. DSHS also waives the standard face-to-face interview for General Assistance (a state-funded income support program) and Medicaid for these offenders. The State legislature allocated special funding to provide more intensive supervision and services for these offenders upon their release into the community.

Both of Washington's partnerships use the State's own disability determination process, rather than the Social Security Administration's determination process. The State's process is quicker and increases the chance that state-funded medical coverage or Medicaid is available upon release. Washington exercises a State plan option to use the State's disability determination service to authorize expedited Medicaid coverage until a final SSI decision is reached. DSHS SSI facilitators, who specialize in the SSI application process, then help the person obtain SSI. Many States with state-funded income support programs, like General Assistance, exercise this option. If the person receives Medicaid services and – after all appeals – SSI determines the person is not eligible, the State must return the federal share of Medicaid service payments. This rarely occurs. When it does, Washington uses a state-funded health services program, Medical Care Services, to pay for these services. The state-funded program is also available for functionally impaired and poor individuals who do not meet SSI disability criteria but who meet more lenient State disability criteria.

SIMPLIFIED ELIGIBILITY DETERMINATION

States can improve Medicaid access for people who are homeless by simplifying the eligibility determination process. Medicaid regulations allow States great flexibility in outreach and in the Medicaid application and eligibility redetermination processes. This section highlights changes in outreach and eligibility determination that may benefit people who are chronically homeless. Many states have implemented some of these practices to reach families and children eligible for Medicaid and SCHIP, but they can also benefit people who qualify for Medicaid because of a disability (in addition to meeting financial requirements). Since several states have implemented these practices, we did not highlight a particular State.

OUTSTATIONING FINANCIAL ELIGIBILITY STAFF: As part of their Medicaid outreach efforts, most States outstation financial eligibility workers at providers that serve a large proportion of poor people. For example, States must outstation financial eligibility workers to all Federally Qualified Health Centers that serve Medicaid-eligible pregnant women and children under age 19, unless the CMS approves an alternative outreach plan to reach pregnant women and children.[12] Federally Qualified Health Centers are community health clinics that provide preventive health services and health care to underserved populations. These clinics include over 150 Health Care for the Homeless (HCH) grantees, which target people who are homeless.[13]

[12] 42 CFR 435.904.

[13] See Department of Health and Human Services, Health Resources and Services Administration. *2002 Health Care for the Homeless Grantee Profiles* September 2002 at http://bphc.hrsa.gov/hchirc/directory/default.asp for a directory of Health Care for the Homeless grantees.

States are not required to outstation financial eligibility staff to all HCH grantees because many grantees do not serve pregnant women and children.

However, outstationing financial eligibility workers at HCH grantees can improve Medicaid access for people who are chronically homeless. HCH grantees can assist Medicaid applicants on their own, but only the State can determine Medicaid eligibility. On-site eligibility staff can address common barriers for people who are chronically homeless, especially applicants' lack of follow-through. First, the eligibility staff are 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 have written permission from the applicant. Third, outstationed staff could 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. A few States also outstation eligibility workers to homeless shelters, although one State (Utah) discontinued this practice because demand was low.

REDUCING FINANCIAL DOCUMENTATION REQUIREMENTS: States can also increase access to Medicaid by reducing documentation requirements. This is particularly important for people who are homeless because they may not have financial and medical records. They may even lose their identification, such as a driver's license or a birth certificate. The only federally required documentation the applicant must provide is 1) proof of disability if a disability is required for Medicaid eligibility, and 2) for non-citizens, proof of legal immigrant registration from Citizenship and Immigration Services. States may require additional documentation or they may collect self-reported information for other eligibility requirements such as income, assets, Social Security Number, and date of birth. The only information States are required to verify is the Social Security Number; States must do this by contacting the Social Security Administration. States can choose to verify other self-reported information to maintain program integrity.[14] The following is a list of information that some States request from Medicaid applicants, but that are not federally required:

- Proof of income, such as pay stubs
- Proof of assets, such as bank account statements
- Proof of Social Security Number
- Proof of identification such as a driver's license or birth certificate
- Repetition of previously collected information during a redetermination (States can print the information they currently have and ask for changes)
- Applicant's signature during renewal (Signatures are required for initial applications)

ALLOWING REMOTE APPLICATIONS: The lack of federally required documentation enables States to allow remote applications to Medicaid, especially for people who do not need to demonstrate a disability. According to the Kaiser Family Foundation, 46 States do not require a face-to-face interview for children that apply for Medicaid. Several States now allow people to submit applications via mail, phone, or the Internet. For phone applications, people must submit their required signature separately. For example, some states accept an application over the telephone

[14] A more detailed description of the flexibility States have to enroll Medicaid participants and to conduct Medicaid redeterminations is available at http://www.cms.hhs.gov/schip/outreach/progress.pdf.

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, they maintain eligibility without replying to the renewal notice.

SSI FACILITATION: Like Washington State, several states assist people in applying for SSI and use Medicaid to pay for medical services while the application is pending. SSI requires more financial documentation than the federal Medicaid requirements, so this practice allows people with disabilities to receive Medicaid while collecting the necessary documents for SSI. In some states, this practice also allows people to collect additional medical records for SSI determination, if the state is willing to make a disability determination with less medical information than SSI requires.

Conclusion

People who are chronically homeless face significant barriers to Medicaid enrollment. Some people are not eligible for Medicaid unless the state uses a waiver to expand eligibility. The eligibility determination process itself presents barriers, particularly for people with no address and for people with mental illness and addiction disorders. Also, people can quickly lose their Medicaid enrollment by incarceration, admission to an Institution for Mental Disease, or by not completing a required redetermination process.

Several States have improved this population's access to Medicaid. Many initiatives highlighted in this report targeted a more broad population than people who are homeless. For example, states covered childless adults in 1115 waivers and simplified their eligibility procedures to reduce the number of uninsured people in general. Also, some Medicaid agencies coordinated with prisons or jails to cooperate with efforts to reduce criminal recidivism, not necessarily to reduce homelessness. States adopting similar initiatives to reduce chronic homelessness may find that the benefits and costs of their efforts reach well beyond the people who are chronically homeless.

Sources

Bazelon Center for Mental Health Law. *Finding the Key to Successful Transition from Jail to Community*. March 2001. Accessed March 2004 at http://www.bazelon.org/issues/criminalization/findingthekey.html.

Burt, Martha R., Laudan Y. Aron, Toby Douglas, Jesse Valente, Edgar Lee, Britta Iwen. *Homelessness: Programs and the People They Serve.* Findings of the National Survey of Homeless Assistance Providers and Clients. Urban Institute for the Interagency Council on Homelessness. December 1999. Accessed March 2004 at http://www.huduser.org/publications/homeless/homelessness/.

Common Ground, Kelly Point Partners, and Clegg & Associates. *Housing for High Risk Offenders: A Partnership for Community Safety: Phase One Final Report* Washington Department of Corrections. July 2002. Accessed March 2004 at http://www.doc.wa.gov/communityprotection/PartnershipReportfinal8802.doc.

Conly, Catherine. *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program* Department of Justice, National Institute of Justice. April 1999. Accessed February 2004 at http://www.ncjrs.org/pdffiles1/175046.pdf.

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. January 2002. Accessed March 2004 at http://www.fanniemaefoundation.org/programs/hpd/pdf/hpd_1301_culhane.pdf.

Delaware Department of Health and Social Services *Original State Health Plan, Delaware Medicaid Managed Care 1115 Waiver Protocol Document* October 23, 1995. Accessed February 2004 at http://www.cms.hhs.gov/medicaid/1115/dedsopprot.pdf.

Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage* August 2001. Accessed March 2004 at http://www.cms.hhs.gov/schip/outreach/progress.pdf.

Department of Health and Human Services, Centers for Medicare and Medicaid Services, *FirstStep* March 2004. Accessed March 2004 at http://www.cms.hhs.gov/medicaid/homeless/firststep/index.html.

Department of Health and Human Services, Centers for Medicare and Medicaid Services. *State Medicaid Manual* October 1999. Accessed March 2004 at http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp.

Department of Health and Human Services, Health Resources and Services Administration. *2002 Health Care for the Homeless Grantee Profiles* September 2002. Accessed March 2004 at http://bphc.hrsa.gov/hchirc/directory/default.asp.

Department of Health and Human Services, Secretary's Work Group on Ending Chronic Homelessness *Ending Chronic Homelessness: Strategies for Action* March 2003. Accessed March 2004 at http://aspe.hhs.gov/hsp/homelessness/strategies03/.

Griffin, Patricia A., Michelle Naples, Richard K. Sherman, Mark Binkley, and Kristin Stainbrook. "Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Abuse Disorders" The National GAINS Center for People with Co-Occurring Disorders in the Justice System. Revised Spring 2002. Accessed February 2004 at http://www.gainsctr.com/pdfs/fact_sheets/Maintaining_Medicaid_02.pdf.

Homeless Planning Council of Delaware. *Delaware Continuum of Care Application*. Submitted to the Department of Housing and Urban Development. 2003. Accessed March 2004 at http://www2.State.de.us/dsha/2003%20Cont%20of%20Care.pdf

Inter-Agency Council on Homelessness *Innovative Initiative One* April 25, 2003. Accessed March 2004 at http://www.ich.gov/innovations/1/.

Kaiser Family Foundation. *State Health Facts Online* Undated. Accessed March 2004 at http://www.Statehealthfacts.kff.org.

Kanapaux, William. *Criminal Justice Primer for State Mental Health Agencies* National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning. September 2002. Accessed March 2004 at http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/Primer.pdf.

Koyanagi, Chris. *A Better Life—A Safer Community Helping Inmates Access Federal Benefits* Bazelon Center for Mental Health Law. January 2003. Accessed February 2004 at http://www.bazelon.org/issues/criminalization/publications/gains/index.htm.

Massachusetts Division of Medical Assistance *Medical Benefit Request Form* Revised November 2003 Accessed March 2004 at http://www.State.ma.us/dma/hivservices/mbr.pdf

Massachusetts Division of Medical Assistance *MassHealth 1115 Demonstration Project Annual Report, SFY2001* March 2002. Accessed March 2004 at http://www.State.ma.us/dma/researchers/res_pdf/1115_2001-demo4AR.pdf

National Association of State Medicaid Directors, *Aged, Blind, and Disabled Medicaid Eligibility Survey*. 2002. Accessed January 2004 at http://www.nasmd.org/eligibility/default.asp.

National Health Care for the Homeless Council "Mainstreaming Health Care for Homeless People" December 2003. Accessed March 2004 at http://www.nhchc.org/Publications/Mainstreaming.pdf

Post, Patricia A. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid* National Health Care for the Homeless Council. May 2001. Accessed March 2004 at http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf.

Shaner, Heidi. *Dual Eligible Outreach and Enrollment: A View from the States* Department of Health and Human Services, Centers for Medicare and Medicaid Services. March 1999. Accessed January 2004 at http://www.cms.hhs.gov/dualeligibles/oereport.pdf.

Texas Council on Offenders with Mental Impairments. *The Biennial Report of the Texas Council on Offenders with Mental Impairments* 2003. Accessed March 2004 at http://www.tdcj.State.tx.us/publications/tcomi/TCOMI-Biennial-Report-2003.PDF.

Washington Department of Social and Health Services, Medical Assistance Administration. *Medical Assistance Eligibility Overview* April 2003. Accessed January 2004 at http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicalOverview.htm